SCOTTISH DRUG STRATEGY DELIVERY COMMISSION

INDEPENDENT EXPERT REVIEW OF OPIOID REPLACEMENT THERAPIES IN SCOTLAND

DELIVERING RECOVERY

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INTRODUCTION

The past 30 years has seen the emergence of substance misuse as a significant cause of illness and early death in Scots. Initially, many of these drugs were injected and sharing of injecting equipment led to the spread of viruses such as those responsible for AIDS and hepatitis. The adoption of oral opioid replacement therapy, usually with methadone, had a significant impact on injecting behaviour, reducing the spread of these diseases. There is little doubt that the use of methadone has had an important and beneficial effect in preventing the spread of viruses amongst drug users.

Methadone use often simply switches one pattern of drug use for another, albeit one which is safer and more manageable. However, methadone treatment is far from risk free and the challenge for Scotland is to find ways of supporting people who are addicted to opioids to achieve sustainable recovery. Despite good progress in a number of local areas where attempts have been made to create local systems to support recovery from addiction, these approaches are not widespread in Scotland and there has been concern about variation in practice and the effectiveness of such attempts. This Independent Review focuses attention to the need to find effective interventions to help recovery and ensure they are implemented.

In the past few years, NHSScotland has embraced the concepts of improvement science. Systematic application of evidence based interventions has transformed the quality of NHS care in Scotland. There is a clear need to apply these new methods to the problems of recovery. Experience suggests that concerted efforts across Scotland using this approach of improvement science will produce significant and sustainable benefits, not just in NHS services but all services supporting recovery. This is especially vital in this area where those with addictions mean they are often amongst the most marginalised and deprived in our society.

The task is not straightforward. Overcoming the stigma and further increasing the numbers of people in recovery will be challenging – but achievable. Adverse social circumstances and lack of social support will require attention as well as the addiction. The integrated health and social care system in Scotland presents us with clear opportunities for success and committed leadership will be an important driver of improvement. The information and evidence in this report is a positive starting point and will, without doubt, trigger further debate. I extend my thanks to its authors and all who assisted them. We now have a good platform to bring people together to co-create a cohesive plan of action for improvement to deliver the outcomes this report directs us towards. More people in recovery; more families and communities free from the damaging impacts of drug addiction.

Sir Harry Burns

The Chief Medical Officer for Scotland

FOREWORD

"For a successful technology, reality must take precedence over public relations, for nature cannot be fooled."

Richard P. Feynman

Nobel Laureate Professor Feynman was a member of the Rogers Commission – convened to consider the deaths of seven astronauts who were aboard the ill-fated Challenger space shuttle in 1986. His comments reflected his view that the Commission had struggled to address the real issues – the evidence – due to concerns about negative public opinion. In 2011, 584 young Scots died in association with their use of illicit drugs. In this context, Professor Feynman's statement remains relevant.

This report describes the findings of an independent review of treatment for those experiencing substance use problems in Scotland. It reflects work undertaken over six months by a small review team, with guidance from a steering group of leading Scottish professionals in the field. Helpful feedback was also received from international experts.

The review was undertaken at the request of the Chief Medical Officer for Scotland, Sir Harry Burns, in response to a public debate regarding the perceived failure by some of the current Scottish strategy – *the Road to Recovery*[1]. This had been fuelled by drug death statistics which had revealed a continuing increase in fatalities. The medical treatment, Opioid Replacement Therapy using the drug methadone, had become the focus of concern.

One key aim was to hear a broad range of views. We took evidence from as many stakeholders as possible - from professionals delivering care, to commissioners, academics and representatives of national bodies. We also met many people who had experienced treatment first hand as well as their families and friends. The review process has been as inclusive as we could make it. The review team missed no opportunity to include any stakeholder. We thank all participants for their frankness and patience as we have tried to develop an understanding of the issues. Some have given permission for us to attribute their comments – but many have not and we have honoured this position in the report.

Five years ago, *the Road to Recovery*[1] promised much. It raised the bar regarding expectations of treatment services – easier access; more choice; better quality of assessment, care planning and delivery; a focus on outcomes; more hope of recovering and being supported to progress from problematic substance use. This report aims to give a platform from which to further improve the outcomes for Scots with substance use problems.

Dr Brian A. Kidd

Independent Chair, Drug Strategy Delivery Commission

ACKNOWLEDGEMENTS

The review team would like to acknowledge the many individuals who have helped us to complete this comprehensive independent review.

Our steering group has guided us through the process and ensured that, while focusing - through necessity - on the issues around Opioid Replacement Therapies, we have considered much broader aspects of how people experiencing substance use problems may be supported, treated and encouraged to improve their lives and achieve their own recovery. Inevitably, in such a tight timeframe, there has been a need to prioritise and the steering group has helped ensure we have not been distracted from the core work of the review. The steering group has also encouraged and supported us in our novel approach to evidence-gathering, ensuring that a wide range of opinions has informed our conclusions and recommendations.

The international experts have been an important touchstone for the review. While the challenges faced here are distinctly "Scottish", it is our view that it is essential that our approaches and performance are considered in context and held up against international evidence. We can learn a lot from such a perspective.

Those responsible at national and local level for the delivery of *the Road to Recovery*[1] have been eager to ensure we have had access to the information we needed to understand the challenges currently faced in Scotland. All Alcohol and Drugs Partnerships (ADPs) responded to our questionnaire and the various government departments involved in the area of problem substance use have made themselves readily available, supplying reports, data and helpful commentary. Their frankness and honesty is commendable and reflects that there is a strong desire at all levels to improve.

Many national and local organisations have approached us to help and have supplied valuable information on their particular areas of interest or expertise. Again, the honesty with which they have engaged with this process is to be commended – it is a difficult task to be objectively critical of oneself, one's organisation or one's partners – especially when these views may appear in a public document.

The stakeholders we have met include service users and their families as well as those delivering a wide range of services, interventions and support to people whose lives are affected by substance use. We have been humbled by the reports of their experiences – but also encouraged by the sense that both those delivering services and those receiving them are much closer in their views and expectations than may be expected by some commentators.

Finally, we wish to thank the ORT Secretariat – Irene Bruce and Karen MacRae. They have worked tirelessly to complete this work and have effectively managed the independent group.

EXECUTIVE SUMMARY AND RECOMMENDATIONS

Background

The Chief Medical Officer for Scotland, Sir Harry Burns, commissioned a review of the place of Opioid Replacement Therapies (ORT) to:

- Ensure that these interventions are being used appropriately and in line with the international evidence base as part of a person-centred recovery focused approach; and

- Consider where further improvement may be made to contribute to the quality emphasis of Phase Three of *the Road to Recovery*[1] strategy delivery programme.

The review

The team reviewed the international evidence for the effectiveness of ORT and the relevant guidance and standards for clinicians and treatment services. They also surveyed all Scottish Alcohol & Drugs Partnerships (ADPs) regarding treatment delivery and local plans to support recovery and also took extensive evidence from a wide range of stakeholders – including service users and their families. The review process and the report writing were guided by a steering group. The draft report was commented on by a group of international reviewers from a range of backgrounds and philosophies.

Context

Scottish strategy and practice have evolved logically in the face of the challenges presented by problematic substance use over the last 30 years. Patterns of substance use problems are strongly associated with a wide range of social, psychological and physical issues. There is a need to ensure local systems of care take these inequalities into account to better address the high levels of morbidity and mortality experienced by this group.

Generic primary care providers – such as both General Practitioners and Community Pharmacists – have been important elements of the system of care offered to substance users and as professional groupings have strongly supported delivery of care for this group. However, there are still huge inconsistencies across the country in terms of even availability of treatment via primary care or the range or quality of care available. Despite the high risks carried by this group, contracting processes in primary care still support an “opt-in” approach to delivering treatment – even in the higher risk communities.

Good practice

The review team identified examples of good practice from around Scotland and many of these have been used throughout the report to help improve the quality emphasis of Phase Three of *the Road to Recovery*[1].

RECOMMENDATIONS

The review makes 12 recommendations set out in the table below under the following six themes.

Theme 1: Social exclusion and health inequalities (Recommendations 1-2)

The demographic characteristics of those using substances who might benefit from ORT have changed in recent years. The average age of the group has markedly increased suggesting that the degree of both physiological and psychological difficulty, already high, is likely to increase further. Equally, as health inequalities continue to increase so the effects on this already multiply deprived and marginalised group will become more extreme.

These factors further compounded by the effects of stigma, will produce a picture of increasingly complex social and medical difficulty which will require a more coordinated approach from all providers of social and medical care than is currently the case. This is especially true of Primary Care whose involvement, whilst excellent in some areas, seems inconsistent and sometimes absent in others. This is a problem driven by the "opt-in" nature of the contracting process.

Theme 2: Opioid replacement therapies in Scotland (Recommendations 3-5)

The issue for Scotland is to ensure that the ORT delivery system is of the highest quality and that staff delivering this care recognise the impetus to offer ORT in the context of a flexible and mixed treatment system. This would ensure that service users and their families are involved in decisions regarding their treatment plans.

Theme 3: Progressing recovery in Scotland (Recommendations 6-7)

The review found considerable variation in local delivery of even the core elements of recovery orientated systems of care (ROSCs). Many areas stated their plans were at very early stages of development. There was little evidence presented by some ADPs regarding a real impetus towards recovery. Stakeholder reports supported this view.

Theme 4: Governance and accountability of the delivery system (Recommendations 8-9)

There are real concerns around the lack of progress we found in many ADP areas regarding the delivery of recovery orientated systems of care and quality assurance for services. The Scottish Government funds ADPs to facilitate local improvement. Despite this, in many areas, basic information seemed to be impossible to access. Clear strategic plans and objective reports of improvement were rare in the responses received by the review. Elements of recovery orientated services were often absent. There was not a strong sense of accountability.

In this field there is a lack of *institutional memory* (at all levels) regarding an agreed understanding of the key issues and the plans which require to be put in place to address them. Without this, systems are destined to continue repeating mistakes or

failing to capitalise on successes. Such inefficiency is at odds with the aspirations contained within the Christie Commission report (Scottish Government, 2012)[2].

Theme 5: Information, research and evaluation (Recommendations 10-11)

Research and academic enquiry into problem substance use has been poorly developed in Scotland despite the magnitude and seriousness of its manifestations. There is an urgent need to develop meaningful information systems which allow routine data to be used to support a high quality national research programme, designed to specifically address Scottish challenges. If such a structure were in place, future assessments of the effectiveness of drug strategy would be planned and resourced as part of an on-going academic programme rather than convened in response to a perceived crisis.

Theme 6: Mechanism for change (Recommendation 12)

The Christie Commission has highlighted the need for the Scottish Government and its partners to develop more efficient, effective and outcome-focused mechanisms for delivering services across government (Scottish Government, 2012).[2] In the area of substance use, several reports have raised similar issues regarding inconsistent delivery and a lack of accountability of a dedicated system (ADATs/ADPs) in recent years. It is now important to avoid further delay and take immediate steps to use an approach which has a track record of delivering change.

Delivering recovery

The DSDC independent review proposes that the specific recommendations (numbers 1-11) should form the basis of an immediate improvement process – giving local and national systems a clear direction for improvement work. In the meantime, officials should be developing plans for use of the '3-Step Improvement Framework for Scotland's Public Services'[3] to put in place sustainable changes to address the issues identified by this review.

INDEPENDENT EXPERT GROUP ON OPIOID REPLACEMENT THERAPIES REVIEW
12 RECOMMENDATIONS

THEME 1	RECOMMENDATIONS
Social exclusion and health inequalities	1. Consideration should be given to the development of mechanisms bringing closer the delivery of approaches to address health inequalities and problem substance use. ➢ As a minimum requirement, all local inequalities strategies should contain reference to plans to address the risks associated with substance use. 2. Primary care services – specifically General Practitioners and Community Pharmacists – are essential elements of the delivery system and should be delivered to national standards. ➢ It is imperative that discussions begin to consider how substance misuse treatment can be best delivered in the primary care setting. This process should be led by the NHS Primary Care structures and discussions should include General Practitioners and Community Pharmacists. ➢ Actions to test service quality improvement should be initiated nationally to reduce variation in practice.
THEME 2	**RECOMMENDATIONS**
Opioid replacement therapies in Scotland	3. Opioid replacement is an essential treatment with a strong evidence base. Its use remains a central component of the treatment for opiate dependency and it should be retained in Scottish services. ➢ In all settings, ORT should be delivered as part of a coherent, person centred recovery plan with SMART (specific, measurable, achievable, realistic, timeous) goals and based upon an assessment of individual recovery capital. ➢ The quality of ORT should be governed and delivery should be in line with national standards and guidance. NHS Medical Directors should hold this responsibility on behalf of local partnerships.

	➢ Fit for purpose information systems should be able to identify individuals on this care pathway and objectively demonstrate their progress. 4. A national specification for pharmacy services for problematic drug users should be developed to ensure that a high quality and consistent service can be provided in Scotland. This should be supported by a nationally agreed guideline for supervised self-administration of ORT medications and initiation of improvement approaches to accelerate progress. ➢ As part of this process, the publication, *Prevention and Treatment of Substance Misuse, Delivering the Right Medicine: A Strategy for Pharmaceutical Care in Scotland* (Scottish Executive, 2005)[4] should be updated to reflect the role of pharmacy within the national drug strategy. 5. The mechanisms in place which determine the reimbursement cost of methadone in Scottish community treatment systems should be reviewed to ensure they deliver best value and that in balancing the competing challenges, the benefits to problem substance users are to the fore.
THEME 3	**RECOMMENDATIONS**
Progressing recovery in Scotland	6. Recovery orientated systems of care (ROSCs) are well described in many guidance documents. All local systems should *immediately* publish prioritised SMART plans to ensure they can demonstrate a process towards delivery of ROSCs. Elements expected in such plans include: ➢ All service users should be offered and actively encouraged to use *Essential Care*[5] services. This offer should be recorded and repeated at regular intervals. This should become the norm in Scotland's services. ➢ In all settings staff should be trained in the delivery of ROSC.

	➢ A full range of *Essential Care*[5] services should be available in every locality – this should include a full range of identifiable community rehabilitation services – including these using people with lived experience; access to detoxification and residential rehabilitation; access to a full range of psychological and psychiatric services; services addressing employability and accommodation issues. 7. Within the medical and other caring professions, it is everyone's responsibility to manage drug users and their problems which extend into every clinical speciality. All practitioners can effect change and have opportunities to address drug-related problems within their professional arena. Local systems should have plans in place to ensure substance users are not excluded from generic services.
THEME 4	**RECOMMENDATIONS**
Governance and accountability of the delivery system	8. The Scottish Government should seriously reconsider how to better facilitate universal and effective partnerships which respond to local need and deliver consistent and measureable outcome improvement for substance users across Scotland. ➢ ADPs' function should be reviewed urgently and clear improvement measures developed and monitored with clear timeframes for change. ➢ In particular, all local systems should immediately publish prioritised SMART plans to ensure they can demonstrate a valid and coherent process to evidence the delivery of ROSCs in line with the *Essential Care* report.[5] 9. There is an urgent need to address the lack of institutional memory in the planning, delivery and governance of these systems of care. In particular, current advisory structures should be reviewed to improve impact on performance – especially with regard to lines of accountability and relationships with the Scottish Government and Scottish Parliament.

THEME 5	RECOMMENDATIONS
Information, research and evaluation	10. The Chief Medical Officer should task the Chief Scientist to consult with the academic community in Scotland and bring forward robust plans to develop a Scottish National Research Programme addressing the key substance use questions for Scotland. The aim should be to support and facilitate the delivery of efficient, high quality research into both the natural history of problem substance use – its development and progression – as well as the effectiveness of a broad range of treatment approaches – including psychological and social approaches as well as novel treatments. 11. Any proposal to further develop national information systems in the area of substance misuse at national level should be subject to meaningful and accountable project management. This should include: external scrutiny of delivery; a risk assessment to identify and address the main obstructions to delivery; publication of a realistic programme of delivery with agreed timeframes with measureable milestones and clear lines of accountability for all elements of the proposed system.
THEME 6	**RECOMMENDATION**
Mechanism for change	12. The variation of practice identified across services should be addressed using a proven improvement methodology, enshrined in the '3-Step Improvement Framework for Scotland's Public Services'.[3] This work should be given high priority by the Scottish Government and its partners. Clearly defined aims, drivers and measures should be developed for agreement at an initial national collaborative learning event organised by the Scottish Government early in 2014.

SECTION 1:
INTRODUCTION TO THE OPIOID REPLACEMENT THERAPIES REVIEW

Section 1: Introduction to the Opioid Replacement Therapies Review

> "Harm reduction or abstinence? – I wonder if abstinence would have been best – we are on the harm reduction road with several 'relapses' along the way."
>
> ***A service user's mother***

1. In the Autumn of 2012, the independent Scottish Drug Strategy Delivery Commission (DSDC) was asked by the Chief Medical Officer for Scotland, Sir Harry Burns, to undertake a review of the use of opioid replacement therapies (ORT) in the treatment of opioid dependency in Scotland. Of particular interest to the Scottish Government was advice regarding how the drug methadone compared to other available ORT treatments (such as Buprenorphine) and whether there was variation in practice across the country, particularly in those areas of treatment which may increase iatrogenic risk – such as diversion of prescribed methadone and supervised dispensing. The concerns of interested MSPs were also to be considered – in particular what research evidence existed to allow objective evaluation of the relative benefits of residential rehabilitation interventions and how widespread was their use in Scotland.

2. This review followed a spirited debate – both political and in the media – regarding the success of the Scottish strategic approach to address problematic substance use. The current Scottish strategy – *the Road to Recovery* – had been published in 2008 (Scottish Government, 2008)[1] and had been the basis of a continuing political consensus regarding how best to promote a culture of *recovery* within treatment services in Scotland – while maintaining the successes achieved through a focus on *harm reduction* which had consistently formed the basis of previous strategies (Scottish Office 1994[6]; Scottish Executive 1999[7]). The Road to Recovery[1] had been accepted by the Scottish Parliament unopposed.

3. In 2012, however, progress towards recovery was being questioned and doubts regarding even the harm-reduction success of the current approach were fuelled by the publication of the annual drug death statistics (General Register Office for Scotland, 2012).[8] Also, a survey of some MSPs by the independent United Kingdom Drug Policy Commission (UKDPC) had reported that a majority of respondents had stated that they felt the current strategic approach was failing to deliver the expected improvement in outcomes (UKDPC, 2012).[9]

4. Media reporting in some Scottish newspapers focused on the place of the drug methadone, with articles reporting in an extremely negative manner and challenging the prominence of opioid replacement therapies in general and methadone in particular, in the context of services attempting to deliver recovery for those suffering from problematic substance use. At a Scottish parliamentary debate on 8th November 2012, the Minister for Community Safety and Legal Affairs, Roseanna Cunningham, announced that the Chief Medical Officer (CMO) was to commission an independent review of the quality of delivery in the use of opioid replacement therapies in Scotland, to report in the spring of 2013. This objective approach was welcomed by MSPs.

Review process, remit and evidence base

5. The independent Drug Strategy Delivery Commission (DSDC) accepted the Chief Medical Officer's invitation to lead the review process. Two lead researchers, Dr Charles Lind and Dr Kennedy Roberts were appointed to undertake a review of literature and information gathering exercises, supported by a steering group, drawn from members of the DSDC and the National Forum for Drug Related Deaths (NFDRD), and a secretariat, provided by the Scottish Government.

6. The steering group – which included members involved in delivering comprehensive medical services as well as from different backgrounds and perspectives – would ensure the review addressed the relevant areas of concern. The group met formally four times in the course of the review offering insights, challenges and comments as well as providing on-going input through correspondence and contributing to and endorsing the report and its recommendations. A number of international experts from the addiction field were also approached to review and offer comment on any outputs. A full list of steering group members, the secretariat and international experts is provided at Annex 2.

Remit

7. The remit of the review below was agreed by the steering group following discussion with the Minister for Community Safety and Legal Affairs and the CMO.

Remit: Independent Expert Review: Opioid Replacement Therapies

- Consider evidence on opioid replacement therapies for people with drug addiction and make recommendations to the Minister for Community Safety and Legal Affairs to ensure that these interventions are being used appropriately and in line with the international evidence base, as part of a person-centred recovery-focused approach.
- Examine the quality of delivery of substance misuse care, treatment and recovery services including opioid replacement therapies and community and residential rehabilitation.
- Address the impact methadone and other opioid replacement therapies are having on national progress towards delivering the recovery-orientated outcomes defined within *the Road to Recovery*[1] strategy.
- Re-consider the value of opioid replacement therapies and provide advice on how best to maximise outcomes achieved from all treatments.
- Articulate how positive progress is understood, identified and measured for people receiving opioid replacement therapy, including methadone.
- Consider where further improvement or gains may be made to contribute to the quality emphasis of Phase Three of *the Road to Recovery*[1] strategy.

Information gathering

8. The review group undertook a number of information gathering exercises, including:

8.1 Literature review (research evidence base)

The timeframes did not allow for a new, full, systematic review of the extensive literature covering the place of ORT in the treatment of substance misuse. However, a focused exercise was being undertaken as part of an on-going research project and this was made available to the review and figures included in the report (Kidd, 2013).[10] This material included:

- The international literature on methadone ORT was reviewed, with particular focus on systematic reviews published since the 2007 Methadone review.

- Published reviews comparing methadone with buprenorphine (the alternative, licensed ORT treatment available in the UK) were also considered.

- The major national longitudinal studies in the UK, USA and Australia were also considered, to place ORT in context of a full range of treatment options – including detoxification and residential rehabilitation approaches.

8.2. A review of the relevant recent strategic and advisory documents relating to the preparation of *the Road to Recovery*[1], delivery reform/improvement and national performance was undertaken.

8.3. A questionnaire survey of all Scottish Alcohol and Drug Partnerships (ADPs) was undertaken and the responses analysed.

There are 30 ADPs in Scotland. While it would have been ideal to be able to schedule visits to observe local systems this was not feasible in the timeframes. Instead, the questionnaire survey allowed ADPs to describe their local processes of care in a standardised and consistent way – in particular with regard to ORT delivery and progress towards delivering better opportunities for recovery. The questionnaire responses were collated by local ADP support and signed off by each ADP Chair. Some ADPs chose to respond in a single response addressing more than one area – so 28 responses were received by the review. Some interested ADP leads also sought the opportunity to be interviewed individually by the review team.

8.4. Evidence gathering on treatment service delivery from a wide range of stakeholders – including service providers, commissioners, strategic bodies, service users and their families.

This process was undertaken in an opportunistic way to increase the chance for stakeholders to give their opinions regarding methadone treatment specifically as well as the delivery of recovery-orientated services across the

country. Evidence gathering included face to face meetings with over 75 organisations and individuals from a wide range of professions, as well as service users and their families. The lead researchers were also actively involved in a wide range of large scale events - conferences, workshops, etc. where they gave presentations and heard views and opinions from lots of people from different perspectives. In total these events were attended by approximately 500 people. The review also received written evidence. A full list of stakeholder contributions is provided at Annex 3.

The evidence base

9. Ministers and MSPs have been faced with conflicting views regarding the relative merits of ORT and other interventions when dealing with substance use problems. These views may be firmly held and are often presented in a passionate and compelling way. Sometimes they represent an overwhelming expert consensus – sometimes a minority view, perhaps based on one individual's experience. It is important, however, that all views are considered in as objective a way as possible. The principles of evidence-based practice should always apply – that the highest quality of evidence should be objectively interrogated and critically appraised to inform decisions about the commissioning of services.

10. Formal research evidence may be sparse – reflecting historic research priorities or challenges in terms of how meaningful research may be delivered. However, it is important that this paucity of evidence does not result in areas of potential benefit being disregarded off hand. This issue is well recognised in the field and in its final report, the independent UK Drug Policy Commission (UKDPC)[9] stated:

"Drug policy is currently a mix of cautious politics and limited evidence and analysis. This is coupled with strident and contested interpretations, both of the causes of problems and the effects of policies. In fact, for as long as there has been a drug policy, there have been gaps in the evidence as well as uncertainty about how to understand and act on the evidence that we do have" (UK Drug Policy Commission [UKDPC] 2012).[9]

11. The Commission went on to give a critique of the current state of information systems to inform the best way to manage drug problems in the UK. The report stated: *"The way we collect, analyse and use evidence in UK drug policy has often been inadequate and this has held back cost-effective policies that could have improved the lives of millions of people"* (UKDPC 2012).[9] They recognised that full blown Randomised Controlled Trials (RCTs) – a gold standard for research evidence - may not always be required to demonstrate effectiveness but also acknowledged that, when such scientific rigour is seen as less relevant, *"too often we have slipped to the other extreme and relied simply on anecdote".*

12. The report authors were of the view that, in the drugs field, evidence had not been given the same position as in other health and social care areas. Instead, *"evidence is often treated as a stakeholder whose interests should be taken into account, rather than a tool that is useful for all participants."* This is clearly an issue which could stand in the way of progress and the UKDPC made a plea for a "*new*

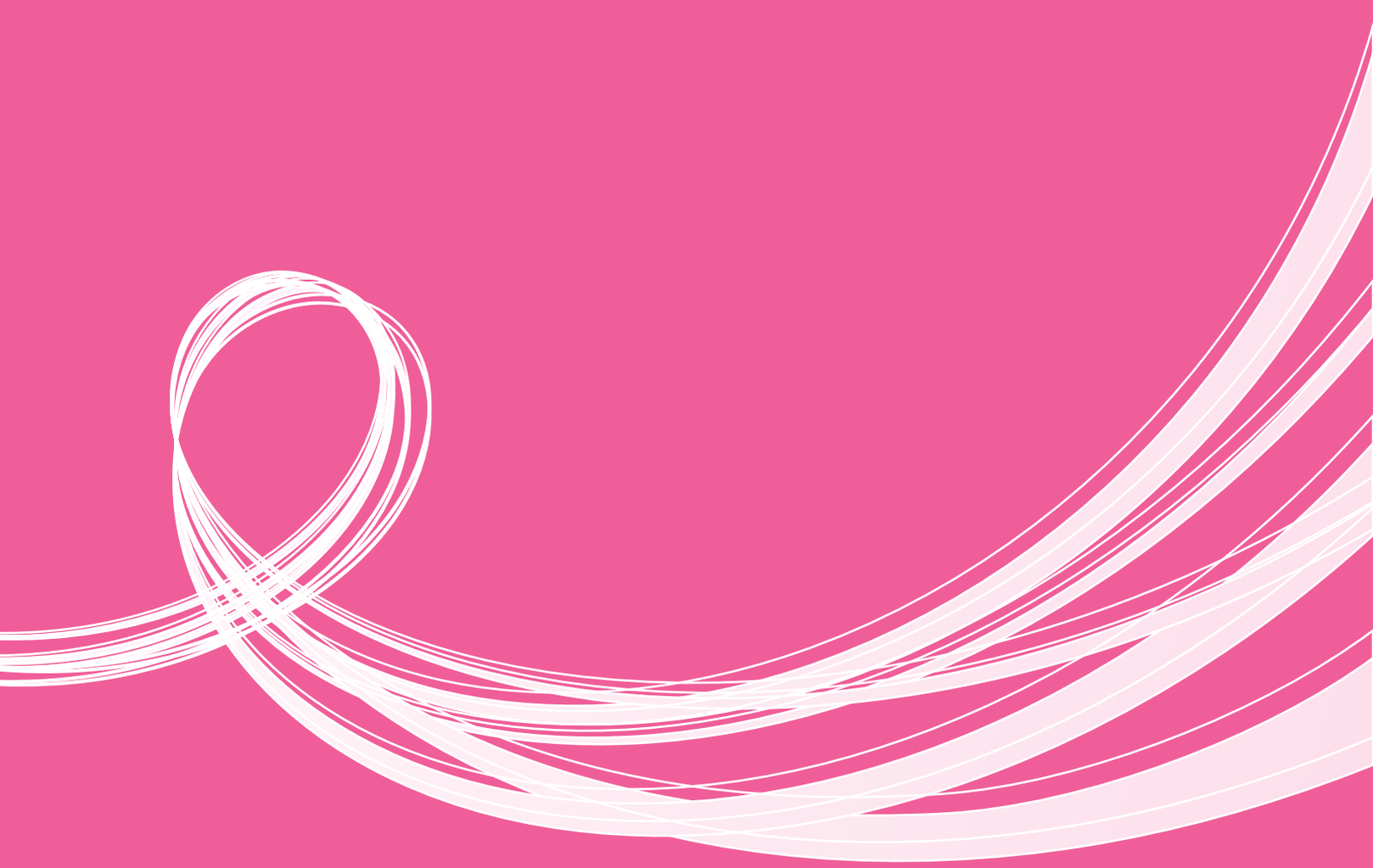
and more mature relationship with evidence". Examples of the change required would include: having a willingness to be guided by evidence and avoidance of *"cherry-picking"* of the evidence when the outcomes are politically challenging; recognising different levels and forms of evidence; being clear regarding the objectives of any intervention being evaluated and accepting both negative and positive results from evaluations of new initiatives or pilot studies.

13. This review has therefore been faced with a similar dilemma. First, the research evidence bases are inconsistent. Some interventions – such as ORT – have very well developed evidence bases supporting the view that they influence particular outcomes – mainly around reducing drug related risks. Others – for example, residential rehabilitation – have less well developed evidence bases, relying more on descriptive research or case examples. The evidence bases supporting particular approaches which may improve progress towards recovery are known to be weak (Best, 2010[11]; Bell, 2012[12]). These evidence bases are explored in later sections of this report.

14. At the same time, people who experience treatment – for themselves or their families – bring a wealth of information about these experiences. Their reports may be at odds with the consensus views regarding the strengths and weaknesses of particular approaches. This raises the question of how such evidence should be treated.

15. This review has met large numbers of individuals involved in delivering and receiving interventions to help them overcome their drug-related problems. We have gathered a wealth of conflicting opinions and perspectives. Though it is a contentious issue, it is the view of the review team and steering group that these reports should be treated with the same status as the formal reports from local and national bodies. It is our view that, if this approach was not taken, valuable information on what is really happening on the ground would be lost – or at least treated in an unbalanced manner.

SECTION 2:
BACKGROUND AND CONTEXT IN SCOTLAND



Section 2: Background and context in Scotland

"We are getting a lot of things right."

Professor Sheila Bird - MRC Biostatistics Unit

"Little doubt that as far as Hepatitis C is concerned opioid substitution has been a success story."

Dr John Dillon, Consultant Hepatologist, NHS, Tayside

The Scottish strategic approach to problem drug use

16. The approach to managing drug problems in Scotland (and the UK) has long been the subject of political and clinical debate. This has meant that until the new millennium, treatment focused on the reduction of drug-related harms – usually involving injecting – by making available to vulnerable substance users a range of interventions, including:

- Needle exchange
- Opioid replacement therapies (usually with the drug methadone)
- Counselling interventions

17. These decisions reflected the evolving international evidence base which guided strategists and clinicians. In the new millennium, however, dissatisfaction with the perceived failure of methadone to deliver a *cure* for opioid dependency and its associated problems resulted in a new debate which pitted *harm reduction* against *abstinence.* In Scotland, this conflict seemed to have been resolved with the Scottish Advisory Committee on Drug Misuse (SACDM) report – *Reducing Harm. Promoting Recovery* (Scottish Executive, 2007)[13] which reviewed methadone use and stated:

"….methadone replacement prescribing remains the main treatment for opiate dependency that should be available within the framework of services across all areas in Scotland. This reflects the overwhelming evidence base which supports its effectiveness in the face of little current credible evidence to support other approaches. The group also agreed that methadone replacement prescribing in Scotland can be improved significantly in terms of consistency and quality of practice and process of care delivery. This is supported strongly by user/carer opinion."

18. The new Scottish Government who received this report, strongly supported this view and in the *Essential Care* report (Scottish Government, 2008)[5] undertook further work to consider what services should be in place in each locality to improve choice and clinical outcomes.

19. The subsequent Scottish strategy – *the Road to Recovery* – (Scottish Government, 2008)[1] gained strong political support and put in place new expectations regarding this field in Scotland. In particular, there was an expectation that local services and systems of care and support would be developed to increase the likelihood of people progressing towards their own recovery. New delivery systems were also developed and introduced to improve performance and accountability – with the expectation that the impact of any changes could be clearly evaluated in terms of meaningful outcomes for people. However, by 2012 – there were again increasing criticisms of ORT – and methadone in particular – surfacing in the media.

20. The technicalities of the arguments regarding the use of methadone are strongly relevant to the findings of this review. The main points of this historic discussion are addressed in detail in the background information at Annex 6 and summarised below. A more detailed analysis can be found in a number of publications (e.g. Royal College of Psychiatrists, 1987[14]; Kidd & Sykes, 1999[15]; Strang & Gossop, 2005).[16]

Stigma

21. It is clear that in the UK, stigma and antipathy towards substance users and their treatment appears to be endemic at all levels in society.

22. In 2008, based on a national process of debate and discussion, the report of the Scotland's Futures Forum was published (Scotland's Futures Forum, 2008).[17] Research had indicated the effect of stigma towards current and former drug users and their families. Stigma can cause considerable distress and may present a 'hidden' barrier to accessing help and achieving recovery from drug problems.

23. In 2010 the independent United Kingdom Drug Policy Commission reported on stigma associated with substance use in Scotland (UKDPC, 2011).[9] Their overall conclusion was that such stigmatisation has a seriously adverse impact on the delivery of government strategy. They reported that drug users and their families felt that poor self-esteem and feelings of worthlessness prevented them seeking help and reduced their belief in their ability to recover. This was reinforced by their feeling very stigmatised by professionals in a wide range of health and social care settings. The attitudes and stereotypes of the public and employers in particular reduced the prospect of employment and reinforced their feelings of being unable to change.

24. Of the broader population there were some findings which suggested a degree of sympathy for those with drug problems and an overall endorsement of the notion that drug dependence is largely similar to other chronic illnesses. In contrast, however, there were also high levels of blame and intolerance and both the fear of and the need to exclude people with drug problems were higher in Scotland than the rest of the UK. These findings are sobering.

25. When surveyed, less than 1 in 10 respondents thought that people who had stopped using illicit drugs but were being prescribed medication such as methadone could be considered *recovered* while over three-quarters thought they could not.

These attitudes towards medication-assisted recovery are more negative in Scotland than for the UK as a whole.

26. With regard to the representation of drug use in the media, an analysis of a sample of newspapers suggested that reporting was sensationalised (being dominated by crime reports and celebrity with much use made of pejorative adjectives such as 'vile'). The media rarely dealt with the complexities of treatment and recovery.

27. It is clear this issue must be addressed – as stigma has been successfully tackled in the mental health arena. When suggesting how the impact of stigma might be reduced the UKDPC report included a number of approaches, including: proactively improving the general public's knowledge and understanding of the complexities of the matter and ensuring professional workforce development to improve service responses. In addition it was felt that active support for recovery networks and the improving of community participation in these should foster more constructive perceptions.

Inequalities

28. There is a clear, if poorly understood, relationship between income and health inequalities and between these inequalities and the consequences of substance use. The large and increasing gap in income inequalities observed in the UK since 1979 drives health inequalities, in turn driving a diminishing ability to deal with the impact of substance use. Users of ORT services come almost exclusively from areas of multiple deprivation.

