DRUG & ALCOHOL FINDINGS *Analysis*

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Drug misuse and dependence: UK guidelines on clinical management.

Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group.
London: Department of Health, 2017.

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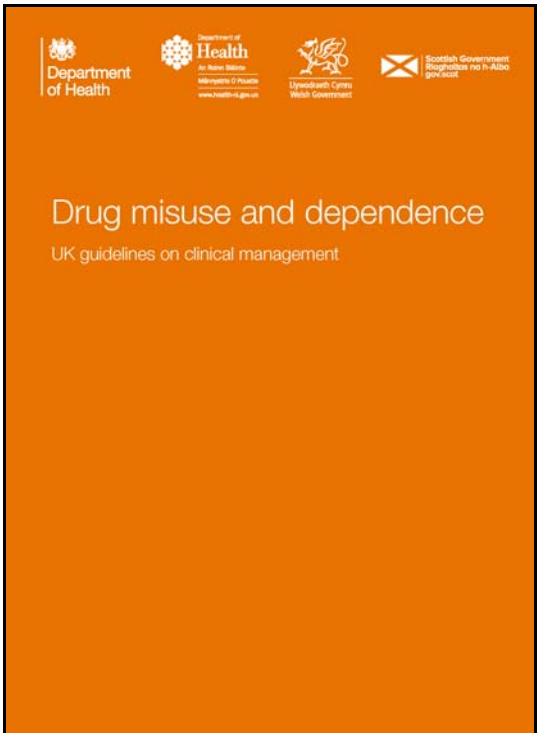
SUMMARY Last published in 2007, there is no more important document for UK clinicians involved in treating problem drug use than the so-called 'Orange guidelines'. This major update offers detailed guidance on the range of problems, settings and patients clinicians encounter. As its predecessor did, it will substantially inform the judgements of tribunals and professional discipline panels on what constitutes acceptable and unacceptable medical practice. Alcohol is dealt with only in so far as drinking may accompany use of other drugs or affect medical care.

The remainder of this summary is adapted from the preface by working group chair John Strang and from the body of the text. After explaining what the guidelines are for and setting the context, the sections headed "Key principles for treatment systems" and "Essential elements of treatment provision: key points" are quoted more or less verbatim from the guidelines. These are followed by issues and passages of particular interest beyond the technical remit of clinicians. It is important to remember that these have been selected from a much larger, more detailed and more comprehensive document which can be downloaded in full free of charge, and should be consulted directly before taking action on the basis of the guidelines. Bold text is not bold in the original but intended to help readers identify the issue being addressed.



About the guidelines

The guidelines are intended primarily for UK clinicians providing drug treatment for people who misuse or are dependent on drugs. They are based on current evidence and professional consensus on how to provide treatment for most patients, in most instances. Incorporation of consensus opinion, which draws extensively on clinical experience as well as on published research, enables the guidelines to make recommendations on important subjects beyond those with a substantial research evidence base and in a way that is of practical use to clinicians.

Professionals are expected to take the recommendations fully into account when exercising their judgement, alongside the individual needs, preferences and values of their patients or service users. The guidelines do not override the responsibility of clinicians to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient (and guardians and carers, if appropriate). However, where clinicians decide to operate outside the specific recommendations within this guidance, they should be able to demonstrate (and should record) the rationale for their decisions. As a general principle, the greater the extent to which a treatment plan departs from evidence-based guidelines, the greater the need to ensure that this departure

from orthodox clinical practice is appropriate. The guidelines have no specific statutory status. However, the standards and quality of care the guidelines set out will be taken into account when the performance of any service or clinician in this clinical area is inspected or assessed.

Local commissioners and providers have a responsibility to develop services that enable the guidelines to be applied. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

The changing context

Despite falling numbers of young people developing heroin dependence, the morbidity, mortality and long-term needs of an ageing cohort of patients with long-term heroin dependence problems means that treatment is increasingly complex and that coordination between services is vital. This includes ever greater integration with mainstream physical and mental health care. Furthermore, the huge number of new psychoactive substances with little-known long-term effects poses fresh challenges for clinicians.

Major changes to the delivery of health and social care have been made in the past decade. The devolution of responsibility to local areas, especially in England, continues to present risks and opportunities for drug treatment.

