▶ Medications in recovery: re-orientating drug dependence treatment.

Strang J. et al.
[UK] National Treatment Agency for Substance Misuse, 2012.

On behalf of the UK government an expert group has developed and documented a clinical consensus on how prescribing-based treatment for heroin addiction can be made more recovery-oriented in line with national strategy. Their report will be the main reference point in tussles over what recovery means for methadone services and patients.

SUMMARY Acting on behalf of the UK Department of Health, in August 2010 the National Treatment Agency for Substance Misuse – a special health authority which aims to improve treatment for drug problems in England – asked Professor John Strang to chair a group of experts (the Recovery Orientated Drug Treatment Expert Group) to guide the drug treatment field on the use of medications to aid recovery from drug addiction and on how patient care can be more fully orientated to optimise recovery, objectives consistent with the 2010 English national drug strategy.

That strategy expressed concern that "for too many people currently on a substitute prescription, what should be the first step on the journey to recovery risks ending there", and wanted to "ensure that all those on a substitute prescription engage in recovery activities". The group's task was to reach a clinical consensus which would guide clinicians and agencies in helping opioid substitution patients achieve their fullest personal recovery, improve support for long-term recovery, and avoid unplanned drift into open-ended maintenance prescribing. The group sought to reflect the evidence and contextualise it within the current UK environment and the ambitions of the 2010 English drug strategy.

In framing its recommendations the expert group had available to it a review of the evidence which combined research findings on evidence-based practice with humanitarian, recovery-based considerations based on values such as responsibility, choice, and empowerment.

The authors' conclusions

This account is based on the summary in the main report.

Heroin users are the largest single group in treatment and use an especially tenacious, habit-forming drug in the most dangerous ways. The main task of the Recovery Orientated Drug Treatment Expert Group was to describe how to meet the national strategy's ambition to help more heroin users recover and break free of dependence.

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

The ambition for more people to recover is legitimate, deliverable and overdue. Previous strategies focused on reducing crime and drug-related harm to public health, in respect of which society benefited from people being retained in treatment as much from completing it. This allowed a culture of commissioning and practice to develop that gave insufficient priority to an individual's desire to overcome his or her drug or alcohol dependence, particularly for heroin users receiving substitution treatment, where the protective benefits have too often become an end in themselves rather than a safe platform from which users might progress towards further recovery.

Overcoming drug or alcohol dependence is often difficult, and especially so for dependence on heroin. US studies suggest that over 30 years, half of all dependent users will die, a fifth will recover, and the remainder will continue to use opiates, some at a lower level. An accessible, evidence-based, drug treatment system in every part of England affords an excellent opportunity to improve on the past, seeing international, historical evidence as the floor for current ambition, not its ceiling.

England has lower rates of drug-related deaths and blood-borne virus infections than most of Europe and North America. Most people who enter treatment want to recover and break free of their drug dependence. More can be helped to realise this ambition if safe, evidence-based, recovery-orientated practice can be allied with the public health and wider social benefits already accrued from treatment.

Research, the international track record, and clinical experience, show that not everyone who comes into treatment will overcome their dependence, but that it is not possible or ethical to predict who will eventually do so – why we are obliged to create a treatment system which makes every effort to provide the right package of support to maximise each individual's chances of recovery.

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

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

Sticking closely to the compelling evidence for effective opioid substitution treatment and existing guidance based on that evidence will deliver many of the improvements needed, but more can and should be done. A determined assessment of the shortfalls in provision, followed by remedial action, is a priority if treatment is to fulfil its potential in supporting recovery. It is not acceptable to leave people in opioid substitution treatment without actively supporting their recovery and regularly reviewing the benefits of their treatment, as well as checking, responding to, and stimulating their readiness for change. Nor is it acceptable to impose time limits on their treatment that take no account of individual history, needs and circumstances, or the benefits of continued treatment. Treatment must be supportive and aspirational, realistic and protective.

