▶ Delivering recovery. Independent expert review of opioid replacement therapies in Scotland.

Scottish Drug Strategy Delivery Commission.
The Scottish Government, 2013.

An expert committee responds to the Scottish government's concerns over the role of methadone prescribing in helping patients along the Road to Recovery signposted in the national strategy. On the ground, that road was often barely constructed but methadone was not the problem, rather the failure to optimise programmes for recovery.

SUMMARY The featured report answers a request to the Scottish Drugs Strategy Delivery Commission from Scotland's Chief Medical Officer to review the use in Scotland of 'opioid replacement therapy' – methadone maintenance and allied treatments which substitute legally prescribed drugs with similar effects for the illegally obtained opiate-type (opioid) drugs on which patients have become dependent. On the basis of the evidence gathered, it was also asked that the report recommend ways to maximise effectiveness.

The commission was established to offer independent expertise and challenge to Scotland's national drug strategy, the *Road to Recovery*. To produce the featured report it set up a steering group from among its members which also drew in other experts, chaired by the addictions psychiatrist who also chairs the commission. Researchers were commissioned to rapidly review research and to survey the 30 Scottish alcohol and drug partnerships responsible for organising addiction services in their areas. Also consulted were relevant organisations and individuals, including service users and their families, and events were attended where views were sought and aired. The resultant draft report was commented on by international experts. The account below is based on the report's own summary.

Background

Patterns of substance use problems are strongly associated with a wide range of social, psychological and physical issues. There is a need to ensure local systems of care take these inequalities into account to better address the high levels of morbidity and mortality experienced by this group.

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

Themes

The review makes twelve recommendations under the following six themes.

Theme 1: Social exclusion and health inequalities

The demographic characteristics of substance users who might benefit from opioid replacement therapy have changed in recent years. Average age has markedly increased, suggesting that the degree of both physiological and psychological difficulty, already high, is likely also to increase. Equally, as health inequalities continue to increase, the effects on this already multiply deprived and marginalised group will become more extreme.

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

Theme 2: Opioid replacement therapies in Scotland

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

Theme 3: Progressing recovery in Scotland

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

Theme 4: Governance and accountability of the delivery system

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

In this field there is a lack of institutional memory [eg, of past mistakes and successes and the essentials of treatment] regarding an agreed understanding of the key issues and the plans which require to be put in place to address them. Without this, systems are destined to continue repeating mistakes or failing to capitalise on successes. Such inefficiency is at odds with the aspirations of the Christie Commission report.

Theme 5: Information, research and evaluation

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

programme rather than convened in response to a perceived crisis.

Theme 6: Mechanism for change

The Christie Commission has highlighted the need for the Scottish Government and its partners to develop more efficient, effective and outcome-focused mechanisms for delivering services. In the area of substance use, recent reports have raised similar issues regarding inconsistent delivery and a lack of accountability of a dedicated system (alcohol and drug action teams; alcohol and drug partnerships). It is now important to avoid further delay and take immediate steps to use an approach which has a track record of delivering change.

Delivering recovery

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

Recommendations

1 Consideration should be given to the development of mechanisms bringing the delivery of approaches to address health inequalities closer to those related to problem substance use.
As a minimum requirement, all local inequalities strategies should contain reference to plans to address the risks associated with substance use.

2 Primary care services – specifically general practitioners and community pharmacists – are essential elements of the delivery system and should be delivered to national standards.
It is imperative that discussions begin to consider how substance misuse treatment can best be delivered in the primary care setting. This process should be led by NHS primary care structures and discussions should include general practitioners and community pharmacists.
Actions to test service quality improvement should be initiated nationally to reduce variation in practice.

3 Opioid replacement is an essential treatment with a strong evidence base. Its use remains a central component of the treatment for opiate dependence and it should be retained in Scottish services.
In all settings, opioid replacement therapy should be delivered as part of a coherent, person-centred recovery plan with SMART (specific, measurable, achievable, realistic, time-bound) goals and based on an assessment of individual recovery capital.
The quality of opioid replacement therapy should be governed and delivery should be in line with national standards and guidance. NHS medical directors should hold this responsibility on behalf of local partnerships.
Fit-for-purpose information systems should be able to identify individuals on this care pathway and objectively demonstrate their progress.

