NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

CENTRE FOR CLINICAL PRACTICE

QUALITY STANDARDS PROGRAMME

Quality standard topic: Drug use disorders

Output: Briefing paper

Introduction

This briefing paper presents a structured evidence review to help determine the suitability of recommendations from the key development sources listed below, to be developed into a NICE quality standard. The draft quality statements and measures presented in this paper are based on published recommendations from these key development sources:

Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007, NHS Evidence accredited). Available from www.nice.org.uk/guidance/CG51

Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007, NHS Evidence Accredited). Available from www.nice.org.uk/guidance/CG52

Drug misuse and dependence: UK guidelines on clinical management. Department of Health (2007). Available from www.dh.gov.uk

Pregnancy and complex social factors. NICE clinical guideline 110 (2010). Available from www.nice.org.uk/guidance/CG110

Needle and syringe programmes: providing people who inject drugs with injecting equipment. Public Health Guidance 18 (2009). Available from www.nice.org.uk/guidance/PH18

Naltrexone for the management of opioid dependence. NICE technology appraisal guidance 115 (2007). Available from www.nice.org.uk/guidance/TA115

Structure of the briefing paper

The body of the paper presents supporting evidence for the draft quality standard reviewed against the three dimensions of quality: clinical effectiveness, patient experience and safety. Information is also provided on available cost-effectiveness evidence and current clinical practice for the proposed standard. Where possible, evidence from the clinical guideline is

presented. When this is not available, other evidence sources have been used.

To note: within some statements particular words have been enclosed by square brackets. These are words that are difficult to define within the quality standard and therefore may need to be reworded.

1 Training and competencies

1.1 NICE CG51 recommendations 1.1.1.4 and 1.4.3.1 [KPI]. NICE CG52 recommendations 1.1.1.9 and 1.5.2.1. DH CG paragraphs 4.2.2 and 4.5

1.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG51 1.1.1.4 All interventions for people who misuse drugs should be delivered by staff who are competent in delivering the intervention and who receive appropriate supervision. 1.4.3.1 (KPI) Drug services should ensure that as part of the introduction of contingency management, staff are trained and competent in appropriate near-patient testing methods and in the delivery of contingency management. NICE CG52 1.1.1.9 All interventions for people who misuse drugs should be delivered by staff who are competent in delivering the intervention and who receive appropriate supervision. 1.5.2.1 Drug services should ensure that as part of the introduction of contingency management, staff are trained and competent in appropriate near-patient testing methods and in the delivery of contingency management. DH CG 4.2.2 Therapeutic alliance 4.5 Competencies to deliver psychosocial interventions
Proposed quality statement	People who misuse drugs receive interventions from staff competent in delivering the interventions.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure people who misuse drugs receive interventions from staff competent in delivering the interventions.
Definitions	Competent staff includes appropriate supervision.....
Discussion points for TEG	What are the right skills and competencies? Is there a specific area within training and competences to focus the statement? The statement as worded lacks precision: one of the characteristics of a good quality statement.

1.1.2 Clinical and cost-effectiveness evidence

Recommendations 1.1.1.4 and 1.4.3.1 in CG51 are based on the consensus of the GDG. No studies were identified in the full guideline that specifically addressed the effect of supervision and training on outcomes. One study noted the importance of discussing the theoretical basis of contingency

management and its ethical implications with staff in order to gain their support.

Recommendation 1.1.1.9 in CG52 is based on GDG consensus.

The DH clinical guideline paragraph 4.5 states that evidence suggests a number of factors may have an impact on the performance of therapists in delivering specific interventions. These include adequate training in the delivery of the intervention, and building training programmes around the identified competencies associated with evidence based interventions.

1.1.3 Patient experience

A service review published in 2009[1] as part of a three year review of services by the NTA and Healthcare commission reported the weakest area of staff competencies related to whether service users felt respected by pharmacy staff. 30% of local drug partnerships scored 'weak' for this question. This was largely because partnerships made insufficient progress in providing training for pharmacy support staff (as opposed to pharmacists), who have the most contact with service users. There had been more progress, however, in relation to providing training to pharmacists themselves.

1.1.4 Patient safety

No issues identified relating specifically to training and competencies (see full accompanying report from the NPSA for broader themes).

1.1.5 Current practice

A joint service review[2] published in 2006 as part of the three year review of services by the NTA and Healthcare Commission stated that the increasing demand for drug treatment workers has resulted in a high proportion of inexperienced staff entering the field. At the local drug partnership level, the percentage of staff with more than three years' experience or accredited training in substance misuse ranged from 25% to 100%. (Staff were defined as practitioners who spent more than 20% of their time in direct client work.) In 11% of local drug partnerships, less than half of the staff were experienced or trained practitioners. In many areas of health and social care, experienced practitioners are sometimes promoted to management roles without any management experience or training. At the local drug partnership level, the percentage of managers (defined as spending less than a fifth of their time in

[1] National Treatment Agency for Substance Misuse (2009) Improving services for substance misuse: Commissioning drug treatment and harm reduction services. Available from www.nta.nhs.uk

[2] National Treatment Agency for Substance Misuse and Healthcare Commission (2006) Improving services for substance misuse a joint review. Available from www.nta.nhs.uk

direct client work) with more than three years' experience or accredited training in management, ranged from 0% to 100%. In 8% of local drug partnerships, less than 50% of those working as managers had previous experience of management. 12% of local drug partnerships did not have a doctor with sufficient specialist training working within the local drug partnership area.

A service review published in 2009[3] by the NTA and Healthcare Commission identified the level of training and experience of staff working in specialist community prescribing services on harm reduction interventions as an area of weak performance with 17% of local drug partnerships scoring 'weak' and 26% scoring 'fair'. The main shortfalls related to: whether staff were:

- trained in providing treatments and dressings related to the care of wounds and lesions
- the supply and exchange of injecting equipment
- supporting individuals to monitor their own healthcare

1.1.6 Current indicators

None identified

[3] National Treatment Agency for Substance Misuse (2009) Improving services for substance misuse: Commissioning drug treatment and harm reduction services. Available from www.nta.nhs.uk

2 Family and carers

2.1 NICE CG51 recommendations 1.1.2.1, 1.1.2.2 and 1.1.2.3. NICE CG52 recommendation 1.1.2.1. DH CG paragraphs 2.7 and 4.3.2.4

2.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG51 1.1.2.1 Staff should ask families and carers about, and discuss concerns regarding, the impact of drug misuse on themselves and other family members, including children. Staff should also: • offer family members and carers an assessment of their personal, social and mental health needs • provide verbal and written information and advice on the impact of drug misuse on service users, families and carers 1.1.2.2 Where the needs of families and carers of people who misuse drugs have been identified, staff should: • offer guided self-help, typically consisting of a single session with the provision of written material • provide information about, and facilitate contact with, support groups, such as self-help groups specifically focused on addressing families' and carers' needs. 1.1.2.3 Where the families of people who misuse drugs have not benefited, or are not likely to benefit, from guided self-help and/or support groups and continue to have significant problems, staff should consider offering individual family meetings. These should: • provide information and education about drug misuse • help to identify sources of stress related to drug misuse • explore and promote effective coping behaviours • normally consist of at least five weekly sessions. NICE CG52 1.1.2.1 Staff should ask families and carers about, and discuss concerns regarding, the impact of drug misuse on themselves and other family members, including children. Staff should also: • offer family members and carers an assessment of their personal, social and mental health needs • provide verbal and written information and advice on the impact of drug misuse on service users, families and carers • provide information about detoxification and the settings in which it may take place • provide information about self-help and support groups for families and carers. DH CG 2.7 Involving carers 4.3.2.4 Family therapy
Proposed quality statement	Families and carers of people who misuse drugs are offered information and support [appropriate] to their personal, social and mental health needs.

Draft quality measure	**Structure:** Evidence of local arrangements to ensure that families and carers of people who misuse drugs are offered information and support appropriate to their personal, social and mental health needs. **Process:** The proportion of families and carers of people who misuse drugs who receive information and support appropriate to their personal, social and mental health needs. Numerator – The number of families and carers in the denominator receiving information and support appropriate to their personal, social and mental health needs. Denominator – The number of families and carers of people who misuse drugs.
Discussion points for TEG	Is the focus of the statement correct? Should we be looking to assess the needs of families and carers and provide support or looking at their involvement in the patient's treatment? Can the statement be made more concise so that it is instantly clear to all audiences what is expected, reflecting only one concept (action, event or intervention)? Can the statement be made more precise, so as to avoid undefined words such as 'appropriate'?.

2.1.2 Clinical and cost-effectiveness evidence

The GDG noted that there is limited evidence on assessing the impact on carers and families of people who misuse drugs and on interventions intended to support them. Most interventions have targeted carers and families primarily to improve outcomes for the person who misuses drugs and only secondarily to address the needs of the family/carer.

Recommendations 1.1.2.1 in CG51 and 1.1.2.1 in CG52 are based on GDG consensus.

The GDG for CG51 considered impact on family members and carers of people who misuse drugs in order to identify the challenges they face. This included on report of 50 close relatives of people who misuse drugs. The study suggested a strong impact on families and carers, which is both psychological (for example, feelings of loneliness, isolation, anxiety and depression) and physical (including raised blood pressure, ulcers).

Recommendations 1.1.2.2 and 1.1.2.3 in CG51 are based on two RCTs on community reinforcement and family training and one cluster RCT on 5-Step intervention. The 5-step intervention seeks to help families and carers in their own right focusing on stress, coping response and the support networks available to them. In both trials on community reinforcement and family training the comparator was with 12-step-based self-help groups for carers. Neither study found statistically significant differences between community reinforcement and family training and 12-step-based self-help groups in relation to carer problems and psychological functioning. One RCT found statistically significant changes from baseline for both groups in relation to carer problems and psychological functioning. The second RCT found no

statistically significant differences in changes from baseline at 12-month follow-up. In the RCT on 5-Step intervention no statistically significant differences were found between the full intervention and the guided self-help conditions for both physical and psychological health.

2.1.3 Patient experience

The NTA user satisfaction survey found that 25% of respondents felt that staff did not offer families and carers enough support[4].

2.1.4 Patient safety

A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care (see Appendix A). A comprehensive analysis of recent reported incidents (please see full accompanying report from the NPSA) identifies the following priority areas relating to patient safety:

- Assessment and support for families and carers.

2.1.5 Current practice

It is difficult to accurately estimate how many people may be affected by the substance misuse of someone else. UK reports[5] have estimated that as many as 17% of the population are likely to be family members affected in this way. Included within this figure is an estimate that between 8–12% of all children are affected by parental drug and alcohol misuse. The UK Drug Policy Commission (UKDPC), in its 2009 study, estimates that 1.2 million family members in England are affected by the use of opiates and/or crack, powder cocaine and cannabis. The 2010 drug strategy[6] reports a third of the adult treatment (drug or alcohol) population have parental responsibility for a child.

