"The task of the Recovery Orientated Drug Treatment Expert Group has been to describe how to meet the ambition of the Drug Strategy 2010 to help more heroin users to recover and break free of dependence…"

MEDICATIONS IN RECOVERY
RE-ORIENTATING DRUG DEPENDENCE TREATMENT

Preface

I am honoured to have been invited to chair the expert group on recovery orientated drug treatment. I have been helped enormously by the commitment and goodwill of the wide range of experienced colleagues from across the field who came together for this important task. I would like to take this opportunity to thank them all.

Our work has involved a re-examination of treatment methods and objectives that can help the recovery of those with addiction problems. This is an important step in meeting the ambitions of the people who use our services and of the government's Drug Strategy 2010.

We have embarked on this work with the advantage of the considerable expertise of the group's members and a substantial international scientific literature. We have sought to use this knowledge to set a new benchmark for the English treatment system that is both radically ambitious and scientifically rigorous. We are not alone in this endeavour, and important steps have already been made by international colleagues, such as US addiction experts Tom McLellan and Bill White, to whom we owe a debt of gratitude and from whom a commentary on our work is being published in conjunction with the report.

On behalf of the expert group, I would like to thank the NTA for its secretariat and support, and government departments for their support for our work.

Finally, I am acutely aware that delivering this ambition will depend on the continued professionalism and commitment of practitioners, and the development of systems that integrate clinical care with the wide range of services required to deliver long-term recovery. It will also depend crucially on the quality of shared vision and effort from those who are (or have been) dependent on drugs, their families and communities, and on the government's continued determination to tackle this important challenge. Our report describes how more can be achieved: the task is now to achieve it.

John Strang, July 2012

Medications in recovery Re-orientating drug dependence treatment

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Medications in recovery Re-orientating drug dependence treatment

EXECUTIVE SUMMARY

1. Investment in drug treatment since 2001 has given more people access to long-term, high-quality treatment, which has substantially improved their health. The task of the Recovery Orientated Drug Treatment Expert Group has been to describe how to meet the ambition of the Drug Strategy 2010 to help more heroin users to recover and break free of dependence[a]. Heroin users are the largest single group in treatment and use an especially tenacious, habit-forming drug in the most dangerous ways.

2. Entering and staying in treatment, coming off opioid substitution treatment (OST) and exiting structured treatment are all important indicators of an individual's recovery progress, but they do not in themselves constitute recovery. Coming off OST or exiting treatment prematurely can harm individuals, especially if it leads to relapse, which is also harmful to society. Recovery is a broader and more complex journey that incorporates overcoming dependence, reducing risk-taking behaviour and offending, improving health, functioning as a productive member of society and becoming personally fulfilled. These recovery outcomes are often mutually reinforcing.

3. The ambition for more people to recover is legitimate, deliverable and overdue. 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.

4. This has been particularly true for heroin users receiving OST, where the protective benefits have too often become an end in themselves rather than providing a safe platform from which users might progress towards further recovery.

5. Overcoming drug or alcohol dependence is often difficult. Only half of established smokers in England are likely to make a long-term recovery from tobacco dependence[1]. In the USA, up to half of the alcohol-dependent population can expect to recover over the long term[2]. Heroin and other opiates have a far worse prognosis: long-term USA studies suggest that, over 30 years, half of dependent users will die, one fifth will recover and the remainder will continue to use opiates, albeit some at a lower level[3].

6. The existence of an accessible, evidence-based, drug treatment system in every part of England gives us an excellent opportunity to improve on the past by using international, historical evidence as the floor for our ambition and not its ceiling.

7. England has lower rates of drug-related deaths and blood-borne virus infections than most of our European and North American neighbours. Most people who enter treatment want to recover and break free of their drug dependence. We can help more to realise this ambition if we can ally safe, evidence-based recovery-orientated practice to the public health and wider social benefits we already accrue from treatment.

8. According to the research, the international track record and clinical experience, not everyone who comes into treatment will overcome their dependence. We know from the same sources that it is not possible or ethical to predict which individuals will eventually overcome their dependence. This is why we are obliged to create a treatment system that makes every effort to provide the right package of support to maximise every individual's chances of recovery.

9. Fewer young people are now coming into treatment for dependence on the most damaging drugs such as heroin, but there is an ageing cohort of drug dependent and ex-dependent individuals who will experience an increase in morbidity and mortality as they develop multisystem diseases that need complex treatment. Primary and secondary care services will be needed to treat them.

10. The Chair's interim report in July 2011 (Strang, 2011) was well-received and with support from the NTA has already resulted in practice improvements. This final report of the expert group details our collective view of how we go about channelling the energy and commitment

of service users, commissioners and practitioners to achieve world-class recovery outcomes.

11. Well-delivered OST provides a platform of stability and safety that protects people and creates the time and space for them to move forward in their personal recovery journeys. OST has an important and legitimate place within recovery-orientated systems of care. The drug strategy is clear that medication-assisted recovery can and does happen. We need to ensure OST is the best platform it can be, but focus equally on the quality, range and purposeful management of the broader care and support it sits within.

12. If we stick closely to the compelling evidence for effective OST, and the existing guidance based upon that evidence, we will deliver many of the improvements needed – but we can and should do more. A determined assessment of the shortfalls in provision, followed by remedial action, is a priority if OST is to fulfil its potential in supporting recovery.

13. There is no justification for poor-quality treatment anywhere in the system. It is not acceptable to leave people on OST without actively supporting their recovery and regularly reviewing the benefits of their treatment (as well as checking, responding to, and stimulating their readiness for change). Nor is it acceptable to impose time-limits on their treatment that take no account of individual history, needs and circumstances, or the benefits of continued treatment. Treatment must be supportive and aspirational, realistic and protective.

14. Some people have a level of personal and other resources (called 'recovery capital') that enables them to stabilise and leave treatment more quickly than others. Many others have long-term problems and complex needs, meaning their recovery may take much longer and they require help to build their recovery capital. Treatment given over this timescale must maintain its recovery orientation.

15. Arbitrarily or prematurely curtailing an individual's OST will not help them sustain their recovery and is not in the interests of the wider community either. It risks losing any advances because it is externally imposed and so has no meaning – the individual does not own the decision. This would likely lead to an increase in blood-borne virus rates, drug-related deaths and crime. However, clear and ambitious goals, with timescales for action, are key components of effective individualised treatment, especially when the individual collaborates in planning them. We strongly support continued reference and adherence to the existing NICE drug misuse guidance (reviewed and unchanged in 2010-11) and to the more practitioner-orientated 2007 Clinical Guidelines.

16. The more ambitious approach outlined will sometimes lead to people following a potentially more hazardous path, with the risk of relapse (or at least occasional lapse) as they seek to disengage from the OST that has supported them. Individuals (and their families), clinicians and services need to understand this potential risk. They need to approach the change with careful planning and increased support, and include a 'safety-net' in case of relapse.

17. OST will improve as a result of changes at a system, service and individual level. These include:

- treatment systems and services having a clear and coherent vision and framework for recovery that are visible to people in treatment, owned by all staff and maintained by strong leadership

- purposeful treatment interventions that are properly assessed, planned, measured, reviewed and adapted

- 'phased and layered' interventions that reflect the different needs of people at different times

- treatment that creates the therapeutic conditions and optimism in which people, and especially those with few internal and external resources, can meet the challenge of initiating and maintaining change

- OST programmes that optimise the medication according to the evidence and guidance

- measuring recovery by assessing and tracking improvements in severity, complexity and recovery capital, then using this information to tailor interventions and support that boost an individual's chances of recovering and improve his or her progress towards that goal

- treatment services that are not expected to deliver recovery on their own but are integrated with, and benefit from, other

services such as mutual aid, employment support and housing

- treatment that works alongside peers and families to give people direct access to, or signposts and facilitated support to, opportunities to reduce and stop their drug use, improve their physical and mental health, engage with others in recovery, improve relationships (including with their children), find meaningful work, build key life skills, and secure housing.

[a]. *"The investment made in the drug treatment system over the last decade has built capacity and enabled people to access treatment for a sufficient period of time to bring about substantial health gains. We now need to … become much more ambitious for individuals to leave treatment free of their drug or alcohol dependence"* Drug Strategy 2010 – 'Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life.'

[1]. Etter and Stapleton, 2006; Stapleton J, personal communication, 14 June 2012

[2]. Dawson et al., 2005; Ojesjö, 1981; Schutte et al., 2003; Vaillant, 2003

[3]. Calabria et al., 2010; Darke, 2011; Degenhardt et al., 2010; Grella and Lovinger, 2011; Hser, 2007

IMPLEMENTING RECOVERY ORIENTATED OPIOID SUBSTITUTION TREATMENT

Professor John Strang's 2011 interim report on our work (www.nta.nhs.uk/uploads/rodt_an_interim_report_july_2011.pdf) described some immediate steps to improve the recovery-orientation of treatments such as prescribing, and to ensure people in treatment get appropriate support to achieve the best gains. Set out below, these still provide a good starting point. They are followed by additional principles and prompts of recovery-orientated drug treatment that commissioners and providers can use to test progress.

Immediate steps to improve recovery orientation

1. Audit the balance in your service between overcoming dependence and reducing harm to ensure both objectives properly coexist; and that individual clinicians understand and apply a personalised assessment for each patient, regularly repeat it, and, based on its findings, re-examine and adjust the treatment plan with the patient.

2. Review all your patients to ensure they have achieved abstinence from their identified problem drug(s) or are working to achieve abstinence. Patients should be offered the opportunity to come off medication after appropriate careful planning, when they are ready.

3. Consider whether to change the current balance between promoting overcoming of dependence and promoting reduction of harms, with the aim of actively encouraging more patients to take opportunities to recover. Although no clinician should take unwarranted risk, neither should they protect patients to the extent that they are not encouraged and enabled to get better. This must always be undertaken in a way that supports each patient to make an informed choice that is relevant to their personal situation and is based on an accurate description of the available options.

4. Ensure exits from treatment are visible to patients from the minute they walk through the door of your service. This means giving them enough information to understand what might comprise a treatment journey, even if their eventual exit appears some way off. And make visible those people who have successfully exited by explicitly linking your service to a recovery community, or employing former service users or using them as a volunteer recovery mentors and coaches.

5. If agonist or antagonist medications are being prescribed, then review, jointly with each patient and with input, as appropriate, from relevant third parties, the extent of benefit still being obtained.

6. For patients who have achieved stability while on medication and who choose to reduce and/or stop the medication, ensure that support mechanisms are in place to support this transition, and also ensure that rapid re-capture avenues are in place and are understood and acceptable to the patient, in the event of failure of the transition.

