

**Reducing harm and
promoting recovery:**

*a report on methadone treatment
for substance misuse in Scotland*

**SACDM
Methadone Project Group**

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Section 1. - Background

1. This paper has been produced by an expert group of clinicians and academics in the field of substance misuse in Scotland and aims to advise ministers on the place of methadone in the treatment of substance misuse in Scotland.
2. Methadone replacement prescribing has evolved rapidly over 20 years in the face of blood-borne virus infection and is now a major element of the treatment of substance misuse in the UK and much of the developed world.
3. Research shows that Methadone is more cost effective in terms of harm reduction than any other medical treatment for opiate dependency. Methadone outcomes improve if delivered as part of a continuum of care with associated psychosocial interventions (wraparound services) available.
4. Harm reduction – including a substantial methadone prescribing programme - is the main plank of Scottish drug treatment strategy since 1994 and Alcohol and Drug Action Teams (ADATs) and providers have been encouraged to improve access to services by reducing waiting times and increasing capacity.
5. Methadone treatment should be delivered as part of a range of services delivering a continuum of care addressing harm reduction and recovery needs to be based on comprehensive assessment, care planning and review processes in line with national guidance.
6. Treatments specifically aiming to detoxify and rehabilitate drug misusers should also be available. The use of such treatments should be based on a rigorous assessment and review process which includes procedures addressing the increased risks inherent in detoxification. Comprehensive follow up and rehabilitation services should be available post-detoxification.
7. Concerns have been raised around methadone treatment in Scotland - focussing on issues around prescribing philosophy; limited availability of treatment options in some areas; inconsistency in practice and quality of service across Scotland; effectiveness of services – in particular relating to the delivery of acceptable harm reduction and recovery outcomes, crime reduction and the safety of children.
8. Information on current performance of Scottish services is sparse. Services struggle to supply meaningful information on process or outcomes of methadone treatment in Scotland and national data systems are currently unable to give a clear understanding of treatment processes or effectiveness.
9. When surveyed, few ADAT area services are able to supply useful information on treatment process and standards. Many struggle to retrieve information collected clinically. Few services routinely report on outcomes.

Section 2 – Optimising methadone treatment in Scotland

A number of areas requiring attention have been identified by the SACDM methadone project group and the user/carer consultation events. These are:

10. Service commissioners are failing to commission these complex services effectively. All services must be subject to rigorous clinical governance processes in line with local NHS requirements. Commissioning of services along with associated governance and accountability processes requires to be effective at all levels.
11. Most services and local systems are unable to supply valid information regarding activity or effectiveness of treatment programmes. Services are rarely evaluated objectively. Ways of coordinating research and evaluation in order to make best use of the available evidence and identify research gaps should be explored.
12. Many services are unable to demonstrate that they are delivering comprehensive care within national guidance and to acceptable standards and that they are delivering ongoing benefits to all who are in receipt of methadone replacement prescribing. Few services make any attempt to assess outcomes.
13. Services must be needs-led, not service-led. Services are often delivering limited care packages – with simple methadone prescribing in isolation the norm in some areas. Methadone replacement prescribing must be offered as part of a coherent, planned care package. This must include opportunities to access essential “wraparound” services including services addressing psychological health and social aspects of recovery including education or employment.

The project group unanimously agreed that methadone replacement prescribing remains the main treatment for opiate dependency that should be available within the framework of services across all areas in Scotland. This reflects the overwhelming evidence base which supports its effectiveness in the face of little current credible evidence to support other approaches. The group also agreed that methadone replacement prescribing in Scotland can be improved significantly in terms of consistency and quality of practice and process of care delivery. This is supported strongly by user/carer opinion. The following actions reflect changes which will improve our ability to objectively evaluate treatment delivered by Scottish services and will also address specific concerns regarding delivery and effectiveness.

Actions – a comprehensive list of actions for the Scottish Executive, ADATs and services is included. Key actions include:

Improving ADAT/NHS board accountability and performance management

14. The Scottish Executive (SE) should consider at a high level their commitment to meaningful joint working regarding commissioning and accountability of substance misuse services - including consideration of the Justice and Health Department performance.

Improving quality of information

15. The SE should set up *as a priority* a national methadone audit system (incorporating local data collection) which will annually report on methadone prescribing activity, quality and outcomes. A baseline audit should be delivered in 2008/9 OR Pilot sites (chosen from areas of good practice) may be supported in the development and of such systems for national roll out.
16. The SE should *prioritise* the processes to ensure CHI numbers are recorded on all GP and specialist methadone prescriptions and maximize compliance with the expanded Scottish Drug Misuse Database. Opportunities to optimize the value of these national data (eg data linkage etc) should be considered by a working group charged with this task, reporting to SACDM.
17. The SE should create a governance and accountability process which assures the delivery of basic data. ADATs should report on their methadone services within this framework. Services should be held accountable under local clinical governance processes to demonstrate they have agreed standards of care and regularly audit against them. Nationally this should be part of the Corporate Action Plan process and the NHS accountability review process.
18. The Scottish Executive should set up a strategic process which facilitates Scottish research into treatment effectiveness in general and methadone effectiveness in particular.

Improving effectiveness of services

19. The SE should agree and articulate a philosophy of care for Scottish services as part of the refreshed national strategy.
20. The SE should set up a process to agree national standards regarding replacement prescribing. These standards must address - accessibility; range of services available; waiting times; aspects of care planning and delivery and outcomes. ADATs and services should report on performance.
21. The SE should require NHS Boards to demonstrate effective use of contractual mechanisms (GP and Pharmacy) and other opportunities (eg Non-medical prescribing) to deliver best value and improved quality.

Integration

22. The SE should require ADATs to report on the degree, nature and effectiveness of integration of services locally

Improving commissioning

- 23.** The SE should ensure the newly reconvened Scottish Advisory Committee on Drug Misuse (SACDM) and associated processes are effective and relevant as an agreed national advisory structure.
- 24.** SE should consider development of a structure which will deliver clear leadership/direction; greater accountability and performance management nationally for substance misuse services – eg a Scottish “NTA” or similar body
- 25.** SE should review funding streams and associated accountabilities to empower ADATs and facilitate improved effectiveness.
- 26.** ADATs must demonstrate that prescribing services are commissioned in the context of their overall service model and are delivering on agreed Key Performance Indicators (KPIs).
- 27.** The SE must require ADATs to ensure that services are improving delivery in accordance with the national quality standards for substance misuse services
- 28.** ADATs should be required to use ADAT support resources at least in part to deliver on improvements in quality and performance. This should be incorporated into the local NHS clinical governance agenda and reported through the NHS accountability review process.

Section 1: Background discussion and evidence

1.1 Introduction and context

This paper has been prepared by the SACDM methadone Project group – a group of clinicians and academics working in the substance misuse field in Scotland. It forms the third element of a comprehensive Scottish review into the use of methadone as a treatment for opiate dependency. This review has been commissioned to inform the debate on how to ensure that methadone prescribing in Scotland is delivered to the highest quality and achieves the best possible outcomes.

The paper therefore reflects considerable debate by a diverse group of professionals and forms a consensus regarding the strengths and weaknesses of methadone treatment in Scotland, clarifying what current services can and cannot achieve and what additional service elements and processes are required to maximise effectiveness. It concludes with recommendations to ministers outlining key actions for Scottish treatment services, local commissioners and the Scottish Executive. The paper was considered by SACDM in May 2007 and members' comments incorporated into this report.

Detailed consideration of social care elements of the treatment and rehabilitation of substance misuse is beyond the scope of this paper. However, it is acknowledged that medical treatment (including methadone replacement prescribing) should, whenever possible, be delivered as part of a comprehensive and integrated process of care, delivered by statutory (Health and Social Work) and voluntary sector partners, to clear standards and reflecting local strategic plans and governance arrangements. An overview of the key elements required to deliver optimal care is contained in Section 5 – “What should services be like?”. A Glossary of terms is included in Appendix 6.

1.2 Methadone treatment in Scotland - history and evidence base

Replacement prescribing with Methadone forms the main plank of medical treatment for opiate dependency in the UK, reflecting a comprehensive and evolving evidence base which consistently demonstrates the effectiveness of methadone in delivering positive outcomes in a complex and demanding population.

1.2.1 History

Drug Dependency Units were established in the UK in 1968, providing Methadone treatment for the small number of known heroin users. In the 1980s, a rapid rise in heroin availability overwhelmed services. Treatment services were reconfigured and began delivering a largely drug-free approach with minimal medical support. The arrival of HIV in Scotland changed this. The McClelland report of 1986¹ advocated urgent reappraisal of services, establishing pilot needle exchanges and methadone substitute prescribing clinics as a matter of urgency – introducing strong support for “harm reduction” approaches which would be formally accepted as the basis of treatment strategies in Scotland from 1994². In the 1990s, as methadone prescribing expanded, its benefits in the Criminal Justice arena were recognised and Criminal Justice services incorporating methadone programmes were developed³. In the 2000s, concern has returned to Blood Borne Virus infection with clear associations between

Hepatitis C and injecting drug use maintaining pressure to increase availability of methadone prescribing to reduce drug-related harm⁴.

1.2.2 Guidance and good practice

Replacement prescribing to such large numbers of drug users is therefore a relatively new phenomenon and guidance to prescribers has evolved considerably over some 20yrs, reflecting the developing confidence in the harm reduction approach and positive evidence base. In 1984, the first UK national treatment guideline⁵ included methadone as a short-term treatment to be followed by detoxification. In the 1991 guideline⁶ methadone replacement prescribing was seen as a more long-term treatment and there was a clear expectation that all doctors should consider methadone when assessing opiate dependent individuals. The 1999 “Orange Guidelines”⁷ continued to promote this view, outlining improved standards regarding quality of assessment, treatment initiation and delivery as well as training and governance requirements for doctors at different levels in the care system. An evolving evidence-base identified optimal doses and promoted safe prescribing through improved clinical processes. An updated Orange Guideline will be available in 2007. This will state clearly that replacement prescribing should continue as the main medical approach for opiate dependency. It will also exploit the vastly improved evidence base to consider alternative medical treatments to methadone (eg Buprenorphine), psychological interventions along with assessment, care planning and delivery processes which aim to promote better outcomes and facilitate patient progress and recovery whenever possible. Robust clinical governance standards will outline training needs and appropriate quality standards for those delivering services⁸.