29. Scotland continues to experience increasing levels of harm and premature death when compared to other EU countries (Whyte and Ajetunmobi, 2012).[18] Even when areas of corresponding de-industrialisation are compared across Europe, Scotland continues to show significantly higher mortality rates. The greatest differences appear to be in the younger (16 to 44 year) age group and the differences in mortality appear to be driven by the use of drugs and alcohol, violence and suicide (Walsh, Bendel, Jones and Hanlon, 2010).[19]

30. It is generally considered that income inequalities must be dealt with at a national level. These are complex issues and detailed analysis is beyond the scope of this focused review. However, it seems likely that issues of inequality account for a significant degree of the variation in negative outcomes – such as drug or alcohol-related deaths – experienced across communities. Failure to address such major influences will reduce the likelihood of addressing death rates. To this end, health inequalities have been given strategic priority by the Scottish Government – including the creation of a cross-cutting Ministerial Task Force.

31. It is acknowledged by this review that many efforts have been made to lessen the impact of income inequalities in Scotland but, to date, these have been only partially successful (Walsh, Bendel, Jones and Hanlon, 2010).[19] Under the current national governance arrangements and the financial pressures experienced in the public sector at this point, there seems some doubt as to first, to what degree there is an appetite to confront and second, just how much the Scottish Government can

realistically do without a higher degree of economic control or closer collaboration with the UK Government.

32. Further debate and objective analysis is required to better understand the relationship between substance misuse, risk behaviours, inequalities and social exclusion.

Summary 1: Background and context in Scotland

Strategy

- Scotland experiences significant inequalities when compared to other comparable countries. Inequalities drive problem substance use. Historically, Scotland has responded pragmatically to the problems associated with substance use – reflected in three national strategies since 1994. An initial launching of harm reduction approaches in response to the HIV epidemic saw a step change in service provision – where innovative practice in Scotland led the world. The 1999 *Action in Partnership*[7] strategy endorsed this approach and invested heavily in service expansion as well as in key elements to improve the ability of the workforce to deliver quality care and the delivery system – DATs – to ensure consistent local delivery. The 2008 *Road to Recovery* strategy[1] responded to the need to expand expectations of services – outlined in the preceding SACDM reports.

Delivery

- Delivering effective services has been a challenge. DATs were launched in 1994 and this type of partnership has repeatedly been found wanting. Investment and practical training, development and support followed the 1999 strategy. However, the 2007 external review[20] and 2009 Audit Scotland report[21] echoed the concerns regarding governance and accountability which had been clear in previous SACDM reports. In response, a new process of *Delivery Reform*[22] was developed along with new national elements put in place – including the Scottish Drugs Recovery Consortium (supporting ADPs to progress recovery–focused services) and the DSDC (to independently feedback to government on its achievements).

Progress and challenges

- A DSDC report (2011)[23], acknowledged areas of progress. The HEAT (Health, Efficiency Access and Treatment) A11 target aimed to ensure no people would wait no longer than 3 weeks to start treatment – bringing Scottish standards in line with England. The report also raised concerns about lack of progress in delivering *recovery*. Key concerns were a lack of valid information and governance of local delivery.

- In 2012, the Annual Report on Scottish Drug Deaths[24] again showed an increase. The prominence of methadone as a factor in these deaths and the reported loss of political consensus led to a debate in the Scottish Parliament and the commissioning of a substantial review of ORT delivery and recovery by the Chief Medical Officer.

SECTION 3:
THE INTERNATIONAL EVIDENCE FOR OPIOID REPLACEMENT THERAPIES

Section 3: The international evidence for Opioid Replacement Therapies

Introduction

33. This section summarises the research evidence base which has supported the development of treatment pathways for opioid dependent individuals, based on the use of Opioid Replacement Therapies (ORT). ORT will be put in context by considering the findings of the large national longitudinal studies – undertaken in the USA, UK and Australia – which, over the last 40 years, have evaluated large numbers of people presenting to a range of treatments with follow up over long time periods. We will then consider the current research evidence base for ORT – in particular, systematic reviews published since the last comprehensive review of methadone treatment in Scotland in 2007. Finally, we will consider the recent UK reviews of the research evidence for delivery of recovery in problem substance users.

International opinion and ORT

34. International debate continues regarding how society may balance the needs of illicit drug users and their families or communities with other national priorities or philosophies – especially with regard to the use of ORT. In-depth analysis of the broader policy debate is beyond the scope of this report. A helpful summary, however, is contained in the publication *Drug Policy and The Public Good* (Babor et al, 2010).[25] In the *Summary and Conclusions* chapter, a number of potential mechanisms – including medical, social, criminal justice and legislative approaches – to address drug-related harm are summarised. The publication specifically addresses the place of ORT. Making the importance of ORT as part of an effective drug policy clear, the authors state:

"We emphasise services for opiate dependent individuals because our review found that: 1. the services available for this population, especially ORT, have the strongest supporting evidence; 2. opiate use poses a high risk of overdose death; and 3. injection drug use has in many societies produced an ensuing epidemic of AIDS and other infectious diseases. Services for opiate users therefore could have a relatively large effect on population indicators of drug-related harm." (Babor et al, 2010).[25]

The European Union

35. European approaches to substance use have, as a rule, engendered a very pragmatic approach. For example the European Union Drugs Strategy (2005-12)[26] stated its [demand reduction] aims as achieving:

"Measurable reduction of the use of drugs, of dependence and of drug-related health and social risks through the development and improvement of an effective and integrated comprehensive knowledge-based demand reduction system including prevention, early intervention, treatment, harm reduction, rehabilitation and social reintegration measures within the EU Member States. Drug demand reduction measures must take into account the health-related and social problems caused by the use of illegal psychoactive substances." (Council of the European Union, 2004).[26]

The United Nations

36. The UN also articulates clearly its support for a range of options to be available to reduce drug related harms across the world. In their 2009 discussion document *Reducing the Adverse Health and Social Consequences of drug abuse: a comprehensive approach* (UN Office on Drugs and Crime [UNODC], 2009)[27] they address the split between those advocating harm reduction or abstinence, stating:

"Harm reduction is often made an unnecessarily controversial issue, as if there were a contradiction between treatment and prevention on the one hand, and reducing the adverse health and social consequences of drug use on the other. This is a false dichotomy. They are complementary." (UNODC, 2009)[27]

37. The UN sees access and engagement as essential elements of any treatment approach and identifies ORT as a key vehicle in this regard, stating:

"For those who are using drugs, providing accessible, evidence-based, good practice treatment for drug abusers and drug dependent individuals has been found to reduce individual and social harm. The option of drug-free oriented treatment, or at least the possibility to reduce illicit drug use, as well as retention in treatment with continuous contacts with health care providers, have proved effective in reducing overdoses, infections, car accidents, legal problems, criminal behaviour, psychiatric hospitalizations and suicide rates. This has been demonstrated for both pharmacologically assisted treatment (long acting opioid-agonists and use of antagonists) and drug-free oriented treatments. Differentiated and targeted treatment should be available for specific subgroups of drug dependent individuals according to the drug of choice, age, socio-cultural situation and possible concomitant psychiatric and physical disorders."

38. They make it clear that ORT is often required for the most difficult to engage, stating:

"These strategies need to target the sub-groups of the population that are not sensitive to prevention programmes, drug dependent individuals who are not motivated to attend treatment facilities, non-responders to treatment who continue to abuse illicit drugs, and those patients who easily relapse into substance abuse."

39. They make it clear that, at times this treatment approach is clearly focused on harm reduction – and not abstinence.

"Low-threshold pharmacological interventions (example opioid-agonists and antagonist drugs), not directly related to drug-free oriented programmes, but to immediate health protection, have to be easily accessible."

40. The UN has also seen opioid replacement as a potential human rights issue – of relevance in the UK as people move through the criminal justice system, or even move into the hospital system. At the UN Human Rights Council in February 2013 it was stated by the special rapporteur on torture and other cruel, inhuman or degrading treatment or punishment that:

"A particular form of ill-treatment and possibly torture of drug users is the denial of opiate substitution treatment, including as a way of eliciting criminal confessions through inducing painful withdrawal symptoms (A/HRC/10/44 and Corr.1, para. 57). The denial of methadone treatment in custodial settings has been declared to be a violation of the right to be free from torture and ill-treatment in certain circumstances (ibid., para. 71). Similar reasoning should apply to the non-custodial context, particularly in instances where Governments impose a complete ban on substitution treatment and harm reduction measures… and

By denying effective drug treatment, State drug policies intentionally subject a large group of people to severe physical pain, suffering and humiliation, effectively punishing them for using drugs and trying to coerce them into abstinence, in complete disregard of the chronic nature of dependency and of the scientific evidence pointing to the ineffectiveness of punitive measures."

International longitudinal studies

41. As ORT (using mainly methadone) became a key approach to the treatment of opioid dependency, a number of longitudinal studies were set up in the USA. These developed, with strong academic oversight, following-up large numbers of new subjects entering a range of treatments over long periods giving good insight into many aspects of service delivery and effectiveness. Similar studies have been undertaken in the UK – National Treatment Outcomes Research Study (NTORS)[28] and Drug Outcome Research in Scotland (DORIS).[29] Details of these studies are contained in the background information at Annex 6.2 and summaries contained in Tables1 & 2 – pages 24-25 (from *Kidd*, 2013 with permission).[10]

What do these longitudinal studies tell us?

42. Though there are issues of research methods and applicability from one country to the other, there are consistent findings in all of these studies. They generally show that being retained in treatment – whatever the type – is associated with clinical improvements. In most treatment modalities, those in treatment do better than those who aren't in terms of drug use and the associated risks, overall health and crime. Staying in treatment for longer is consistently shown to be an important indicator of better outcomes over time. ORT has consistently been found to be associated with better retention. Detoxification interventions (at least for "self-selecting" individuals) have repeatedly been found to be associated with higher risk. Indeed in one large US longitudinal study, this treatment option was removed from the study because of high relapse rates.

43. In the UK context, the NTORS study[28] found that in their sample improvements were seen at 1 year and were broadly maintained to 5 years for those they reviewed. The Scottish DORIS study[29] found differences between Scotland and England regarding abstinence-based outcomes – though the validity of these conclusions (such as the outcomes used not being comparable) has been raised as a concern.

44. Of particular relevance to the recovery agenda, the US Drug Abuse Treatment Outcome Study (DATOS)[30], raised issues around the drug user's ability to engage with treatment services (or the services' ability to facilitate such engagement). Also of relevance in the recovery debate, the Australian Treatment Outcome Study (ATOS)[31] showed that co-morbid mental health issues (in this case depression) may impact on the outcome achieved and that "treatment dose" – the number of attendances – was associated with more positive outcomes.

Table 1. Longitudinal Studies – UK (from Kidd, 2013)[10]

Study	Country	Dates & duration	Notes
The National Treatment Outcome Research Study – NTORS[28]	**UK (England)**	**1996-2001** **5 year follow up**	Prospective Longitudinal cohort study of 1075 subjects inducted from 54 services in 4 treatment modalities: • specialist in-patient treatment • residential rehabilitation programmes • community-based methadone maintenance • methadone reduction/detox programmes *Data collected:* at intake; 6/12; one year and at 2-3 years and 4-5 years after intake. 763 reviewed at 1yr. 496 at 5 years. **Conclusions:** "Treatment works". Showed improvements in terms of reduced drug use and crime, increased abstinence, and health. 1year improvements were maintained at 5 years. Time in treatment was an important positive factor. Concern regarding poor outcomes on alcohol and stimulants.
The Drug Treatment Outcomes Research Study – DTORS[32]	**UK (England)**	**2009** **13 month follow up**	Prospective longitudinal study of 1796 subjects from 342 agencies across England. Type of agencies not defined – but in line with NTA "menu" of treatment options. Also qualitative study and cost-effectiveness element *Data collected* : intake, 3-5/12 (1131 cases) & 11-13/12 (504) **Assessment is essentially of process and <u>not</u> outcome.** **Conclusions:** Despite increased demand and changes in drug use patterns since NTORS[28], services still effective and reducing harms, improving health and wellbeing. Services responsive and patients satisfied. Cost effectiveness high.
Drug Outcomes Research in Scotland – DORIS[29]	**UK (Scotland)**	**2001-2004** **33 month follow up**	Prospective longitudinal study of 1033 subjects in a range of treatments (including prison). These were: • Opiate replacement • Other replacement • Counselling/non-medical • residential rehabilitation • detoxification *Data collected* : at baseline (MAP), 8, 16 and 33 months Also qualitative element to the study. **Conclusions:** Mainly focused on achievement of abstinence and not harm reduction. Concluded Scottish services poorer than English (NTORS) at achieving abstinence although different definitions of this outcome were used.

Table 2. Longitudinal Studies – USA and Australia (from Kidd, 2013)[10]

Study	Country	Dates & duration	Notes
Drug Abuse Reporting Programme – DARP[33]	**USA**	**1969-1972** **(select data <1981)** **12 year follow up for some elements** **Mean 6yr follow up of over 6000 cases**	Prospective Longitudinal Cohort Study of 43,943 subjects from 52 agencies in 4 modalities (+controls): methadone maintenance; therapeutic communities; out-patient drug – free; out-patient detoxification. Data collected at intake and then 2 monthly. **Conclusions:** Demographic and sociological characteristics only limited importance. Length of time in treatment & behaviour in treatment most important.
Treatment Outcome Prospective Study – TOPS[34]	**USA**	**1979-1981** **Maximum** **5 years follow up for some elements – up to 4270 cases**	Prospective longitudinal study of 11,759 subjects from 41 services (10 cities) in 4 treatment groups: methadone maintenance; detoxification; residential care; op drug-free. Subjects interviewed: intake & 1, 3, 6, 9 and 12 months. After leaving treatment, follow-up at 3/12, 1, 2 & 3-5years. **Conclusions:** Drug abuse treatment reduces illicit drug use and criminal activity. Time in treatment important factor.
Drug Abuse Treatment Outcome Study – DATOS[30]	**USA**	**1991-1993** **3 month follow up &** **12 months follow up post discharge** **5 year follow up of 2966 cases**	Prospective longitudinal study of 10,010 subjects from 96 services in 4 treatment groups: methadone maintenance; residential long term; residential short term; out-patient drug-free. Data collected: 1 & 3/12 in treatment and 1yr post treatment. **Conclusions:** Drug use reduced >50% in all groups with methadone treatment affecting opiate use most. Retention and aspects of engagement (influenced by service characteristics) also affected outcomes.
The Australian Treatment Outcome Study – ATOS[31]	**Australia**	**2003-2006** **3 & 12 month follow up with a 3 year follow up for one sample (NSW)**	Prospective longitudinal study of ~ 615 new patients – 535 entering 3 treatment types: methadone maintenance – 201 cases; detoxification – 201 cases; residential settings – 133 cases. Data collected: 3 & 12/12 (and 24 & 36/12 for NSW sample) **Conclusions:** Drug use associated risks and crime reduced across all modalities at 3 months and was maintained to 3 years. Time in treatment positively affected outcome except in detoxification. Depression negatively affected outcome.

Effectiveness of Methadone ORT – systematic reviews

45. The review group could not deliver a systematic review of the literature in the timeframes required to report to government. However, an ongoing "review of reviews" as part of a research project was made available (Kidd, 2013).[10] This had considered recent authoritative systematic reviews of treatment with particular relevance to UK practice (e.g. Lingford-Hughes et al, 2012).[35] Also, using specific search criteria, the review had identified a further 13 relevant systematic reviews considering the effectiveness of ORT using methadone. Some of those reviews cited had considered both Methadone and Buprenorphine (Subutex® and Suboxone®). The reviews are summarised on pages 28-31 (from Kidd, 2013, with permission)[10] with more detailed text in the background information at Annex 6.3.

Effectiveness of ORT

46. Systematic reviews have repeatedly concluded that ORT is associated with improved retention in treatment, reduced illicit opioid/heroin use and reduced HIV and blood borne virus risk behaviours – related to injecting. There is less consensus, in these reviews, regarding positive effects on criminal activity and mortality.

Recovery or abstinence

47. Regarding recovery and abstinence – as shown in the review commissioned by the Scottish Government (Best et al 2010)[11] the evidence bases are not compelling – perhaps reflecting the challenge of the research approach required – and there is clearly a need for more quality research to be undertaken to identify best practice.

Factors affecting outcome of ORT

48. Effectiveness of ORT seems to be affected by dose of the medication (higher doses are more effective). Regarding other ways of improving the outcome – there is a question over the effectiveness of additional psychosocial interventions, but this may reflect poor quality or short term research which is unable to determine added value. However, there is compelling support for the view that the amount of treatment exposure – number of attendances or treatment "dose" – may positively affect outcome. There is also evidence that the quality of therapeutic relationships is key.

Quality of the evidence

49. It must be acknowledged that published systematic reviews have consistently commented on the poor quality of the core research evidence. Randomised Controlled Trials of ORT are a rarity. Studies often have small samples and short periods of follow up. Heterogeneous populations are commonly used. Research questions are often unclear and outcomes neither objective nor compatible.

50. The interventions being delivered (e.g. ORT) may be delivered in a way which is unlike normal treatment in the community – for example using fixed doses of

methadone, not allowing take home methadone or failing to also deliver counselling or psychosocial supports. In the context of the delivery of British services, little high quality research has emerged from the UK, with most randomised controlled trials (RCTs) arising from the USA. This can make generalising any findings to UK practice challenging.

Analysis – what do these reviews tell us?

51. ORT with methadone benefits from a consistent finding that its use is associated with particular benefits for opioid dependent individuals. The evidence base has weaknesses and more research is required to deliver research evidence of more relevance to UK/Scottish practice. The benefits to positive physical health and reduction in BBVs are strongly supported by the evidence.

52. There is no compelling evidence regarding choice of ORT agent – with Buprenorphine, Buprenorphine/Naloxone and Methadone found to be equally effective at delivering harm reduction outcomes. As shown by Bell (2012)[12] and Best (2010)[11] there is no consistent research evidence to direct specific aspects of ORT delivery in a way which may improve recovery outcomes.

Table 3. Literature review – Summary of reviews and meta-analyses (from Kidd, 2013)[10]

Table 3a. Substance use outcomes		
Source	**Details of review – summary of methods and conclusions**	**Notes**
Marsch 1998[36]	*Focus: GENERAL EFFECTIVENESS OF ORT* *Methods:* 43 studies reviewed. 11 (2056 participants) considered ongoing illicit drug use; 24 (7173 participants) criminal activity; 8 studies (1,797) HIV risk behaviours. Conclusions: being in receipt of ORT reduces drug use, risk behaviours and criminal activity	
Simoens et al 2005[37]	*Focus: GENERAL EFFECTIVENESS OF ORT (methadone or buprenorphine)* *Methods:* 48 RCTs reviewed 14 ORT - M, 20 BRT and 14 both. Issues of quality and consistency of review – criteria not clear. **Conclusions:** ORT- M and BRT treatment positively predicts retention, and abstinence or reduction	
Connock et al 2007 NICE Technology Appraisal 2007[38] (TA114)	*Focus: RELATIVE EFFECTIVENESS OF OST (methadone or buprenorphine)* *Methods:* Guidelines for Clinicians in the UK (report produced to support update of UK National Treatment Guidance in 2007).[39] Expert committee took evidence on both ORT and BRT from a wide range of stakeholders. Reviewed 31 existing systematic reviews, 87 additional RCTs and 11 economic evaluations. No UK RCTs – 16 from USA. Most studies had fixed dosing, relatively restrictive delivery (supervised consumption etc.) no psychosocial interventions and short follow up (<1yr). **Conclusions** (ORT**):** 1. ORT supports retention;, reduced opiate use; reduced HIV risk behaviours and sero-conversions; reduced mortality (with 4x increased risk of death on discharge); reduced criminal activity. 2. Higher fixed doses more effective than lower fixed doses	***Issues:*** -fixed dose treatments do not reflect normal clinical practice. -evidence not sufficient to draw conclusions regarding cost-effectiveness. -recognising lack of UK evidence and heterogeneity of economic evaluations, states: "none used all of the appropriate parameters, effectiveness data, perspectives and comparators required to make their results generalisable to the NHS."
Mattick et al 2009[40]	*Focus: GENERAL EFFECTIVENESS OF ORT* *Methods:* Cochrane Systematic Review of all RCTs comparing ORT with placebo or non-pharmacological therapy. Reviewed 11RCT – 2 double blind – covering 1969 participants. Outcomes assessed from 45 days to maximum of 2 years. **Conclusions:** Methadone increases retention and reduces heroin use. No effect on criminal activity.	***Issues:*** Authors acknowledge -lack of evidence in key outcomes (e.g. dose and deaths; social outcomes) -no research addressing relationship between medical treatment and psychosocial treatments -methodological concerns in many studies make generalising from research impossible.

Veilleux et al 2010[41]	*Focus: TREATMENT EFFECTIVENESS SUMMARY (ALL TREATMENTS)* Aim to "synthesize the current status of opioid dependence treatment". *Methods:* Systematic review article aiming to address ORT and forms of detoxification and abstinence maintenance in a range of substances. For ORT - reviewed existing systematic reviews plus additional meta-analyses or controlled trials published since the most recent update of each Cochrane review. Cited 10 publications, covering 155 studies involving 28,999 subjects. **Conclusions:** ORT improves retention, reduces opiate use and withdrawal symptoms. There are dose effects. There is a need to broaden quality research to address a range of outcomes, including abstinence.	***Issues:*** Authors raise issues of -difficulty in executing meta-analyses due to range of methods and outcomes. -research questions not covering full treatment range.
Lingford-Hughes et al 2012[35]	*Focus: DELIVERY OF RANGE OF SUBSTANCE MISUSE OUTCOMES* Aim - guideline for clinicians *Methods:* Three year process overseen by expert panel. Evidence for ORT reviewed as part of comprehensive review of all addictions treatments. Systematic review of existing reviews from credible sources (e.g. Cochrane database) or RCTs when possible. Recognition of complexity of evidence base - categorization of evidence and strength of recommendation often reflects extrapolation from lower grade evidence. If evidence low grade but strong clinical consensus in place given "S" status – standard of care. **Conclusions:** 1. ORT supports retention in treatment; reduced heroin use; trend regarding reduced mortality; reduced drug-related risk behaviours (NOT sexual risk) 2. Higher dose ORT more effective at improving retention and reducing heroin and cocaine use 3. NO evidence for an added effect of psychosocial interventions 4. NO evidence of reduction in criminal justice activity.	***Issues:*** Little reference to potential confounders: -quality of primary evidence base – heterogeneity of subjects; clarity of research question; sample size and representativeness -timescales of effects – value in long term maintenance and "recovery" -largely USA-based evidence base – value in UK setting.
Faggiano et al 2008[42]	*Focus: METHADONE DOSE AND EFFECTIVENESS IN RANGE OF OUTCOMES* Aim was to evaluate the efficacy of different dosages of MMT in modifying health and social outcomes and in promoting patients' familiar, occupational & relational functioning. *Methods:* Randomised Controlled Trials and Controlled Prospective Studies evaluating methadone maintenance at different dosages in the management of opioid dependence. Non-randomised trials were included when proper adjustment for confounding factors was performed at the analysis stage. Reviewed 21 studies. 11 RCTs – all from USA (2279 subjects for 7-53 weeks) and 10 CPS (3715 subjects for 1-10 years). **Conclusions:** Higher dose ORT (60-100mg) more effective at improving retention, reducing opiate and cocaine use.	***Issues:*** Authors raise issues of heterogeneity and inconsistency of sampling etc. affecting quality of studies. RCTs all from USA and timeframes are <1 year only. Lack of sufficient evidence to assess certain outcomes – e.g. mortality, criminal activity and social outcomes

Table 3b. Harm reduction outcomes		
Source	**Details of review – summary of methods and conclusions**	**Notes**
Sorensen et al 2000[43]	*Focus: HARM REDUCTION – RISK BEHAVIOUR AND HIV* *Methods:* 33 studies with over 17,000 participants reviewed. Numerous methodological issues raised. *Conclusions:* ORT predicts reduced drug use, risk behaviour and criminal activity.	
Gowing et al 2011[44]	*Focus: HARM REDUCTION – HIV RISK BEHAVIOURS AND SEROCONVERSION* Aim was to assess the effect of oral substitution treatment for opioid dependent injecting drug users on risk behaviours and rates of HIV infections *Methods:* Cochrane Systematic Review of Studies which considered the incidence of risk behaviours, or the incidence of HIV infection related to (any) substitution treatment of opioid dependence. All types of original studies were considered. 38 studies involving 12,400 subjects were included. Mainly descriptive studies, or studies in which randomisation processes did not relate to the data extracted. Most studies "at high risk of bias". *Conclusions:* ORT reduces opiate use, IV use, needle sharing and HIV seroconversion. May also affect sexual risk behaviours for HIV.	***Issues:*** Authors acknowledge that "The lack of data from randomised controlled studies limits the strength of the evidence presented in this review."
Turner et al 2011[45]	*Focus: HARM REDUCTION - HEPATITIS C SEROCONVERSION* Aim to examine effect of harm reduction (needle exchange and ORT) availability and seroconversion. *Methods:* Meta-analysis and pooled analysis of data on 2986 subjects in six areas of the UK from 2001-9. Questionnaire survey to clarify availability of ORT and needle exchange. Primary outcome of new HCV infection. 919 subjects supplied information on interventions. 40 new HCV cases identified. *Conclusions:* Access to harm reduction interventions significantly reduced new HCV seroconversions.	***Issues:*** Authors acknowledge that "The review, actually, did not evaluate the question of whether any ancillary psychosocial intervention is needed when methadone maintenance is provided, but the narrower question of whether a specific more structured intervention provides any additional benefit to a standard psychosocial support". -raises methodological questions. -also issue of USA based evidence (relevance to UK practice). -issue of short timeframes.

Table 3c. Delivering Recovery Outcomes		
Source	**Details of review – summary of methods and conclusions**	**Notes**
Best et al 2010[11]	*Focus: RECOVERY* Aim to "assess the current state of the evidence base" supporting recovery in the field of illicit drug use. *Methods:* Commissioned research by Scottish Government to support their national strategy. Systematic literature search and review resulted in 205 articles covering treatment (79 papers), children/families (62 papers), criminal justice (27 articles) and prevention/education (37 papers). Process of critical appraisal is not well defined and descriptive articles by recovery "experts" are widely cited. It is noted that much of the evidence on recovery is from overseas (USA) and is in other areas of addiction. **Conclusions:** Sustained recovery is the norm but pathways are "individualistic"; "recovery capital" is "the best predictor" of recovery outcome; there are an identifiable range of "barriers" to recovery; structured treatment has a role but social support is also required.	***Issues:*** The authors acknowledge the lack of systematic, consistent and relevant research in this area – mainly foreign research from related care areas. Indeed they make a plea for a new approach to research – based on longer term outcomes.
De Maeyer et al 2010[46]	*Focus: QUALITY OF LIFE* Aim to examine the relationship between treatment and QoL outcomes. *Method:* Systematic review of the literature. 38 studies identified of which 16 considered QoL changes with ORT treatment. They found that QoL was very low on entry, did improve significantly in the first few months of treatment but then declined – though not to pre-treatment levels. **Conclusions:** QoL is a measure of success in ORT – but services need to address more than the drug use to achieve sustained improvement.	
Bell 2012[12]	*Focus: RECOVERY* Aim to "seeks to integrate, as far as is possible, the discourse of evidence-based practice (built on observation and measurement), with the humanitarian, recovery-based discourse based on values (such as responsibility, choice, and empowerment)". *Methods:* Part of government-funded expert advice group. Selective review of papers identified by sub-group of this national expert panel. Reiterated evidence base for harm reduction effects of OST. Also focused on: achieving abstinence; re-integration; quality of life. **Conclusions:** *Not optimistic about current state of evidence base. Stated:* "individuals need long-term social supports and personal psychological resources to sustain recovery. Formal treatment can be a powerful factor in building these social supports and psychological resources to facilitate positive change, but on its own it typically does not have a lasting influence."	***Issues:*** No search strategy defined and range of papers reviewed unclear. Highly personal selective review.

Summary 2: The international evidence for ORT

- As stated in the 2007 methadone review, international opinion repeatedly expresses strong support for ORT in general and methadone specifically as an effective treatment for opioid dependency.

- For over 40 years researchers have been considering effectiveness of a range of treatment types and large national longitudinal studies have identified key aspects of treatment delivery which are repeatedly shown to be associated with positive outcomes – particularly regarding treatment retention and delivery of harm reduction outcomes.

- Despite limitations regarding research methods, there is a consistent finding from the international academic world, that ORT with methadone is an effective treatment at delivering a range of outcomes, including: improved retention, reduced illicit opioid/heroin use and reduced HIV risk behaviours – related to injecting. International experts acknowledge that, to date, no other treatment options enjoy such a strong evidence base.

- Recent rigorous systematic reviews of the literature (including the recent Cochrane reviews) have identified that the research evidence base in this field has limitations. These include selection bias in subjects of research projects, measurement of mainly short term outcomes, use of small samples of poorly defined subjects, in receipt of treatments which are not consistent with mainstream clinical practice. Much of the published research (including all RCTs) is from outside the UK, making it difficult to generalise some findings into UK practice.

- The evidence-base for effectiveness in achieving abstinence or promoting long term recovery – as opposed to reducing harm – remains much less compelling. This in part reflects the challenges in delivering the research required to address key questions.

- There is clearly a need for more high quality Scottish research on large representative samples over relevant timeframes to inform practice realistically and with relevance to Scottish practice.

SECTION 4:
SCOTTISH AND UK GUIDANCE ON DELIVERING RECOVERY-ORIENTATED TREATMENT

Section 4: Scottish and UK guidance on delivering recovery-orientated treatment

> "It would be good to see what the optimum support package would look like – not something that is made up as the addict goes along the Road to Recovery and depends on what is available at the time."
>
> ***A service user's relative***

Definitions of recovery

53. It seems obvious that it is helpful to start with a clear definition of what recovery means for an individual experiencing problematic substance use. However, part of the challenge in this area is that different stakeholders – from service users to strategists – often struggle to form a consensus regarding what should form the basis of such a definition. Questions which arise include whether a person can be "in recovery" if they continue to use substances? Can a person be in recovery while prescribed drugs with abuse potential – such as methadone or diazepam? Is a person in recovery if they are actively engaging in their society – perhaps working, paying taxes or fulfilling childcare responsibilities – but still using illicit substances?

The recovery consensus statements 2007/8

54. There are examples of inclusive attempts to agree a working definition of recovery. In 2007 the Betty Ford Institute in the USA (an abstinence-orientated organisation) convened an expert panel and facilitated a process to develop a consensus statement on recovery – aiming to give a working definition which people involved in the field at all levels could see as relevant to their practice (Betty Ford Consensus Panel, 2007)[47]. In the context of the polarised discussion in the UK at that time, this initiative gave an opportunity for those from the different schools of thought in the UK to work together to develop a consensus view of what all services should be trying to deliver. The UK Drug Policy Commission progressed this work, publishing their consensus statement in 2008 (UKDPC, 2008).[48] The following draft consensus statement was agreed by the UKDPC group:

"The process of recovery from problematic substance use is characterized by voluntarily sustained control over substance use which maximizes health and wellbeing and participation in the rights, roles and responsibilities of society."

55. The statement was then taken into the field for comment by a wide group of stakeholders. A consistent view from this process was that the statement did seem to capture the correct tone – allowing many views of addiction to be seen as relevant – and potentially opening the discussion to allow a more diverse range of interventions, with more individual significance, to become available. The 'UK Drug Policy Commission Consensus Group: A Vision for Recovery' is illustrated at Section 6, page 67.

The Road to Recovery

56. In *the Road to Recovery*[1] strategy, the Scottish Government made it clear that recovery is defined by the individual. They stated:

"What do we mean by recovery? We mean a process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society. Furthermore, it incorporates the principle that recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment. In short, an aspirational, person-centred process."

57. This broad-based and inclusive definition is in line with other recovery statements. The Betty Ford Institute (BFI) Consensus Panel[47] specifically addressed the question of Opioid Treatment Program (OTP) medications and recovery status by defining recovery in terms of sobriety, global health, and citizenship, and then by clearly stating that: "*…formerly opioid-dependent individuals who take naltrexone, buprenorphine, or methadone as prescribed and are abstinent from alcohol and all other non-prescribed drugs would meet this definition of sobriety"* (White, 2013).[49]

58. Addressing the practical detail of what this could mean, they went on:

"In practice, recovery will mean different things at different times to each individual person with problem drug use. Above all, people aspiring to milestones in recovery must have the confidence that they can achieve their personal goals. For an individual, the 'road to recovery' might mean developing the skills to prevent relapse into further illegal drug taking, rebuilding broken relationships or forging new ones, actively engaging in meaningful activities and taking steps to build a home and provide for themselves and their families. Milestones could be as simple as gaining weight, re-establishing relationships with friends, or building self-esteem. What is key is that recovery is sustained."

59. Finally, making their aspirations clear – in terms of a change of approach, they stated:

"The strength of the recovery principle is that it can bring about a shift in thinking – a change in attitude both by service providers and by the individual with the drug problem. There is no right or wrong way to recover. Recovery is about helping an individual achieve their full potential – with the ultimate goal being what is important to the individual, rather than the means by which it is achieved."

National Guidance and Standards – the 2007 Orange Guidelines[39]

60. Comprehensive treatment guidance for clinicians in the UK was first published in 1991 in the face of an HIV epidemic and a sea-change in the expectations of treatment services (Department of Health, 1991).[50] Since then the evidence base supporting medical approaches has improved and developed. The 2007 UK treatment guideline (*The Orange Guidelines*)[39] is the current "live" guidance for clinicians and is the most comprehensive yet (Department of Health et al, 2007).[39]

61. *The Orange Guideline*[39] was produced by a diverse committee of clinicians (from a range of professions), as well as service users and treatment providers from a range of philosophies and backgrounds. Government officials and advisors were also involved in the process. Though in essence the guideline represents a report by an expert group, for the first time in the UK, the process of guideline development was supported by the commissioning of systematic reviews of the research evidence base. These were taken forward by the National Institute for Health and Clinical Excellence (NICE). NICE Guidelines and Technology Appraisals covering all of the key medical and psychological interventions were considered by the guideline group (NICE, 2007a; 2007b; 2007c; 2007d).[51] The group also took into account any live guidance or evidence bases in other associated areas of work, such as pain management and mental health dual diagnosis.

62. In this environment of scrutiny, this was the first national treatment guideline to comprehensively address the evidence base for the effectiveness of psychosocial interventions for substance misusers. It was also timely that, when medical care for drug users was under public scrutiny, the guideline emphasised the need for high levels of clinical governance and quality standards in this area of work.

63. The guideline addressed key aspects of the process of care delivery, emphasising that drug misuse treatment involves a range of interventions, "*not just prescribing"* They stated that *"all drug misusers entering structured treatment should have a care or treatment plan which is regularly reviewed*" managed and delivered by a *"named individual".* It was acknowledged that there were already comprehensive guidance documents in the field which gave clear practical advice regarding these processes. From a Scottish perspective, *Integrated Care for Drug Users: Principles and Practice* (Scottish Executive Effective Interventions Unit, 2002)[52] was cited.

Quality of treatment

64. Chapter 5 of the guideline specifically addresses issues of quality of care, standards and expectations when prescribing ORT. Prescribing should follow a comprehensive assessment and clear guidance on the required process – aiming to ensure patient safety – is given. It is stated that:

"Before prescribing substitute drugs the clinician should conduct a full or comprehensive assessment and agree a care or treatment plan with the patient."