A report by Adfam stated the provision of services for families of people who misuse drugs was found to be rather limited but even where these services were available, many families were either not aware of them or how to access them.

2.1.6 Current indicators

None identified

[4] NICE full clinical guideline 51 (2007) Drug misuse: Psychosocial interventions. Available from www.nice.org.uk

[5] National Treatment Agency for Substance Misuse (2008) Supporting and involving carers: a guide for commissioners and providers. Available from www.nta.nhs.uk

[6] HM Government (2010) 2010 drug strategy, Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life. Available from www.homeoffice.gov.uk

3 Needle and syringe exchange programmes

3.1 NICE PH18 recommendation 1(2), 2(1) and 3(1)

3.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE PH18 1(2) Use these data to ensure NSP services meet local need (for example, in terms of opening times and locations), taking the geography of the location into account (for example, whether it is in an urban or rural area). 2(1) Commission a mix of generic and targeted NSP services to meet local need within the area covered by the LSP (see recommendation 1). Targeted services should focus on specific groups (for example, homeless people and women who inject drugs). Services should aim to: − increase the proportion of people who have over 100% 'coverage' (that is, the number who have more than one sterile needle and syringe available for every injection) − increase the proportion of people from each group of injecting drug users who are in contact with NSPs − ensure syringes and needles are available in a range of sizes and at a range of locations throughout the area − offer advice and information on, and referrals to, services which aim to: reduce the harm associated with injecting drug use; encourage people to stop using drugs or to switch to non-injecting methods (for example, opioid substitution therapy); and address their other health needs. 3(1) Use pharmacies, specialist NSPs and other healthcare settings to provide a balanced mix of the following levels of service: − level one: distribution of injecting equipment either loose or in packs, with written information on harm reduction (for example, on safer injecting or overdose prevention) − level two: distribution of 'pick and mix' (bespoke) injecting equipment plus health promotion advice (including advice and information on how to reduce the harms caused by injecting drugs) − level three: level two plus provision of, or referral to, specialist services (for example, vaccinations, drug treatment and secondary care).
Proposed quality statement	People who misuse drugs have access to a range of needle and syringe exchange services [appropriate to their needs]
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that people who misuse drugs have access to a range of needle and syringe exchange services appropriate to their needs **Outcome:** Increase in the number of people who misuse drugs who access needle and syringe exchange services.
Definitions	A range of needle and syringe exchange services could be defined as....
Discussion points for TEG	Are we be referring to needle and syringe exchange services or programmes?

	What is the population for this statement, injecting drug users? Can the statement be made more precise, so as to avoid undefined words such as 'appropriate to their needs'?

3.1.2 Clinical and cost-effectiveness evidence

The Guideline recommendations are based on a review of effectiveness and cost effectiveness for needle and syringe programmes (NSPs) for injecting drug users (IDUs). The review included systematic reviews and meta-analysis and concluded that (NSPs) are an effective way to reduce some of the risks associated with injecting drugs, in particular self-reported needle sharing of needles and syringes, and frequency of injection. The evidence from two systematic reviews supports the effectiveness of NSPs in reducing HIV infection among injecting drug users (IDUs) however there is insufficient evidence to determine the impact of NSPs on hepatitis C virus infection in IDU.

A cohort study suggested that the provision of NSP-based health care services may decrease emergency department utilization.

Evidence from cost-effectiveness analyses (CEAs) and one cost benefit analysis (mainly from the USA, there was none from the UK) suggests that in terms of reducing HIV incidence and prevalence among IDUs, NSPs are cost effective. Evidence from one CEA suggests that cost-effective allocation within a multi-site NSP requires that sites are located where the density of IDUs is highest and that the number of syringes exchanged per client is equal across sites. The cost of providing health services to someone who injects drugs is estimated to be about £35,000 over their lifetime. The related costs of crime are estimated to be an additional £445,000 over a lifetime.

3.1.3 Patient experience

None identified

3.1.4 Patient safety

No issues identified relating specifically to needle and syringe exchange programmes (see full accompanying report from the NPSA for broader themes).

3.1.5 Current practice

In 2009/10 there were an estimated 306,150 opiate and/or crack cocaine users in England aged 15-64, of which 103,185 were injecting[7].

[7] The Centre for Drug Misuse Research, University of Glasgow and The National Drug Evidence Centre, University of Manchester (2011) National and regional estimates of the

In 2010, the Health Protection Agency stated 21% of respondents to the Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) in England reported sharing needles and syringes in the previous 4 weeks. 40% reported that they had shared needles and syringes as well as filters, mixing containers and water within that time[8].

Current NSP services

PH18 states in 2005, there was an estimated 1700 needle and syringe programmes in England. The majority (over 70%) were provided by pharmacies, with the rest offered by specialist services, outreach/mobile services, custody suites and accident and emergency departments. The majority provided sharps bins and condoms, but the provision of equipment such as citric acid and spoons varied significantly. Currently, the accessibility and availability of these services (along with harm-reduction interventions) varies widely. There is also wide variation in the number of people who use them – and how often. McVeigh et al (2003) suggest that these services are the only contact that some users of performance- and image-enhancing drugs will have with health services.

A service review published in 2009[9]by the NTA and Healthcare Commission stated there was a national shortfall in the provision of out-of-hours needle exchange. Only 21% of local drug partnerships opened most of their needle exchange services on Saturdays and only 2% opened them on Sundays.

3.1.6 Current indicators

None identified

prevalence of opiate and/or crack cocaine use 2009-10: a summary of key findings. Available from www.nta.nhs.uk

[8] Health Protection Agency (2011) Data tables of the Unlinked Anonymous Monitoring Survey of HIV and Hepatitis in Injecting Drug Users.

[9] National Treatment Agency for Substance Misuse (2009) Improving services for substance misuse: Commissioning drug treatment and harm reduction services. Available from www.nta.nhs.uk

4 Assessment and care planning - Assessment

4.1 NICE CG51 recommendations 1.2.2.1 and 1.2.2.3. DH CG paragraph 3.2.3.2

4.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG51 1.2.2.1 When making an assessment and developing and agreeing a care plan, staff should consider the service user's • Medical, psychological, social and occupational needs • History of drug use • Experience of previous treatment, if any • Goals in relation to his or her drug use • Treatment preferences 1.2.2.3 Healthcare professionals should use biological testing (for example, of urine or oral fluid samples) as part of a comprehensive assessment of drug use, but they should not rely on it as the sole method of diagnosis and assessment DH CG 3.2.3.2 Aims of full or comprehensive assessment
Proposed quality statement	People who misuse drugs are offered a comprehensive assessment of their drug use.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure people who misuse drugs are offered a comprehensive assessment of drug use. **Process:** The proportion of people who misuse drugs who receive a comprehensive assessment of drug use Numerator – The number of people in the denominator receiving a comprehensive assessment of drug use. Denominator – The number of people who misuse drugs
Definitions	The DH clinical guideline suggests a drug misuse assessment should include: • Treating the emergency or acute problem. • Confirming the patient is taking drugs (history, examination and drug testing). • Assessing the degree of dependence. • Identifying social problems, including housing, employment and domestic violence and offending. • Assessing risk behaviour. • Determining the patient's expectations of treatment and desire to change. • Determining the need for substitute medication. • For drug-misusing parents with dependent children, obtaining information on the children and any drug-related risks to which they may be exposed.
Discussion points	The need to ensure assessment has an appropriate scope and

for TEG	assesses recovery needs

4.1.2 Clinical and cost-effectiveness evidence

Recommendation 1.2.2.1 is based on GDG consensus. Information was identified stating drug use was so prevalent, all healthcare professionals, wherever they practice, should be able to identify and carry out a basic assessment of people who use drugs.

Recommendation 1.2.2.3 is derived from evidence showing urinalysis and oral fluid testing both appear to be useful methods of identifying drug use; however, both testing matrices have associated problems. Urinalysis is not easy to administer as a routine identification instrument and has also low acceptability to service users in non-specialist healthcare settings, while oral fluid has a more limited window of opportunity for detecting drug use and there is limited research assessing possible interference or manipulation of samples. However, these two testing methods appear to be more easily implemented than hair analysis, which requires a great deal more expertise.

4.1.3 Patient experience

None identified

4.1.4 Patient safety

A comprehensive analysis of recent reported incidents (please see full accompanying report from the NPSA) identifies the following priority areas relating to patient safety:

- Assessment and care plans

4.1.5 Current practice

The Joint service review[10] published in 2006 by the NTA and Healthcare Commission scored local drug partnerships on assessment for both community prescribing services and structured community services.

- **Comprehensive assessment:** 38% of local drug partnerships (community prescribing services) scored 'weak 'and 41% scored 'good' or 'excellent'. 50% of local drug partnerships (structured community services) scored 'weak' and 23% scored 'good' or 'excellent'. Individual service level scores ranged from 11% to 97%.
- **Risk assessment:** 50% of local drug partnerships (community prescribing services) scored ‘weak’ and 25% scored 'good' or 'excellent'. 70% of local drug partnerships (Structured community services) scored 'weak' on risk

[10] National Treatment Agency for Substance Misuse and Healthcare Commission (2006) Improving services for substance misuse a joint review. Available from www.nta.nhs.uk

and 15% scored 'good' or 'excellent'. Individual service level scores ranged from 8% to 100%.

With comprehensive assessments, 21% of services did not assess overdose history, despite the need to reduce drug-related deaths. 61% did not assess domestic violence history, an important factor in assessing risk of harm. 20% did not include a risk management plan, or a plan of how to ensure the risks identified in an assessment were addressed, checked and minimised. 13% did not ask about contact with mental health services. 19% did not record pregnancy, which if present would indicate a treatment priority. Finally, 52% did not assess for abscesses, which occur at injecting sites on the body and cause physical health problems.

Within risk assessments, 30% did not ask about where people inject their bodies, so were not enabling the provision of advice to reduce harm. 15% of services did not assess sharing of injecting equipment and 38% did not assess safer sex practices, both a significant risk in transmission of blood-borne viruses, 62% did not assess transmission of blood borne viruses. Finally, 48% did not check which other people lived in the same house as the service user, even though this could have an impact on a range of issues, including child welfare.