Involvement of primary care in drug treatment varies substantially from area to area. General practitioners are a vital part of the provision of health care in the UK and still have a responsibility to provide general medical care to people who use drugs, even though they may only provide specialist drug treatment if this is directly commissioned. There are new opportunities for non-medical prescribers, and more pharmacists and nurses have acquired the training required to prescribe for their patients.

Essential elements of treatment provision: key points

• The needs of all drug misusers should be assessed across the four domains of drug and alcohol misuse, health, social functioning and criminal involvement.
• Risks to the individual, to at-risk adults and to potentially affected children should be assessed.
• All drug misusers receiving structured treatment should have consented to their treatment and recovery care plan, which should be regularly reviewed.
• A keyworker – usually a consistent, named keyworker – should develop and review the care plan and may deliver elements of care.
• Drug testing can be a useful tool in diagnosis and assessment and in monitoring compliance and outcomes of treatment.
• Drug misuse treatment involves offering a range of psychosocial treatment and support interventions, not just prescribing.
• Identifying and responding to general health care needs is increasingly important and means working in partnership with primary and secondary care services.
• A proactive, flexible organisational ethos that actively involves service users and carers can support an effective and engaging therapeutic milieu, and can address stigmatisation and help promote positive service developments.

KEY PRINCIPLES FOR TREATMENT SYSTEMS

Whatever the local treatment system model, the following principles are still key:

Local drug treatment systems based on local need Local commissioners and providers need to work together to ensure drug treatment systems are available to meet the changing needs of local drug-misusing populations.

Partnership Many drug misusers have a myriad of health and social problems, which require interventions from a range of providers. Therefore, joint working across health and social care and between hospital, prison, primary care and community drug services is a key feature of effective treatment partnerships.

Staff with a range of competencies Each local system will need to have a cohort of doctors providing treatment for drug misusers, ranging from those able to provide general medical services to those with specialist competencies in treating drug dependence. Other health and social care professionals with a range of competencies are also needed.

Involving patients Involving patients as active partners in their drug treatment and recovery is essential and is associated with good outcomes. Patients should be fully involved in the development of their plans for treatment, care and recovery, in setting appropriate goals and reviewing their progress. It is also good practice to involve patients in the design, planning, development and evaluation of services, and in advocacy and support groups linked to local drug treatment systems. Patients may also be involved in providing peer support and education.

Involving carers The families and other carers of drug-misusing patients are a valuable resource in drug treatment and can be involved wherever possible and agreed by the patient. However, they are often in need of information and support

• All drug services need competence in identifying and addressing the effects of trauma on service users and the effects of intimate partner or other domestic violence.

> for themselves, and their needs should not be overlooked.

• Aftercare support and pathways for rapid re-engagement in treatment are important to address risks of relapse and harm, and support recovery in the period after leaving treatment.

Selected issues

Risks to **dependent children** should be assessed as soon as possible after contact with services. At initial assessment, all service users should be asked about their own children and other children in the home and otherwise in close contact, the ages of the children and the level of contact. Any important current risks should be clarified and reflected in a risk management plan.

If a patient has successfully completed a period in drug treatment, they still may have needs to prevent relapse into drug and alcohol misuse. Many people with a history of drug misuse relapse and it is important that they can gain speedy access back to treatment. A review should plan **aftercare** as a treatment episode ends (eg, after community detoxification and relapse prevention work or following conclusion of a period of inpatient care or residential rehabilitation). After this, pre-scheduled recovery check-ups should be arranged to monitor recovery, adjust recovery supports, and if appropriate to support rapid access back into treatment at early signs of relapse risk. Patients may also require a package of aftercare, which may include psychosocial support. Some high-risk, heroin-dependent individuals recently abstinent and leaving prison, may be particularly vulnerable if not assessed rapidly after release to explore their support needs. Others, such as those recently discharged from inpatient care, may have similar needs.

It is inappropriate … for services to create a sense that those opting for opioid substitute maintenance [such as methadone maintenance] are making a poorer choice than those opting for an abstinence-oriented or abstinence-based treatment. Equally, prescribing services should not discourage a patient who wishes to pursue detoxification, but should provide the best information on benefits and risks, and support the patient's considered decision. Staff should **convey all the options** suitably optimistically and realistically, and with sensitivity to the service user's personal situation and risks.