4 A national specification for pharmacy services for problematic drug users should be developed to ensure that a high quality and consistent service can be provided. This should be supported by a nationally agreed guideline for supervised self-administration of opioid replacement therapy medications and initiation of improvement approaches to accelerate progress.
As part of this process, *Prevention and treatment of substance misuse, delivering the right medicine* should be updated to reflect the role of pharmacy within the national drug strategy.

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

6 Recovery-orientated systems of care are well described in many guidance documents. All local systems should immediately publish prioritised SMART plans to ensure they can demonstrate a process towards delivery of these systems. Elements expected in such plans include:
• All service users should be offered and actively encouraged to use *Essential Care* services. This offer should be recorded and repeated at regular intervals. This should become the norm in Scotland's services.
• In all settings staff should be trained in the delivery of recovery-orientated systems of care.
• A full range of *Essential Care* services should be available in every locality. This should include a full range of identifiable community rehabilitation services, including: those using people with lived experience; access to detoxification and residential rehabilitation; access to a full range of psychological and psychiatric services; services addressing employability and accommodation.

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

8 The Scottish Government should seriously reconsider how to better facilitate universal and effective partnerships which respond to local need and deliver consistent and measureable outcome improvement for substance users across Scotland.
The functions of alcohol and drug partnerships should be reviewed urgently and clear improvement measures developed and monitored with clear time-frames for change.
In particular, all local systems should immediately publish prioritised SMART plans to ensure they can demonstrate a valid and coherent process to evidence the delivery of recovery-orientated systems of care in line with the *Essential Care* report.

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

10 The Chief Medical Officer should task the Chief Scientist to consult with the academic community in Scotland and bring forward robust plans to develop a Scottish national research programme addressing the key substance use questions for Scotland. The aim should be to support and facilitate the delivery of efficient, high quality research into the natural history of problem substance use – its development and progression – as well as the effectiveness of a broad range of treatment approaches, including psychological and social approaches and novel treatments.

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

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

FINDINGS COMMENTARY This report comes in the year after the corresponding report for England. Both were concerned with

establishing and augmenting the 'recovery' credentials of maintenance prescribing, seen in some quarters as antithetical to the holistic life changes entailed in recovery, while retaining harm reduction benefits such as protection against disease and not least, prevention of early death. In both cases the reports were formally requested by the countries' chief medical officers, but they acted as a conduit for political concerns and in Scotland also public concern as expressed in and/or generated by the media. The Chief Medical Officer's foreword to the Scottish report hints at the concerns leading to his request: that methadone treatment "often simply switches one pattern of drug use for another" and "is far from risk free", an allusion to the concern in Scotland about overdose deaths linked to the drug. It also reflected what is perhaps the core concern – that methadone has been portrayed as dominating treatment provision to the point where other options are in practice excluded.

For the committee there was more than enough evidence to indicate that methadone and allied treatments are "essential" components of treatment services whose costs are justified by "extensive impact ... on health, criminal justice, social care, costs to the economy and wider costs to society". Yet despite these strengths, the report found "The evidence-base for effectiveness in achieving abstinence or promoting long term recovery – as opposed to reducing harm – remains much less compelling", possibly due to inadequate research.

Though for some a key issue, for these experts treatment duration was not a problem: "for maximum long term benefit some may require to receive [opioid replacement therapy] indefinitely ... this outcome... should not be considered a failure". Instead the main problem not lay not with maintenance prescribing itself or its duration, but with the suboptimal nature of much current provision, including the lack of ancillary inputs such as psychosocial therapy, an overloaded staff unable to do much more than prescribe medications and complete required paperwork, and under-developed links with services which could address the multiple needs of the patients.

They did accept there was underuse of and obstructed access to alternative addiction treatment programmes such as residential rehabilitation, but their recipe would entail more resources for maintenance programmes and their patients, not their constriction. These and other features of treatment commissioning and provision meant that despite national policy, recovery-oriented service provision could rarely be shown to be a reality on the ground, though in some respects (especially links with mutual aid and other peer networks) it was moving forward.