4.1.6 Current indicators

None identified

5 Assessment and care planning – care plan and review

5.1 NICE CG51 recommendations 1.2.2.1 and 1.2.2.2. NICE CG52 recommendation 1.1.1.4. DH CG paragraph 3.2.4

5.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG51 1.2.2.1 When making an assessment and developing and agreeing a care plan, staff should consider the service user's • Medical, psychological, social and occupational needs • History of drug use • Experience of previous treatment, if any • Goals in relation to his or her drug use • Treatment preferences 1.2.2.2 Staff who are responsible for the delivery and monitoring of a care plan should: • establish and sustain a respectful and supportive relationship with the service user • help the service user to identify situations or states when he or she is vulnerable to drug misuse and to explore alternative coping strategies • ensure that all service users have full access to a wide range of services • ensure that maintaining the service user's engagement with services remains a major focus of the care plan • maintain effective collaboration with other care providers. NICE CG52 1.1.1.4 Staff who are responsible for the delivery and monitoring of a care plan should: • develop and agree the plan with the service user • establish and sustain a respectful and supportive relationship with the service user • help the service user to identify situations or states when he or she is vulnerable to drug misuse and to explore alternative coping strategies • ensure that all service users have full access to a wide range of services • ensure that maintaining the service user's engagement with services remains a major focus of the care plan • review regularly the care plan of a service user receiving maintenance treatment to ascertain whether detoxification should be considered • maintain effective collaboration with other care providers. DH CG 3.2.4 Care or treatment plan
Proposed quality statement	People who misuse drugs jointly develop a recovery care plan which is regularly reviewed

Draft quality measure	**Structure:** Evidence of local arrangements to ensure that people who misuse drugs jointly develop a recovery care plan which is regularly reviewed. **Process:** a) The proportion of people who misuse drugs who jointly develop a recovery care plan. Numerator – The number of people in the denominator who jointly develop a recovery care plan Denominator – The number of people who misuse drugs. b) The proportion of people who have a recovery care plan which is regularly reviewed. Numerator – The number of people in the denominator whose recovery care plan is regularly reviewed. Denominator – The number of people with a recovery care plan.
Definitions	The DH clinical guideline states the care plan should cover one or more of the following domains • Drug use • Physical and psychological health • Criminal involvement and offending • Social functioning
Discussion points for TEG	Do we need to state who the care plan is jointly developed with? Can we state how often the care plan should be reviewed?

5.1.2 Clinical and cost-effectiveness evidence

Recommendations from both CG51 and CG52 are based on GDG consensus as there was a lack of evidence on care planning.

In CG51 information was identified on the clinical management of drug misuse which stated care planning and keyworking should form a core part of subsequent treatment and care.

5.1.3 Patient experience

Recent research reported in an NTA report on good practice in care planning[11] confirmed that the satisfaction of service users is strongly linked to having an up-to-date care plan, which they understand and feel involved in, meets their individual needs and is reviewed regularly and as necessary.

5.1.4 Patient safety

A comprehensive analysis of recent reported incidents (please see full accompanying report from the NPSA) identifies the following priority areas relating to patient safety:

[11] National Treatment Agency for Substance Misuse (2007) Good practice in care planning. Available from www.nta.nhs.uk

- Assessment and care plans

5.1.5 Current practice

An improvement review published in 2007[12] by the NTA, scored local DAT partnerships on care planning and care co-ordination. The results showed that although the majority of local DAT partnerships scored “fair”, improvements could be made. A total of seven partnerships scored “excellent”, 33 scored “good”, 106 were “fair” and two were “weak”. All service users in structured treatment should have a comprehensive assessment of their needs and a personal care plan outlining the best course of treatment for them. The Improvement Review found that not enough service users had a care plan, with 48% of local DAT partnerships being “weak” in this area, and 32% scoring “fair”.

The National Drug Evidence Centre, University of Manchester and National Treatment Agency for Substance Misuse (Accessed February 2012) National Drug Treatment Monitoring System Core Dataset – Care plan started date and Treatment outcomes profile (TOP) date. Available from www.ndtms.net

5.1.6 Current indicators

None identified

[12] National Treatment Agency for Substance Misuse (2007) Good practice in care planning. Available from www.nta.nhs.uk

6 Keyworking – Drug related and harm reduction information and advice

6.1 NICE CG51 recommendation 1.1.1.1. DH CG paragraphs 3.3.2, 4.3.1.1 and 4.3.1.3

6.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG51 1.1.1.1 To enable people who misuse drugs to make informed decisions about their treatment and care, staff should explain options for abstinence-orientated, maintenance-orientated and harm-reduction interventions at the person's initial contact with services and at subsequent formal reviews. DH CG 3.3.2 Content of keyworking 4.3.1.1 Drug related advice and information 4.3.1.3 Harm reduction
Proposed quality statement	People who misuse drugs receive recovery advice about abstinence, maintenance and harm-reduction interventions.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure people who misuse drugs receive recovery advice about abstinence, maintenance and harm-reduction interventions. **Process:** The proportion of people who misuse drugs who receive recovery advice about abstinence, maintenance and harm-reduction interventions. Numerator – The number of people in the denominator receiving recovery advice about abstinence, maintenance and harm-reduction interventions Denominator – The number of people who misuse drugs.
Definitions	Advice could be defined as..... Advice to be given at initial contact with services and at subsequent formal reviews.

6.1.2 Clinical and cost-effectiveness evidence

Recommendation 1.1.1.1 is based on GDG consensus as there was a lack of evidence on information and advice.

6.1.3 Patient experience

Nearly half (48%) of the service users surveyed during a service review[13] by the NTA and Healthcare Commission thought that the harm reduction services they received were not comprehensive enough. This related particularly to wound and abscess dressing, advice on alcohol and training to deal with overdose.

6.1.4 Patient safety

No issues identified relating specifically to drug related information and advice (see full accompanying report from the NPSA for broader themes).

6.1.5 Current practice

Community prescribing services were assessed as providing a mainly good range of harm reduction interventions. In particular, partnerships provided good advice on safer injecting and preventing overdoses[14]

6.1.6 Current indicators

None identified

[13] National Treatment Agency for Substance Misuse (2009) Improving services for substance misuse: Commissioning drug treatment and harm reduction services. Available from www.nta.nhs.uk

[14] National Treatment Agency for Substance Misuse (2009) Improving services for substance misuse: Commissioning drug treatment and harm reduction services. Available from www.nta.nhs.uk

7 Keyworking – Content of keyworking

7.1 DH CG paragraphs 3.3.2, 4.2.1, 4.3.1.4, 4.3.1.5 and 4.3.1.6

7.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	DH CG 3.3.2 Content of keyworking 4.2.1 Psychosocial interventions and keyworking 4.3.1.4 Motivational interviewing and other motivational enhancement techniques 4.3.1.5 Relapse prevention 4.3.1.6 Mapping techniques
Proposed quality statement	People who misuse drugs have a keyworker who delivers psychosocial interventions OR People who misuse drugs are offered appropriate psychosocial interventions.
raft quality measure	**Statement 1** **Structure:** Evidence of local arrangements to ensure that people who misuse drugs have a keyworker who delivers psychosocial interventions. **Process:** The proportion of people who misuse drugs who have a keyworker who delivers psychosocial interventions. Numerator – The number of people in the denominator who have a keyworker who delivers psychosocial interventions. Denominator – The number of people who misuse drugs **Statement 2** **Structure:** Evidence of local arrangements to ensure that people who misuse drugs are offered appropriate psychosocial interventions. **Process:** The proportion of people who misuse drugs who receive psychological interventions. Numerator – The number of people in the denominator receiving relevant psychological interventions. Denominator – The number of people who misuse drugs.
Definitions	The DH clinical guideline defines psychosocial interventions that can be delivered by a keyworker as ....
Discussion points for TEG	Is the focus of this area of care that people who misuse drugs have a keyworker or they receive the psychosocial interventions that a keyworker should be able to provide? Should we be talking about case management including psychosocial

	techniques as part of keyworking?

7.1.2 Clinical and cost-effectiveness evidence

The DH clinical guideline paragraph 4.3.1.6 on mapping techniques stated techniques such as node-link mapping record interactions between a patient and a clinician, based on cognitive behavioural principles. The clinician and patient work together to produce visual maps of factors such as behaviours, relationships, emotions and coping strategies, which assist in planning and executing treatment. These have been found to enhance both the therapeutic relationship and treatment engagement, and to improve the patient's memory and understanding of the therapeutic session.

7.1.3 Patient experience

None identified

7.1.4 Patient safety

No issues identified relating specifically to content of keyworking (see full accompanying report from the NPSA for broader themes).

7.1.5 Current practice

No current practice data identified

7.1.6 Current indicators

None identified

8 Keyworking – Recovery and reintegration

8.1 DH CG paragraphs 3.2.5, 4.3.1.2 and 4.3.1.7

8.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	DH CG 3.2.5 Discharge from treatment and support to prevent relapse 4.3.1.2 Advice and support for social problems 4.3.1.7 Other non-treatment interventions
Proposed quality statement	People who misuse drugs are offered advice to support recovery and reintegration which includes housing, education, employment and benefits
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that people who misuse drugs are offered advice to support recovery and reintegration which includes housing, employment and benefits. **Process:** The proportion of people who misuse drugs who receive advice to support recovery and reintegration. Numerator – The number of people in the denominator receiving advice to support recovery and reintegration. Denominator – The number of people who misuse drugs.
Discussion points for TEG	Are there other areas we should include? Is there a way to make the statement more active instead of just offering advice?

8.1.2 Clinical and cost-effectiveness evidence

The DH clinical guideline paragraphs 3.2.5, 4.3.1.2 and 4.3.1.7 are based on the consensus of the clinical guideline working group.

8.1.3 Patient experience

None identified

8.1.4 Patient safety

No issues identified relating specifically to recovery and reintegration (see full accompanying report from the NPSA for broader themes).

8.1.5 Current practice

Housing

The National Audit Office report on tackling problem drug misuse[15] states the shortage of suitable housing and support in local authorities remains a significant constraint to reintegrating drug users. There is currently no UK research on the efficacy of measures to put problem drug users in appropriate accommodation. About 100,000 problem drug users have a housing problem.

People who are drug dependent are at greater risk of cycling in and out of homelessness, rough sleeping or living in poor quality accommodation. A high incidence of drug use exists amongst rough sleepers, for example, 38% of people sleeping rough in London have drug support needs[16].

The NDTMS[17] records the clients housing situation. Where housing situation was recorded (71,322 clients), 9% reported an urgent housing problem (where they have no fixed abode), 15% reported a housing problem (such as staying with friends or family as a short term guest or residing at a short-term hostel) and 74% reported no housing problem. An acute housing problem (i.e. no fixed abode) was recorded for 16.9% of clients at the start of treatment and fell to 11.7% at six month follow up. 7.8% of clients reported a housing risk (i.e. risk of eviction) at the start of treatment and this fell to 5.3% at review.

Employment

The 2010 Drug strategy states in England, an estimated 80% of heroin or crack cocaine users are in receipt of benefits, often for many years and their drug use presents a significant barrier to employment[18]. The strategy aims to increase the number of drug dependent benefit claimants who successfully engage with treatment and rehabilitation services and ultimately find employment, which is a key contributor to a sustained recovery.

Only eight per cent of drug users receiving help into employment are able to obtain a job and keep it for 13 weeks or more[19].