Choice of drug

65. At the time of guideline development methadone was the standard treatment in the UK, but Buprenorphine has become a common alternative. Reviewing the evidence at that time, NICE had made a clear statement regarding choice.

"Evidence suggests that methadone is more likely to retain patients in treatment but the evidence for the relative effectiveness of methadone and buprenorphine at preventing illicit opioid misuse is mixed. NICE's recommendation is: 'If both drugs are equally suitable, methadone should be prescribed as the first choice.'(NICE, 2007a)."[51]

Dose

66. During *induction* the main issue is to avoid accidental overdosing. The guideline gives detailed advice on how best to maintain patient safety. During dose optimisation, the research evidence base has been described – which suggests that higher doses may be required to be effective. It must be emphasised that there is no 'therapeutic window' for these drugs – but it is clear that some patients may require higher doses and the range of 60-120mg is cited in the guideline as a dose range most likely to meet the needs of most patients at this stabilisation stage. This reflects a consensus from experts and not a specific research evidence base.

Orange Guidelines suggestions on diversion and supervision

67. The guideline addresses the issue of supervision of methadone consumption. It is stated that supervision of consumption provides the best guarantee that a medicine is being taken as directed and asserted that, in the UK, since the advent of supervision, drug deaths have reduced at a time when more methadone is being prescribed – suggesting that supervision is protective.

68. Good practice recommendations on supervision were made as follows:

1. In most cases, new patients being prescribed methadone or buprenorphine should be required to take their daily doses under the direct supervision of a professional for a period of time that may be around three months, subject to assessment of patients' compliance and individual circumstances.

   The guideline acknowledges that there may be variation in practice across the UK with durations from *"just a couple of weeks in highly compliant patients"* to *"much longer in patients who fail to respond to conventional treatment*." It is stated that "*the clinical need for supervised consumption should be reviewed regularly and the decision on when to relax the requirement for supervised consumption is one for the individual clinician."* [39]

2. Long-term, daily supervised consumption would probably not be appropriate for a patient in regular, full-time work where supervision would be a clear barrier to engagement in treatment.

3. When a patient restarts methadone or buprenorphine after a break, or receives a significant increase in the methadone dose, daily dispensing – ideally with supervised consumption – should be reinstated for a period of time agreed in local guidelines and protocols.

4. In patients whose treatment is failing, a period in supervised consumption can improve observation of progress and increase interventions to improve outcomes.

5. Supervised consumption is often a situation where therapeutic relationships can be built with patients and efforts should be made to stop it being viewed as a punishment.

69. Regarding processes, they state that there should be multi-agency protocols in place to ensure a consistent high standard of service is provided. As part of the service, there should be systems in place to ensure information about patients can be fed to and from the prescriber and keyworker, as well as agreement from the patient that confidential information can be shared between the pharmacist and named members of the multidisciplinary team.

70. Regarding when *stopping supervision* is appropriate:

1. Relaxation of requirements for supervised consumption and for instalment dispensing should be a stepped process in which a patient first stops taking doses observed by a professional but remains on daily dispensing. Later, after further progress – such as improvements in terms of drug use, psychological presentation or social functioning – the frequency of dispensing may be gradually reduced. The relaxation of supervision can be seen as an important component of the rehabilitation process as it increases the user's personal responsibility for their own treatment.

2. Supervised consumption should only be relaxed if the prescriber has good reason to believe that compliance will be maintained.

3. In general the prescriber needs to assess the following: changes in drug-taking behaviours (such as injecting); compliance with prescribed drug treatment; abstinence from or significant change in drug misuse and compliance with other elements of a care plan, for example, attendance at appointments.

71. Take-home doses should not normally be prescribed where: a patient has not reached a stable dose; the patient shows a continued and unstable pattern of drug misuse; the patient has a significant, unstable psychiatric illness or is threatening self-harm; there is continuing concern that the prescribed medicine is being, or may be, diverted or used inappropriately; there are concerns about the safety of medicines stored in the home and possible risk to children. However, flexibility is still embedded in the guideline which states that: *"In some of these cases, especially the latter, take-home doses might be permitted but the dose taken home limited by frequent dispensing."* [39]

The place of treatment in recovery

72. The national treatment guidance aimed to place medical treatment in an holistic context – but inevitably focused in detail on the medical interventions. Previous guidance had considered the broader care and treatment issues (e.g. *Integrated Care,* 2002)[52] but a recent report in England – *Medications in Recovery* (NTA, 2012)[53] – explored the issues around balancing medical treatments – in particular ORT – with all other elements of the care process.

Medications in recovery ï Re-orientating drug dependence treatment (2012)

73. In support of the UK government drug strategy (Home Office, 2010)[54] the National Treatment Agency (NTA) was asked to set up a new expert group to bring

forward advice on the delivery of a more recovery-orientated approach to treatment. This work was published in the summer of 2012 (NTA, 2012).[53]

The task of this group was: *"To describe how to meet the ambition of the Drug Strategy 2010 to help more heroin users to recover and break free of dependence."*

Acknowledging the progress made across the UK in the previous 10 years, the report also recognised that this report was timely. It stated:

"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."

74. The report emphasised those significant harm reduction achievements of previous strategies, including the achievement of less drug deaths and BBV infections than many neighbouring countries. However, the report also intended to *"allay safe, evidence-based recovery-orientated practice to the public health and wider social benefits we already accrue from treatment."* It went on to describe how this could be achieved – emphasising the clear need for quality assurance of ORT treatments to ensure consistent high quality prescribing; introducing the need to help service users build their *"recovery capital";* delivering individualised, tailored care programmes based on individual need; using the techniques of *"phasing and layering"* of interventions – essentially delivering the most relevant interventions at the correct time as part of an individual's recovery plan.

Summary 3: Scottish and UK guidance on delivering recovery-orientated treatment

Definitions of recovery

- Many in the field have fixed views regarding what recovery entails and how it should be defined. However, strong definitions aligned with the views of international institutions exist, having gone through facilitated processes of development and consultation.
- The **UKDPC consensus statement**[76] has been seen as relevant by many in the field in the UK: "*The process of recovery from problematic substance use is characterized by voluntarily sustained control over substance use which maximizes health and wellbeing and participation in the rights roles and responsibilities of society."*
- **The Scottish Government**[1] has already stated its view: *"What do we mean by recovery? We mean a process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society. Furthermore, it incorporates the principle that recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment. In short, an aspirational, person-centred process."*
- **The Betty Ford Institute (BFI)**[47] Consensus Panel specifically addressed the question of Opioid Treatment Program (OTP) medications and recovery status by defining recovery in terms of sobriety, global health, and citizenship, and then by clearly stating that: "*…formerly opioid-dependent individuals who take naltrexone, buprenorphine, or methadone as prescribed and are abstinent from alcohol and all other non-prescribed drugs would meet this definition of sobriety."*

Clinical standards and guidance – medical treatments and recovery

- Treatment guidance for clinicians in the UK was last refreshed in 2007.[39] That guidance, for the first time included a dedicated/commissioned evidence base addressing all relevant medical treatments and also psychosocial interventions.
- Specific guidance on starting ORT safely, optimising dosage, demonstrating progress and reducing the likelihood of diversion is available in the guideline.
- The guidelines repeatedly emphasise the place of individual clinical judgement in making these decisions.
- Guidelines on the best way to deliver integrated care has been available since 2002 in the (Scottish) *Integrated Care for Drug Users: Principles and Practice* document (EIU, 2002)[52] or (English) *Models of Care Update* (NTA, 2006)[56] documents. More recently, the NTA-led *Medications in Recovery:Re-orientating drug dependence treatment*[53] has delivered a clearly articulated, UK-relevant view of potential mechanisms to improve recovery potential in ORT patients, if delivered.

SECTION 5:
FINDINGS: MEDICAL TREATMENT, PRESCRIBING AND DISPENSING OF OPIOID REPLACEMENT THERAPIES IN SCOTLAND

Section 5: Findings: medical treatment, prescribing and dispensing of Opioid Replacement Therapies in Scotland

"Substitute medication is effective to stabilise – it avoids illicit drug use – but it seems like trading one addiction for another.

- Is there a timescale to stop taking medication? (Know that everyone is different and needs may differ).
- What effect does the medication have on your body physically? (Not just side effects listed on accompanying leaflet)
- What effect does the medication have on you mentally?
- Does the time you remain on the medication affect your ability to come off it? i.e. If you are on medication for a long time does this in effect prolong the addiction and make it harder to stop?"

A service user's mother

Introduction

75. In the time that was available for this review it was not possible to visit or directly contact every specialist drug use service in Scotland. As stated earlier in the report *the Road to Recovery*[1] strategy aimed to build aspiration and opportunity into treatment services and was followed by a major revision of accountability arrangements with the Alcohol and Drugs Partnerships (ADPs) replacing the Drug Action Teams (DATs). In this context, it was decided to contact the ADPs – as the bodies coordinating the local response – to seek information on service delivery and provision.

76. The review team carried out a questionnaire survey of all 30 Scottish ADPs to ascertain what level of progress had been made in terms of governance and oversight of treatment delivery since the last review of methadone treatment in 2007. [As some ADPs chose to reply jointly, 28 responses were received by the review. All ADPs did respond and the discussions and data described below refer to 28 ADP responses for this reason.]

77. The questionnaire and 'results at a glance' are available at Annexes 4 and 5 respectively. The Chair of each of the ADPs signed off the completed questionnaire. In addition, some specific ADPs were visited – mainly opportunistically or as they had requested the opportunity to give evidence. Relevant evidence collected during the broader evidence gathering process is also included where relevant, reflecting a broad range of views regarding issues affecting the current delivery of treatment and recovery.

Quality of prescribing services

78. Information was collected regarding various aspects of ORT prescribing. The questions we asked ADPs about ORT were:

- How many people are currently being prescribed methadone or buprenorphine?
- What are the dose ranges and how long have people been on a prescription?
- What are the supervision arrangements?
- How many people have voluntarily detoxified from methadone or buprenorphine in the last two years?

79. From the questionnaire survey, six ADPs (21%) could give a complete breakdown and analysis of their prescribing activity. Seventeen (60%) could provide the range of doses prescribed. Four could only state that dose was a "matter for the prescriber" but was in line with national guidelines while one ADP provided no information at all.

80. Information was provided by ADP Lead Officers and signed off by the ADP Chair. Our assumption has to be that the data provided was of the highest quality. Missing data is, however, a serious concern and the reviewers would have preferred to ascertain why in some cases data was not fully provided. This could reflect that data was simply not being collected or was not in an auditable form. Time constraints meant this question remained unanswered. What is clear is that such information is not freely available in a useable form.

Numbers on ORT

81. *Regarding numbers on ORT:* Most ADPs – 21 (75%) could tell us how many people were on ORT in their area. Some six ADPs (21%) could give only partial information and one ADP gave none.

82. *Regarding dose:* Information on dose was less likely to be available. Some six ADPs (21%) could give precise information as to individual doses. Eight (29%) could give precise information as to the range of doses (highest to lowest) and 11 (39%) could only give partial information, expressed as an average dose across their services. In three ADPs (11%) no information was available on dose.

83. *Duration:* Some seven ADPs (25%) gave detailed information as to the length of time people had been on prescriptions (although four of these gave the longest as 'greater than five years' – suggesting data was incomplete for longer-term cases). The remainder gave no information.

84. *Supervision:* Some 18 ADPs (64%) could give accurate information on the number of people whose prescriptions were supervised. Nine ADPs gave partial information and one gave none. Perhaps surprisingly – with only 18 reporting the numbers supervised – 24 (86%) gave accurate *costs* of supervision while four gave none. It may be that specific funding of this service element makes collection of that cost information more consistent as it will be collected as a part of corporate

governance systems which may be more robustly overseen than those systems overseeing clinical standards. Some 23 ADPs (82%) could describe the circumstances under which people would be returned to supervision while five ADPs could not.

85. *Detoxification:* Some 19 ADPs (68%) were unable to state how many people had discontinued ORT in the previous two years. Only nine (32%) could say how many had voluntarily discontinued their prescription in the previous two years while three services in Scotland were able to satisfactorily produce individual outcomes.

National perspective

86. There was generally consistency of practice among the prescribing services from whom information was available. From evidence gathered from stakeholders and the ADP questionnaire replies there appeared to be satisfactory dosages of ORT used and good clinical practice generally. However, there was marked variation in the drug used for ORT and the use of supervised self-consumption of ORT.

Choice of drug for ORT

87. Choice of drug for ORT is at the clinical discretion of the prescriber – though this is in the context of national guidance and local policies or standards – and is agreed in consultation with their patient. The ratio of methadone to high dose buprenorphine prescribed in Scotland was very variable. The majority of ADPs who could comment stated the ratio was about 95% methadone to 5% buprenorphine except for two ADPs (65% methadone to 35% buprenorphine). Methadone was by far the commonest ORT treatment option. Choice, from the service user's point of view would seem to be constrained. Reasons given for a reduced availability of buprenorphine were not consistent, but included:

- Costs of the ingredient (some areas have considered use of buprenorphine but costed the use of buprenorphine up to 3 times the cost of a comparable dosage of methadone).

- Cost of supervision (buprenorphine requires much longer time to supervise, making it more expensive for pharmacists to deliver or impractical in busy city centre pharmacies).

- The length of time to supervise buprenorphine and the greater ease with which a tablet may be concealed and diverted compared to a liquid, are a serious consideration for the Scottish Prison Service (SPS) and it is unlikely they would plan to increase their use of buprenorphine at this time unless there is an increase in resources. SPS staff also gave isolated reports of diversion of buprenorphine/naloxone combinations in the prison setting.

- Even in those areas where buprenorphine is not used routinely as a first line treatment, it is often available to service transfers entering the area when already prescribed buprenorphine. It is also being used by services in cases where there are specific concerns regarding use of methadone (for example cardiac/ECG issues) or in cases of failure to stabilise on methadone ORT.

88. It must also be acknowledged that, as stated in recent systematic reviews of the research evidence, the current UK national guidance states that both drugs are equally effective treatments and methadone should normally be the first line ORT treatment unless there are specific clinical reasons to consider an alternative.

Service users' views

89. Individual service users expressed a desire to be given a choice of drug for ORT on commencing treatment in a service. They also wished to be given a choice of whether to choose long term maintenance on ORT or a detoxification regimen. Both service users and their families wanted their wishes to be taken into account when prescribing decisions were being made – for example, when they wanted to reduce the dosage of ORT following stabilisation. Some clinicians on the other hand, had concerns that this might lead to sub-optimal dosing, raising risks of "topping up" and increased overdose risk associated with reduced tolerance.

Quality of pharmaceutical support and services

> "There has been a vast improvement especially over the past 10 years in the treatment of drug users. People who use drugs can be treated humanely in pharmacies."
>
> ***Dennis Robertson MSP***

90. The role of pharmacists in the community is central to the delivery of high quality ORT as part of a ROSC and gives an opportunity to positively impact on the care received by an individual. The pharmacist may be the professional who sees the individual service user more frequently than any other. Their role brings great potential regarding improving quality and consistency of delivery across Scotland. In addition to other stakeholders, the researchers gathered evidence from the Scottish Government's Chief Pharmaceutical Officer and his team, the Royal Pharmaceutical Society, Community Pharmacy Scotland and other individual pharmacists in the field, including prescribing pharmacists.

National perspective

91. Since the turn of the millennium there have been increases not just in the number of pharmacies providing services and support, but also increases in the range and quality of their services and premises. Across the health field, there are ongoing developments around better utilisation of pharmacists by the NHS to contribute to better health outcomes. There are already services being delivered by pharmacists which enhance availability of a broader range of pharmaceutical care and enhance the quality of care and data collection – including the Chronic Medication Service which allows the pharmacist to support patients with their medicine who have a long-term condition.

92. In the substance use field, pharmacists already deliver key functions such as needle exchange and have supported the roll-out of the take home naloxone programme. They deliver other NHS pharmaceutical services of relevance to the

substance using population including, for example, the minor ailment service, acute medicine, the chronic medication service, sexual health, public health and smoking cessation. In addition, at all levels there is recognition that pharmacists could make a huge contribution to basic data collection (providing information on dosage, supervision etc.). There is a need to endorse further the notion of pharmacists as an integral part of the care team – as they are already in some areas, to look at joint training and better integration within the broader addiction services in a locality.

93. Pharmacists accepted the inextricable link between availability of supervision and diversion and would welcome national standards and criteria for supervision. They see those service users who are on supervised self-consumption far more often than other staff – usually daily – and would like to be routinely involved in decisions to change levels of supervision. They often have knowledge that would inform the level of supervision, but there are currently no formal pathways for the regular transfer of routine agreed information between pharmacies and services. This is in addition to the existing communication linked to the pharmacist's professional responsibilities associated with prescription dispensing.

94. Pharmacists stated that they would benefit from access to more formal referral systems to other care providers. Consideration should be given to extend access by pharmacists to shared information systems to facilitate a flow of essential information, including prescribed and dispensed medicines, across the care pathway. As stated in *Essential Care*,[5] the single case record/recovery plan should be owned by the service user. Consideration should be given to the patient having access to if not control of their record. Such systems have worked well for many years in maternity services, and it is normal in some countries for patients to have possession of their own medical records and results of investigations, such as X-rays, blood tests etc.

Locality issues

95. Pharmacies are much more likely to be present in areas of high deprivation than any other health care provider. Pharmacists in the community provide supervised self-administration of ORT in many areas with a high prevalence of problem substance use and are keen to continue to provide their services in those locations where they are most needed. It should be recognised that many community pharmacists have greatly improved their services and premises to this end – including, for example, employing extra staff to attend specifically to needs such as needle exchange and other public health and preventative measures for substance using clients. In many pharmacies the Scottish Government funded premises improvement monies which has been used to install and update private and screened consultation areas with resulting benefits for substance misuse patients and the wider population attending community pharmacies.

96. Other service providers, especially prescribers, recognised and valued very highly the service and support they received from their pharmacist colleagues. Several prescribers expressed the view that without the help and support from community pharmacy it would not be possible to have so many service users on ORT. One service provider felt that the pharmacy services should be fully incorporated with NHS services – rather than independent contractors.

Variation in outcomes, practice and services

97. Data quality makes conclusions difficult to validate. However, from the ADP questionnaire responses we received, there did not appear to be significant differences in prescribing practice generally across the country. From the evidence received, most areas reported that their services prescribed in line with the current live UK guidelines. It must be noted that these guidelines emphasise the place of individual clinical judgement in the management of individual cases. While they give clear standards regarding the management of the majority of cases, they acknowledge that in individual cases, a practitioner may choose to work outside these guidelines. In these circumstances, variation may be seen as positive – but may also mask significant differences in process, range of treatment options available or quality of care delivered. Local governance systems would be expected to ensure that any variation was appropriate and acceptable.

Diversion of prescribed drugs into the illicit market

98. Diversion* of ORT drugs is common and widespread – this is agreed by service users, providers and the criminal justice system. People involved in drug enforcement reported to the review that during drug raids it is not uncommon for empty methadone bottles to be found with either the patients names removed or the individual whom the methadone is prescribed for not knowingly residing at the address being raided. However, the review cannot conclude that methadone has necessarily been diverted.

99. Some service providers expressed the view that if there were no diversion of methadone then other substances would simply be used. There is no evidence for this but it is accepted that when supplies of a particular drug are reduced or absent then other drugs – such as those used in ORT – are sought as alternatives.

100. Some stakeholders and other commentators see supervision of consumption as one potential mechanism to reduce diversion – and some services promote supervision as the standard for the majority of ORT patients. Others see supervision as an element of the care process – in which the act of coming off supervision may be used as a "reward" in a contingency management process.

101. The recent reports of the National Forum on Drug-Related Deaths made no specific recommendations to do with supervision (Scottish Government, 2013).[24] They pointed out that in the majority of deaths where people had been on a methadone prescription most (64 of 89) were supervised. The forum stated:

"Questions about the nature of methadone prescribing and the value and protective effect of supervision are of pressing importance. There are clearly patients who die despite methadone supervision and others where methadone is implicated where the individual was not known to be in receipt of a prescription. Any clarity on the circumstances of these situations and the combination of risk factors which result in death is important."

* The unauthorised transference of a prescribed ORT to another individual for whom it was not prescribed

The most recent report also suggested that three-quarters of deaths were supervised and one quarter not (out of 110 deaths).

102. It is recognised that diversion is a serious, legitimate concern, and ideally a consistent response is required from prescribing clinicians and all involved service providers. It is the responsibility of a prescriber who is prescribing a controlled and potentially lethal drug to take reasonable action to prevent its diversion. The national treatment guideline, however, again emphasises clinical judgement.

Diversion and availability of supervision self-administration

103. In Scotland, one area of considerable variation was that of availability and use of supervised self-administration. Some areas in Scotland have traditionally delivered low levels of supervision – only supervising at selected periods of the year to ensure the person has maintained tolerance to opioids. Some have delivered very long term supervision of the majority of people on ORT. Most areas see themselves as attempting to respond to individual need – i.e. when circumstances change – work or training etc. – supervision may be less rigorous, if the person's stability is assured and risks can be ameliorated.

104. Many respondents – particularly service users, those in recovery and some service providers – believe that absolute supervision is a bar to recovery and resumption of work, education and employment. Unfortunately there is little evidence regarding what level of supervision is most efficacious in terms of treatment outcome. A US study suggested that there was no difference in retention in treatment between two to five days supervision at higher doses while at lower doses retention was reduced if five day supervision is used (Rhoades et al, 1999).[57] A Scottish survey of clinicians found wide variation in clinical practice regarding supervised self-consumption (Holland et al, 2009).[58]

105. There has also been little up to date research exploring any link between the supervision of ORT dispensing and the level of diversion. In 2004, the Clinical Resource and Audit Group – CRAG (which became part of NHS Quality Improvement Scotland – now Healthcare Improvement Scotland) supported a Confidential Enquiry into Scottish Methadone Related Deaths (MRD) (CRAG, 2004).[59]

106. The report described a review of 77 MRDs in Scotland in 2001, carried out in response to a concern that methadone had become more prominent as a potential cause of death – increasing by 39% from the previous year. The Confidential Enquiry process aimed to allow all staff involved in such deaths to be frank about what had occurred. The information collected was then reviewed by independent experts, anonymously – ensuring a more objective assessment. The purpose of the review was improvement – in particular, identification of any risk factors which could be modified.

107. The 2004 CRAG report[59] found that, in 2001, sixty four deaths had been classified as being *"directly related to methadone use".* At that time, one area was found to have a higher rate of *"methadone sole deaths"* – deaths attributed solely to

methadone – by a factor of 4. It is notable that this area had low levels of supervision at that time – but also prescribed low doses of methadone – with a mean dose of ~40mg/day. Despite large numbers of patients being prescribed methadone in Glasgow, *"there were no deaths caused solely by consuming methadone in the Greater Glasgow Health Board area which has a high rate of supervised consumption."*

108. The report asserted that it was important to be cautious when attempting to attribute cause and effect based on these data. Numbers at the time were small and what seem to be large differences may not have been significant. The report stated:

"It is important to emphasise that supervised consumption does not protect an individual user from a drug-related death. The cost-benefit of the further extension of supervised consumption should, therefore, be defined. The extension of supervision should also address the patient's autonomy within the community to take methadone in a private place. Rapidly flexible prescribing regimes need to be in place, particularly during times of crisis, including chemist access seven days per week with supervised dispensing when required."

It also cautioned that:

"Access to pharmacies dispensing methadone, with the option of supervision, plus private facilities, open 7-days a week may be becoming a rate limiting factor to treatment."

109. A recommendation that the use of this improvement process – the Confidential Enquiry – should be a standard activity in the Scottish treatment system was unfortunately not supported. In 2003, the Scottish Executive had commissioned a review of all deaths in Scotland (Zador et al, 2005)[60] and a new national process was launched. From 2006, the NFDRD has produced reports on deaths and continues to make recommendations to government in response to the available data – but the Confidential Enquiry process into methadone deaths was not rolled out.

110. Now, in 2013, improved intelligence and analysis is required to ensure high quality care is in place and improvement is embedded in ORT delivery. The reviewers note that NFDRDs has secured a commitment from the Scottish Government to establish a post which will investigate more fully the association between supervision and drug deaths.

Access to treatment

111. There is inevitably a tension between the desire to give rapid access to a medical treatment – such as ORT – and the need to ensure that the person's needs are comprehensively assessed and reflected in their care plan. There is a balance to be struck. Whilst any unnecessary delays are unacceptable, there is a need to afford such time as is necessary for assessment to ensure safe and appropriate delivery of the treatment options agreed with the service user. Whilst it is relatively straightforward to provide ORT safely and quickly, it is more challenging to provide access to an adequate person-centred recovery care plan.

HEAT A11

112. As part of the delivery reform process, the Scottish Government developed a target for local systems of care – HEAT A11.[61]

"*The purpose of HEAT A11 is to ensure that all individuals with drug or alcohol problems have access to a wide range of services at the point of need that are appropriate to their needs and which support their recovery."* (Scottish Government, 2009).[61]

113. The HEAT A11 target reports on access to nine "treatment types" which encompass the full range of interventions likely to be available for those experiencing problematic substance use. This includes prescribed treatments, detoxification and community based and residential rehabilitation interventions (Smith and Massaro Malinson, 2010).[62] National data reports that in all areas the national target – that 90% of individuals receive their first "intervention" within three weeks – has been achieved (ISD, 2013).[63] Unfortunately, the data available does not yet make clear how this has affected availability of all treatments or of ORT specifically. This further emphasises the need for improvements in the provision of useful datasets to better understand how treatment is delivered.

Length of time on opioid replacement therapies

114. It is not possible to provide an accurate report on the length of time persons spend on ORT in Scotland as, despite the issue of poor information being raised in the 2007 methadone review, data has not been routinely collected and, even now, is only being collected in a minority of services. It is currently not part of the national data collected through processes such as the relevant Scottish Morbidity Record (SMR25). Our survey found that a small minority of ADPs were collecting some data on length of time in treatment and whether or not any clients were detoxified (successfully or otherwise). Whilst no data existed in auditable form a few ADPs and clinicians interviewed gave their estimates or opinions on the length of time a person was on or needed to be on ORT.

115. The reviewers would have preferred to investigate whether auditable data existed but (for some reason) was not supplied to the review and to explore the reasons for these apparent deficiencies further. This is an important issue when considering improvement methodologies. The lack of data could not be investigated further due to the time constraints of this review.

Conclusions from ADPs and clinicians interviewed

116. The length of time an individual should be on ORT is variable and should represent individual circumstances as well as their personal resources and the services, care and support required to help them progress. Their history will be relevant. It may depend on the length of time a person has been using illicit substances, the severity of dependency, the associated impact on physical and mental health (or preceding health problems), degree of social impairment and many other factors. Some experience greater negative impacts on their lives.

117. Many drug misusers have pre-existing mental health problems. Research consistently demonstrates associations between substance use and mental illness. Intoxication, harmful use, withdrawal and dependence may lead to or exacerbate psychiatric or psychological symptoms. Conversely, psychological morbidity and psychiatric disorder may lead to substance use, harmful use and dependence (addiction) as part of a "self- medication" approach. The most common associations for substance misuse are with depression, anxiety and schizophrenia, but eating disorders, post-traumatic stress disorders (PTSD), attention deficit, hyperactivity disorder (ADHD) and memory disorders also commonly occur (Crome I, 2006).[64]

118. When entering ORT, many users quickly show objective change in their drug use, health status and social functioning. However, avoiding illicit painkilling drugs, which ameliorate distress, often means that underlying issues – pain, psychiatric issues, insomnia – become more prominent. At times these may be manageable using basic psychologically-based approaches (anxiety management; sleep hygiene etc.). But for many – especially those on long term high doses of ORT – more specialist psychological or psychiatric treatments may be indicated. Access (or otherwise) to these will affect progress from ORT.

119. The reported time on ORT varies from a few months to many years. Some respondents suggest that those with a short/uncomplicated history of illicit use and who have good *recovery capital* should not be offered ORT at all or should only be offered ORT as part of a short detoxification regimen. This may have a degree of face validity – and certainly fits the views of service users – but there remains a lack of research evidence to support or refute such a view. Indeed, some of the observational longitudinal studies in the USA (cited above) found that over years, those who accessed detoxification tended to return to regular use, often leading inevitably to ORT. There are many factors which could influence such outcomes – including the degree and quality of support and psychological treatment available. Clearly, further valid research is necessary to clarify what services are essential and how these should be delivered.

120. Some clinicians stated firmly that they had no concerns with prescribing long term ORT and regarded ORT as being comparable to any chronic therapy as for diabetes, asthma or hypertension. This may seem to challenge the aspirations and hopes embedded in the concept of recovery – particularly in cases where the goal is towards abstinence. But the reviewers consider that recovery must ultimately be about personal journeys. Some service users state they would prefer long term ORT – having experienced stability which has been lost when they came off ORT. Some clinicians prefer long term ORT as they are concerned about lost tolerance after detoxification, potentially resulting in a fatality.

121. What is more important, is that service users are afforded all the services they require to meet their needs at any point in their own journey with regular opportunities for review and, when they are ready to do so, are given the opportunity to come off ORT safely. It is equally important that those who do choose to cease ORT are not "lost to follow up" but are monitored and reviewed for at least a year and have the opportunity to restart ORT without delay if they do struggle to progress and require to do so.

122. One large long-term observational cohort study of Scottish drug users particularly looked at the potential benefits of ORT in prolonged treatment and demonstrates the challenges faced in this field – and the research required to direct treatment approaches (Kimber et al, 2011).[65] This study was conducted in a practice in Edinburgh and followed up samples of a cohort of 794 patients recruited from 1980 – 2007. Many had been on ORT for varying periods during the follow up. The study reported that morbidity and mortality continued to improve – especially in those on ORT for more than five years. For each additional year of ORT the hazard of death before long term cessation fell by 13%. However, the investigators also found that exposure to ORT was inversely related to the chances of achieving long-term abstinence. ORT patients were less likely to die but also less likely to become abstinent.

Opinions expressed by stakeholders:

123. These are as follows:

Healthcare professionals

- Most healthcare professionals – including prescribing clinicians – felt that long term prescribing was not problematic – provided it met the needs of the patient and there was a process whereby the patient was regularly reviewed.

- Healthcare opinion was divided as to whether abstinence was the absolute goal for everyone. Some prescribing clinicians felt that due to the high level of relapse following becoming drug free and the associated risks this brought – to detoxify anyone was to put them at increased risk of death.

- Other service providers felt that person-centred and recovery-focused systems of care should facilitate and support the individual's informed treatment option – although always with a safety net. This should include regular review of progress against their own plans and immediate re-entry into prescribing services if they relapsed for a year after detoxification from illicit drugs or ORT.

The issue of length of treatment was the subject of correspondence with one of our international referees. William White stated:

"Preoccupations with how long someone is involved in ORT obscure the more critical issues of the circumstances under which ORT is terminated and the lack of assertive monitoring and early re-intervention following such cessation. In the U.S., there are periodic moral panics about the idea of patients being on methadone for prolonged periods—an image that obscures the real problem which is that most patients are not on methadone long enough, e.g., high rates of early drop-out, administrative discharge and rapid resumption of opioid addiction." (Personal Communication to Review Team. William White, 2013).[49]

Despite the real differences between the services delivered in the USA and the UK this statement has synchronicity and resonance.

Families

- Scottish Families Affected by Drugs (SFAD) gave an opportunity for the review to hear the families' concerns. *[This was based on a Conference presentation to SFAD and a Question and Answer session followed by a face to face consultation with some 20 delegates – personal communications were also received].* The consensus was clearly that these families generally do not support the use of ORT.

- Most concerned family members felt that ORT reflected a process which simply replaced one addiction with another – often perceived (by the families) to be worse – and harder to move on from. Methadone was at times seen as abhorrent while Suboxone or Subutex were perceived to be less so. It was not clear why this different view was held with regard to these drugs. Many expressed overt hostility to the use of methadone as a treatment. A few respondents, following discussion of the evidence for ORT with the reviewer, conceded that in extreme cases methadone might be used in stabilisation and detoxification. But they were of the view that this should take place over a maximum period of a few months.

- There has been considerable development of plans to support communities and families in Scotland and governmental support to key groups – such as SFAD and SRC – was widely welcomed. Despite this, families clearly expressed a need for more easily available support and advice. Again there are inconsistencies described. It was reported that, apart from SFAD, SRC, the Lighthouse Foundation and Al-Anon, there is often little organised support for families across Scotland – including for families who have experienced the death of a loved one. Some services describe making services available – but families not finding them appropriate or practically useful. Like substance users, families have differing needs at different stages in the recovery process.

- The reviewers were asked by one MSP regarding research into anxiety or depression in families affected by substance misuse. Was there an increase in psychiatric illness in this group? These are thoughtful questions which deserve an answer and perhaps SFAD would be prepared to be involved in this particular area as well as developing partnerships and networks across the country.

Service users

- User groups, people in recovery and with lived experience delivered a strong consensus regarding the place of methadone in treatment. They largely felt that some time on methadone or other ORT was often an essential component of the recovery journey. Many of them felt, however, that methadone had been all they were offered when asking for treatment. Many felt they were not reviewed regularly nor supported in their desire to reduce their methadone dose or detoxify.

"Methadone was really useful to me at first. It helped me stop using street drugs and get things stable again but I was on it too long and no-one seemed to want to help me come off. There weren't enough staff about and they were all far too busy. Their case loads were far too high to expect them to give anyone much help. I took myself off in the end."

"It saved my life. I stopped injecting, stopped using drugs. Got to know my family again."

"I'm working now as a painter and decorator. I pick up my script weekly and will look at coming off it sometime but not at the moment. My wife wants me to but we both worry about what might happen if I started using again."

"Methadone just zoned me out. It was like a cosh. I couldn't think, didn't want to do anything. It's everywhere. It's too easy to get. It's just swapping one addiction for another. It's not an answer."

"It seems to be killing a lot of people at the moment. When the cure kills more people than the problem then that's difficult."

Service Users

Methadone dose

124. Opinions from stakeholders are divided regarding dose. Patients often do not wish to be on high doses as they believe this will make coming off more difficult in the future. Some clinicians expressed caution regarding reducing the dose of methadone. Even when patients were relatively stable, they felt that reduction was often dangerous as it resulted in people being maintained on "sub-therapeutic" doses which exposed them to increased dangers of relapse or "topping up" with other substances including benzodiazepines and/or alcohol. Other clinicians expressed a broader holistic picture of the person's progress and stated that they include their recovery aspirations in any decision-making.

125. Clearly, just as a universal supervision rule could impact on recovery potential, insisting on patients staying on ORT – or on a higher dose – will inevitably reduce progress. The *Orange Guidelines*[39] again promote individual clinical judgement – making it clear that the clinician's objective assessment and a process which engages the user in planning their own care is key.

Availability of additional support, counselling and "wraparound services"

126. When in treatment, guidance makes it clear that additional support is valuable in helping individuals take control of their drug use, avoid lapses and potentially progress to recovery. *Essential Care*[5] describes how such services should be organised and based on the service user's needs and goals. While services clearly aim to deliver such holistic care, many struggle to realise this.

