Our mission is to help people change the direction of their lives, grow as a person and live life to its full potential.

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Improving medication-assisted treatment

Toolkit

Our mission is to help people change the direction of their lives, grow as a person and live life to its full potential.

Saving lives and improving outcomes

Preface

Change Grow Live provides treatment to around 30% of people receiving opioid Medication-Assisted Treatment (MAT) in England. With this programme of work to improve MAT, we are taking an important opportunity to significantly improve the lives of service users and reduce the risk of overdose and drug-related death. Using our unique data set, and providing 'live data' to front-line services, we want to work with service users and front-line staff to build 'bottom-up' solutions to improve opioid MAT and the recovery outcomes of service users in every locality. The initial focus of the Improving MAT project will be on helping service users reduce illicit opioid use 'on-top' by improving prescribing practice and psychosocial interventions to optimise treatment.

By implementing a 'plan, do, study, act' methodology we will create the opportunity to share our learning across the organisation and with other treatment providers for the benefit of all service users.

We would encourage you to participate fully in this programme of work. It will make a massive difference to our service users' lives and improve the effectiveness and efficiency of our services. We know how committed the Change Grow Live team is to doing the best for the people who use our services and thank you in advance for helping to make this project a success.

Dr Prun Bijral
Medical Director

Bernie Casey
Executive Director

October 2018

Contents

1. Introduction

1.1 What is the Improving MAT project toolkit

Improving the quality and effectiveness of opioid Medication-Assisted Treatment (MAT) is an organisational priority for Change Grow Live for 2018/19. This toolkit outlines how we will enable our services to improve opioid MAT by implementing a continuous improvement programme that includes regular feedback of data to our services and providing resources to enable the development and implementation of local, bottom-up solutions.

1.2 Organisational priority work stream and national context

There is strong evidence that good quality opioid MAT can help service users achieve recovery outcomes and improve their lives and the lives of their families and communities. MAT can also protect service users from overdose deaths, contracting blood borne viruses and involvement in crime. However, there is also evidence that service users derive limited benefit from poor quality opioid MAT, which may cause more harm than good.

The requirement to optimise MAT is not a new concept; under-dosing of people on opioid medication was reported in a 2006 **national review** by the (now defunct) National Treatment Agency. However, given the increasing rates of drug-related deaths and the cohort of people who are increasingly vulnerable, and socially disadvantaged with poor health and wellbeing, there is an imperative to act.

We also know this is likely to be a relevant issue across the treatment sector and, as one of the main providers of treatment in the UK, we recognise our responsibility to lead on this, and to share our learning widely for the benefit of all service users. Equally, we will seek and welcome collaboration from other treatment providers, so as to maximise our chances of learning and improving, thus delivering better outcomes for our own service users.

While a significant amount of work has already taken place in this area, we must do more to realise our ambition of providing the best quality treatment possible. Therefore, we have committed to increase our focus on this area as one of our organisational priorities, delivered through a collaborative Continuous Improvement Plan. We know that MAT can provide a protective and supportive platform for people to build recovery capital and help them overcome illicit opioid dependence. All services should have a systematic approach to ensure MAT is optimised to meet individual service user needs, in terms of medication, dose, supervised consumption and psychosocial interventions. By optimising MAT we can significantly reduce the risk of overdose and preventable death.

Our aspiration is for people who use illicit opioids to achieve recovery outcomes. However, we recognise that some people, particularly those with complex problems, may require significant time in opioid maintenance as a platform from which to build recovery capital and improve their health, wellbeing and self-efficacy. Furthermore, although many opioid users may express a desire to be drug free or overcome dependence on substances, the reality is that this may be a long process, and some may never totally stop using, even in MAT. Regardless, our focus is to help keep people safe and empower them to improve the quality of their lives. This must be our primary goal and responsibility.

1.3 Our approach

The Improving MAT project will use a ‘plan, do, study, act’ (PDSA) cycle throughout. This is an evidence-based method of quality improvement to systematically plan and explore an issue, test solutions on the ground, study whether or not improvement is achieved, and then act or implement the solutions that have been shown to create improvement.

1.4 Timelines

Improving MAT will be delivered in phases and the full project timetable can be found in **Appendix C**.

We are pleased to launch this national continuous improvement programme, which will run until September 2019. Our central clinical and information team have been working to determine the extent of improvement required and to create a new set of data reports for services and resources to support its implementation. This toolkit outlines how we will work together in a ‘bottom-up approach’ to improve opioid MAT.

2. Opioid Medication-Assisted Treatment

2.1 Service users in MAT

We provide treatment for around 30% of all opioid users in treatment in England. Not all of these service users will be in opioid MAT but the vast majority are: as of October 2018 there were 27,080 service users on an active MAT prescription.

2.2 New opioid pathway

We have updated our opioid treatment model in light of the new national and international guidelines – specifically the Drug Misuse and Dependence: UK guidelines on clinical management (Department of Health 2017), commonly known as the Orange Guidelines (and referred to in this document as OG), and the International Standards on the Treatment of Drug use Disorders (WHO/UNODC 2016). Our new pathways have a 'phased and layered' approach that combines the international and national guidelines.

We have also updated the opioid prescribing policies and Prescribing Assisted Recovery (PAR) stages in light of the new guidance, new model and pathways. We have renamed the PAR stages as the Medication-Assisted Treatment (MAT) stages, in line with international norms. This has been cross referenced with the opioid pathways stages.

Each phase and MAT stage has clear goals to provide a clearer focus for staff and service users and that can be measured using its core data, summarised in Table 1.

We recognise that an individual's treatment journeys may not progress in a linear way and they may move backwards or forwards along this pathway. Our layered approach recognises that whilst most service users will require standard, evidence-based pathways, certain individuals, at certain points in their journey, may require an enhanced pathway to meet severe or complex needs.

Table 2 provides descriptions, primary goals and measurement of each MAT stage. Data will also be provided for those with OG[1] maintenance dose (60-120mg methadone or buprenorphine doses higher than 12mg) and those under OG maintenance dose.