7. Check that all treatment is optimised so patients are receiving the range and intensity of interventions that will give them the best chance of recovery. This may include optimised doses of appropriate medications; the reintroduction, reduction or dropping of supervised consumption as appropriate; active keyworking, including case management and psychosocial interventions that keyworkers are competent to provide; access to other psychosocial interventions requiring additional competences; etc. As a first step, audit the availability of key NICE-recommended psychosocial interventions, using the audit tool in the NTA/BPS Toolkit.

8. Strengthen or develop patients' social networks, involving families where appropriate and facilitating access to mutual aid by, for example, providing information, transport, or premises for meetings, and by bringing local recovery champions into the service to meet patients.

9. Establish opportunities to accrue 'social capital' via work experience placements or employment, training opportunities, volunteer work, etc.

10. Ensure all keyworkers are trained and supervised to deliver psychosocial interventions of a type and intensity appropriate to their competence. Effective keyworking entails recovery care planning, case management, advocacy and risk management, and collaborative interventions that raise the insight and awareness of patients and help them plan and build a new life. This will often involve attention to employment and housing.

11. Review the quality of your service's recovery care planning and take steps to improve it, where possible. Recovery care plans should be personally meaningful documents, developed over a period of comprehensive assessment, and reviewed and adapted regularly, so that they are important to and owned by the patient.

12. Ensure your service works with local housing and employment services, and with commissioners, to ensure there is supported and integrated access to relevant provision.

Principles and features of recovery orientated drug treatment and how to test they are being achieved

PRINCIPLES AND FEATURES OF RECOVERY-ORIENTATED DRUG TREATMENT	PROMPTS TO TEST WHETHER THEY ARE BEING ACHIEVED
FOR COMMISSIONERS	
Integrated recovery-orientated systems of care are needed to build and maintain recovery	Is a full range of treatment options commissioned, including residential rehabilitation, so that there is the necessary flexibility to build a range of treatment and recovery pathways for different needs: from brief interventions for those not needing structured treatment to full packages of care-managed pharmacological, psychosocial and recovery interventions for those with complex needs?
Arbitrarily curtailing or limiting the use of OST does not achieve sustainable recovery and is not in the interests of people in treatment or the wider community	• Do contracts avoid imposing arbitrary time limits on treatment or elements of it, such as prescribing? • Are services expected to set clear and ambitious goals for each individual's treatment, with planned timescales for action, and expect targets for general improvements in treatment and recovery, such as: • increased psychosocial interventions • hosting of 12-step meetings • development of aftercare functions and peer support?
Drug treatment is not expected to deliver recovery on its own but can integrate with and benefit from other support	Is an integrated recovery-orientated system of care being created that involved other health and social care services with drug treatment to provide recovery support, including mental health, employment, housing, mutual aid, recovery communities, etc?
FOR SERVICES	
Closer adherence to the compelling evidence for effective OST, and the existing guidance based upon it, will deliver many of the improvements needed but more can and should be done	• Is practice audited (and, where needed, improved) against recommendations in the NICE 2007 suite of drug misuse guidance (and forthcoming quality standards) and the 2007 Clinical Guidelines? • Do supervisors have the appropriate competences to supervise all the techniques or interventions being used by the practitioners they are supervising?
Some people entering treatment have a level of personal and other resources (often called recovery capital) that will enable them to stabilise and leave treatment more quickly than others as long as they are provided with the support they need. Many others have long-term problems and complex needs – their recovery may take a long time and require long-term treatment to build their recovery capital.	Is recovery capital assessed and then individual treatment plans designed that utilise the strengths and aspirations of each service user?
Arbitrarily curtailing or limiting the use of OST does not achieve sustainable recovery and is not in the interests of people in treatment or the wider community	• Are arbitrary time limits for treatment or elements of it avoided but clear and ambitious treatment goals set, with planned timescales for action and regular reviews? • Are service users, peer support and recovery champions involved at all levels of organisational planning and where appropriate in delivery of peer-based interventions and service promotion, e.g. peer support available at assessment? • Are pathways through and out of treatment made visible, for example involving service users in promotion of services, developing peer support services, involving service users in delivery of groups, promoting recovery events, hosting 12 step meetings?
Recovery is made visible, including the 'hand and footholds' at each stage of recovery through access to peers who are perhaps just little further along in their recovery journey	Are opportunities promoted for contact between people in treatment and others further in their recovery journeys?
Mutual identification through mutual aid and peer support is important	Is access to mutual aid facilitated by advocating for it, accompanying service users, providing meeting space, attending open meetings, providing or arranging transport, etc?

FEATURES OF RECOVERY-ORIENTATED DRUG TREATMENT SYSTEMS AND SERVICES	
A clear and coherent vision and framework for recovery that is visible to people in treatment, owned by all staff and maintained by strong clinical leadership.	Does the service participate in the building of communities of recovery that overlap with treatment, advocating for mutual aid, utilising peer supporters, ensuring recovery is visible to service users?
Purposeful treatment interventions that are properly assessed, planned, measured, reviewed and adapted.	Are assessment, planning, review and optimisation processes all arranged so that treatment is active, individualised, and based on a proper understanding (and regular reviews) of an individual's changing problems, needs and strengths?
'Phased and layered' interventions that reflect the different needs of people at different times.	- Is the service developing a local solution to phasing and layering interventions so that, at every point in a treatment journey, they can be offered in a way that is appropriate to an individual's stage of recovery and how much intervention they need? - Is a range of treatment interventions available to meet the needs of a range of clients including those with more complex needs that may require high intensity interventions?
Treatment that creates the therapeutic conditions and optimism in which the challenge of initiating and maintaining change can be met, especially by those with few internal and external resources.	Do managers ensure keyworkers understand how and when to use a range of techniques and tools, including goal setting, empathetic listening, exploring the impact and negative consequences of current behaviour and the benefits of change, strategic use of problem recognition to amplify ambivalence about the status quo, managing rewards and negative contingencies, and involving social networks?
OST programmes that optimise the medication aspect of the treatment according to the evidence and guidance.	Are OST programmes audited to ensure: - Effective doses of OST are being prescribed as recommended in clinical guidance and tailored to the individual? - Supervised consumption is used as recommended in clinical guidance and tailored to the individual to minimise risk while enabling opportunities for recovery such as self-directed medication, employment, childcare?
Recovery measured by assessing and then tracking improvements in severity, complexity and recovery capital, and by using this information to better understand how to tailor interventions and support to improve an individual's chances of and progress in achieving recovery.	Is progress in treatment regularly measured, and responded to, through intelligent use of the Treatment Outcomes Profile (TOP), drug testing, and measures of dependence, change motivation and engagement, skills and participation, environment, personality and relationships, risk and safeguarding, financial support, etc?
Drug treatment not expected to deliver recovery on its own but integrated with and benefiting from other support such as mutual aid, employment support and housing.	Has the service developed partnerships, joint working protocols and other ways of working with others able to provide recovery support, including mental health, employment, housing, mutual aid, recovery communities?
Drug treatment – alongside peers and families – that provides direct access, signposts and or facilitated support to opportunities for reducing and stopping drug use, improving physical and mental health, engaging with others in recovery, improving relationships (including with children), finding meaningful work, building key life skills, and securing housing.	Are arrangements in place for access to a broad range of recovery supports?

1   INTRODUCTION

1.1   In August 2010, the NTA – on behalf of the Department of Health – asked Professor John Strang to chair a group to guide the drug treatment field on the proper use of medications to aid recovery and on how the care for those in need of effective and evidence-based drug treatment is more fully orientated to optimise recovery. This approach was consistent with the new drug strategy published in December 2010 (HMG, 2010) and its focus on recovery. The drug strategy made clear the government's concern that "for too many people currently on a substitute prescription, what should be the first step on the journey to recovery risks ending there" and wanted to "ensure that all those on a substitute prescription engage in recovery activities". Our task was to provide guidance to clinicians and agencies so they can help individuals on opioid substitution treatment (OST) achieve their fullest personal recovery, improve support for long-term recovery, and avoid unplanned drift into open-ended maintenance prescribing.

1.2   The chair published an interim report in July 2011. This described some of the common ground we had found, and suggested how services and systems could immediately improve the treatment they offer. The report was well-received and, with support from the NTA, has already resulted in practice improvements.

1.3   Our next step, promised in the interim report, was to be this final report. Our job has been to reflect the evidence and contextualise it within the current environment and the ambitions of 2010 Drug Strategy: framing a clinical consensus for how treatment that includes a prescribing component can be made more recovery-orientated.

2   A CONCEPTUAL FRAMEWORK FOR PROMOTING RECOVERY

2.1   Recovery from drug dependence is an "individual, person-centred journey" (HMG, 2010). It will often include some element of challenge to individuals, especially if their journey involves continued drug use or harmful drinking.

2.2   For many people, treatment is an important part of their recovery journey. It is a component of a broader recovery-orientated system of health and social care and support that harnesses the full range of individual, social and community assets. Exiting structured treatment is an indicator of, or milestone in, an individual's progress in their recovery journey but does not in itself constitute recovery. If premature, it can be harmful, especially if it leads to relapse.

2.3   The challenge of treatment for the individual is in changing entrenched patterns of drug-using

behaviour. Treatment services' response to this should manifest itself through well-structured and regularly reviewed care plans and goals. Behaviour change requires concerted effort and focus. It is difficult and requires a range of internal and external resources to initiate and maintain. Some people have few of these resources and, for them, rising to the challenge of treatment may be difficult. Keyworkers have a crucial role in creating the therapeutic conditions and optimism that can help. This will mean doing different things with people at different points in the treatment journey but could include: goal setting, empathetic listening, exploring the impact and negative consequences of current behaviour and the benefits of change, strategic use of problem recognition to amplify ambivalence about their current position and behaviour, managing rewards and negative contingencies, and involving social networks.

2.4   Treatment services need to create an accessible and integrated 'offer' of treatment that is personalised and optimised to promote and support wide recovery objectives for every person in treatment. Medication to support abstinence from illicit drugs will remain a necessary component of treatment for many but medication alone is unlikely to be sufficient to support an individual achieving recovery. Neither is abstinence alone.

2.5   The way treatment services are organised can promote recovery as the norm by exposing people in treatment to others who are further on in their recovery journeys. Advocating the benefits of mutual aid, utilising peer supporters, and participating in building communities of recovery will all help.

2.6   Facilitating an individual's recovery starts with the first treatment contact, harnessing the motivational momentum that led to that contact. The subsequent recovery journey through treatment is underpinned by a comprehensive assessment and recovery care plan process, which is regularly reviewed and adapted as needed. The aim is for individuals to exit treatment with the best possible chance of sustaining and building on the gains they have made in treatment.

