



Public Health
England

Medications in recovery:
best practice in reviewing treatment
Supplementary advice from the
Recovery Orientated Drug Treatment Expert Group

About Public Health England

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Contents

Forewords	4
Introduction and summary	5
Responding to particular findings in a review	8
The expert group's advice:	
Re-orientating drug dependence treatment: supplementary advice on the frequency and context of reviews	9
1 The frequency and timing of care plan review, including strategic review	9
2 Elements of strategic review processes	11
Appendices	14
Appendix A – Evidence-based guidance	15
Appendix B – The context for reviewing progress	16
Appendix C – Scenarios for possible responses to a review's findings	18
Appendix D – Members of the group and observers	20
Appendix E – Members' declarations of interest (available separately)	

Forewords



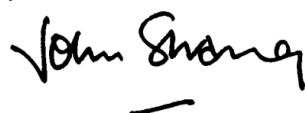
'Medications in recovery' – 2012's report from the Recovery Orientated Drug Treatment (RODT) expert group – provided drug treatment commissioners and services with invaluable advice on how to ensure drug dependent patients' recovery ambitions can be best realised while ensuring their continued protection from the risks of relapse to drug use. Earlier this year, I asked John Strang to reconvene the expert group to provide me with some further advice on the frequency and content of treatment reviews that can ensure continued treatment benefit. I am grateful to Professor Strang and his group for quickly and effectively providing me with that advice, which Public Health England's Alcohol and Drug team has then framed for the benefit of commissioners and services.

A handwritten signature in black ink that reads "Sally Davies".

Professor Dame Sally Davies, Chief Medical Officer



It is vital to review the progress of any medical treatment and to tailor treatment accordingly. This supplementary report from the RODT expert group describes the nature of the different review processes that should take place during drug treatment to ensure that patients are deriving the most benefit possible from the available interventions. Review is both an integral and ongoing part of every contact with a patient, and a periodic opportunity to step back and more thoroughly review the interventions being provided and the individual patient's response to them. If greater benefit might be derived from changing the interventions, their intensity or their setting, then review provides the information and opportunity for patient and clinician to revise the treatment plan.

A handwritten signature in black ink that reads "John Strang".

Professor John Strang, Chair, Recovery Orientated Drug Treatment Expert Group

Introduction and summary

In 2012, the Recovery Orientated Drug Treatment Expert Group published its report, Medications in recovery: re-orientating drug dependence treatment. The report supports a radical ambition to place prescribing within a fully recovery-orientated system of care, with changes at system, service and individual levels. The report makes clear that this involves treatment services continuing to re-orient their delivery of care to provide active and visible support for recovery from the point of entry to treatment, during treatment and after exit, and that successful recovery also relies on support from others, including mutual aid, employment and housing services.

In the summer of 2013, the Chief Medical Officer (CMO) asked for further advice from the expert group 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 responded to CMO in September 2013 and, following her review of their advice, she has agreed with the group that PHE should publish the advice for the benefit of the field.

The group's advice makes clear that:

- 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 clinical advice to be followed locally, commissioners will want to ensure their services:

- have the resources (sufficient staff, with appropriate competences and the time) to conduct ongoing, specific and strategic reviews as specified
- 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

PHE's forthcoming 'Turning evidence into practice' briefing on optimising opioid substitution treatment will also be useful to commissioners and providers.

The group sets its advice within the context that:

- effective review of progress in treatment plays a key role in the continuing ambition for treatment to be sensitive to the needs and circumstances of each patient, and purposeful and adaptive in its approach
- dependent drug use is a severe and multi-dimensional disorder causing impairment across health domains and, crucially, extending into non-health domains
- effective drug treatment provides benefits and improvements across these domains
- for some people, early abstinence is achievable and must be supported but, for many, despite effective treatment provided, dependent drug use is a long-term disorder – often with periods of remission – with intermittent acute episodes. Both short- and long-term considerations are important to improve long-term benefit
- the risk of premature death is increased by drug use and, in the long-term, reduced in treatment. There is also a transient elevated risk of death in the very early stages of treatment and, briefly, following the end of treatment
- these risks require careful assessment and attention to medication dose and compliance, and to other relapse risks. Strategic reviews balance support for recovery steps – and fully-informed risk-taking to achieve them – and reduction of risk of premature drop-out and avoidable harm and death
- effective assessment involves service users in the planning of their care, and covers all key dimensions of their life, to lead to clarity on goals, and plans to develop support and skills to reduce risks
- drug treatment often occurs in episodes and its benefits are iterative, building over time to reduce the risk of future relapse