127. There may be many causes for these problems, including: some medical services may have been designed to focus on ORT and not on the additional services recommended; staff may not be trained or skilled or may lack empathic attitudes and attributes to promote recovery; caseloads may be so high or other demands – such as administration – may mean that staff cannot find the time to deliver these elements of care; partnerships may be poorly developed – or partners may not be fully equipped to fulfil their obligations in that plan; some essential services (e.g. psychology or psychiatry) may not be available in an area or may not prioritise the specific concerns of substance users.

128. Many of those service users in recovery who were interviewed as well as members of SFAD stated a clear view that many service providers were not encouraging or empathic, giving the expectation that long term ORT was all the service user could aspire to and resisting requests to reduce their ORT, detoxify or consider residential rehabilitation facilities. This complaint from the users of services has been a consistent feature when service users' views have been sought from *Reducing Harm, Promoting recovery* (2007),[13] *Essential Care*[5] (2008) and during *The Great Debate* (Roberts, 2009).[66] One underlying issue remains the stigma held by many – including professional staff – towards substance users (UKDPC, 2010).[67]

Workforce development

129. The *Road to Recovery*[1] strategy had identified the need for workforce development to enable practitioners to progress beyond an emphasis on harm reduction and embrace the holistic, person-centred approach required to be able to facilitate recovery. The 2009 delivery framework, A New Framework for Local Partnerships on Alcohol and Drugs, outlined the leadership and decision-making arrangements for delivery of action to reduce drug and alcohol misuse. It set requirements for local alcohol and drug strategies that included the requirement to "consider issues such as workforce development and ensuring the workforce is equipped with the skills to deliver".

130. The Scottish Government strategic statement on the drug and alcohol workforce (2010)[68] described the alcohol and drug workforce and identified learning priorities for all levels of the workforce including commissioners of services; professional bodies and education & training providers; service providers and managers; and individuals within the workforce. These priorities go beyond a narrow perspective of workforce development as participating in training courses and address a combination of competence, skills, expertise and values. The statement, developed in collaboration with COSLA; NHS Health Scotland; Scottish Drugs Recovery Consortium; Alcohol Focus Scotland; NHS Education Scotland; Scottish Training on Drugs and Alcohol and others, contributes to the wider public service reform agenda and importantly acknowledges the expertise of service users and people in long-term recovery.

131. In many cases, there is a clear need for managers to be able to discern the learning needs of the workforce as an inextricable part of strategic planning to achieve outcomes. Workforce development in the context of the drug and alcohol workforce therefore represents more than simply training people to perform certain

operational functions. In this context the value of engaging with people with lived experience of recovery is critical:

"Scotland's drug and alcohol workforce is drawn from a wide range of sectors, including health, education, social work and the voluntary sector. Our aim is for this workforce to be united around a shared vision, focused on the needs of individuals. The workforce will learn from and value the service user, who is an expert by experience - and enable them to lead satisfying, hopeful and contributing lives. In the near future, it is likely that the more traditional 'workforce' will be joined by people in recovery themselves, recruited because of their 'lived experience' of addiction. Contributing as peer mentors and supporters of those in recovery, they must also be skilled and trained to become an effective part of the alcohol and drug 'workforce'."

132. A number of programmes are now in place to support progress towards these goals – The Scottish Recovery Consortium has developed tools and courses delivered in local areas ensuring that practitioners have a developed understanding of and belief in recovery; following a strategic re-alignment STRADA is developing approaches and tools for Alcohol and Drugs Partnerships to undertake assessment of local workforce learning needs; The Scottish Drugs Forum is working directly with services to assess and improve quality and develop effective engagement with service users. A national knowledge portal[69] has been developed containing education and development resources and tools derived from good practice that are freely accessible to the entire drug and alcohol workforce.

133. In the professional sectors – following research commissioned to explore the potential of social work in drugs and alcohol recovery, a project (Scottish Government, 2011)[70] is currently underway to map current sources of professional education and training and ensure that further and higher education for social work is aligned to the national learning priorities. The learning from this work will be used to develop similar approaches for other relevant professional sectors including clinicians and pharmacists.

Professional training in relation to recovery-focused ORT

Service level issues

134. Training for front line staff at all levels may come from several sources, including: in-house, joint training with other services and disciplines; training packages supplied by national providers such as Scottish Training on Drugs and Alcohol (STRADA); further and higher educational institutions; specific professional training (from Royal Colleges or a range of specialist professional bodies). Staff will have differing needs – reflecting their roles in association with substance misuse. Professional staff will also be required to balance any specialist training needs alongside more generic or "mandatory" training expectations in their organisation. Funding is inevitably an issue – not just the cost of the training itself, but also the time off work required.

135. Stakeholders gave a number of views on training. Joint training with other disciplines and agencies has long been thought to promote teamwork and co-operation but at times it may be forgotten that those delivering specific (specialist)

therapies also require specialist training, supervision and continuing professional development (CPD) too. It is recognised that training will need to be tiered and structured but there must be a governance system in place to assure quality and value.

136. The Royal College of General Practitioners (RCGP) substance misuse lead in Scotland believes if GPs were funded to undertake appropriate training they could greatly increase their role in service provision. The RCGP Certificate Course originally had Scottish Government funding, now – as in most types of professional training – GPs are expected to subsidise themselves.

137. The issue of lack of relevant training was a common concern raised with the review team. STRADA were among several stakeholders consulted who felt addiction services had become too generic, and many commentators referred to it as *"dumbing down"* of services. Service providers too, particularly those who had worked in secondary care and specialist community mental health services, felt their skills were not being utilised, and expressed concerns that skills unused would be lost or need updated.

138. STRADA more precisely stated that, in their view, there was a risk of "*de-professionalisation"* among trained staff delivering services with increasing numbers of drugs workers insufficiently trained or lacking the necessary skills or abilities at present. Views expressed from front line workers from NHS services regularly supported the view that they were unable to deliver services that they were trained and competent to do (Cognitive Behavioural Therapy – CBT – was one such treatment option frequently cited) as a result of time pressures - partly reflecting the size of their case loads, but also the need to perform more generic duties or to lose time through use of inefficient recording and administration systems.

Issues for the individual

139. All individuals require appropriate training, clinical supervision, and governance to be able to do their job effectively. Appropriate supervision should direct continuing personal and professional development, identifying training needs and facilitating appropriate action to address deficits. Individuals with professional qualifications are also required to satisfy their professional bodies through appropriate levels of Continuing Professional Development (CPD). Like other professional staff, lived experience workers also need training and clinical supervision.

Support and supervision of workers

140. Many workers in addiction teams expressed the view that their operational managers were oblivious to their concerns and objections regarding increasing case loads, the lack of useful IT systems and expectations regarding the use of multiple assessments/recording systems/databases relating to NHS and Social Care.

141. Generally, it was reported that supervision was available to professional staff. It was mainly described as satisfactory although some frontline workers complained of not being supported to attend the specific training courses they had requested.

Some (negative) reports stated that service needs were often more important than personal development and some workers felt obliged to attend courses that they did not feel were necessary or helpful to their Personal Development or CPD but *"ticked boxes"* for the team.

142. It is appreciated by the review that it is difficult for managers to assure that team members have access to relevant essential training as well as opportunity to fulfil personal aspirations.

Good Practice Example - Prescribing Services

- Service user offered choice of ORT drug at first presentation.
- Well structured, properly reasoned sequence of supervision.
- Broad economy of prescribers (specialist, GP and Non-Medical Prescribers).
- Well recorded and documented progress through service.
- Good access to services in rural and semi-rural area.
- Good levels of appropriate psychosocial support.
- Good contact of services with recovery communities and mutual aid groups.
- Provision of smart recovery plans and regular reviews including risk assessment.

Drug-related deaths

143. In most parts of the world access to ORT as part of treatment is associated with reduced drug deaths. In association with increased availability of ORT in many parts of the UK, drug-related deaths have reduced. Unfortunately, despite having delivered increased availability and uptake of ORT, Scotland has not followed this trend and reducing drug deaths has rightly been a national priority for some years.

144. The most recent drug deaths data are contained in the General Register Office for Scotland (GROS) Report, Drug-Related Deaths in Scotland in 2011

(GROS, 2012).[8] In 2011, 584 cases were included in the cohort of which nearly two-thirds had a history of drug injecting. In 68.9% more than one drug was implicated in the death.

145. Regarding the issue of ORT, key points include:

- 64.5% had been in contact with a drug treatment service at some point and in the 6 months prior to death. One-third had been released from police custody and almost a fifth from prison.

- The proportion of deaths with heroin/morphine and alcohol decreased from 2009-2011, while the proportion of deaths with methadone, diazepam and anti-depressants increased over this period. In 2011, diazepam was the drug most frequently found at death (81.4%) and methadone was the drug most frequently implicated in the death (53.4%).

- The majority of individuals (150, 60.7%) with methadone found in their toxicology were not in receipt of a methadone prescription at the time of death.

- 73.8% were not currently in receipt of a prescribed substitute drug.

146. It is clear that drug deaths remain a major and increasing challenge. Key points of note from this review are:

- There is a substantial group who were not in treatment – but may have been accessing more generic services – in particular primary care, criminal justice and mainstream NHS services. This includes the prison release population.

- The issue of methadone diversion has become increasingly important.

- Diazepam remains the most common drug found – but its relevance is not clear.

147. Action to address drug deaths must be focused on using the evidence base to better impact on this tragic outcome. This is a complex issue – as many potential risk factors have been found to have limited predictive value in research studies. However, prior to their deaths many fatalities have been in contact with services including the service they had previously been treated by, Primary Care, Accident and Emergency or Criminal Justice departments. If information about these persons' vulnerability had been shared, opportunities to intervene could be identified and exploited.

148. In Scotland, the Scottish National Forum on Drug Related Deaths is tasked with giving advice to government regarding how best to address drug deaths. The Forum has just published its most recent annual report.[71] Regarding ORT, the Forum suggested areas which may reduce drugs deaths if addressed. These included:

- Better choice of ORT – pharmacology implies that buprenorphine (a partial antagonist at opioid receptors) should be more protective than methadone (though research evidence is not compelling currently).

- Quality issues – how ORT is inducted and optimized; degree of skilled counselling and support available; dose; retention in treatment.

- Treatment setting and interface issues – e.g. the criminal justice system; discharges from prison or hospital etc.

- Issues of supervision and diversion.

- Use of new approaches – contingency management.

- Exploring alternative ORT treatments which are available outwith Scotland or consider using them in the Scottish context especially in cases of treatment failure (still using injectable illicit drugs despite being on an optimized ORT regimen and service) – e.g. offering injectable methadone or Diamorphine.

- Potentially using safe injecting rooms.

149. Such approaches are controversial, expensive and their use would require considerable strategic planning in Scotland. They are not easy options but their use has been associated with positive outcomes in other countries. However, these examples have been developed as part of a comprehensive and long term range of services.

The cost of methadone to the NHS

150. One important issue raised in the Parliamentary debate (reflecting the preceding news coverage) was concern regarding the way methadone dispensing is funded – with some critics perceiving that this resulted in community pharmacists achieving excessive profits from the delivery of an essential service. The political and media debate around this point was often heated and was therefore an important area to explore as part of this review.

151. In this context, opinions have been received by the review team regarding the need to explore whether methadone ingredient costs could be minimised, with any potential savings recycled into the development of recovery-orientated services and the extension and development of the quality of pharmaceutical care services in the community. It has been stated that, in high volume services such as those involved in the delivery of methadone ORT across Scotland, even small fluctuations in the cost of the drug ingredients or their delivery can impact considerably on the overall cost of the medical treatment component of the delivery system. Problem substance users are already a marginalised patient group, at higher risk of significant morbidity and premature death than their peers. It is essential that all resources available to ameliorate this risk are used efficiently and targeted towards effective interventions.

152. The review team took advice from members of the Scottish Specialist Pharmacists in Substance Misuse (SPiSM) – who offer expertise and governance to

local substance use services regarding prescribing issues, interviewed pharmacists as part of the stakeholder evidence gathering exercise and had initial discussions regarding funding issues with the Chief Pharmaceutical Officer for Scotland. Local service providers – NHS managers and prescribers often had strong views regarding this issue.

Payments to pharmacies

153. The mechanisms in place to set the prices paid by NHS Scotland for drugs dispensed in Primary Care and for the remuneration for the delivery of Pharmaceutical Services are complex and at times can seem opaque. However the review group has received the following clarification from the Scottish Government in respect of both reimbursement and remuneration arrangements. These are subject to consultation with Community Pharmacy Scotland (CPS) as the body recognised by the Scottish Government as representative of community pharmacy owners/contractors. The detailed arrangements from time to time in force are detailed in the Scottish Drug Tariff which is published on line by NHS National Services Scotland Information and Statistics Division.

154. Reimbursement and related discount clawback arrangements for drugs dispensed by community pharmacy owners/contractors are set to take account of both overarching agreements such as the Pharmaceutical Price Regulation Scheme (PPRS) in respect of proprietary drugs and local Scottish arrangements for the management of margins achieved by Scottish owners/contractors on both proprietary and generic drugs. This means that reimbursement prices for generic drugs as a whole are set to manage margins in a way that delivers an overall funding envelope across all owner/contractors, which is necessary to fund the Scottish network of community pharmacy owner/contractors.

155. The Scottish Government in conjunction with CPS regularly monitors on a sample basis the prices being paid by owner/contractors for dispensed generic drugs including methadone. Reimbursement prices for all generic drugs are subject to ongoing review but the Scottish Government believes that those currently set for generic methadone preparations remain above that available in the market so that those dispensing methadone can still make a fair margin on those purchases and are incentivised to seek out the best prices available on the market.

156. Payment received by pharmacists for delivering methadone has three elements. These are:

Dispensing and supervision fees

157. Dispensing fees and additional supervision fees for supervised consumption provide community pharmacists with fees for delivering a professional service. The setting of methadone dispensing and supervision fees for community pharmacy owner/contractors is devolved to Health Board level. These fees vary across Scotland as they are negotiated locally by NHS Boards and reflect local circumstances and expectations. These negotiations bring opportunities to improve the quality and range of interventions available to the patient.

Re-imbursement of the ingredient costs of the drug

158. The reimbursement costs of all drugs are complex and set out in the Scottish Drug Tariff[72] as outlined to the review group and detailed above. In response to a parliamentary question in 2012 (S4W-09271) the Minister responded:

"Methadone solution is purchased by community pharmacies who dispense it against NHS prescriptions and are then reimbursed for all dispensings. The purchase price varies by contractor, and over time as they strive to achieve the best possible purchase price from suppliers on behalf of the NHS. A reimbursement price is set for Scotland after consultation with pharmacy contractor representatives and published in the Drug Tariff. The current reimbursement price for generic methadone hydrochloride solution 1mg/ml 500mls, which is the most common prescribed form, is £4.70. Pharmacy contractors dispensing methadone may also receive dispensing and supervision fees set by the relevant health board. These fees are agreed locally and vary between health boards."

159. From the information the review group received it appears that methadone ingredient costs are inextricably linked to the totality of the pharmacy remuneration negotiations.

160. The Chief Pharmaceutical Officer confirmed that the approach to methadone costs in Scotland was now *"more pragmatic in that the price is set by negotiation between Scottish Government and the owner/contractor body in Scotland (CPS) based on sample information of purchase prices actually being achieved and an agreed process for factoring the aggregate sampled purchase margin achieved for methadone into the calculations on the overall funding envelope for community pharmacists in Scotland"*. He confirmed that this process had been introduced *because "previous arrangements based on the process in England was producing inappropriately high reimbursement prices e.g. £9.57. This now results in the much lower reimbursement price in Scotland (£4.58 by comparison with £6.42 in England)."*

Outcome

161. The review group recognises that there are complex issues to be addressed regarding reimbursement of methadone ingredient costs and that attempts to reduce this in isolation brings potential risks to the stability of the system as a whole. However, methadone is an essential component part of treatment services and is unlike the majority of other prescribed drugs dispensed in community pharmacies due to the extensive impact of treatment on "health, criminal justice, social care, costs to the economy and wider costs to society" (Casey, Hay, Godfrey and Parrot, 2009,2).[73] Against this background there is a logical argument that methadone ingredient costs should be treated as a separate element in pharmacy payment negotiations. The review group recognise that this is not currently possible within the existing arrangements as described governing pharmacy remuneration but recommend that this is an area worthy of further exploration.

162. Although it is possible to identify and track individual dispensing, supervision and drug ingredient costs for methadone it is difficult to extricate the impact of changes in methadone ingredient costs alone and how this would impact on the totality of the pharmacy remuneration package. However, in the context of a drug that is prescribed in such high volumes for long term treatment that ultimately has an impact across a wide range of health, social, justice and community factors – it is important to ensure that best value is being achieved – in line with the principles described by the Christie Commission[2].

163. It is recommended that steps are taken to investigate the complexities of the current pricing structures and to explore if any potential alternative new mechanisms could be developed to further reduce drug costs.

Good Practice Example: General Practice

A service which offers comprehensive care in local communities

- Family practice with responsibility for all members of the family of people with problem drug and alcohol use.
- All aspects of mental health and physical health care included in assessment and treatment.
- Able to access all aspects of primary and community care and to refer to all specialists NHS has available.
- Liaison with third sector community groups, schools and social work departments.
- Value for money in GP enhanced service contract and core medical services.
- Shared premises with nursing, midwife, counselling and advocacy services.
- Teaching and research capability.
- Linked in to Primary Care audit and management departments.

Summary 4: Medical treatment, prescribing and dispensing of ORT in Scotland

- Service users are not routinely offered a choice as to which opioid substitute drug is used. Service users, likewise, are not afforded a choice as to whether they have maintenance ORT or detoxification, and report, as do their families, that their wishes are not acted upon in this respect during treatment with ORT either.

- Information was poor generally. However, dosage levels and clinical practice regarding ORT prescribing (when reported) seem to be reasonably consistent throughout Scotland and other than large variation in the use of supervised self-consumption of opioid substitute drugs there are no major issues identified.

- The development of pharmacy services and community pharmacists as part of the team in delivering ORT has had an immense and welcome impact.

- Methadone drug costs reflect a complex and integrated pricing formula involving many different elements. While it is recognised that this may be a challenge to address, it is recommended that steps are taken to investigate the complexities of the current pricing structures and to explore if any potential alternative new mechanisms could be developed to further reduce drug costs.

SECTION 6:
FINDINGS: RECOVERY-ORIENTATED TREATMENT

Section 6: Findings: recovery-orientated treatment

> "The 'recovery package' should continue as long as is necessary, remaining standard and robust, not ending when the addict reduces or ceases the medication or completes a programme of therapy. There should be inbuilt expectations.
>
> The addict may not know intricately what they really need at that precise moment – they are not leading very structured, disciplined lives – but need to be able to feel that they are making progress and taking steps to recovery and that as part of a bigger picture they will recover."
>
> ***A service user's mother***

Recovery-Orientated Systems of Care (ROSC)

164. A *Recovery-Orientated System of Care* can be seen as a coordinated network of community-based services and supports that is person-centred and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence (which may include a person stable on ORT), and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems. The publication *Recovery Oriented Methadone Maintenance* (White and Mojer-Torres, 2010)[74] helped establish and structure the issues addressed in this part of the review and the elements investigated. These are:

- Treatment should be needs-led;
- Person-centred choice of treatment options;
- Service-user involvement;
- Family involvement;
- Use of the person with lived experience;
- Choice of opioid replacement therapies;
- Quality of relationship between prescribing and recovery services;
- Connection to broader recovery communities.

165. A number of commentators (Gilman M., 2008)[75] have likened the ROSC to a bridge linking the world of Treatment Services to Recovery Communities and the wider community. The UK Drug Policy Commission Consensus Group's Vision for Recovery[76] referred to at Section 4, para 55 is illustrated below.

UK DRUG POLICY COMMISSION CONSENSUS GROUP: A VISION FOR RECOVERY

Recovery must be **voluntarily-sustained** in order to be lasting, although it may sometimes be initiated or assisted by 'coerced' or 'mandated' interventions within the criminal justice system.

Recovery is a **process**, not a single event, and may take time to achieve and effort to maintain. The process and the time required will vary between individuals.

Recovery requires **control over substance use** (although it is not sufficient on its own). This means a comfortable and sustained freedom from compulsion to use. For many people this may require abstinence from the problem substance or all substances, but for others it may mean abstinence supported by prescribed medication or consistently moderate use of some substances.

Recovery requires **aspirations and hope** from the individual drug user, their family and those providing services and support.

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

Recovery may be associated with a number of different types of **support and interventions** or may occur without any formal external help**: no 'one size fits all'.**

Recovery is about building a satisfying and meaningful life, as defined by the person themselves, and involves **participation in the rights, roles and responsibilities of society**. The word 'rights' is included here in recognition of the stigma that is often associated with problematic substance use and the discrimination users may experience and which may inhibit recovery. Recovery embraces inclusion, or a re-entry into society, and the improved self-identity that comes with a productive and meaningful role. For many people this is likely to include being able to participate fully in family life and undertake work in a paid or voluntary capacity.

Recovery **maximises health and well-being**, encompassing both physical and mental good health as far as they may be attained for a person, as well as a satisfactory social environment.

Recovery is about the accrual of **positive benefits**, not just reducing or removing harms caused by substance use.

UK Drug Policy Commission: www.ukdpc.org.uk

Good Practice Example from an ADP area
(Other ADPs have made similar arrangements)

Recovery Orientated Systems of Care (ROSC)

- One ADP area has commissioned a new alcohol and drug recovery support service based on the principles of the ROSC and working alongside NHS treatment services. The ROSC group is a sub- group of the ADP and draws representation from services and service users as well as health, local authority, education, employment, criminal justice and welfare agencies and the local family support group.

- The ADP has simultaneously supported the development of a Recovery Community Group which has been formally constituted with a broad membership and which has service users and previous service users as its executive officers. This group acts as the main conduit for service user opinion and action and has representatives on both the ADP and the ROSC sub-group (of which it is the vice-chair).

- Over the last year the Recovery Group has established a weekly, well attended Cafe, in conjunction with the Salvation Army, which includes a structured volunteer programme allowing people to develop skills and to access training and a variety of activities to support their sustained recovery. The cafe also hosts mutual aid groups.

- The Recovery Group has also organised a recovery walk attended by over 200 people and, with the support of the ADP and Creative Scotland, a Christmas fair and pantomime produced and acted by their members. This was held in the Town Hall and attended by many members of the public which helped to begin the process of reintegrating service users with the broader community (the Lord Provost subsequently wrote the group a letter of thanks and congratulation). Subsequently funding has been made available for regular drama workshops with the Group and Creative Scotland. The group has successfully negotiated with a local college for the use of 10 acres of land as allotment space.

- The ADP has now put aside funding to support the employment of two Peer Support Workers as an essential part of the alcohol and drugs workforce. It has also set aside further funding for training for trainers in Peer Working. This is aimed at members of the Recovery Group in conjunction with the SDRC and Crew 2000.

- The ADP funded the use of the Recovery Knowledge Inventory Survey taken by all alcohol and drugs workers to assess the extent of staff comfort when working with recovery. A series of Action Learning Sets were then established with staff to address those deficits identified, to build a consensus of the principles of a ROSC and to generate solutions for its continuing implementation. These Action Learning Sets were subsequently also extended to service users and ultimately were offered jointly to both staff and service users.

- The ADP supported the development of a Methadone Cessation service to provide intensive support for those who wished to discontinue methadone as part of their work towards recovery. This has been very positively evaluated by service users.

- NHS staff have been trained as WRAP (Wellness Recovery Action Plan) facilitators to ensure that service users are continually encouraged to identify strengths as they build recovery capital. In addition all services are benchmarked against SRI (Scottish Recovery Indicator 2).

ADP survey: Recovery-Orientated Systems of Care (ROSCs)

166. The questions assessing the degree of the development of recovery oriented systems of care in the ADP survey included:

- What arrangements are in place for service user representation in ADP decision making and how are you pursuing the establishment of peer education and peer working?
- How confident are prescribing service workers in pursuing recovery?
- What are your arrangements for delivering a ROSC and engaging with local communities?
- What contact do services have with mutual aid groups?
- What use is made of residential rehabilitation?
- What use is made of community rehabilitation services?

Service user involvement

167. Some nine of 28 ADPs (32%) had service users as members. However, 14 out of the other 19 (50%) had robust mechanisms in place to access service user opinion on decision-making. Four ADPs did not appear to have any mechanism in place for incorporating the views of service users but all four stated their aspirations to this in future. One ADP had neither representation nor means of seeking service user opinion, and made no mention of any plans for doing so. There was clear evidence of the establishment of peer education/working in 10 of 28 ADPs (36%), plans to do so in six (21%) and no evidence in 12 (43%).

Staff attitudes to recovery

168. Most ADPs did not appear to have any doubts that service providers were pursuing recovery oriented systems of care. Two replied they were 'perfectly confident' and offered no further comment. Ten (36%) offered no evidence as to how they had established that this proposition was correct and gave no suggestion of any plans so to do. Twelve (43%) had developed on-going worker development whilst five (18%) had put in place one-off training exercises for existing workers and gave no suggestion that there was more to be done in pursuing the recovery agenda with staff. There was no evidence offered by these ADPs to suggest that more was required.

169. The three areas that had attempted to measure staff attitudes to recovery (using for instance, the Recovery Attitudinal Questionnaire) found, however, that staff in the main were broadly pessimistic regarding recovery and had subsequently put into place regular and ongoing training measures for their staff. One ADP area, having undergone a recovery oriented redesign of services is now in a coaching relationship with another ADP in an attempt to replicate this process.

170. It is worth mentioning that the Scottish Drugs Forum have recently been appraising the quality of staff attitudes towards recovery with devices such as the 'mystery shopper" and regular conversations with service users although it is too early to draw much in the way of conclusions from this. The Scottish Recovery Consortium has been working with a number of ADPs at both a regional and local

level to try and raise awareness that there may be a deficit in attitudes to and implementation of recovery orientation and arranging meetings and conversation cafes to address the issue.

171. Some authorities (e.g. William White, 2013)[49] would suggest that such therapeutic pessimism is influenced by the pathology-focus of (often medical) addiction treatment and the lack of recovery-orientation within the training of those charged with treating addiction.

Delivering recovery-orientated systems of care and community engagement

172. The ADP survey suggested that most areas recognised the importance of developing ROSCs and 13 (46%) had either established a ROSC sub-group of the ADP or had a variety of groups dealing with the individual components to support the recovery agenda. More than half of these – 15 (54%) – were aspirational rather than actual. Most recognised the importance of engagement with local communities to promote recovery. Despite the clear evidence that the community is an essential element of recovery (Best et al, 2010)[11] only six (21%) ADPs formally attended community groups or had developed robust processes aiming to establish a direct dialogue. The most common response, by 22 ADPs (79%) involved the sharing of strategic aims with other strategic partners often through the formal structures of the Community Planning Partnership.

Mutual aid

173. Some 18 ADP areas (64%) described proactive engagement with mutual aid groups. Ten (36%) said that services were aware of mutual aid groups and had information available for service users if requested whilst five (18%) talked more of the difficulty in establishing relationships with mutual aid groups. Very few ADPs – five (18%) – said that they co-located services with mutual aid groups and very few demonstrated the use of assertive linkage procedures to these groups (i.e. procedures designed to make it as easy as possible for clients to access mutual aid resources).

174. According to NICE, there is evidence that 12 step programmes have a positive impact on substance misuse outcomes suggesting that treatment staff should routinely provide information about mutual aid groups and facilitate access for those who are interested in attending. (NICE, 2007, 2011, 2012)[77]

Residential rehabilitation services

175. Residential rehabilitation (RR) is dealt with in more detail in a later section but from the ADP survey the overwhelmingly most common response to the question about residential rehabilitation services was a variation of *'used as required, based on assessment'*. Three areas had commissioned dedicated beds which were felt mainly to be used as a precursor to residential rehabilitation whilst one area had a comprehensive service dedicated to finding the best match for service users and then offering proactive support before and after their stay.

176. In all areas who responded, use of residential rehabilitation was felt to be an option reserved for those who it was felt had not been able to make constructive use of other services. There is, however, no evidence to support this being the best use of residential rehabilitation as opposed to, for instance, being a first intervention based on expressed preference.

177. Most areas (23 out of 28–82%) stated that, by definition, all of their community services were recovery focussed. Four ADPs had commissioned specific community recovery programmes, while one reported they had none. The third sector provided the majority of the community programmes which were determined to be recovery focussed. The information presented as evidence for effectiveness varied greatly amongst the ADPs with two reporting the use of external audit (delivered by Figure 8 and SDF) and the other 26 including giving a wide range of responses. One ADP could report successful discharge rates following rehabilitation.

Good practice example

Residential Rehabilitation Team

- Open door self-referral for anyone seeking residential rehabilitation (RR).
- Person-centred individual care plans as part of a ROSC.
- Work with referrals for 6 weeks and redirect to community options if unsuitable for RR.
- Cross reference to any or all other services involved before deciding on RR.
- Arrange for detoxification for those on up to 70mg of methadone if required.
- All RR units are visited included scrutiny of care inspectorate/commission reports prior to placing service user there. Visits are made in tandem with the service user.
- Visit service user in RR to assure individual care plan is being implemented successfully.
- Use advice from workers and service users on their experience.
- Offer a year's service post RR including peer group support.
- Have developed an "eclectic" assessment tool which is similar to the WHO tool.
- Have a budget for a rolling programme with about 30 in RR in any one year.
- Enthusiastic and aspirational team.

Commentary – Extent of ROSC delivery

ADP level

178. On the basis of the replies to the questionnaire, 10 (36%) of Scottish ADPs presented strong evidence of good practice in terms of ROSC, 8 (28%) presented some evidence, and the remaining 10 (36%) little credible evidence. It also has to be said that only four of the ten showing good evidence (14% of all ADPs) could demonstrate that they had been doing this for more than a year. Most areas presenting some evidence had only progressed this work within the past year with some elements still in the commissioning stage and not yet realised.

Service level

179. There were examples of excellent practice with enthusiastic, dedicated, and competent workers following good practice. This positive finding was confirmed during the evidence gathering from service providers and wide consultation with service users, those in recovery and family members. It was an interesting finding (reflecting the evidence base) that many persons in recovery attributed their ability to change not just to their own strengths and determination but one particular worker whose empathic relationship with them made the difference. The evidence gathering revealed four ADP areas where at service level, recovery was only just being considered and any changes in practice implementation had not commenced.

Individual level

180. The evidence gathering revealed diverse opinions regarding personal experience of services. Regarding some key issues – expanded below – there was remarkable consistency and agreement on what should be available and what was actually in place.

Needs led

181. Several experts commented on the fact that many persons using illicit substances had suffered what they described as “many negative impacts”. They felt that the effects of these impacts needed to be dealt with before recovery was possible. Many had suffered abuse – physical, emotional or sexual. Many were separated from their families and some homeless. Significant numbers had little formal education, little or no employment history and many had significant physical and mental health problems which preceded the substance misuse or had developed in association with their substance use.

182. Individuals in recovery were extremely consistent in stating clearly that ORT had been an essential factor in their own recovery – but too often they said that ORT was the only treatment they received with little choice or additional counselling support made available. User groups’ evidence commonly reported a similar experience.

183. There was agreement that the waiting times to access ORT were very much shorter and was now measured in weeks or even less (confirming the national HEAT A11 reports),[61] rather than the many months commonly experienced before HEAT. Some older individuals reminded the researchers that it wasn't all that long ago that it was virtually impossible to access ORT in some parts of Scotland.

Person-centred choice

184. A common response from service users was that many services offered little but long term ORT. Some stated that the worker delivering the service was dismissive of any aspiration that they might have to move on. They stated there was often insufficient information provided about the effects of ORT – positive or negative – or the likely length of time in treatment.

185. There seems to have been little progress in terms of treatment choice. All the service users spoken to at SFAD and SRC conferences reported that residential rehabilitation had not been offered as a choice on entry to a service, and some reported they had been denied access to a community detoxification intervention – which was their preference. However, service providers generally indicated that this was not the current position in their services – indicating to reviewers that there is a mismatch of what services believe is being offered and the experience of those accessing services.

Service user involvement and use of persons with lived experience

186. The evidence gathered from service users indicates in some ADP areas some form of service user involvement – in service planning or delivery – is a reality and works well, but in others it has failed or has never started. It seems to be gathering momentum in many areas, and those service users interviewed, who were actively involved, were strongly positive about the experience.

187. There was almost universal agreement across the stakeholders' responses that people with lived experience brought an invaluable contribution to the recovery process. Most felt it was a useful and worthwhile contribution to successful outcomes. The Scottish Recovery Consortium (SRC) believes that it is essential for those in recovery to be involved in helping others into recovery. The reports of those with lived experience believe their contribution is positive. Service managers and commissioners expressed the positive view that progression from "fresher to senior and successful graduate" can facilitate an individual to participate in a mixed team (professionals alongside those with lived experience) which many felt was more stable and tenable than more traditional treatment models and more likely to support sustained recovery.

Family involvement

188. There was a very obvious difference between the opinions expressed by service users and their families regarding treatment in Scotland. The organisation Scottish Families Affected by Drugs (SFAD) and many other family members who provided evidence felt that most services particularly excluded family involvement

which they found frustrating. The usual reasons families were given for this was "*confidentiality*".

189. It may seem surprising that service users themselves often expressed the view that they were broadly content to have their families excluded during the early stages of treatment though they were keen to have them included once their condition and situation had improved. Most service users stated they did not want their family knowing the extent of their issues or specific details which would be too distressing or destructive. Service users accepted that families can offer and provide support but stated that they can also cause difficulties both during treatment and in recovery.

190. This is a complex area – perhaps illustrating perfectly the individual and changing nature of recovery and the need for services to engage sensitively with the process. For instance, SFAD have recently started delivering CRAFT (Community Reinforcement and Family Training) programmes in some ADP areas to try and help resolve this issue.

Choice of opioid replacement therapies

191. Service users reported that choice was seldom offered to them. Reports from third sector and other bodies indicate that it is not usual to be offered a choice. Services indicate that they have been increasingly offering service users a choice, but are clear the choice of which drug used in ORT would largely be a medical decision – albeit involving discussion with the service user. It is reported that this decision reflects the evidence base (methadone and ORT having similar efficacy), national and local guidance (unless there are specific indications, methadone is the first line treatment of choice), practical delivery and risk (buprenorphine supervision takes longer) and costs of some treatments, relative to others (buprenorphine is more expensive in terms of ingredients and usually incurs higher pharmacist costs for supervision). There are also issues in specific environments – some reports from the Scottish prison service have stated it cannot practically deliver high volumes of buprenorphine.

192. Our conclusion is that a choice of drug for ORT is not offered routinely to service users across Scotland.

Quality of relationship between prescribing and recovery services

193. The evidence gathered implies that this relationship is extremely variable across Scotland and tended to be dependent on individuals rather than services/systems or governance and accountability arrangements. In areas where there were positive relationships, reports were of positive joint-working. The ADPs consulted with directly (i.e. outwith the questionnaire survey) were very positive of a growing recovery community which they felt had excellent relationships with the prescribing services. Some third sector services, on the other hand, believed they were better placed to provide a ROSC with the prescribing element removed from the NHS and added to their service.

Connection to recovery communities

194. In the majority of ADP areas it was stated clearly that, if this isn't happening it is being planned for. Some 11 ADP areas (39%) reportedly well established and effective connections with recovery communities, with 10 (91% of these and 36% of ADPs) established in the past 6 months. Four ADPs reported themselves to be in the planning stage and three feel their area is so remote and/or service users so few, or accompanied by confidentiality issues that it is unlikely they will be able to develop these. The researchers' experience from the evidence gathering is that there is a desire for this type of relationship to develop and this approach shows growing momentum.