1.2.3 Effectiveness – the evidence base

Evidence from many international studies has established that, properly prescribed and adequately supported, methadone prescribing achieves harm reduction outcomes in opiate dependent patients. It is associated with reduced deaths, improved lifestyles and less criminal behaviour. A recent NICE Guideline has confirmed that methadone is the most cost effective medical intervention available⁹. The evidence base supplied by the key UK prospective study - NTORS¹⁰ - shows that all treatment modalities are effective. This work shows that users access many different treatments during their journey, making it hard to clarify what factors are most influential at promoting recovery and rehabilitation in any particular case. However, the international research evidence clearly shows that replacement prescribing with methadone is consistently associated with positive outcomes.

1.2.4 Care processes – responding to need and maximising outcomes

The 2007 Guidelines update reflects the complex nature of drug misusers attending services and clearly describes the processes of assessment and care planning within which any replacement prescribing should be placed⁸.

When assessed, many drug misusers are chaotic with complex needs. They are more likely to suffer mental illness than the general population and also experience considerable social instability. Though alternative medical options to replacement prescribing – such as detoxification - may be available (or even requested) at this stage, the nature of the presenting problems may make these abstinence-based approaches more hazardous or less likely to deliver a reduction in drug-related harm. Methadone prescribing offers an approach proven to deliver successful harm

reduction outcomes even in the most intransigent of cases as well as forming an important link between the drug misuser and service which has the potential to lead to change. It is for this reason that in most areas, methadone is seen as the appropriate initial treatment approach, offered to reduce the risks associated with drug misuse as well as to attract and retain vulnerable patients in services, giving an opportunity to engage the misuser in a therapeutic process which may lead to recovery.

Once established on methadone, progress from maintenance to detoxification and abstinence will depend on the misuser's circumstances and resources as well as the quality and range of services available. Achieving abstinence may be difficult for many and in cases where abstinence is an unlikely outcome in the medium term, life on methadone may not only be tolerable but positive, facilitating improvements in many areas of health, psychology and social functioning. Effective services retain users on methadone with the aim of addressing concurrent physical, psychological or social issues, ultimately intending to increase the likelihood of success should detoxification be seen as a realistic option in the future. Indeed research shows that treatment retention is strongly associated with positive outcomes.

In summary, replacement prescribing with methadone remains the main plank of medical treatment for opiate dependency in the UK. Harm reduction approaches, incorporating methadone treatment, have evolved rapidly in the face of blood-borne virus infection. It has also been seen to be effective in the Criminal Justice arena by reducing the need for imprisonment. Methadone is more cost effective than any other medical treatment for dependency, though other effective interventions should be part of any comprehensive programme, improving patient choice. Outcomes improve if delivered with associated counselling interventions and these should also be standard. The challenge with methadone is to optimise delivery of harm reduction whilst ensuring that progress to recovery is encouraged, facilitating a way out of methadone treatment whenever appropriate.

1.3 Areas of Concern around Methadone

Despite the very strong evidence that it is a treatment that can deliver significant benefits in the management of opiate dependent individuals, aspects of methadone prescribing raise concerns in society and are also debated amongst clinicians in the field. Popular concern has been raised that some misusers on methadone appear to be no different from untreated misusers – continuing to use illicit drugs freely, involved in ongoing criminal activity, struggling with social hardship and family breakdown and failing to achieve meaningful employment. Some suggest that methadone is the only treatment offered to the majority of substance misusers – when alternatives, which may meet their needs better, are unavailable locally. If valid, such limitations may be underpinned by a philosophical debate regarding the relative merits of harm reduction versus abstinence-orientated treatments – a debate which can affect the ability of methadone prescribing services to offer robust programmes which facilitate progress and recovery. There is also considerable variation in how methadone services function across the country. In Scotland while hard outcome and activity data is generally unavailable, published local research suggests that delivery of methadone treatment may be less successful than elsewhere with poorer harm-reduction

outcomes and less progress towards a drug-free lifestyle¹¹. These concerns are discussed below.

1.3.1 Prescribing Philosophy

Concern has been raised that in some areas in Scotland methadone is prescribed not as an aid to recovery but as a de facto lifelong prescription with some doctors and services actively resisting detoxification or progress to a drug-free lifestyle. Such rigid philosophies would not truly reflect the evidence base which acknowledges that patients are individuals and require personalised programmes of care, delivered by skilled staff to achieve the best outcomes. In Scotland, this inconsistency of approach may mean that, for some, methadone has become a long term (even lifelong) treatment when more comprehensive services or treatment approaches may offer more misusers the opportunity to progress to a drug-free lifestyle.

1.3.2 Scale of its Use – impression of excessive use of methadone in Scotland

There is a perception that methadone has become the default treatment for drug misuse problems in Scotland today. The national prevalence study in 2003 estimated a Scottish prevalence of 51,582 opiate or benzodiazepine misusers¹². The Scottish Executive estimates that 18,017 (34.9%) were receiving methadone in 2003, though, no definitive audit of drug users in treatment has ever been carried out in Scotland. The prevalence study also reviewed drug treatment databases in every council area in Scotland and identified a total of 18,037 individuals in treatment. Approximately half of all drug misusers are thought to be in contact with services in England¹³. If the proportions were similar in Scotland, these figures suggest that a very high proportion (~70%) of all Scottish drug misusers in treatment are prescribed methadone. This supports the view that methadone is the main treatment available in Scotland and that few substance misusers are accessing any alternative. This may reflect appropriate treatment decisions – and therefore be a success in terms of engagement - but alternatively may be a result of limited availability of alternative treatment options.

1.3.3 Variation in delivery

1.3.3.1 Lack of data on exiting methadone – impression that few become drug free

There is a lack of robust information on the number of drug users who successfully come off methadone once prescribed though some (unpublished) research has found as many as 11% free of all drug 5 years after commencing methadone treatment¹⁴. This may reflect the difficulty in measuring such change. It can however lead to the impression that, while methadone services have successfully increased the numbers of drug misusers in treatment, in line with Scottish Executive objectives, in some areas insufficient attention (or resources) has been given to getting people to the stage where they can contemplate life without drugs. If this is the case, some Scottish methadone treatment services become a one-way road which brings people in but does not deliver progress to recovery or offer this option when the misuser is ready to progress.

1.3.3.2 Variation in prescribing practice - dosage prescribed and duration

There is anxiety that there is no clear and consistent practice in relation to methadone prescribing in Scotland with variation in practice regarding methadone prescribing standards. Whilst there are published guidelines on the most appropriate dosage range

there are indications that there are doctors who are consistently prescribing well below or in excess of them despite concern from fellow clinicians in the field that this is inappropriate. There is also wide variation in the duration of methadone prescribing with some areas in Scotland favouring relatively short periods and others opting for long term maintenance prescribing. Finally, there are key treatment environments in which appropriate treatment may be harder to access - examples include the criminal justice services (prisons and police surgeons) or general hospitals.

1.3.3.3. Leakage and Supervision – different standards of work/delivery

The level of leakage of methadone and nature of supervision of methadone consumption varies enormously across Scotland (ISD). There have been cases where leakage has been linked with methadone-related death. This can create public and political anxiety as to how well controlled and safe methadone prescribing actually is. Clinically there continues to be a debate regarding the relative benefits of supervision (increased community safety) or “take home” (promotes a return to normal life and responsibilities, facilitates employment etc) reflected in differing local policies.

1.3.4 Effectiveness of methadone treatment in Scotland

1.3.4.1 Achieving Abstinence from illicit drugs – failure to demonstrate objective progress

The Drug Outcome Research in Scotland (DORIS) study has found that compared to England (as evidenced in results from the National Treatment Outcome Research Study - NTORS) fewer drug users in Scotland achieve abstinence nearly three years after starting treatment¹¹. In NTORS ~35% of drug users receiving residential rehabilitation were abstinent (apart from prescribed methadone) for at least 90 days at their two year follow up interview compared to 25% of those treated in the community. In DORIS, 33% receiving residential rehabilitation were drug free for the 90 day period nearly 3 years into their treatment compared to only 11% of those treated in the community. Only 6.6% of drug users in the methadone arm of the DORIS study were totally drug free (ie had progressed off methadone – though still using Cannabis) after nearly three years in treatment. Another (unpublished) study, however, found that 11% of those on methadone were free of all drugs at five years, while 77% were free of illicit drugs¹⁴. These research studies do vary in some aspects of methodology and require careful interpretation. However, the differences described may reflect real variation in practice across the country - including philosophy, delivery of care or lack of services (eg employability services) supporting the route out of methadone - and thus merit further investigation.

1.3.4.2 Impact on criminal activity

There is clear evidence that methadone has assisted in reducing the frequency of offending by substance misusers and this has been supported by some Scottish research¹⁴. However, some Scottish research has shown that approximately 80% of those on prescribed methadone are still committing crimes¹⁵.

1.3.4.3 Topping Up

There is concern that a substantial number of drug users are topping up their methadone prescription with illegally obtained additional drugs. Within the DORIS study 70% of those on methadone reported supplementing their prescribed drugs.

There are indications that this may reflect sub-optimal dosing of prescribed methadone or other limitations in some local methadone programmes.

1.3.4.4. Safety of children

There is concern across the UK that the process around methadone prescribing practice could be failing to reduce risks to children. There has been a drive to increase services' concerns around risks to children^{16,17} but recent Scottish research shows that little valid information is known by treatment services about child care responsibilities of substance misusers¹⁸. There have been a number of cases in Scotland where children have been able to access or been administered methadone prescribed to their parents or siblings. This implies that, in some cases, take home methadone is being provided without adequate risk assessment or assurances regarding safe storage.

