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RECOVERY-ORIENTATED DRUG TREATMENT AN INTERIM REPORT

BY PROFESSOR JOHN STRANG, CHAIR OF THE EXPERT GROUP

Recovery-Orientated Drug Treatment

An interim report by Professor John Strang, chair of the expert group

BACKGROUND

In August 2010, the NTA – on behalf of the Department of Health – asked me to chair a group to provide guidance to the drug treatment field on the proper use of medications to aid recovery and on how the care for those in need of effective and evidence-based drug treatment is more fully orientated to optimise recovery. This work would also address the critical observation, subsequently highlighted in the 2010 Drug Strategy¹, that “for too many people currently on a substitute prescription, what should be the first step on the journey to recovery risks ending there.” As an example of the recovery orientation, the strategy expected that “all those on a substitute prescription engage in recovery activities”.

The group’s task would be to provide guidance to clinicians about the more effective provision of recovery-orientated opioid substitution and other drug treatments as part of broader personalised recovery plans. For some individuals with heroin addiction, the best treatment may include substitute medication, while for others this may be inappropriate or unnecessary. In all instances, the objective is to enable individuals to achieve their fullest personal recovery. The expert group would develop clinical protocols to guide clinicians and agencies so they can help individuals make progress towards this objective, improve support for long-term recovery, and avoid unplanned drift into open-ended maintenance prescribing.

This project was a central plank of the NTA’s business plan for 2010-11².

I selected a wide group of experts from across the country. Many of these were experienced clinicians

whose working practice includes prescribing medications for addiction treatments in primary and secondary care settings. Experts also came from a range of other clinical and rehabilitative settings, often bringing a breadth of knowledge and experience of recovery-orientated programmes. The group included colleagues who have voiced criticisms of the current system, and others who brought experience of driving improvements in the recovery focus of addiction treatments.

The group was joined by observers from government departments and the NTA, which also provided its secretariat. We also have the benefit of a number of experts from across the world who have kindly agreed to provide advice by correspondence.

The group’s agreed terms of reference are appended.

Since the group was convened in October 2010 we have met six times and covered much ground. Further work has taken place outside the full meetings, including that of sub-groups (reported below). We still have more to do and we expect to produce a substantial product which reports conclusions and recommendations early next year. In the meantime, I am able to provide some early observations about where we have found common ground, how treatment services and systems can immediately improve the treatment they offer to patients*, and a vision for recovery-orientated drug treatment.

*I have used the term ‘patient’ throughout, in part because of the clinician orientation of this document, but we are aware others may prefer different terms. Whatever the terminology and framework, we are looking to ensure an orientation of nurturing recovery and a style of working with people to help them recover.

COMMON GROUND

The group noted the remarkably strong body of research evidence for the effectiveness of opioid substitution treatment (OST), albeit mostly from other countries. When delivered correctly to the right individuals at the right time, OST retains patients in treatment, supports improvements in health and social functioning, reduces crime and illicit drug use, prevents the spread of blood-borne viruses and protects against overdose.

We need to hold on to what is good, and use it as a platform from which to achieve more. We have listened and heard evidence from drug users and colleagues around the country that, too often, people with addiction problems could be better supported in their recovery, and that there could be greater ambition for and focus on their potential to make further progress.

There has been a growing recognition of imbalance within the system over the last few years. The re-examination of drug strategy following the election of the coalition government in May 2010 was the catalyst for the review we are currently undertaking.

The group also noted the diversity and complexity of both drug misuse and the needs of those who use drugs. It has rarely been the case that a problem with a single drug requires a single, simple solution; many people in need of treatment have complex physical, mental health and social problems requiring complex interventions.

The drive in recent years to reduce waiting lists and retain people in treatment has generally been successful with the result that much larger numbers of patients with addiction problems now enter treatment. This has undoubtedly been accompanied by significant benefits for many patients and the communities in which they live.

However, the desire of clinicians to secure these benefits has led, in some instances, to over-reliance on medication and patients being allowed to drift into long-term maintenance. As a consequence, insufficient attention may have been paid to reviewing the actual benefits gained, reconsidering alternative methods to maximise the prospect of personal recovery, and adjusting treatments so that greater recovery could be achieved.