Increased focus on the **recovery agenda** in most of the UK has led to local planners extending their commissioning or contracting scope beyond the most evidence-based pharmacological and psychosocial treatment interventions traditionally provided by 'clinical' and NHS services to a broader range of rehabilitative interventions, typically involving additional interventions that have more limited evidence of effectiveness, and from a wider range of providers. This change aims to support people with drug use problems to progress further in their wider recovery. Planners and commissioners of such systems of care need to maintain the crucial health benefits and reduced harms from the well evidence-based and cost-effective interventions, while providing a suitably balanced and responsive range of options to meet the wider needs for recovery support … One of the challenges during the lifespan of the *2017 Clinical Guidelines* will be for planners and commissioners, with assistance from clinicians, to continue to deliver the different forms of appropriate treatment as well as to improve outcomes, when resources may be more limited.

Ultra-rapid detoxification under general anaesthesia or heavy sedation (where the airway needs to be supported) must not be offered. This is because of the risk of serious adverse events, including death.

Treatment for drug misuse should always involve a **psychosocial component** to help support an individual's recovery … However, access to medication should not be contingent on compliance with a psychosocial programme. Rather, services should offer a programme that service users will wish to engage with voluntarily.

Opioid substitute prescribing

For most cases, it will be appropriate for new patients being prescribed methadone or buprenorphine to be required to take their daily **doses under the direct supervision** of a professional for a period of time to allow monitoring of progress and an ongoing risk assessment. The risk assessment should include a review of compliance and individual circumstances, including whether the home environment is suitable for safe storage of medications. In some cases, following this the supervision will be needed for an extended period, while for others it may be assessed as only being needed for a short period. Duration of supervision should be dependent on assessed clinical need and should not be applied in an

arbitrary way.

A key goal of [opioid substitution treatment] is to provide the **dose** that leads to complete cessation of heroin (and other illicit opioid) use, which may be higher than the dose at which the patient feels 'stable'. Sometimes, a patient may be unwilling to increase their prescribed dose into the recommended range that is more likely to be effective, and this may be because they intend to continue using heroin. This is likely to reduce the benefit that the patient derives from treatment and should be avoided, if possible. However, there can still be many other benefits of being on the medication and of engaging in treatment. For example, there may be large reductions in illicit heroin use and other evidence of improved wellbeing. Intermittent use 'on top' is evidence of less benefit from treatment than was hoped for and should be addressed, but should not stop positive feedback to patients that recognises other important improvements.

Opioid maintenance treatment is an effective management strategy for reducing harms associated with opioid dependence. The **duration** of maintenance should reflect the patient's own preferences and their clinical circumstances (which may include the opportunities available to them to support their recovery and management of risk).

It may seem to some observers that, in all cases, progress in treatment should lead towards detoxification and ultimately **abstinence**. Patients and their families (as well as some clinicians) may hold the view that this progression is required for treatment to be deemed to have succeeded. Complete abstinence from all drugs (prescribed and non-prescribed) may not be a realistic or preferred goal at various times in a patient's treatment journey and there will be circumstances when prolonged periods of maintenance [opioid substitution treatment] are indicated. In some cases, this will turn out to be lifelong. It is important to emphasise that this is not a failure. Many such patients will be fulfilling their social and family responsibilities while successfully avoiding drug-related risk and progressing their recovery opportunities. It should also be emphasised, however, that clinicians must ensure that patients are repeatedly made aware of all their treatment options, including at treatment entry, and are regularly given the opportunity to consider alternatives to maintenance treatment.

Clinicians, however, will frequently be faced with decisions concerning what action to take if a patient is **failing to maintain benefit** from a treatment programme. Any response should be based on the assessment of relative risks to the patient and staff, while maintaining the integrity of the treatment programme.

Treatment in the criminal justice system

Treatment and care for those with drug and alcohol problems in the criminal justice system (CJS) should aim to be excellent, safe, effective and **broadly equivalent** to that in the community.

The main purposes for prescribing **[opioid substitution treatment]** in prison are:
• following initial prison entry, to provide opioid-dependent patients with the most effective, evidence-based treatment at an appropriate dose to help them achieve stabilisation (with cessation of illicit opioids and wider stability);
• following the initial stabilisation, to maintain the [opioid substitution treatment]:
– either continuing it throughout the imprisonment and seamlessly following release (with the benefits to health and offending behaviour from such clinical throughcare); or
– continuing [opioid substitution treatment] in prison only until the patient decides … on a supported detoxification (which should only be considered after properly discussing with the patient the substantial increased risk of relapse and of mortality from this path, but then actively supporting the decision of informed patients who do opt for this).