In summary, concern around Scottish methadone treatment focuses on: **Prescribing philosophy** – some service philosophies may not balance harm reduction and recovery-based approaches; **Limited treatment options** – basic national data is unavailable. Estimates suggest that the majority of those in treatment for substance misuse in Scotland are on methadone. This may be at the cost of other treatment programmes in some areas; **Variation in practice** - there is variation in delivery of methadone across Scotland, particularly dose, duration and availability of supervision; **Effectiveness of service** – when compared to UK, Scottish research suggests that Scottish methadone treatment may be less successful at achieving positive outcomes in some areas; **Safety of children** - there continue to be rare, but tragic, examples of children consuming their parent/sibling's methadone despite clear guidance and advice regarding professional responsibilities and risk assessment.

1.4. Current Scottish services – description and performance

Other elements of the review process have gathered information on what treatment services are currently available in Scotland. The information collected is presented in the report “Review of Methadone in Drug Treatment: Prescribing Information and Practice” and findings from a consultation of service users, carers and frontline workers.

Methadone Project Group survey of service providers

For the purpose of this report, The SACDM methadone project group asked all Scottish drug treatment services to supply any data from local audit or research activity which could give an assessment of the nature of delivery or effectiveness of methadone services. This was very much a pragmatic approach to inform discussions in a very tight timeframe. A list of responses received is included in Appendix 4.

Most Scottish services did not return any material though some information was returned by services from five NHS Board areas. Some service leads contacted the group less formally, describing their attempts to demonstrate outcomes and the challenges they faced. Those who responded largely sent information on process though some were able to describe harm reduction outcomes in a few specific services. It is likely that those responding represent those services where staff are actively considering these quality issues and who also have dedicated resources

committed to aspects of clinical governance. Often these will be services specifically commissioned for a purpose – eg DTTO – where resources to support evaluation are included in commissioning. Findings of the survey are described below. This section ends with a description of services where aspects of delivery could be seen as examples of good practice. The full text regarding these is contained in Appendix 5.

1.4.1 Information on effectiveness – activity and outcomes

Some services supplied activity data. The health department report suggests that services in many areas in Scotland now collect data associated with the monitoring of the new GP contract. However little information was supplied. These data are generally not collected in any uniform way and for the majority it is not clear to what use these data are put. Lothian's annual report comprehensively describes their NES and its performance. Others supplied examples of their prescribing policies, care processes or paperwork. Regarding outcomes or effectiveness there was little hard evidence available from any service and no recent published work. There were two audits of a reasonable standard supplied (200 and 30 patients respectively). The group was also made aware of at least four other substantial audit projects in Scotland of service users addressing, process, outcomes and users' perceptions of their care. In all these cases data had been collected but the project was awaiting either data entry into a database system or analysis. Resources/priorities are delaying services' ability to report on these data.

1.4.2 Care processes

Some respondents sent examples of their assessment protocols. For most areas there was little evidence put forward to show what use might be being made of any assessment information as part of a care planning process in treatment services.

1.4.3 Examples of good practice

The survey identified that in some areas in Scotland, aspects of service delivery could be evidenced as being examples of good practice. Services that responded were actively addressing at least one area of quality practice in terms of: Policies and procedures; standards and audit; process of care delivery; information systems; outcome measurement.

(i) Policies, procedures and clinical governance

All services should work to clear policies and procedures which describe in detail the processes undertaken when considering the delivery of treatment. It is essential that, in the area of substance misuse, where prescribing may be delivered by doctors of differing experience and training in diverse settings all prescribers are encouraged to work consistently. Finally, all NHS systems have clear clinical governance and accountability processes. Substance misuse services must ensure they are included in this process. Group members are aware that some services have led the way in such developments while other services do not prioritise this activity.

Tayside substance misuse services (TSMS) has developed a comprehensive package comprising – prescribing protocol; associated standards and audit tools; paperwork relating to treatment agreements; information sharing, prescribing, tolerance testing and review of progress. The protocol is due for review this year and as a member of the East Central Scotland Addiction Services Managed Care Network (with NHS Fife and Forth Valley services) TSMS will be undertaking this process with its MCN

partners to improve efficiency and consistency. *NHS Grampian* and its ADAT partners have convened a multidisciplinary group, the Clinical Effectiveness and Reference Group for Addictions (CERGA), with membership drawn from Public Health, General Practice, the specialist Substance Misuse Services, Pharmacy and the University of Aberdeen. The remit is to inform the service of clinically effective approaches, and ensure development is informed by the most up to date research. A formal agreement with the University secures academic time to provide constant updates on the research evidence.

(ii) Standards and audit (including numbers in treatment)

With clear procedures in place, local service managers and commissioners must ensure that clinicians are adhering to this system of quality care. Doctors often work eclectically but at the very least, should be prepared to justify why their practice falls outside the norm. Managers and commissioners should be prepared and empowered to challenge inconsistency. Contracts and clinical governance processes are key levers.

Lothian National Enhanced Service (NES) is supported by a rigorous governance process which encourages GPs to treat substance misusers in a consistent manner. A monitoring group oversees practice regarding – prescribing within minimum standards; Hepatitis B screening and immunisation and “best practice” factors – eg around hepatitis C and HIV. GPs contact with patients is monitored and they are encouraged to assess progress using the Christo inventory annually. Six monthly audits are carried out. Underperforming practices are identified and offered additional support which is usually associated with improvements in standards. *NHS Grampian* has a detailed service specification for a locally enhanced GP service (LES). Data is routinely abstracted on numbers in treatment, numbers discharged and reasons for discharge. The University of Aberdeen is being commissioned to undertake a detailed review of the quantity and quality of services being delivered under the LES.

(iii) Process of care delivery

There is clear evidence that treatment effectiveness can be enhanced if methadone is delivered as an element of a coherent care pathway involving wraparound services addressing psychosocial aspects of care. For services which developed in a harm reduction environment it can be a challenge to reorganise to address both harm reduction and recovery needs. This requires a robust process of leadership and commitment – and usually substantial investment from commissioners.

Glasgow Addiction Services has undertaken significant redesign and expansion over recent years to offer a more comprehensive range of approaches delivered in a highly integrated service design. The stated aim is to deliver more assertive services. They have increased access to psychosocial support services - with over 90% of all methadone-prescribed people in receipt of such input – and have improved access to other social interventions around homelessness, training and work opportunities. *Tayside Substance Misuse Service* has redesigned its methadone prescribing service to address a range of performance issues. Key features of the new service are an increased capacity, agreed standards of accessibility, a clear care pathway for those requiring medical treatments – with associated standards – and a new service design with two discreet service elements - one offering assessment, initiation onto methadone/alternatives and stability; the other (a partnership between NHS and Voluntary sector) offering more rehabilitative services with the aim of moving

misusers on into recovery. In *Lothian*, locality clinics were set up to support GP practices in the management of drug misuse. These clinics bring together GPs, CPNs from the specialist drug service and non-stat drug workers within one integrated team, to provide a comprehensive medical and psychosocial/counselling service to newly presenting or chaotic drug users. The clinics take referrals from primary or secondary care, the criminal justice system including SPS and the non-stat sector. These clients are offered intensive assessment, support and care over a 3 month period. The aim is to achieve harm reduction, stability and cessation of illicit use, with methadone treatment often being central to this. Clients are then discharged back to the care of their own GP, with on going support and key working from the non-stat drug agency as needed.

This service actively fosters strong working relationships with the non-stat sector, promoting skill sharing, cross referring and joint working.

(iv) Information systems

Methadone prescribing may involve many professionals each of whom needs to be linked into a care planning and delivery process to ensure safe delivery of care. There is always the potential for prescribing to be duplicated or errors to occur. If misusers cross service interfaces (eg primary/specialist care or community/prison) this can become a serious risk. Misusers may also have difficulties ensuring care is continued in a timely fashion. Recent concerns around child safety increase the need for robust, real-time systems to allow information sharing.

In *NHS Tayside* the Dundee LHCC has supported the development of a real time Intranet-based methadone prescribing database. This system aims to give those with access rights (specialist services; GPs; pharmacists – potentially SPS/Police surgeons) access to live prescribing and dispensing information as well as a messaging system to raise alerts etc. *NHS Grampian* has developed a computerised database which captures information and outcomes generated by the Single Shared Assessment and Review system across 23 dimensions of drug/alcohol use and health and psycho social issues. The database is currently being piloted in Aberdeen City and full roll out is anticipated over the next year.

(v) Outcome measurements

Some criticism of methadone services reflect an inability to demonstrate consistency of practice and achievement of the key outcomes despite substantial investment. Services and their commissioners must deliver systems which can show effectiveness. This requires local systems to be more innovative and consider links with those in the NHS managing population data (eg in public health) or local academic institutions.

Lothian DTTO shows how a simple process of data collection can be effectively delivered in a clinical setting to supply useful information on effectiveness. *NHS Ayrshire Addiction Service* routinely completes Christo inventories to assess progress. As was reported by many services – resource limitations allowed them only to supply a brief report, pulling out broad themes from their data. *Lothian low threshold service* aims to attract people into services, reduce harm and help these individuals (many of whom do not engage with other more traditional services) to move onto core services or even detoxify. Their robust data shows objective improvements in drug use, risk taking and impact of drug use in the lives of those attending these services.

Glasgow and Lothian services supplied research papers which aimed to demonstrate impact of methadone treatment on outcomes. These reports show that links between NHS services and academic institutions may offer an opportunity to commit resources to more rigorous objective assessment of outcome. *NHS Tayside* services have formal links with the University of Dundee and are exploiting these links to support the development of substantial data systems which will ultimately supply prospective data on outcome. These links are actively supported and funded by the Tayside NHS Board and its associated structures. *NHS Grampian* has also exploited such relationships.

1.4.4 National information

Scottish information reflects that available elsewhere in the UK. There are a number of processes which as part of routine data collection gather information on service activity. Examples include the SMR25, waiting times database and DAAT Corporate Action Plans. All have significant limitations and interpretation of these data requires caution. None were established with the objective of measuring outcomes (harm reduction or abstinence) or recovery rates, instead focussing on entry to services and numbers in treatment. Plans to expand the Substance Misuse Database to allow identification of substance misusers' data - and therefore linking to follow-up data - are developing. New contractual arrangements (eg NES) offer further opportunities to improve outcome measurement.