New opioid pathway

PHASE	GOALS
OUTREACH	• Reduce harms for those not in treatment eg NEX • Screening and referral to treatment
ASSESSMENT	• Assess and place in pathway
ENGAGEMENT	• Induction on opioid medication (MAT 1) • Help manage acute issues • Increase motivation & engagement
BEHAVIOUR CHANGE	• Stop illicit opioid use 'on top' (MAT 2) • Address other substance use • Build recovery capital
EARLY RECOVERY	• Build recovery capital from a platform of MAT without illicit opioid use (MAT 3) • Then if desired detoxification and post detox support (MAT 4)
SUSTAINED RECOVERY	• Discharge with recovery support to prevent relapse • Naloxone, recovery check-ups, mutual aid

Table 1: Change Grow Live opioid pathway summary

STAGE	DESCRIPTION	PRIMARY GOAL	DEFINITION
MAT 1	Induction onto opioid medication	Successfully induct SU onto MAT	SU starts MAT and has a continuous prescription for up to 28 days
MAT 2	SU in MAT who continues illicit opioid use on top	enable SU who uses opioids 'on top' to stop by personal optimisation of treatment	SU in MAT with 'on top' illicit opioid use
MAT 3	SU in MAT who has stopped opioid use on top	is for SU to use MAT as a platform from which to build recovery capital and wellbeing, without recourse to illicit opioid use	SU in MAT with no illicit opioid use
MAT 4	SU chooses to detoxify from MAT	to enable SU to detoxify from MAT without relapse	SU in MAT with a reducing dose plan that reaches 0mg within 3 months

Table 2: MAT Stages

[1] *OG: Orange Guidelines*

3. The Plan

3.1 Overview

The opioid MAT continuous improvement plan has four elements:

Element 1:
Improving induction onto MAT

Element 2:
Improving opioid maintenance

Element 3:
Improving detoxification and recovery support for those who want to come off MAT

Element 4:
Improving supervised consumption

Although all four elements are important, the organisational priority is that services focus initially on the second element: Improving opioid maintenance. In particular, we want to prioritise improving MAT for those who continue to use illicit opioid drugs 'on top'. The plan will run in two distinct phases.

3.2 Phased approach to improve quality of MAT

3.2.1

Phase 1

*Resources to support this page can be found in the **Appendices***

1. PLAN	2. DO	3. STUDY	4. ACT
We will provide key data to each service from date of launch and bi-monthly thereafter, allowing comparison with organisational averages and other services. This toolkit outlines the process we wish services to follow, evidence-based practice in line with the Orange Guidelines (OG) and some key questions and issues to explore locally. Services will wish to look at their data, consult service users and staff to identify key issues, consider how these may be resolved, and plan to make changes.	All services will be expected to develop and implement a Service Response Plan on the organisational priority of improving opioid maintenance for the SU cohort in MAT 2. This will be supported with revised opioid prescribing policies, training, briefings, learning opportunities for staff and service users, and monthly performance updates on MAT data.	We will collate all improvement plans and feedback from staff and service users and track improvement progress using the core data set. We will also undertake case studies on our services with the help of Manchester University, to help us track progress and identify good practice.	After six months we will review progress and share organisational good practice from services that have made significant improvement. Interventions and processes that have improved the quality of opioid maintenance will inform development of organisational structures and practice.

3.2.2

Service-level actions required to support Phase 1

The following actions will significantly improve the ability of any service to deliver against the plan, and should be completed at the earliest opportunity and certainly no later than March 2019.

Service Manager and Lead Clinician:

- Service sets up an Improving MAT group
- The Improving MAT group explores the available data with the help of the local data manager
- Ensure appropriate prioritisation:

  Priority 1: Identify service users in MAT 2 at highest risk of overdose.

  Priority 2: Help those in MAT 2 below OG dose to stop use 'on top'.

  Priority 3: Focus on those in MAT 2 who are above OG doses and using 'on top'.

  Priority 4: Using ASCI[2], improve the use of supervised consumption for those who may benefit and remove from those who are stable.

  Priority 5: Improve MAT 3 to ensure service users receive adequate input to build recovery capital.

Frontline staff:

- Ensure all people in MAT have a recent TOP[3] or drug screen.
- Use the risk profile report to identify those most at risk in MAT 2.

[2] ASCI: Appropriateness of Supervised Consumption Inventory [3] TOP: Treatment Outcome Profile

3.2.3

Phase 2

From March 2019, we will begin the next phase of implementing improvements in MAT 1 – Induction and MAT 4 - Detoxification, using the same PDSA approach. Services will receive additional data on aspects of their induction and detoxification practices and a new toolkit relevant to this phase of the programme.

4. Using data to improve MAT

4.1 Organisational data (for services that use CRIiS)

Figure 1 shows the baseline performance of organisational MAT delivery over the last twelve months with the main priority cohort indicated in the RED bars. An explanation of the different stacks is provided in the key below. In October 2018, the organisational mean for the RED cohort was 22%, with an improvement of 4% since November 2017.

Red (MAT 2) - MAT dose below OG and still using heroin – a lower % is better.

Amber (MAT 2) - MAT dose above OG and still using heroin – a lower % is better.