- a wide range of intervention options – at different intensities and changing during the course of treatment – needs to be available
- reviews aim to maintain or modify treatment and recovery interventions – and other supports – to sustain or improve the patient’s response and recovery
- support should continue after the end of formal treatment to monitor, maintain and support recovery, provide additional support over critical transitional periods, and provide rapid access back into treatment at the first sign of relapse

Responding to particular findings in a review

Finding	Possible response
Demonstrated adherence to and stability on opioid substitution treatment	Introduce option of some take-home doses
Further good continued medication adherence and clinical benefit	Extend provision of take-home doses
Deterioration of adherence to opioid substitution treatment	Reinstate supervised dosing, along with a schedule of earlier re-review
Benefit previously achieved from OST but no further accrual of benefit occurring	Examine whether benefit is still being achieved and has reached a plateau (and decide whether it should be usefully continued), or whether the treatment is now no longer necessary. Any change in medical management, such as reduction or cessation of protective medication, should be applied cautiously, with contingent arrangements in place for revision of the care plan in the event of the recurrence of the condition being treated.
Benefit from treatment appears less than originally anticipated	Consider the progress of the patient over the longer period and recognise partial degrees of benefit, as these can be important for the patient and for society (e.g. cessation of injecting, cessation of crime, improved physical or psychological health, improved parenting). Consider adjustments or supplementary interventions that may increase the effectiveness of the interventions.
No appearance of benefit being achieved	Re-consider the wider range of available interventions and, if agreed suitable, make arrangements to access alternative treatments.
Good progress	Step up the recovery support being provided, such as accelerating access to education and employment opportunities, and providing options to support others in their recovery.

Re-orientating drug dependence treatment: supplementary advice on the frequency and context of reviews

1 The frequency and timing of care plan review, including strategic review

“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)”

- 1.1 Ongoing clinical review must be part of every one-to-one, structured appointment between the patient and their keyworker.
- 1.2 In addition to this ongoing process of monitoring of care (which can lead to updating of specific elements of the care plan), there are planned reviews of particular actions and goals, and comprehensive 'strategic' reviews of progress.
- 1.3 For patients who are on treatment that includes opioid substitution treatment, strategic reviews will normally be necessary within three months (and no later than six months) of treatment entry. It will then usually be repeated at six-monthly intervals, although this interval may be shortened (or in carefully considered cases extended) in the light of the findings from the previous review and in agreement with the patient.
- 1.4 The group gave careful consideration to whether there should be a fixed scheduling of the exact timings of reviews. It concluded that, rather than a fixed timetable, decisions on frequency should be personalised and deliberative, taking into account the patient's circumstances and progress.
- 1.5 The frequency of strategic review can often be reduced when the patient is deriving clear benefit from the interventions currently being provided and no significant change to treatment over the coming period is envisaged. In this circumstance, ongoing reviews would examine whether adjustment to the care plan has the potential to increase benefit further.

- 1.6 Review is likely to be called earlier and more frequently for patients who are early in their treatment; who are on treatments of short-term duration; whose condition is complex, comorbid or problematic; for whom treatment is not producing the expected benefits; and at times of personal transition or changes in setting and situation.
- 1.7 Reviews should continue after treatment (i.e. after the end of a specific element of treatment, such as conclusion of detox, conclusion of OST, or conclusion of period of in-patient care or residential rehab) in the form of pre-scheduled recovery check-ups that monitor recovery, allow for recovery supports to be maintained or increased, and provide rapid access back into treatment at early signs of relapse risk.

2 Elements of strategic review processes

“The structure of the review meetings (what should be considered, how to assess the benefit a patient is receiving, tools for decision making, etc).”