The prescribing of any medication (and perhaps especially of OST) must not be allowed to become detached and delivered in isolation from other crucial components of effective treatment. Other elements

of overall care need also to be considered, including individual recovery care planning, psychosocial interventions and integration with mutual aid and peer support. All of these, in different combinations with different patients, and adjusted over time, can and do support recovery.

Services have grown significantly during the sector's rapid expansion, which has been a time of greater reliance on medication. Staff working in these services may need additional training and support to gain the competences to improve the quality of regular review and restructuring of personalised care to support recovery.

We already have considerable experience and expertise within the UK available to us, and we also have good international links so we can learn from the best practitioners and researchers in the world. Consequently we are in a strong position to deliver any changes that, as a result of our review, we consider necessary.

EXISTING GUIDANCE, AND THE EXTENSIVE EVIDENCE ON WHICH IT IS BASED, ALREADY DESCRIBES MUCH OF WHAT IS BEST PRACTICE

In its initial deliberations the group reconsidered some of the key elements of effective drug treatment and concluded that to a large extent they were already described in existing clinical and other guidance, although not always followed in practice. The previously identified extensive research evidence base had also been further strengthened.

A comprehensive assessment of need is an essential early (and ongoing) step in the planning of personalised treatment and it should also be an integral part of the therapeutic process. Assessment should not be a process that happens to someone but one in which they are actively involved, to the fullest appropriate degree, and about which they develop their own understanding of their situation alongside the understanding provided by the clinician.

The recovery care plan that results from this assessment, and subsequent revisions when progress is reviewed, must be developed collaboratively so that it is personally relevant and 'owned' by the patient. This will increase the likelihood that they commit to, and are motivated by, a personal recovery care plan that is meaningful to them.

The construction of a recovery care plan should be built around the individual patient. Pre-existing packages of care may be used, but they must be carefully and

deliberately chosen to support the individually relevant personalised treatment that is essential to ensure an individual response based on need.

The provision of a prescription alone should not be considered to constitute the totality of treatment. Previous guidance³ has made it abundantly clear that better results can generally be achieved by the proper incorporation of psychosocial interventions within a comprehensive OST programme. However it needs to be noted that even OST with minimal psychological input can reduce injecting and drug-related deaths.

In our opinion, while the gains from the medication component of treatment can be significant, there would be benefit from incorporating more of these non-medication elements of treatment and from aiming for higher achievement from such treatments. The competent provision of the medication element of the treatment – and tailoring it to the individual – may be important, but it is still only the medication element.

Medication can valuably support individuals to make changes to harmful behaviour, just as nicotine replacement treatments can help individuals to quit their previous smoking; but in such cases, active commitment and effort is required from the individual in order to maximise the impact of the medication.

Regular reviews of progress enable the clinician and patient to assess continuing and changed need, and appropriate responses. The Treatment Outcomes Profile (TOP) has been specifically developed and validated⁴ for use in reviewing progress, and has been widely adopted on a routine regular basis by many treatment agencies.

We have considered criticisms of the TOP as a tool and of its intrusion into clinical practice. There may be room for improvement – and the NTA is addressing this – but it is essential that a culture of regular use of common validated measures becomes part of our clinical practice. This includes tracking progress as evidenced by change over time, and ensuring widespread use of the same (or directly comparable) measures across clinicians and services.

Repeated reviews should result not only in a personalised assessment but also the optimised treatment for the individual. This should include – but certainly not be limited to – attention to elements of the medication component of treatment. If an individual is deriving little or no benefit from an intervention, then it should be modified and tailored in partnership with the patient so that the provision of the treatment delivers identified and valued benefit.

THE TOTAL PACKAGE MAY APPEAR COMPLEX AND WILL FOLLOW, BUT THIS IS WHAT CAN ALREADY BE DONE

The total package for delivering recovery-orientated drug treatment is likely, in its full description, to be complex. It may take time for some treatment services and systems to fully re-orientate to achieve the best balance between reduction of negatives and accrual of positives. Our full report, described on page 7, will cover this balance in more detail.