The NDTMS[20] reports the patient's employment status. At the start of treatment, 17% of clients were employed and were engaged in work for an average of 17.5 days out of the 28 days preceding the start of treatment. At

[15] National Audit Office (2009) Tackling problem drug use. Available from www.nao.org.uk

[16] HM Government (2010) 2010 drug strategy, Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life. Available from www.homeoffice.gov.uk

[17] National Treatment Agency for Substance Misuse (2010) Annual statistical reports from NDTMS. Available from www.ndtms.net

[18] HM Government (2010) 2010 drug strategy, Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life. Available from www.homeoffice.gov.uk

[19] National Audit Office (2009) Tackling problem drug use. Available from www.nao.org.uk

[20] National Treatment Agency for Substance Misuse (2010) Annual statistical reports from NDTMS. Available from www.ndtms.net

the six month review, 20% of clients were employed and they were working an average of 17.3 days of the previous 28 at this point.

Education

The NDTMS data reported 2.9% of clients were enrolled in a course at the start of treatment, spending on average 10.4 days studying in the month preceding treatment. At the six month review, the percentage of the cohort in education increased to 3.9% and these clients were studying for an average of 9.5 days over the preceding 28 days[21].

8.1.6 Current indicators

None identified

[21] National Treatment Agency for Substance Misuse (2010) Annual statistical reports from NDTMS Available from www.ndtms.net

9 Keyworking – Mutual aid

9.1 NICE CG51 recommendations 1.3.2.1 [KPI] and 1.3.2.2. NICE CG52 recommendation 1.1.1.6. DH CG paragraph 4.3.2.5

9.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG51 1.3.2.1 (KPI) Staff should routinely provide people who misuse drugs with information about self-help groups. These groups should normally be based on 12-step principles; for example, Narcotics Anonymous and Cocaine Anonymous. 1.3.2.2 If a person who misuses drugs has expressed an interest in attending a 12-step self-help group, staff should consider facilitating the person's initial contact with the group, for example by making the appointment, arranging transport, accompanying him or her to the first session and dealing with any concerns. NICE CG52 1.1.1.6 Service users considering Opioid detoxification should be provided with information about self-help groups (such as 12-step groups) and support groups (such as the Alliance); staff should consider facilitating engagement with such services. DH CG 4.3.2.5 Mutual-aid (self-help) approaches
Proposed quality statement	People who misuse drugs are offered information about joining a mutual aid group OR People who misuse drugs are [facilitated] to attend a mutual aid group
Draft quality measure	**Statement 1** **Structure:** Evidence of local arrangements to ensure that people who misuse drugs are offered information about joining a mutual aid group. **Process:** The proportion of people who misuse drugs who receive information about joining a mutual aid group. Numerator – The number of people in the denominator receiving information about joining a mutual aid group. Denominator – The number of people who misuse drugs **Statement 2** **Structure:** Evidence of local arrangements to ensure that people who misuse drugs are facilitated to attend a mutual aid group. **Process:** The proportion of people who misuse drugs who are facilitated to attend a mutual aid group. Numerator – The number of people in the denominator who are facilitated to attend a mutual aid group.

	Denominator – The number of people who misuse drugs.
Definitions	Mutual aid groups should normally be based on 12-step principles, for example Narcotics Anonymous and Cocaine Anonymous Facilitated is defined as making the appointment, arranging transport, accompanying him or her to the first session or dealing with any concerns.
Discussion points for TEG	What is the focus of this area of care, providing the information about mutual aid groups or actual facilitation? Should we be recommending actual facilitation?

9.1.2 Clinical and cost-effectiveness evidence

Recommendations 1.3.2.1 and 1.3.2.2 in CG51 are based on evidence largely on the use of self-help groups (12-step based groups). The evidence reviewed indicated that 12-step involvement has a positive impact on outcomes, for example lower cocaine use in the following month, higher rates of successful treatment completion among regular attenders, and increasing levels of participation produced a significant incremental benefit. However, the GDG noted that in most studies, attendance at self-help groups was assessed alongside other treatment programmes and that the impact of self-help groups outside intensive treatment programmes has not been assessed in enough detail.

Evidence from RCTs and observational studies suggest that people receiving 12-step based treatment, when compared to CBT or eclectic (based on a combination of 12-step and CBT principles) had positive outcomes including superior abstinence. Intensive versus standard referral to self-help groups (based on the 12-step model), was also investigated. At 6 months' follow-up, the intensive referral group showed greater attendance of and participation in self-help groups compared with those in the standard referral group. Furthermore, those in the intensive referral group showed greater reduction in alcohol and drug use and were more likely to be abstinent compared with those in the standard referral group.

Recommendation 1.1.1.6 in CG52 is based on GDG consensus and from the GDG's interpretation of the evidence in relation to self help. There is evidence which states encouraging engagement with a social support network is important, as it may be a factor in determining whether the service user stays in treatment. It is often argued that psychosocial interventions are an important element of detoxification programmes. The aim of these interventions include: supporting retention in treatment for a period long enough to complete detoxification; providing an opportunity to learn about how to reduce the risk of relapse; and addressing the psychological, social and relationship problems that may have initiated or be maintaining drug use. This is supported by recent cohort study evidence which suggests that service users who remain in contact after detoxification have reduced overdose

mortality rates. The abstinence-oriented 12-steps and related self-help approaches, which were assessed by NICE (2007), may have an important role in supporting those undergoing opioid detoxification and pursuing abstinence.

9.1.3 Patient experience

None identified

9.1.4 Patient safety

No issues identified relating specifically to mutual aid (see full accompanying report from the NPSA for broader themes).

9.1.5 Current practice

Over the past 15 years, there has been a marked increase in availability of self-help group meetings in the UK[22]. In 2003, there were approximately 500 regular narcotics anonymous (NA) group meetings nationwide; by 2006, this had risen to 800. Many individuals will make use of self-help groups without first having contact with statutory drug services, either self-referring or attending following advice from a non-drug specialist such as a GP or other member of the primary care team. The growth of NA in the UK suggests that there is some acceptability of this resource among people who misuse drugs.

9.1.6 Current indicators

None identified

[22] NICE full clinical guideline 51 (2007) Drug misuse: Psychosocial interventions. Available from www.nice.org.uk

10 Formal psychosocial interventions – Brief motivational interventions

10.1 NICE CG51 recommendations 1.3.1.3 [KPI] and 1.3.1.4. DH CG paragraph 4.3.2.1

10.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG51 1.3.1.3 (KPI) Opportunistic brief interventions focused on motivation should be offered to people in limited contact with drug services (for example, those attending a needle and syringe exchange or primary care settings) if concerns about drug misuse are identified by the service user or staff member. These interventions should: • normally consist of two sessions each lasting 10–45 minutes • explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour, and provide non-judgemental feedback. 1.3.1.4 Opportunistic brief interventions focused on motivation should be offered to people not in contact with drug services (for example, in primary or secondary care settings, occupational health or tertiary education) if concerns about drug misuse are identified by the person or staff member. These interventions should: • normally consist of two sessions each lasting 10–45 minutes • explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour, and provide non-judgemental feedback. DH CG 4.3.2.1 Brief motivational techniques
Proposed quality statement	People who misuse drugs with no or limited contact with drug services are offered brief motivational interventions.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that people who misuse drugs with no or limited contact with drug services are offered brief motivational interventions. **Process:** The proportion of people who misuse drugs with no or limited contact with drug services who receive brief motivational interventions. Numerator – The number of people in the denominator receiving brief motivational interventions. Denominator – The number of people who misuse drugs with no or limited contact with drug services.
Definitions	Brief motivational interventions are defined as..... Limited contact is defined as..... No contact is defined as.....
Discussion points for TEG	Measurement issues – how would the denominator be captured?

10.1.2 Clinical and cost-effectiveness evidence

Recommendations 1.3.1.3 and 1.3.1.4 in are based on meta-analysis of RCTs, most of which relate to people who misuse cannabis or stimulants and are not in formal drug treatment, for whom brief interventions were associated with greater abstinence and reduced drug use compared with no treatment. One RCT conducted on people misusing opioids and who are not in formal drug treatment suggested brief interventions may also be effective for this group.

An economic model was developed and analysis for brief interventions was performed focussing on drug users not in formal drug treatment. Despite the limitations of the analysis, the results indicate that provision of brief interventions for cannabis or stimulant users not in formal treatment is a cost-effective intervention.

10.1.3 Patient experience

None identified

10.1.4 Patient safety

No issues identified relating specifically to brief motivational interventions (see full accompanying report from the NPSA for broader themes).

10.1.5 Current practice

The full clinical guideline for drug misuse: psychosocial interventions[23] stated although brief interventions are considered to be an important component of psychosocial treatment in open-access drug services provision of such interventions varies widely throughout England and Wales. They have been provided in evaluative studies in a range of settings, including inpatient psychiatric settings, schools, higher education and general healthcare as well as in formal drug treatment services. Despite this work, the precise extent of the use and distribution of these interventions is not well understood, but it is reasonable to assume that they are not widely implemented in the UK at the present time.

10.1.6 Current indicators

None identified

[23] NICE full clinical guideline 51 (2007) Drug misuse: Psychosocial interventions. Available from www.nice.org.uk

11 Formal psychosocial interventions – Psychosocial interventions

11.1 NICE CG51 recommendations 1.4.1.4 [KPI], 1.4.2.1 [KPI], 1.4.1.3 and 1.4.4.1. NICE CG52 recommendations 1.5.1.2 and 1.5.1.3. DH CG paragraph 4.2.3

11.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG51 1.4.1.4 (KPI) Contingency management aimed at reducing illicit drug use for people receiving methadone maintenance treatment or who primarily misuse stimulants should be based on the following principles. • The programme should offer incentives (usually vouchers that can be exchanged for goods or services of the service user's choice, or privileges such as take-home methadone doses) contingent on each presentation of a drug-negative test (for example, free from cocaine or non-prescribed opioids). • If vouchers are used, they should have monetary values that start in the region of £2 and increase with each additional, continuous period of abstinence. • The frequency of screening should be set at three tests per week for the first 3 weeks, two tests per week for the next 3 weeks, and one per week thereafter until stability is achieved. • Urinalysis should be the preferred method of testing but oral fluid tests may be considered as an alternative. 1.4.2.1 (KPI) For people at risk of physical health problems (including transmittable diseases) resulting from their drug misuse, material incentives (for example, shopping vouchers of up to £10 in value) should be considered to encourage harm reduction. Incentives should be offered on a one-off basis or over a limited duration, contingent on concordance with or completion of each intervention, in particular for: • hepatitis B/C and HIV testing • hepatitis B immunisation • tuberculosis testing. 1.4.1.3 Staff delivering contingency management programmes should ensure that: • the target is agreed in collaboration with the service user • the incentives are provided in a timely and consistent manner • the service user fully understands the relationship between the treatment goal and the incentive schedule • the incentive is perceived to be reinforcing and supports a healthy/drug-free lifestyle. 1.4.4.1 Behavioural couples therapy should be considered for people who are in close contact with a non-drug-misusing partner and who present for treatment of stimulant or opioid misuse (including those who continue to use illicit drugs while receiving opioid maintenance treatment or after completing opioid detoxification). The intervention should: • focus on the service user's drug misuse • consist of at least 12 weekly sessions.