Green (MAT 3) - MAT dose above OG and not using heroin – a higher % is better

Grey (MAT 3) - MAT dose below OG and not using on top – a higher % is better

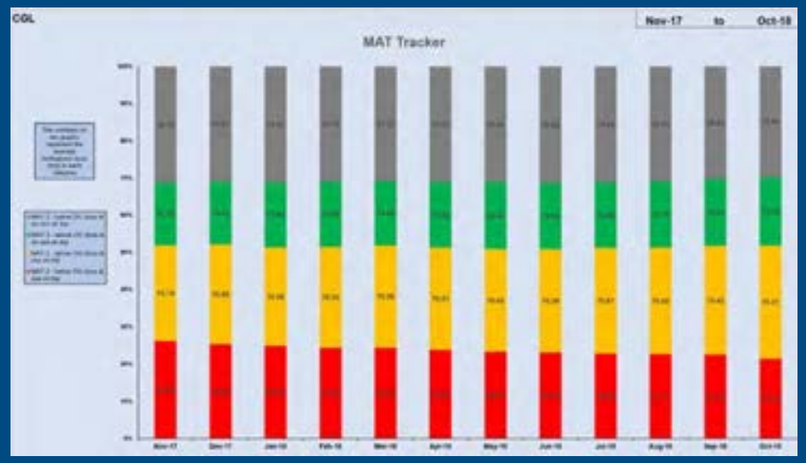

Figure 1: CGL Tracker November 2017 to October 2018 — The figure within each stacked bar is the mean methadone dose – higher is better, with 60mg regarded as the lower threshold of effective dose.

MAT for October 2018 across all services:
MAT 2 mean dose: methadone 58.22mg, buprenorphine 11.63mg.
MAT 3 mean dose: methadone 49.92mg, buprenorphine 9.32mg.
7.25% of service users are not captured in the above tracker as they do not have a recent TOPs or urine drug screen recorded on CRIiS.

5. Understanding and exploring opioid MAT data for your service

5.1 Overview of MAT data

The Phase 1 data accompanying this toolkit covers: distribution of service users in MAT stages; number and percentage of service users who use opioids 'on top' of MAT; opioid MAT doses in maintenance (MAT 2 and MAT 3), and prescribing regimes (whether doses are increasing, static or decreasing). Phase 2 data will include additional data on induction phase (MAT 1) and detoxification stage (MAT 4). The data allows services to compare themselves to organisational averages. You can also view data on any other service by selecting the service name in the drop-down menu.

This section walks you through the data and how we recommend it is used in services to inform your actions to improve MAT. We also recommend you cross reference with:

- your work to reduce drug-related deaths (including identification of those at most risk of opioid overdose using Risk Profile Tool – Opioid Overdose); and
- your data on supervised consumption obtained through use of ASCI tool (Appropriateness of Supervised Consumption Inventory).

For ease of use we recommend you download the Excel file before opening and working with the data.

The MAT data will be updated monthly and can be found **here** on the intranet data management section, under monthly clinical reporting tools.

Click here to recap on MAT stage description and data definition

5.2 Examining your data: distribution of service users in MAT stages

5.2.1

Phase 1

The first tab on the spreadsheet is the Service Tracker (Figure 3), where you can pick your service from the drop-down list.

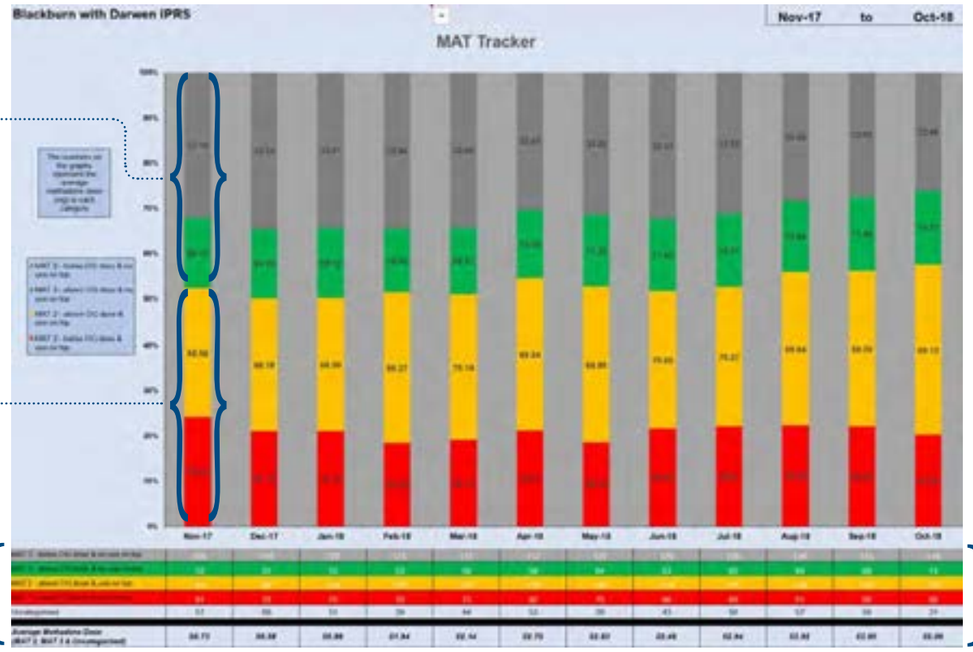

Figure 3: MAT Service Tracker

Number of service users in each cohort is available in the detailed data at the bottom of the Service Tracker (Figure 4). Identifying the uncategorised service users will be important.

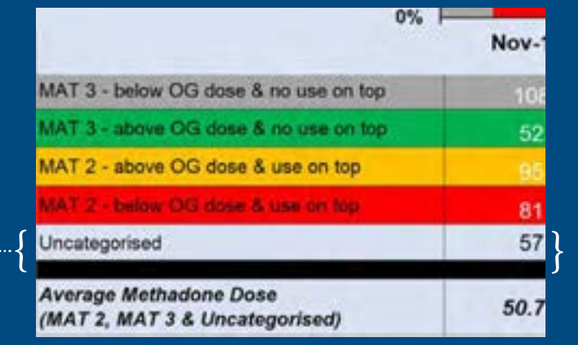

Figure 4: MAT cohort numbers and 'Uncategorised'

The second tab is Service Data (Figure 5), where you can see detailed MAT metrics for your service and compare against organisational data. Choosing a different service on the Service Tracker tab will be automatically reflected in the Service Data tab.