Continued maintenance prescribing in prison, along with plans for seamless follow-up in the community, is usually the most appropriate and evidence-based approach for those with severe dependence in receipt of a **short sentence**.

It is difficult to justify on the basis of clinical evidence, a required withdrawal of [opioid substitution treatment] from a prisoner based on a particular **duration** of imprisonment … For example, some prisoners with severe heroin dependence, a history of multiple relapses and high-risk behaviours, may reasonably be expected to require opioid substitution treatment on release even after a long sentence. For these prisoners, it may well be safer to remain on a maintenance dose for the duration of the sentence with an active transfer of treatment to community services on release.

While some prisoners, particularly long-term prisoners, will wish to use their time in prison to become abstinent from both illicit and prescribed opioids, any plan for

reduction and cessation of [opioid substitution treatment] should be based on the clinical judgement of the prescriber in collaboration with the prisoner and the wider team. Reduction and cessation should not be on an arbitrary or mandatory basis but rather require careful clinical assessment and review. There should not normally be mandatory opioid reduction regimens for dependence.

Prison does offer [some] the opportunity … to be supported … to achieve a period of **abstinence from all opioids**, which needs to be offered and managed positively. To be able to obtain properly informed consent, it is essential, however, that the potential risks and the potential benefits are discussed with the patient first, based on a clear understanding of the evidence base including the natural history of the disorder and the risks of relapse, as well as the positive support available for achieving and sustaining abstinence.

For those who come off opioids successfully in prison and plan to stay abstinent on release, plans need to be put in place to help them **sustain abstinence** and to manage any relapse. This might include use of naltrexone, information on overdose risk and provision of take-home naloxone.

For others, who feel they will be unable to stay heroin-free on release, clinical assessment of their risk of relapse and of fatal overdose may lead to consideration of **re-toxification** back on to [opioid substitution treatment] prior to release, or to a request for immediate (preferably same-day as release) assessment by a community drug service that could offer prescribing. Re-induction could be considered for those who are about to leave prison and who have a clearly identifiable risk of overdose and a high likelihood of relapse … Given the high relapse rates for heroin dependence and the high mortality rates from overdose following prison release, it is important to recognise this request may be a sound judgement and may support effective re-engagement with community services.

Transitions to, from and between criminal justice settings, such as between police custody and courts, or prison release, create the potential for interruptions in the delivery of required treatment and heighten the risk of relapse and of overdose deaths. The strong evidence for the level of these preventable risks places a clear responsibility on all clinical assessment services and treatment providers … to ensure that there are effective and timely referral routes and channels of communication to address these risks and to enhance safe **continuity of care**. The rapid exchange of suitable patient information can be crucial to facilitate continuity of prescribing. Skilled risk assessments, clear discharge planning and systematic links with community services are essential.

Coexisting mental health problems

It is important that individuals are not turned away from either drug and alcohol treatment services or mental health services due to their coexisting illness but rather that such services should aim to be perceived by service users and their carers as supportive with **'no wrong door'** through which to enter services (whether based on levels of alcohol and/or drug dependence or on presence or absence of specific diagnoses of mental illness), even if subsequently this sometimes leads to referral for alternative pathways of care.

Given the high prevalence of comorbid problems in all drug and alcohol services and all mental health services, suitable interventions are needed for substance problem(s) in all mental health services, and for mental health problems in all substance misuse services, with competent staff available to deliver such interventions.

Where feasible, care for comorbidity may best be provided in one service (**integrated model**). Undoubtedly, provision for those in need of information and advice and in need of basic motivational skills can be feasible in almost all treatment services. More specific interventions may also be provided in some services with suitably skilled workers, particularly for patients who are unable or unwilling to engage with more than one service. However, in other and more complex cases of comorbidity, where there is need for additional specialist interventions, such provision may only be practical as additional treatment from a specialist substance misuse or mental health treatment service, when the emphasis should still be on adequate collaboration, good communication and ensuring patients do not fall between gaps (**parallel model**).

Access to provision … should be made as seamless as possible and carefully supported to limit dropout between services. **Sequential models** of treatment prioritise the treatment of one disorder over another until the successful stabilisation of the

[prioritised disorder]. Given the recognised reciprocal relationship between mental health and substance use disorders, this approach is not normally recommended, given that an untreated disorder can potentially limit the effectiveness of treatment for the other comorbidity, but initial timing can sometimes be affected by the current severity and stability of one or other disorder.