Some data are available but require careful interpretation. The prevalence of problematic drug use in England is approximately 60% that of Scotland, while ring-fenced funding for drug treatment allocated by central government in England is comparatively generous. In 2007/08 funding allocated in a pooled budget from the Department of Health and the Home Office in support of community based treatment in England is £373.3 million, targeting an estimated problematic drug using population of 327,466 [2004/05 figures]. The May 2007 NTA Board meeting performance report shows that pooled funding in England has risen to £385m, total funding is £640m and total numbers in treatment are 206,285. Comparable Scotland figures are £23.7 million allocated in 2007/08 to target an estimated 52,581 problematic drug users [2003 figure]. Estimates of numbers in treatment in Scotland are unreliable. The 2003 Prevalence Study estimated 18,037 in treatment from service returns¹².

In summary, a few Scottish services supplied helpful information on various aspects of their methadone treatment programme and notable examples of good practice were recovered in the areas of accessibility, treatment processes, quality and standards and outcome measurement. The information generally available however, is limited, inconsistent and cannot be generalised. Despite Enhanced Service contracts with GPs even basic activity data would appear to be hard to retrieve in most areas and is not comparable across Scotland. Some services had carried out audit work – sometimes with large databases containing clinical data - but many reported being unable to analyse their data due to prioritisation and resource issues. Links with academic institutions appear to be helpful. National statistics are extremely limited, focussing on accessibility and making no attempt to assess outcomes or recovery. As in the rest

of the UK, in Scotland no definitive statistics are available regarding the numbers of misusers on methadone prescriptions. There may be a significant difference in funding available in England and Scotland.

1.5 Child protection and substance misuse

Our collective responsibility to care for and protect children is embedded in the report of the national audit and review of child protection, 'It's Everyone's Job to Make Sure I'm Alright'¹⁹. Other reports, 'Getting Our Priorities Right'¹⁶ and 'Hidden Harm'¹⁷, highlight the particular issues that confront children affected by substance misuse. This large area of un-met need had hitherto been largely unidentified.

In response NHS boards have developed local inter-agency guidelines to enhance and standardize practice across a range of agencies. This welcome development has obvious resource implications for service providers and many services are now labouring under increased workloads due to this intensive additional work. Prioritising this activity impacts on the capacity of services to respond to other service user needs. This can be seen, in particular, in General Practices in disadvantaged areas, where anecdotally Health Visitors are now routinely able to offer little more than a child protection service. Substance misuse services constantly face challenges in terms of capacity and their ability to deliver of a full range of treatment options. Child protection issues have added considerable pressures to these struggling services with little identified resource allocated to support delivery. A well co-ordinated response from integrated health and social care agencies is required and should be a key action in all ADAT areas. Specific areas for action may include: redistribution of Health Visitors in line with Hall 4 recommendations; augmenting the provision of day nursery places; addressing the paucity of statutory services for the over 5's. The issue of poor inter-service communication needs to be addressed – an essential element being the development of appropriate integrated or linked IT systems, to facilitate data sharing.

In summary, there is now clear guidance for professionals regarding their obligations in terms of child protection – especially in families affected by substance misuse. This guidance and associated standards has been supported by development of child protection services but has created considerable pressure on treatment services with no associated increase in capacity. This phenomenon impacts on prioritization of services which some areas are struggling to manage. There is a need for action to increase services' capacity to manage these pressures.

1.6 What should services be like?

Medical interventions for substance misuse should be part of a coherent integrated range of services – both medical and psychosocial - which meet the changing needs of substance misusers through their journey to recovery. Harm reduction is the initial goal. The pace of progress will depend on individual circumstances. Assessment; care planning and monitoring of progress are key elements in the delivery of effective methadone prescribing¹⁰. The National Treatment Agency (NTA) has published advice on models of service delivery and audits of services focusing on consistency of

practice^{20,21}. The SACDM integrated care subgroup is addressing coordination and integration of care²².

1.6.1 Medical interventions

1.6.1.1 Replacement prescribing

Replacement prescribing should be readily available and delivered to a high standard in all areas. Methadone remains the first line treatment. Buprenorphine may be considered for some patients and other suitable products should be assessed for specific user groups as they are introduced and evaluated. Treatment is delivered through Primary or Secondary Care services based on local agreements. Services should exploit the opportunities presented by Non Medical Prescribing (NMP) to improve patient access. Supervised self administration (SSA) is critical and should be commissioned to best meet local need. SSA allows pharmacists to provide additional support and services²³.

1.6.1.2 Detoxification and abstinence/relapse-prevention services

Access to community or residential structured detoxification programmes should be available²⁴. These should be followed by structured relapse-prevention programmes including naltrexone prescribing where appropriate²⁵. Such programmes are not without risk and must be targeted to appropriate individuals and incorporate risk assessment. They must be delivered as part of a comprehensive programme including skilled counselling and practical support.

1.6.1.3 Medical/Psychiatric care

Services should offer access to medical/psychiatric assessment and care as required.

1.6.2 Non-medical interventions

1.6.2.1 Care planning, practical support, counselling, and psychological interventions

Medical interventions should be delivered as part of an agreed care plan. All aspects may be delivered by the GP in an uncomplicated progressing case – but may still require a keyworker. Support to deal with housing/family issues or social pressures requires skilled social care staff. Counselling improves outcomes but requires skills, governance and supervision to maximise effectiveness²⁶. Psychological/psychotherapeutic interventions should be targeted in most cases and require highly skilled staff working in structured settings. More behaviourally orientated approaches may form the basis of service delivery systems and positively influence outcomes^{27,28}.

1.6.2.2 Structured, intensive day care and community based rehabilitation services

Programmes should offer access to services offering structured rehabilitative work in a non-residential setting. These services focus on reduction of reliance on prescribed medication and professional support, promoting stability, recovery and progress towards abstinence. Employment/educational/training opportunities are key elements, having potential to improve the impact of prescribing interventions.

1.6.2.3 Residential Rehabilitation

Residential rehabilitation incorporates a diverse range of facilities which offer a long term approach to address substance misuse. There is huge variation in what is

available in terms of philosophy, quality, demonstration of valid outcomes and cost. These facilities generally cater for people at the detoxification stage who are actively contemplating a drug-free lifestyle. Services must ensure that referral to such a facility is an appropriate option for the individual. Evidence is sparse regarding effectiveness though it is clear that such interventions bring benefit to suitable candidates¹¹. Increased use would bring significant financial pressures on existing local funding systems and would require planning. A Scottish Executive report has shown rehabilitation facilities to have a high drop out rate (40% at 3 months) and identified that success relates to ability to meet individual need and availability of aftercare²⁹. An audit of Scottish specialist doctors referring to such facilities showed that there was huge variation in practice across the country. NHS Boards had different systems for commissioning places and different budgets in place. Few doctors had knowledge of effectiveness of the facilities to which they referred. Referral seemed to reflect mainly patient choice³⁰. Comprehensive assessment will promote effective use of residential rehabilitation which should be available as a planned and integrated intervention, usually for those who have constructively utilised all available community strategies to achieve abstinence without success or who do not meet the criteria for community services and have identified residential rehabilitation as a viable option in their circumstances. A National commissioning strategy may help – residential care needs to be available across Scotland and not just based in the central belt. It also needs to be cost effective – but also financially attractive to the voluntary and independent sector to deliver.

1.6.2.4 In-patient services

Recent National Treatment Agency (NTA) and Specialist Clinical Addiction Network (SCAN) reviews considered the place of specialist NHS in-patient facilities in the management of substance misusers^{31,32}. Though evidence is sparse, there are areas of care which are optimised by having access to such facilities. These include: management of complex cases; detoxification; rapid induction onto replacement prescribing programmes; assessment and management of physical health problems.

Access to specialist in-patient provision adds to the range of services available. They must be delivered as part of a care continuum and admissions followed up by throughcare – via community based structured day services. In much of Scotland, where dedicated beds have been decommissioned, development of these facilities would present significant cost-pressures which could easily cause an imbalance of services. Local commissioners would require to carefully assess the potential impact of such developments on their core services.

1.6.3 Optimising systems of care

Delivery of optimised medical and non-medical interventions requires clearly defined processes of care delivered by integrated services – ie involving NHS a social care agencies working in a person-centred needs-led way. This process includes initial assessment of need (through single shared assessment)²² care planning/review – and identification of individual ‘key workers/care managers’^{20,21}. Governance arrangements must be in place – including adequate training and supervision of staff, quality assurance, standards and audit to ensure quality and consistency of practice.

In summary – though long term methadone prescribing is often an appropriate intervention, especially during initial stages of treatment, services cannot simply deliver harm reduction and retention on a methadone prescription. Services must become more aspirational and challenge commissioners to develop services which genuinely aim to promote recovery and help to rebuild lives. This implies that alongside the delivery of key harm reduction outcomes, services offer a continuum of care through recovery, managed by a robust care planning process to ensure that those in treatment receiving optimal care matched to their needs. Services must demonstrate achievement of a continuum of outcomes - reductions in illicit use and associated risks; improved social functioning (including genuine training/ employment opportunities); reduced criminality; improved health; abstinence; improved public health outcomes and community safety. This requires well governed integrated services – incorporating medical and social care services in both statutory and voluntary sectors - delivered by appropriately trained, skilled and compassionate staff.

1.7 Summary: Challenges for the methadone programme in Scotland

Harm reduction approaches - incorporating replacement prescribing – appropriately form the basis of treatment programmes for substance misuse in the UK and the developed world. This is supported by a comprehensive international evidence base which underpins clinical guidance for prescribers. In the UK, Methadone is the most cost-effective treatment available. Methadone prescribing is more effective if delivered as part of a process of planned care, especially if psychological interventions are included. Other medical treatments - focussed on achieving a drug-free state - are also supported by evidence. However, drug misusers carry a high risk of premature death and all interventions should be targeted to ensure they will best meet need and will not paradoxically increase risks. As these individual needs change review of progress and re-setting of goals ensures the best match of service user to treatment and is likely to deliver the best outcomes. Such approaches are in keeping with national guidance.

