Public Health England

TURNING EVIDENCE INTO PRACTICE

Optimising opioid substitution treatment

Although opioid substitution treatment (OST) is the most effective intervention for heroin use and dependence, the medication itself, and accompanying psychosocial/recovery interventions, need to be optimised to give the user the best chance of recovery and sustained abstinence. This briefing focuses on elements that can be optimised and provides key messages to help achieve this. The content is drawn from authoritative guidance, published evidence and service provider feedback.

What is the issue?

While more service users are completing treatment drug-free and are showing evidence of sustaining their recovery, others find such change difficult. We know that various treatment factors can help to encourage positive change and promote recovery (such as using recommended 'high' doses of OST; providing flexible and responsive services; and engaging service users in psychosocial and recovery-support interventions). Older, more severely affected and complex users who have been in treatment for many years are likely to need particularly careful care planning if they are to make significant gains.

A comprehensive recovery framework for optimising OST

Individuals whose treatment has been optimised in line with the evidence base will have their care competently and regularly reviewed.[1] Agreement will be reached with users on the most appropriate combination and intensity of pharmacological, co-morbid, psychosocial and recovery support interventions for their treatment and recovery goals. Care will continue to be optimised throughout their treatment journeys, along with personalised needs assessments and regular progress reviews. Treatment will be adapted where evidence shows it is not meeting need. It is not possible to predict exactly what support options, or their order and combination, a particular service user will need. Providing a menu of options, carefully discussed with users within a positive, flexible, therapeutic and motivational framework of care is likely to be most effective, including targeted incentivisation (contingency management) when appropriate. OST may be most effective in supporting recovery within a broad evidence-based framework of care. "Arbitrarily curtailing or limiting the use of OST does not achieve sustainable recovery and is not in the interests of people in treatment or the wider community."[2]

Prompts

1. Is there a clear vision and framework for recovery within the local system?

2. Is there an established process of initial and ongoing need assessments within the service?

3. Can the local system provide packages of care that allow for treatment to be adapted, layered and phased according to individual need and changes during a recovery journey?

4. Are the competences required to deliver enhanced and intensive interventions available within the local system?

5. "Are arbitrary time limits for treatment or elements of it avoided but clear and ambitious treatment goals set, with planned timescales for action and regular reviews?"[2]

6. Is there an established process for reviewing progress that includes measuring improvements in severity, complexity and recovery capital?

7. Do users receive psychosocial interventions that are delivered by competent keyworkers?

8. Does the range of psychosocial and recovery support interventions effectively meet the needs of the local treatment population?

Shelford Treatment and Recovery Service (STARS), North Lincolnshire
STARS was set up in October 2012 to improve the recovery orientation of OST locally. Service users at STARS have their OST reviewed fortnightly – a process that is explained during their induction. The keyworker and an independent nurse prescriber conduct the reviews in collaboration with the user, and the keyworker reports on the user's progress and drug test results. Medication doses are increased or decreased, depending on need, with psychosocial interventions added or changed in response to the user's progress (or lack of it). Previously nearly all users on OST received methadone. Now treatment is tailored to the specific needs of the user, two in every five STARS service users receive buprenorphine or buprenorphine-with-naloxone.

Achieving adequate opioid levels

The recommended higher doses of OST are associated with positive treatment outcomes (including longer-term recovery with sustained abstinence). The recommended average effective doses are 60-120mg/day of methadone, and 12-16mg/day (or up to 32mg in some cases) of buprenorphine.[3] The primary reason for prescribing ongoing OST is to stop all on-top heroin use (or other opioid use). Higher dose OST can also help achieve greater stability overall. Some users opt for lower doses of OST and it is quite appropriate to prescribe this given the known value of responsive and flexible provision, and given the likely benefits that will accrue even if there is initially only partial substitution. For those who have not stopped using heroin and who are less stable, safe prescribing and dispensing systems (including access to supervised consumption) can help limit the risk of diversion. When a user receives a OST dose that is adequate for them, they will generally be in a better position to make informed choices about their next steps for recovery, including if or when to pursue sustained abstinence.

Prompts

1. Is there an induction procedure that ensures users are given information about the medications they will receive, including the consequences of sub-optimal doses?

2. Does the workforce have the necessary competences to ensure this information is effectively communicated to users?

3. Do initial care plans include goals for progressively increasing OST doses, until the service user stops using on top and/or reaches a dose of 120mg/day methadone (or occasionally more) or 16mg/day buprenorphine (or up to 32mg in some cases)?

4. Do local prescribing policies and dispensing arrangements include provisions for split dosing for users who receive methadone but still experience low-grade withdrawal symptoms[4] (including those on doses of more than 100mg/day)?

5. Have medications and dosing been audited to determine what proportion of the treatment population is being provided an ongoing OST dose that is less than the recommended average range?

6. Has the service identified any users receiving sub-optimal doses? If so, is there a plan to undertake a focused piece of work to optimise their treatment?

7. Are users regularly drug tested (including those taking less than the recommended doses for ongoing OST) to identify those who are still using on top? Does evidence of ongoing use automatically lead to an appropriate focus in the keyworking or other one-to-one reviews?

West Essex Community Drug and Alcohol Team
All service users starting OST at West Essex CDAT have one-to-one inductions with a medical professional to discuss what treatment is available, how treatment works in terms of recovery, users' expectations, and any concerns they may have. The induction also covers the consequences of sub-optimal doses and debunks the myths users starting treatment often have about OST (which can be barriers for optimising doses) and harm minimisation (including safe practices and high-risk behaviour).