Where any mental health symptoms are assessed as due to intoxication or withdrawal, **apparent comorbidity may only present temporarily** and careful consideration and further assessment of such possible comorbidity may be needed prior to any referral to adult mental health services, when this does not present as an acute mental health crisis. Equally, where those in need of treatment of adult mental health disorder have not been found to have dependent use of substances but rather need education and advice, or are using substances secondary to untreated mental disorder, referral for involvement of substance misuse treatment services may simply complicate care.

Patients who have both **mild**, common mental health problems and mild substance misuse problems may not meet the access criteria locally either for the mental health or the substance misuse service, despite the combination of problems requiring assistance. They may benefit from brief interventions for substance misuse or from primary care or IAPT [Improving Access to Psychological Therapies – a National Health Service initiative to provide psychotherapy to the general population] involvement around their mental health. Clear pathways for assessment of such patients and for provision to meet their care needs should be explicit. They should be agreed between commissioners and local providers to ensure adequate provision when such patients do present, and to avoid patients simply being identified as not meeting any service's criteria.

Many patients who meet the diagnostic criteria for **mild to moderate mental illness** (including cases of depression and anxiety), and many patients who have evidence of personality disorder, present with a need for treatment for substance misuse disorders. Their drug treatment should usually be met without referring to secondary care mental health services unless the conditions are particularly severe or complex to manage. Depending on the severity or complexity of their mental health disorder, in line with agreed protocols between substance misuse and mental health services/commissioners locally, these patients could have their mental health treatment needs met in primary care services (GP or psychological therapy services), substance misuse treatment services, mental health services, or a combination.

Individuals with **severe mental health problems** should be supported to have access to as fully integrated care as possible within mental health services. This care should support all treatment goals, whether the treatments are formally 'integrated' or provided through a 'parallel' model of delivery.

Treating young people

Specialist drug treatment for young people is **different** to that for adults (relating to factors such as age and maturity, responsibility, safeguarding duties, the legal framework, developmental needs and the patterns of substance use problems). Treatment services for young people that address substance use problems need to sit within the wider framework and standards for young people, which support both engagement and access of children and young people to services and appropriate responses to young people and their parents.

Implementing the treatment process within such a framework involves comprehensive assessment, active engagement, collaborative teamwork across local health, social care, family, education and employment services, utilisation of the broad range of evidence-based interventions for substance use/misuse and for comorbid conditions, and active follow-up. Coordinated, well-led interventions should mobilise resources of local communities, including safeguarding, education, training, mental health and resilience building.

Treating older people

An increasing number of service users in drug treatment are maintained on opioid substitution treatment into their 50s and beyond, have **complex comorbidities**, and are prescribed multiple medicines. Seamless and supportive care for these patients is helped by a named clinician developing good relationships and communications with the patient's pharmacist and primary care team, and with, as appropriate, mental health or other specialist health and social care services.

It is important that older patients established on **long-term prescribing** for drug

dependence, particularly with more uncommon treatments or on higher than average doses, where there is no current evidence of instability or deterioration in problems with dependence, should not be faced with arbitrary withdrawal of such treatments simply due to change of prescriber or change of service provider. Decisions about such prescribing should be based on careful, individualised assessment and should take account of all relevant factors including historical assessments of need and responses to treatment; and should also take account of and respect the older person's right to equitable care (including adequate involvement in decisions that affect them and consideration of use of second opinion where there is disagreement about continuing a previous long-term prescribing arrangement). Such patients should, of course, never have their treatment withdrawn in an arbitrary fashion and any review should take account of whether their current treatment or an alternative is meeting or will better meet their needs.

[In addition the guidelines identify considerations specific to or more important for the care of older substance users, such as home care when required, recognising the needs of family members or carers, setting aside extra time for assessment and physical examination and investigations, age-appropriate general health screening and monitoring, caution with medications which may cause dependence or increase the risk of falls or confusion, possibility of chronic hepatitis C infection, setting a lower threshold for arranging inpatient detoxification, and offering integrated service delivery involving substance misuse, mental health, primary care and social care services, coordinated by a named individual.]