Some people have the personal and other resources ('recovery capital') which enable them to stabilise and leave treatment more quickly than others. Many others have long-term problems and complex needs, meaning their recovery may take much longer and they require help to build their recovery capital. Treatment given over this time scale must maintain its recovery orientation.

Arbitrarily or prematurely curtailing opioid substitution treatment will not help the patient sustain their recovery and is not in the interests of the wider community. It risks losing any advances because it is externally imposed and so has no meaning; the individual does not own the decision. This would likely lead to an increase in blood-borne virus rates, drug-related deaths, and crime. However, clear and ambitious goals, with time scales for action, are key components of effective individualised treatment, especially when the individual collaborates in planning them. The expert group strongly supports continued reference and adherence to NICE drug misuse guidance and to the more practitioner-orientated 2007 clinical guidelines.

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

Opioid substitution treatment will improve as a result of changes at a system, service and individual level. These include:
• treatment systems and services having a clear and coherent vision and framework for recovery visible to people in treatment, owned by all staff and maintained by strong leadership;
• purposeful treatment interventions that are properly assessed, planned, measured, reviewed and adapted;
• 'phased and layered' interventions that reflect the different needs of people at different times;
• treatment that creates the therapeutic conditions and optimism through which people, and especially those with few internal and external resources, can meet the challenge of initiating and maintaining change;
• programmes that optimise the medication according to the evidence and guidance;
• measuring recovery by assessing and tracking improvements in severity, complexity and recovery capital, then using this information to tailor interventions and support that boost an individual's chances of recovering and promote progress towards that goal;
• treatment services that are not expected to deliver recovery on their own but are integrated with, and benefit from, other services such as mutual aid, employment support and housing; and
• treatment that works alongside peers and families to give people direct access to, or signposts and facilitated support to, opportunities to reduce and stop their drug use, improve their physical and mental health, engage with others in recovery, improve relationships (including with their children), find meaningful work, build key life skills, and secure housing.

Supplement on reviewing treatment

Following the publication of the report the Chief Medical Officer asked the same expert group for further advice on:
• the frequency at which an individual receiving treatment for addiction should be reviewed (to determine the benefit of the treatment and thus whether alternative treatments should be tried);
• the structure of the review meetings (what should be considered, how to assess the benefit a patient is receiving, tools for decision making, etc).

The group's response was published in 2013. It recommended:
• care planning, with its ongoing and planned reviews of specific goals and actions, should be part of a phased and layered treatment programme;
• a strategic review of the client's recovery pathway will normally be necessary within three months (and no later than six months) of treatment entry, and will then usually be repeated at six-monthly intervals;
• a strategic review should always revisit recovery goals and pathways (to support clients to move towards a drug-free lifestyle);
• drug treatment should be reviewed based on an assessment of improvement (or preservation of benefit) across the core domains of successful recovery.

To enable this to happen, the group said commissioners will want to ensure that the services they support: have the resources (sufficient staff, with appropriate competences and the time) to conduct ongoing, specific and strategic reviews; monitor a range of recovery outcomes to understand and demonstrate the benefits being derived from treatment; have access to a diverse range of interventions, intensities and settings (including residential) to optimise treatment and care.

FINDINGS COMMENTARY The featured report can be understood as facing two ways. Firstly it faces forward to show that methadone maintenance and allied treatments can be part of the new recovery agenda, despite that agenda's associations in some quarters with abstinence from all drugs including legal substitutes (no methadone) and with leaving treatment (no or curtailed maintenance). At the same time it faces backward to protect previously accepted views critiqued and threatened by this agenda: acceptance of the need for long-term and even indefinite prescribing in the face of the tenacity of heroin addiction and the vulnerabilities of its sufferers; the legitimacy in recovery terms of staying in as well as leaving treatment; and the value of harm reduction objectives and achievements short of what it accepts is the abstinence ideal.

In particular, it draws 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", with specifically engineered safety nets to respond to actual or impending relapse through treatment re-entry. It accepts the government's vision of more people successfully leaving treatment, but rejects as life-threatening and counterproductive any attempt to enforce this from outside the therapeutic relationship. In this respect it continues the tradition most notably established by the 1926 Rolleston report, which protected the privileged doctor-patient relationship in the treatment of addiction from encroachment by penal drug control regulations.