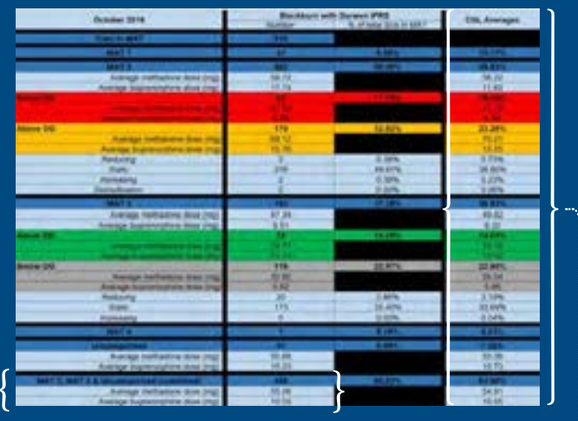

Figure 5: MAT Service Data with organisational means for comparison

5.2.2

Curious questions

Examine your data on MAT stages and opioid service users:

- Is there anything you need to check in terms of data quality?
- What is the number and percentage of ‘uncategorised’ service users (those without a recent TOP or drug screen)?
- How can you decrease the number of ‘unclassified’ service users and ensure all services users in MAT have a TOP/ drug screen at least every three months (including those in detoxification MAT 4), to assess whether they are using illicit opioids ‘on top’, are at risk of overdose or are doing well in treatment.
- Does the service use TOP tools with service user to help them reflect on their progress? How can use be encouraged? See **Appendix B** for further guidance on TOP.
- What other curious questions can you identify to help understand your service data?

5.2.3

Suggested actions

- Service data manager identifies those individual service users who are ‘uncategorised’.
- The Improving MAT group develops and implements a plan to ensure all uncategorised service users receive a TOP and/or a drug screen as soon as possible and reduce ‘uncategorised’ to a minimum.
- The service data analyst creates their own tracker or time-series graph so the service MAT stage utilisation and proportion of uncategorised service users can be tracked over time with each data release.

5.3 Understanding data on illicit opioid use ‘on top’ and MAT doses

5.3.1

Where to find the data

All service users who are using illicit opioid ‘on top’ are in MAT 2 by definition. Data on mean methadone and buprenorphine opioid doses in MAT 2 and MAT 3 are located in the service data page. The mean methadone doses (mg) are also displayed in each stack (Figure 6).

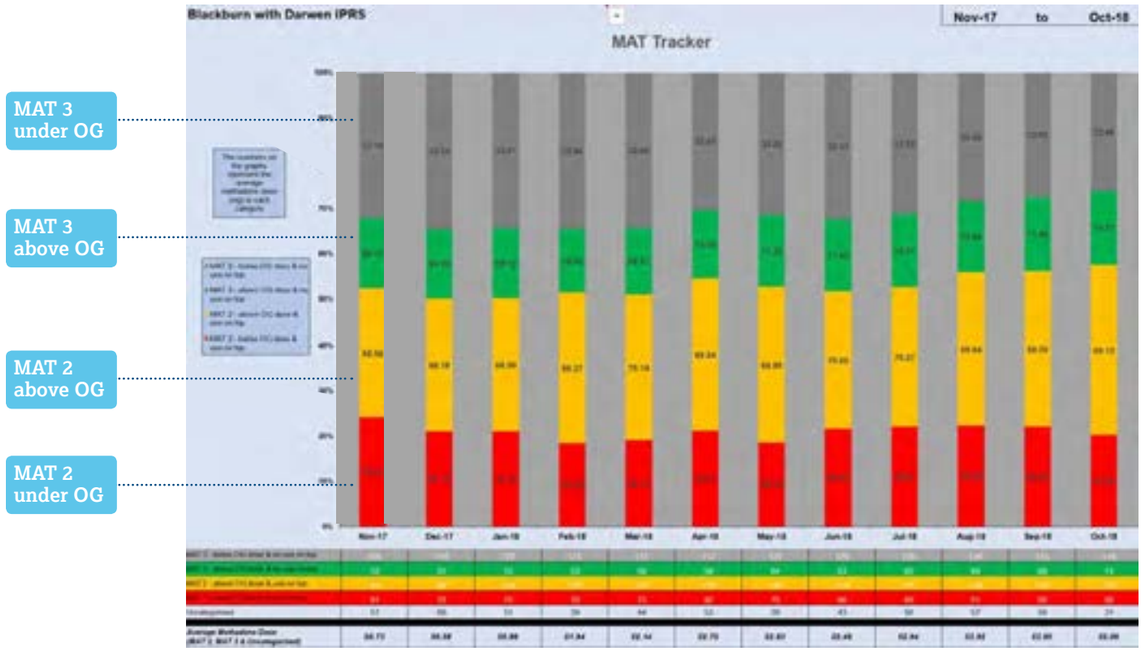

Figure 6: MAT 2 and MAT 3 cohorts with mean methadone doses

5.3.2

Curious questions

Examine your data on MAT 2 and MAT 3:

- Consider the numbers in MAT 2 who are using opioids ‘on top’? How do you compare to the organisational average and other similar services?
- What are your service average doses of methadone and buprenorphine? Are your average doses above the Orange Guidelines (OG) threshold doses? If not, how much lower are they? What is the range of doses? How do you compare to organisational averages and other similar services?
- What are your initial thoughts on your patterns of lower dose prescribing: is this the prescribing practice of particular clinicians, teams, or groups of service users?

5.3.3

Suggested actions

- **Service Improving MAT group looks at and discusses the data**
- **Service data manager explores the data further in relation to Improving MAT group suggestions.**

For guidance on using the Risk Profile Tool report click here

6. Priorities for improving MAT

6.1 Priority 1: Identifying service users in MAT 2 at highest risk of overdose

6.1.1

Where to find the data

The data file MAT Breakdown will enable the data manager to identify individual service users in MAT 2. The data manager could support identification of individuals in MAT 2 thought to be most at risk by cross-referencing with the Risk Profile report. Both reports (MAT Breakdown and Risk Profile Tool), can be downloaded via CRIiS, under the 'Exporting' Tab/Miscellaneous Data Exports/Prescribing MDES (Figure 7). Guidance on use of the Risk Profile Tool report can be found here. For ease of use the data manager may wish to combine both files using VLOOKUP function in Excel.