In response to the threat of blood-borne virus infection, Scotland's strategic approach to substance misuse has embodied harm reduction since 1994. The Scottish Executive has invested considerably in service developments for substance misusers and has set clear objectives to ensure rapid access to treatment - specifically measuring numbers in treatment and waiting times. Services have responded to this challenge. However, there has, to date, been little focus on the next stage - progressing those who are suitable towards a more active recovery process. Concerns about lack of availability of alternative medical treatments, consistency of practice, child safety and the ability of services to deliver specific outcomes has stimulated a debate, focussing on how to constructively appraise methadone prescribing services across Scotland and deliver improved outcomes in keeping with national strategic objectives.

It is clear that there are examples of good practice in Scottish treatment services. However, most services struggle to demonstrate the extent of their activity and few collect usable outcome data which could show effectiveness. It is also clear that there are inconsistencies across Scotland regarding what services are commissioned, how they are governed and how they deliver methadone services as part of a locally integrated system of care which can address harm reduction and recovery needs.

In the next section, we will address what can be seen as gaps in provision of Scottish treatment services and will identify actions for services, local commissioners and the Scottish Executive which will aim to address them. These gaps and associated responses can be considered in terms of:

- Improving accountability and performance management
- Quality of information available – the ability to demonstrate effectiveness of treatment services in Scotland
- Effectiveness of services – nature and consistency of practice across Scotland
- Integration of services – including availability of alternative medical treatments and care pathways
- Improved commissioning – lack of an effective and credible national and local strategic process/operational delivery system.

Section 2: Optimising methadone treatment in Scotland

This section will describe the areas which require attention and the actions required in order to improve the delivery of methadone treatment services in Scotland.

2.1 Gaps in Scottish service provision

There are a number of key delivery areas where it is clear that action is required to improve Scottish treatment services.

2.1.1 Improving accountability and performance management

There is a need to put in place a meaningful governance and accountability structure which is of relevance and which local systems are required to answer to through robust performance management systems

Accountability arrangements for ADATs are currently being reviewed in light of concern that ADAT performance must improve. An ADAT review in 1998 led to new accountability arrangements incorporating increased support for ADATs to upgrade support officers and improve effectiveness and that support currently runs at £2.2m per annum. More recently the SE put in place “performance contracts” to require ADATs to demonstrate effectiveness with regard to new funding. National standards and actions around waiting times and drug deaths have created further obligations with no obvious impact on performance.

Methadone prescribing is one area where effectiveness of ADATs – and the quality of their partnership arrangements – is reflected in local quality and performance. Medical services are managed by NHS partners and, unless locally coordinated in an accountable way, it is likely that there will be diversity of practice and delivery – even between the various service elements in a local ADAT area.

1.1 *There is an urgent need for the Scottish Executive Health and Justice Departments to work together* to put in place arrangements that cement meaningful accountability arrangements with key performance indicators relating to 1. new funding availability for services and 2. ADAT support. Ultimately this process should evolve to govern all spending of ring-fenced resources on substance misuse and should inform the accountability process for non-ring-fenced NHS and Local Authority resources. Key Performance Indicators (KPIs) should be developed and should include the ability to demonstrate coherent strategic direction; quality commissioning which requires reporting of outcomes and improvement plans for failing services.

1.2 *There is a need for the SE to consider improved governance arrangements - looking elsewhere in the UK* – eg the development of a new national body (similar to the National Treatment Agency (NTA) for England and Wales) incorporating elements of existing national bodies/processes (eg Quality standards; Scottish Association of Alcohol and Drug Action Teams - SAADAT) and funded through existing ADAT support resources. The NTA has seen improved performance from services in England but would require an innovative approach from the SE to address its current performance around this key cross-cutting agenda.

2.1.2 Improving quality of information – demonstrating effectiveness

Most services are unable to supply robust information regarding activity or effectiveness. Services are rarely evaluated objectively. There is a need to improve the coordination and impact of Scottish research in substance misuse treatment.

2.1 There is a ***lack of good quality monitoring/audit data*** on who is prescribed methadone, by whom, with what dosage, duration, and effectiveness in terms of improvements in risk-taking, motivation, social circumstance and level of dependency.

2.2 More broadly there is a ***lack of independent evaluation*** of the majority of our drug treatment services with which to assess the relative impact of individual services or combinations of services.

2.3 There is a ***need to improve the quality and coordination of Scottish research in this area***. A meaningful research strategy which considers treatment options and their delivery needs to be put in place, building on and coordinating the activity of Scottish researchers in the field. The (primarily) policy-based research which is currently commissioned does not appear to be part of a coherent programme. Coordination with other UK or international researchers and strategies should be improved.

2.1.3 Improving effectiveness of services

Services require to demonstrate that they are delivering comprehensive care within national guidance and to acceptable standards and that they are delivering ongoing benefits to all who are in receipt of methadone replacement prescribing.

3.1 *Philosophy of treatment services* and the outcomes expected by commissioners need to be clearly described locally and nationally in the relevant documentation (eg strategies, prescribing policies). While long-term methadone is required in many cases, this must not simply be a default position and if delivered must be associated with objective progress (both harm reduction and recovery outcomes) and based on an agreed and recorded care plan.

3.2 *Objective quality of harm reduction services must be improved.* Quality and effectiveness of services is inconsistent across Scotland. Outcomes are often hard to determine. Objective outcomes must be clearly recorded against an agreed care plan and should be the basis of a reporting system.

3.3 There is often a ***lack of a clear local strategy to manage the capacity of services***. This would involve continuous review of resource management to meet need and would include the requirement that access to methadone is linked with clear objective review of progress against agreed harm reduction and recovery goals and service performance indicators. If functioning optimally – but struggling to meet need – commissioners require to consider investment in services.

3.4 *Opportunities to embed quality agendas into prescribing/dispensing* through contractual mechanisms and opportunities (eg enhanced service contracts for GPs; Locally negotiated community pharmacy contract; non-medical prescribing) have not been capitalised on. Participation in such contractual arrangements should include a requirement to adhere to national standards alongside robust local clinical governance.

3.5 There is a ***lack of consistency and quality regarding information sharing***. Communication between agencies is inconsistent. This inevitably impacts on care planning and case management – and ultimately effectiveness.

3.6 There is a *lack of clarity regarding expectations of treatment*. This includes the service's expectations of those receiving treatment and the user's expectations of the service. We need to be much clearer with what aim treatment is being provided and what are the short term, intermediate and long term goals. This must be discussed and the treatment agreement recorded. An ongoing process of care planning is required to ensure services continue to assess need and respond as individuals' needs change.

3.7 There is a *lack of consistency in terms of users' and families' involvement* in the process. This impacts on choice of treatment options and may limit progress.

3.8 There is a *lack of choice for the service user in pharmacological treatments*. It must be clear what is locally available and why such prioritisation decisions have been made.

3.9 *There is a lack of adequately trained staff* to deliver comprehensive care packages. There is a need to ensure staff are appropriately trained in delivery of treatment programmes.

3.10 *Child protection must be a central element of service delivery*. Systems must be in place to ensure this is addressed.

2.1.4 Integration – methadone replacement prescribing must fit into a coherent, planned care package

Methadone replacement prescribing must not be delivered in isolation but must be offered as part of a coherent, planned care package. This must include opportunities to access essential “wraparound” services including services addressing psychological health and social aspects of recovery including education or employment.

4.1 There is *poor integration* between our medical (replacement prescribing) services, other - abstinence orientated - medical services (eg detoxification and naltrexone) and those additional - non medical - service elements (either in the community or within residential settings) eg counselling/wraparound services; care planning and integration of care around the user; availability of psychosocial therapies/moving on services/etc.

4.2 There is a *lack of availability of structured “wraparound” psychosocial care* services alongside prescriptions. This should include more effective working between drug services and training, education and employment services.

4.3 There is a *lack of care planning with associated goal setting and review of individual progress* in prescribing services.

4.4 There is *little evidence of effective engagement with self-help approaches*.

4.5 There is a *need to set basic standards regarding information-sharing* in clinical services

2.1.5 Improving commissioning – national and local strategic issues must be addressed

Commissioning of services along with associated governance and accountability processes requires to be effective nationally and locally.

5.1 There is a *lack of coherent leadership at national level*. SACDM's role and credibility have suffered in recent years. National strategy requires to be refreshed in a manner which increases credibility of governmental response. The decision to share

policy responsibility by Scottish Executive Health and Justice departments has helped neither service effectiveness nor integration. Services need meaningful feedback from Ministers/SE in order to improve their functioning alongside encouragement to be innovative and effective in service delivery – eg service integration or MCNs.

5.2 *Quality of commissioning is inconsistent.* National funding streams do not facilitate ADAT effectiveness. Local ADAT partnerships must demonstrate clear processes of needs assessment, targeted commissioning and evaluation and effective governance of resources. Funding for core prescribing services should reflect local need and delivery of acceptable performance against locally agreed outcomes in line with national targets. This should be subject to meaningful accountability processes. High demand can lead to reduced quality of care. Areas of high demand should have active plans in place to address waiting times as well as effectiveness of services in terms of outcomes and progress to recovery.

5.3 There is a ***lack of coordination and funding for audit/ governance activity.*** We need a national organisation using agreed tools for quality/process and outcome measuring. This must be reflected in local commitments to NHS clinical governance processes incorporating all relevant NHS elements – primary care; specialist services; commissioning.

2.2 Recommendations

There are clear areas for action at all levels – Scottish Executive (Health Dept and Justice Dept), commissioners of services, service providers - which require to be addressed if the delivery of methadone services in Scotland is to continue to be accessible while delivering improved outcomes.