2.7   There is a large literature on the concepts of recovery and many have defined it, with varying degrees of success and acceptance. Work by many people and organisations (most notably the Betty Ford Institute (2007), UKDPC (2008) and SAMHSA (2011), and more broadly the mental health movement in the UK) captures something of the spirit of recovery, which we endorse – that it is, or should be:
- an individual process or journey rather than a pre-determined destination
- built on hope, in order to sustain motivation and

support expectations of an individually fulfilled life

- about enabling people to gain a sense of control over their own problems, the services they receive, and their lives
- helping people to find opportunities to participate in wider society
- culturally appropriate.

2.8   One approach to understanding how recovery might be achieved is to focus on the concept of 'recovery capital', which the 2010 national drugs strategy defines as:

"the resources necessary to start, and sustain recovery from drug and alcohol dependence." (HMG, 2010)

This focuses attention on what an individual needs to begin treatment and those aspects that are needed to maintain or build change. These needs may be different at the start of treatment, and when the individual is working to build or sustain their recovery.

2.9   The strategy goes on to list four kinds of recovery capital, or resource (Best and Laudet, 2010):

- social: support from and obligations to family, partners, children, friends and peers
- physical: finances and safe accommodation
- human: skills, mental and physical health, a job
- cultural: values, beliefs and attitudes held by the individual.

2.10   Assessment and recovery care-planning should identify the key resources that will help support recovery for each individual, and help them build up and, hopefully, draw on such resources during their recovery journey. Although there is a research literature on some of these factors, in practice they will be different for each person.

2.11   Treatment can provide opportunities for individuals to fulfil pro-recovery social roles, for example, as peer mentors or facilitators of SMART recovery groups, which in turn can inspire others in their recovery journeys.

2.12   The process by which individuals define their recovery choices may be enhanced by exposure to others also on a recovery journey. Mutual aid and peer support will be vital to ensure recovery is prominent in services and treatment systems. The mutual identification processes that happen through mutual aid and peer support are important. People need to identify with someone whose place in their recovery journey is not too remote to their own. Someone who has been abstinent for many years and in stable employment can be an important beacon of what can achieved in the long term but their experiences may

be very different and mutual identification could be difficult. It is important that people can see the 'hand and footholds' at each stage of recovery through access to peers who are perhaps just a little further along the road to recovery than themselves.

2.13   There is a clear need for appropriate leadership across all providers of care in establishing explicit recovery-orientated assessment and care planning processes and in developing a more visible and overt recovery culture in services and across the systems of care.

2.14   An increasing number of people with past or current heroin dependence have intractable mental health or physical health problems. Some represent a complex medical problem requiring multidisciplinary coordination of care.

2.15   It is also important that treatment is delivered within clear and accountable clinical governance structures. Adequate supervision is a key component of this. It is particularly important that supervisors have the appropriate competences to supervise all the techniques or interventions being used by the practitioners they are supervising.

3   ASSESSMENT AND RECOVERY CARE PLANNING: PLAN, REVIEW, OPTIMISE
3.1   Introduction
3.1.1   Vital elements in an effective journey of treatment and recovery are:

- properly assessing and regularly reviewing an individual's needs
- planning treatment to respond to these needs as they change during treatment
- optimising or adapting treatment interventions to respond to failure to benefit or to capitalise on windows of opportunities for faster recovery.

3.1.2   Done well, assessment, recovery care planning and review are more than exercises in form completion. As well as gathering vital information, assessing risk and informing the professional's formulation, assessment can be an important therapeutic process in its own right. It can give people in treatment objective feedback on their situation and help them gain a different perspective or a more objective view of their lives – effectively a process of self-assessment and self-evaluation of their situation. This shared or joint assessment can then act as a platform on which to review and develop goals, and from which a recovery-focused care plan is agreed collaboratively. This process is likely to be of most therapeutic value if the resultant plan is going to be meaningful to individuals and owned by them. The

use of first-person statements and the person's own words may help facilitate this ownership but, most fundamentally, the process should be a detailed and collaborative exploration of resources, goals, strategies, options, benefits and risks. These useful processes can set out the framework for further recovery care-planning and review.

3.2   Assessment

3.2.1   There needs to be an initial, as well as an ongoing, process of comprehensive assessment for recovery that helps to underpin the core process of recovery care planning. Assessment for recovery aims to deliver an informed understanding of the person's wishes, substance use, and the severity and complexity of clinical and other problems; and it needs to identify their strengths and any key obstacles to their recovery.

3.2.2   The assessment process needs to help individuals consider their current and potential future 'recovery capital'. This will include personal skills, availability of safe accommodation, presence of supportive relationships, current levels of personal responsibility, engagement with a supportive local community, and positive participation in wider society.

3.2.3   The visibility of those in recovery and exposure to the varied pathways of recovery are likely to be key elements of a truly comprehensive and collaborative assessment process. At initial assessment, the attention of many people coming into treatment will be on relieving acute distress or addressing urgent issues, and services may be concerned to minimise acute health risks such as overdose. So in many cases, initial stabilisation on OST will be a key priority as an early step to recovery. For others, active support for detoxification, followed by relapse prevention, may be appropriate. However, assessment and recovery care-planning is an ongoing process and, once initially stabilised on OST, collaborative and active care-planning (e.g. using mapping tools and motivational approaches) to consider options across a wide range of personal recovery goals will be an important part of a recovery-orientated culture. For people to make informed choices through the assessment process, they need information and advice. As well as promoting clear pathways to recovery and abstinence, it is vital the nature of dependence is discussed and any risks of treatment and moving to abstinence are made clear. For collaborative recovery care-planning, people need balanced advice based on evidence, so they can weigh up their preferences and options in an informed way.

Mental health

3.2.4   Drug treatment services need to be able to screen, assess and identify treatment need for mental health problems. Individuals with severe problems

should have "high quality, patient-focused care", delivered though close collaboration with mental health services (DH, 2002; DH & devolved administrations, 2007). Mental health services normally lead the care for these people, with drug services providing guidance and support on managing dependence. This may include joint-working arrangements.

3.2.5   Drug treatment services need some ability to treat people with mild to moderate co-morbidity as the two conditions often share a common cause, or may require concurrent or sequential interventions for treatment to be most effective.

3.2.6   Up to 70% of the drug treatment population have been reported to have common mental health problems such as anxiety disorders (Weaver et al., 2004). IAPT services have been developed to work with depression and some anxiety disorders and can address the need in the drug treatment population, particularly for those stable on OST. IAPT services do not necessarily have the expertise to work with complex cases of trauma or with those who have not stabilised sufficiently on OST. Drug treatment services will need to be able to provide suitable support to people with such complex presentations.

Physical health

3.2.7   For some people – and especially as the treatment population ages – physical health problems may be a persistent barrier to recovery. Drug treatment services need to be able to assess and identify treatment need for such problems, and work closely with healthcare providers to treat physical diseases that may be affecting multiple systems in the body.

3.2.8   The provision and organisation of physical (as well as mental) healthcare for those in drug treatment needs to reflect the problems of access and stigmatisation commonly faced by drug users. Support may be needed for them to effectively use health and care services, including through proactive communication and advocacy, and – when appropriate – through direct provision of care within drug treatment services. Primary health care services can play a pivotal role in providing for the physical health needs of drug users but may need support from drug services.

3.3   Recovery care planning

3.3.1   A collaborative recovery care planning process should be able to identify preferred options from an attractive and flexible menu through which process someone in treatment can be helped to define their intended recovery journey. Recovery care planning will identify practical and staged actions that can promote progression to recovery. Individualised

recovery care plans for those receiving substitution treatments should not differ in any substantial way from those pursuing abstinence-based pathways.

3.3.2   It is important that recovery care-planning reflects and responds to the ambitions of service users, and gives them space, time and support to make meaningful decisions about their futures. Some people may have ambitions, or request related interventions, that are not currently achievable or clinically appropriate because of suitability, risk factors or contraindications. It is important that individuals do not experience these difficulties as a professional blocking their progress. Focus should normally be turned to developing plans, with realistic steps or milestones, that manage the risk or suitability issues appropriately while clearly maintaining or supporting a reframing of the original ambition and momentum.

3.3.3   An individual's activity while in a treatment programme needs to be understood in relation to the phase of treatment they are in, the next phase to be attained, and the full context of a recovery journey that engages with and is supported by wider community structures. Section 4 describes this in detail.

3.4   Review and optimise

3.4.1   Good practice and care planning guidance (NTA, 2006) stress the importance of regular review. Reviewing the recovery care plan provides the opportunity to measure progress, evaluate the progress towards goals, including the impact of interventions, and set new goals that move individuals along their recovery journey. Measuring treatment benefit and progress is an integral part of this process.

Measuring treatment benefit

3.4.2   There is robust evidence showing that OST can significantly improve outcomes for most opioid dependent people. Treatment can reduce symptoms of dependence, and being in treatment can help to reduce associated difficulties. However, more improvement in a broader range of domains is needed if someone is to fully recover. Many of these are covered by the term 'recovery capital' described earlier.

3.4.3   The ability to measure an individual's recovery capital and its accumulation during treatment, using a set of agreed outcomes that represent change during drug treatment, and to demonstrate to an individual their specific improvements (or deteriorations) in treatment can help to:
- make effective decisions on which areas to target with adapted or optimised treatment interventions
- support the person's confidence in their recovery and so support further progress in treatment.

3.4.4   The Treatment Outcomes Profile (TOP) is the national clinical instrument for monitoring outcomes in drug treatment. The TOP is now embedded in the treatment system and offers a core set of outcome measures to assess OST benefit.

3.4.5   While the TOP does measure some elements of recovery, additional measures of recovery capital are likely to be needed to present a better picture of recovery. Although some of these additional aspects of recovery may be difficult to observe or measure directly, they can be adequately represented by observable variables, such as the subjective rating of quality of life already used in the TOP. This approach is common in other areas of medicine.

3.4.6   Additional measures of recovery capital might cover, for example, change motivation and engagement, the support available to someone from their family and social network, skills and participation, and the environment in which they are living.

3.4.7   A core recovery measure for OST would be the extent to which the person in treatment is experiencing reductions in the psychological aspects of dependence, such as the desire or compulsion to take heroin, difficulties in controlling heroin use, and time devoted to obtaining or taking the drug or to recovering from its effects. There are standardised clinical interviews for the assessment of dependence (e.g. Composite International Diagnostic Interview (CIDI)) and validated clinical instruments for assessment of withdrawal (e.g. Subjective Opioid Withdrawal Scale (SOWS)), from which measures can be drawn.