The report's commitment to the new vision of recovery and how much this means services will need to change is most visible in the passages which stress links with local mutual aid networks and other peer-based recovery support groups such as Narcotics Anonymous, and the need to help support and create such networks. For many prescribing services, this kind of community inreach and outreach will not even have been peripheral, let alone central, to their work. To foster recovery as understood by the national drug strategy, they are now expected to: identify and appoint local strategic, therapeutic and community 'recovery champions'; integrate with peer support structures; link with key contacts in the various local mutual aid and peer support groups and services; undertake related staff training; ensure all patients have access to a recovery coach or can speak to people who are in recovery through local peer support services; invite mutual aid representatives in to their services to address patients and staff; offer their premises for meetings; and maximise attendance at mutual aid meetings by their patients, including making the initial contact for them, organising travel, and accompanying them to their first meeting.

Pre-recovery origins

The report traces its impetus to the 2010 English drug strategy formulated by the new Conservative-led UK government, but its origins date back to the preceding Labour years. Before the discovery of recovery as an overarching rationale, the emphasis had already shifted to getting patients to the point where they could leave treatment as a counter to the previous emphasis on retention. Since long-term retention in continuous treatment is characteristic of opioid substitute 'maintenance' programmes, the sometimes unspoken challenge was to the dominance of this approach in the treatment of heroin addiction.

In 2005 an "efficiency" strategy developed by the National Treatment Agency for Substance Misuse complained of the "lack of

emphasis on progression through the treatment system" leading to "insufficient attention ... to planning for exit". Foreseeing a time when funding would be less available, the agency's board was told that "Moving people through and out of treatment" will create the space for new entrants "without having continually to expand capacity". This trend was given what at the time was an unwelcome boost when in 2007 the crime-reduction justification for investing in treatment was challenged by the BBC on the grounds that treatment should be about getting people off drugs, leading to the admission that in England in 2006/07 just 3% of patients had completed treatment for drug problems and left drug-free.

The shock of that challenge fed through to Labour's 2008 English national drug policy, in which the word 'recovery' in the sense of recovering from addiction was used just once and incidentally. Instead the emphasis was on components (in particular those which would relieve the burden on the state at a time of when policy sought to rein in public spending) later to be subsumed under recovery – leaving treatment, getting off benefits, and going back to work: "In return for benefit payments, claimants will have a responsibility to move successfully through treatment and into employment". Announcement of a three-year standstill in central treatment funding until 2011 while numbers were expected to rise, further focused attention on squaring the circle by more patients leaving as well as coming in to treatment.

The featured report extracts what the experts on the group saw as the positives (in therapeutic terms) from these challenges, in the form of a renewed emphasis on patients progressing in treatment towards what for them and for society are more satisfactory and fulfilling lives – which mean more *can* stop drug use and leave treatment sooner – while rejecting extensions to this ambition which pose moving out of treatment as a *must do* step in the process of moving forwards to what has been dubbed 'full' recovery marked by abstinence from drugs and from legal substitutes. Neither leaving treatment in general, nor withdrawing from prescribing-based treatments in particular, are seen in the report as essential to recovery.

That supplementary advice was called for may be indicative that government concern over patients 'getting stuck' in maintenance programmes was not assuaged by the initial report. Those concerned over this issue may gain reassurance from the group's advice that six-monthly reviews should "revisit recovery goals and pathways" with a view to supporting clients "to move towards a drug-free lifestyle". However, the group maintained the initial report's opposition to "arbitrarily or prematurely curtailing opioid substitution treatment", its insistence that such decisions are for the individual patient and clinical team, and that both will need to balance risk and maintenance of gains with the ambition to move on: "Balancing support for optimistic, abstinence-based recovery steps – and fully-informed risk-taking to achieve this – and supporting reduction of risk of premature drop-out and avoidable harm and death, is an important contextual issue within which strategic reviews of care always take place, and need to be addressed with the patient".