This section describes headline and priority actions agreed by the SACDM methadone project group. Potential areas for pilots to be commissioned are identified - [*Pilots*]

2.2.1 Improving accountability and performance management

There is a need to put in place a meaningful governance and accountability structure which is of relevance and which local systems are required to answer to through robust performance management systems

- 1.1** The SE should consider at a high level their commitment to meaningful joint working regarding commissioning and accountability of substance misuse services. This must include consideration of the Scottish Executive's commitment to addressing substance misuse and the place of SACDM. If there is such commitment –
- 1.2** The SE should ensure reconvened SACDM and associated processes are effective and relevant and should ensure key processes – eg refreshing national strategy or specific strategic actions - have taken stock of expert opinions through an agreed and credible national advisory structure
- 1.3** The SE must address inconsistencies regarding Justice/Health Dept. approaches to accountability and governance and ensure priorities are aligned.
- 1.4** The SE should convene an expert group which may include ADAT Chairs/Lead officers, professionals from statutory (health, criminal justice and social work) and voluntary sectors along with key Substance Misuse Division and Health Department staff to bring forward options for the development and delivery of a

new accountability structure to address the long term failings, from SE to service level, of current arrangements. This body may mirror elements of the NTA. Its remit should be to create a firm accountability and governance structure utilising existing resources when possible as well as creating a national network requiring local partners to effectively use resources to improve governance and accountability; development of quality standards and KPIs around these services; development of and support for an evaluation, audit and research strategy.

- 1.5 The SE should consider development of a process which better facilitates high quality Scottish research into treatment effectiveness (including methadone).

2.2.2 Improving quality of information – demonstrating effectiveness

Most services are unable to supply robust information regarding activity or effectiveness. Services are rarely evaluated objectively. There is a need to improve the coordination and impact of Scottish research in substance misuse treatment.

- 2.1 The SE should set up *as a priority* a national methadone audit system (incorporating local data collection) which will annually report on methadone prescribing activity, quality and outcomes. A baseline audit should be delivered in 2007/8 OR Pilot sites may be supported in the development of robust quality systems *[Pilots]*
- 2.2 The SE should support local ADATs in the development of systems to capture key data, incorporating: development of an agreed national minimum dataset to monitor activity and outcomes; commissioning the development/modification of IT-based systems of data management which deliver key information to the services, ADATs and the SE. *[Pilots]*
- 2.3 The SE should *prioritise* the processes to ensure CHI numbers are captured on all GP and specialist methadone prescriptions and maximize compliance with the expanded Scottish Drug Misuse Database.
- 2.4 ADATs should identify how they will meet their responsibilities regarding implementation of the National Quality Standards in particular regarding arrangements for monitoring and evaluating services. *[Pilots]*
- 2.5 NHS services should be held accountable under local clinical governance processes to demonstrate they have agreed standards of care [2.4] and regularly audit against them. Nationally this should be part of the Corporate Action Plan (CAP) process and the NHS accountability review process

2.2.3 Improving effectiveness of services

Services require to demonstrate that they are delivering comprehensive care within national guidance and to acceptable standards and that they are delivering ongoing benefits to all who are in receipt of methadone replacement prescribing.

- 3.1 The SE should agree and clearly articulate the philosophy of care for Scottish services as part of the refreshed national strategy – this must address the need to maintain harm reduction as a key requirement but emphasise the need to promote recovery.
- 3.2 Delivery partners should ensure availability of clear local policies/procedures regarding prescribing – these should address issues of philosophy of care.

- 3.3 The SE should agree national standards regarding accessibility; range of services; waiting times; key aspects of care planning and delivery and desirable outcomes.
- 3.4 The accountability process must include a requirement that services deliver against agreed national standards OR can demonstrate credible mechanisms to address deficits identified in baseline data.
- 3.5 All ADATs should clarify how they aim to utilise the developing contractual opportunities (eg GMS National Enhanced Services; Community Pharmacy; Non-medical prescribing) to improve quality. Plans submitted should form the basis of ongoing ADAT accountability process. SE should consider opportunities to deliver and evaluate pilot projects regarding these key areas in areas of innovation.
- [Pilots]**
- 3.6 *Needs assessment* - SE should require all areas to undertake local needs assessment regarding information sharing process – availability of protocols and standards; performance; improvement plans. This needs assessment must address such areas as child protection and service interfaces (SPS; in-patient admissions)
- 3.7 *Information and contracts* - SE should require ADATs to report on the use of goal setting/contracts. ADATs should agree with service providers information requirements regarding what services are available and the processes associated with their delivery. This must include standards regarding timeframes and communication; process elements including review and care planning; accessibility of advocacy services and complaints procedures. ADATs should agree with service providers a mechanism which ensures there is agreement regarding treatment goals and procedures which is subject to regular review.
- 3.8 *Range of services* - Using existing evidence and national guidance the SE should develop national standards regarding what treatments should be available locally in a comprehensive care system. Local systems should make clear statements regarding availability of medical treatments – what is available and in what circumstances; associated processes and standards; what is not available and why. This should incorporate user information systems.
- 3.9 *Staff training* – Local systems must have clear staff development plans which are aligned with their strategic and operational objectives. National organizations (eg STRADA) should work with ADATs to deliver tailored training packages to meet changing needs.
- 3.10 *Child protection* – Local systems must have in place robust plans to ensure child protection performance is audited and meeting national standards.

2.2.4 Integration – methadone replacement prescribing must fit into a coherent, planned care package

Methadone replacement prescribing must not be delivered in isolation but must be offered as part of a coherent, planned care package. This must include opportunities to access essential “wraparound” services including services addressing psychological health and social aspects of recovery including education of employment.

- 4.1 SE should require ADATs to report on degree, nature and effectiveness of integration of services locally (incorporating work of SACDM integration sub-group)
- 4.2 SE should also address local delivery of “A Joint Future” through existing accountability processes

- 4.3 SE should require ADATs to have clearly articulated plan to address self-help element of recovery process and should report on progress as part of governance process
- 4.4 Services should be required to demonstrate that they have systems which support information-sharing between services/professional groups

2.2.5 Improving commissioning – national and local strategic issues must be addressed

Commissioning of services along with associated governance and accountability processes requires to be effective at all levels – SE/ADAT and NHS Boards/Services.

- 5.1 SE should explore options for delivery of improved clinical governance networks to enhance consistency of services – eg MCNs [*Pilots*]
- 5.2 SE should review funding streams and associated accountabilities to empower ADATs and facilitate improved effectiveness.
- 5.3 SE should exploit current structures – ADATs/SAADAT - to identify baseline in terms of nature and quality of local commissioning processes. SE should set basic standards regarding quality of commissioning and assess all ADATs against these standards. ADATs/partners should ensure membership is fit for purpose – including links with local medical structures – eg Area Medical Committees.
- 5.4 ADATs must demonstrate that prescribing services are commissioned in the context of their overall service model and are delivering on agreed KPIs
- 5.5 ADATs should be required to use ADAT support resources at least in part to deliver on improvements in quality and performance. This should be incorporated into the NHS clinical governance agenda and NHS accountability review process.
- 5.6 Services must supply ADATs with coherent and valid plans for managing demand. If they cannot the ADAT must develop and deliver a valid and coherent plan which will identify what processes are being undertaken to prioritize commissioning of services.

2.3 In conclusion

International evidence shows that Methadone works and in the Scottish context it is entirely appropriate for methadone to hold a position as the major element of the treatment available for substance misuse.

In Scotland services have responded to a clear strategic direction, rapidly increasing demand and concerns around waiting times to increase accessibility to methadone treatment programmes. These services often aim to deliver harm reduction but may not address broader aspects of recovery effectively. This approach, though understandable, may have had a negative effect on the development of more comprehensive and integrated services and may also have reduced investment in alternative treatment approaches such as detoxification.

Scottish services struggle to demonstrate quality, consistency of practice and crucially outcomes achieved. There are examples of good practice but, in the absence of adequate audit information, local research implies that some elements of methadone prescribing are less effective than elsewhere in the UK. National data systems are inadequate and currently cannot address these concerns robustly.

Actions are required by the Scottish Executive, ADATs and NHS Boards and services themselves to ensure that the current gaps are filled and that commissioners and services are encouraged to deliver improved comprehensive services which can demonstrate their effectiveness in terms of both harm reduction and recovery.

Priorities for action include:

- Developing a national strategic approach to the treatment of substance misuse
- Improving the consistency and delivery of a national approach to substance misuse – addressing the perceived splits and inefficiencies between the Health and Justice Departments of the Scottish Executive.
- Setting up a national accountability structure/body. This will deliver: increased ADAT empowerment and effectiveness; improved information; agreed quality standards; improved quality and range of services; an improved governance and accountability structure.
- Setting up a national methadone audit process to quickly ascertain numbers on methadone and their current state of recovery
- Supporting pilots of good practice in the areas of policies and procedures; clinical governance; standards and audit; information systems; processes of care; outcome measurement.
- Setting up a strategic process to facilitate and coordinate quality research into methadone treatment in Scotland.

Appendix 1 – SACDM Methadone Project Group membership

Dr. Brian A. Kidd (Chair)	Clinical Senior Lecturer in Addiction Psychiatry, Tayside Substance Misuse Services and Centre for Addiction Research and Education, Scotland, University of Dundee. SACDM member
Dr Ceri Barclay	GP Glasgow
Professor Christine Bond	Professor of Primary Care, University of Aberdeen. SACDM member
Dr John Budd	GP Edinburgh
Pauline Fox	Specialist nurse, Edinburgh
Neil Hunter	Joint General Manager, Glasgow Addiction Services
Mike McCarron	National Substance Misuse Officer, SAADAT. SACDM member
Professor Neil McKeganey	Director, Centre for Drug Misuse research, University of Glasgow
Dr. Roy Robertson	GP Edinburgh. SACDM member
Carole Ross	Scottish Executive Justice Department: Safer Communities Division: Drug Treatment and Rehabilitation
Ruth Whatling	Scottish Executive Justice Department: Analytical Services Division

SCOTTISH ADVISORY COMMITTEE ON DRUG MISUSE: PLACE OF METHADONE IN DRUG TREATMENT PROJECT GROUP

TERMS OF REFERENCE AND PROJECT OUTLINE

Background

1. In May this year the First Minister announced a review of the place of methadone in drug treatment. We are committed to taking this forward within a timescale specified by Ministers. There are three main themes to the review: Scoping the Issue; Reviewing Current Practice and Improving Current Practice. Work on some of these themes has already started.

2. We are “Scoping the Issue” by summarising the effects of international evidence on the effects of methadone for Ministers and collating information held by NHS Boards on the level and circumstances of methadone use in Scotland. Information from Boards includes the number of people receiving methadone treatment for drug misuse, the number of those on a daily supervised consumption regime and the number of those who receive methadone who have children under the age of 16 living with them all or part of the time. This work is nearing completion.