	NICE CG52 1.5.1.2 Contingency management during and after detoxification should be based on the following principles. • The programme should offer incentives (usually vouchers that can be exchanged for goods or services of the service user's choice, or privileges such as take-home methadone doses) contingent on each presentation of a drug-negative test (for example, free from cocaine or non-prescribed opioids). • If vouchers are used, they should have monetary values that start in the region of £2 and increase with each additional, continuous period of abstinence • The frequency of screening should be set at three tests per week for the first 3 weeks, two tests per week for the next 3 weeks, and one per week thereafter until stability is achieved. • Urinalysis should be the preferred method of testing but oral fluid tests may be considered as an alternative. 1.5.1.3 Staff delivering contingency management programmes should ensure that: • the target is agreed in collaboration with the service user • the incentives are provided in a timely and consistent manner • the service user fully understands the relationship between the treatment goal and the incentive schedule • the incentive is perceived to be reinforcing and supports a healthy/drug-free lifestyle. DH CG 4.2.3 Formal psychosocial interventions
Proposed quality statement	People who misuse drugs are offered contingency management and/or behavioural couples therapy
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that people who misuse drugs are offered contingency management and/or behavioural couples therapy. **Process:** a) The proportion of people who misuse drugs who receive contingency management. Numerator – The number of people in the denominator receiving contingency management Denominator – The number of people who misuse drugs b) The proportion of people who misuse drugs and present with a non-drug-misusing partner who receive behavioural couples therapy Numerator – The number of people in the denominator receiving behavioural couples therapy. Denominator – The number of people who misuse drugs and present with a non-drug-misusing partner
Definitions	Contingency management could be defined as....
Discussion points for TEG	Which patients should have these interventions?

11.1.2 Clinical and cost-effectiveness evidence

Recommendation 1.4.2.1 in CG51 is based on evidence from US and Canadian RCTs on the efficacy of contingency management, as well as trials on implementing contingency management and reinforcing return for TB test. The studies showed contingency management interventions are considerably more successful than standard care or outreach in increasing the proportion of participants presenting for TB tests, vaccinations for hepatitis B and concordance with TB and HIV medications. The large effect sizes and the consistency of results across a range of physical health interventions drawn from large trials suggest that this is a robust finding. Although TB is possibly not as prevalent among drug users in the UK in comparison with the US, it is likely that these findings can be generalised to physical health problems more common in the UK (such as hepatitis C).

Contingency management as a one-off practice for improving adherence to physical healthcare was found to be a low-cost intervention with cost-effective, and in some cases even cost-saving, implications.

Recommendation 1.4.1.4 in CG51 was based on trials assessing methadone or buprenorphine maintenance in combination with contingency management. The trials showed for people in methadone maintenance treatment programmes who misuse drugs, contingency management leads to clinically significant reductions in illicit drug use (including both opioids and cocaine), during treatment and at follow-up. Despite strong evidence for the effectiveness of contingency management this intervention has not yet been widely used in the UK. In contrast, the evidence for the efficacy of contingency management for people maintained on buprenorphine was weak, with no effects comparable to those obtained with contingency management and methadone maintenance treatment. This may reflect differences in the population in the trials or comparator groups, or possibly the impact of the differential effects of the methadone and buprenorphine on the reward system underpinning contingency management.

Recommendation 1.4.4.1 in CG51 was based on trials which showed for individuals who have contact with a family member or carer and who are receiving methadone maintenance treatment, the addition of behavioural couple’s therapy can lead to reduction in the use of illicit opioids or cocaine.

Recommendations 1.5.1.2 and 1.5.1.3 in CG52 are based on six trials which reviewed contingency management in combination with detoxification (mostly community detoxification) and one trial reviewing family interventions. Provision of contingency management in the included studies usually began after stabilisation had occurred and continued throughout the detoxification process up to completion of treatment. People receiving contingency management were more likely to be abstinent at the end of treatment and to complete treatment. This effect was found for short-term interventions (for example, 2 weeks) and those of longer duration (for example, 6 months).

NICE (2007) reviewed studies concerned with the implementation of contingency management in drug treatment services and the frequency of testing. It was concluded that a tapering strategy of biological testing beginning with three tests per week for the first 3 weeks, followed by two tests per week for the next 3 weeks, followed by one test per week for the remaining treatment period was best supported by the available evidence. The trial of family interventions consisted of 16 sessions over an indefinite period of time beginning once every 2 weeks and then when needed. Participants in the family intervention group were more likely to be abstinent than the control group but the percentage of abstinent participants in both groups was low suggesting benefits were minimal.

An economic model was developed for the recommendations in CG51 and CG52 which although had various limitations including GDG estimate of intervention costs, showed that contingency management was a cost-effective option under most scenarios explored from an NHS/PPS perspective. When a wider perspective including criminal justice and crime victim costs were considered contingency managements was cost effective under all scenarios.

11.1.3 Patient experience

None identified

11.1.4 Patient safety

No issues identified relating specifically to psychosocial interventions (see full accompanying report from the NPSA for broader themes).

11.1.5 Current practice

During 2009/10, 206,889 people were in contact with structured drug treatment services (those aged 18 and over), a 0.5% decrease from 2008/09, where the number was 207,580[24].

Statistics from the NDTMS[25] shows the interventions received by all clients in treatment in 2010-11. The table below reports the combination of intervention types received.

Pathway	n	%
Prescribing (including keyworking)	100,822	49
Structured intervention	18,424	9

[24] NHS Information Centre (2011) Statistics on Drug Misuse, England - 2010 Report. Available from www.ic.nhs.uk

[25] National Treatment Agency for Substance Misuse (2010) Annual statistical reports from NDTMS Available from www.ndtms.net

Psychosocial	16,941	8
Structured Day Programme (SDP)	6,417	3
Prescribing (inc keyworking) and psychosocial	28,779	14
Prescribing (inc keyworking) and SDP	10,160	5
Inpatient detoxification (IP)	712	0
Residential Rehabilitation (RR)	1,196	1
Prescribing (inc keyworking) and IP	3,145	2
Prescribing (inc keyworking) and RR	971	0
Prescribing (inc keyworking), psychosocial/SDP and RR	1,623	1
Psychosocial/SDP and RR	442	0
Prescribing (inc keyworking), SDP and psychosocial	5,026	2
All other combinations	4,900	2
No adult modality	4,915	2
Total	204,473	100

The table below shows the treatment population broken down by the combination of interventions received during their last treatment journey in 2010-11. This shows that 27% received psychosocial interventions.

Intervention	**n**	**%**
Prescribing (including keyworking)	153,733	75
Structured psychosocial intervention	55,972	27
Structured day programme	26,027	13
Residential rehabilitation	4,232	2
Inpatient detoxification	9,273	4
Structured intervention	63,127	30
Total	204,473	100

The National Drug Evidence Centre, University of Manchester and National Treatment Agency for Substance Misuse (Accessed February 2012) National Drug Treatment Monitoring System Core Dataset – Treatment modality. Available from www.ndtms.net

11.1.6 Current indicators

None identified

12 Formal psychosocial interventions – Cognitive behaviour therapy (CBT) for depression and anxiety

12.1 NICE CG51 recommendation 1.4.6.2. DH CG paragraph 4.3.3

12.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG51 1.4.6.2 Evidence-based psychological treatments (in particular, cognitive behavioural therapy) should be considered for the treatment of comorbid depression and anxiety disorders in line with existing NICE guidance (see section 6) for people who misuse cannabis or stimulants, and for those who have achieved abstinence or are stabilised on opioid maintenance treatment. DH CG 4.3.3 Psychosocial interventions to address common mental disorders
Proposed quality statement	People who misuse cannabis or stimulants, who achieve abstinence or are stabilised on opioid maintenance treatment and have comorbid depression or anxiety disorders are offered psychological treatments.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that patients who misuse cannabis or stimulants, who achieve abstinence or are stabilised on opioid maintenance treatment and have comorbid depression or anxiety disorders are offered psychological treatments. **Process:** The proportion of people who misuse cannabis or stimulants, who achieve abstinence or are stabilised on Opioid maintenance treatment and have comorbid depression or anxiety disorders who receive psychological treatments. Numerator – The number of people in the denominator receiving psychological treatments. Denominator – The number of people who misuse cannabis or stimulants, who achieve abstinence or are stabilised on Opioid maintenance treatment and have comorbid depression or anxiety disorders.
Definitions	Psychological treatments include.....

12.1.2 Clinical and cost-effectiveness evidence

Recommendation 1.4.6.2 in CG51 is based on the consensus of the GDG. The GDG considered that although the presence of substance misuse problems may impact, for example, on the duration of a formal psychological treatment, there is no evidence supporting the view that psychological treatments for common mental disorders are ineffective for people with substance misuse disorders.

12.1.3 Patient experience

None identified

12.1.4 Patient safety

No issues identified relating specifically to cognitive behaviour therapy (CBT) for depression and anxiety (see full accompanying report from the NPSA for broader themes).

12.1.5 Current practice

Psychological and psychiatric disorders often occur in conjunction with drug misuse problems. Anxiety and depressed mood are more prevalent among drug users in treatment than in the general population (Kessler *et al*, 1994; Farrell *et al*, 1998). In some studies, around half of opioid- or cocaine-dependent drug users in treatment report a lifetime depressive episode, while a third may have depressed mood at intake to addiction treatment (Kleinman *et al*, 1990a). In a national study of treatment admissions in the United States, depending on the treatment modality, between a quarter and a half of the sample reported depressive and suicidal thinking (Hubbard *et al*, 1989)[26].