6.1.2

Understanding your data on illicit opioid use 'on top' and prioritising risk

Your Improving MAT group should discuss the service data on patterns of use 'on top'.

Look at the risk profile data on those in MAT 2. Improving MAT should agree on who is most at risk, eg people in MAT 2 who are on a reducing prescription. Decide which service users should be prioritised for action in MAT 2; supported by Recovery Worker caseload awareness and use of the risk-profile tool.

6.1.3

What we already know about risk in this group

Factors we know increase a person's risk of overdose include:

- Illicit opioid use 'on top' of an opioid prescription
- Injecting as the route of use
- Dependence on or use of other depressant drugs and/or alcohol
- Recent experience of an overdose
- Lowered tolerance due to leaving prison, hospital or residential rehabilitation.
- Use of more potent opioids such as fentanyl
- Acute housing issues
- Health problems including thinking about suicide

The presence/absence of these factors can be identified via the Risk Profile Report for your service.

Although service users who use opioid and depressant drugs dependently are at risk, those with intermittent or binge illicit opioid use combined with alcohol or benzodiazepines are also at risk, as their tolerance may not be as high as those dependent on multiple depressant drugs.

Addressing any of the above factors could reduce the risk of overdose for an individual.

6.1.4

Curious questions

- Do you routinely prioritise and provide urgent interventions to people at higher risk of overdose?
- What are your service's responses to service users who continue to use illicit opioids 'on top'?
- How can your service have a clearer focus on helping people stop illicit opioid use 'on top'?
- How do we encourage people who inject to adopt safer practice? Are they a priority for the service?
- What coverage of naloxone does the service have for those in MAT 2? How does it compare with other services and organisational averages?
- What does treatment look like for individuals with concurrent benzodiazepine and alcohol use risks?

6.1.5

Suggested actions

- Identify those at most risk of overdose in MAT 2 (eg reducing prescription and below OG dose).
- Once identified, move to the next stage to plan the appropriate intervention.

6.2 Priority 2: Helping those in MAT 2 (below OG dose) stop use ‘on top’

Our next priority is to first improve MAT for those on a reducing prescription in MAT 2, then static (indicated as Stable in the MAT tracker) prescriptions, where the medication is below OG doses.

6.2.1

Where to find the data

Data on service users in MAT 2 who are below OG can be found in the MAT Tracker, with detail available on the Service Data tab. Figure 8 highlights reducing prescriptions.

October 2018	Blackburn with Darwen IPRS		CGL Averages
	Number	*% of total SUs in MAT*	
Total in MAT	518		
MAT 1	31	5.98%	15.77%
MAT 2	262	50.58%	39.83%
Average methadone dose (mg)	59.72		58.22
Average buprenorphine dose (mg)	11.74		11.63
Below OG	92	17.76%	16.54%
Average methadone dose (mg)	41.26		41.16
Average buprenorphine dose (mg)	6.86		6.89
Above OG	170	32.82%	23.28%
Average methadone dose (mg)	69.12		70.21
Average buprenorphine dose (mg)	15.76		15.25
Reducing	2	0.39%	0.73%
Static	258	49.81%	38.80%
Increasing	2	0.39%	0.23%
Detoxification	0	0.00%	0.06%

Figure 8: MAT 2 with reducing prescriptions highlighted

MAT 2 reducing

MAT 2 detail

6.2.2

Understanding your data

We have provided data on:

- Numbers and percentage of service users in MAT 2 by whether they are under or over OG dose
- Service users in MAT 2 who are under OG doses by whether their opioid prescriptions are increasing, static, or reducing (see above)
- The data manager should cross reference this data with the service Risk Profile data and identify service users who are most at risk in MAT 2: are they on increasing, static, or reducing opioid prescriptions?
- Improving MAT group should explore and discuss the data
- Priorities for action will be those on under OG doses who are:
  a) on reducing prescriptions and
  b) on static prescriptions
- The priority is to identify service users who are on reducing doses. It can be presumed that those on increasing prescriptions are in the process of having MAT dose optimised, provided the target dose is above OG threshold dose.

6.2.3

What we know

- There is a clear evidence that methadone doses of 60-120mg and buprenorphine doses of 12mg or higher (OG dose) are associated with less opioid use ‘on-top’.
- The OG stress that a dose that leads to complete cessation of heroin (or other illicit opioid use), is the key goal and this dose may be higher “than the dose at which the patent feels stable”.
- Clinicians should seek to ensure that the opioid medication does not just remove withdrawal symptoms but also reduces the cravings for illicit opioids.
- Clinicians should optimise treatment interventions for patients who are continuing to use illicit opioids ‘on top’ by intensifying pharmacological and psychosocial support (rather than reducing it) – see ‘Optimising opioid MAT’ box below.
- Slow reduction regimes have very little evidence and can become suboptimal prescribing in a reducing regime. This should be discouraged.
- The OG and our new opioid prescribing policy do not advocate reducing to 30mg methadone prior to starting a community detoxification regime. Service users should be encouraged to be on OG dose maintenance (or a dose that enables no illicit opioid use ‘on top’), until ready to undertake a detoxification which ideally should last no more than three months.

6.2.4

Curious questions

- Are individuals in MAT 2 who are under OG doses receiving reducing prescriptions (when ideally their doses should increase)? What can be done to help this group?
- Are individuals in MAT 2 on static (but under OG doses) prescriptions (when again – ideally their dose should increase). What can be done to help these individuals?
- Explore the service patterns of under OG dose prescribing in MAT 2: is this the prescribing practice of particular clinicians; is this for particular individuals or groups of service users?
- What can the service do to optimise dosing of people who continue to use ‘on top’?