In the meantime, there are some immediate steps that can be taken to improve the recovery orientation of treatments that include prescribing, and to ensure there is appropriate support for patients to achieve the best secure gains:

1. Conduct an audit of the balance in your service between overcoming dependence and reducing harm to ensure that both objectives properly co-exist; and that individual clinicians understand and apply a personalised assessment for each patient, repeat it at regular intervals, and on the basis of its findings re-examine and adjust the treatment plan jointly with the patient
2. Review all your patients to ensure they have achieved abstinence from their identified problem drug(s) or are working actively to achieve abstinence. Patients should also be offered the opportunity to come off medication after appropriate careful planning, when they are ready
3. Consider whether to change the current balance between promoting overcoming of dependence and promoting reduction of harms, with the aim of actively encouraging more patients to take opportunities to recover. Although no clinician should take unwarranted risk, neither should they protect patients to the extent that they are not encouraged and enabled to get better. This must always be undertaken in a way that supports each patient to make an informed choice that is relevant to their personal situation and is based on an accurate description of the available options
4. Ensure exits from treatment are visible to patients from the minute they walk through the door of your service. This means giving them enough information to understand what might comprise a treatment journey, even if their eventual exit appears to some way off. And make visible those people who have successfully exited by explicitly linking your service to a recovery community, or employing ex-service users or using them in a volunteer capacity as recovery mentors and coaches

5. If agonist or antagonist medications are being prescribed, then review, jointly with each patient and with input, as appropriate, from relevant third parties, the extent of benefit still being obtained
6. For patients who have achieved stability while on medication and who choose to reduce and/or stop the medication, ensure that support mechanisms are in place to support this transition, and also ensure that rapid re-capture avenues are in place and are understood and acceptable to the patient, in the event of failure of the transition
7. Check that all treatment is optimised so patients are receiving the range and intensity of interventions that will give them the best chance of recovery. This may include optimised doses of appropriate medications; the reintroduction, reduction or dropping of supervised consumption as appropriate; active keyworking, including case management and psychosocial interventions that keyworkers are competent to provide; access to other psychosocial interventions requiring additional competences; etc. As a first step, audit the availability of key NICE-recommended psychosocial interventions⁵, using the audit tool in the NTA/BPS Toolkit⁶
8. Strengthen or develop patients' social networks, involving families where appropriate and facilitating access to mutual aid by, for example, providing information, transport, or premises for meetings, and by bringing local recovery champions into the service to meet patients
9. Establish opportunities to accrue 'social capital' via work experience placements or employment, training opportunities, volunteer work, etc
10. Ensure all keyworkers are trained and supervised to deliver psychosocial interventions of a type and intensity appropriate to their competence. Effective keyworking entails not only recovery care planning, case management, advocacy and risk management, but also collaborative interventions designed to raise the insight and awareness of patients and help them plan and build a new life. This will often involve attention to employment and housing
11. Review the quality of your service's recovery care planning and take steps to improve it, wherever possible. Recovery care plans should be personally meaningful documents, developed over a period of comprehensive assessment, and reviewed and adapted regularly, so that they are important to and owned by the patient
12. Ensure your service works with local housing and employment services, and in partnership with commissioners, to ensure there is supported and integrated access to relevant provision.

WE WILL NEED A RENEWED EMPHASIS ON IMPROVING PEOPLE'S RECOVERY

The new agenda is about more than business as usual (or even business as it should have been). The new emphasis on recovery will often best be addressed by recourse to constructing personalised recovery care plans which include reintegration and peer support.

While not losing the benefits from reduction of the harms associated with drug use and addiction, the new emphasis will probably also require more prominent attention to efforts to obtain the positives, by embracing a more proactive and aspirational approach, identifying strengths and increasing ambition to make important behavioural changes.

For the future, we envisage a much stronger and more explicit focus on supporting the individual to reintegrate within mainstream society. Not only does this bring advantages and responsibilities, but it is also as 'therapeutic' in its own right, with discernible positives for the individual themselves as well as for society at large. Drug treatment services, working in conjunction with individual patients, will need to establish mechanisms of joint working with the wide range of services that can support someone to get a job, housing, healthcare, etc.