3.4.8   Self-reported drug use or abstinence, such as measured in the TOP, is an important part of ongoing assessment of treatment benefit but testing biological samples for evidence of recent drug use can also be useful and sometimes vital. If people in treatment understand that drug tests will be requested at key points, the accuracy of self-reported abstinence is likely to be improved. Testing can also be used as another tool of the review and adaptation process but only if clinicians understand (and explain) how, why and what they are testing and how they will use the results – and understand the limitations of testing (see, for example, Goldstein & Brown, 2003). Drug testing during treatment is used to confirm treatment compliance (that someone is taking prescribed medication as directed) and as an indicator of progress in treatment – confirming abstinence or monitoring any continued drug use, including to support a drug-specific treatment intervention (e.g. as part of a psychosocial intervention like contingency management). Because of the risks of continued illicit opiate use for those on OST, a positive test result should lead to a careful

review of progress and the care plan, and of the need for increased treatment support or enhanced safety measures. A negative test result can be used to support and encourage someone in their continued progress.

3.4.9   Other measures of benefit and improvement beyond those recorded in the TOP might cover finances, relationships, risk and safeguarding issues.

3.4.10   The importance of these measures is not the tool used to collect them but the ways in which the information they provide is used meaningfully in a clinical setting with an individual and to optimise or adapt the treatment offered.

Optimising and adapting treatment
3.4.11   If little or no improvement results from the current treatment interventions they may need to be adapted then reviewed again. This can help ensure treatment remains dynamic and responsive to need. Identifying 'little or no improvement' is important but must take into account continued harm reduction benefits and the prevention of deterioration.

3.4.12   It is important that treatment can be adapted or optimised within the same intensity 'layer' of treatment (see section 4). Service and treatment systems need a 'breadth' of interventions and a range of modifications they can make to these interventions to allow treatment to be adapted before its intensity is substantially stepped-up. A narrow, one-dimensional model of stepped care is not desirable as people could be escalated through it too quickly, deriving no benefit, when benefit could have been derived if the current level of treatment were adapted or modified.

4   THE PHASING AND LAYERING OF INTERVENTIONS
4.1   Introduction
4.1.1   This component of the report focuses on how opioid substitution treatment can be delivered in a dynamic way which does not allow people to drift into long-term maintenance prescribing without effort being made to promote their recovery.

4.1.2   It proposes structuring packages of care in two main ways:
- firstly, by 'phasing' or sequencing care in a progressive and dynamic recovery journey that delivers different interventions as appropriate at different stages
- secondly, by 'layering' in different intensities, deployed according to need, choice, efficacy and progress towards recovery.

4.1.3   It also outlines a set of principles, or components of good practice, which should underpin

the approach. These principles are to ensure the approach is dynamic and personalised, safe and ethical. They should also, if adhered to, minimise the likelihood of any unwanted, unintended consequences being generated by the approach.

4.1.4   Interventions and packages of care need to provide the flexibility to respond to individuals' different rates or directions of movement, at different times in their recovery journey.

4.1.5   The design of services and of practice needs to provide for recovery pathways that include opioid substitution treatment and abstinence, and for moving from one to the other as goals and recovery capital change. Regardless of the pathway and its duration, people in treatment can – and should be supported to – achieve substantial recovery goals.

4.2   Phasing and layering
4.2.1   Phasing of interventions through care pathways, treatment phases or stages is already used in many substance misuse services. Layering interventions or packages of care in a stepped care approach is also used in some substance misuse services, as well as in mental health care and in dedicated psychological therapy services. Care is often phased and layered on a case-by-case basis through independent clinical and/or managerial decisions. A more planned approach to service or treatment system design can assist in meeting the full range of need, which changes during a recovery journey. It can also assist in developing the competence of staff to meet this range of need in a more planned and strategic way. Furthermore different intensities of treatment support a rational and systematic approach to managing limited resources.

4.2.2   The phasing of interventions for those on OST could potentially allow for the more precise targeting of interventions. It could also follow that measurement is designed to measure progress through the phases and its outputs used as a basis to plan interventions that promote movement through the phases. The phases suggested here are conceptual and this may lead to problems of definition and in locating people in a particular phase, but they are only a suggestion to be used when it is useful to do so. The aim is to cluster interventions into phases to support their sequenced deployment.

4.2.3   Change can often be a cyclical and iterative process and, in contrast, the phases may appear to be strictly linear. This has a greater potential to engender movement, a sense of clear goals and a recovery-orientated direction of travel. But clinical judgment and person-centred case management will be needed

to mitigate the risks inherent in a linear model: of only starting people at the beginning, driving them through before they are ready, and not allowing them to slip back to an earlier phase if they lapse, relapse or fail to benefit from treatment. Non-linear movement through phases, crises, fluctuations in motivation and 'dips' in and out treatment, will all need to be considered in the application of any phased approach.

4.2.4   What follows is a suggested approach to phasing and layering treatment. It is not intended as a rigid blueprint but rather as an illustration of the approach, to aid the development of local solutions. It consists of four phases of treatment: engagement and stabilisation, preparation for change, active change, and completion. It also consists of three layers of intensity: standard, enhanced and intensive:

effect, the intensity can be increased to an enhanced level and utilise more formal motivational interviewing, contingency management and assertive outreach. Finally, if the initial goals of this phase are not achieved the intensive option of inpatient assessment and stabilisation could be considered based on clinical need.

Preparation for change

4.2.7   This phase includes interventions that seek to refine treatment goals and prepare people for change. For some, with high levels of recovery or social capital, this phase could be very short, for others it will be more complex and take longer. After the initial engagement and stabilisation phase, some will opt for a period of OST maintenance (perhaps expressing an intention to come off OST in the future). Interventions

LAYERS \ PHASES	ENGAGEMENT AND STABILISATION	PREPARATION FOR CHANGE	ACTIVE CHANGE	COMPLETION
STANDARD TREATMENT	Packages of interventions	Packages of interventions	Packages of interventions	Packages of interventions
ENHANCED TREATMENT	Packages of interventions	Packages of interventions	Packages of interventions	Packages of interventions
INTENSIVE TREATMENT	Packages of interventions	Packages of interventions	Packages of interventions	Packages of interventions

THE TREATMENT JOURNEY

4.2.5   An example of how a treatment system or packages of care could be configured using this approach is included in table A (p19). Core keyworking interventions, such as harm reduction, assessment, care planning, referral and advocacy are listed in table B. They should be available as a standard and core component throughout any treatment journey.

Engagement and stabilisation

4.2.6   At the beginning of treatment, people may not have decided to become immediately abstinent and may not have agreed their level of need and the full package of care. There is also a risk of early treatment drop-out. The engagement and stabilisation phase seeks to engage people in their own treatment and, if they drop out, bring them back in quickly. First impressions are important and the service will want to make it quick and easy for people to be assessed, start to receive treatment and address their presenting concerns, such as benefits or a forthcoming court appearance. Interventions seek to develop the therapeutic relationship and establish the components of keyworking designed to reduce harm, involve individuals in their treatment and help them navigate through their treatment journey. Important components of standard intensity care during this phase are: dose titration and optimisation; drug testing; and proactive and facilitated referral to mutual aid and low intensity psychosocial interventions. If such a package of care does not achieve the desired

designed to build their motivation should be utilised, strategically amplifying any dissonance, focussing on strengths, building self-efficacy and self-esteem and using any contingencies as appropriate. Others will present with or develop more motivation for change, insight and/or recovery or social capital. For this group, interventions focussed on preparation for the next phase will be appropriate. Both of these packages could be offered at three layers of intensity: standard, enhanced or intensive, according to the person's level of stability and ambition:

- standard care for those stable on OST and wanting minimal other interventions but still including regular review and prompts for change
- enhanced care for those with limited initial motivation, perhaps with particular social needs (such as stable housing), or those with high level of motivation, insight or recovery capital who will benefit from more active and more structured interventions and peer support
- intensive care for those who fail to derive substantial benefit from enhanced care, or who are not stable enough to engage.

4.2.8   In some cases, if people do not respond to enhanced and intensive care (they could be showing partial benefit but care plan goals are not being wholly achieved) it may be appropriate to step back down to a lower level of care.

4.2.9 It is important to differentiate standard maintenance on OST in a recovery-orientated system of care from the criticism that some people have been 'parked' on methadone. Regular recovery care plan reviews and the recovery-orientated culture, enhanced visibility and facilitated access to mutual aid, and a more overt collaborative approach to care planning should ensure nobody stays on OST for any longer than appropriate. However, it is equally vital that resources are used efficiently and are not wasted in providing interventions that are not likely to be successful.

Active change

4.2.10 The focus in this phase is on interventions that seek to initiate and maintain change, especially detoxification, and social and rehabilitative options. For some this phase could come quickly; others may spend longer in the 'Preparation for change' phase. Standard packages could include community detoxification, keyworking and low intensity psychosocial interventions. Enhanced packages could include more formal psychosocial interventions. Intensive packages would include in-patient and medically-monitored residential detoxification, residential rehabilitation and structured community rehabilitation programmes. Proactive and supported engagement with mutual aid and peer support should be a priority in this phase.

Completion

4.2.11 This phase includes interventions that help people reflect on, prepare for and exit from formal treatment. NICE recommends: "Following successful opioid detoxification, and irrespective of the setting in which it was delivered, all service users should be offered continued treatment, support and monitoring designed to maintain abstinence. This should normally be for a period of at least 6 months." (NICE, 2007a)

4.2.12 Aftercare planning and engagement in mutual aid should be prominent. The phase includes interventions that seek to strengthen community integration and further develop recovery capital. The components of care packages are similar to those in the active change phase, but ownership of plans and their fulfilment should be located firmly with the individual, a progression which should have started in the earlier phases. The addition of relapse prevention medications, such as naltrexone, could be considered.

It is important that the planning of treatment exit and post-treatment support start early, well before the end of structured treatment, and is detailed and realistic.

4.2.13 After someone has left treatment, services may want to provide recovery check-ups (see section 5.7.3). Rapid access back into structured treatment should also be available, if needed.

4.3 Phasing treatment in prison

4.3.1 A particular combination of factors informs drug treatment approaches in prisons:
- a high concentration of drug users within the population (Stewart, 2008)
- a significant reduction in drug consumption during imprisonment (NOMS, 2009)
- a marked reduction in injecting drug use during imprisonment (but where it does occur, a higher incidence of sharing of needles and other equipment: Bellis et al., 1997)
- the high volume and frequency of movement of prisoners in treatment (one spell of custody can involve brief residency in four prisons: Marteau & Farrell, 2005)
- the high risk of overdose on release (Farrell & Marsden, 2005)
- a correlation between drug withdrawal and suicide in the first week of custody (Shaw et al., 2003)
- the high value of drugs relative to prisoners' small incomes (DH & devolved administrations, 2007).