The National Drug Evidence Centre, University of Manchester and National Treatment Agency for Substance Misuse (Accessed February 2012) National Drug Treatment Monitoring System Core Dataset – Treatment modality. Available from www.ndtms.net

12.1.6 Current indicators

None identified

[26] National Treatment Agency for Substance Misuse (2006) Treating drug misuse problems: evidence of effectiveness. Available from www.nta.nhs.uk

13 Pharmacological interventions – Opioid maintenance prescribing

13.1 NICE CG52 recommendations 1.3.1.1 [KPI] and 1.3.2.1. DH CG paragraphs 5.4.1, 5.6.1, 5.6.2 and 5.6.3

13.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG52 1.3.1.1 (KPI) Methadone or buprenorphine should be offered as the first-line treatment in opioid detoxification. When deciding between these medications, healthcare professionals should take into account: • whether the service user is receiving maintenance treatment with methadone or buprenorphine; if so, opioid detoxification should normally be started with the same medication • the preference of the service user. 1.3.2.1 When determining the starting dose, duration and regimen (for example, linear or stepped) of opioid detoxification, healthcare professionals, in discussion with the service user, should take into account the: • severity of dependence (particular caution should be exercised where there is uncertainty about dependence) • stability of the service user (including polydrug and alcohol use, and comorbid mental health problems) • pharmacology of the chosen detoxification medication and any adjunctive medication • setting in which detoxification is conducted. DH CG 5.4.1 When and how to use supervised consumption 5.6.1 Introduction to Opioid maintenance prescribing 5.6.2 Maintenance treatment with methadone and buprenorphine 5.6.3 Dosing regimen for maintenance treatment
Proposed quality statement	People who misuse opioids are offered opioid substitution in accordance with NICE guidance.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure the people who misuse opioids are offered opioid substitution in accordance with NICE guidance. **Process:** The proportion of people who misuse opioids who receive Opioid substitution in accordance with NICE guidance. Numerator – The number of people in the denominator receiving Opioid substitution. Denominator – The number of people who misuse opioids
Discussion points for TEG	Should we be referring to people who misuse opioids or people who are opioid dependent? What should be the focus of the statement, offering the treatment or the regime used (drug choice, dosage, supervised consumption etc)?

13.1.2 Clinical and cost-effectiveness evidence

Recommendation 1.3.1.1 is based on evidence from numerous RCTs. Twelve RCTs compared methadone against other opioid agonists, clonidine or lofexidine. Methodone was found to have a better adverse-event profile, especially in relation to hypotension and was associated with better completion of detoxification.

Twelve RCTs compared buprenorphine with methadone, clonidine or lofexidine. People who underwent buprenorphine detoxification achieved clearly better outcomes on most measures, including completion, abstinence and withdrawal severity, compared with those who used clonidine or lofexidine. Buprenorphine did not differ significantly from methadone on completion rate for detoxification; however, no extractable data were available for abstinence outcomes. It is not clear if there is any difference in efficacy between methadone and buprenorphine for detoxification.

Recommendation 1.3.2.1 was based on limited evidence. Two studies showed that for methadone, a high starting dose (80–100 mg/day) appeared to be superior to a standard starting dose (40–50 mg/day) in abstinence and completion outcomes, although it may be argued whether abstinence during treatment is a meaningful outcome in this context, given that a higher methadone dose would be expected to reduce the desire to use additional illicit opioids. Improved completion rates could be the result of participants being better stabilised at the outset on a higher dose. Regarding the duration of detoxification, neither a long methadone taper (up to 70 days) nor a fairly short programme (14 days) was any better than a standard 21-day taper. Also, keeping service users fully informed about different aspects of detoxification appears to have some effect in improving completion rates and minimising reported withdrawal severity. There is a lack of data assessing dosage and duration for detoxification using buprenorphine or alpha2 adrenergic agonists. Therefore it is not yet possible to draw conclusions on these issues at present.

DH clinical guideline paragraph 5.4.1 states that since the advent of supervised consumption, the number of drug-related deaths involving methadone has reduced, during a period when more methadone is being prescribed, providing indirect evidence that supervising the consumption of medication may reduce diversion.

DH clinical guideline paragraph 5.6.3 states there is less consensus about the effective dose levels of buprenorphine required to optimise outcome once dose induction and stabilisation have taken place compared to methadone. Trials have shown that higher doses result in lower levels of opiate use and higher treatment retention.

13.1.3 Patient experience

None identified

13.1.4 Patient safety

A comprehensive analysis of recent reported incidents (please see full accompanying report from the NPSA) identifies the following priority areas relating to patient safety:

- Medication

13.1.5 Current practice

Statistics from the NDTMS[27] report the interventions received by all clients in treatment in 2010-11. 49% received prescribing interventions only whilst 24% received prescribing interventions in combination with other interventions. The treatment population broken down by the combination of interventions received during their last treatment journey in 2010-11 was also reported. This showed that three-quarters of clients (75%) received prescribing (including key working).

The NDTMS data also reported a breakdown of clients receiving prescribing by the length of time that they have been receiving this intervention. 29,517 (19%) had been receiving prescribing for five or more years, while 54,440 (36%) had been receiving prescribing for less than 12 months

The Clinical Guidelines state: “there is a consistent finding of greater benefit from maintaining individuals on a daily dose between 60mg and 120mg.” 64% of services had more than 60% of continued maintenance doses below 60mg or above 90mg. 76% of services have less than 60% of service users in the ideal range for buprenorphine doses for maintenance prescribing. Among patients admitted to NTORS methadone programmes[28] the average initial daily dose was 48mg.

In relation to methadone, the Clinical Guidelines state 'supervised consumption is recommended for new prescriptions for a minimum of three months, and should be relaxed only when the patient's compliance is assured. Supervision of its use reduces the risks of methadone being diverted to the illegal drug market and, for example, being sold on to other drug users’. 43% of services had less than 70% of people being supervised for three or more days in the first 12 weeks of treatment suggesting insufficient supervision. As service users progress with treatment, supervision can be relaxed, based on

[27] National Treatment Agency for Substance Misuse (2010) Annual statistical reports from NDTMS Available from www.ndtms.net

[28] National Treatment Agency for Substance Misuse (2006) Treating drug misuse problems: evidence of effectiveness. Available from www.nta.nhs.uk

individual circumstances. 39% of services had 90% of people being supervised for more than four days, or less than one day after 12 weeks for methadone prescriptions. 64% of local drug partnerships had less than 70% of service users being supervised on buprenorphine for three or more days in the first 12 weeks. 15% of services stated that none of their service users were supervised at all. 60% of services had 90% of people being supervised for more than four days or less than one day.

13.1.6 Current indicators

Office for National Statistics (ONS) (2010) Deaths related to drug poisoning in England and Wales. Available from www.ons.gov.uk

- Number of deaths from drug-related poisoning or drug misuse by sex, underlying cause and age, England and Wales, 1993-2010

14 Withdrawal – preparation/readiness to change

14.1 NICE CG52 recommendation 1.1.1.1 [KPI]. DH CG paragraph 5.7.1

14.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG52 1.1.1.1 (KPI) Detoxification should be a readily available treatment option for people who are opioid dependent and have expressed an informed choice to become abstinent. DH CG 5.7.1 Opioid detoxification - Introduction
Proposed quality statement	People who are opioid dependent and choose to become abstinent are offered detoxification
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that people who are opioid dependent and choose to become abstinent are offered detoxification. **Process:** The proportion of people who are opioid dependent and choose to become abstinent who receive detoxification. Numerator – The number of people in the denominator receiving detoxification. Denominator – The number of people who are opioid dependent and choose to become abstinent.
Definitions	Choice could be defined as.....
Discussion points for TEG	Can we define choice? Quality Standards are intended to be challenging: to drive up the quality of care by reflecting areas where specific improvements are required. What is the purpose of this statement?

14.1.2 Clinical and cost-effectiveness evidence

Recommendation 1.1.1.1 is based on GDG consensus as there was a lack of clinical evidence. CG52 did state ‘readiness to change’ may predict a positive therapeutic alliance and there is some evidence to suggest that a positive alliance is associated with a positive outcome in those who are dependent on alcohol or involved in methadone maintenance.

The DH clinical guideline paragraph 5.7.1 states there is evidence that coerced detoxification against a patient’s express will is likely to lead to relapse and increased risks of harms such as overdose and blood-borne viruses.

14.1.3 Patient experience

None identified

14.1.4 Patient safety

No issues identified relating specifically to preparation/readiness to change (see full accompanying report from the NPSA for broader themes).

14.1.5 Current practice

No current practice data identified

14.1.6 Current indicators

None identified

15 Withdrawal - Setting

15.1 NICE CG52 recommendations 1.4.1.1 [KPI], 1.4.1.2, 1.4.1.3, 1.4.1.4 and 1.4.3.2

15.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG52 1.4.1.1 (KPI) Staff should routinely offer a community-based programme to all service users considering opioid detoxification. Exceptions to this may include service users who: • have not benefited from previous formal community-based detoxification • need medical and/or nursing care because of significant comorbid physical or mental health problems • require complex polydrug detoxification, for example concurrent detoxification from alcohol or benzodiazepines • are experiencing significant social problems that will limit the benefit of community-based detoxification. 1.4.1.2 Residential detoxification should normally only be considered for people who have significant comorbid physical or mental health problems, or who require concurrent detoxification from opioids and benzodiazepines or sequential detoxification from opioids and alcohol. 1.4.1.3 Residential detoxification may also be considered for people who have less severe levels of opioid dependence, for example those early in their drug-using career, or for people who would benefit significantly from a residential rehabilitation programme during and after detoxification. 1.4.1.4 Inpatient, rather than residential detoxification should normally only be considered for people who need a high level of medical and/or nursing support because of significant and severe comorbid physical or mental health problems, or who need concurrent detoxification from alcohol or other drugs that requires a high level of medical and nursing expertise. 1.4.3.2 Inpatient and residential detoxification should be conducted with 24-hour medical and nursing support commensurate with the complexity of the service user's drug misuse and comorbid physical and mental health problems. Both pharmacological and psychological interventions should be available to support treatment of the drug misuse as well as other significant comorbid physical or mental health problems.
Proposed quality statement	People undergoing detoxification are offered a community-based programme And/or without People undergoing detoxification where a community-based programme is not appropriate are offered inpatient or residential detoxification.
Draft quality measure	**Statement 1** **Structure:** Evidence of local arrangements to ensure that people

	undergoing detoxification are offered a community-based programme. **Process:** The proportion of people undergoing detoxification who receive a community-based programme. Numerator – The number of people in the denominator receiving a community based programme Denominator – The number of people undergoing detoxification. **Statement 2** **Structure:** Evidence of local arrangements to ensure people undergoing detoxification where a community-based programme is not appropriate are offered inpatient or residential detoxification. **Process:** The proportion of people undergoing detoxification where a community-based programme is not appropriate who receive inpatient or residential detoxification. Numerator – The number of people in the denominator receiving inpatient or residential detoxification. Denominator – The number of people undergoing detoxification where a community-based programme is not appropriate.
Definitions	Exceptions to a community-based programme where inpatient or residential detoxification is considered more appropriate may includes service users who: • have not benefited from previous formal community-based detoxification • need medical and/or nursing care because of significant comorbid physical or mental health problems • require complex polydrug detoxification, for example concurrent detoxification from alcohol or benzodiazepines • are experiencing significant social problems that will limit the benefit of community-based detoxification. (Definitions for statement 1 on community-based programmes only)
Discussion points for TEG	Which of the two statements should be taken forward?

15.1.2 Clinical and cost-effectiveness evidence

Recommendations 1.4.1.1, 1.4.1.2, 1.4.1.3, 1.4.1.4 and 1.4.3.2 in CG52 are based on limited clinical evidence.