6.2.5

Suggested actions

- Develop and implement an urgent response plan to improve MAT for service users on prescriptions under OG dose which are reducing and who are using ‘on top’.
- Develop and implement a response plan to improve MAT for service users on static but under OG dose prescriptions and who are using ‘on top’.

6.2.6

Case study

The central clinical team looked at data from across the organisation on service users who were using opioids ‘on top’ (so in MAT 2), and being prescribed under OG dose who were on reducing prescriptions. The main reasons for this scenario were:

- Service users’ requested a reducing dose against medical advice
- Service users’ request with medical and/or key worker advice
- Service users who were on slow reduction regimens that had briefly lapsed but who still wanted to reduce
- Service users being discharged from the service

Learning

- All service users in MAT 2 who are on reducing prescriptions should be reviewed and individually considered.
- In general terms, service users who are still using opioids ‘on top’ should be encouraged to increase their dose of medication NOT reduce it.
- Reducing MAT where there is ongoing illicit use would rarely be supported by medical advice, however, if an individual makes an informed decision to reduce their prescription against medical advice, then this must be accurately recorded in the clinical record.

Other basic principles

- Opioid medication should never be reduced as a punitive measure.
- Opioid medication should not be reduced as a result of a service user not attending psychosocial intervention sessions – there should be a review and strategies put in place to reward attendance beneficial to the service user.
- Those on detoxification or slow reduction regimes that continue to use illicit opioids ‘on top’ are very unlikely to maintain abstinence once detoxified and should be encouraged to return to an opioid maintenance regime and build recovery capital.

6.3 Priority 3: Focus on those in MAT 2 who are over OG doses and using 'on top'

6.3.1

Where to find the data

Data on service users in MAT 2 who are above OG doses can be found in the MAT Tracker, with detail available on the Service Data tab.

6.3.2

Understanding your data

We have provided data on:

- Numbers and percentage of service users in MAT 2 by whether they are under or over OG doses
- The data manager should cross reference this data with the service Risk Profile data and identify service users most at risk in MAT 2 over OG doses.
- Improving MAT group should explore and discuss the data
- The priorities for action are those service users who are most at risk according to the risk profile data.

6.3.3

What we know

- There is a clear evidence that methadone doses of 60-120mg and buprenorphine doses of 12mg or higher (OG dose) are associated with less opioid use 'on-top'.
- The OG stress that a dose that leads to complete cessation of heroin (or other illicit opioid use), is the key goal and this dose may be higher "than the dose at which the patent feels stable".
- Clinicians should seek to ensure that the opioid medication does not just remove withdrawal symptoms but also reduces the cravings for illicit opioids.
- Clinicians should optimise treatment interventions for patients who are continuing to use illicit opioids 'on top' by intensifying pharmacological and psychosocial support (rather than reducing it) – see 'Optimising opioid MAT' box below.
- Slow reduction regimes have very little evidence and can become suboptimal prescribing in a reducing regime. This should be discouraged.
- The OG and our new opioid prescribing policy do not advocate reducing to 30mg methadone prior to starting a community detoxification regime. Service users should be encouraged to be on OG dose maintenance (or a dose that enables no illicit opioid use 'on top'), until ready to undertake a detoxification which ideally should last no more than three months.

6.3.4

Curious questions

- Explore the service patterns of over OG dose prescribing in MAT 2: is this the prescribing practice of particular clinicians? Is this for particular individuals or groups of service users?
- Explore the patterns of opioid use 'on top': is it occasional use or very regular use? Do service users continue to inject opioid drugs?
- Have you been able to identify those most at risk using the risk profile – are there any trends?
- Do service users receive enough harm reduction information and interventions (including naloxone), if they continue to use illicit opioids 'on top'? What can the service do to reduce sub-optimal dosing of people who continue to use 'on top'?
- Is the service providing enough psychosocial interventions to encourage them to stop, undertake relapse prevention work, examine and develop strategies to manage triggers, craving and high-risk situations? Does the service provide contingency management?
- Does the service provide treatment for other substances including stimulants?
- Are unmet needs such as mental health, physical health (eg pain), or social issues maintaining factors?

6.3.5

Suggested actions

- Identify those service users with higher risk profiles and prioritise for immediate review and optimisation of treatment.
- Optimise MAT for all those who continue to use illicit opioids 'on top'.

6.3.6

Case study: Birmingham

Early work and analysis of Birmingham data in January 2017 (Figure 9) showed that around 55% of service users in MAT continued to use illicit opioids ‘on top’ (amber and red) and 30% (red) were being prescribed under OG doses. The service made improvements to increase MAT doses and by March 2018 only 10% of service users in MAT were prescribed under OG doses. The percentage using illicit opioids ‘on top’ also reduced. The Birmingham consultant and Service Manager explored why the levels of use ‘on top’ were still high and concluded that, although service users had been moved to OG dose ranges lower limits, MAT opioid doses required further optimisation to meet the needs of individual patients. A pilot ‘optimisation clinic’ was therefore implemented for those still using ‘on top’, resulting in individual ‘optimisation’ plans for those service users in line with Orange Guidelines (2017).

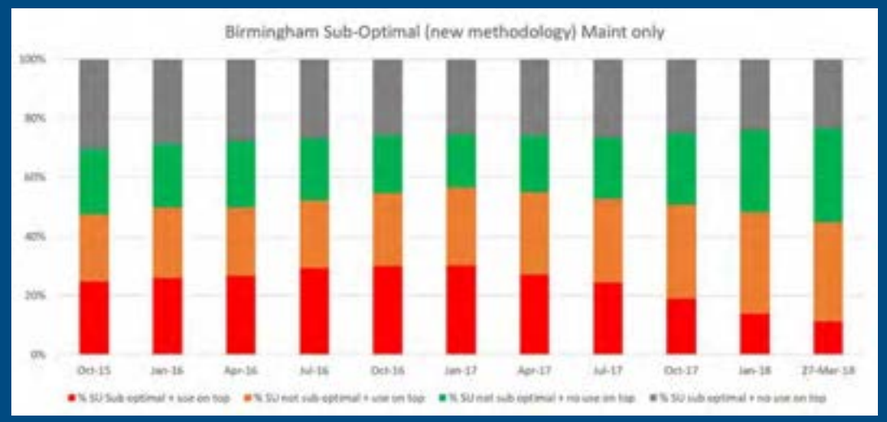

Figure 9: MAT Optimisation in the West Midlands

6.4 Priority 4: Improving use of supervised consumption

6.4.1

Why supervise consumption of opioid medication?