We are exploring the extent to which a greater emphasis on peer-led recovery (e.g. greater incorporation of, and reliance on, peer-support and mutual aid) may be beneficial, at least for some patients and at some particular stages of treatment and rehabilitation. This may require clinicians to recognise the strengths brought by our patients and their peers to enable one another to achieve and sustain recovery, and to give them greater control over how and where treatment and recovery occur.

OUR WORK HAS BEGUN TO ADDRESS FOUR KEY AREAS, AND MARKED TWO MORE AS NEEDING FUTURE ATTENTION

The group identified gaps or a lack of consensus in four main areas, one of which has already been the subject of a formal sub-group reporting to the main group, and three of which have been the subject of attention from subsets of the main group.

The area immediately delegated to a sub-group was around understanding the proportion of patients who might be expected to rapidly recover with no or limited substitute prescribing and what proportion will need long-term care, including substitute prescribing. A sub-group chaired by Dr David Best was asked to develop thinking on "patient placement criteria" (see below). The sub-group's terms of reference are appended.

Patient placement criteria

The sub-group commissioned to examine patient placement criteria developed in two areas:

1. Segmentation locality assessment

Developing models for dividing up treatment and recovery populations to allow for an understanding of differential rates of recovery probability

2. Treatment and recovery indicators

Developing a set of indicators that can be used by keyworkers at assessment and review to identify treatments and specific interventions from which clients may be most likely to benefit.

The PPC sub-group is still busily engaged in its work. It heard the initial outcomes of the Segmentation Locality Assessment work in April and plans to follow this with an initial tool for testing the treatment and recovery indicators. All of this work will first come to the full RODT group for consideration and incorporation (as appropriate) and, while it is ongoing, forms no further part of this interim report.

The next three areas settled on by the main RODT group as needing further attention were:

A. Understanding the dimensions of recovery and how these fit into a conceptual framework

As the first step on the road to recovery, treatment needs to focus not only on preventing immediate and longer-term harm but also on helping patients to build the resources they will need to sustain that recovery: 'recovery capital'. The 2010 Drug Strategy gives us a framework for recovery and the work in this first area focussed on the implications of that framework for prescribing practice. Sometimes clinicians may be too ready to accept the reduction of negatives which can occur rapidly with prescribing interventions as sufficient impact of the treatment, and they may consequently fail to work with their patient on the accrual of positives, with the involvement in treatment acting as a platform for increasing someone's social, physical, human and cultural recovery capital.

B. Determining how progress in treatment and the accumulation of 'positive capital' can be measured

Monitoring the benefits from, and progress of, treatment is an essential element of good clinical practice. The work in this second area has been to consider how recovery capital and its accumulation can best be measured in treatment. We are considering the potential contribution of various possible measures of such recovery capital. We are mindful of the wide current use of the Treatment Outcomes Profile (TOP) which has been central to the NTA's recent work in this area, but it has been agreed that the measurement of recovery (what we have taken to calling 'recoverometry') will require greater attention to the dimensions of recovery identified in the first area of work.

C. Developing an understanding of how interventions can be layered and sequenced to support a personally-relevant and evolving journey of treatment and recovery.

Bringing the previous two areas together, the third area of work is then concerned with how treatment interventions and the systems in which they are provided can be better sequenced and/or layered: an analysis of who gets what when, and how it is best delivered. We are exploring how, through a closer definition of the components of treatment and organising them into varying intensities and phases, it may be possible for there to be more effective and more efficient deployment of available resources in such a way as to maximise overall individual and societal benefit.

The two areas requiring future attention are:

- How to optimise opioid substitution therapy, which may involve different intensities and need targeted phases of treatment
- The potential wider future use of a range of medications (existing and in development, and also considering new emerging technologies) in a range of treatment and recovery settings.

A VISION FOR THE FUTURE

Our vision for the future is a system:

- In which the valuable role of prescribing continues to be recognised, though it is not an end in itself but a component of a phased, integrated package of treatment that minimises risk while being ambitious for each individual patient's recovery
- That develops and supports staff to adopt recovery-orientated practice and in which they are trained to deliver evidence-based psychosocial interventions alongside medical interventions
- In which everyone entering treatment is enabled to see and understand the range of treatment and recovery options open to them, the trajectories of the journey on which they are embarked, and the possible destinations of that journey
- That seeks to maximise what individuals can achieve, with a clear overall sense of movement and progress for patients, even during those periods when they are appropriately allowed to settle and stabilise
- That recognises the real achievement of preventing the deterioration that would otherwise have occurred to more severely damaged patients
- That closely involves families and carers in patients' treatment, and supports them in their own right
- That has close links to its community, that works alongside other systems to facilitate access to a broad range of reintegration and recovery support
- In which there are well-defined roles for current and future medications in stabilising, maintaining and detoxifying patients, and preventing relapse in different settings.