FINDINGS COMMENTARY Reading the guidelines (with annexes, 317 pages) brings home the complexity of ensuring as far as possible safe and effective treatment for vulnerable patients whose substance use itself is often life-threatening, for whom (mis)treatment can increase the risk of death, who generally come with other serious illnesses and/or problems, who may not share your treatment objectives or comply with your treatment regimen – and for whom refusing or terminating treatment on those grounds may itself be considered malpractice which places the patient at increased risk of overdose and infection. It was partly this minefield – treading what was judged the wrong part of which has ended the substance use treatment careers of several doctors – which led and still does lead many GPs to avoid addiction treatment. The guidelines plot a path through these complications while at the same time reminding us of their existence, and of the possible consequences of a wrong turning for patient and doctor.

Pros and cons of orthodoxy

Guidelines can be seen as setting out what *should* happen – ideal practice within the limits of feasibility. Inevitably, that ideal is the ideal of a set group of people formulating it in a set context, not necessarily that of all doctors and patients involved or potentially involved in substance use treatment; it can and has changed as views change. To a large extent, the guidelines derive not from evidence but from common sense, wider principles of patient-centred and ethical medical care, the experience of the contributors, and accepted orthodoxy. The last source has been a bone of contention, some doctors feeling themselves attacked for failing to toe the line rather than because their care is demonstrably any more unsafe or ineffective than orthodox care.

How 'orthodoxy' can be merged with 'evidence' in a way which makes unorthodox – or innovative or unusual – practice risky, is exemplified by the guidelines' caution that, "As a general principle, the greater the extent to which a treatment plan departs from *evidence*-based guidelines, the greater the need to ensure that this departure from *orthodox* clinical practice is appropriate" (emphasis added). However, the guidelines emerge from a history of addiction treatment in the UK in which the individual clinician's idiosyncrasies and waves of professional 'fashion' have imposed on patients what today would be considered unacceptable treatment or changes in treatment. In this context, elevating orthodoxy to the level of a contributor to guidelines alongside evidence arguably has an important safeguarding role.

Ideals in a context of recovery and shrinking resources

In recommending as good clinical practice programmes and activities not currently provided, implicitly the guidelines criticise current practice as sub-standard and in some cases implicitly brand government (non)policy as encouraging or allowing subs-standard practice.

By insisting that "All at-risk drug misusers should be offered testing and, if required, treatment for hepatitis C and HIV infections", referring to the "practical difficulties of getting to specialist clinics or previous poor experience of such referrals", and noting that "many service users find hospitals give them poorer care than they expect or deserve", the guidelines are calling for greater practical and better quality access to new, more effective and less onerous – but also expensive – treatments for infection with hepatitis C. The reality is that in England, the infections of about half the injectors with hepatitis C remain undiagnosed.

On turning the tide of the increase in overdose deaths, the guidelines call on clinicians and services "to reflect on whether all reasonable actions are being taken". The recommendation for same-day (or at least, "prompt") access to treatment for prison leavers to prevent overdose is an ideal it will take some effort to realise, and the observation that "Retaining patients in high-quality treatment is protective against overdose" flies in the face of recent government policy to promote treatment exit and non-return (more below). Also to prevent deaths, "training in the use of naloxone should be widespread", yet there is no national programme in England like those mounted in other UK nations. Drug consumption rooms where users can safely inject their own drugs are given a positive write-up, yet there are none in the UK and they have been rejected by government. The rider in the previous guidelines that prescribing injectable opioids like heroin should only be considered if oral treatments have failed is omitted in the current guidelines, opening the way to greater (but highly controlled) use of an option which has not received the blessing of the UK government and is very rarely implemented.

The guidelines allude to two features of today which further aggravate the difficulties of matching the ideals they embody. A responsibility is placed on "Local commissioners and providers … to develop services that enable the guidelines to be applied," but immediately this is qualified by saying they "should do so in the context of local and national priorities for funding and developing services".

Mention of funding reminds us that the structures, organisations and resources which might have helped to optimise practice in the guidelines' direction all seem recently to have diminished. Mention of national priorities links to the guidelines' observation that the UK government's recovery agenda "has led to local planners extending their commissioning or contracting scope beyond the most evidence-based pharmacological and psychosocial treatment interventions … to a broader range of rehabilitative interventions, typically involving additional interventions that have more limited evidence of effectiveness". This extension into new interventions in the name of recovery is happening in an era when, according to the guidelines, "resources may be more limited". Reading between the lines, the guidelines group feared something will have to give, and that 'something' will be the ability to "maintain the crucial health benefits and reduced harms from the well evidence-based and cost-effective interventions".