Quality of and access to residential and community rehabilitation

195. *Essential Care* (Scottish Government, 2008)[5] lists community and residential rehabilitation as treatment choices that should be offered to any persons requiring them in every locality. The NTA (The National Treatment Agency for Substance Misuse) and NICE (National Institute for Health and Clinical Excellence) have both produced guidance on the use of rehabilitation. In its report The *Role of Residential Rehabilitation in an Integrated Treatment System* (NTA, 2012)[78] the NTA states:

"Drug treatment comes in a variety of forms and settings. The popular notion of a spell in rehab, beloved of the tabloids, is not representative of mainstream treatment and recovery services provided in England. The reality is more complex… "

196. There are several issues which apply at national, local and individual service user level which impact on the current status of the debate regarding use of residential rehabilitation facilities. These include:

- Evidence for effectiveness
- Assessment of who is likely to benefit from rehabilitation.
- Availability of suitable facilities
- Quality of interventions
- Use of facilities
- Funding issues

Evidence for effectiveness

197. There is a commonly held view, amongst some in the field, that the evidence base for the effectiveness of residential rehabilitation units is limited and that much of the information supporting their value comes from audits performed by the services themselves. Some research, however, suggests a clear role for such facilities. The longitudinal studies cited in this document, for example, did find that residential facilities had positive outcomes for certain individuals, especially when longer term outcomes were examined. Indeed, in the UK NTORS study,[28] the cohort of users who accessed residential facilities were often those with more complex, multiple problems – including serious alcohol use. This group did better than community treatment groups, including those on ORT, in some outcomes.

198. From our evidence-gathering as part of this review, many residential rehabilitation facilities rated their own success rate at as high as 80% still drug free (Personal communications from stakeholders: SDRC Recovery Conference, Perth 2012). It must be noted that they were citing short term follow up. Unlike many facilities, Lothian and Edinburgh Abstinence Programme (LEAP) is independently audited (Figure 8, 2011)[79] and their reported results suggest they have a Number Needed to Treat (NNT) ratio of 1.6 (i.e. they need to treat 1.6 persons for every 1 person that becomes drug free) which would suggest cost effectiveness in terms of this group engaging effectively with a recovery process. They are also participating in a 4 year study of outcomes.

199. There remains, however, an issue regarding the quality of research evidence available for many of these interventions which preclude meaningful comparison and makes their position vulnerable. Even when research has been carried out, this is often descriptive and does not carry the weight needed to allow the level of comparison required with other (community) treatments. The narrative of such reports is often compelling and affirms that these interventions are felt by some who experience them to be advantageous. Some authorities have presented work expressing a clear supportive view of the strength of the evidence base (e.g. de Leon, 2010).[80] Others have presented a case regarding cost effectiveness (e.g.Yates, 2010).[81] But there is a need for a body of high quality research allowing more direct comparisons between treatments.

200. One major concern often expressed by clinicians is the belief that there is an increased likelihood of relapse following a period of detoxification and residential rehabilitation – and consequently an increased risk of death. Research suggests that between early drop out and post detoxification relapse only one in four subjects remain drug free between 3 to 5 years later (Ghodse, Reynolds and Baldacchino, 2002[82]; Effective Interventions Unit, 2004[83]; NICE, 2007[51]; Vanderplasschen, Colpaert, Autrique et al, 2013).[84] It must be noted that studies repeatedly show that many of the persons admitted to residential rehabilitation programmes have longer and more complex histories. Also, their length of time in the rehabilitation facility and subsequent aftercare differ in many studies – making valid comparisons difficult. The quality of follow up care may be a key factor. In their extensive report, *Recovery-Orientated Methadone Maintenance* (2010)[74] White & Mojer-Torres found that only 10% of cases had accessed aftercare following residential rehabilitation. When aftercare was accessed, this intervention increased success by 35%.

201. As is clearly the case in any chronic relapsing condition – and therefore of relevance to all interventions for substance use – stakeholders from services providing rehabilitation felt that it is difficult to produce compelling evidence of long-term outcome. They felt there is a need for a robust programme which monitors outcomes on those leaving all services which would include regular reviews (or *recovery check- ups*). Meantime, clinicians – especially medical staff – often remain reluctant to use interventions which they feel do not have a reasonable evidence base.

Assessment of who is likely to benefit from rehabilitation

202. Anecdotally it seems that those with higher levels of Recovery Capital are more likely to insist on residential rehabilitation as a first line intervention, often to the point of paying for it, rather than accepting offers of ORT within community based mainstream services as a first intervention. The corollary of this is perhaps found in the responses in the ADP survey to the question of what use was made of residential rehabilitation. In these cases it seemed more likely to be offered to those who did not appear to have benefited from a number of preceding interventions such as ORT.

203. As was made clear in the National Treatment Guideline, prior to considering any treatment option, comprehensive assessment is necessary. It is commonly believed that repeated assessment and screening can demotivate service users. Some authorities in the recovery field disagree with this assertion (e.g. D. Best. Personal Communication to Review Team, 2013).[85] Clinical guidance is available – NICE have given clear instructions of what information needs to be provided. NICE Guidelines 51 and 52 (2007)[51] state:

"Detoxification should be a readily available treatment option for people who are opioid dependent and have expressed an informed choice to become abstinent. Clinicians should provide detailed information about detoxification and the associated risks. This discussion should address a number of areas, including:

- *physical and psychological aspects of opioid withdrawal, including the duration and intensity of symptoms and their management*
- *the use of non-pharmacological approaches to cope with withdrawal symptoms*
- *loss of opioid tolerance following detoxification, and the ensuing increased risk of overdose and death from illicit drug use that may be potentiated by the use of alcohol or benzodiazepines*
- *the importance of continued support, as well as psychosocial and pharmacological interventions, to maintain abstinence, treat co morbid mental health problems and reduce the risk of adverse outcomes (including death)."*

Availability of services

204. In 23 ADP areas there is stated to be full access to both community and residential rehabilitation facilities – delivered locally and nationally. Two ADP areas give access only to local residential services. One ADP area reported that it made no use of residential rehabilitation at all and no formal (i.e. funded) referrals to residential rehabilitation services have been made there. In that area, it was reported that people can attend a local church-funded supported accommodation. Two ADPs reported that, if necessary, service users could be sent to rehabilitation but did not provide any other information, and did not confirm that there had been any such referrals. Three ADPs reported less than 5 persons per year in residential rehabilitation and one ADP had no persons at all in residential rehabilitation in 2011.

205. It is common practice after discharge from residential rehabilitation for community rehabilitation to be offered in the area they were referred from. One ADP believes and practises the opposite, preferring service users to be rehoused and

further supported in the area where the residential rehabilitation was located – often a considerable distance from their home. LEAP believes that delivering on-going community rehabilitation in the same area the person came from is an important factor influencing their ability to maintain recovery in the wider community. There appear to be differing opinions amongst expert stakeholders and providers on this issue, with majority opinion concerned about potentially adverse results if a person is returned to the community they came from after a period in a residential rehabilitation facility. This debate is not informed by any meaningful research evidence base and would clearly benefit from a programme of research to clarify the important factors influencing outcome.

Quality

206. It is currently impossible to objectively assess the quality of the many and diverse rehabilitation services in a meaningful way. Units often aim to have unique, personalised programmes and there is no independent review mechanism which can assess the service in a valid manner and give useful advice to commissioners who may be considering rehabilitation. Residential rehabilitation services do have to meet Care Commission standards regarding aspects of their delivery – but this is not usually to do with the programme itself nor its efficacy.

207. There is clearly an urgent need to develop a meaningful quality programme for such facilities which should include assessment of long term outcomes. This would facilitate better, more targeted use of those facilities which achieve the best outcomes and the service user groups in which the best outcomes can be predicted.

Use of residential rehabilitation facilities - ADPs

208. In the past, access to residential rehabilitation was the treatment of choice in some NHS Board areas with “block contracts” in place allowing GPs or other clinicians to send any substance user presenting for treatment to such a facility. In these areas there was often limited access to other, evidence-based, treatments such as ORT or even community detoxification. This is no longer the case in the majority of areas. Now, evidence suggests that most services use residential rehabilitation as a crisis intervention (respite) or as a last resort when other community interventions have failed – often repeatedly.

209. The survey results suggest that there has been a recent change in several ADP areas with most – 24 (86%) – now recognising the importance of developing ROSC and person-centred approaches in their areas. More people are seeking the residential option and ADPs recognise that processes must be developed to accommodate that treatment choice. The remaining ADPs suggest they are cognisant of this developing need or are claim to be actively planning to move in that direction. It is likely that the HEAT target will also expose limitations on access, as time allows more comprehensive information to be collected on residential rehabilitation – either as second and third treatment options or, indeed as a first treatment option for consideration alongside the more common choices of “preparatory counselling”, ORT and detoxification.

Service users and families

210. The review team was given a strong and consistent message from service users in recovery and families associated with Scottish Families Affected by Drugs, that they would like to see better access to rehabilitation as a first line option. For some, they felt this should be in place of ORT though some service users in recovery would see a short term ORT detoxification as necessary for some individuals prior to admission. Many still seem to see residential rehabilitation and ORT as options which are in direct competition, rather than two useful treatment options which should be available in a consistent manner to meet individuals' needs. At the very least, there is a need to facilitate a more constructive discussion to unpick some of the misapprehensions about all valid interventions, the evidence for their effectiveness and their availability.

Funding

211. Scottish ring-fenced funding for drug treatment has increased annually for many years from 1999 and is currently at record levels. Despite this, as the waiting time targets result in more new entrants to services, funding comes under pressure for all services. In such circumstances, facilities which are not an integral part of the local delivery system (but are offering an intervention usually unavailable locally) may have restrictions applied to funding – affecting availability to local service users. In their evidence, some providers of these facilities agreed there is an issue regarding the funding flow for these national services when competing against local needs (which may be given priority). It has been suggested that uncoupling these two funding streams centrally might be productive whilst others have suggested that good quality local commissioning would include the real possibility of factoring in residential rehabilitation as a fundamental component of the treatment flow. It is also worth mentioning that there are international examples of therapeutic communities based on social enterprise which are entirely self-funding and do not charge their residents.

Community rehabilitation

212. One key aspect of a person's rehabilitation is their access to a range of local interventions and supports to help them address the issues which are commonly associated with problem substance use. These may include psychological or psychiatric problems – needing specialist care and support as well as interventions designed to help the individual re-integrate with their community.

213. There are a range of community rehabilitation services across Scotland. They can vary greatly in content and approach. However the overall aim is generally the same about providing structured (often daily) support to people in their own communities to assist people to move on from problematic substance misuse. The majority work in partnership with prescribing services. Some providers can produce outcome data but this is usually compiled internally. As with residential services independent research would be valuable in assessing the effectiveness of community rehabs. Most Community Rehabs have developed robust partnerships with recovery communities and some have developed their own.

214. It is worth noting that there is diversification amongst recovery communities – for example, SMART, NA or CA – all of whom may have very different attitudes towards medication and ORT.

Psychological interventions

> "His Community Psychiatric Nurse does not seem to be able to reassure him that he will be supported through the process, physically and mentally. This seems to be a crucial time and concentrated effort from all seems required - not a dismissal or fruitless discussion."
>
> ***Service User's relative***

215. Addictive behaviours have been framed as having a strong "behavioural" component – as part of a broad range of factors which may influence development and maintenance of such problems. Addiction often coexists with a range of mental health issues. US research has attempted to understand the potential impact of making psychosocial interventions available to those in any treatment modality and in England, the NTA has developed clear frameworks to ensure better and more consistent delivery of the appropriate intervention at the right time in a person's recovery journey (NTA, 2012).[53] Recent systematic reviews of the effectiveness of psychological therapies have been disappointing (Nice, 2007[51]; Amato, 2011[86]) – but have acknowledged that the quality of primary research in this field is very poor – for example finding that most studies consider outcomes over a period of months.

216. In Scotland, this issue has been considered prior to the publication of *the Road to Recovery*[1] with clear guidance regarding the importance of psychological interventions in the delivery of the new recovery expectations of services. *Essential Care* (Scottish Government, 2008)[5] stated:

"Psychological therapies should form an essential element of care for people with substance use problems – assisting people to reduce harm to themselves, moving them through a recovery process which seeks to assist them in achieving mental well-being and building resilience as well as empowering them in their own recovery. Thus, a psychological therapies framework for people experiencing problems with substance use and mental health problems should be developed in each NHS Board area, based on the recommendations already set out in key national documents."

Key working staff

217. Clearly those staff engaging with patients regularly should be able to engage effectively with any person attending for help with their substance use problem. This requires adequate training, support and skilled supervision as well as access to an appropriate environment and the time and facilities to deliver high quality care.

218. Many staff in both statutory and third sector services reported that they were frustrated by their lack of ability to deliver the more psychological interventions. At times this reflected specialist therapies – such as CBT – but also basic engagement

and development of an effective therapeutic relationship. They cited time pressures and competing demands as key reasons for this – caseloads of 100 plus do not allow such activity. This seems to be a common experience with such evidence received from across the country.

Specialist psychology

219. The review team met Lead Psychologists in Addiction Services Scotland (LPASS) – a group of Consultant Psychologists involved in leading delivery of specialist addictions psychology services across Scotland. There is – perhaps surprisingly in services purporting to be supportive of recovery – a huge issue regarding resources in this area. Currently, only 6 out of 14 Health Boards (43%) have *any* access to specialist addictions psychological services. Even when they are deployed – there is often minimal provision – for example, there is only one qualified Clinical Psychologist for all Addiction Services in NHS Forth Valley. In some areas there are no plans to provide such services. In others posts are difficult to fill – either because they are short-term funded or staff are unavailable to appoint. When staff are appointed, the premises provided are often unsuitable for assessment or delivery of psychological treatments. LPASS confirmed their view that patients who are felt to be stable on ORT tend to get less of *Essential Care*[5] services and believe that they are often "parked on methadone". They firmly believe that a more therapeutic view is needed across the services.

220. LPASS expressed the view that all treatment should be person–centred. They felt that assessment of need and consideration of all treatment options should inform an individual care plan which should be in place before ORT is prescribed. LPASS were also among the many contributors who referred to the multiple negative influences experienced by service users – including childhood trauma, experience of substance misuse for generations, lack of positive role models, lack of personal support and preceding mental health problems. They asserted that more attention must be given to the need for these to be seen as a barrier to recovery with more effective treatment to address such issues made available. They often experience service users who stabilise well on methadone – only to destabilise, often repeatedly, when they attempt to come off. This group may require extensive and frequent specialist support (weekly appointments for months) to overcome emotions associated with trauma and abuse or destructive behaviours. An inability to access this level of support is clearly a barrier to progress from methadone.

221. Psychologists can actively support key workers to better manage their patients with complex needs and challenging behaviour by the clear use of psychological theory as well as delivering therapeutic interventions. Key working staff need to be able to form effective therapeutic relationships and deliver effective interventions – which may be supported by psychology training and supervision. Psychological interventions, known to be effective – such as contingency management (the reinforcement of the desired behavioural outcome with some form of gain for the service user, e.g. shopping vouchers) – must be delivered appropriately.

222. LPASS also stated, like many respondents, that HEAT A11[61] was very successful at getting people into treatment but that this had been the priority for

services and commissioners – often to the detriment of service standards. There is a need to reconcile HEAT A11[61] with capacity. Issues that have been expressed by other stakeholders such as lack of worker training, and competencies are confirmed by LPASS. But,more importantly, they voiced concern about an endemic lack of belief among staff that substance users are capable of recovery or that they as workers can facilitate that change.

223. LPASS is of the view that a lack of hope, aspiration, understanding, empathy and compassion are commonly observed amongst workers in addiction teams. If workers do not believe in the possibility of recovery, then that pessimism filters down to service users and their families.

Relationships between statutory bodies and third sector – co-location and integration

224. One aspect of the delivery of ROSC is the need for a range of service providers – both statutory and third sector – to apply their expertise in a coordinated and needs-led way for the benefit of the service users and their communities. Such arrangements are well described in many guidance documents including *Integrated Care (SE 2002)*[52] and *Essential Care (SG 2008).*[5] Such approaches are in line with the views expressed by the Christie Commission. (SG 2012)[2]

225. The evidence received by the review team suggests this remains a challenge in many parts of Scotland with notable tensions between the statutory and third sector. These tensions seem to reflect a common perception that different partners are treated differently by local commissioners – held to account less and under less pressure to deliver efficient or effective services. It was proposed by third sector providers that co-location of all services – not just the statutory partners – was an achievable step forward in beginning to remedy these matters – though clearly this would not be the full solution in itself.

Integration of Health and Social Care Services in Scotland (2013)

226. New plans for the integration of services in Scotland – initially for the elderly – may give some pointers regarding the new approaches required (and expected) to better deliver services in future. In their recently published response to the 2012 consultation on integration, the Scottish Cabinet Secretary for Health and Wellbeing, Alex Neil stated:

"Perhaps most ambitiously, it is about establishing a public service landscape in which different public bodies are required to work together, and with their partners in the third and independent sectors, removing unhelpful boundaries and using their combined resources, to achieve maximum benefit for patients, service users, carers and families."

227. The evidence received by the review team shows that there are some ADP areas which have developed well integrated and functional structures involving the statutory and third sector. As had been previously reported (ADAT Stocktake, Cameron, 2007).[20] These seem to have developed through individual cooperation rather than local organisational facilitation. As would be expected in such

arrangements, these examples of effective working may not be sustained if these champions move on to other positions and there is a lack of corporate support.

228. It is clear that some statutory services are trying to better collaborate with third sector services as part of a ROSC though, perhaps paradoxically, in some areas statutory services are accessing third sector services less. A large group of managers from a nationally represented third sector agency told us that in some ADP areas there are commissioned third sector services with availability, expertise, and willingness to provide a service whilst statutory sector workers reportedly have caseloads of often over a hundred. Such a situation is not conducive to providing a safe or effective service and local commissioning arrangements should be capable ensuring that partnership arrangements are such that treatment flow is not disrupted and progress is facilitated.

229. The Scottish Government's plan to develop new *Health & Social Care Partnerships* clearly requires these potential schisms to be addressed in a way which improves the outcomes achieved (as part of the national outcomes framework) through ever increasing degrees of integration and improved local accountability.

Summary 5: Recovery-orientated treatment

A recovery-orientated system of care (ROSC) should mean that:

- Treatment is strength based;
- A person-centred choice of treatment options is available;
- Service-user involvement in planning and delivery of care is evident;
- People with lived experience are utilized in services;
- Families are involved in the process;
- There is a choice of ORT drugs;
- There are strong relationships between prescribing and recovery-orientated services and the broader community.

Despite *the Road to Recovery*[1] being published in 2008, ADPs report that such ROSCs are not highly developed across Scotland – or are at least inconsistent in their delivery.

- There has been a substantial time delay before the implementation of ROSC with only 10 (36%) of ADPs providing good evidence of developing ROSC and only four of those(15%) had been doing so for more than a year.

- 64% of ADPs could either provide no (36%) or only some (28%) evidence of ROSC development. Of the (8) 28% of ADPs providing some evidence only 4 (14%) had done so for more than the previous year.

- Local governance and accountability deficits remain, meaning that – even this review process – has struggled to access valid information on progress from many ADPs.

Specific deficits in service provision are evident:

- Only 6 Scottish NHS boards have access to specialist psychology services.

- Integration of services – NHS, local authority and third sector is an essential element of delivering a ROSC – but other than notable examplars, relationships are often sub-optimal.

- Use of residential and community rehabilitation facilities is extremely inconsistent across the country.

SECTION 7:
FINDINGS: GOVERNANCE AND ACCOUNTABILITY SYSTEMS

Section 7: Findings: governance and accountability systems

> "Statistics are not available at present on our council website and what I have seen are very limited and seem biased towards waiting times. Although waiting times are crucial when someone makes initial contact with professionals for help, where can you find statistics on when people leave the service? i.e. who have successfully stopped the medication/ treatment, has anyone successfully stopped taking subutex/suboxone after a few years of taking it?"
>
> ***A service user's mother***

Context

230. In terms of the treatment required to address problematic drug use, *the Road to Recovery*[1] successfully drew together the two main dogmas of *Harm Reduction* and *Abstinence* – which had previously been seen by some as irreconcilable – under the banner of *recovery*. The strategy aimed to limit both individual and public harm with the provision of a range of interventions, including good quality, highly accessible Opioid Replacement Therapies. Simultaneously, availability of recovery-orientated care planning along with ready access to a comprehensive range of services – as described in *Essential Care* (2008)[5] – and much wider use of mutual aid organisations would facilitate the production of recovery-orientated systems of care.

231. This aspiration was supported by the creation of Alcohol & Drug Partnerships (ADPs) to replace ADATs and form the basis of local delivery. A process of *Delivery Reform* (Scottish Government, 2009)[22] had assessed the reasons for the failings of the ADAT system. Key to ADP development was the need to bring the accountability of local systems of planning and delivery in line with the other (generic) public services. ADPs were expected to form close links with the agenda of the local Community Planning Partnership (CPP) – the main planning structure for co-operative Local Authority and NHS Board production of the Single Outcome Agreement. Ring- fencing of the centrally-distributed alcohol and drugs budget was retained and national coordinators appointed to facilitate a smooth transition and to support the development of strategic capacity. The independent Drug Strategy Delivery Commission (DSDC) was created to give objective feedback to government on performance, ensuring continuous improvement.

232. In this new alignment of accountability, there was an expectation that medical treatment services – such as ORT – would be overseen, on behalf of the local partnership, by local NHS governance systems, ensuring the quality and accountability of such services – as is the case in all other medical arenas. This quality would ultimately be underpinned by the development of individual outcome measurement (the *Delivery Reform*[22] process had already proposed an outcomes framework) and supported by the development of information systems which would facilitate reporting of progress. There had been repeated failings in information systems despite efforts to improve them in previous years. Critical to the strategy's

success therefore would be greater accountability at all levels of the structure, much improved governance and more effective information systems. Inherent in this is also the expectation of improved partnership working and the subsequent integration of all those various services required to ensure that full benefit can be obtained for those individuals within a Recovery Oriented System of Care.

233. In this context, as part of the review a survey of the Scottish ADPs was undertaken to determine to what extent progress had been made in the key areas of governance and accountability of ORT treatment in the ADP localities.

ADP questionnaire survey

234. All Scottish ADPs were asked to complete a questionnaire which aimed to describe local services and processes relating to ORT. There was 100% response rate and all completed returns were signed off by the local ADP Chair. The questionnaire and 'results at a glance' can be found at Annexes 4 and 5 respectively. Some responses from the survey have already been reported as relevant to previous chapter topics.

Information on activity or outcomes regarding ORT

235. ADPs were asked to report in relation to their information systems - including questions on basic processes. These questions reflected areas which were found wanting in the NHS Board survey which had underpinned the previous methadone review – *Reducing Harm. Promoting Recovery* (2007).[13] It was expected that all areas would be able to supply this basic information – not least as, since the Shipman Enquiry,[87] all areas in the UK have been required to more closely govern the prescribing of controlled drugs and national guidance is in place regarding the processes as well as the quality of prescription writing and recording which is required (The Shipman Inquiry fourth report. The Regulation of Controlled Drugs in the Community, Cm. 6249, 2004).

Results

236. The detailed results have been shown in Section 5. Our survey showed that, although there were some excellent examples of locally developed, bespoke information systems which could give much of this information, there were surprising deficits.

Commentary – Information and ORT

237. These results show that, while there have been improvements since 2007, there are still large gaps in the information readily available to ADPs and their partners to give oversight of these prescribing services. There are examples of very good systems but also variation. Some ADPs can report very little objective information in this area. This is disappointing – especially in light of the overt public criticism of ORT and the quality of its delivery which had preceded this review. The lack of NHS Board leadership on this issue – in light of the recommendations of Shipman 4 (2004)[87] – is equally disappointing and perhaps gives some insight into

the quality of some local partnerships. It is important that giving a leadership role to partnerships does not dilute professional or organisational accountability.

238. Nor is this a new issue. Poor information systems have been a continual challenge for Scottish substance use treatment systems for the last fifteen years and have been commented upon as being a significant limiting factor in the development of services by a number of reviews – particularly in the previous methadone review (SACDM, 2007).[13] Advice on the information systems required has been made available in key Government reports (e.g. *Integrated Care*, 2002[52]; *Essential Care*, 2008).[5] Following the *Delivery Reform*[22] changes, the DSDC reviewed a number of aspects of service delivery in its first year, taking stock of the challenges facing the Scottish delivery system. Information deficits were seen as a key barrier to progress in many domains. The first DSDC report of 2011[23] stated:

"Action should be prioritised to enable the assessment of progress towards recovery-focused outcomes at local and national level. This should include: – inputs (evidence of recovery-orientated process – e.g. Recovery Plans); outputs (evidence of improvement in performance – e.g. more people progressing/accessing recovery activities such as education, training or work placements); outcomes (evidence of more people positively moving on, in or from treatment programmes and demonstrable evidence of recovery progress, such as abstinence and/or improved work prospects and better family relationships. An NHS process to improve governance and delivery of treatment services for substance users should be pursued with some urgency." (DSDC, 2011)

Information challenges: evidence from stakeholders

239. Introduction of efficient and useful information systems in public services is often an activity which brings challenges. Common difficulties include the need to ensure that: the relevant data are being collected by frontline staff – with the use of minimum datasets; that software systems are fit for purpose and are supported by the availability of functional hardware; that staff understand the need for these data and are trained and supported to deliver it to a high quality; ongoing quality improvement is required to ensure optimal data quality levels.

240. Each of these elements is essential to deliver a working system – but it seems rare for such system roll outs to be wholly successful. (A noteworthy exception might be considered to be the Scottish Care Information-Diabetes Collaboration (SCI-DC). This dataset is the national electronic diabetes register. It has existed since 2000 and contains population-based data for more than 99.5 per cent of people diagnosed with diabetes in Scotland. The database is populated, and updated daily, with demographic and clinical data relevant to primary and secondary diabetes care).

241. It should be noted that the Scottish Government and ISD report very high levels of compliance by services in the use of the waiting times database, supporting the delivery of the HEAT A11[61] target. Also, the English National Treatment Agency (NTA) reports high levels of compliance in the use of its NDTMS system – making national performance data available for English services. It seems relevant that both

of these systems are part of a robust governance system – i.e. there are consequences for the services/local systems themselves if data is unavailable.

242. In the stakeholder meetings we asked many staff about their experiences regarding the collection of data. There were frequent comments from workers across the country about the challenges for services regarding information gathering. These included:

- Workers often cited having to use too many different systems and the duplication of information required. Nationally – i.e. before they use any local systems – many clinical staff are required to complete SMR25a/b forms and the waiting times database. They are usually then required to complete other forms on clinical assessment/care as well as risk assessments and child and adult protection forms – depending on their own service requirements.

- Staff reported that information collection was often prioritised over clinical care – reflecting the limited time available in any session and the volume of data required. Some services had put new administration support in place to ensure they met the HEAT reporting requirements.

- Many services lacked access to useful technology which would allow for 'realtime' updating of databases. This includes basic hardware and software issues. One service was expected to deliver information via centralised IT systems – but had very poor (slow) internet access, making this a laborious and time-consuming task.

- Services sharing accommodation – NHS and local authority or third sector – reported issues around shared use of IT systems which limited their access to their own systems.

- In some services there remained issues around the use of both IT based and manual information systems simultaneously. One stakeholder estimated that 'improved' systems had meant an increase in administration time of up to one hour per day – which came out of direct clinical care time.

- Some staff felt that, in the NHS, reductions in administration support had meant that clinical staff were fulfilling these (often skilled) functions – but without additional resources (time) to do it.

- One service reported a move to electronic case-files had not been supported by increased availability of computers.

243. We heard of few examples of ADPs and frontline services collaboratively owning responsibility for the development and functionality of their local systems or the quality of data collection and outputs. Reports suggested that, often, ADPs simply expected information from providers but frontline staff rarely received any feedback from their managers regarding performance.

244. Our impression was that in many areas, the basic collaborative approaches required to make such systems work were absent.

Quality and robustness of information

National perspective – ISD: SMR25 and the Scottish Drug Misuse Database

245. For many years repeated reports have highlighted concerns regarding the availability of meaningful data in this field. These concerns include:

- Lack of basic demographic data – to help understand the size of the national and local problem (epidemiology);
- Lack of operational data – to report on activity and give some indication of the range of interventions available and quality of care delivered;
- Lack of outcome data – to report on impact and inform improvement of effective services.

246. These were a large part of the concerns raised publicly which led to this review.

Essential Care: A Report on the Approach Required to Maximise Opportunity for Recovery from Problem Substance Use in Scotland (Scottish Government, 2008)[5] stated:

"There should be a commitment to collection of standardised data for analysis based on a nationally agreed, ideally web-based, core minimum dataset. Reports could be provided to local commissioners and service providers on a regular basis to inform needs assessment and on-going outcome reporting."

247. Information Services Division (ISD) currently holds responsibility for national data on substance use as it does for many care groups. ISD gave evidence to the review team and coincidentally presented data to a full DSDC meeting during the review period allowing more in-depth discussions about their challenges and proposed solutions. ISD reports poor compliance generally in local services with many of the current information systems – with one main exception, the HEAT A11[61] waiting times database.

Main concerns

248. Currently ISD is unable to give ADPs or others meaningful outcome data while reporting basic activity data is also a challenge. This may reflect a number of issues, including:

- Services' compliance with SMR 25a (baseline) is poor;
- Services' compliance with SMR 25b (follow up) is even poorer;
- Services compliance with HEAT A11[61] is high – and this may have been a local priority – further eroding SMR data quality in some areas;

- Prescribing data is of very variable quality and (partly because of the failure to ensure prescriptions have a CHI identifier) cannot be linked to what SMR data is available. Some prescriptions are still hand-written – despite guidance that this should no longer be the case;

- Some (usually direct access) services choose not to identify their SMR25a data – citing concerns about "confidentiality". This issue, however, was examined by SACDM over 5 years ago and their findings made it clear that this was an anomaly and was frustrating performance management. It was expected that national and local systems would have resolved this issue;

- Some services – frustrated with delays in availability of national systems – have developed their own local systems – and these may struggle to interface with ISD's systems.

249. It is clear that a solution is required urgently. As stated so clearly in previous reports, it remains totally unacceptable for basic data on these services' activity, quality or outcomes to be unavailable. Locally ADPs should be required to make this a priority supported by robust national information systems. We also note that previously ISD has struggled to deliver effective national systems in a timely way. There is clearly frustration at all levels regarding the lack of delivery of these information systems.

Local systems

250. In the absence of useful national systems, we have seen examples of good quality databases developed by local services/ADPs which give access to both basic demographic information and recovery oriented outcomes – used by services and commissioners. These systems also seem to have addressed a number of the common challenges faced when developing and delivering systems – see good practice examples below.

Good Practice Examples
Information systems

- The ***SUMIT*** system is in an advanced stage of development. SUMIT uses an NHS e-record to collect live information on day to day care and the CHI (identifier) allows linkage with other NHS data on ambulance callouts, Out-patient attendances, labs, admissions
- Data sharing agreements allow non-NHS partners (local authority and third sector) to input data or link their information in a "safe haven". Information is then available on a wide range of developmental factors or clinical outcomes for service providers and commissioners.
- "Live" reporting is being developed to offer "dashboards" containing key performance information for frontline teams, supporting improvement.
- Anonymised datasets can also be generated – supporting primary research.

- The Shared Addiction Management System ***SAMS*** is contributed to by all locality substance use agencies. This system can track the client's journey and response to a wide range of ORT doses and the circumstances of any change.
- Information is recorded onto a bespoke Mental Health database allowing excellent communication of data between Addiction and Mental Health Services.
- Recent developments include: introduction of an assessment using the ARC (Assessment of Recovery Capital) which forms the basis of future recovery planning and goal setting.
- This has been accompanied by the 'Questionnaire for interventions outcomes profile' which allows subsequent changes in recovery capital in a wide variety of fields (Substance Use, Housing, Mental and Physical Health, Education and Employment, Criminal Activity and Community and Family Involvement) to be tracked longitudinally in partnership with the service user.

251. It may be that a national solution can be found. ISD is currently consulting on unifying and further expanding their information sets – Drug and Alcohol Information System (DAISy) – a process that is meant to be due to conclude in July, 2013. A detailed report of this activity is available in the report *Consultation with Stakeholders on Substance Misuse Information Needs* (ISD, 2012).[88] The data set for the SMR25 is being reviewed and the aim is to incorporate waiting times data – along with drug and alcohol data – into one dataset. Specific recovery indicators are intended to be included in this new expanded dataset. Clearly the integration of reliable and valid outcome data with demographic data would be welcomed if the project were to come to timeous fruition. In their evidence, ISD advised the review team that subsequent improvements in terms of drugs data are estimated to be in place within

approximately 15 months (i.e. in 2014). Recent reports – to the DSDC (2013) and the NHS eHealth leads group (July 2013) have suggested that these timelines are not rigid and delivery by 2015/6 was cited as a more realistic timeframe for these plans.

252. Though it is clear that national information systems are not functioning at an acceptable level it is far less clear that the approach currently being proposed and led by ISD is any more likely to deliver the vital information required to improve clinical care and achieve better outcomes for service users. All members of the review team and steering group have many years of experience in this field and many have observed (as well as participated actively in) repeated attempts to address this deficit. It is a simple fact that, if current (unsuccessful) approaches continue to be pursued – with the added variable of the development of an even more comprehensive dataset and data collection system – it is extremely unlikely that a favourable outcome will be achieved. Improvement principles suggest small scale achievable improvements are more likely to succeed.

253. It is the review team's opinion that there are significant risks around the development of the proposed new DAISy national database. At the very least it seems unlikely, from the evidence received, that the current approach will deliver meaningful outcome data in an acceptable timeframe. If so, the Scottish strategy will remain open to criticism – not necessarily because it isn't delivering but because it is unable to evidence even when it is.

254. There is therefore an urgent need for a new, coherent, concerted and collaborative approach, prioritised by all relevant partners and robustly project-managed to ensure delivery of functional national information systems. We have heard from at least three ADP areas of locally developed systems which are already beginning to successfully integrate basic demographic data with service outcomes and with valid and reliable measures of changing Recovery Capital as the individual progresses through recovery. These are largely ready now as opposed to the timeline given and subsequently revised by ISD. Successful local systems should therefore be considered as the basis for any new developments. Valid improvement processes should be applied to this area.

Governance structures

ADP performance

255. The 2007 ADAT review and the Audit Scotland report (2009)[21] reported that ADAT performance was inconsistent and that performance broadly reflected the quality of the leadership and partnership-working abilities of the Chair, the membership and the local coordinators. In response the Scottish Government brought forward a process of *Delivery Reform* (SG, 2009)[22] which created the new ADPs. It was intended that ADPs would be accountable in the broader context of the Community Planning Partnership, as signed off by the Scottish Government, COSLA and NHS Scotland making substance use an issue to be addressed more generically by the whole local planning system.

256. Ring fenced resources to support the ADP structure/staff/function were retained (over £3m per annum) but accountability processes were to be made part of the CPP/NHS board processes – through HEAT and the Single Outcome Agreement (SOA).