THE GROUP'S FULL REPORT

Our full report later this year is expected to cover:

- A summary of the key evidence for medication factors important in promoting recovery
- A conceptual framework of recovery which specifically examines how benefits of medication can be harnessed to best effect
- Guidance on measuring treatment benefit to support progress
- A description of how to optimise both opioid substitution therapy and also the accompanying psychological and psychosocial treatments, which, for both, may involve different intensities and need targeted phases of treatment
- Strategies to encourage greater constructive use of peer role-models and peer support
- Guidance on how it might be possible to open up new opportunities for patients making progress in their personal recovery to be supported further with employment opportunities and other ways of accruing 'social capital'
- The potential for the use of a range of medications in treatment and recovery settings.



Professor John Strang is a consultant psychiatrist, director of the National Addiction Centre, and head of the Addictions Department at King's College, London

References

- ¹HMGovernment (2010) Drug Strategy 2010 'Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life'. London: H M Government
- ²NTA (2010) NTA Business Plan 2010-11. London: National Treatment Agency for Substance Misuse
- ³E.g. 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, and the NICE suite of 2007 drug misuse guidance on which the Clinical Guidelines draw
- ⁴Marsden J, Farrell M, Bradbury C, Dale-Perera A, Eastwood B, Roxburgh M & Taylor S (2008). 'Development of the Treatment Outcomes Profile'. Addiction, 2008; 103 (9): 1450–1460
- ⁵NICE (2007) 'Drug Misuse: Psychosocial Interventions'. NICE clinical guideline 51. London: National Institute for Health and Clinical Excellence
- ⁶Pilling S, Hesketh K & Mitcheson L (2010) 'Routes to Recovery: Psychosocial Interventions for Drug Misuse. A Framework and Toolkit for Implementing NICE-recommended Treatment Interventions'. London: National Treatment Agency for Substance Misuse & British Psychological Society

APPENDIX A TERMS OF REFERENCE FOR THE EXPERT GROUP

THE GROUP'S TASK

Background

During 2010-11 the NTA will work to reposition the treatment system to focus on safe and sustained recovery, and to demonstrate transparent outcomes, while consistently providing more for less. As part of this work the NTA is convening an expert group of clinicians and other interested parties to develop clinical guidance and tools in two closely related areas.

Firstly, the NTA is committed to exploring the principle that open-ended substitute prescribing in the community should only be used in exceptional circumstances and only on the basis of a rigorous, multidisciplinary review of a patient's ongoing needs. The objective is to make the system more dynamic. We do not want to allow service users to drift into long-term maintenance prescribing without effort being made to promote beneficial change in their lives. Sound, evidence-based clinical judgement endorsed by clinical governance will be able to identify cases where the approach would not be appropriate, but the intent is to see a fundamental shift in the balance of treatment for opiate dependence, away from the unreviewed provision of long-term maintenance towards supporting individuals to overcome dependence and to recover fully.

The expert group will develop a clinical consensus and resultant protocols that focus practitioners and clients on supporting long-term recovery as the desired outcome of treatment and prevent unplanned drift into long-term maintenance.

Secondly, we wish to develop patient placement criteria to maximise access to recovery-focused pathways, ensure a consistent and transparent approach to the commissioning of community and residential rehabilitation, and achieve a cost-effective balance between different types of treatment. This will be based on a consensus on which individual drug users would benefit most from which treatment service models. This would distinguish between those requiring long-term treatment and those who can safely and quickly overcome their dependence and achieve long-term recovery. The expert group will advise on the development of a model to match individual clinical need as closely as possible to the location, intensity and duration of the treatment that is most likely to be effective at promoting recovery including indicating those who are likely to benefit from residential treatment.