Comes to a head on the issue of time limits

Specifically how that ability to maintain current benefits might be undermined was addressed by a group also chaired by Professor John Strang, set up partly to respond to repeated demands from within government that the duration of opioid substitute prescribing be curtailed. Their reports published in 2012 and 2013 drew what we called a "line in the sand", rejecting the imposition of time limits or treatment exits other than those decided between clinician and patient "When they are ready".

In 2014 that line was entrenched by the government's own appointed expert advisers. They were responding to a request to advise the UK government's drug policy committee on whether the evidence supports the case for time-limiting opioid substitution therapy. 'No,' was the unambiguous answer to what had become an unambiguous attempt to garner approval for bringing "an urgent end to the current drift of far too many people into indefinite maintenance, which is a replacement of one dependency with another" – an ambition of the 2012 UK government "roadmap for building a new treatment system based on recovery". The advisers went further: not only was there no positive evidence for time limits, but the evidence strongly suggested the result would be negative – more drug-driven crime, overdose deaths, and blood-borne viral infections.

With the new guidelines that entrenchment has been fortified into what amounts to a professional obligation on clinicians and service commissioners and providers to make

non-agreed termination of treatment very much the exception, and a decision taken under the weight of the knowledge that it could place the patient – and their associates and the wider community – at greater risk. That line is taken even in respect of treatment in prison, where the guidance explicitly rejects earlier guidelines introduced in April 2010 which set "strict time-limits to end the practice of open-ended substitute prescribing in prisons". Six months was the limit before prisoners "should be expected to work towards becoming drug-free", an approach to be extended to outside prison. Contradicting this approach, the new guidelines say, "It is difficult to justify on the basis of clinical evidence, a required withdrawal of [opioid substitution treatment] from a prisoner based on a particular duration of imprisonment".

That this tussle might not yet be over is suggested by the new UK drug strategy's doffing of the hat to the term "full recovery", used in the Conservative Party's 2015 election manifesto as shorthand for a treatment system with abstinence as its goal "instead of the routine maintenance of people's addictions with substitute drugs", though the strategy itself largely neglects rather than showing overt hostility to maintenance.

Pre-set key goals versus client choice

Another bastion against imposition of inappropriate treatment options and changes is the guidelines' insistence on the consent of patients and on involving them as active partners in their treatment, lines it could not fail to take without singling out this set of patients as beyond the usual protections of ethical medical care.

What to do when a patient continues to use illegal drugs despite being prescribed legal substitutes, is one issue where the guidelines' insistence on client consent and choice rubs uncomfortably against their appeal to orthodoxy. For the guidelines, "A key goal of [opioid substitution treatment] is to provide the dose that leads to complete cessation of heroin (and other illicit opioid) use, which may be higher than the dose at which the patient feels 'stable'." But this may not be a patient's "key goal" at all, or at least, not for the time being. Instead they may want to stabilise, reduce the expense, hassle and risk of illegal heroin use, but still keep their methadone dose low enough (or be able to skip a dose) to 'enjoy' – or re-enjoy – the occasional hit of injected heroin 'on top', or to use other drugs such as crack.

> *Insistence on client consent and choice rubs uncomfortably against the appeal to orthodoxy*

For whatever reason, six months or a year after starting treatment, most opiate-addicted patients in England are still using illegal opiates to some degree. Faced with such a situation, the guidelines are prepared to compromise on the "key goal" of ending illegal opioid use: "Intermittent use on top is evidence of less benefit from treatment than was hoped for and should be addressed but it should not stop positive feedback to patients that recognises other important improvements they are achieving". The potential clash is evident between what some patients may see as the 'benefits' of treatment, and those prioritised by the guidelines working group. In the tradition of British pragmatism in addiction treatment, that clash is sidestepped by appeal to other benefits which doctor, patient and the wider community may be able to agree on, not least of which is staying alive, no longer being in a position (or being in less of a position) to spread infection, and having less reason to commit crimes to fund drug purchases. In this respect as in others, the guidelines are a master class in setting ideals for practitioners, planners – and patients – while at the same time not being bound by them if reality is not amenable.

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