4.3.2 These factors mean it is appropriate to take a modified approach in which stabilisation is offered from the first night of custody, and extended prescribing is reviewed at least every three months (DH, 2010). Unless there are clinical reasons to the contrary, individuals whose sentence exceeds 26 weeks are expected to work towards becoming drug free.

4.3.3 UK clinical guidelines (DH & devolved administrations, 2007; DH et al., 2006) currently recommend treatment options that address the clinical risks and opportunities that prisons afford:

First week of custody
- timely stabilisation for opioid withdrawal
- enhanced observation for those in stimulant withdrawal
- timely stabilisation or reduction for alcohol and benzodiazepines.

Weeks that follow
- option of opioid maintenance or detoxification
- range of evidence-based interventions (Patel, 2010)
- treatment reviews.

For sentences beyond six months
- opioid reduction (detoxification) where indicated (DH et al., 2006)
- range of evidence-based interventions
- treatment reviews.

Prior to release
- enhanced support (via mutual aid, peer mentoring, offender management)

- naltrexone in accordance with NICE technology appraisal (NICE, 2007b)
- consideration of re-induction (DH & devolved administrations, 2007)
- continuation of treatment and support (Patel, 2010).

4.4 Some key principles for delivering packages of care

4.4.1 The following principles, or components of good practice, should underpin the phasing and layering approach described above. These principles are to ensure the approach is dynamic and personalised but also safe and ethical. They should also, if adhered to, minimise the likelihood of the approach generating any unintended consequences.

The maintenance of adequate harm reduction interventions

4.4.2 OST has a substantial role in reducing harm and in preventing deterioration. Together with measures such as needle and syringe provision, OST has been responsible for the UK having one of the lowest rates in the world of HIV/AIDS among injecting drug users. Harm reduction interventions provide an underpinning of safety for all and should be appropriately embedded in all recovery pathways – they are included in the core keyworking activities undertaken in every phase of treatment (table B).

Timescales

4.4.3 Robust application of dynamic recovery care planning cycles should ensure that arbitrary timescales for interventions are not required to promote recovery. This allows for recognition of the evidence in relation to the length of drug using careers but also maintains a sense of dynamism or progress in the system. Local issues, such as access to housing, education, employment and training can also have a significant impact on timescales.

4.4.4 It is also crucial to acknowledge that, while there is political and clinical consensus that treatment needs to support individuals to maximise their recovery, we do not yet have adequate evidence on the likely scale of impact from developing a more recovery-orientated culture around the use of OST. So, we cannot predict with any assurance the numbers likely to fall in each category described (phase or intensity), nor the greater proportion likely to achieve successful sustained abstinence. We will also need to monitor any possible negative impact on increased harms (such as overdoses and drug deaths). This is not least because some of the possible key factors that could affect positive recovery outcomes such as housing access and support for training and employment may vary widely in availability and

impact. However, it is clear from current knowledge and experience that many of those on OST will need to be on it for several years.

Psychosocial interventions

4.4.5 The enhanced level of intensity, defined in table A, contains a number of psychosocial interventions, all of which are in the 2007 Clinical Guidelines (DH & devolved administrations, 2007) and some of which are recommended as priorities for implementation because of their high-quality evidence by the NICE guideline on psychosocial interventions in drug misuse (NICE, 2007c). The interventions at this level require specialist training or reference to implementation and clinical governance frameworks developed for the needs of research trials rather than the delivery of clinical services. While these represent an aspirational standard, in day-to-day practice it may be neither feasible nor desirable to adhere rigidly to these protocols. However, these enhanced interventions have important elements that keyworkers can adopt and deliver in addition to their core duties. This may enhance the standard offer of treatment. For example, if collaborative review identified the need for more supportive social networks, if SBNT was available this could be utilised. Alternatively, low- intensity psychosocial interventions could focus on this area, using relevant techniques, such as mapping, to support someone to explore, develop and use social networks.

4.4.6 Adapting evidence-based interventions to the platform of keyworking requires clinical leadership and a clinical governance architecture (particularly supervision) to ensure critical ingredients are not so diluted they become meaningless. Within a robust clinical outcomes-driven framework, a key role of senior clinicians is to oversee this adaptation of psychosocial interventions in terms of overall programme design and the needs of people in treatment.

4.5 Residential and non-residential rehabilitation

4.5.1 Clinicians, and people in treatment, need to be aware of the range of options available for residential and non-residential rehabilitation, their benefits and how they might be used at different phases of the treatment journey. Collaborative recovery care planning needs to be based on a platform of informed choice.

4.5.2 It seems clear that, for some people, recovery is likely to be better supported in a service that provides a safe environment, daily structure, range of psychosocial interventions, higher intensity, accessible peer support, etc – all conducive to recovery.

4.5.3 Rehabilitative treatment has often been reserved until the later phases of an individual's drug

use or treatment journey, and residential treatment reserved for those with no or unstable housing or for whom non-residential options have been unsuccessful. However, in line with the phasing and layering approach described in section 4.2, rehabilitation may be cost effective when used earlier for someone who is ready for active change and a higher intensity treatment.

4.5.4   Residential services are currently developing evidence, workforce competences and a means of categorising the broad range of available models.

4.6   Medications in different settings

4.6.1   There is further work to be done in examining the possibilities for existing and potential new medications to be used in a range of settings, including some where medication is currently little used. These potentials can be understood across a number of axes: the medications themselves, the points in a treatment journey where they might be appropriately used, and their stage of development or use.

4.6.2   Medications that we believe merit further attention are those that can contribute to:
- the prevention of co-morbidity, such as vaccines against blood-borne viruses
- replacing (if only temporarily) a drug on which someone has become dependent, including nicotine replacement therapies and existing or new formulations of opioid agonists
- the prevention of relapse to illicit drug use following a course of treatment, including different formulations of naltrexone and possible future vaccines
- the treatment of the complications and consequences of drug misuse, including hepatitis C treatment and naloxone.

4.6.3   All of these medications may be able to find appropriate uses at the following points in a treatment journey:
- before someone goes into a particular treatment setting
- during treatment in a particular setting
- immediately following a course of treatment
- in the longer term, following treatment.

4.6.4   The range of medications to be considered covers a wide range of stages of development and use, including those:
- that already exist, are available and whose use is widespread and familiar to clinicians
- that already exist and are available but whose take-up has not reflected their apparent promise
- that exist but that are largely unavailable perhaps because their use is still being developed, including in clinical trials

- new medications that can already be seen on the horizon of development.

4.6.5   One of the issues to be addressed in relation to these medications is settings in which their use is currently minimal or non-existent because the support they provide is considered to be against the very ethos of the setting or liable to cause problems of equity among the treatment population. An example might be the use of the relapse-preventing opioid antagonist, naltrexone, in some abstinent rehabilitation programmes. In this example, is a resident to whom a long-acting naltrexone formulation has been administered somehow going against the ethos – and the interests of other residents – of a programme that lays great store on (and expects of its other residents) strength of will and the ability to resist temptation in the absence of any medicinal support?

4.6.6   These are complex issues and another group of experts is considering them with a view to publishing a separate report that will complement ours.

Table A. A suggested approach to the phasing and layering of treatment

	ENGAGEMENT AND STABILISATION	PREPARATION FOR CHANGE	ACTIVE CHANGE	COMPLETION
STANDARD TREATMENT	- Keyworking (table B) - Opioid substitution treatment: – buprenorphine/oral methadone – supervised consumption – optimised dose – testing - Proactive/facilitated referral to mutual aid - Mental health assessment, monitoring and integrated access to appropriate mental health services - Health monitoring and access to healthcare - Low intensity psychosocial intervention (see table C).	- Keyworking (table B) - Opioid substitution treatment: – buprenorphine/oral methadone – supervised consumption if appropriate – optimised dose – testing (less frequent) - Proactive/facilitated referral to mutual aid - Health and mental health monitoring and access to appropriate services - Regular review and opportunities engage with more active and intensive recovery-focused treatment. Reviews should focus on: – cost-benefit of drug use – ambivalence – risk awareness – personal strengths and resources - Low intensity psychosocial intervention (see table C).	- Keyworking (table B) - Community detoxification: – buprenorphine/oral methadone – testing - Maintenance OST if achieving significant outcomes in other recovery domains - Proactive/facilitated referral to and supported engagement with mutual aid - Health/mental health monitoring and access to appropriate services - Low intensity psychosocial intervention (see table C).	- Keyworking (table B) - Naltrexone maintenance as component in relapse prevention - Maintenance OST if achieving significant outcomes in other recovery domains - Proactive/facilitated referral to and supported engagement with mutual aid - Health/mental health monitoring and access to appropriate services - Low intensity psychosocial intervention (see table C).
ENHANCED TREATMENT	As above, with the addition of, dependent on need, a combination of any of the following: - additional low-intensity psychosocial interventions (as in table C) targeted according to need. - motivational interviewing - motivational enhancement therapy - contingency management (attendance) - assertive outreach.	As above, with the addition of, dependent on need, a combination of any of the following: - additional low intensity psychosocial interventions (as in table C) targeted according to need. - social behaviour and network therapy. - low intensity interventions for common mental illness: – computer-based CBT – guided self-help - behavioural activation - contingency management - community reinforcement approach.	As above, with the addition of, dependent on need, a combination of any of the following: - additional low intensity psychosocial interventions (as in table C) targeted according to need - community reinforcement approach - social behaviour and network therapy - behavioural couples therapy - family therapy - psychodynamic therapy - contingency management (behavioural change).	As left, with the exception that CM is used to maintain behaviour change, e.g. CM + naltrexone.
INTENSIVE TREATMENT	Inpatient assessment & stabilisation followed by return to enhanced OST.	- Inpatient assessment & stabilisation followed by return to enhanced OST OR - As above, replacing oral with Injectable Opioid Treatment - Structured day programme.	- In-patient detoxification - Medically monitored residential detoxification - Residential rehabilitation - Structured community rehabilitation programme.	- Residential rehabilitation - Structured community rehabilitation programme.

Table B. The components of 'core' keyworking

- Comprehensive assessment including:
  - safeguarding
  - family support needs
  - risk
- Assessment/reassessment of recovery capital
- Recovery/care planning
- Multiagency work, including:
  - safeguarding
  - family support services
  - mental health
- Care coordination (if applicable)
- Risk management
- Crisis management
- Health monitoring
- Advocacy
- Pro-active engagement/ re-engagement
- Harm reduction
- Appropriate supported/ facilitated referrals to:
  - healthcare
  - mutual aid
  - financial and legal advice
  - housing, employment, education and training.