These tasks, and the expert group's deliberations, are expected to feed into the NTA's development of an explicit, recovery-orientated vision for the treatment system to replace the current framework, Models of Care for Treatment of Adult Drug Misusers, last updated in 2006. The document and accompanying implementation will facilitate the transformation of local treatment systems to enshrine that greater ambition, and ensure that achieving sustained recovery from addiction is the basis of all local commissioning and service delivery in prison and community settings.

Proposed work

The proposal is therefore that an expert working group should:

Develop, for and with the National Treatment Agency, clinical consensus and appropriate clinical protocols for substitute prescribing, and a model for the segmentation of the treatment population and suitable treatment placement indicators, both in the context of the developing recovery framework.

It is likely that sub-groups may be needed to work on specific aspects of this wide-ranging task.

Status

The process of development by a respected expert group, with NTA and Department of Health support, will ensure the protocols and models are accepted as an important guide to best practice by the drug misuse treatment field and relevant professional bodies.

Coverage

The work relates to England only.

COMPOSITION

Membership

Professor John Strang (chair)
 Mike Ashton – Findings
 Dr Alison Battersby – Psychiatrist, Plymouth
 Dr James Bell – Physician, SLAM
 Dr David Best – University of West Scotland
 Dr Owen Bowden-Jones – RCPsych addictions faculty chair
 Jayne Bridge – Nurse, Mersey Care NHS Trust
 Anne Charlesworth – Commissioner, Rotherham
 Professor Alex Copello – Birmingham
 Dr Ed Day – Psychiatrist, Birmingham
 Selina Douglas – Commissioner, Westminster
 Vivienne Evans – Adfam
 Dr Eilish Gilvarry – Psychiatrist, NTW
 Jason Gough – Service user voice, Sheffield
 Kate Hall – NHS service director, GMW
 Dr Linda Harris – RCGP substance misuse unit director
 Dr Michael Kelleher – Psychiatrist, SLAM
 Dr Brian Kidd – Psychiatrist, Scotland

Tim Leighton – Action on Addiction (residential sector)
 Peter McDermott – Service user voice, The Alliance
 Professor Neil McKeganey – University of Glasgow
 Dr Luke Mitcheson – Psychologist, SLAM
 Dr Gordon Morse – GP Somerset
 Morag Murray – NHS service director, Sussex
 Noreen Oliver – BAC O'Connor
 Professor Steve Pilling – NICE and NCCMH
 Dr Roy Robertson – University of Edinburgh
 Ian Wardle – Lifeline

Observers/secretariat

Department of Health Substance Misuse team
 Department of Health Offender Health team
 Home Office drugs strategy team
 National Treatment Agency (observers and secretariat)

Corresponding members

Dr Laura Amato – Cochrane Drugs and Alcohol Group, Department of Epidemiology, Rome, Italy
 Professor Wayne Hall – National Health and Medical Research Council, Australia
 Professor Keith Humphreys – Stanford University School of Medicine, USA
 Professor A Thomas McLellan – University of Pennsylvania and Treatment Research Institute, USA
 William L White – Chestnut Health Systems, USA

Declaration of interests

Members will be required to declare any potentially conflicting interests in line with established DH policy and procedures.

Timetable

It is proposed that the initial meeting of the expert group will take place in September 2010; that the subsequent meeting schedule will be determined by the work plan of the group, and that sub groups may meet more frequently. Meetings will usually be a half or full day and mostly held in London.

The final publications are expected in 2011-12, with:

- An interim report on options for clinical protocols for substitute prescribing planned for quarter 4 2010-11
- National consultation on treatment placement indicators scheduled for quarter 3 2010-11. Piloting of the approach in selected parts of the country to refine their effectiveness is scheduled for quarter 4 2010-11.

Outputs

- The publication of clinical protocols for substitute prescribing
- A model for segmentation of the treatment population and suitable treatment placement indicators.

INPUTS

Support and costs

The expert group will be serviced and supported by the NTA, which will also fund meeting costs including travel costs for working group members.

Working group members will be able to claim hotel expenses for one night if necessary/appropriate. Expenses will be reimbursed on production of appropriate receipts and completed claim forms, according to NTA financial procedures.