There is some evidence suggesting inpatient detoxification is more effective than community-based detoxification. Three trials met the eligibility criteria comparing inpatient/residential detoxification with community based detoxification. The trials found that those receiving inpatient detoxification were more likely to complete their detoxification than those receiving this treatment in the community however this should be interpreted with caution. In one trial 81% of the inpatient group were successfully detoxified from opioids compared with 17% in the community-based group. But two of the three trials (WILSON1975; Gossop *et al.*, 1986) had significant methodological limitations that make these findings difficult to interpret.

In one trial comparing inpatient detoxification and generic detoxification, follow-up at 7 months found a trend favouring greater abstinence (27.5%) in the drug dependency unit group compared with the general psychiatric ward group (13.3%). A number of significant limitations to this study raise questions as to whether differences in outcome were due to the setting or some other confounding factor and therefore preclude any specific recommendations arising from this study. Firstly, different medication was used for detoxification in the drug dependency unit (methadone) and general psychiatric ward (clonidine) groups; therefore there is some uncertainty over whether the reported differences in outcome were due to the setting or the medication. In addition, all participants had previously been referred to a specialist service, thus allocation to a general psychiatric ward may have contributed towards resistance, a higher dropout rate and poorer outcomes.

Effectiveness data comparing inpatient versus community detoxification are poor and do not indicate significant differences between them in terms of abstinence. Inpatient treatment is substantially more expensive compared with community detoxification, due to hospitalisation costs and more intensive pharmacological regimes. As a consequence, and in light of the very poor evidence for increased cost effectiveness for inpatient services and the lack of information on particular patient sub-groups, the current data would suggest that community detoxification should be provided as first-line treatment

15.1.3 Patient experience

None identified

15.1.4 Patient safety

No issues identified relating specifically to setting (see full accompanying report from the NPSA for broader themes).

15.1.5 Current practice

A service review of published in 2009[29] by the NTA and Healthcare Commissions reported that in 2006/07 almost half (48%) of local drug treatment partnerships did not commission residential and inpatient treatment in line with national guidance.

The joint service review published in 2009[30] by NTA and Healthcare Commission, reported there was good awareness of the eligibility criteria for

[29] National Treatment Agency for Substance Misuse (2009) Improving services for substance misuse: Commissioning drug treatment and harm reduction services. Available from www.nta.nhs.uk

[30] National Treatment Agency for Substance Misuse (2009) Improving services for substance misuse: diversity, and inpatient and residential rehabilitation services. Available from www.nta.nhs.uk

inpatient and residential services within local drug treatment systems: 89% of local drug partnerships said all their community-based services were fully aware of the criteria.

There was widespread evidence of good practice in providing both inpatient and residential services:

- 86% of inpatient detoxification services had prescribing regimes that were in line with NICE clinical guidelines.
- The majority (88%) of inpatient and residential rehabilitation services had policies on the development of exit plans for service users to ensure effective re-integration back into the community and the provision of appropriate aftercare.
- All inpatient services and nearly all residential rehabilitation services (97%) had procedures for notifying community-based care coordinators of unplanned discharge.

Day and colleagues (2005) conducted a survey on provision of inpatient and residential detoxification. There were an estimated 532 beds available for people detoxifying from drugs in residential rehabilitation units in the UK, with a total of 1,085 admissions per year. There were estimated to be 356 specialist inpatient beds available for drug detoxification, with an estimated 6,829 annual admissions. In addition, there were an estimated 103 beds available in non-specialist psychiatric or medical wards, with a total of 2,077 admissions per year for drug detoxification. This resulted in a combined estimate of 10,711 annual admissions for people who misuse drugs in inpatient and residential treatment (Day *et al.*, 2005).

15.1.6 Current indicators

None identified

16 Withdrawal – Support and monitoring before and after detoxification

16.1 NICE CG52 recommendations 1.1.1.2 [KPI], 1.1.1.3 and 1.4.2.1. DH CG paragraph 5.8. NICE TA115

16.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG52 1.1.1.2 (KPI) In order to obtain informed consent, staff should give detailed information to service users about detoxification and the associated risks, including: • the physical and psychological aspects of opioid withdrawal, including the duration and intensity of symptoms, and how these may be managed • the use of non-pharmacological approaches to manage or cope with opioid withdrawal symptoms • the loss of opioid tolerance following detoxification, and the ensuing increased risk of overdose and death from illicit drug use that may be potentiated by the use of alcohol or benzodiazepines • the importance of continued support, as well as psychosocial and appropriate pharmacological interventions, to maintain abstinence, treat comorbid mental health problems and reduce the risk of adverse outcomes (including death). 1.1.1.3 Service users should be offered advice on aspects of lifestyle that require particular attention during opioid detoxification. These include: • a balanced diet • adequate hydration • sleep hygiene • regular physical exercise. 1.4.2.1 Following successful opioid detoxification, and irrespective of the setting in which it was delivered, all service users should be offered continued treatment, support and monitoring designed to maintain abstinence. This should normally be for a period of at least 6 months. DH CG 5.8 Naltrexone for relapse prevention. NICE TA115 (Specific recommendations were not prioritised for this statement)
Proposed quality statement	People who undergo successful opioid detoxification are offered support and monitoring, including pharmacological support, for a period of at least 6 months
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that people who undergo successful opioid detoxification are offered support and monitoring, including pharmacological support, for a period of at least 6 months. **Process:** The proportion of people who undergo successful Opioid detoxification who receive support and monitoring, including pharmacological support, for a period of at least 6 months.

	Numerator – The number of people in the denominator receiving support and monitoring, including pharmacological support for a period of at least 6 months. Denominator – The number of people who undergo1 successful opioid detoxification.
Discussion points for TEG	Can the statement be made more precise, what is meant by support and how is it measured?

16.1.2 Clinical and cost-effectiveness evidence

Recommendations 1.1.1.2, 1.1.1.3 and 1.4.2.1 are based on GDG consensus.

16.1.3 Patient experience

None identified

16.1.4 Patient safety

No issues identified relating specifically to support and monitoring before and after detoxification (see full accompanying report from the NPSA for broader themes).

16.1.5 Current practice

No current practice data identified

16.1.6 Current indicators

None identified

17 Health considerations – Blood borne infections

17.1 NICE CG51 recommendation 1.3.1.1. DH CG paragraphs 6.2.2 and 6.2.4

17.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG52 1.3.1.1 During routine contacts and opportunistically (for example, at needle and syringe exchanges), staff should provide information and advice to all people who misuse drugs about reducing exposure to blood-borne viruses. This should include advice on reducing sexual and injection risk behaviours. Staff should consider offering testing for blood-borne viruses. DH CG 6.2.2 Prevention and testing 6.2.4 Viral Infections
Proposed quality statement	People who misuse drugs are offered vaccination for hepatitis B and testing and treatment for blood-borne viruses
Draft quality measure	**Structure:** Evidence of local arrangements to ensure people who misuse drugs are offered testing and treatment for blood-borne viruses. **Process:** a) The proportion of people who misuse drugs who receive testing for blood-borne viruses Numerator – The number of people in the denominator receiving testing for blood borne viruses Denominator – The number of people who misuse drugs b) The proportion of people misusing drugs testing positive for blood borne viruses who receive treatment Numerator – The number of people in the denominator treated for blood borne viruses Denominator – The number of people who misuse drugs testing positive for blood borne viruses **Outcome:** Reduction in the number of people with blood borne viruses
Definitions	Blood borne viruses are defined as hepatitis B, hepatitis C and human immunodeficiency virus (HIV).

17.1.2 Clinical and cost-effectiveness evidence

Recommendation 1.3.1.1 was based on GDG consensus.

DH clinical guidelines paragraph 6.2.4 states that based on current evidence it is recommended that injecting drug users are vaccinated against hepatitis A

and B. A combined vaccine is available that may improve uptake. However, the benefits of hepatitis A vaccination are modest and the benefits of hepatitis B vaccination are substantial.

17.1.3 Patient experience

None identified

17.1.4 Patient safety

No issues identified relating specifically to blood borne infections (see full accompanying report from the NPSA for broader themes).

17.1.5 Current practice

Blood-borne virus infections can cause chronic poor health and can lead to serious disease and to premature death. Blood-borne virus rates are high among drug users, particularly those who inject drugs. In 2009/10 the number of injecting drug users (IDU) was 103,185[31].

In 2010, the Health Protection Agency as part of the Unlinked Anonymous Prevalence Monitoring Programme (UAPMP)[32] reported the current prevalence of hepatitis C among IDUs in England, as 49%, increasing from 39% in 2000. There is a wide geographic variation, ranging from 65% in North West to 28% in West Midlands and variation with age ranging from 27% in under 25's to 58% in those aged 35 and over (Data for England, Wales and Northern Ireland). Uptake of the voluntary confidential testing for hepatitis C virus amongst injecting drug users reached 83% in 2010.

In 2010 the prevalence of hepatitis B in IDUs was 17% and the rate of self-reported hepatitis B vaccination doubled from 36% in 2000 to 75%.

HIV prevalence amongst IDU was 1.2% in 2010, a decrease from 1.6% in 2009. Uptake of the voluntary confidential testing for HIV has been continually increasing since 2000 from 52% to 75% in 2010.

A service review by the NTA and Healthcare Commission[33] identified some key messages for harm reduction services:

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[31] The Centre for Drug Misuse Research, University of Glasgow and The National Drug Evidence Centre, University of Manchester (2011) National and regional estimates of the prevalence of opiate and/or crack cocaine use 2009-10: a summary of key findings. Available from www.nta.nhs.uk

[32] Health Protection Agency (2011) Data tables of the Unlinked Anonymous Monitoring Survey of HIV and Hepatitis in Injecting Drug Users.

[33] National Treatment Agency for Substance Misuse (2009) Improving services for substance misuse: Commissioning drug treatment and harm reduction services. Available from www.nta.nhs.uk

- **Strategic planning for harm reduction services was assessed as generally good.** However, additional action needed to increase the rates of testing and vaccination.
- **Vaccination for hepatitis B and testing and treatment for hepatitis C was not provided widely enough by local drug treatment partnerships.** 95.3% partnerships offered less than 75% of their service users a hepatitis B vaccination and less than 50% of their service users had a recorded test date for hepatitis C.
- **Harm reduction interventions were not provided broadly enough across the treatment system or sufficiently integrated into it.** 37% of partnerships did not have access to HIV testing with access to pre and post-test counselling integrated with their inpatient drug treatment services. 36% of partnerships did not have hepatitis C testing integrated into their open access services.