Evidence from stakeholders

257. We have heard evidence that the aspirations of the *Delivery Reform*[22] process are not being realised in all areas of Scotland and that there are areas where ADP activity is either under-represented or even ignored, in the production of SOAs. This can have a subsequent deleterious effect on the integration of treatment services with those more generic services – such as general NHS services, housing or community development – essential to the delivery of meaningful recovery outcomes. NHS Boards and Local Authorities are reported in some areas as being unwilling to include ORT systems into their governance structures in any meaningful way. This lack of accountability can be stark.

258. There continue to be examples reported to this review, of the available ring-fenced central funding for drugs and alcohol being diverted into other clinical areas which are seen as a higher local priority. Stakeholders had different views regarding why such decisions may be made. A number of respondents expressed the view that this reflected ineffective strategic planning or management structures within NHS Boards. Others suggested that the national core outcomes remain too vague and ill-defined to form a useful basis for meaningful measurement of local system/ADP alignment to national strategic aims. Strategic leads or operational managers, on the other hand, have reported that ring-fencing limits an organisation's ability to use its resources effectively to best manage its priorities.

Institutional memory

259. Stakeholders – in particular service users and their families, but also service providers – have repeatedly asked the reviewers why previous reports, often with similar findings and recommendations, have not been effectively implemented. This raises the issue of the lack of *institutional memory* inherent in the structures responsible for the planning, delivery and governance of these systems of care. This was raised as an issue in the 2011 DSDC report (DSDC, 2011).[23] There may be many reasons for this. Perhaps it reflects the relatively rapid turnover of accountable individuals responsible for addressing drug use at national or local level. It may signal an inherent inability within national or local partnerships to address agreed priorities at times when governments, officers or demands change. The issue of stigma towards this group is also likely to have a negative impact on the pace of delivery at all levels.

260. Whatever the cause, this is certainly an area in which major improvement is required to allow this work to better align with the expectations expressed in the recent Christie Commission report (Scottish Government, 2012).[2]

261. The Christie Commission[2] report expects a more efficient delivery of priority outcomes. Key objectives – relevant to this element of the DSDC review include the expectation that *"public service organisations work together effectively to achieve*

outcomes" and *"all public services constantly seek to improve performance and reduce costs, and are open, transparent and accountable."*

262. Priority areas of most relevance to the substance use agenda described include:

- *Maximising scarce resources by utilising all available resources from the public, private and third sectors, individuals, groups and communities.*
- *Driving continuing reform across all public services based on outcomes, improved performance and cost reduction.*

263. If the issue of a lack of institutional memory is not addressed, this will result in continued failure to deliver the solutions which have been repeatedly identified in reviews of national and local performance. Advisory structures – previously SACDM, more recently DSDC – as well as funded national bodies, such as SDF, STRADA, SRC, SFAD and professional organisations (Royal Colleges and others) are important reservoirs of knowledge which are under-utilised. There remains an urgent need to acknowledge and address this issue if we are to avoid repeating past failures.

Local accountability - ADPs

264. The ADP questionnaire asked 10 questions specifically focused on ORT and ROSC delivery in their areas. Four were concerned with prescribing, supervision, and whether or not people were being detoxified. Most ADPs could report how many people were on ORT but less were able to comment on the dose range while mainly only estimates were available on the length of time an individual was on ORT. The questions on detoxification revealed that most ADPs were unable to answer on these more personalised queries from the data their services were collecting, although a few made estimates based on retrospective data analysis.

Consistency of ADP performance

265. There is a credibility issue for ADPs raised by this review. For some, Lead Officers or Chairs offer a credible, knowledgeable and authoritative leadership which can deliver a clear analysis of local issues that is likely to support a coherent, prioritised approach to address local problems as part of the (largely nationally funded) programme of delivery. There are however, examples of ADPs being unable to demonstrate such leadership attributes.

266. This may reflect a lack of knowledge or skills in this field. Scottish Training on Drugs and Alcohol (STRADA) felt that commissioners and ADP members would benefit from specific training programmes to further develop their understanding of addiction issues. Various other sources (especially service providers and family members) also expressed the opinion that ADPs would benefit from training in understanding addictions better with some saying that they had encountered a number of senior staff involved in ADPs, who demonstrated insufficient specialist knowledge to effectively deliver the services or interventions required.

267. DATs were created in 1994 to offer meaningful local leadership to an expanding area of concern – increasing injecting drug use in the context of HIV infection. Further development of DATs was recognised as a specific need in 1999, when DAT performance had already been challenged by an independent SACDM review. At that time, STRADA, as the new, nationally commissioned training organisation, embarked on a development programme for DATs. In 2009, ADPs evolved, replacing DATs following further ongoing criticism of DAT performance. More recently STRADA has again been involved in delivering training for ADP co-ordinators and in two ADP areas have been facilitating workforce development capacity building. STRADA is now of the view that these programmes should be rolled out for other ADP members who may have no background in addiction service provision.

In conclusion

268. There are few care groups for which central government supplies ring-fenced budgets to support local dedicated delivery systems. In this field, such systems have now been in place for nearly 20 years, under consecutive Conservative, Labour and SNP governments. From their genesis in 1994, DATs were externally reviewed on three occasions and were not found to be operating at an acceptable level, despite investment in improvement support from STRADA from 1999. In 2009, the *Delivery Reform*[22] process offered a new, more integrated approach – ADPs – but retained ring-fenced national funding of local systems (Scottish Government, 2009).[22] The 2011 DSDC report,[23] however, continued to highlight concerns regarding consistency and a lack of progress against the objectives contained within *the Road to Recovery*[1].

269. This review has found that, with regard to the specific issue of local governance and accountability of ORT delivery, ADPs remain highly inconsistent. We have found similar inconsistencies with regard to planning, delivery and governance of recovery orientated systems of care (ROSCs). Basic information systems are often lacking. We have speculated on the possible reasons for this inconsistency. However, it is clear that there is an urgent need to bring forward plans for the improvement of local delivery. This should include minimum standards regarding the delivery of basic activity data.

270. Finally, it is not clear whether current national structures deliver added value to the operationalisation of drug strategy in general and ORT and ROSC development in particular. The Scottish Government supports a range of bodies, tasked with progressing many aspects of substance use response. In 2009, it also launched the DSDC – seeking a more “independent” oversight of its performance. There is, in our view, a need to reconsider these national structures – in particular to determine whether they offer added value in line with the recommendations of the Christie Commission report (Scottish Government, 2012).[2]

Summary 6: Governance and accountability systems

- The commissioning function of ADPs cost the Scottish Government over £3 million annually.

- ADPs were created to improve performance – following repeated reports of DATs' inconsistent delivery and performance across Scotland and to streamline accountability processes.

- Despite clear guidance – it appears from our observations that some ADPs do not have the most basic systems in place with which to govern delivery of ORT.

- Information is unavailable in some areas even in terms of basic numbers of people on ORT – a failing identified in the last methadone review in 2007.

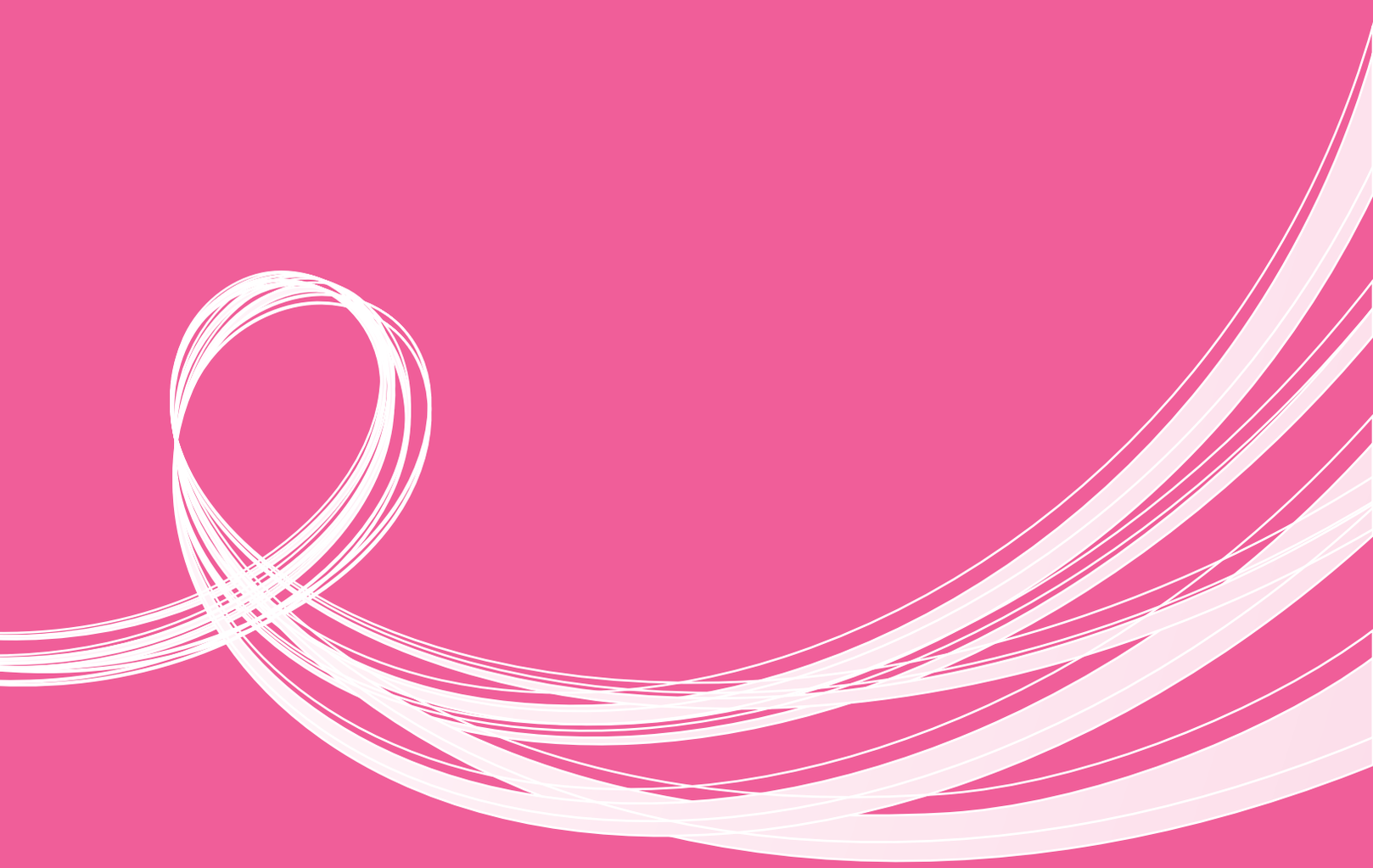
- Recovery orientated systems of care – are poorly developed in some areas and in many seem to be at a very early stage of gestation – 5 years after the national strategy.

- There are good examples of some ADPs dealing with their local challenges and demonstrating clearly that they are improving performance.

- There is an urgent need to improve the consistency of ADP performance.

- The Scottish Government should reconsider how it receives and actions expert advice – in particular, the place of nationally funded bodies and the reporting arrangements for the DSDC.

SECTION 8:
THE PLACE FOR RESEARCH IN SUBSTANCE MISUSE IN SCOTLAND



Section 8: The place for research in substance misuse in Scotland

Evidencing treatment effectiveness in Scotland and England

271. The recent direct challenge to the Scottish Government's drug strategy reflects, to some extent, a lack of convincing evidence – from formal research or local/national reporting – for the effectiveness of Scottish treatment services – particularly regarding progress towards recovery. Also, it is not understood why trends in drug deaths in Scotland differ from elsewhere. This may be explained – in part – by a lack of prioritisation of high quality research into the natural history and effective treatment of problem substance use in Scotland.

Funding of substance misuse research

272. This deficiency in Scottish research in the field can be illustrated by reviewing the reports on research activity from the Chief Scientist's Office (CSO) for Scotland. Though clearly CSO is only one funder of research in Scotland it is one of only a few sources of funding for project grants and its records can give some indication of research activity. The CSO publishes reports of all research funded by that office on an annual basis (Chief Scientist for Scotland [CSO], 2012).[89] The most recent report shows that, since the publication of *the Road to Recovery*[1] in 2008, the CSO has received reports of only 5 research studies they funded, relating to substance misuse outcomes. During this same period, the CSO received reports of 216 studies on other topics. According to their own report, only 2.7% of CSO funding, under all headings, was in the area of substance misuse.

273. There is a need to explore the role of the CSO in proactively developing a meaningful research agenda in this field. It is acknowledged that the CSO funding and guidance should at the very least, be supporting engagement of Scottish research activity in Scottish, UK national and international research programmes.

274. Ring-fenced resources for substance misuse services in Scotland currently consume some £36 million per annum. If the additional costs incurred by social care, child protection, criminal justice and generic NHS services were taken into account, the cost to the Scottish tax payer is more realistically estimated to be in the region of £3.5 billion (Scottish Government, 2009).[90] This high cost problem – in terms of monetary and societal costs – should be a national research priority for Scotland. Failure to address this is a false economy.

Quality of routine clinical information

275. Also a gap in availability of valuable routine clinical information has been identified in the recent report by ISD in their consultation on information needs in the field of substance misuse across Scotland (ISD, 2012).[63] When interviewing a range of stakeholders, the issue of the need for evidence of treatment effectiveness – a recurring issue in this report – was high on the agenda. The report stated:

"Effectiveness of interventions was a prominent response to this question... Some interviewees focused on knowing interventions' effects while others discussed ways

to determine effectiveness. Effectiveness can be measured in several ways and different interviewees had different priorities. A common concern was that at present there was a lack of awareness of the effectiveness of interventions that are being used across Scotland."

276. In particular, ISD reported real concerns from those in the field about the need to demonstrate meaningful outcomes – a key aspect of the change contained in *the Road to Recovery*[1] and *Delivery Reform*[22] reports. One interview clearly raised the question of ISD supporting an ongoing process of service evaluation:

"For large cohorts of service users, you could evaluate new treatments, in effect a natural experiment, which would be valuable given the difficulty in carrying out randomised controlled trials for methodological reasons and political reasons."

The ISD consultation report concluded that:

"Perhaps the most prevalent need identified, one that sits at both the population and individual levels, was a clear understanding of what works. This could be the effectiveness of interventions; what treatment works and what does not. But there was more than this, it extended out to needing to identify which policies worked and why, which patient journeys generated positive outcomes, what could be considered a 'positive outcome'."

Effective Interventions Unit

277. In Scotland, significant increases in service funding were supported by the first Scottish Executive in 1999 after a long period when new funding for treatment had been largely unavailable. At that time, and clearly pertinent to the current situation in Scotland, the Scottish Advisory Committee on Drug Misuse (SACDM) set up a research sub-committee, supported by the Effective Interventions Unit (EIU) – a newly created and innovative support unit, tasked with producing authoritative evidence for the substance misuse field in Scotland – and asked leading Scottish academics to advise on how best to evidence the government's strategic aims. Regarding treatment, this final report stated:

"There is a commitment within the UK and Scottish drug misuse strategies to develop effective drug misuse treatment services. This aim is currently hampered by the lack of detailed information on the effectiveness of drug misuse services within Scotland. Where research has been undertaken into the provision of methadone this would appear to have an important role in the treatment of opiate dependent drug misusers. However, it is not possible to say within Scotland what the long term impact of drug misuse treatment services is. There is a need to develop a programme of drug misuse treatment evaluation that is both comprehensive in its coverage across Scotland and in its inclusion of the range of treatment modalities that are currently available within Scotland." (McKeganey & McIntosh 2000).[91]

The future – research programmes

278. This challenge, identified over ten years ago, remains. Reports have repeatedly made the same assertion – that Scotland would benefit from an adequately funded and coordinated programme of research to address national concerns and objectives.

279. ORT has specifically been the focus of two specialist reviews, commissioned by Government, in 6 years. A pragmatic approach to substance misuse, encompassed by the notion of *recovery*, has been introduced to bridge the harm reduction benefits of a range of interventions – especially ORT – and the personal recovery journey towards more normality which is the aspiration for the majority of substance users. In the context of an information vacuum, the treatment debate continues to be driven by opinions and beliefs rather than compelling evidence – but repeatedly acknowledges that many of the key research questions cannot be answered without a commitment to support long-term, high quality research programmes, of Scottish relevance.

280. Such research programmes should not simply address medical treatment interventions. They must also encompass social research, developmental research and "translational research" – acknowledging the basic science which underpins addictive behaviours and may hold the key to the understanding of its development, associated risks and effective approaches to prevent or treat the condition.

Stakeholder evidence

281. A number of Scottish academics gave evidence to the review. A consistent view was expressed repeatedly which is in line with the ISD consultation and previous EIU guidance – that the current approach to research in Scotland is unlikely to address many of the challenges we face.

282. Scottish academics in this field are spread thinly across a number of institutions and are currently developing their own research into key areas of concern for the Scottish Government and of relevance to this review. Coordination of such work could bring added value. Selected examples of relevant work include:

- Assessing cognitive function in opioid users;
- Eradicating Hepatitis C in drug using populations by improving access to low threshold methadone programmes;
- Assessing the long term outcomes of methadone patients (30+ years);
- Effectiveness of abstinence programmes – long term outcomes;
- Identifying factors predicting long term outcomes in drug treatment;
- Aspects of community pharmacy delivery in delivering drug treatment;
- Impact of mental health issues and pain on long term outcomes in ORT;
- Functional and structural imaging of the brains of opioid users;
- Impact of contingency management on outcomes in ORT treatment failure;
- Impact of homelessness on drug deaths;
- Staff attitudes and recovery.

Use of routine information

283. When people access services, information is collected about their presenting problems, case histories and social circumstances. Rich, detailed information should therefore be being recorded about people with substance use problems across the country. If this information could be managed in a coordinated way, it would be possible to characterise the population experiencing substance use problems and those their problems impact on – such as their families and communities. There is a need to capitalise on this resource to help us to better understand substance use, its consequences and the interventions which help address it.

284. It is clear that, if well managed and governed, routine clinical information can form the basis of a strong research culture. Indeed, in some areas in Scotland, systems have been developed which aim to allow routine information from NHS e-case files to be anonymously analysed to address key research questions. These systems are overseen by NHS Caldicott Guardians and local ethics committees to ensure patient information is secure.

285. Scotland is compact with a small but accessible population. Delivery of much improved information systems should not present the challenges it has in this field to date and – as has been shown in the collection of HEAT A11[61] data – is possible if prioritised by organisations and required by national officers.

286. If routine clinical data can be made available within acceptable data management agreements for the purposes of research, such an approach could become the basis of a coordinated national programme of research activity. Similar systems are already in place for other care groups – including chronic diseases such as diabetes. If extended to include substance misuse, Scotland could rapidly develop a gold standard evidence based approach to service development and delivery.

A new approach to evidence in Scotland

287. There is a strong consensus from academics in the field that coordinated research activity must be supported and directed if we are to avoid repeated patterns of development and review. We are aware that the current approach to research funding has not resulted in an environment in which robust academic activity in substance use can flourish. Historically, in other countries (USA, Australia, England), facing the challenge of increasing, complex substance use problems, national processes were set up to efficiently develop the infrastructure required to support programmes of the long term, high quality research that is required to address the unresolved questions we face in Scotland today.

In conclusion

288. Scotland requires a new coordinated national approach to develop the relevant evidence base to support a better understanding of the natural history of substance use problems and the delivery of improved treatment and recovery outcomes. Systematic collection and management of routine data from services should be the foundation for this work.

Summary 7: The place for research in substance misuse in Scotland

- There are numerous research gaps in the field of substance use – in areas including vulnerability to substance use problems; the natural history of these conditions; effectiveness of a range of treatments; factors affecting treatment outcome.

- Previous reports on key challenges in the field in Scotland – drug deaths; demonstrating treatment effectiveness – have recommended a coordinated programme of research in substance misuse.

- Isolated research teams/centres in Scotland have progressed specific research objectives but this activity is not targeted at national priorities and, currently, minimal CSO funding to this field supports substance use projects.

- Substance use is a complicated area to research effectively – requiring representative samples in large numbers, reviewed over long periods, measuring effectiveness using valid measures. This presents serious challenges for researchers if their research is to be meaningful and influence practice.

- ISD has found in their recent consultation that stakeholders see the collection of information should include potential use in evaluating effectiveness of interventions.

- Information systems do exist in some localities which have designed novel approaches to make routine data available for research – within existing governance arrangements.

SECTION 9:
DISCUSSION AND RECOMMENDATIONS

Section 9: Discussion and recommendations

What have we found? - What should be done?

This section describes the main findings arising from the independent review and sets out 12 recommendations.

289. The review team identified many examples of good practice from around Scotland, some of which have been used as anonymised examples to illustrate the report. These examples should be used to give guidance to those local systems which are known to be falling short of the standards expected in Scottish services.

290. In addition, the review proposes that the issues facing the delivery of improved outcomes for those experiencing problem substance use should be addressed using a proven improvement methodology. This process should be prioritised by the Scottish Government.

291. Finally, the review makes specific recommendations addressing those areas where the application of existing advice or agreed evidence-based clinical standards offers "quick wins" in terms of objective improvement.

Context

292. Scottish strategy and practice have, in our view, evolved logically in the face of the challenges presented by problematic substance use over the last 30 years. There was a strong leadership response to the first discovery of a link between HIV and injecting drug use in the 1980s – with the endorsement of harm reduction as an outcome of treatment in the 1994 Ministerial Task Force Report (Scottish Office, 1994).[6] In line with the international evidence base and specialist opinion, harm reduction then evolved pragmatically – including such areas as criminal justice and child protection outcomes.

293. The first UK guideline on good clinical practice had been published by the Department of Health and Social Security in 1984, reflecting the clinical concerns at that time and containing recommendations relating, largely, to the achievement of abstinence from opioid use through a combination of careful assessment, support and short term prescribing. The proven link with blood borne viruses changed this. Guidance and standards improved through the 1990s (UK guidance supporting harm reduction was published in 1991 and then updated in 1999 and 2007 as primary research evidence accumulated) and the availability of needle exchange schemes and ORT have repeatedly been shown to have a huge effect on drug-related risk-taking and physical health problems in injecting drug users. A recent large UK study found that good access to such services could reduce sero-conversion rates for Hepatitis C by as much as 80% (Turner et al, 2011).[92]

294. International expert opinion recognises that some in ORT treatment may continue to use illicit drugs sporadically and it is possible that for maximum long term benefit some may require to receive ORT indefinitely. This review is of the view that, for those in these circumstances, this outcome – long-term ORT – should not be considered a failure. Indeed, any intervention which helps to stabilise such a

complex picture can help shift people to a position where they can begin to accumulate positive recovery capital to help them move towards their recovery goals – a view supported by the majority of those experts in the area of recovery from around the world.

295. Despite the strong international consensus regarding these benefits, however, there has remained a degree of enmity towards the use of ORT from some groups of service users, families, communities and even professionals in Scotland. Such enmity may seem understandable if we fail to have in place effective mechanisms to ensure that all stakeholders are well educated about the evidence around substance use, its associated risks and the options available for effective treatment.

296. In association with this doubt regarding the value of treatment, however, has been a repeated challenge to the use of ORT in Scotland and this report now represents the second review of its use in 6 years. The previous 2007 review – *Reducing Harm. Promoting Recovery*[13] – acknowledged the strengths of ORT but also identified some clear weaknesses in the context of Scottish services, giving guidance on how delivery should be improved and opportunities for recovery expanded. Some 6 years later, however, the expected outcomes of ORT and the complexity of factors that affect these do not seem to be well understood beyond the treatment community.

297. Likewise, those factors which may be associated with vulnerability towards addiction or its severity are rarely debated in public arenas. Neurobiological and genetic vulnerabilities, the potential effects of these on brain function and interactions with psychosocial factors have potential to improve considerably the ability of the care system to identify and manage problem substance use. In depth scrutiny of these interactions is beyond the scope of this review. However, in the Scottish context, the potential impact of social exclusion, health inequalities and stigma are of particular relevance.

Social exclusion and health inequalities

298. The demographic characteristics of those problematic substance users who might benefit from ORT have evolved in recent years. The median age of the group has increased significantly as drug using habits have changed and the number of new users of heroin has decreased, meaning that the levels of physical and psychological morbidity, already high in the group, have become more extreme and more demanding requiring a more coordinated response from all aspects of Health Care and from Local Authorities. Increasing levels of income inequalities, the associated impact on health inequalities and the effects of multiple deprivation have produced an increasingly complex picture of health and social need requiring skilled and imaginative responses from services if they are to be met. These difficulties are strongly amplified by the high levels of stigma directed towards this group by the public (including prospective employers, educators and health and social care professionals) and the media. Changes in benefits systems or housing policy can clearly disadvantage this group even more.

299. For clinicians it has become increasingly apparent that many individuals with problematic substance use have more than one medical problem to address. In a

single individual it is common to have a constellation of symptoms and diagnoses, some relating to increasing age. It is essential that their doctor is aware of the need to monitor for and respond to a wide range of challenges. General medical monitoring is therefore essential in this group.

300. Both General Practitioners and Community Pharmacists have been important elements of the system of care offered to substance users and as professional groupings have strongly supported delivery of care for this group. However, there are still huge inconsistencies in terms of even availability of treatment via primary care or the range or quality of care available. Despite the high risks carried by this group, contracting processes in primary care still support an "opt-in" approach to delivering treatment. This anomaly continues to drive health inequalities and stigma.

Recommendations 1-2

1. Consideration should be given to the development of mechanisms bringing closer the delivery of approaches to address health inequalities and problem substance use.

- As a minimum requirement, all local inequalities strategies must contain reference to plans to address the risks associated with substance use.

2. Primary care services – specifically General Practice and Community Pharmacy – are essential elements of the delivery system and should be delivered to national standards.

- It is imperative that discussions begin to consider how substance misuse treatment can be best delivered in the primary care setting. This process should be led by the NHS Primary Care structures and discussions should include General Practitioner and Community Pharmacist contractors.

- Actions to test service quality improvement should be initiated nationally to reduce variation in practice.

Guidance for clinicians – an evolving response to a changing problem

301. The guidance and standards of care available for doctors in the UK – *the Orange Guidelines* – are regularly updated with the last version published in 2007 (Home Office et al, 2007).[39] Specific guidance has also been published specifically for GPs (RCGP, 2011).[93] Recently in England, the NTA led the development of guidance for clinicians regarding the delivery of services which are more likely to facilitate recovery (NTA, 2012).[53] In 2012, the British Association of Psychopharmacology published its most recent evidence-based guidance for clinicians – bringing the current recommendations (on all medical treatments for drug and alcohol use) up to date with the current evidence base (Lingford-Hughes et al, 2012).[35]

302. Many areas have produced local guidelines to supplement National Guidelines. These allow a degree of variation in delivery to reflect local needs but are usually strongly influenced by *the Orange Guidelines*.[39] This flexibility, however,

also has the potential to increase inconsistency of practice. While the available guidance makes it clear that individual clinical judgement is required to allow more flexible treatment – there are very clear standards requiring assessment, treatment choice, induction of ORT and the process of on-going care. Issues of concern or associated with risk – such as optimal dose requirements, diversion and dispensing arrangements – are all acknowledged and guidance is clear regarding how a clinician should manage these issues and ameliorate risk.

Opioid replacement therapies in Scotland

303. A review of the international evidence and statements by national bodies makes it clear that ORT remains an intervention which has support from one of the strongest evidence bases in this field. There is a clear consensus which can be drawn from the primary research across the world – that ORT with methadone (and buprenorphine) represents an effective treatment for opioid dependency, reducing injecting drug use/risk, blood borne virus transmission and death in high risk populations.

Costs

304. Regarding the cost of the methadone ingredient in Scotland**,** the review group recognised that there are complex issues to be addressed regarding reimbursement of costs to pharmacists which may affect the existing reimbursement system as a whole if addressed in isolation. However ORT using methadone is an essential component part of treatment services and is unlike the majority of other prescribed drugs dispensed in community pharmacies due to its extensive impact of treatment on "health, criminal justice, social care, costs to the economy and wider costs to society". There is a logical argument that methadone should be treated as a separate element in pharmacy payment negotiations – though this would require changes in the legislative framework governing pharmacy remuneration.

Evidence-based practice and quality of care

305. Regarding evidence-based practice and the quality of care delivered, the ADP questionnaire specifically addressed these issues. All 30 ADPs completed our questionnaire – and many also supplied additional evidence or were visited by the reviewers for more in-depth discussions. Unfortunately, from their submissions, it was often difficult to obtain accurate information regarding local systems of ORT delivery – in terms of activity, process or outcomes. Some very good examples of aspects of clinical practice and some innovative information systems were observed – but these were the exception and often the information supplied was insufficient to make any judgement on the quality of local services. Stakeholders' evidence we obtained supported the view (evident in these ADP returns) that there was considerable variation in service delivery.

306. As in 2007, the issue for Scotland is to ensure that the ORT delivery system is of the highest quality and that staff delivering this care recognise the impetus to offer ORT in the context of a flexible and mixed treatment system which ensures that service users and their families are involved in the decision regarding their treatment plans. Evidence from some professionals and service users implied that the positive

effect of the HEAT A11[61] target – improving access – has not been associated with improved quality of service. This should be addressed urgently.

Recommendations 3-5

3. Opioid replacement is an essential treatment with a strong evidence base. Its use remains a central component of the treatment for opiate dependency and it should be retained in Scottish services.

- In all settings, ORT should be delivered as part of a coherent person centred recovery plan with SMART goals and based upon an assessment of individual recovery capital.

- The quality of ORT should be governed and delivery should be in line with national standards and guidance. NHS Medical Directors should hold this responsibility on behalf of local partnerships.

- Fit for purpose information systems should be able to identify individuals on this care pathway and objectively demonstrate what progress is being made.

4 A national specification for pharmacy services for problematic drug users should be developed to ensure that a high quality and consistent service can be provided in Scotland. This should be supported by a nationally agreed guideline for supervised self-administration of ORT medications and initiation of improvement approaches to accelerate progress.

- As part of this process, the publication, *Prevention and Treatment of Substance Misuse, Delivering the Right Medicine: A Strategy for Pharmaceutical Care in Scotland* (Scottish Executive, 2005)[4] should be updated to reflect the role of pharmacy within the national drug strategy.

5. The mechanisms in place which determine the reimbursement cost of methadone in Scottish community treatment systems should be reviewed to ensure they deliver best value and that in balancing the competing challenges, the benefits to problem substance users are to the fore.

Progressing recovery in Scotland

307. *Integrated Care* (2002)[52] and *Essential Care* (2008)[5] as well as the recent NTA report on treatment and recovery (NTA, 2012)[53] make it very clear what is required in any locality in terms of the range of services/interventions, the systems they should work within and the standards required to increase the likelihood of recovery for problem substance users. The review of the recovery literature, commissioned by the Scottish Government (Best et al, 2010)[11] has also given an up to date understanding of the state of the evidence base. It is clear that evidence is currently weak for many of the interventions described. However, the report *Recovery Oriented Methadone Maintenance,* cited widely in these recent reports, gives a practical framework for local care systems to improve their effectiveness (White and Mojer-Torres, 2010).[74] The 2011 DSDC report[23] gave clear advice

regarding a graded approach to facilitate the change required – proposing that ADPs should be able to demonstrate they had plans in place and were delivering on activities – whilst acknowledging that ultimately delivering improved outcomes may be a longer-term aim.

308. Again, in this area, we found in the evidence given – by ADPs and stakeholders – that there was considerable variation in terms of local delivery of even the essential core elements of recovery orientated systems of care. Many areas stated their plans to deliver such services were at very early stages of development. There was little valid evidence presented by a number of ADPs regarding a real impetus behind a move towards recovery. Stakeholders' reports supported this observation. Professionals, acknowledging the need to become more effective clinicians, reported that current working practices often precluded delivery of the care they felt people needed. Services reported that they often worked together – but also continued to express a sense of frustration with partners and commissioners. This had become focused in some areas as a schism between statutory and third sector services.

309. Some service elements which one would expect to be strategic priorities in a recovery environment clearly are not. Reported use of service users/people with lived experience is sparse. The development of community rehabilitation approaches or improved access to residential rehabilitation facilities are yet to be realised in many areas. Specialist Clinical Psychology services are unavailable in the majority of NHS board areas.

310. When a very large proportion of funding resource is supporting one service element – ORT (methadone) prescribing and the NHS services largely delivering it – those *"Wraparound"* (now "*Essential")* services inevitably find themselves developing with less practical or financial support. It is a paradox that, as ORT services seem now to be beginning to meet demand more efficiently (as shown by HEAT A11[61]) this introduces a large number of treatment-seeking individuals into the care system when these other services may lack the resources to respond. Coordinated local action – including effective commissioning of appropriately-funded services – is then required to meet this increasing need and to deliver those additional services – often addressing more psychosocial issues – with more potential to support progress towards recovery. There has been little evidence supplied to this review of a meaningful local response to this resource deficit.

311. It is not surprising that, in such a situation, partners see the treatment – ORT – as the issue, rather than the failure to deliver this evidence-based medical treatment optimally nor the failure to effectively commission an adequate range of services in a balanced manner to best meet local needs.

312. The review team is of the view that this inability to gather local momentum behind the recovery agenda is a key finding which should be addressed.

Recommendations 6-7

6. Recovery-orientated systems of care (ROSCs) are well described in many guidance documents. All local systems should *immediately* publish prioritised SMART plans to ensure they can demonstrate a process towards delivery of ROSCs. Elements expected in such plans include:

- All service users should be offered and actively encouraged to use *Essential Care*[5] services. This offer should be recorded and repeated at regular intervals. This should become the norm in Scotland's services.

- In all settings staff should be trained in the delivery of ROSC.

- A full range of *Essential Care*[5] services should be available in every locality – this should include a full range of identifiable community rehabilitation services – including these using people with lived experience; access to detoxification and residential rehabilitation; access to a full range of psychological and psychiatric services; services addressing employability and accommodation issues.

7. Within the medical and other caring professions, it is everyone's responsibility to manage drug users and their problems which extend into every clinical speciality. All practitioners can effect change and have opportunities to address drug-related problems within their profession arena. Local systems should have plans in place to ensure substance users are not excluded from generic services.

Governance and accountability of the delivery system

313. Echoing previous work, this review has also specifically addressed ongoing concerns regarding the local delivery system – in particular the ADPs which were created to ensure improved accountability systems, more consistency and better outcomes. National ADP funding [i.e. funding paying for the governance, accountability and commissioning function – NOT services themselves] is now subsumed into a total local grant. In 2011/12 (the last year this element was defined) the ADP support funding for Scotland amounted to £3,241,529.

314. There are real concerns around the lack of progress we found in many ADP areas regarding the delivery of more recovery orientated systems of care and quality assurance for services. There are very few care areas/groups for whom the Scottish Government makes a specific grant to local systems to facilitate local improvement. Despite this dedicated resource, for many areas, basic information – even on activity - seemed to be impossible to access – at least for this CMO review. Clear local strategic plans and objective reports of improvement were rare in the responses received. Elements of recovery orientated services were often absent. There was not a strong sense of accountability.

315. Improvement has been seen in one area – that of HEAT A11.[61] In the absence of consistent improvement in other aspects of delivery, it may be that this

reflects the nature of the HEAT relationship between the local NHS Board and NHS Executive (i.e. this is not necessarily reflective of the partnerships' effectiveness).

316. Information systems remain a focus for this lack of progress. Nationally, ISD has consulted on how best to develop meaningful systems (ISD, 2012)[63] – but the review team has concerns regarding the validity and deliverability of their current proposals and timeframes.