Supervised consumption (SC) can be a useful tool for service users in MAT. SC can be useful to prevent diversion of opioid prescription medication, helpful during induction, the early stages of MAT, and when service users experience a period of instability or poly substance use. Pharmacy staff can build a positive relationship with service users and can alert the prescriber or key worker if issues occur. However, there is also evidence that SC can be a barrier to service users engaging in MAT if SC does not fit with other commitments such as work or childcare, or if access to the SC is too difficult or expensive.

The Orange Guidelines (2017) recommend SC as a useful strategy to be utilised while a service user achieves stability. When stability is achieved, SC should be relaxed. While the guidelines do recommend the use of SC, a growing body of evidence suggests that it may not be a significant factor in reducing risks to the individual service user. Judicious use of SC is also critical due to the costs of SC and to ensure it isn't a barrier to people accessing treatment.

6.4.2

Organisational data on supervised consumption

The average SC rate for the organisation is 52%, which we feel is probably too high. A significant amount of novel work has been done in this area, primarily to understand the clinical rationale behind decisions, and through the introduction of bespoke tools (ASCI) for services to try and improve consistency of practice; there is a wide variation in SC.

3,808 ASCIs were completed between February and August 2018. Of these, 2,173 service users (57%) were not on SC and 1,635 (43%) were in SC (Figure 10). Research by the University of Manchester has shown there were high levels of agreement between ASCI scales and SC decisions (around 85% of cases), and that ACSI is a useful tool for prescribers.

Three out of 12 ASCI items appeared to drive decision making:

- was medication diverted this episode
- is the service user vulnerable or at risk of exploitation
- regular illicit opioid use in the last 28 days

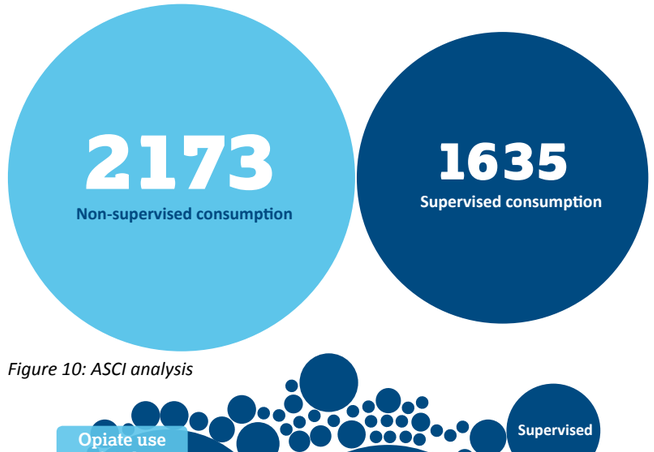

Figure 10: ASCI analysis

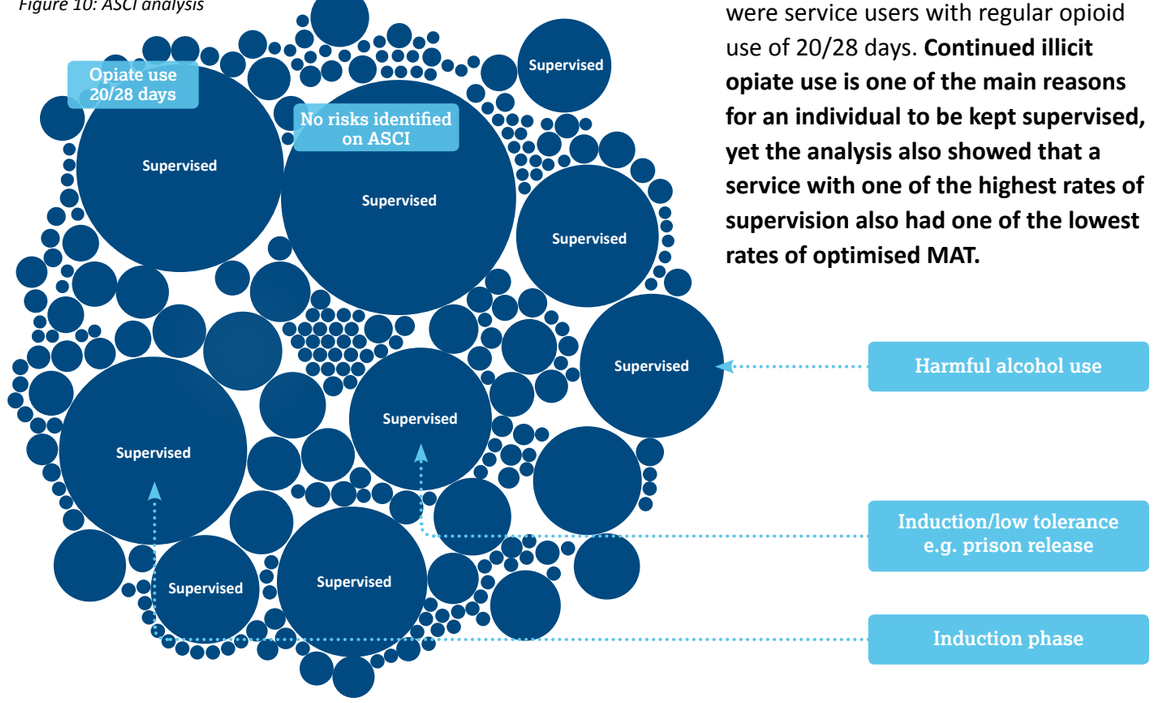

Figure 11: ASCI Risk permutations, with main single item risk groups

The analysis also placed service users into profiles of risk according to ASCI; many different permutations of risk were identified. Of the 3,808 ASCIs, the groups with a single risk were analysed (Figure 11). It was found that the largest single group (263), who remained on supervised consumption were those with no ASCI-definition risk identified. The second largest group on SC (179) were service users with regular opioid use of 20/28 days. **Continued illicit opiate use is one of the main reasons for an individual to be kept supervised, yet the analysis also showed that a service with one of the highest rates of supervision also had one of the lowest rates of optimised MAT.**