A distinctive feature of Scottish drug policy and policy debate is the centrality of income and health inequalities, apparent to the report in the multiple deprivation characterising the home areas of most drug service patients. Inequality is seen as a significant driver of negative outcomes such as drug and alcohol-related deaths. Though outside their remit, the committee warned that unless inequality is addressed, other efforts will struggle to curb the deaths, but they were not hopeful that Scotland wants to or can do enough on this front. More on these and other issues in small text below.

The Scottish Government has responded positively to the report. Aligned with the report's themes, an "alcohol and drug quality improvement framework" is being developed to "ensure quality in the provision of care, treatment and recovery services as well as in the data that will evidence outcomes". It is intended to set out what someone who accesses a service can expect to receive and achieve, including: "high-quality, evidence-based interventions; workers who are appropriately trained and supervised; full strengths-based assessments and person-centred recovery plans that are agreed and regularly reviewed; and, if it is helpful to the individual, the opportunity for their family to be involved".

The review noted that "Some service elements which one would expect to be strategic priorities in a recovery environment clearly are not." Among those lacking were making use of current or former problem drug users, the development of community rehabilitation, improved access to residential rehabilitation, and access to specialist clinical psychology services. With "a very large proportion of funding" devoted to methadone prescribing, these 'wrap-around' services were relatively starved of practical and financial support: "There has been little evidence supplied to this review of a meaningful local response to this resource deficit". Not surprisingly, it was argued, in this situation opioid replacement therapy is seen as the problem, rather than "the failure to deliver this evidence-based medical treatment optimally nor the failure to effectively commission an adequate range of services in a balanced manner to best meet local needs".

Though in most areas services and commissioners engaged with mutual aid groups, rarely were these promoted to patients in the most effective ways. In few areas were groups co-located with treatment services and very few could show they assertively linked patients to groups rather than leaving them to find (or not find) their own ways. Universally among responding areas, residential rehabilitation was seen as an option reserved for patients who had not done well in other services, not as a possible first-line option for some patients.

For the review there was no set duration for opioid replacement therapy. Instead duration would depend on the patient's circumstances and resources and (importantly) also on the services, care and support required to help them progress. The implication is that opioid replacement treatment careers might be shortened if patients were "afforded all the services they require to meet their needs at any point in their own [recovery] journey with regular opportunities for review and, when they are ready to do so, are given the opportunity to come off [opioid replacement therapy] safely". If they do, they should be monitored for at least a year and if needed, be able to restart therapy immediately. Instead, (ex)patients, though acknowledging that methadone maintenance was often essential to recovery, felt it had not been a 'component', but *all* they had been offered when asking for treatment. Many felt they were not reviewed regularly nor supported in their desire to reduce their methadone dose or detoxify.

The commission endorsed the views of US recovery advocate William White (who commented on their report in draft) and felt they had resonance for Scotland. He had argued that "periodic moral panics about the idea of patients being on methadone for prolonged periods ... obscures the real problem which is that most patients are not on methadone long enough, eg, high rates of early drop-out, administrative discharge and rapid resumption of opioid addiction".

To judge by prescribing patterns, in most areas patients and clinicians were not as free to choose buprenorphine as they were methadone, the former being sidelined due to the cost of the drug and the cost or impracticality of supervising its administration (it has to dissolve under the tongue) in pharmacies.

The review accepted that services clearly aimed to deliver holistic care, but also felt many struggled to do so, due among other things to the focus on prescribing, lack of competence among staff, high caseloads and administrative burdens restricting the time available to offer anything more than basic treatment, poorly developed partnerships with other services or their inadequacy, and poor access to inputs such as specialist psychology or psychiatry services or the lack of priority given by those services to substance users. How crucial staff competence could be seemed reflected in the comment from many in recovery that one particular worker's empathic relationship with them had made the difference.

Thanks for their comments on this entry in draft to Brian Kidd of the University of Dundee Medical School in Scotland, who chaired the group which produced the featured report. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 07 April 2014. First uploaded 31 March 2014

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