317. Finally in this field there is a lack of *institutional memory* (at both national and local levels) regarding an agreed understanding of the key issues and the plans which require to be put in place to address them. Without such an *institutional memory* systems are destined to continue repeating mistakes or failing to capitalise on successes. Such inefficiency is at odds with the aspirations contained within the Christie Commission report (Scottish Government, 2012).[2]

Recommendations 8-9

8. The Scottish Government should seriously reconsider how to better facilitate universal and effective partnerships which respond to local need and deliver consistent and measureable outcome improvement for substance users across Scotland.

- ADPs' function should be reviewed urgently and clear improvement measures developed and monitored with clear timeframes for change.

- In particular, all local systems should immediately publish prioritised SMART plans to ensure they can demonstrate a valid and coherent process to evidence the delivery of ROSCs in line with the *Essential Care*[5] report.

9. There is an urgent need to address the lack of institutional memory in the planning, delivery and governance of these systems of care. In particular, current advisory structures should be reviewed to improve impact on performance – especially with regard to lines of accountability and relationships with the Scottish Government and Scottish Parliament.

Information, research and evaluation

318. One of the main reasons that there continue to be concerns regarding effectiveness of treatment in Scotland is an inability to address what seem to be local anomalies – such as the increasing death rate at a time when access to treatment has massively increased. International evidence tells us that the reverse should be true. Poor use of residential facilities, or resistance to offer detoxification – even when requested by service users – are often argued on the basis of "the evidence base" or a lack of it.

319. This review cites previously published systematic reviews which make it clear that – even for individual medical interventions such as ORT – there are deficits in our evidence base. Academics interviewed repeatedly acknowledged the urgent need for better research into the effectiveness of a whole range of treatments and

interventions which may influence the development of or recovery from problematic substance use. A coordinated development of Scottish research capacity in this field was previously proposed in a report commissioned by the Scottish Executive's Effective Interventions Unit in 2000 and this advice has been repeated in many subsequent reports – but has yet to be progressed.

320. Scotland has unique problems and a local approach to research is required. Such research requires to be of high quality and to address specific research questions of relevance to Scotland and its challenges. It should be longitudinal (i.e. addressing a period of follow up – not just a cross sectional survey of small samples of subjects), of sufficient power to answer the key research questions (large enough numbers) and follow up subjects for a long enough period to be meaningful in the context of the long time periods required for recovery to be meaningful.

321. We have found that, currently, though there is isolated academic activity in many institutions across Scotland, very few research grants from the CSO – a key funder of primary research in Scotland – address this area. Research rarely addresses comparisons between different treatment approaches. Collaborations are few and usually short-lived as they are based on specific research grants or are recruited to bolster subject numbers in larger studies. This activity does not help to build a meaningful research infrastructure for Scotland. This is an inefficient way to approach this issue and if not addressed will ensure the same questions will remain unanswered and become the focus of future reviews.

322. Meanwhile, the ISD consultation has shown that stakeholders would value access to standardised information systems which can supply valid information to demonstrate their effectiveness and support primary research into effective interventions. We have found that some locally-developed information systems are already in place delivering on some of these needs at a local level. Such projects have already addressed many of the challenges which affect delivery of effective information systems. Any future developments should learn from or build on existing expertise.

323. Research and academic enquiry into problem substance use has been poorly developed in Scotland despite the magnitude and seriousness of its manifestations. There is also a clear and urgent need to bring together the essential elements required – developing meaningful information systems which allow routine data to be used to support a high quality national research programme which is designed to specifically address key Scottish challenges. If such a structure were in place, future assessments of the effectiveness of drug strategy would be planned and resourced as part of an ongoing academic programme rather than convened in response to a perceived crisis.

Recommendations 10-11

10. The Chief Medical Officer should task the Chief Scientist to consult with the academic community in Scotland and bring forward robust plans to develop a Scottish National Research Programme addressing the key substance use questions for Scotland. The aim should be to support and facilitate the delivery of efficient, high quality research into both the natural history of problem substance

use – its development and progression – as well as the effectiveness of a broad range of treatment approaches – including psychological and social approaches.

11. Any proposal to further develop national information systems in the area of substance misuse at national level should be subject to meaningful and accountable project management. This should include: external scrutiny of delivery; a risk assessment to identify and address the main obstructions to delivery; publication of a realistic programme of delivery with agreed timeframes with measureable milestones; clear lines of accountability for all elements of the proposed system.

Mechanism for change

324. The Christie Commission has highlighted the need for the Scottish Government and its partners to develop more efficient, effective and outcome-focused mechanisms for delivering services across government (Scottish Government, 2012).[2] In the area of substance use, several reports have raised similar issues regarding inconsistent delivery and a lack of accountability of a dedicated system (ADATs/ADPs) in recent years. The delay in delivery was highlighted by the DSDC in its first report to Ministers (DSDC, 2011).[23] It is now important to avoid further delay and take immediate steps to use an approach which has a track record of delivering change.

325. Having consulted key advisers within the Scottish Government, the review group recommends that the variation identified in the delivery of Recovery Orientated Systems of Care and the associated medical treatments (such as ORT) should be addressed using a proven improvement methodology.

326. The Scottish Government set out their approach to transformational change in their 3-Step Improvement Framework for Scotland's Public Services[3], which provides a guide to put change ideas into action at every stage of significant change programmes. It recognises the need to create the right conditions for improvement and to empower and engage local leaders. The Framework was developed to help unlock and channel the collective knowledge and energy of people towards a common goal of real and lasting improvement across public services. There is often a lot of evidence of what works, but how to implement that everywhere is not always known. The Improvement Framework provides a method for change and helps to support the implementation of those changes to make the improvement happen locally, everywhere.

327. We think that the Improvement Framework and the Improvement Science surrounding it will help us in this case. We know what we want to change and we need help to make it happen consistently and reliably for everyone who needs this support. Using the Improvement Framework will ensure that we develop a defined understanding of what we are trying to accomplish, have a way to measure so that we know we have made an improvement not just a change, and know what changes we want to test out. Putting these improvement principles into practice will allow us to identify and generate the right changes, develop the tools to spread those changes and ultimately maximise improvement across/in this area.

328. This methodology would therefore create the conditions for improvement by empowering and engaging local leaders and working with front line practitioners and service users to plan and test improvement in local services.

329. This collaborative approach could draw from the experience of the Early Years Collaborative[94] which is already underway in Scotland. The Early Years Collaborative is a national, multi-agency quality improvement programme, implemented locally by Community Planning Partnerships to share learning, successes and challenges with each other. It draws on learning from the highly successful Scottish Patient Safety Programme and the collaborative approach it used to develop a sustainable infrastructure for quality improvement in the NHS in Scotland while embedding a culture of safety into the everyday practice of healthcare staff.

Recommendation 12

12. The variation of practice identified across services should be addressed using a proven improvement methodology, enshrined in the '3-Step Improvement Framework for Scotland's Public Services'.[3] This work should be given high priority by the Scottish Government and its partners. Clearly defined aims, drivers and measures should be developed, for agreement at an initial national collaborative learning event, organised by the Scottish Government early in 2014.

Delivering recovery

330. The DSDC independent review proposes that the specific recommendations above (numbers 1-11) should form the basis of an immediate improvement process – giving local and national systems a clear direction for improvement work. In the meantime, officials should be developing plans for use of the '3-Step Improvement Framework for Scotland's Public Services'[3] to put in place sustainable changes to address the issues identified by this review. That process should be in place by early 2014.

ANNEX 1:
GLOSSARY

ANNEX 1

GLOSSARY

AA	Alcoholics Anonymous
ABCD	Asset-Based Community Development (Model)
AC	Acute Care
ACC	Assertive Continuing Care
ACMD	Advisory Council on the Misuse of Drugs
ACT	Assertive Community Team
ADAT	Alcohol and Drug Action Team
AOD	Alcohol and Other Drug
ATOS	Australian Treatment Outcome Study
ADP	Alcohol and Drugs Partnership
BBV	Blood Borne Viruses
BFI	Betty Ford Institute
CAPSM	Children Affected by Parental Substance Misuse
CCAP	California Civil Addict Programme
CBT	Cognitive Behaviour Therapy
CA	Cocaine Anonymous
CAT	Community Addiction Team
CSIP	Care Services Improvement Partnership
CHRISTIE COMMISSION[2]	Report on the Future Delivery of Public Services by the Commission chaired by Dr Campbell Christie
CPP	Community Planning Partnership
CPD	Continuing Professional Development
DAISy	Drug and Alcohol Information System
DARP	Drug Abuse Reporting Programme
DAT	Drug Action Team
DATOS	Drug Abuse Treatment Outcome Study
DfES	Department for Education and Skills
DoH	Department of Health
DTX	Detoxification
DHC	Dihydrocodeine
DIP	Drug Interventions Programme
DORIS	Drug Outcome Research in Scotland
DRD	Drug Related Deaths
DSDC	Drug Strategy Delivery Commission
DTTO	Drug Treatment and Testing Order
DTORS	Drug Treatment Outcome Research Study
EU	European Union
GROS	General Register Office for Scotland
HEAT	Health, Efficiency, Access & Treatment (Targets)
HPS	Health Protection Scotland
ISD	Information Services Division Scotland
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus (Causative of AI Injecting Drug Use/Intravenous Drug Misuser

LAADS	Lanarkshire Alcohol and Drug Service
LPASS	Lead Psychologists in Addiction Services Scotland
LEAP	Lothian and Edinburgh Abstinence Programme
LRRRT	Lothian Residential Rehabilitation & Resettlement Team
MCN	Managed Clinical Care Network
MRC	Medical Research Council
MRD	Methadone Related Death
MMT	Methadone Maintenance Treatment
NA	Narcotics Anonymous
NDTMS	National Drug Treatment Monitoring System
NES	National Enhanced Service
NIAAA	National Institute of Alcohol Abuse & Alcoholism
NESI	Needle Exchange Surveillance Initiative
NICE	National Institute for Clinical Excellence
NIHCE	National Institute of Health & Clinical Excellence
NMP	Non-Medical Prescribing
NTA	National Treatment Agency
NTORS	National Treatment Outcomes Research Study
ORANGE BOOK	Drug Misuse and Dependence UK guidelines on Clinical Management
ORT	Opioid Replacement Therapy
PTSD	Post-Traumatic Stress Disorder
PWID	Person(s) who inject drugs
RCGP	Royal College of General Practitioners
RCT	Randomised Controlled Trial
RR	Residential Rehabilitation
SACDM	Scottish Advisory Committee on Drug Misuse
SDF	Scottish Drug Forum
SDMD	Scottish Drug Misuse Database
SFAD	Scottish Families Affected by Drugs
SG	Scottish Government
SMART	Specific, measurable, achievable, realistic, timeous
SMR25	Assessment Report to SDMD on an individual entering treatment
SPS	Scottish Prison Service
SRC	Scottish Recovery Consortium
SSA	Supervised Self Administration
SSC	Supervised Self Consumption
STRADA	Scottish Training on Drugs and Alcohol
UKDPC	United Kingdom Drug Policy Commission

ANNEX 2:
REVIEW TEAM, STEERING GROUP, SECRETARIAT AND INTERNATIONAL EXPERTS

ANNEX 2

REVIEW TEAM AND STEERING GROUP

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ANNEX 3:
STAKEHOLDER CONTRIBUTIONS

STAKEHOLDER CONTRIBUTIONS

The Independent Expert Group would like to acknowledge the valuable contributions made by the individuals and organisations listed below.

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ALCOHOL AND DRUGS PARTNERSHIPS

• Aberdeen City	• Aberdeenshire
• Angus	• Argyll & Bute
• Borders	• Dumfries & Galloway
• Dundee City	• East Ayrshire
• East Dunbartonshire	• East Renfrewshire
• Edinburgh	• Fife
• Forth Valley ADPs: Clackmannanshire, Stirling & Falkirk *(joint response)*	• Glasgow City
• Inverclyde	• Highland
• Mid and East Lothian *(joint response)*	• Lanarkshire
• North Ayrshire	• Moray
• Outer Hebrides	• Orkney
• Renfrewshire	• Perth & Kinross
• South Ayrshire	• Shetland
• West Lothian	• West Dunbartonshire

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- Scottish Crime Drug Enforcement Agency (now Police Scotland) – Detective Inspector Tommy Crombie
- Scottish Government, Chief Pharmaceutical Officer – Bill Scott, Deputy Chief Pharmaceutical Officer – Alpana Mair and Martin Moffat, Pharmacy and Medicines Division
- Scottish Government, Chief Scientist's Office – Andrew Morris & Peter Craig
- Scottish Government, Drugs Policy Unit – Gillian Russell, Maureen Bruce, Hilary Smith and Julie Carr
- Scottish Government, Total Quality Unit, Clinical Director – Jason Leitch

- Scottish Prison Service – Colin McConnell (Chief Executive Officer), Ruth Parker (Head of Healthcare), Jane Richardson (Head of Commissioning)

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Community Pharmacy Scotland	• Martin Green – Chair Board Members: • Colin Ferguson • Alan Gluach & Mark Feeney
Glasgow Centre for Population Health	• David Walsh – Public Health Programme Manager
Lead Psychologists in Addiction Services Scotland	• Dr Peter Littlewood – Chair
NHS Forth Valley	Substance Misuse Practitioners: • Calum Blair • Rab Doig
NHS Health Protection Scotland	• David Goldberg – Consultant (Public Health) • Sharon Hutchison – Statistical Epidemiologist • Kirsty Roy – Epidemiologist • Nora Palmateer – Epidemiologist
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NHS Lanarkshire	• Dr Brodie – Psychiatrist, Clinical Director • Dr Conroy – Lead Clinician • Duncan Hill – Specialist Pharmacist • Stewart Marshall – ADP Co-ordinator
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- Dr Alex Wodak – St Vincent's Hospital, Sydney, Australia

NATIONAL GROUPS

- Addaction Scotland
- Cocaine Anonymous
- Drug Strategy Delivery Commission
- Narcotics Anonymous
- National Forum for Drug Related Deaths
- Scottish Drugs Forum
- Scottish Families Affected by Drugs
- Scottish Recovery Consortium
- Scottish Training on Drugs and Alcohol (STRADA)
- Turning Point

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- Jenny Marra – MSP (Scottish Labour)
- Graeme Pearson – MSP (Scottish Labour)
- Dennis Robertson – MSP (Scottish National Party)
- Cross-Party Group on Drugs & Alcohol Misuse

RESIDENTIAL REHABILITATION

- Jericho House
- Lothian and Edinburgh Abstinence Programme (LEAP)
- Residential Rehab Referral Team, Edinburgh

SPECIFIC THERAPIES

- Dynamic Attitudes – Johnny Walker
- NHS Education for Scotland – Laura Freeman
- Partners in Evaluation, Scotland – Mark Bitel, Evaluation Officer
- Rehabgrads – Phil Grant, Communications Officer
- Transform Drug Policy Foundation – Stuart Rodger

EVENTS		
Organisation	**Event**	**Audience**
Addaction Scotland	Workshop	• Service providers
Cross Party Group on Drugs & Alcohol Misuse, Scottish Parliament	Information gathering meeting	• MSPs Representatives from: • Academics • ADP Co-ordinators • Elected Councillors • Families • Health Professionals • Pharmaceutical industry • Scottish Drugs Forum • Scottish Families Affected by Drugs • Scottish Training on Drugs and Alcohol (STRADA) • Service providers • Third sector • Turning Point
Glasgow City Council/NHS Greater Glasgow and Clyde	Conference – "Parked on Methadone – Myth or Reality?"	• ADP representatives • Health professionals • Service providers
Jericho House	Workshop	• Service providers • Service users
Scottish Families Affected by Drugs	Conference	• Citizen's Advice • Department of Work and Pensions • Families • Police • Scottish Government • Service users
Scottish Recovery Consortium	The Recovery Summit	• Academics • ADP representatives • Health professionals • Individuals with lived experience • Scottish Government • Service providers • Service users and ex-service users • Support services
Scottish Recovery Consortium	Conference - Letting Residential Rehab Shine	• Academics • ADP representatives • Health professionals • Graduates of residential rehab • Representatives from residential rehab • Scottish Government • Service providers • Service users and ex-service users

ANNEX 4:
ALCOHOL AND DRUGS PARTNERSHIPS QUESTIONNAIRE

ANNEX 4

ALCOHOL AND DRUGS PARTNERSHIPS QUESTIONNAIRE

1. How many people are currently being prescribed methadone or buprenorphine?

2. What are the dose ranges? What is the range of times on substitute prescriptions?

3. What are the supervision arrangements and the proportion of service users at each level of supervision? What are the supervision costs? Under what circumstances would someone be returned to supervision?

4. How many have voluntarily detoxified from methadone or buprenorphine in the last 2 years? How many have had their prescription stopped involuntarily in that time?

5. What arrangements have you for service user representation in ADP and service decision making? How are you pursuing the establishment of peer education systems and peer support workers?

6. How confident are prescribing service workers in pursuing recovery? How can you evidence this?

7. What are your arrangements for delivering a recovery oriented system of care? How are you engaging with local communities?

8. What contact do services have with mutual aid groups?

9. What use do you make of residential rehabilitation services?

10. What use do you make of community rehabilitation services?

ANNEX 5:
ALCOHOL AND DRUGS PARTNERSHIPS ‘RESULTS AT A GLANCE’

ALCOHOL AND DRUGS PARTNERSHIPS QUESTIONNAIRE – 'RESULTS AT A GLANCE'			
Number of people on a replacement prescription	➢ 22 gave exact information ➢ 5 gave partial information ➢ 1 gave no information	**Dose ranges**	➢ 14 gave information ➢ 11 gave averages ➢ 3 gave none
Length of time on prescription	➢ 7 could say how long (3 in the form of>5years) ➢ 6 gave partial information ➢ 15 gave none	**Supervision rates**	➢ 18 gave full information (number on each type), ➢ 9 gave partial information ➢ 1 gave none
Supervision costings	➢ 24 gave costings ➢ 4 gave none	**Reasons for return to supervision**	➢ 23 gave information ➢ 5 gave none
Voluntarily come off replacement prescription	➢ 9 could say how many in last 2 years ➢ 19 gave none	**Involuntarily detoxification**	➢ 10 gave numbers ➢ 18 gave none
Service user involvement	➢ 9 were direct (i.e. sitting on ADP) ➢ 18 were indirect (consultation primarily) ➢ 1 said none	**Peer working arrangements**	➢ 10 gave good examples ➢ 6 were aspirational ➢ 12 gave none
Confidence in pursuing recovery	➢ 14 gave good evidence of which 12 described ongoing education arrangements to pursue this ➢ 4 described one off education events ➢ 10 gave no evidence other than aspirations	**Recovery Orientated Systems of Care**	➢ 13 had clear arrangements ➢ 15 were unclear
Working relationships with communities	➢ 6 had clear arrangements ➢ 22 were unclear	**Mutual Aid**	➢ 18 had proactive relationships ➢ 10 made reference to its existence
Residential rehabilitation	➢ 11 gave numbers and criteria for referral ➢ 9 gave numbers only ➢ 8 were unclear	**Community rehabilitation**	➢ 15 gave good evidence ➢ 9 claimed its existence without evidence ➢ 4 gave no details

ANNEX 6:
BACKGROUND INFORMATION

ANNEX 6

BACKGROUND INFORMATION

This Annex provides background information and is split into three parts as follows:

- Annex 6.1 A recent history of opioid replacement therapy in Scotland
- Annex 6.2 The international longitudinal studies
- Annex 6.3 Systematic reviews – a review

ANNEX 6.1

A RECENT HISTORY OF OPIOID REPLACEMENT THERAPY IN SCOTLAND

1. Changes in the social structure and behaviours of British society have been associated with fluctuations in the extent and nature of problematic substance use. This in turn has seen political responses reflecting social and moral concerns as well as the available scientific evidence. Historic approaches to the treatment of opiate (mainly heroin) dependency had included the legal supply of opioid drugs to substance users for over a century in the so-called *British System*. The drug 6-Dimethylamino-4, 4-Diphenyl-3-Heptanone – or *methadone* – is a long-acting synthetic opioid. Methadone has the advantage of requiring a single dose per day and was thought not to have any particularly pleasurable effect. These properties meant it was encouraged as a replacement for Heroin and has been used as such since the 1960s.

2. Concerns about unsafe prescribing in the UK in the 1960s had briefly curtailed availability of such treatments and by the late 1970s out with the major English cities, opioid substitute prescribing was almost unknown. But by the 1980s, the emergence of a potential link between HIV infection and injecting drug use – first identified in Edinburgh – re-energized the place of ORT in general and methadone in particular (Robertson et al, 1986[95]; Greenwood, 1990[96]). An expert committee reviewed the evidence with a view to identifying effective interventions to address this threat in Scotland and the resulting McLelland report (Scottish Home and Health Department [SHHD], 1986)[97] proposed that services should aim for intermediate goals on the path to abstinence, in order to reduce drug-related harms. These goals included: stopping or reducing injecting with unsterile equipment; taking drugs more safely (by mouth or inhalation); and taking prescribed (legal) rather than illicit drugs. Echoing the McLelland Committee findings, the 1988 ACMD report[98] on HIV prevention stated that:

"...HIV is a greater threat to public and individual health than drug misuse. The first goal of work with drug misusers must therefore be to prevent them acquiring or transmitting the virus. In some cases this will be achieved through abstinence. In others, abstinence will not be achievable for the time being and efforts will have to

focus on risk reduction. Abstinence remains the ultimate goal but efforts to bring it about in individual cases must not jeopardise any reduction in HIV risk behaviour which has already been achieved." (ACMD 1988)[98]

3. This phenomenon reversed the abstinence-orientated prescribing policy of the preceding years as it legitimised longer-term opioid prescribing to enable users to stop injecting. This concept of "harm reduction" in the UK later developed to encompass other emerging potential injection-related health risks – such as Hepatitis C infection – but also to include more social outcomes such as attempts to reduce criminal activity or improve employability.

Scottish strategic response

4. In 1994 the report of the Ministerial Drugs Task Force set up by the Scottish Affairs Committee was published (Scottish Office, 1994).[6] This encouraged further service development and brought new funding for treatment services.
This report gave enthusiastic support to harm reduction and, in particular, Methadone which it was felt should be available throughout Scotland. The report agreed that the harm reduction benefits were such that *"no inhibition should be placed on the use of Methadone in appropriate maintenance doses"* and the authors stated that there should be no *"arbitrary"* limits on doses or length of treatment. This report also saw the creation of local strategic Drug Action Teams, new local partnerships tasked to oversee local delivery and a Scottish advisory committee (SACDM) to ensure Ministers received the highest quality advice.

5. By the new millennium, a new Scottish Parliament and Labour government had delivered an updated strategy for Scotland – *Action in Partnership* (Scottish Executive, 1999).[7] This endorsed the broad harm-reduction approach of treatment delivery but also heralded a sustained period of increased funding for local systems to address their drug problems. This investment included considerable support for the Drug Action Teams as well as support for their development with the aim that they become more effective.

6. However, by 2007, there were increasing public concerns being raised regarding the quality and consistency of treatment in Scotland. Finally, in response to a tragic methadone-related death, the First Minister announced a review of methadone prescribing in Scotland. Alongside other seminar reports this set the scene for a period of significant change in strategy.

The 2007 Methadone review

7. *Reducing Harm and Promoting Recovery* (SACDM, 2007)[13] represented a consensus of views from across the treatment divide. The report reiterated the strong evidence base supporting the use of methadone in Scotland. However, it also expressed concern regarding the quality of care delivered and the range of additional supports available for those in treatment. The report also noted the paucity of valid information available in local and national systems as well as the quality of local commissioning - reflecting a lack of effective governance and failure of accountability systems. The report made a number of recommendations aimed at improving quality

through enhanced governance and accountability of treatment delivery in line with national standards (Table 1).

Report of the Stocktake of Alcohol and Drug Action Teams – 2007

8. The *Report of the Stocktake of Alcohol and Drug Action Teams*[20] was also published in 2007. This document, delivered by a previous ADAT Chair who had also Chaired the National ADAT Association, reported a further review, commissioned by government addressing ADAT performance. It raised concerns about the quality and consistency of local governance of the response to substance misuse by ADATs, despite the extensive development funding in 1999. The report made a number of recommendations, the two most important of which were:

- *'The Scottish Executive should review the responsibilities of ADATs in consultation with them and set this out in a single guidance framework which should identify the respective national and local responsibilities and those which will benefit most from the strength of a local partnership' approach. The framework should be kept under review and take into account changes in policies, strategies and partnerships.*

- *'The Scottish Executive should review with ADATs (1) the number and size of strategic partnerships to enhance strategic capability and; (2) the best structure for implementation at local level to ensure a good fit in particular with Community Planning Partnerships.'*

Table 1. Reducing harm and promoting recovery. Recommendations (SACDM 2007)

- The Scottish Executive should consider at a high level its commitment to meaningful joint working regarding commissioning and accountability of substance misuse services.
- The setting up of a national methadone audit system to report annually.
- The prioritisation of processes to ensure the recording of CHI numbers on all methadone prescriptions and to maximise compliance with the Scottish Drugs Misuse Database.
- The creation by the Executive of a governance and accountability process which assures the delivery of basic data. ADATs should report on their methadone services within this framework. Services should be held accountable under local clinical governance processes to demonstrate they have agreed standards of care and regularly audit against them.
- The development by the Executive of a strategic process which would facilitate Scottish research into treatment effectiveness in general and methadone effectiveness in particular.
- The Scottish Executive should agree and articulate an overall philosophy of care for Scottish services as part of a refreshed national strategy.
- The Scottish Executive should set up a process to agree national standards regarding replacement prescribing. These standards must address - accessibility; range of services available; waiting times; aspects of care planning and delivery and outcomes. ADATs and services should report on performance.
- The Scottish Executive should require NHS Boards to demonstrate effective use of contractual mechanisms (GP and Pharmacy) and other opportunities (e.g. Non-Medical Prescribing) to deliver best value and improved quality and availability.
- The Scottish Executive should require ADATs to report on the degree, nature and effectiveness of integration of all services locally.
- The Scottish Executive should ensure the newly reconvened Scottish Advisory Committee on Drug Misuse (SACDM) and associated processes are effective and relevant as an agreed national advisory structure.
- Scottish Executive should consider development of a structure which would deliver clear leadership/direction; greater accountability and performance management nationally for substance misuse services – e.g. a Scottish “NTA” or similar body.
- Scottish Executive should review funding streams and associated accountabilities to empower ADATs and facilitate improved effectiveness.
- ADATs must demonstrate that prescribing services are commissioned in the context of their overall service model and are delivering on agreed Key Performance Indicators (KPIs).
- The Scottish Executive must require ADATs to ensure that services are improving delivery in accordance with the national quality standards for substance misuse services.
- ADATs should be required to use ADAT support resources at least in part to deliver on improvements in quality and performance. This should be incorporated into the local NHS clinical governance agenda and reported through the NHS accountability review process.

Local service delivery – the Essential Care report – 2008[5]

9. There swiftly followed, in 2008, a further SACDM document *Essential Care, a report on the approach required to maximise opportunity for recovery from problem substance use in Scotland* (Scottish Government, 2008).[5] This report had been commissioned by SACDM in response to the methadone review and reflected SACDM's assertion that a broader, more holistic approach to treatment was required in Scotland.

10. Previous comprehensive guidance documents had been produced by the (now defunct) Effective Interventions Unit (EIU) – a small specialist unit based in the Scottish Executive which, in response to the *Action in Partnership* strategy[7] had focussed on developing evidence-based advice and guidance for the field. This need (along with a need for enhanced training opportunities – creating STRADA) had been identified by SACDM to ensure the planned increased investment in services was effective.

11. The EIU had worked extensively with stakeholders in the field to produce a comprehensive guidance document *Integrated Care for Drug Users. Principles and Practice* (Scottish Executive, 2003).[52] This document firmly put the substance user at the centre of their own care and proposed an approach which would aim to ensure that people received high quality assessment, were offered care plans which reflected their needs and had access to a range of options.

12. Five years on, these processes were still not the norm and, echoing many of the issues addressed in *Integrated Care for Drug Users*[52], the *Essential Care* report[5] noted key issues the expert group felt should be addressed (Table 2). To address these observations the report made a number of specific recommendations (Table 3).

Table 2. Essential Care – key issues

- Scottish services – in association with prescribing services – have successfully increased the numbers in contact with services delivering approaches dominated by 'harm reduction''. These services are not available equitably reflecting funding, demand and strategic priority.
- There has been poor integration of detoxification and rehabilitation services with harm reduction services.
- Services may be reducing individual options and aspirations as a result.
- Harm reduction and recovery together constituted a continuum of care rather than being mutually exclusive.
- As with other conditions, there was an opportunity to develop an approach which was aspirational and puts the service user at the centre of care and this would involve the development of a national philosophy of care with a focus on recovery.
- Service delivery should reflect key principles, including:
  a. recognition that people with substance use problems have aspirations to have healthy and happy families and fulfilling lives;
  b. disadvantage, poverty and exclusion are closely aligned with problem substance use and plans to improve health must reflect this;
  c. recovery must become a key focus of the care available rather than an ideology which advocates any particular type of treatment;
  d. recovery may not involve abstinence – all services and commissioning partners must put service users at the heart of their activities;
  e. all people should have access to a full range of the essential services described in this document in an accessible location;
  f. care plans must be holistic in approach and address the totality of peoples' lives;
  g. all people with problem substance use must have access to the same generic services as everyone else – this includes the right to be registered with a General Practitioner (GP) and to access primary health care services as needed.
- The local commissioning process must become more effective and must involve the 'core components' of needs assessment, governance and accountability, data sharing and outcome measurement.
- Operational delivery must increase effectiveness of the services participating in the care process. The 'primary requisites of effective care' – assessment, review, named key workers and agreed written plans – are essential elements.
- Essential services – 'key aspects of service provision' – include services addressing an individual's physical, psychological and social functioning. These must be available in every area and there should be governance processes in place to promote equity of access.
- Substance users have the right to the same quality of care as the rest of us.

Table 3. Essential Care – recommendations

National recommendations

1. In its strategic approach to problem substance use, the Scottish Government should develop and introduce governance and accountability processes which scrutinize local performance in terms of both reducing harm and promoting recovery. These should be supported by agreed contractual levels of activity and performance monitoring – including relevant outcome measurement and could be delivered through a national quality improvement unit working in association with reconstituted ADATs.

2. The Scottish Government should require that all areas demonstrate the local availability of a full range of the essential interventions listed in this document and that service providers are engaging service users in approaches aimed at promoting recovery.

3. In its national strategy, the Scottish Government should bring forward options for establishing a Scottish Problem Substance Use recovery network.

Local recommendations

4. All service users have the right to a comprehensive assessment of need which will lead to an inclusive recovery plan that is measurable, achievable, realistic and timeous (SMART) in design. The plan will place the service user – the owner of the plan – at its centre; be agreed and signed by both the assessor and service user; and include a timetable for on-going formal review of changing needs. The plan will be coordinated by a named professional who will be responsible for assisting the person to achieve their goals; arranging, facilitating and recording reviews and updating the plan; and advocating for the service user when required to ensure that their needs are met.

5. Local strategic planning partnerships should regularly undertake a comprehensive needs assessment including service user views and review of their current care, treatment and rehabilitation provision and available funding and current spending with a view to informing the future configuration of services. This must address ring-fenced substance use funding, other ring-fenced resources of special relevance to substance use and 'generic' funding. Any resulting reconfiguration should integrate specialist care and treatment services and the range of essential interventions described in this report. This will require a plan to address workforce development. Best value principles should apply.

6. Further recommendations were made with regard to specific areas of the recovery journey. These included:

- The explicit addressing of substance misuse issues in other relevant national strategies

- The improvement of primary care involvement by use of GMS governance arrangements.
- Ensuring the development of staff in the full range of required skills and competencies.
- The availability of a full range of recognised psychological interventions locally.
- All women attending services must receive care to help them protect and control their fertility to ensure optimal timing of pregnancies.
- Integration of local housing, homelessness and substance use services.
- ADATs should be required to demonstrate mechanisms for ensuring access to free independent specialist legal services.
- The development of a robust national strategy to improve prospects for employment or meaningful activity and the setting of a national employability target.
- Local agreements of employability and educational performance measures.
- Community Justice Authorities to have in place a strategy demonstrating how targeted criminal justice resources will be used to increase access to treatment services as an option for the courts and in custody.
- The role and approach of all services in relation to children of substance misusing parents needs to be explicitly stated to ensure consistency of approach and support across Scotland. Each area will agree and publish the support it offers substance-using parents. This statement will be designed to ensure consistency of approach within the locality and ensure support is available at the earliest opportunity – even before pregnancy; services must publish their confidentiality policy and informed consent process. Information-sharing between professionals should be in line with good practice (as articulated in GIRFEC). There must be recognition that the needs of children at risk are paramount.

The Road to Recovery – 2008

13. In 2008 *the Road to Recovery*[1], Scotland's new drug strategy was published which, in terms of treatment, enshrined the aspirations of both *Reducing harm and promoting Recovery*[13] and *Essential Care*[5]. It acknowledged the value of ORT both as a way of reducing harm but also as a key element for many on the path to recovery. These formed a continuum, centred around the needs of the individual service user rather than the service provider. It also recognised that people with substance use problems often came from seriously deprived backgrounds and were at high risk of poor health and poor social functioning, but, like the rest of society had aspirations relating to happy, healthy families, a nurturing home environment and the opportunity to progress through training or employment. It endorsed the wide range of interventions that needed to be available locally for recovery to flourish.

Inequalities

14. There is a clear, if poorly understood, relationship between income inequalities and health inequalities and between these health inequalities and the consequences of substance use.

15. The large and increasing gap in income inequalities since 1979 drives health inequalities and this in turn drives a diminishing ability to deal with the impact of substance use. Users of substitute prescribing services come almost exclusively from areas of multiple deprivation. Scotland continues to experience increasing levels of harm and premature death when compared to other areas of Europe and England. Even when areas of corresponding deindustrialisation are compared across Europe Scotland continues to show significantly higher mortality rates. The greatest differences appear to be in the 16 to 44 year age group and the differences in mortality appear to be driven by the use of drugs, the use of alcohol, violence and suicide (Walsh, Bendel, Jones and Hanlon, 2010).[19]

16. The forum acknowledged the many local efforts have been made to try and lessen the impact of income inequalities but these have been only partially successful. It is generally accepted by those in the field that income inequalities need to be dealt with nationally as an issue in its own right. Under the current national arrangements there is some doubt as to firstly whether there is any appetite so to do and secondly just how much the Scottish Government can realistically do without a higher degree of economic control.

Stigma

17. The Forum also raised the issue of stigma. Research has indicated that stigma towards current and former drug users and their families can use considerable distress and may present a 'hidden' barrier to accessing help and achieving recovery from drug problems.

18. In 2010 the Scottish Drug Recovery Consortium commissioned the United Kingdom Drug Policy Commission to report on stigma associated with substance use in Scotland (UKDPC, 2011).[67] *Getting Serious about Stigma in Scotland: The problem with stigmatising drug users*[67] was published in conjunction with an ongoing

UK-wide study of the perceptions of service users and their families and the attitudes of the public at large.