APPENDIX B

THE PPC SUB-GROUP TERMS OF REFERENCE

nb. These terms of reference should be read with reference to the terms of reference of the main RODT expert group.

THE SUB-GROUP'S TASK

Background

The NTA wishes to develop patient placement criteria to maximise access to abstinence-focused pathways, ensure a consistent and transparent approach to commissioning community and residential rehabilitation, and achieve a cost-effective balance between different types of treatment. This will be based on a consensus on which drug users would benefit most from which service models and recovery-oriented pathways. This would distinguish between those requiring long-term treatment and those who could be safely and quickly moved to abstinence, and indicate those who are likely to benefit from residential treatment. The expert sub-group will advise on the development of a model to match individual clinical need as closely as possible to the location, intensity and duration of the treatment that is most likely to effectively promote recovery.

This is a sub-group of the RODT expert group, whose aim is to:

"Develop, for and with the National Treatment Agency, clinical consensus and appropriate clinical protocols for substitute prescribing, and a model for the segmentation of the treatment population and suitable treatment placement indicators, both in the context of the developing recovery framework."

The chair of the sub-group, David Best, will report back to the RODT group and will act as the link between the groups.

Proposed work

The proposal is that an expert sub-group should:

Develop, for and with the National Treatment Agency, a model for the segmentation of the treatment population and the 'at-need' group not currently

engaged in treatment, in terms of their likely recovery pathways and journeys. This will prepare the way for matching to suitable treatment placement indicators, in the context of the developing recovery framework. Overall, the aims of the group are to agree a process for meaningful segmentation and to utilise this as a way of identifying matching criteria for treatment journeys and ongoing recovery pathways.

The work of the group will be to focus on initial assessment and the decision-making at different stages of recovery journeys, and will examine wider needs, including populations whose needs may be met without recourse to formal treatment.

Status

The process of development by a respected expert group, with NTA and Department of Health support, will ensure the protocols and models are accepted as an important guide to best practice by the drug misuse treatment field and relevant professional bodies.

Coverage

The work relates to England only.

COMPOSITION

Membership

Members will primarily be drawn from the main RODT expert group but supplemented by the co-option of other key individuals.

RODT

Dr David Best (chair) – University of the West of Scotland
 Jayne Bridge – Mersey Care NHS Trust
 Dr Ed Day – University of Birmingham
 Vivienne Evans – Adfam
 Jason Gough – Service user voice
 Kate Hall – Greater Manchester West
 Linda Harris – Wakefield & RCGP
 Tim Leighton – Action on Addiction
 Peter McDermott – The Alliance

Co-opted

Nichola Adamson – Worcestershire DAAT
 Karen Biggs – Phoenix Futures
 Wendy Dawson – The Ley Community
 Tom Kirkwood – Trust the Process
 Dave Knight – RCN
 Dr David McCartney – LEAP

PPC Project Team

Colin Bradbury – NTA
 Pete Burkinshaw – Skills and Development Manager
 Alison Keating – NTA regional manager
 Dr Michael Kelleher – NTA & SLAM

Dr John Marsden – NTA & IoP
 Christopher Whiteley – NTA and East London NHS Trust

Observers/secretariat

Department of Health Substance Misuse team –
 Dr Mark Prunty, Amy Edens
 National Treatment Agency, secretariat – Steve Taylor

Corresponding members

William White
 Alexandre Laudet
 Arthur Evans
 Mike Dennis
 Robert Ali
 Steve Shoptaw
 Min Zhao

Declaration of interests

Members will be required to declare any potentially conflicting interests in line with established DH policy and procedures.

Timetable

The initial meeting of the main expert group will take place in December 2010, when consideration will be given to the frequency and timings of meetings of the sub group.

Outputs

- An outline of segmentation methods and categories for drug users in and out of treatment
- A model for segmentation of the treatment population and suitable treatment placement indicators.

INPUTS

Support and costs

The sub-group will be serviced and supported by the NTA, which will also fund meeting costs including travel costs (if needed) for members.

Working group members will be able to claim hotel expenses for one night if necessary/appropriate. Expenses will be reimbursed on production of appropriate receipts and completed claim forms, according to NTA financial procedures.