Table C. Suggested topics covered by low intensity psychosocial interventions

ENGAGEMENT AND STABILISATION	PREPARATION FOR CHANGE	ACTIVE CHANGE	COMPLETION
Low intensity psychosocial interventions focused on: building the therapeutic relationship; engagement with the care-planning process; building motivation for change and setting initial treatment goals. Session topics could include: • personal strengths and resources • cost-benefit of drug use • ambivalence • risk awareness and may be supported by protocols and mapping tools, and delivered in 1:1 or group settings.	Low intensity psychosocial interventions focused on: refining treatment goals and preparing for change. Session topics could include: • commitment to change • recovery goals & change plans • triggers for using & management strategies • personal & community resources and may be supported by protocols and mapping tools, and delivered in 1:1 or group settings.	Low intensity psychosocial interventions focused on: initiating and maintaining changes in substance use; behaviour and cognition; and building recovery capital. Session topics could include: • cravings • relapse prevention and lapse management • leisure/vocational/ educational plans • personal and community resources • skill development (social, personal, vocational) and may be supported by protocols and mapping tools, and delivered in 1:1 or group settings.	Low intensity psychosocial interventions focused on: graduation from treatment; reviewing achievements; planning for reintegration; developing recovery capital and exiting formal treatment. Session topics could include: • recovery check lists • personal strengths • reviewing changes achieved • relapse prevention and lapse management • undertaking leisure/vocational/ educational plans • personal and community resources • skill development (social, personal, vocational) and may be supported by protocols and mapping tools, and delivered in 1:1 or group settings.

5   RECOVERY SUPPORT

5.1   Introduction

5.1.1   We have been clear about the importance of building on the 'recovery capital' someone needs in order to attain and sustain their recovery: their social, physical, human and cultural resources. Drug treatment services have only a part of play in this – it depends heavily on the contributions of other health and social care services, housing and employment, family, friends and peers, etc. But treatment's part can, and for many should, be vital and substantial:

- initiating recovery with a clear rationale for interventions in the context of achieving self-sustained recovery
- directly helping to build capital in those starting from a low base
- involving support networks in treatment through interventions such as family support and social behaviour network therapy
- referring to, and actively supporting, contact with other services and peer support group
- involving peers directly through models such as peer role-models and recovery coaching
- bridge-building with peer communities of support.

This section is focused on the ways treatment services can support, rather than directly contribute to, recovery.

5.2   Peer role-models and peer support

5.2.1   To promote recovery within local systems and services it must be visible, as an active process that is being undertaken and as a possibility that is understood through the experience of others. Peer-based recovery support is an effective means of communicating to people in treatment that 'recovery is possible'. Making recovery visible – through peer role-models (including recovery champions, recovery coaches, networks of peer-based recovery support and mutual aid groups) will, for many, effectively improve understanding, heighten people's treatment ambitions and motivate them to work towards recovery.

5.2.2   A body of evidence suggests that self-help approaches, alone or in combination with a package of structured treatment, can help people to reduce or stop their drug use and sustain recovery. The National Institute for Health and Clinical Excellence (NICE) recognises the efficacy of self-help approaches, particularly those based on 12-step principles. NICE recommends that information about self-help groups should be routinely provided by drug treatment staff and that access to 12-step and other self-help groups should be facilitated by, for example, making initial contact, arranging travel and accompanying people to their first meeting). Well-developed networks of peer support will be effective in meeting the more general needs of those in treatment. They help to empower

people to take greater responsibility for their lives and can result in reduced dependence on drug treatment services for general advice, information and support.

5.2.3   Ensuring pathways to recovery are visible can be a powerful feedback and motivating tool. The mutual identification processes that happen through mutual aid and/or peer support are important. It is also important that individuals can identify with someone whose place in their recovery journey is not too remote to their own. Someone who has been abstinent for many years and in stable employment can be a beacon of what can be achieved in the long term but their experiences may be different and mutual identification may be difficult. People should have access to peers who are perhaps just a little further along the road to recovery than themselves, who are easier to identify with and who can share common experiences. Some service user involvement, like gathering feedback, is another way of making recovery visible. Visible pathways can show people in treatment (and staff) the progress they have made in a treatment journey and the possible ways forward. Recovery communities and champions can be useful components to achieve this. Although recovery journeys are individual, they describe a common path with familiar landmarks such as: stability of use, stable accommodation, positive support networks, reduced medication, and detoxification. When services seek to increase the visibility of recovery they should not restrict themselves to the recovery examples associated with a reintegrated abstinent end state, but seek to make visible the 'hand and footholds' at each stage of recovery. Capturing recovery stories from people and displaying them in treatment services also makes recovery more visible.

5.2.4   To optimise the benefits of self-help approaches it will be crucial that local areas develop good relationships with existing local mutual aid networks and other peer-based recovery support groups and encourage the development of new local groups/services in the community and within the treatment population. A number of steps may be useful to encourage and support engagement:

- identify and appoint local strategic, therapeutic and community recovery champions:
  – with the remit of understanding, developing and communicating a locally agreed narrative of recovery
  – improve integration between drug treatment and peer support
  – develop links between drug treatment providers and key contacts within the various local mutual aid, peer support groups/services
  – ensure that staff have access to appropriate information and training about the various mutual aid organisations

- improve the visibility of recovery by:
  – ensuring everyone has access to a recovery coach, or the opportunity to speak with people who are in recovery through local peer-support services
  – inviting the Hospitals and Institutions (H&I) service post-holder of the various 12-step fellowships or appropriate representative of SMART recovery and other local groups to talk to people in treatment

- improve knowledge and understanding of peer support among staff and those in treatment by:
  – staff attending open meetings, which anyone, including professionals, can attend as observers
  – inviting Public Information (PI) service post-holders of 12-step fellowships to give presentations at team meetings to improve staff knowledge
  – inviting H&I service post-holders to talk to people in treatment as above

- support the development of mutual aid and peer support meetings by:
  – ensuring drug treatment premises are available for meetings
  – working with mutual aid groups to time meetings to maximise attendance by those in treatment

- promote choice by:
  – ensuring people in treatment have a range of peer-support options including 12-step, SMART Recovery and other local peer-support services

- facilitate access by:
  – making initial contact on behalf of someone
  – organising travel, where necessary
  – accompanying them to their first meeting
  – taking time to explain what meetings can offer and how they operate, dispelling any myths or preconceptions
  – organising for a member of the mutual aid group to meet with someone who is considering attending for the first time so they can explain what happens at a meeting, explore any concerns and establish a contact within the group.

5.3   Employment support

5.3.1   Work, paid or unpaid, can be a vital part of recovery, helping people to gain self-esteem and build their social identity. Routes into work during recovery can help to sustain gains made in treatment. There is also a wider benefit to society from reduced costs to the welfare system.

5.3.2   But drug users' employability can be affected by physical and mental health problems, unstable accommodation, offending histories and limited skills or employment experience.

5.3.3   Employability may also be affected by the attitudes of employers and people in treatment to OST. It needs to be clear to both that, far from being a disability to working, OST can be the stabiliser that enables someone to work.

5.3.4   Treatment providers can raise the profile of employment as an integral part of the recovery pathway. Through their own services, local recovery communities or partnerships with others they can introduce people to work experience in ways that are flexible and appropriate to individuals' needs.

5.3.5   Drug and alcohol treatment providers already discuss education, skills and employment-related needs, and other aspects of social functioning, as part of the assessment process, and the person in treatment and their keyworker agree goals as part of the recovery care plan. It may be useful to identify and record specific information in relation to employment and benefits, such as whether the person is claiming JSA or ESA and has a Jobseeker's Agreement or action plan agreed and, if so, what needs and goals have been agreed and whether they match those identified in the comprehensive assessment.

5.3.6   Treatment providers can facilitate closer working arrangements between people in treatment, Jobcentre Plus (JCP) and (when relevant) the Work Programme provider. Better information sharing and joint-working between JCP (and Work Programme providers) and treatment providers can help to identify individual employment, training and skills needs as early as possible during a recovery journey, so appropriate provision and funding can be put in place at the right time. It can also help ensure the Jobseeker's Agreement and action plans reflect progress in treatment and that support is tailored and appropriate. Services can also help people comply with any benefit conditionality or required interaction with JCP services.

5.4   Family and social networks

5.4.1   Family and other social network support can be vital to recovery as they contribute to a person's social recovery capital. The addition of just one abstinent person to a drinker's social network increased the probability of abstinence in the next year by 27% (Litt et al., 2009).

5.4.2   NICE's 2007 guide to psychosocial interventions recommends behavioural couples therapy or behavioural family interventions for those in close contact with a non-drug-misusing family member, carer or partner (NICE, 2007c).

5.4.3   Other psychosocial interventions such as the Community Reinforcement Approach and Social Behaviour and Network Therapy may be useful to involve, or – where they do not already exist – build, social networks (DH & devolved administrations, 2007).

5.4.4   Families may also need support in their own right. They should – as appropriate – be offered assessment, guided self-help, information and advice, facilitated contact with support groups, and individual family meetings (NICE, 2007c). They may also benefit from manualised interventions such as the 5-Step Method (Copello et al., 2010). Some may benefit from a formal carers' assessment.

5.4.5   Mutual aid groups have long provided social network support for recovering drug users. New recovery communities play an increasing role in providing similar, and sometimes extended, support.

5.5   Housing support
5.5.1   Housing – and access to it – is, perhaps, the recovery resource least open to influence by drug services. A lack of appropriate local housing stock may seriously hamper efforts to support recovery and there may be little if anything that drug services can do directly to improve the situation. However, drug treatment workers and their services can take a few steps to improve people's ability to secure and retain accommodation conducive to recovery, for example:
• assess housing-related need at entry to treatment and review it regularly. This is not just about housing status but about the skills necessary to maintain independent living
• optimise treatment to improve someone's stability and ability to satisfy a landlord of their ability to maintain a tenancy
• provide advice, information and advocacy to ensure people in treatment are being paid appropriate benefits
• provide training and support (or access to them) in the skills needed to maintain a household and tenancy, including financial and debt management to ensure rent is paid
• work with people to improve chances of employment, which can help with housing
• provide, often in partnership with others, second-stage or other supported accommodation
• provide housing support.

5.5.2   Beyond this work with individuals, drug services will also want to work, directly and through local drug partnerships, with local housing planners and providers to ensure they understand the benefit to individuals and the community of stable housing for drug users, that local need for housing has been assessed, and that appropriate housing stock to meet

these needs is made available to people in treatment and recovery.

5.5.3   There is a balance to be struck between providing independent housing to someone to support their recovery and providing it too early in their recovery journey. The pressure of maintaining a tenancy may increase the risk of relapse and of losing the housing.