Challenges to the challenges

The report's challenging agenda itself faces challenges from outside the world of humane and patient-centred medical practice within which its recommendations were framed. The economic forces and moral (or in some eyes, moralistic) values which predated recovery and helped elevate it to an overarching principle remain. Falling per-patient spending in addiction treatment allied with austerity threatening general support for the poor and vulnerable will make it harder to build the 'recovery capital' the report saw as often the prerequisite to safe treatment exit. At the same time, health service funding restrictions and the possible diversion of addiction treatment funding to other public health objectives will make it harder to fund continued treatment.

The temptation will be for commissioners and services to make non-patient centred limitations on the length and intensity of treatment journeys, and to focus on simple and clear 'recovery' outcomes like end-of-treatment abstinence and treatment exit, in lieu of more nebulous and harder to evidence outcomes like a more satisfying and productive life and the prevention of disease, or those much more difficult to engineer like a job and a house and the resumption of family life.

Another option is to find the resources to implement the spirit of the report's recommendations and ambitions by cutting patient numbers. The report might be seen as justifying increased investment in building the 'recovery capital' of the subset of actual or potential methadone patients committed to recovery in the form of abstinence and social reintegration and for whom these are feasible aims – transitioning methadone from a mass but relatively low intensity public health intervention for the many, to more of a Rolls Royce option for the few. The result may be more complete recovery for those who qualify, but also to jeopardise the crime reduction benefits which in economic terms justify services, and to weaken the lifesaving impact of mass treatment entry resulting in heroin use reductions seemingly unavailable on this scale from other treatment modalities. In April 2010 the chair of the group which produced the featured report was among 41 experts who came together to defend "this life-saving treatment", an unprecedented alliance which shows how seriously they took moves to curtail methadone. It should, they said, "be readily available to every person using heroin that seeks help, accepts this option and meets national criteria." Those who agree with this sentiment might not want a 'recovery-oriented' service if this means making methadone less available and cutting patient numbers. For the time being treatment funding allocations largely based on numbers in treatment will it is thought restrain this tendency. The saving grace which might rescue services from this dilemma is the retreat from heroin use across the population, automatically reducing patient numbers.

Any form of patient-centred treatment, whether or not under the umbrella of recovery, is threatened by 'payment by results' schemes which pre-set the treatment destination in detail without reference to what the individual patient wants, and in a way services cannot afford to ignore because their financial survival depends on meeting the criteria for payment. Some local schemes have created a space for the patient's ambitions in their payment criteria, but this is not a required element, or one which sits easily within a system predicated on observable outcomes the public and their representatives recognise and are willing to pay for.

At the same time the upheaval caused by these developments and the loosening of central control both force and permit innovative ways of working by new players, which some treatment systems and some patients may be able to take advantage of to breach the boundaries of custom and risk aversion which have limited productive change.

The editor of Drug and Alcohol Findings who drafted this analysis was a member of the expert group responsible for the featured report.

Thanks for their comments on this entry in draft to John Strang of the National Addiction Centre in London who chaired the expert group, and to Jon Derricot. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 15 January 2014. First uploaded 30 July 2012

Top 10 most closely related documents on this site. For more try a **subject** or **free text** search

The Patel report: Reducing drug-related crime and rehabilitating offenders DOCUMENT 2010
Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence DOCUMENT 2009
The SUMMIT Trial: a field comparison of buprenorphine versus methadone maintenance treatment STUDY 2010
What is the role of harm reduction when drug users say they want abstinence? STUDY 2011
Long-term outcomes of aftercare participation following various forms of drug abuse treatment in Scotland STUDY 2010
The effectiveness of opioid maintenance treatment in prison settings: a systematic review STUDY 2012
Drug policy and the public good: evidence for effective interventions REVIEW 2012
Changing attitudes and beliefs of staff working in methadone maintenance programs STUDY 1998
International review and UK guidance weigh merits of buprenorphine versus methadone maintenance REVIEW 2008

Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care DOCUMENT 2011