A range of medications

Optimised oral methadone and buprenorphine are the first-line pharmacological interventions for opioid dependence[5,6] and effectively help many users to substantially reduce or stop their heroin use. However, a small proportion of people fails to benefit significantly from these medications and may instead benefit from other medications.

Prompts

1. Does the local system offer a range of OST medications for users who fail to benefit from first-line interventions and who show a clinical need for alternative medications to be considered?

2. Are the necessary clinical competences and experience available in the local treatment system to support the availability and use of a range of medications?

3. Is the workforce suitably knowledgeable about the evidence and guidance for OST?

4. Do local prescribing policies support the use of a range of OST medications?

5. Is information available to users to enable them to make informed choices about the medication they may be prescribed?

6. Are users actively encouraged to get involved in making decisions about the medication to be prescribed?

Supervised consumption: monitoring safety and providing support

Supervised consumption supports safer initial OST titration, as it assures continued protective tolerance for users and reduces the risk of them diverting their medication. When provided positively and confidentiality, supervision can be a source of regular and frequent support for users and is a way to closely monitor their day-to-day progress (as is daily collection to a lesser degree). UK studies have shown that users understand and value the role of supervised consumption[7] but still consider it important to have the opportunity to move away from supervision as they make progress in treatment.[8]

Prompts

1. Are local protocols in place for supervised consumption and are they consistent with national clinical guidelines?

2. Are the process and purposes of supervised consumption effectively communicated to users in a positive and supportive way?

3. Is there local capacity to ensure that all new users are supervised during the titration process and can be supervised for a further three months or more?

4. Is supervised consumption flexible enough to meet individual need, ie, shorter for more stable users and longer (even indefinite) for those who fail to respond (who may continue to pose a danger to themselves or to others)?

5. Are clinical decisions to relax, drop or reinstate supervised consumption regularly reviewed and based on individual users' present circumstances, taking into account their level of stability, work commitments and level of risk (especially to children)?

6. Is supervised consumption implemented in a way that incentivises compliance (using contingency management principles) and offers a real opportunity to move away from supervision?

Torbay Primary Care Drug Service
Torbay's guidelines for supervised consumption ensure sufficient capacity for OST medications to be dispensed daily and consumed under pharmacy supervision for all new users. They are informed at the outset of treatment that the decision for daily supervised consumption will be reviewed within three months and of the criteria that must be met if supervision is to be relaxed. Users are assessed on their own merits and the requirement for supervised consumption is relaxed in stages providing the stability criteria are met. There are four stages over a 12-month period: 1) daily supervised consumption, 2) daily pick up, 3) twice-weekly pick up, 4) weekly pick up. If there are concerns at any time, daily supervised consumption will be reinstated.

Biological testing to monitor compliance and reinforce change

Testing biological fluids for prescribed and non-prescribed drugs can be a powerful motivator for users. Tests can confirm treatment compliance (eg, the user is taking medication as prescribed) and progress (eg, confirming abstinence), and monitor continued drug use.

Prompts

1. Are local protocols in place that clearly communicate to staff the role of drug testing during OST and how it should be implemented to support optimised treatment?
2. Are users provided with sufficient information about the uses of drug testing, including how it is used to inform the treatment they receive?
3. Are drug tests used in combination with a range of other monitoring measures to regularly review the user's progress?
4. Do tests cover a range of drugs (and alcohol), taking into account that users may transfer dependence from one drug to another while in treatment?
5. Are drug tests used to corroborate and reinforce self-reported abstinence?
6. Is a negative test result used motivationally, to support and encourage service users in continuing to make progress?
7. Is a series of negative drug tests used to review, reinforce and reward treatment progress, with relaxation of supervised consumption where appropriate?
8. Do positive drug tests for those on OST lead to reviews of progress and care plans, and to increased treatment support or enhanced safety measures where appropriate?

Using contingency management to reinforce compliance

Though the contribution of contingency management (ie, receiving valued incentives for clearly defined progress or goals) to longer-term recovery is not yet clear, it is based on the simple principle that if behaviour is reinforced it is more likely to occur again.[9] Contingency management can be very effective in supporting improvements in treatment compliance, in achieving and sustaining periods of continuous abstinence, and in helping to reduce or eliminate the use of crack cocaine among users engaged in OST programmes.

Prompts

1. Are local protocols in place to support the delivery of contingency management interventions to improve OST optimisation and support intensified treatment?
2. Is there local agreement on what sort of behaviour contingency management may target, such as drug abstinence, compliance, etc?
3. Is there sufficient expertise in the local area to effectively deliver contingency management interventions?

4. Are contingency management interventions used to support engagement and stabilisation during the initial phases of treatment?

Bridge Project, Bradford
Following rapid titration and stabilisation, users at the Bridge Project in Bradford start an intense, eight-week programme that involves contingency management and supports engagement and stabilisation. The programme involves weekly random drug testing. Those who test negative for their presenting drugs receive a congratulatory letter from the service. Letters are personalised and contain inspirational messages. The service has found that the letters are important to users, who find them motivating – they like to keep them and show them to their family members. Staff at the service are trained in the practical and theoretical aspects of contingency management, including what it is (and is not), the research and evidence base that supports it, and the importance of consistency. Staff also have a contingency management protocol that provides step-by-step guidance on delivering the programme.

Other briefings in the 'Turning evidence into practice' series:

- Helping service users to access and engage with mutual aid [NTA, 2013]
- Helping service users to engage with treatment and stay the course [PHE, 2013]
- Biological testing in drug and alcohol treatment [PHE, 2013]

References

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Produced by the Health & Wellbeing Directorate, Public Health England

Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
www.gov.uk/phe
Twitter: @PHE_uk

PHE publications gateway number: 2013380
January 2014