3. We are “Reviewing Current Practice” by gathering information from Boards about their own arrangements for monitoring the implementation of current UK national and any local clinical guidelines. On our behalf, the Scottish Drugs Forum is gathering views from service users and carers through focus groups, and from a wider selection of stakeholders through open meetings and a postal questionnaire. A report on this work is expected in late November. Scotland is represented on the UK-wide review group established to update the UK clinical guidelines which should finish work next summer.

4. There is already a large amount of ongoing work aimed at “Improving Current Practice”. Professional training funded by the Executive is being delivered by the Royal College of General Practitioners. National Quality Standards for Substance Misuse Services were published in September 2006. The Scottish Drug Misuse Database is being expanded.

5. The review is **not** about deciding whether or not methadone should be used to treat drug addiction. It is about building a picture of methadone use in Scotland from a variety of perspectives, indicating for Ministers where improvements should and could be made. It is important to stress that Ministers wish to be made aware of current practice.

6. This SACDM working group will form part of the review, by capturing the views of clinicians and other practitioners involved in treating people receiving methadone.

Remit

7. This project group would aim to:

- summarise current experience of methadone treatment across Scotland from the perspective of those who prescribe methadone and/or those who supply additional support to clients;
- summarise what additional support is currently provided to people receiving methadone treatment in different locations; and
- identify examples of good practice.

Scope and methodology

8. As this forms part of the review of methadone in drug treatment requested by the First Minister, the group should focus exclusively on the substitute prescribing of methadone. While comparisons would be interesting, the prescribing of other substitute drugs such as buprenorphine is outwith the remit of this work.

9. The project group will draw on their own experience and those of colleagues in their professional and other networks to build a picture of current activity and practice in Scotland, to describe both the benefits and the limitations of current methadone treatment. The group will need to consider how they wish to gather this information [by survey/questionnaire or other means.] The group will also need to consider whether there should be a focus on particular factors, such as dosage levels and supervised or take home doses.

10. While a definitive study of practice across Scotland could take many months, the purpose of this group is to provide Ministers with the most realistic ‘snapshot’ possible, while taking account of the fact that current practice of any treatment regime is by nature a dynamic process.

Key outputs

11. The key outputs of this project group will be as follows:

- A briefing paper for Ministers describing what support is available to those currently accessing methadone treatment and people’s experiences of providing this support.
- Practical recommendations for how service commissioners and service providers can improve that support.

Appendix 3. – References

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Appendix 4 – Response to SACDM Project Group service survey

General / Background

Drug Misuse Statistics Scotland 2006

<http://www.drugmisuse.isdscotland.org/publications/06dmss/06dmssb.htm>

National Quality Standards for Substance Misuse Services

<http://www.scotland.gov.uk/Publications/2006/09/25092710/0> Scottish Executive

Research by University of Aberdeen on Community Pharmacy services for Drug Misusers

<http://www.sehd.scot.nhs.uk/cso/index.htm>

National Investigation into Drug-related Deaths – research report and supporting information

(Scottish Executive).

<http://www.scotland.gov.uk/Publications/2005/08/03161745/17507>

Scottish Executive Report on Impact of GMS Contracts (April 2006)

(Scottish Executive)

Scottish Executive statistics on drug seizures, including methadone (January 2007)

(Scottish Executive)

http://www.drugmisuse.isdscotland.org/publications/abstracts/drug_seizures_04to06.htm

Waiting Times Information from Waiting Times Information Framework (March 2007)

<http://www.drugmisuse.isdscotland.org/wtpilot/reports.htm>

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Information gathered Locally on Outcomes

Lothian

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Contract between NHS Lothian and a GP medical practice for patients suffering from drug misuse. NHS Lothian.

Case Studies and Audit report for April-September 2006, Lothian National Enhanced Service for Drug Users, Edinburgh Homeless Practice and North Edinburgh Drug Advice Centre..

Glasgow

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Glasgow Addiction Services – Report to Scottish Parliament Health Committee. Nine case studies showing positive outcomes for clients prescribed methadone in Glasgow. (March 2007)

Shared Care Methadone Audit for Rutherglen and Cambuslang 05/06

Tayside

Medical Treatments for Drug Misusers in Tayside : Tayside Prescribing Protocol and associated governance documentation December 2005

Grampian

Contract between NHS Grampian and a GP medical practice for patients suffering from drug misuse. NHS Grampian.

Proposals for Quality and Audit of Drug Addiction Services in Aberdeen City.

Other sources

Ayrshire Christo Inventory for Substance – misuse Services (CISS) information (April – September 2006).

Scottish Association of Alcohol and Drug Action Teams. Methadone and Drugs Treatment. Statement January 2007.

Appendix 5 – Summaries of Examples received

Policies, procedures and clinical governance

Tayside substance misuse services supplied their prescribing protocol which covers all prescribing associated with substance misuse. This development was led by the specialist service in partnership with primary care (GPs, pharmacists and their representatives) and local ADATs. Once completed and signed off by all relevant bodies, standards were developed which allow the clinical governance facilitator to assess performance in terms of consistency and quality of care in all clinical areas. The facilitator post was prioritised by the services to ensure quality of care delivery. The package was introduced to the NHS Tayside clinical governance process – allowing the NHS to oversee prescribing practice in all sectors. The service now reports annually on performance to the NHS Board. The protocol has improved quality of care – with initiation of all prescriptions following comprehensive assessment and care planning and prescribing of methadone only proceeding with associated keyworking (wraparound) services.

Introduction of the protocol (and associated clinical governance processes – training for GPs; improved communication with pharmacists) has resulted in objective improvements in local care – for example, methadone leakage (previously highest in Scotland) has reduced significantly.

Standards and audit

The Lothian nGMS Contract- elements required for National Enhanced Service (NES) for drug users – NHS Lothian. The contract devised by NHS Lothian contains a simple but comprehensive description of what is required to deliver good practice to patients suffering from drug misuse, in an accountable way.

- It sets out things that need to be already in place – such as an accurate register of patients, good links and liaison with all other relevant agencies and services and systems to record prescribing, interventions and review.
- Funding provided though the contract is expected to deliver care for patients which is in line with guidelines, provide a range of treatment and support, taking account of co-existing physical, emotional, social and legal problems wherever possible, audit and training.
- An annual review, which includes assessment of outcomes is clearly part of the contract, as well as clinical audit of prescribing and prevention of blood borne viruses.
- The skills of the practitioner to assess, advise, test and treat patients are defined, including working in an appropriate multidisciplinary manner.
- GPs receiving funding to treat drug misusers are expected to identify and meet appropriate training requirements.

The contract also contains a ‘checklist’ of key requirements such as adherence to local and national guidelines, submission of records to the Scottish Drug Misuse database, audit requirements, prevention and care of associated viral infections, outcomes for patients using the Christo Inventory process and recording.

The contract also draws attention to the importance of having systems to record dependent children and sharing information with other professionals.

NHS Lothian has also been monitoring the level and quality of delivery of services under NES arrangements. Through this NHS Lothian is able to identify the number of drug users in treatment, the number of times they see their GP annually about their drug use. For patients receiving methadone the total number and those being supervised are known, together with the average dose they receive. There has been an increase in the numbers of patients being drug tested during treatment. Immunisation or testing for blood borne viruses has increased since the start of the contract. Evaluation of outcomes, using the Christo Inventory assessment tool is now used by 86% of practices, compared to only 27% in April-September 2004.

The audit also identified practices who have difficulty maintaining standards, who should then be visited by the Primary Care Facilitator Team with follow-on audit data to confirm that appropriate changes had taken place.

The Lothian Harm Reduction Team offers a comprehensive programme of care ranging from intensive support on a daily basis through a weekly programme with a Community Psychiatric nurse to low level support. It regularly monitors and evaluates the effectiveness of the various programmes they offer their clients, through an audit group set up for this purpose. Their most recent report, describing the period from April 2005-March 2006 presents findings from evaluations carried out during this period and presents implications for future service delivery. It includes information about outcome measures, including the proportions of clients testing negative for illicit substances, which increase as clients progress through treatment. In a recent evaluation, 46% of respondents had been abstinent from heroin during the previous 30 days. Spending on heroin decreased by 97% in total, while there was a substantial reduction in injecting behaviour with 63% of clients reporting no injecting at all. Clients views about various aspects of their treatment were also sought.

This data will be reviewed on an annual basis and there are plans for another client survey. In particular an evaluation of the comprehensive packages of psychological support services available to clients will be conducted soon. Other evaluations envisaged are investigate the prevalence of co-morbid post traumatic stress symptoms in clients and evaluate the new guidelines for the protection of children of parents with substance misuse problems. Clients motivation to change is currently being assessed. A user involvement group is currently being established.

Process of Care delivery

NHS Tayside reports availability of detailed information on developing care pathways which have been developed using an evidence-based process of prioritisation – the PBMA process (Programme Budget Marginal Analysis). This process involves all service providers and commissioners agreeing needs assessment; programme budget currently delivering services; services delivered and their effectiveness before entering a process of “investment or disinvestments” where resources may be removed from ineffective services (or services whose value is no longer demonstrable) and used to develop new services.

NHS Grampian has introduced a single integrated service in 2000. This service involved the NHS, social services and voluntary sector. Under this agreement Single Shared Assessment, Review and Careplanning Tools have been developed. A community rehabilitation service integrated with substitute prescribing services has been piloted. A new Integrated Careplanning and Stabilisation service is being developed that will bring together Specialist GPs, Nursing, Social Work and Voluntary Sector to work with clients to undertake multi-disciplinary assessment, stabilise drug use through enhanced prescribing and careplanning, with clients then moving onto community services. Aberdeen City has a high proportion of GP practices participating in Shared Care and the new service will further enhance that provision by redesigning Specialist GP inputs to the most complex and time consuming part of assessing and stabilising drug users.

Information systems

Many services advised they collected data but had insufficient resources/expertise to retrieve this information.