19. The overall conclusion was that such stigmatisation has a seriously adverse impact on the delivery of government strategy. They reported that both drug users and their families felt that poor self-esteem and feelings of worthlessness prevented them seeking help and reduced their belief in their ability to recover. This was reinforced by their feeling very stigmatised by professionals in a wide range of healthcare and social care settings. The attitudes and stereotypes of the public and employers in particular reduced the prospect of employment and reinforced their feelings of being unable to change.

20. Of the broader population there were some findings which suggested a degree of sympathy for those with drug problems and an overall endorsement of the notion that drug dependence is largely similar to other chronic illnesses. In contrast there were also high levels of blame and intolerance and both the fear of and the need to exclude people with drug problems were higher in Scotland than the rest of the UK.

21. The findings are sobering. When surveyed, less than 1 in 10 respondents thought that people who have stopped using illicit drugs but are being prescribed medication such as methadone can be considered recovered while over three-quarters thought they could not. These attitudes towards medication-assisted recovery are more negative in Scotland than for the UK as a whole.

22. With regard to the representation of drug use in the media an analysis of a sample of newspapers suggested that reporting was sensationalised (being dominated by crime reports and celebrity with much use made of pejorative adjectives such as 'vile') and only rarely dealt with the complexities of treatment and recovery.

23. When suggesting how the impact of stigma might be reduced the report included proactively improving the general public's knowledge and understanding of the complexities of the matter and ensuring professional workforce development to improve service responses. In addition it was felt that active support for recovery networks and the improving of community participation in these should foster more constructive perceptions.

Audit Scotland report on service delivery – 2009

24. In 2009 Audit Scotland published '*Drug and Alcohol Services in Scotland*'[21] which again criticised service delivery across Scotland. The report made recommendations to the Scottish Government which was advised to:

- Set clear national minimum standards for drug and alcohol services including their range, quality and accessibility.
- Receive assurance that these standards are implemented in line with set timescales.
- Ensure performance was regularly monitored and publicly reported.

25. It was also required to clarify accountability and governance arrangements for the delivery services and clearly define roles and responsibilities of partner agencies. Public sector bodies were expected to base services on thorough needs assessment and ensure that they were regularly evaluated in terms of service activity and quality as well as setting clear criteria of effectiveness and expected outcomes.

Alcohol and Drugs Delivery Reform Group

26. In response to this, also in 2009, the Scottish Government established the *Alcohol and Drugs Delivery Reform Group* which was designed to improve alcohol and drug delivery arrangements and to ensure better outcomes for services users, taking into account the Concordat between the Scottish Government and COSLA (including the development of Single Outcome Agreements), the Stocktake Review of Alcohol and Drug Action Teams and the new alcohol and drug strategies. In order to be effective it agreed that a new framework would need to clearly set out (Scottish Government, 2009).[22]

- The roles and responsibilities of the Scottish Government, local government, NHS Boards, agencies and partnerships, and the accountability arrangements required.

- The capacity required to carry out those roles and responsibilities.

- The forms of support which are available to those carrying out their responsibilities.

- The way in which the desired outcomes should guide the configuration of delivery arrangements. Outcomes also needed to be clearly described and linked to measurable progress.

27. This process concluded that existing arrangements had not allowed accountability to work effectively and recommended a new approach (Table 4).

Table 4. Delivery reform process – recommendations

- Local partnerships should be founded directly upon the underpinning accountability relationships between the Scottish Government and local partners – namely, the National Performance Framework, Single Outcome Agreements and community planning more broadly; and the NHS performance management arrangements, including HEAT.
- A target relating to HEAT would be adopted for drug treatment waiting times in 2009/10 to ensure that the quality and availability of drug services would feature more prominently in the wider NHS performance management arrangements (such as Annual Reviews).
- The Scottish Government should ensure there are appropriate mechanisms at a national level to oversee delivery of the drugs and alcohol strategies, including issues arising from the delivery of HEAT targets on alcohol and drugs. These should build on the roles and functions of the Scottish Advisory Committee on the Misuse of Drugs and Scottish Ministerial Advisory Committee on Alcohol Problems.
- The Scottish Government should require NHS Boards to demonstrate they had spent all hypothecated resources from their unified budgets in support of alcohol and drug outcomes; demonstrate the impact this investment had; demonstrate how effectively they have participated in, and committed to, local partnership arrangements, and evaluate the degree of effective joint working based on other partners' contributions.
- Local authorities and NHS Boards should *each*:
    - participate in the design of local partnership arrangements most appropriate to the circumstances of the local area, taking due account of the importance of the voluntary and private sectors and the views of service users.
    - ensure that these arrangements provide a clear process for including all relevant partners to different degrees depending on need, including the police, prison service, Community Justice Authorities, the education sector, the private sector, trades unions, and other relevant agencies, together with communities of interest such as the third sector, carers and service user groups;
    - participate fully and transparently in the operation of those arrangements, including the development and implementation of a comprehensive evidence-based alcohol and drugs strategy for the area concerned, based on the joint identification, pursuit and achievement of shared outcomes;
    - identify and commit to deploying the resources necessary for the partnership to deliver the agreed strategy or strategies for their area, and commit to agreeing with partners how those resources are to be deployed on the basis of collective, partnership decision-making.
- Each local alcohol and drug strategy should:
    - provide a clear assessment of local needs and circumstances, including both met and unmet needs;
    - identify key outcomes relating to drugs and alcohol, their place within the wider framework of priority outcomes contained within Single Outcome Agreements, and how their achievement will be measured;

    - set out clearly and openly the totality of resources that each partner is directing to the pursuit of alcohol and drugs outcomes;
    - set out a broad outline of the services to be provided and/or commissioned, reflecting the local assessment of need;
    - consider issues such as workforce development and ensuring the workforce is equipped with the skills to deliver;
    - set out an approach to the commissioning and delivery of services, including preventive interventions, in pursuit of the outcomes identified.
- These partnerships should be named Alcohol and Drugs Partnerships (hereafter referred to as ADPs).
- Leadership and commitment will be critical to the success of the ADP. As such the role of Chair is of vital importance. The Chair needs to be of the appropriate seniority – that is, should be involved in the operation of the Community Planning Partnership at a strategic level, should possess the skills needed to lead the ADP and give strategic direction, and should be able to give the time and commitment that the role requires.
- Local budget-holding delivery bodies would be expected to commission services in line with local alcohol and drug strategies.
- It is critical for ADPs to be equipped to operate effectively within an outcomes based environment.
- The goal is to create an environment for the delivery of client-centred actions that achieve lasting change in the lives of individuals across Scotland, be they substance misusers, their families, or members of the communities in which they live.

To support the shift towards outcomes an ‘outcomes toolkit’ was developed and a number of National Coordinators were appointed to try and ensure the smooth transition to ADPs.

Scottish Drug Strategy Delivery Commission First Annual Report 2010

28. In 2011 the Scottish Drug Strategy Delivery Commission issued its first report and recommendations to the minister (DSDC, 2011).[23] The report reflected a proactive process of hearing evidence from key stakeholders regarding the priorities the commission had set regarding delivery of *the Road to Recovery.*[1] Using its own *Impact Assessment Framework*, the DSDC aimed to help move the field forward – feeling that many of the issues were understood, solutions had already been described and agreed at strategic level, but the delivery system had struggled to demonstrate the key changes required.

29. Whilst acknowledging that considerable effort and service improvement had been made, the DSDC identified key deficiencies in the delivery of the strategy to date. In particular, it felt that considerable work was still needed in the areas of the quality and reliability of national and local data, the effectiveness of cross-cutting work at a national and local level and the governance and accountability of the ADP-based local delivery system. With regard to care and treatment, the DSDC stated: *"To be able to test and record Scotland's progress in achieving the goals of* the *Road to Recovery*[1]*, it is imperative that local partnerships are able to account for their contribution in terms of the progress of individuals moving into recovery.*

Systematic collection and reporting of evidence of local change in terms of progressing the recovery agenda must now be prioritised as a matter of urgency. In the absence of this evidence, DSDC has two areas of concern. These are:

- *Ability to deliver recovery outcomes;*
- *Quality assurance of medical interventions."*

30. To facilitate improvement in the area of care and treatment, the report made a number of recommendations (Table 5). These included reference to two fundamental elements of the governance structure: the existing quality assurance bodies who had a role in overseeing improvement in the range and quality of care (and which to date, were not prioritising substance use services); the national/local strategic process itself – incorporating the government, the advisory structures and DATs/ADPs. The DSDC called for an improved *"institutional memory"* to avoid seeming to repeatedly address the same challenges.

Table 5. DSDC recommendations

Delivering recovery outcomes

- The Scottish Government should be able to demonstrate the impact the Scottish Drugs Recovery Consortium is making in promoting the recovery of individuals, family members and communities from drug problems.
- At a minimum, ADPs should now be able to demonstrate early progress towards delivery of key process elements of recovery including personalised care packages and promotion of peer support/mutual aid.
- Action should be prioritised to enable the assessment of progress towards recovery-focused outcomes at local and national level. This should include: – inputs (evidence of recovery-orientated process – e.g. Recovery Plans); outputs (evidence of improvement in performance – e.g. more people progressing/accessing recovery activities such as education, training or work placements); outcomes (evidence of more people positively moving on, in or from treatment programmes and demonstrable evidence of recovery progress, such as abstinence and/or improved work prospects and better family relationships.

Delivering consistent high quality medical interventions

- Development of a quality programme for medical treatments in Scotland, including the need to ensure all patients have a comprehensive assessment to determine their recovery potential, should now be prioritised.
- National (UK) guidelines for health care professionals are an essential part of the treatment infrastructure and need to be urgently updated and reformatted to better reflect the Recovery Agenda and Scottish context.
- Work to complete a national evidence and research strategy with clearly identified priorities should be progressed as a matter of urgency, and active links with bodies overseeing national research funding should now be explored.
- The Minister should prioritise action aimed at securing the inclusion of drug and alcohol treatment as a core (General Medical Services) service for general practice patients.

Governance and accountability of the delivery system - demonstrating impact

- ADPs should be able to demonstrate that assessment and regular measurement of recovery capital underpins treatment plans.
- ADPs should be able to evidence that progress in a number of basic inputs is completed now in all areas, including the Audit Scotland self-assessment; local needs assessments; a local strategy coherent with the local needs assessment and focused on outcomes.

- There is an urgent need to report on progress in a number of basic outputs which should be completed in timeframes agreed with the Scottish Government. These include: all areas should have clear systems to demonstrate improved choice; should be able to demonstrate significant meaningful involvement of service users in service planning and governance; should be engaged with the SDRC and its support activities; and should have quality assurance processes in place – in line with Essential Care.[5]
- ADPs should be able to evidence that agreed national core outcomes are adequately represented in the Community Planning process and baseline data on performance/impact should be available from which progress can be determined in subsequent years.

Prioritisation of substance use issues by quality assurance organisations

- Ministers should continue to highlight substance use service delivery and leadership as a priority for national scrutiny processes ensuring that substance misuse is a priority element of inspection activity.
- An NHS process to improve governance and delivery of treatment services for substance users should be pursued with some urgency.

Institutional memory

- DSDC recommends that the Minister should work with DSDC to put in place a mechanism which ensures all strategic activity is evaluated and recorded and this history is used as a basis for continuing improvement.

ANNEX 6.2

THE INTERNATIONAL LONGITUDINAL STUDIES

31. The summaries in Tables 1 and 2 in Section 3 of this report, pages 24-25 describe studies from the eariest days of methadone/harm reduction to the new millennium. They have limitations in terms of research methods. However, they studied very large samples of treatment-seeking substance users over long periods, giving us a strong indication of how treatment can effect outcomes.

Drug Abuse Reporting Programme (DARP) USA (1969-1981)[33]

32. This early longitudinal study examined data from 4 treatment groups – methadone maintenance, therapeutic communities, outpatient drug-free, outpatient detoxification – and non-treatment controls. Some 43,943 clients from 52 services were assessed at intake and 2 monthly thereafter (with post-treatment follow ups for up to 12 years for some samples). This was a large comprehensive and carefully constructed naturalistic longitudinal study, supported by federal funding and assessing services across the USA. For the first time, DARP identified factors influencing outcome and in particular showed that time in treatment (retention) was a key factor. There are over 100 reports describing the process and various findings. A summary is available (Simpson & Sells, 1982).[99]

Treatment Outcome Prospective Study (TOPS) USA (1979-81)[34]

33. The TOPS study[34] was again federally funded and aimed to expand on the findings of DARP[33] by providing a framework for more specialized studies, such as those dealing with changing drug use patterns, the effect of comorbidity on outcomes, the impact of legal involvement on treatment and the overall cost-effectiveness of drug abuse treatment. This study examined data from 4 treatment groups – methadone maintenance, detoxification, residential care and outpatient drug-free. Some 11,759 clients entering 41 services were recruited. Subjects were interviewed on accessing the service and then at 1, 3, 6, 9 and 12 months. After leaving treatment, some selected subjects were followed-up at 3 months 1 year, 2 years and 3-5 years.

34. **Conclusions –** The study duplicated one key finding of DARP[33] that detoxification was significantly less effective than other interventions in these subjects. Consequently, the detoxification cohort was removed from study due to persistently poor outcomes. All remaining treatment modalities showed dramatic reduction in drug use and criminal activity over the first 3 months. At 1 year after treatment there was a clear reduction in drug use, crime and mental health issues if subjects were retained in treatment for 3 months or more. There were no differences reported in outcomes comparing those in methadone maintenance or residential programmes. Over 50% of all subjects were abstinent from heroin at 1 year post treatment. The researchers concluded that time in treatment was the most important predictor of outcome. Significant changes in regular heroin use were seen only after 1 year in treatment.

Drug Abuse Treatment Outcome Study (DATOS) – USA (1991-1993)[30]

35. Following on from the lessons of DARP and TOPS, DATOS was designed to *"capture a longitudinal snapshot of drug abuse patterns and treatment responses in the USA"* (Simpson & Curry, 1997).[100]

36. A naturalistic design recruited from a large number of treatment programmes with the aim of identifying changes in treatment populations and service delivery over the study period. Key observations included: reductions in opioid use and increases in cocaine use in the treatment-seeking population; considering the implications of an emerging ageing treatment population; reductions in the availability of a range of health and social care services for this population across the USA (Flynn et al 1997).[101]

37. **Conclusions:** Overall, they found that most treatment approaches had an effect on illicit drug use with methadone maintenance having the main effect on opioid use specifically. Treatment retention was again strongly associated with positive outcomes – longer periods in treatment had the most effect. The study looked in-depth at "softer" issues relating to the client or treatment process. Aspects of patient motivation and engagement seemed to have some effect on treatment outcomes (Simpson & Brown, 1999).[30]

Australian Outcome Treatment Study (ATOS) 2003-6[31]

38. ATOS[31] was the first large-scale longitudinal study of treatment outcome for heroin dependence to be conducted in Australia. This longitudinal prospective study aimed to describe the characteristics of people entering treatment for heroin dependence, the treatments received and 3 and 12 month outcomes achieved – in terms of drug use, criminal behaviour and mental health as well as assessing the associated costs. Longer term outcomes at 24 and 36 months were also examined in a specific follow up sample. The sample was some 825 active heroin users entering 38 agencies offering three treatment modalities: 277 entering methadone maintenance; 288 detoxification and 180 residential rehabilitation. Eighty non-treatment controls were also assessed.

39. The clinical measures used examined drug use and risk behaviours, treatment history, criminality, general health, health service utilisation, and psychopathology. Self-report was used to determine changes in illicit drug use – there is no report of objective testing. A health economic evaluation was also included. After baseline assessment, subjects were followed up at 3 months. The various reports give differing follow up rates which range from 80% at 12 months to 70% at 3 years.

40. **Conclusions:** Some 70% of the sample were followed up at 3 years. From self-report, reductions in drug use, associated risk-taking and crime were observed at 3 months and maintained over the 36 months. These outcomes were related to time in treatment (except in the case of the detoxification group). Depression appeared to negatively affect outcome in all groups.

National Treatment Outcome Research Study (NTORS) – UK (England) 1996-2001[28]

41. NTORS was the first major prospective study in the UK and is clearly relevant today. It must be recognised that the study commenced at a time when recovery was not a priority for services – harm reduction was seen as the clear goal and national strategies across the UK were focussed on increasing capacity of harm reduction services – in particular Opioid Replacement Therapy using methadone. The 1999 National Treatment Guideline was still 3 years from publication and service development was at an early stage, with large inconsistencies in service delivery across the UK.

42. NTORS was a UK government (Department of Health) funded national prospective study which followed from and was modelled on, the prospective studies in the USA. NTORS recruited 1075 subjects entering 54 services across England – comprising 8 in-patient units; 15 residential rehabilitation facilities; 16 methadone maintenance services and 15 methadone reduction/detoxification services. Their distribution was: 122 (11.3% of cohort) in specialist in-patient facilities; 286 (26.6%) in residential rehabs; 458 (42.6%) in methadone maintenance programmes; 209 (19.4%) in methadone reduction programmes. The modalities were chosen to best represent the modes of treatment delivery commonly available across the UK. There were no control subjects.

43. Data were collected at intake to the study, six months, one year then subsequently at 2-3 years and 4-5 years after intake. The study population has been described in detail (Gossop et al, 1996[102]; Gossop et al, 1998[103]). Those choosing to enter methadone reduction were younger, had shorter drug histories and more simple/less complex drug use histories associated with less risk-taking. Those accessing residential facilities were found to describe, in general, a more serious range of problems with longer heroin careers. They were more likely to use stimulants or have a heavy alcohol intake and showed evidence of more needle sharing/risk taking behaviours. This latter group also had worse offending histories.

Follow up studies

44. Six month follow up saw considerable improvements in all groups (Gossop et al 1997[104]). At one year outcome data was available on 769 subjects (71% of the original cohort), of whom 753 successfully completed a follow up interview. There were significant improvements in drug use and risk-taking across the cohort. There were significant differences in outcome, reflecting treatment modality attended. The residential facilities often saw greater improvements – particularly regarding alcohol use.

45. There was huge variation in service performance however, in all modalities, with the worst performing services showing virtually no impact on drug use. There were 16 deaths - mainly attributed to overdose. Crime fell in all groups to similar amounts. The authors concluded that at 1 year, treatment was effective with subjects more likely to be abstinent and to reduce their use of drugs and risk-taking as well as criminal activity. They raised concerns regarding the poor general impact of

treatment on drinking behaviour and health outcomes. They particularly emphasised that methadone maintenance programmes had more success regarding retention in treatment. The issue of the huge service variation (threefold from best to worst) raised issues of consistency of practice and quality of commissioning in the UK.

46. **Follow up studies - Five years** (Gossop, Marsden & Stewart, 2001)[105]
A sample of 650 cases from the NTORS cohort was followed up at 5 years. This represents 46% of the original cohort. With regard to drug use, the 1 year success already described was maintained at 2 and 5 years. Less subjects were using any drugs and those still using were using less frequently in all settings. Injecting fell overall by nearly half, as did sharing of injecting equipment. Alcohol use reduced in the residential group but showed no change in the methadone group.

Drug Outcomes research in Scotland (DORIS) – Scotland 2001-2004[29]

47. This Scottish outcome study started in 2001 and had a research design similar to NTORS[28] and DORIS[29] recruited a cohort of 1033 drug misusers who were entering a range of 5 types of drug treatment services. A baseline assessment was undertaken using a standardized assessment tool. Subjects were then reviewed in "sweeps" at 8, 16 and 33 months thereafter. Additional qualitative data were also collected. The aim of the study was to establish whether drug users in treatment progressed, what outcomes were being achieved and what types of treatment services were associated with the best outcomes.

48. On entering the DORIS study, researchers accessed a sample representing some 1 in 12 of all substance misusers entering treatment in Scotland in 2001. Of those invited to participate, 89% accepted and undertook a baseline interview. Using a standardized assessment of dependence, they found (unlike NTORS) that there were no significant differences in the groups accessing different treatment types.

Results

49. Unlike the NTORS publications, none of the reports addressed changes in drug use from the perspective of a harm-reduction outcome (i.e. assessing changes in the nature/extent of drug use and drug-related harms). One paper in particular – *Abstinence and drug abuse treatment: Results from the Drug Outcome Research in Scotland study* (McKeganey et al 2006)[106] – reported only on achievement of abstinence in different treatment modalities at 33 month follow up.

50. This paper reported 33 month outcomes on 695 subjects (67% of the DORIS cohort) and reported that 88% of respondents had used heroin in the 90 days prior to 33 month follow up assessment. Some 60% had injected and 11% overdosed in that period. They found that only 5.9% of females and 9% of males were abstinent at 33 months follow up and this group was heavily skewed towards those who had been accessing residential rehabilitation programmes. When the definition of "abstinence" was aligned with that used in NTORS, the authors reported that, of residential rehabilitation patients, 35.9% (NTORS) and 33.3% (DORIS) would be abstinent for 90 days. For ORT, patents, 24.3% (NTORS) compared with only 11% (DORIS) would be abstinent for 90 days.

51. **Conclusions:** The authors concluded that *"There is a need to establish why so few drug users in contact with the methadone programme in Scotland appear able to become drug free 33 months after having contacted this service."* They went on to plea for improved access to residential rehabilitation in Scotland and felt there was a need to address *"why it is that such a small proportion of drug users receiving methadone maintenance within Scotland appear to be able to achieve a 90-day drug-free period."* It should be noted that very different definitions of abstinence were used in DORIS. In the English study abstinence was allowed if cannabis had been used. In DORIS cannabis users were excluded from the definition.

ANNEX 6.3

SYSTEMATIC REVIEWS – A REVIEW

Is ORT associated with improved outcomes?

52. Considering the effectiveness of ORT in reducing illicit opiate (heroin) use, HIV risk behaviour and criminality, Marsch (1998)[107] reviewed 43 studies (involving around 11,000 participants) and concluded that there is a consistent, statistically-significant relationship between ORT and the reduction of illicit opioid use, HIV risk behaviours and drug and property-related criminal behaviours with effectiveness of ORT most apparent in its ability to reduce drug-related criminal behaviours. Another review of community ORT considered 48 RCTs – 14 of methadone, 20 buprenorphine and 14 comparing both – concluding that the results supported the effectiveness of community maintenance treatments with methadone or buprenorphine.

53. The authors raised significant issues regarding the quality of evidence – including: use of different treatment groups in the studies; variable drug dosing in different studies; high drop-out rates; small sample sizes; short treatment duration. Despite these concerns, the reviewers felt that the studies supported the view that community maintenance ORT was effective in terms of treatment retention, abstinence and reduction in illicit opiate use. They also concluded that both methadone and buprenorphine were more effective at higher doses (Simoens et al, 2005).[108]

54. As part of a range of reviews being undertaken to support delivery of updated clinical guidance for UK doctors, an expert group reviewed 31 existing systematic reviews and 28 additional RCTs as well as 11 economic evaluations considering the evidence of effectiveness of ORT using methadone or Buprenorphine (Connock et al 2007[38]; NICE 2007a).[51] There were no RCTs from the UK – with the majority originating in the USA and the RCTs reviewed usually used fixed dosing, very restrictive delivery (e.g. supervised consumption), had no additional psychosocial interventions and short follow up (<1year). The authors commented on the quality and generalizability of the evidence. However, in balance they still felt they could conclude that ORT supports retention, reduced opioid use, reduced HIV risk behaviours and sero - conversions, reduced mortality and reduced criminal activity. They also stated that higher fixed doses were more effective than lower fixed doses.

55. In 2009 a Cochrane Review examined all RCTs comparing ORT with placebo or a non-pharmacological therapy (Mattick , Breen, Kimber & Davoli, 2009).[109] They reviewed 11 RCTs (1969 subjects) with outcomes assessed up to 2 years. The authors commented on the lack of evidence on some key outcomes of interest (such as deaths, social outcomes) and the relationship between medical and psychosocial treatments. They also felt that the methodological failings of much of the research made it difficult to generalise from the evidence base. They concluded however, that ORT does improve retention and does reduce heroin use though they could not conclude that it reduces criminal activity.

56. A systematic review of the evidence for a range of treatment options for opioid dependence aimed to "synthesize the current status of opioid dependence treatment" (Veilleux et al, 2010).[41] They reviewed existing systematic reviews from the Cochrane database and supplemented this with additional meta-analyses of RCTs published since the most recent Cochrane reviews. Again the authors raised the challenge of carrying out a meta-analysis as studies used a broad range of methods and approaches and felt that there was a need to broaden quality research to better scrutinize more clinical outcomes including abstinence. Citing 155 studies (28,999 subjects), they commented on effectiveness of ORT, concluding that ORT improves treatment retention, reduces opioid use and reduces withdrawal symptoms in opioid dependent individuals. They identified clear evidence of dose effects – with higher doses more effective at delivering these desired outcomes.

57. In 2012, the British Association of Psychopharmacology published an update of its 2004 advice for UK clinicians on the treatment of a range of substance use disorders (Lingford-Hughes, Welch, Peters & Nutt, 2012).[35] This advice was based on a rigorous systematic review of the literature, overseen by an invited expert panel. They sourced previous systematic reviews from credible sources and other RCTs when possible. These authors also commented on the complexity of the evidence base and the fact that the evidence base was largely from the US health system making generalizability to the UK a concern. They acknowledged that at times the strength of recommendations made was extrapolated from relatively low grade evidence or expert consensus. They concluded that ORT improves treatment retention, reduces heroin use, shows a trend towards reducing mortality and reduces injecting related risk behaviours – but not sexual risk behaviours. Higher doses seemed to be more effective at achieving these outcomes. There was no evidence for an added effect from psychosocial interventions nor for an effect on criminal activity.

Dose effects

58. A Cochrane review was undertaken in 2008 to comprehensively assess the evidence regarding the effect of ORT dose on outcome (Faggiano et al, 2008).[42] They reviewed 21 studies including 11 RCTs (5994 subjects), all from the USA and using follow up periods of <1yr. Controlled prospective studies (CPS) were also cited, following patients up for <10 years. The authors acknowledged that the short follow up period of RCTs reduced the relevance of the review findings. They concluded there was insufficient evidence to comment on some outcomes – such as mortality, criminal activity and social outcomes. They did, however conclude that higher doses ORT (60-100mg) were more effective at retaining patients and reducing opioid and cocaine use.

Evidence for specific outcomes – the purpose of treatment

59. Some reviews have considered evidence that ORT can deliver specific outcomes along a continuum of progress towards ultimately being entirely drug free (abstinent). The key first step of retention in treatment has been addressed in the reviews cited above. The next key (harm reduction) outcome would be reduction in risk behaviours and reduced Blood Borne Virus (BBV) infections and sero-conversions.

Preventing blood-borne virus (BBV) transmission

60. The effectiveness of drug treatment in preventing HIV spread in intravenous drug users was explored in a review by Sorensen & Copeland (2000).[43] They reviewed 33 studies (17,000 participants). Despite serious methodological problems in the literature, they concluded that there is strong evidence that ORT reduces HIV risk behaviours, particularly needle use. A more recent Cochrane Review aimed to assess the effect of oral ORT on risk behaviours and HIV sero-conversions (Gowing et al, 2011).[44] Due to the lack of RCTs they included all types of original research. Reviewing 38 studies (12,400 subjects), the authors noted that their conclusions were affected by the lack of data from randomized controlled studies. They concluded, however, that ORT reduces opioid use, intravenous use, needle sharing and HIV sero-conversion. They also felt there may be an effect on sexual risk behaviours for HIV.

61. Though not technically a systematic review, a recent UK study aimed to examine the effect of harm reduction availability and Hepatitis C (HCV) sero-conversion (Turner et al, 2011).[45] The researchers carried out a meta-analysis and pooled analysis on data for 2986 subjects from six areas in the UK over 8 years. They used questionnaire information to determine availability of ORT and needle exchanges locally. Some 40 new HCV cases were identified in the period. The study concluded that improved access to both ORT and needle exchange was associated with a considerably reduced rate of HCV sero-conversion.

Reductions in Illicit drug use and abstinence

62. An early meta-analysis was carried out to identify risk factors for continued drug use in patients treated for *"opiate abuse"* in a range of interventions, including ORT (Brewer et al, 1998).[110] Some 69 studies were examined. Ten variables were felt to show statistically significant and longitudinally predictive relationships with continued use while in treatment.

63. One review specifically explored abstinence from opioid use in subjects on ORT programmes (Kornor & Waal 2005).[111] This review estimated opioid abstinence rates and explored possible relationships with characteristics of the patients or treatment programmes they had received. Twelve "follow-up studies" (9,718 subjects) met the inclusion criteria for the review. Two of the studies appeared to be randomised controlled trials and follow-up was <103.2 months. Overall, 33% of patients had a period of abstinence from opioids for an average of 2 years following detoxification. The rates of abstinence ranged from 22% to 86%. The authors concluded that ORT maintenance programmes may be suitable for a subgroup of patients. They did state that further research was needed to better tailor programmes to achieve the goal of abstinence from illicit opioids and describe characteristics of the patients and programmes which may influence outcome.

Recovery and broader treatment outcomes

64. Few reviews have considered how effective ORT is at delivering recovery outcomes. A review of the evidence regarding improvements in the Quality of Life (QoL) of drug users in treatment was reported in 2010 (de Maeyer, Vanderplasschen & Broekaert, 2010).[46] The authors reviewed 38 studies which had assessed QoL as

at least one measure of treatment effectiveness of which 16 followed up those on some form of ORT. They found that QoL was very low on entry to ORT but improved with treatment. This improvement occurred early and deteriorated again after only a few months (though normally not to pre-treatment levels). There were no definitive differences between ORT types/drugs in the nine studies which made these comparisons. The authors concluded that services must address more than the drug use as other factors are likely to affect QoL. They felt that ORT has a significant effect on QoL in the early stages of treatment and though this tends to deteriorate, improvement is sustained beyond the level found on entry.

65. One published review explored the research evidence for improved recovery (Best et al 2010).[11] The authors described a systematic review of the published literature which identified 205 relevant articles. The process of critical appraisal was not well defined in this review and descriptive articles by experts in the recovery field are widely cited. The authors note that much of the evidence is from overseas (almost exclusively the USA) and is from other areas of addiction such as alcohol or the broader mental health field – so may not translate well into the field of opioid dependence. The authors emphasise the lack of relevant systematic research in this area in the opioid dependent population in the UK. They conclude that in opioid dependency, *"sustained recovery is the norm"* pointing out that pathways towards achieving this outcome are *"individualistic"*.

66. They identify the phenomenon of *"recovery capital"* – positive attributes in a person's life – as *"the best predictor"* of recovery outcomes. They also define an identifiable range of *"barriers"* to recovery. They conclude that structured treatment has a part to play but emphasise that social support is also required if opioid dependent individuals are to progress from serious problem drug use. The review gives a helpful overview of the poor quality of evidence addressing the elements which constitute the specific outcome of *recovery* from substance misuse and concludes that there is presently a dearth of high quality research evidence available to assess potential for recovery in the opioid dependency field in the UK.

67. In 2012 the English National treatment Agency (NTA) published their report *Medications in Recovery: Re-orientating Drug Dependence Treatment* (NTA, 2012).[53] The report was produced by an invited expert group of stakeholders from a range of backgrounds including leading academics in the field in the UK and was supported by authorities from the USA.

68. As an Appendix to the report, a small sub expert group prepared a review of the literature to date – *Opioid Substitution treatment and its effectiveness: review of the evidence* (Bell, 2012).[12] Recognising that recovery may be supported by less sound, high-quality research, the author states that the review *"seeks to integrate, as far as is possible, the discourse of evidence-based practice (built on observation and measurement), with the humanitarian, recovery-based discourse based on values (such as responsibility, choice, and empowerment)".*

69. The approach taken was *"to identify the broadly-agreed objectives of treatment, and to review the empirical evidence as to the effectiveness of ORT. The paper then reviews the factors associated with variations in treatment effectiveness."*

70. No search strategy or agreed process of exclusion/inclusion of references, nor critical appraisal process is included in the review.

71. The review re-iterates the published evidence base regarding the many harm reduction benefits of ORT. However, the authors are less optimistic regarding the evidence for improvements in those areas relating to long term recovery. Areas addressed include:

- *Quality of Life* –They conclude that measureable improvements in quality of life have been seen in the short term but there is little evidence for this being sustained beyond the early (6 month) phase of treatment.
- *Re-integration to society* –The review could identify no compelling quantitative research in this area. Qualitative research methods have raised the ambivalence of those on methadone, who recognised that being on methadone may improve the conditions for recovery – as users are not in a constant state of withdrawal – but the stigma and control associated with methadone treatment has negative effects too. Thematic analyses have identified key themes which potentially contributed to improvements in quality of life. These were: availability of good caring relationships; having an occupation; independence; having a meaningful life.
- *Achieving abstinence* –This issue was contextualised in the review – recognising that the philosophy of ORT recognises the chronic relapsing nature of addiction and does not necessarily hold abstinence at its centre. The review discusses the implications of developing a *"recovery focus"* in ORT. The authors acknowledge that *"therapy requires a rationale"* and recognise the paradox of committing an individual to long term maintenance medical therapy when one aim is to help them take control of the challenge of their own lives.
- The historic evidence base is cited – and shows the challenge of offering effective counselling/therapeutic approaches in this group. The authors state that a recovery focus can *"provide direction and structure"* for the service user and clinician. The person's own community is also seen to have a role to play. However, the authors recognise the challenge of delivering recovery. Citing Moos (2003),[112] they state *"individuals need long-term social supports and personal psychological resources to sustain recovery. Formal treatment can be a powerful factor in building these social supports and psychological resources to facilitate positive change, but on its own it typically does not have a lasting influence."*

What is the effect of how the ORT is delivered?

72. Some reviews have considered whether the mechanisms of treatment delivery affect outcomes in ORT. One meta-analysis reviewed 143 studies to explore the impact of programme [delivery] factors on treatment outcomes (Prendergast, Podus & Chang, 2000).[113] They concluded that the heterogeneity of the studies led to complexity in terms of interpretation of results.

73. Studies examined differing interventions, delivered to different heterogeneous groups of subjects and using differing outcomes and timeframes. They did conclude however, that some programme factors were found consistently to significantly

correlate with better outcome. These included treatment exposure (number of appointments) and methadone dose.

74. The same research team subsequently used meta-analysis techniques to identify methodological factors which may be affecting outcome in 78 studies (Prendergast, Podus, Chang & Urada 2002).[114] In this review, they concluded that treatment reduced illicit drug use and criminal activity. The specific factors which predicted better drug use outcomes included: how consistently treatment approaches were implemented (e.g. manualised delivery of programmes by well-trained and supervised staff); programmes with less *"theoretical grounding"* – i.e. where the staff were less influenced by the background theories; those with strong *"researcher allegiance"*. Projects for younger adults were felt to deliver better crime outcomes. Other factors were not shown to be predictors of outcome in this review.

Does inclusion of additional therapies/service delivery elements affect outcome?

75. A Cochrane review of the added effect of psychosocial interventions to ORT was undertaken (Amato et al, 2011).[86] The review included some 35 studies (4319 subjects) in 13 distinct intervention types. Duration of these studies was relatively short term, from 6-48 weeks with a mean of only 17 weeks. Researchers were unable to demonstrate any added effect from the introduction of any psychosocial intervention with regard to the outcomes of retention, abstinence, compliance with treatment or improvements in psychological symptoms. The researchers however did acknowledge that they *"did not evaluate the question of whether any ancillary psychosocial intervention is needed when ORT is provided, but the narrower question of whether a specific more structured intervention provides any additional benefit".* They also acknowledged the issue of short timeframes.

ANNEX 7:
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