The National Drug Evidence Centre, University of Manchester and National Treatment Agency for Substance Misuse (Accessed February 2012) National Drug Treatment Monitoring System Core Dataset – Hep C Intervention status, Hep B Intervention status. Available from www.ndtms.net

17.1.6 Current indicators

None identified

18 Health considerations – Monitoring long term health

18.1 DH CG paragraph 3.5

18.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	DH CG 3.5 General health assessment at presentation and in treatment
Proposed quality statement	People who misuse drugs and are not in regular contact with their GP are offered a general health assessment.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure people who misuse drugs and are not in regular contact with their GP are offered a general health assessment. **Process:** The proportion of people who misuse drugs and are not in regular contact with their GP who receive a general health assessment Numerator – The number of people in the denominator receiving a general health assessment Denominator – The number of people who misuse drugs and are not in regular contact with their GP
Definitions	General health assessment is defined as..... Regular contact is defined as.....

18.1.2 Clinical and cost-effectiveness evidence

The DH clinical guideline paragraph 3.5 was based on the consensus of the clinical guideline working group.

18.1.3 Patient experience

None identified

18.1.4 Patient safety

A comprehensive analysis of recent reported incidents (please see full accompanying report from the NPSA) identifies the following priority areas relating to patient safety:

- Physiological health assessment and physical health

18.1.5 Current practice

The National Drug Evidence Centre, University of Manchester and National Treatment Agency for Substance Misuse (Accessed February 2012) National Drug Treatment Monitoring System Core Dataset – Drug treatment health care assessment date. Available from www.ndtms.net

18.1.6 Current indicators

None identified

19 Care settings and populations – Criminal justice and prison setting

19.1 NICE CG51 recommendations 1.5.2.1 and 1.5.2.2. NICE CG52 recommendation 1.4.4.1

19.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG51 1.5.2.1 For people who misuse drugs, access to and choice of treatment should be the same whether they participate in treatment voluntarily or are legally required to do so. 1.5.2.2 For people in prison who have dug misuse problems, treatment options should be comparable to those available in the community. Healthcare professionals should take into account additional considerations specific to the prison setting, which include: • The length of sentence or remand period, and the possibility of unplanned release • Risks of self-harm, death or post-release overdose. NICE CG52 1.4.4.1 People in prison should have the same treatment options for Opioid detoxification as people in the community. Healthcare professionals should take into account additional considerations specific to the prison setting, including: • Practical difficulties in assessing dependence and the associated risk of Opioid toxicity early in treatment • Length of sentence or remand period, and the possibility of unplanned release • Risks of self-harm, death or post-release overdose
Proposed quality statement	People in prison who misuse drugs are offered the same treatment options as people in the community
Draft quality measure	**Structure:** Evidence of local arrangements to ensure people in prison who misuse drugs are offered the same treatment options as people in the community. **Process:** The proportion of people in prison who misuse drugs who receive the same treatment options as people in the community. Numerator – The number of people in the denominator receiving the same treatment options as people in the community. Denominator – The number of people in prison who misuse drugs.
Discussion points for TEG	If the opening section of the quality standard references that all settings are covered is this statement needed?

19.1.2 Clinical and cost-effectiveness evidence

Recommendation 1.5.2.1 in CG51 is derived from limited research assessing the efficacy of legally coerced treatment.

Recommendation 1.5.2.2 in CG51 is derived from three US RCT studies evaluating the evidence for psychosocial interventions. The therapeutic community approach in prison settings appeared to be associated with a reduction in reincarceration rates, criminal activity and recidivism and these effects were maintained at follow-up. The evidence also suggests that, subsequent to release from prison, continuing community-based interventions such as therapeutic community attendance or involvement in community-based work programmes may be important in maintaining the benefits of the intervention.

Recommendation 1.4.4.1 in CG52 is based on GDG consensus.

19.1.3 Patient experience

None identified

19.1.4 Patient safety

No issues identified relating specifically to clinical justice and prison setting (see full accompanying report from the NPSA for broader themes).

19.1.5 Current practice

Prisons have a high concentration of problematic drug misusers present in one place at any one time. The NTA 2006 models of care update[34] states 'there is an annual throughflow of approximately 130,000 offenders and an average of 84,500 drug-misusing prisoners may be in custody during the course of a year – with around 49,000 present at any one time'

A joint review published in 2009[35] reported that for the second year, the quality of the provision of healthcare in prisons was variable. All prisons included in this report have clear links to their PCTs' overall arrangements for controlled drugs and management of medicine. All PCTs said that relevant prisons were in the process of implementing an integrated drug treatment system and they were monitoring progress.

No current practice data on the availability of services provided within prisons was identified

19.1.6 Current indicators

None identified

[34] National Treatment Agency for Substance Misuse (2006) Models of care for treatment of adult drug misusers: update 2006 . Available from www.nta.nhs.uk

[35] Care Quality Commission (2009) Commissioning healthcare in prisons. Available from www.cqc.org.uk

20 Care settings and population – Pregnancy

20.1 NICE CG110 recommendations 1.2.2 [KPI], 1.2.5 [KPI], 1.2.1 and 1.2.3

20.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG110 1.2.2 (KPI) Healthcare commissioners and those responsible for providing local antenatal services should work with local agencies, including social care and third-sector agencies that provide substance misuse services, to coordinate antenatal care by, for example: • Jointly developing care plans across agencies • Including information about opiate replacement therapy in care plans • Co-locating services • Offering women information about the services provided by other agencies. 1.2.5 (KPI) Healthcare professionals should be given training on the social and psychological needs of women who misuse substances. 1.2.1 Work with social care professionals to overcome barriers to care for women who misuse substances. Particular attention should be paid to: • Integrating care from different services • Ensuring that the attitudes of staff do not prevent women from using services • Addressing women's fears about the involvement of children's services and potential removal of this child, providing information tailored to their needs • Addressing women's feelings of guilt about their misuse of substances and the potential effects on their baby. 1.2.3 Consider ways of ensuring that, for each woman who misuses substances: • Progress is tracked through the relevant agencies involved in their care • Notes from the different agencies involved in her care are combined into a single document • There is a coordinated care plan.
Proposed quality statement	Pregnant women who misuse drugs have access to integrated care from [different services].
Draft quality measure	**Structure:** Evidence of local arrangement to ensure pregnant women who misuse drugs have access to integrated care from different services. **Process:** The proportion of pregnant women who misuse drugs who receive integrated care from different services. Numerator – The number of people in the denominator receiving care from integrated services. Denominator – The number of pregnant women who misuse drugs.
Definitions	Integrated care is defined as……

	Different services is defined as ……
Discussion points for TEG	To review the appropriateness of the statement considering the other quality standards (in particular antenatal care) in development.

20.1.2 Clinical and cost-effectiveness evidence

The Guideline recommendations are based on low quality clinical evidence and GDG consensus using the GDGs own experiences. The GDG identified, a large number of barriers for women with substance misuse to access antenatal care. The evidence from 10 low quality studies show women with a substance misuse problem value: staff consistency; staff with non-judgmental attitudes; reassurance about confidentiality and child protection proceedings; information; and a high level of support in terms of number of visits and time given at each appointment. The evidence also indicates staff are not always comfortable exploring the issue of substance misuse and are often unaware of the support services available. The GDG agreed that these findings accurately reflected their own experience and recommended that women should be given information about the availability of additional services so that they can access all the care they require.

Staff attitudes: Given the strength of evidence showing the prevalence of poor staff attitudes and the potential negative effect that these have the GDG recommended healthcare professionals should receive training to help them understand the emotional and social needs of substance misusing women.

Co-ordinated care and care plan: The GDG agreed that there would be value in considering joint commissioning of services and joint provision of care in order to maximise limited resources, facilitate good communication between different service providers, identify the specific needs of substance misusing pregnant women and improve access. One study identified poor communication between agencies being a barrier. From experience, the GDG noted that, where women have appointments to attend with a number of services, such as social care, parole services, substance misuse treatment and antenatal care, it is common for women to miss appointments and for communication between agencies to be fragmented and slow. The need for a coordinated care plan drawn up between, and agreed by, different agencies as well as the woman herself, which would contain details of the lead professional responsible for coordinating care, is recommended, based on GDG consensus.

Co-locating services: From the studies reviewed access to drug treatment services and antenatal services in the same location encouraged attendance at antenatal visits. Evidence from integrated antenatal treatment and support programmes and groups provided alongside antenatal clinics supports this view. The GDG agreed that services should be co-located where possible.

A health economic model was developed to assess the cost effectiveness of additional care versus normal antenatal care services. This demonstrated for women who misuse substances that an additional service could be considered cost effective if it was able to book more women in the first trimester and maintain contact than if only routine antenatal care was provided. The number of women needed to book early to make a service cost effective varies, depending on the cost of the service provided.

20.1.3 Patient experience

None identified

20.1.4 Patient safety

No issues identified relating specifically to pregnancy (see full accompanying report from the NPSA for broader themes).

20.1.5 Current practice

The full clinical guideline for women and complex social factors[36] states of the 295 maternal deaths identified in this triennium (2003–2005), 93 of the women who died had problems with substance misuse. Of these, 52 were drug addicts, another 32 were occasional drug users and the remaining women were alcohol dependent. Seven died in early pregnancy before they could access maternity care. Of all the deaths due to, or associated with, substance misuse, it is noteworthy that the majority took place after 42 days after birth.

An increasing number of maternity services within the UK have appointed specialist midwives to coordinate the care for substance misusing women and to promote inter-agency care planning. Funding is also often jointly commissioned with local drug and alcohol strategy teams, leading to shared responsibility and improved communication. *Saving Mothers' Lives*, 2007 recommended that integration be achieved for each maternity service, ideally by joint care provision between addiction and maternity services for these vulnerable women. If that was not possible, there should be joint discussion of care plans between services to improve the information held by each

20.1.6 Current indicators

None identified

[36] NICE full clinical guideline 110 (2010) Pregnancy and complex social factors. Available from www.nice.org.uk

Appendix A: Definition of patient safety

The National Patient Safety Agency (NPSA) defines patient safety in the following terms:

Every day more than a million people are treated safely and successfully in the NHS, but the evidence tells us that in complex healthcare systems things will and do go wrong, no matter how dedicated and professional the staff. When things go wrong, patients are at risk of harm, and the effects are widespread and often devastating for patients, their families and the staff involved. Safety incidents also incur costs through litigation and extra treatment, and in 2009/10 the NHSLA paid out approximately £827,000,000 in litigation costs and damages. These incidents are often caused by poor system design rather than the error of individuals i.e. ‘they are an accident waiting to happen’.

In short patient safety could be summarised as ‘The identification and reduction of risk and harm associated with the care provided to patients ‘or ‘Preventing patients from being harmed by their treatment’. Examples of this might be ‘operating on or removing the wrong organ, ten times the dose of an opioid, giving a colonoscopy to the wrong patient with the same name as someone else in the waiting room etc.’ These risks are unlikely to be identified through clinical trials or traditional evidence bases and so other evidence sources, such as the National Reporting and Learning System, need to be analysed to highlight the risks and improve system development. This does not however give an accurate picture of prevalence in that way that methods such as casenote review may do.