Outcome measurement

Lothian DTTO supplied the report “Delivering Effective Drug Treatment in the Criminal Justice System”. This report showed how a simple system of data collection in the clinical setting can supply valuable data on effectiveness – with the DTTO able to report on characteristics of their client group at assessment as well as progress by regular and frequent drug testing and injection sites through physical examination.**

Glasgow addiction services supplied the research report “Impact of methadone on crime in Glasgow”. This reported research carried out by SCIEH and described the law-breaking activity of drug misusers in treatment on methadone - supporting the view that crime often reduces initially. The report did note that offending increased after this initial improvement.

Tayside substance misuse services has assessed all patients on methadone in all settings as part of its service redesign. A database was designed and NHS Tayside made resources available to support data entry. This allows initial assessment of the treatment population using the MAP as well as a number of screening tools for co-morbidities such as anxiety, PTSD, chronic pain etc. This exercise is ongoing – but some 21% of those prescribed methadone have been assessed as “stable” against a range of criteria which includes clean urinalysis. The service is now collecting 3 monthly outcome data and is exploring ways of having a robust data management system which will allow reporting of these outcomes regularly.

Tayside also has access to the MEMO database – a clinical database containing all prescriptions issued by GPs in Tayside from 1992 – Chi identified. The MEMO system allows these data to be linked with other Chi data (eg drug deaths; admissions etc) and then anonymised. This raises the potential to look at long term outcomes in very large datasets (4000 patients prescribed methadone over ten years) and consider epidemiological analyses of risks etc.

Lothian low threshold methadone programme supplied the research paper “Evaluation of a pilot low-threshold methadone programme” produced by service staff and NHS Board public health. This paper showed significant short term impact on risk behaviour and health indices up to 8 weeks into treatment.

Specific service examples

Methadone Maintenance Treatment in Scottish Prisons

In July 2003, 587 prisoners were in receipt of a substitute prescribing regime, by June 2005 this figure had increased to 886 prisoners. To evaluate its policy on methadone maintenance the SPS commissioned research into the effectiveness of the change in MMT policy. The principal aim of this study was to examine the role and impact of methadone maintenance treatment for the individual prisoner receiving it and collectively for the prison.

The study was located in five establishments. These establishments were chosen as they held different prisoner subgroups (long-term, short-term and female prisoners). Prisoners were recruited from each of the five prisons. The sample was stratified into 30 long-term male prisoners, 30 short-term male offenders and 30 female offenders. Each group was divided into two groups of 15 from two different establishments. Between three and five prison staff, from different occupational groups, were recruited from each establishment.

Semi-structured qualitative interviews were conducted with 90 prisoners and 17 staff between March and December 2004. Topics discussed at interview with prisoners and staff were ‘why intravenous drug users decide to start MMT in prison and why some choose not to; prisoners’ perceptions of the process of methadone prescribing in the prison setting; the effect that MMT has on the quality of an individual’s life in prison; the impact of methadone on behaviour including areas such as risk behaviour avoidance, social interactions, relationships and networks; perceptions as to whether MMT alters prison dynamics and levels of violence or intimidation between prisoners; whether MMT motivates drug users to seek help to address social and psychological problems attendant with incarceration. Attitudes of staff towards MMT were also sought.

The research identified a number of disincentives MMT and some problematic issues but its overall findings are that many benefits to be gained from MMT in the SPS, and the evidence is overwhelmingly in support of continued investment. However, if potential benefits are to be maximised an improvement is required in the management of this treatment.

Community Rehabilitation and Wrap-around Services NEW HORIZON, Glasgow

ETHOS: The approach taken by New Horizon is epitomised in its mission statement ‘To Empower’. This statement applies to service users and staff alike and emphasises the vision of realising the full potential of workers and service users.

SERVICES: These include- Key Work, Group Work, Relapse Prevention, Cognitive Behaviour Therapy, Auricular Acupuncture, Yoga, Fitness Suite, Community Café, Music and Drama Workshops, Personal and Social Development, Family Support, Volunteer Opportunities, Service User Involvement, Further Education Learning Centre and Employment Guidance.

STAGES:

1. **PRE-ENTRY:** Designed for those who are still drinking or using drugs this stage focuses on the motivation and change required to progress to the main programme.

2. **MAIN PROGRAMME:** For those who are on Methadone only, verified by testing, or alcohol/drug free. 5 modules aim to assist individuals with issues relating to their dependence while at the same time introducing a focus on future aspirations towards training, education and employability. It is during this stage that some service users express a wish to detox from methadone. This would be arranged with the agreement of the service user, case manager, prescriber and the New Horizon key worker.

3. **POST PROGRAMME:** Provides ongoing support with issues relating to dependency and a more in-depth focus on employability. Collaboration between therapeutic and employability staff enables service users to access the support required to work towards their aspirations in relation to learning and employment. This stage involves linking in with other partners and agencies to ensure that all the elements of the employment pathway meet the needs and aspirations of the service user. It is at this stage of the programme many service users aspire to be alcohol and drug free which would entail being free from methadone and all illicit drugs.

AFTERCARE: On completion of the programme ongoing support is provided with the aim of sustaining progress and maintaining momentum towards personal goals.

MOVEMENT BETWEEN PROGRAMMES: Movement between stages is determined through the assessment and review processes and aims to match the service user with the appropriate stage in the programme. Drug and alcohol testing is part of the assessment process.

OUTCOMES: In 2006-7, 125 clients engaged with the service. 78 people participated in stage 1, 97 in stage 2 and 71 in stage 3. 15 people detoxed from methadone, 6 from alcohol. 97 accessed learning, 23 accessed college, 9 entered a training programme. 11 took up voluntary work, 7 part-time work and 8 full-time work.

Community Pharmacy Services for Drug Misusers

Three national surveys about community pharmacy services have been conducted in 1995, 2000 and 2005. A postal questionnaire was sent to all community pharmacists in Scotland (n=1166) to be completed by the main pharmacists. The same questionnaire was used in 1995, 2000 and 2005 with only minor changes so that results could be compared. The questionnaire covered:

- Attitudes to drug users and providing professional service
- Involvement in professional services (needle exchange, dispensing - including methadone supervision)

- Training experience and needs

There has been a significant rise in pharmacists' involvement in dispensing for drug misuse, with 79% dispensing methadone in 2005 compared to 69% in 2000 to 54% in 1995. 72% of pharmacists supervised methadone consumption of patients. The mean number of methadone patients per pharmacy is 20 increased from 13 in 2000 and 7 in 1995. In total, over 17,000 people are estimated to be dispensed methadone from all pharmacies in Scotland. Of these, 57% take their methadone under pharmacy supervision. Although two thirds of pharmacists have had specialist training there is still a need for more. Methadone dispensing workload is now considerable and although pharmacists seem largely positive about providing this service the volume may become too great. This needs to be planned for now. The increase in clients using needle exchanges but the relatively low level of pharmacy service provision need review.

A further CSO funded study has explored a pilot project in which 11 community pharmacists supervising the self administration of methadone have been trained in motivational interviewing techniques. The study showed positive changes in pharmacists' attitudes and belief in self-efficacy and patient reported changes in pharmacist behaviour indicate that the training could be effective. Funding for a large scale Scottish wide RCT to further evaluate this training has been applied for.

Case studies - contribution of methadone treatment to recovery

Case studies can add an important personal aspect to a debate which is dominated by cold objectivity. All clinicians can (and do) quote examples of how their own approach was effective and how others' was not. However, these few are included – not as support for or rejection of the use of methadone – but to illustrate what the evidence base actually shows – a range of approaches is required for most substance misusers and a coherent process of care involving a partnership between skilled professionals and the misuser can achieve impressive results.

The range of different ways in which methadone can contribute to recovery to opiate addiction was illustrated by nine case studies involving clients of Glasgow Addiction Services. In five of these cases, clients are now drug free, including in three family situations.

In three of the cases, residential treatment was also part of the care process. The treatment journeys were :

- Methadone treatment with regular contact, support, setting of goals and identification of barriers led to detoxification in residential rehabilitation, a drug – free life and plans for employment
- Methadone detoxification within a residential setting followed by relapse on release, which, after a further period of high risk drug use, led to successful residential rehabilitation, ability to live in supported accommodation, rebuild family relationships and pursue an electrical apprenticeship.
- Relapse after residential rehabilitation led to community rehabilitation and successfully detoxing from diazepam. Although still receiving methadone, client is accessing college, managing stress, has a greater awareness of trigger situations and improved coping skills.

Appendix 6 – Glossary of terms

Methadone Replacement Prescribing is the clinical process of prescribing the opiate drug methadone to substance misusers who are dependent on opiate drugs – mainly intravenous heroin. Prescribing methadone in this way does not “cure” a dependent individual from their dependency. Instead it allows that individual, if they wish to, to change their drug using behaviours, reducing the frequency and risks of injecting, and drug use overall as well as engaging them with a therapeutic service which can support them as they make changes in their lives. Ultimately some may stop using illicit drugs altogether.

A glossary of terms used in the paper is included below:

ADAT	Alcohol and Drug Action Team
BBV	Blood Borne Virus
CHI	Community Health Index
DORIS	Drug Outcome Research in Scotland
DTTO	Drug Treatment and Testing Order
ECSAS	East Central Scotland Addiction Services
GMS	General Medical Services
Hall 4	Current strategy for development of health visitor services
HIV	Human Immunodeficiency Virus
LHCC	Local Health Co-ordinating Committee
MAP	Maudsley Addiction Profile
MCN	Managed Clinical/Care Network
MMT	Methadone Maintenance Treatment
NES	National Enhanced Service
NMP	Non Medical Prescribing
NTA	National Treatment Agency
NTORS	National Treatment Outcomes Research Study
PBMA	Programme Budget Marginal Analysis
PTSD	Post Traumatic Stress Disorder
SAADAT	Scottish Association of Alcohol and Drug Action Teams
SACDM	Scottish Advisory Committee on Drug Misuse
SCIEH*	Scottish Centre for Infection and Environmental Health
SDMD	Scottish Drug Misuse Database
SE	Scottish Executive
SMR25	Assessment Report to SDMD on an individual entering treatment
SSA	Supervised Self Administration
TSMS	Tayside Substance Misuse Services

*SCIEH is now part of Health Protection Scotland