5.6   Improving well-being
5.6.1   There is good evidence the general population can secure improvements in mental health and well-being through the 'five ways to well-being' (Aked, Marks, et al., 2008):
• Connect. With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day
• Be active. Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy; one that suits your level of mobility and fitness
• Take notice. Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are on a train, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you
• Keep learning. Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident, as well as being fun to do
• Give. Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and will create connections with the people around you.

5.6.2   It is not known whether the evidence that supports the five ways to well-being can be extrapolated to the treatment population, many of whom may have multiple, complex needs that overshadow the five ways. However, as these needs are addressed and they progress in their recovery journey, it seems likely that the five ways to well-being

will become more pertinent to people in treatment, and that treatment services and recovery communities can, and should, provide ways to support them.

5.6.3   For example, some treatment services provide access to sport and exercise, and to learning. Recovery communities create connections for people and let them give back in exchange for the support they have received.

5.7   Post-treatment support

5.7.1   Drug-related aftercare may typically include educational, psychosocial, and pharmacological interventions or a combination of these interventions. For example, somebody recovering from heroin dependence may benefit from pharmacological interventions like naltrexone, perhaps combined with a psychosocial intervention like contingency management (NICE, 2007c).

5.7.2   The level and intensity of ongoing recovery support that might be offered to someone following treatment will differ depending on their recovery capital. However, some key components may include:
- access to mutual-aid groups or peer support
- support from a recovery coach
- engagement with housing, employment and educational support
- family and parenting support.

5.7.3   Local treatment systems may also want to provide recovery check-ups: regular phone calls to (or other contact with) people who have left structured treatment. Long-term monitoring through regular check-ups and early re-intervention can facilitate early detection of relapse, reduce the time to treatment re-entry and improve long-term outcomes (Scott and Dennis, 2009). Recovery check-ups are done more frequently when someone has first left treatment (at least once a quarter) and then tail off (to no less than once a year). They may continue for as long as five years. However, the duration and intensity of check-ups for a particular individual will be based on their problem severity and recovery capital. A recovery check-up provides an opportunity to:
- assess how the person's recovery is progressing
- provide feedback and support
- provide rapid access back into structured treatment, if needed

Scott and Dennis (2003) provide more detailed information in their model for recovery management checkups.

5.7.4   A rapid and clear route back into structured treatment is vital in case someone experiences difficulties in maintaining their recovery (DH & devolved administrations, 2007). Local treatment systems should ensure that referral pathways are in place, and treatment services have a rapid re-entry option.

6   THE EVIDENCE ON OST AND ITS EFFECTIVENESS

6.1   Introduction

6.1.1   Our evidence review had two goals:
- to summarise and interpret the evidence for OST
- to identify, from the evidence, those elements of OST that most obviously ensure its effectiveness.

The sections below summarise our principal findings for each of these goals, but the detail is in appendix C.

6.1.2   We also considered what proportion of those who become dependent on heroin might be expected to recover, or least become abstinent from the drug, which is the measure usually used in the research.

6.1.3   The available evidence on specific aspects of OST is often limited and may come from only a few, often small-scale, studies in other countries. England's National Drug Treatment Monitoring System (NDTMS) is increasingly able to supplement these findings with its population-scale reports on the features and outcomes of treatment in this country.

6.1.4   But the published evidence is clear that, at aggregated population levels, time-limited OST is not effective; that coming off OST can lead to greater risks of relapse, BBVs and overdose; and that treatment orientated to rapid abstinence produces worse outcomes than treatment initially orientated to maintenance (Ball and Ross, 1991). However, an initial orientation to maintenance does not mean people should be discouraged from seeking to withdraw from treatment if they are doing well, and have or can gain sufficient recovery capital to sustain long-term abstinence. People who achieve good social reintegration, particularly employment, are more likely to leave treatment without relapse (Milby, 1988). Initially orientating OST to maintenance allows people the time, space and platform to make meaningful choices. This process is best supported by ambitious, integrated, diverse and targeted interventions and other support. It is not supported by limiting choice through unilaterally curtailing or time limiting OST.

6.1.5   The task of recovery orientated drug treatment is to do all it can to help people do well, to boost their recovery capital and ensure they have the resources necessary to protect against relapse.

6.2   The effectiveness of OST

6.2.1   The evidence is good that OST:
- prevents people dropping out of treatment –. however, in itself, preventing drop-out is only

a predictor of benefit, not an end in itself. A programme focused only on retaining people lacks an adequate direction for treatment. This is the critical role of the recovery agenda in shaping OST. It sets out treatment objectives that provide direction and structure for people in treatment and clinicians

- suppresses illicit use of heroin – three large studies from different countries provide surprisingly consistent results. Heroin use was reduced, with only 25-35% of users reporting continuing heroin use three to five years after beginning their index treatment

- reduces crime – OST reduces involvement in crime among heroin users participating in treatment (Lind et al., 2005) and the expansion of treatment is associated with reduced property crime in the community (Moffatt et al., 2005). OST given prior to release from prison can reduce re-offending (Gordon et al., 2008; Dolan et al., 2005)

- reduces the risk of BBV transmission – coupled with the availability of needle and syringe programmes (NSP), OST reduces the risk of BBV transmission (NICE, 2009), including in prisons (Singleton et al., 1998)

- reduces risk of death – OST reduces the risk of death among heroin users participating in treatment (Clausen et al., 2008), and the expansion of OST (specifically buprenorphine) reduced the overall rate of opioid overdose deaths in the community (Romelsjö, 2010). OST in prison may also reduce self-inflicted death in the first 28 days of imprisonment (Marteau, Palmer & Stoever 2010) and pre-release OST can reduce the high risk of fatal overdose during the first month of liberty (Gordon et al., 2008; Dolan et al., 2005).

6.2.2   The evidence is less persuasive that OST:
- suppresses other drug use – results of large, observational studies suggest OST is minimally effective at suppressing use of drugs other than heroin

- promotes abstinence from all drugs, including – in the longer term, OST medications themselves

- improves physical and mental health – there is relatively little data on which to assess health outcomes (other than reduced risk of overdose and BBV) but, broadly, the evidence suggests rapid and substantial improvements on treatment entry, which may or may not be maintained or further improved

- improves social reintegration of marginalised heroin users – there is little quantitative data available on which to assess the extent to which people in OST are able to achieve social reintegration.

6.2.3   The evidence also alerts us to the risks of prescribing OST, especially to people who may find it difficult not to take illicit drugs or drink to excess:
- mortality in the first few weeks of OST is significantly elevated, as it is in the weeks after leaving treatment (Cornish et al., 2010)

- induction onto methadone is hazardous and needs to be undertaken with care, with the person taking the medication understanding the risks involved (DH & devolved administrations, 2007).

6.3   The components of effective OST

6.3.1   The evidence also indicates the treatment components more likely to deliver the benefits described above. They include:
- engaged, stable clinical leadership that provides clear goals and maintains the cohesion, focus and engagement of clinicians to sustain a therapeutic milieu in which to optimise recovery (Ball and Ross, 1991; Magura et al., 1999)

- an organisation and staff able to support and sustain change, including motivated staff with appropriate qualifications, confidence in their skills, and a proportion in recovery themselves (CSAT, 2009), effectively supervised by competent clinicians and managers (Miller et al., 1995; Stitzer and Kellogg, 2008)

- longer retention in OST (Simpson & Sells, 1982; Zhang et al., 2003; Cornish et al., 2010) and an initial orientation to maintenance for up to one year or more but with people encouraged to move on from treatment if they are doing well, and have or can gain sufficient recovery capital to sustain long-term abstinence (Milby, 1988)

- staff who believe in the treatment they are delivering, have a genuine interest and concern for the people they work with and respond empathically towards them (Rogers, 1957), who treat them with respect and dignity that allows them to develop a different image of themselves, and who have a belief in their capacity to change, and a sense of their role in fostering that change (Dole & Nyswander, 1973)

- a structured programme focused on recovery that sets out treatment goals for OST that provide direction and structure for people in treatment and clinicians (Moos, 2003)

- a range and quality of psychosocial interventions that enable emotional, psychological, and social well-being. NICE's 2007 review found good evidence for contingency management supporting longer continuous periods of abstinence during and after treatment. Behavioural couples therapy and family-based interventions were also associated with reductions in illicit drug use. CBT for addressing common

mental health problems was also recommended. Active referral to and facilitation of contact with self-help (12-step) groups produced better sustained attendance at groups (NICE, 2007c)

- a sufficient dose of OST to prevent withdrawals or, if needed, high enough to increase tolerance and attenuate any response to injected heroin. And the provision of alternative medications or dosing schedules for those who experience low-grade withdrawal symptoms in the latter half of the dosing interval and continue to use heroin despite receiving adequate doses of methadone
- availability of a range of OST medications, and of supervised consumption, to tailor treatment to individual needs, incentivise participation and maximise retention in structured treatment, and ensure safety
- links to recovery-orientated community organisations outside of treatment to enhance social reintegration, especially though employment
- continued treatment, support and monitoring designed to maintain abstinence for a period of at least six months following detoxification (NICE, 2007a)
- availability of naltrexone, with adequate supervision and a programme of care, as a treatment option for detoxified people highly motivated to remain in an abstinence programme (NICE, 2007c)

6.3.2   While this summarises what the evidence says about the components of effective OST, it says little about whether these or other components can lead to long-term recovery. In particular, the evidence is mixed in demonstrating the effectiveness of psychosocial interventions on improving the target outcomes of OST. However, it seems clear that if we are to help people recover rather than just protect them from the harm of illicit drug use, we need staff who are competent in building relationships, able to provide structure and review, and with the flexibility to review progress and provide personalised access to a range of interventions. These are all the province of psychosocial interventions.

6.4   Beyond the limitations of OST

6.4.1   The critical limitation of OST, and all forms of treatment, is that individuals need long-term social support and personal psychological resources to sustain recovery. Formal treatment can be a powerful factor in building social support and psychological resources to facilitate positive change, but on its own it typically does not have a lasting influence (Moos, 2003).