- 2.1 There is no single format for strategic review but the patient should always be the central participant
- 2.2 Where there are high risks, involving multiple contributors, a full multidisciplinary and multi-agency meeting with the patient, to review the overall recovery care plan, may be appropriate, and in inpatient and residential settings, such reviews may be the norm.
- 2.3 However organised, the strategic review should be rigorous. It must always involve a 'stepping-back' overview of the care plan previously agreed with the patient.
- 2.4 In some cases, the keyworker may best review the care and progress of their patient as part of that keyworker's reflective practice and professional development, within supervision and within multidisciplinary team support and overview arrangements. Where any such strategic supervision may take place in the absence of a patient, the review should only be considered complete when this has properly involved the patient (usually before and after), and when any decision that has been made to amend or to maintain the current recovery care plan, between the patient and the keyworker, has followed in light of that involvement.
- 2.5 Leading a review requires expertise and knowledge. A senior practitioner will usually lead a strategic review, especially when treatment includes prescribing. This senior practitioner must be skilled in the addictions field and knowledgeable about the diversity of treatment options and the associated quality evidence bases (eg, NICE, Cochrane, DH Guidelines), as well as the potential confounding factors such as co-morbidities. The practitioner needs to be provided with effective administrative and keyworker support to ensure they have ready access to all relevant information and to make most efficient use of their time.
- 2.6 Other relevant people to involve in the strategic review process, in addition to the keyworker, patient and senior practitioner, might include

team psychologists, nurses, doctors and recovery workers; relevant third-parties (eg, perspectives from the patient's family, partner or employer); extended team members (such as dispensing pharmacists and social workers); and workers from other agencies involved (such as skill-support/reintegration workers and probation officers). In practical terms, how these relevant inputs are obtained will vary from case to case.

- 2.7 A broad range of indicators and measures of treatment benefit and recovery need to be considered in strategic review. Fundamentally, these will include both the progress on the current recovery care plan goals and actions, and also the progress, or otherwise, that has been made since initial entry to treatment. This consideration of progress should also include any other measures relevant to a patient's gains (or losses) in recovery capital and in addressing identified problems/pathology, including objective measures that are available.
- 2.8 The patient's self-report and comments from the family (and any significant others) are also important elements of the review.
- 2.9 Objective measures and indicators will typically include:
- scores from the Treatment Outcomes Profile (TOP), including measures of physical health and psychological wellbeing
 - drug testing results (ie, compilation of results from urine-testing, and/or breathalyser and or other newer possible methods such as saliva or sweat testing for drugs), as a measure of (i) compliance with prescribed medication, (ii) stopping problem drug use, and (iii) to corroborate the patient's self-report
 - independent assessment and/or measures of stability/recovery: employment, housing, engagement with family, taking responsibility for childcare, etc
 - compliance with pharmacy attendance and with supervised dosing requirements (eg, reports back from dispensing and supervising community pharmacists)
- 2.10 In order to avoid undue focus only on current care plan goals and interventions, the strategic review needs to measure improvements with regard to the primary diagnosis and the main problem drug (or drug class) and then consider the possible co-existence of other addictive problems and other co-morbidities. The review needs to re-assess the current state of progress in all the core assessment and care planning domains: drug and alcohol use (including associated

hazardous behaviours such as injecting and sharing equipment), physical and psychological health, criminal involvement and offending, and social functioning. The relative balance of importance of each and the nature of what is considered will change according to the individual and their progress.

- 2.11 It is important that strategic reviews do not become unduly narrow in focus, particularly for those patients who have received prescribed substitute or other medication. The review should specifically consider both the medications being prescribed and other interventions being provided, and the benefit being derived from each (and possible interplay or potential positive or negative interactions). Successful progress in recovery for those on substitute medication, whilst needing properly to take account of the continued use of any necessary medication, must be based on assessment of improvements (or otherwise) across all the core domains of successful recovery.
- 2.12 It is important that all reviews, including strategic reviews, are focused on adding real value to care, as efficiently and effectively as possible. Reviews should not be rigid and formulaic but should reflect the place of the individual in their recovery journey. In general, one may expect the emphasis of such reviews to be different for different stages of the recovery journeys. Early on, reductions of hazardous patterns of drug use, arrangements for substitute prescribing, treatment of comorbid problems and/or support for emergency housing may be key strategic focuses for those commencing opioid substitution treatments, alongside early consideration of the potential trajectories for successful exits; while at a later stage, skill assessments and development, therapeutic family work and improving social relations may have a greater focus for the strategic reviews, and involve more and different contributors. As treatment and recovery progress, it is appropriate for the goals and actions of recovery care plans to be increasingly self-managed by the patient.
- 2.13 The group's 2012 report addressed the need for purposeful, adaptive treatment and recommended a phased and layered approach, which includes a full range of community and residential treatment options, available to respond to an individual's changing needs or the failure of a particular course of action to deliver clear benefit.
- 2.14 If difficulties are encountered in optimising treatment and care due to problems in accessing the diverse menu of interventions, intensities and settings (including residential) so as to impair recovery, it is

important that this is recorded as part of strategic reviews and for it to be reported within teams, with provider organisations and to commissioners as evidence of possible unmet need locally.