6.4.2   People need alternative rewards in their lives if they are to recover from drug dependence. The rewards of everyday life (for most people, a stable,

intimate relationship, fulfilling work, and family life) are less accessible for people marginalised, and who lack interpersonal and vocational skills, entrenched by drug dependence

6.4.3   There is some evidence that participation in training and employment can be fostered by treatment. One early randomised trial comparing treatment with methadone to drug-free treatment included intensive vocational retraining, and limit-setting in relation to continued drug use. It demonstrated that OST, in a package with other measures, can dramatically improve social reintegration (Gunne & Grondbladh, 1981)

6.4.4   OST, like all forms of treatment for drug dependence, relies on motivation: willingness to accept treatment, and more importantly, the willingness, personal resources and social opportunities to take advantage of the respite from dependence to make steps towards sustained recovery. All of these factors can be enhanced by service and staff factors, and psychosocial interventions described earlier

6.4.5   A focus on recovery can enhance the effectiveness of treatment through clarity of therapeutic goals. Every clinical interaction is most useful if focused on specific performance goals related to the person's circumstances (Moos, 2003). Such focus can be enhanced by specific treatment protocols, and implementation of treatment concordant with treatment guidelines can enhance outcomes (Barnett et al., 2010).

6.5   How many people dependent on heroin become abstinent?

6.5.1   It is important to develop an understanding of how many people might be expected to recover from drug – and especially heroin – dependence but recovery is difficult to measure objectively. Researchers have therefore usually measured only remission from heroin dependence, actualised as abstinence over a defined period of time.

6.5.2   It is first useful, though, to provide some comparison with work done on recovery from alcohol and tobacco dependence. Vaillant's follow-up study of 174 men previously diagnosed with alcohol dependence showed that among 91 surviving participants at age 70, 53% had been stably abstinent for at least three years, 5% were drinking with no problems, and 42% had chronic drinking problems (Vaillant, 2003). Schutte and colleagues (2003) reported on a ten-year follow-up of 292 surviving older former problem drinkers (55-65 years of age at baseline). They reported that 89% did not report any drinking problems throughout the follow-up.

Among this group, 37% were abstinent at baseline and follow-up and the remainder continued to drink alcohol but at lower levels than a comparison group of lifetime non-problem drinkers. In Sweden, Ojesjö (1981) reported on 15-year follow-up outcomes among 96 males with alcohol dependence. Thirty per cent were judged recovered, 43% unchanged or worse, and 27% had died. Using cross-sectional data from a representative sample of US adults (n=4,422), Dawson and her colleagues (2005) assessed full and partial remission from alcohol dependence among those previously diagnosed dependent in the year prior to the past year before recruitment to the study. The researchers classified the status of this sample as follows: 18% were abstainers and 18% were low-risk drinkers; 12% were asymptomatic but hazardous drinkers, 27% were judged to be in partial remission, and 25% were still dependent. Taking these studies together suggests that 30-50% of individuals taking part in long-term outcome studies will recover from alcohol dependence. The recovery rate is higher if non-symptomatic drinkers are included.

6.5.3   Etter and Stapleton (2006) reviewed 12 long-term outcome evaluations (from two to eight years) of nearly 5,000 people who smoke tobacco and have received nicotine replacement therapy (NRT) or placebo. In these studies the smoking status of all participants treated with NRT was determined after 12 months. The crude average smoking cessation rate was 12% and 18% at longer-term follow-up. When including placebo-treated participants, these studies indicate that about 30% of quitters at 12 months will relapse. The authors suggest the modest long-term benefit of NRT suggests that tobacco dependence "might be better viewed as a chronic, relapsing disorder, requiring repeated episodes of treatment".

6.5.4   For many people, heroin dependence is a remarkably persistent, relapsing disorder which can last for decades (Hser et al., 2001). Using illicit opioids is also hazardous: international studies point to a crude annual mortality rate of about 1-3% (Degenhardt et al., 2010), mainly resulting from overdose and disease (Darke, 2011). Epidemiological studies suggest that up to 50% of dependent users do not live beyond their fifth decade and life expectancy among survivors is reduced by 18 years.

6.5.5   That many individuals do completely recover from heroin dependence is beyond question. Many resolve problems on their own without formal treatment. There is also consistent and strong evidence that appropriate and well-delivered treatment plays a key role in the lives of heroin users and is associated with reduced substance use and related problems. People retained in treatment have a substantially

reduced risk of death. In a recent study, Cornish and colleagues (2010) reported a crude mortality rate that was almost double among opioid users not in treatment compared to those in OST (1.3 per 100 person years vs. 0.7). Compared with the general population of England and Wales, the standardised mortality ratio was 5.3 in treatment and 10.9 off treatment.

6.5.6   It should not be expected that a single episode of treatment will secure lasting abstinence in all but a small minority of drug users. It is the norm for an individual to re-enter treatment several times before reaching stable remission (three to four episodes have been reported in the literature (Anglin et al., 1997; Hser et al., 1997). For example, in the USA, Dennis et al., (2005) reported on the duration of dependence among a heterogeneous sample of 1,326 adults (41% male) with substance dependence recruited between 1996 and 1998 from public addiction services in Chicago. Over a three-year follow-up, they looked for the point where each participant was able to achieve one or more years of abstinence from substance use. The median duration of addiction career was 27 years and the median treatment career (the time from first treatment to one or more years of abstinence) of three to four episodes spanned nine years.

6.5.7   The question of how many people with heroin dependence recover is difficult to answer. Few studies have tracked heroin users into their fifth and sixth decade, and the small literature of longitudinal research relates to studies done at different times, in different cultures and often using different methods. Nevertheless, taken together this research sheds light on the course of heroin dependence. It is important to note that these studies are also vulnerable to selection and differential loss to follow-up leading to bias.

6.5.8   Recently, Calabria and colleagues reviewed 18 international longitudinal studies that have reported remission rates from drug dependence (Calabria et al., 2010). Ten studies looked at opioids, with a total of 1,833 participants followed up after three to 33 years (the recruited number of participants ranged from 16-1,000). The remission rate for these studies ranged from 23%-93%. Among the larger and longer-term of these studies, Hser (2007) reported that 43% of 242 individuals followed-up after 33 years had been stably abstinent from heroin for five years or more. Using these ten studies Calabria estimated that the annual remission rate (i.e. the proportion expected to become abstinent or non-dependent each year) for heroin dependence lies between 9% and 22%.

6.5.9   A notable study from the USA adds granularity to this picture. In the late 1970s, William McGlothlin and colleagues recruited a sample of 921

heroin addicts enrolled in Californian methadone maintenance programs and successive research teams have followed-up this cohort over three decades. After 30 years, nearly half of the original sample was deceased. Grella and Lovinger (2011) interviewed 343 (71%) of the survivors 30 years after recruitment. The cohort did not follow a single course over the intervening years. Four distinct groups were discernible:

- about 25% of the sample made a relatively rapid decrease in heroin use and quit altogether after ten to 20 years from initiation
- 15% achieved a more moderate decrease before quitting after ten to 20 years
- 25% achieved a gradual decrease in heroin use over the 30-year follow-up
- 25% did not reduce their heroin use at all, and were still using at follow-up.

6.5.10   Among the rapid and moderate-decrease heroin users who attained stable remission (40%), 18%-25% of their lives were spent enrolled in OST (five to eight years). The no-decrease group had the highest average time using cocaine (16%) and the rapid-decrease group the lowest (6%), and both groups had a higher prevalence of psychological and personality problems.

6.5.11   A cautious conclusion from this literature is that among survivors 40% of heroin users eventually attain stable remission (over one to two decades). When evaluated after three to five years 20%- 80% are likely to be in remission.

6.5.12   However, the research covered by the literature reflects the treatment and populations primarily of the US and countries other than the UK. The appropriate figures for current remission in the UK and in particular areas in this country may be markedly changed by the profile of the treatment population and by the nature of the treatment.

6.5.13   In addition, these figures should not be accepted as a basis for future treatment system expectations. It is not possible to screen individuals for the likelihood of long-term recovery. It is likely that there are different factors associated with the severity and complexity of each case, and with long-term recovery. The literature does suggest there is likely to be a subpopulation that achieve rapid reductions in heroin use and another subpopulation that will be visible early in treatment because of their continued heroin use. Treatment providers should respond appropriately in each case – for the former by exploring ways of strengthening and accelerating recovery, and for the latter by conducting a priority clinical review with the person on how to personalise the treatment plan to secure a reduction in heroin use.

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APPENDIX A – MEMBERS OF THE RECOVERY ORIENTATED DRUG TREATMENT EXPERT GROUP

(Other appendices to this report are available as separate downloads)

- Professor John Strang – National Addiction Centre (chair)
- Mike Ashton – Drug and Alcohol Findings
- Dr Alison Battersby – Psychiatrist, Plymouth
- Dr James Bell – Physician, South London and Maudsley
- Dr David Best (to June 2011) – University of West Scotland
- Karen Biggs (from October 2011) – Phoenix Futures
- Dr Owen Bowden-Jones – Royal College of Psychiatrists faculty of addictions
- Jayne Bridge – Nurse, Mersey Care NHS Trust
- Anne Charlesworth – Commissioner, Rotherham
- Professor Alex Copello – Psychologist, Birmingham
- Dr Ed Day – Psychiatrist, Birmingham
- Selina Douglas – Commissioner, Westminster (to July 2011)
- Vivienne Evans – Adfam
- Professor Eilish Gilvarry – Psychiatrist, Newcastle, Tyne and Wear
- Jason Gough – Service user voice, Sheffield
- Kate Hall – NHS service director, Greater Manchester West
- Dr Linda Harris – Royal College of General Practitioners Substance Misuse and Associated Health
- Dr Michael Kelleher – Psychiatrist, South London and Maudsley
- Dr Brian Kidd – Psychiatrist, Scotland
- Tim Leighton – Action on Addiction
- Peter McDermott – Service user voice, The Alliance
- Professor Neil McKeganey – Centre for Drug Misuse Research
- Dr Luke Mitcheson – Psychologist, South London and Maudsley
- Dr Gordon Morse – GP, Somerset
- Morag Murray – NHS service director, Sussex
- Noreen Oliver – BAC O'Connor
- Professor Steve Pilling – NICE and NCCMH
- Dr Roy Robertson – University of Edinburgh
- Ian Wardle – Lifeline.

Corresponding members:
- Dr Laura Amato – Cochrane Drugs and Alcohol Group, Department of Epidemiology, Rome, Italy
- Professor Wayne Hall – University of Queensland, Brisbane, Australia
- Professor Keith Humphreys – Stanford University School of Medicine, USA

- Professor A Thomas McLellan – University of Pennsylvania and Treatment Research Institute, USA
- William L White – Chestnut Health Systems, USA.

Observers attended from:
- Department of Health drug and alcohol team (Dr Mark Prunty, Amy Edens)
- Department of Health offender health team (David Marteau)
- Home Office drugs strategy team (Ruth Fowler, Fiona Mackay)
- National Treatment Agency (Paul Hayes, Rosanna O'Connor, Helen Clark, Peter Burkinshaw, John Marsden, Mark Gilman), which also provided secretariat (Steve Taylor).