Appendices

A – Evidence-based guidance

B – The context for reviewing progress

C – Scenarios for possible responses to a review's findings

D – Members of the group and observers

E – Members' declarations of interest (available separately)

Appendix A – Evidence-based guidance

There is already extensive evidence-based guidance relevant to any review of processes to guide clinicians, and which the group have reflected in preparing this note. The guidance includes:

- Technology Appraisals and Clinical Guidelines from the National Institute for Health and Care Excellence
 - NICE (2007) Drug misuse: opiate detoxification. NICE Clinical Guideline 52. London: National Institute for Health and Clinical Excellence
 - NICE (2007) Drug misuse: psychosocial interventions. NICE Clinical Guideline 51. London: National Institute for Health and Clinical Excellence
 - NICE (2007) Methadone and buprenorphine for the management of opioid dependence. NICE Technology Appraisal guidance 114. London: National Institute for Health and Clinical Excellence
 - NICE (2007) Naltrexone for the management of opioid dependence. NICE Technology Appraisal guidance 115. London: National Institute for Health and Clinical Excellence

NB The above technology appraisals and clinical guidelines were reviewed by NICE in 2010 and 2011 respectively, when they decided no new evidence had been published that was likely to have a material effect on the guidance, which therefore remains current in 2013.

- The 2007 Clinical Guidelines
 - Department of Health (England) and the devolved administrations (2007) 'Drug Misuse and Dependence: UK Guidelines on Clinical Management'. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive
- Cochrane reviews
 - Cochrane Database of Systematic Reviews – over 50 drug dependence reviews available at www.thecochranelibrary.com
- The National Treatment Agency's care planning practice guide
 - NTA (2006) Care Planning Practice Guide. London: National Treatment Agency for Substance Misuse.
- The RODT group's 2012 report
 - Recovery Orientated Drug Treatment Expert Group (2012) Medications in Recovery: Re-Orientating Drug Dependence Treatment. London: National Treatment Agency for Substance Misuse.

Appendix B – The context for reviewing progress

As our 2012 report¹ made clear, there is “an accessible, evidence-based, drug treatment system in every part of England”. It is highly effective but needs constant vigilance to ensure that it is firmly rooted in the evidence base while also being sensitive to the different needs and circumstances of each individual patient, being ambitious for the individual, and being purposeful and adaptive in its approach. Effective review of progress in treatment plays a key role in that ambition.

Dependent drug use is a severe and multi-dimensional disorder causing impairment across health domains and, crucially, extending into non-health domains such as crime, child protection, and inter-generational transfer. It can have a profound impact on an individual’s life and functioning, and relationships, and lead to social deterioration.

Effective drug treatment provides benefits and improvements across these domains.

While, for some people, early abstinence is achievable and must be supported, for many, despite effective treatment provided, the pattern of dependent drug use is that of an acute-on-chronic disorder, in which a long-term disorder, often with periods of remission, has intermittent acute episodes. In the addiction treatment field, both the short-term and the long-term considerations are important, in order to improve long-term benefit.

The risk of premature death is increased by drug use and, in the long-term, reduced in treatment. But there is also a transient elevated risk of death in the very early stages of treatment and, briefly, following the end of treatment, which requires careful assessment of risk, and attention to dosing of any medications, medication compliance and to other risk factors for relapse that may usefully still be addressed prior to departure from treatment. In view of the known risks of fatality in the initial weeks of abstinence or after leaving treatment, care plans need to incorporate knowledge and understanding of the risks and the development of patients’ skills needed to reduce or minimise them. 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

¹ Recovery Orientated Drug Treatment Expert Group (2012) Medications in Recovery: Re-Orientating Drug Dependence Treatment. London: National Treatment Agency for Substance Misuse.

contextual issue within which strategic reviews of care always take place, and need to be addressed with the patient.

Effective assessment at the beginning of treatment focuses on active involvement of the patient in all elements of the assessment and planning of care, and covers all key dimensions of their life, to lead to clarity on the agreement of positive and realistic goals, and those plans to develop support and skills to reduce key risks.

Drug treatment is holistic, addressing all the domains of a patient's life and functioning. Because of the nature of the condition, it often occurs in episodes and is iterative, building over time to enable the patient to derive health benefit and to reduce the risk of future relapse.

To do this, a wide range of intervention options – at different intensities and changing during the course of treatment – needs to be available, including social supports that involve the family or peers. Where there are only limited opportunities to address an individual's identified key needs, such as for education, training or stable housing, this can limit the effectiveness of any review process.

Reviewing treatment interventions, the benefits derived from them and the progress the patient is making, is an ongoing and integral part of treatment, of the therapeutic alliance between patient and practitioner, and of an effective practitioner's reflective practice. In addition to regular and frequent keyworker review, there will also be specific dated reviews of goals and actions within the patient's care plan, and more intensive and strategic review processes in which those involved in the patient's care 'step back' and analyse the patient's care and response with the benefit of collected data and other information, and input from colleagues.

Whatever the form of reviews, the aim will be to maintain or modify the treatment and recovery interventions, and other supports being provided, in order to sustain or improve the patient's response and recovery.

Support for the patient does not end with treatment. It needs to monitor, maintain and support continuing and accumulating recovery, provide any necessary additional structure and support over critical transitional periods, and provide rapid access back into treatment at the first sign of relapse.

Appendix C – Scenarios for possible responses to a review’s findings

The 2007 Clinical Guidelines² already describe some possible responses to patients failing to benefit from treatment for specified reasons. They also cover consideration of possible termination of a failing treatment. Based on these considerations, what follows is a more detailed description of how reviewers might need to respond to particular findings in a review.

1. For patients being prescribed opioid substitution treatments (usually oral methadone or sublingual buprenorphine), the findings at review will guide consideration of modification of arrangements for dispensing, such as potential introduction of provision of take-home doses for a patient with demonstrated stability, and extension of this provision after later evidence of good continued medication adherence following earlier introduction of take-home doses. However if evidence is elicited of deterioration of adherence, then reinstatement of supervised dosing would often follow, along with a schedule of earlier re-review.
2. For patients where benefit has been achieved through opioid substitution treatment but where no further accrual of benefit is occurring, the senior clinician and the patient need to use the occasion of the review to examine whether benefit is still being achieved and has reached a plateau (and a decision made about whether it should be usefully continued), or whether the treatment is now no longer necessary. It is often difficult to make a correct judgement, in much the same way as when good benefit has been achieved with medications in the treatment of other conditions such as depression, epilepsy and hypertension. In each instance, any change in medical management, such as reduction or cessation of the protective medication, should be applied cautiously, with prior plans for revision of the care plan in the event of the earliest signs of recurrence of the condition being treated. Furthermore this increased vigilance and support are particularly important over any such planned period of medication change, and in the period following.
3. For patients where benefit from treatment appears less than originally anticipated, the senior reviewer must make sure to consider the progress of the patient over the longer period and be able to recognise partial degrees of benefit, as these can be important for the patient and for society (e.g. cessation of injecting, cessation of crime, improved physical

² Department of Health (England) and the devolved administrations (2007) Drug Misuse and Dependence: UK Guidelines on Clinical Management. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive

or psychological health, improved parenting). The purpose of the review should then include consideration of adjustments or supplementary interventions that may increase the effectiveness of the interventions.

4. For patients where it appears that no benefit is being achieved, the senior reviewer and the patient need to re-consider the range of available interventions and, if agreed suitable, make arrangements to access alternative treatments.
5. For a patient making good progress, it will likely be appropriate to step up the recovery support being provided, such as accelerating access to education and employment opportunities, and providing options to support others in their recovery.
6. The aim of the clinician will be to gradually step back as the patient becomes more in control of managing their condition and their recovery.

Appendix D – Members of the group and observers

Members:

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

Observers attended from:

- Department for Work and Pensions (Rachel Radice)
- Department of Health drug and alcohol team (John McCracken, Dr Mark Prunty, Ray Smith)
- Home Office drugs strategy team (Ahmed Azam)
- NHS England (Christine Kelly)
- Welsh Government (Dr Rhian Hills)
- Public Health England alcohol and drugs (Helen Clark, Peter Burkinshaw, John Marsden, Mark Gilman), which also provided secretariat (Steve Taylor, Daniel Burn)