It follows that addressing the latter issue would then positively impact on the supervision rate. Use of the Assessing Supervised Consumption Inventory (ASCI) tool enables prescribers to make informed and consistent decisions in relation to when service users should be on supervised consumption.

6.4.3

Suggested actions

- Each service should examine their ASCI data: what are your trends?
- Ensure that all services users in MAT have an ASCI.
- Remove supervision for service users on SC with no risks identified. Initially move to daily pickup, but review to see whether this can be further relaxed.
- Prioritise the risk group who are using illicit opioids ‘on top’ more than 20/28 days. Optimise MAT – particularly medication dose. This will reduce reliance on SC to monitor risks.
- For those with risks identified on ASCI, consider whether daily pickup and an active plan to address the risk may be more beneficial to the service user than remaining on supervised consumption.

Improving MAT with dose optimisation should reduce the requirement for supervised consumption over time.

6.5 Priority 5: Focus on those in MAT 3: building recovery capital

6.5.1

Where to find the data

Data on service users in MAT 2 who are above OG doses can be found in the MAT Tracker, with detail available on the Service Data tab.

6.5.2

Understanding your data

We have provided data on:

Numbers and percentage of service users in MAT 3 by whether they are under or over OG doses.

- We have also given data by whether they are on an increasing dose, static maintenance dose or reducing dose. It is likely that some individuals may be on reduction regimes and may be working towards detoxification.
- The data manager may wish to explore data on individuals in this group further and look at how long service users have been in treatment and data from TOP on their health status, employment, housing and social capital.
- Improving MAT group should explore and discuss the data.
- Can you distinguish between those on reduction and static maintenance regimes?

6.5.3

What we know

- MAT provides a platform from which service users can build health and recovery capital and improve the quality of their lives, whilst being protected from the risks associated with illicit opioid use.
- Many service users in MAT aspire to 'a better life' and could achieve their aspirations whether in MAT or free from all dependence. Aspirations may include: being healthier and fitter; having meaningful occupation or employment; having supportive family and friends and being part of their local communities.
- Some service users may need MAT for many years and others may require a shorter time in MAT prior to attempting an opioid detoxification.
- Services should encourage all service users in MAT to build recovery capital, while encouraging and supporting service users to come off MAT when they feel ready.
- Service users in MAT should receive regular reviews – including TOP.
- Service users in MAT should also have facilitated access to mutual aid or peer support and opportunities for volunteering, training and employment.
- Service users that want to detoxify from opioid maintenance (MAT 4) should be supported to do so and receive evidence-based detoxification (within three months), rather than slow reduction (which has a limited evidence-base).
- Evidence suggests that service users who detoxify from MAT require at least six months recovery support (and often much longer) to prevent relapse.

6.5.4

Curious questions

- What are the prescribing regimes of service users in MAT 3? How many are on static or increasing regimes and how many are reducing?
- Are there clear pathways to mutual aid, peer support, and volunteering for service user in MAT 3?
- What psychosocial interventions are employed to support those in MAT 3?
- Are there pathways to enable service users to get treatment for underlying physical or mental health issues, including IAPT services, smoking cessation, treatment for Hepatitis and COPD?
- Are there service users who may benefit from shared care?
- Are there clear supportive detoxification (rather than slow reduction) pathways for those wishing to come off MAT?

6.5.5

Suggested actions

- Improving MAT group to discuss how MAT 3 can be improved to ensure all service users have access to interventions to help them build recovery capital in the key domains of:
  - health and wellbeing;
  - social connections;
  - meaningful occupation, training, volunteering or employment; and
  - social stability such as housing.
- Review service users on reducing prescriptions. If they are seeking to come off MAT, help them review their recovery capital and if sufficient place in a supportive (three month) detoxification regime with post-detoxification support.
- Consider placing stable service users in GP shared care (if appropriate), retaining regular reviews with TOP.

7. An outline of Phase 2 Priorities

From March 2019, we hope to have made significant progress on improving opioid maintenance (MAT 2 and 3) and will shift priorities to improving MAT (1 and 4) induction and detoxification. Below is a brief outline of the data and improvement work we will undertake during this phase of work.

7.1 Improving induction (MAT 1)

We wish to improve induction onto MAT by creating more service user-focussed and efficient induction processes that reduce the drop-out rate when moving to the 'behaviour change' phase and reduce the need for re-induction. This work will link with the improving entry into treatment programme.

7.1.1

Data

Induction (MAT 1) will be measured by four weeks of a continuous MAT prescription from the date of starting a prescription to 28 days. In March 2019, we will provide additional data on MAT 1, which is likely to include information on the numbers and percentage in induction, mean opioid medication doses after 28 days, and levels of drop-out and return.

7.1.2

What we know

- Induction onto opioid medication should be service user-focussed and as swift as safety allows.
- Poor induction processes can contribute to service user drop-out and/or continued high-risk drug use
- Induction onto methadone is associated with an increased risk of overdose compared to induction with buprenorphine, although the risk reduces after around a month.

7.1.3

Actions for services

We will ask services via Improving MAT groups to examine the data they are given on induction, reflect on whether their service has efficient and effective induction processes and how can they be improved.

7.1.4

Case study:

Contingency management induction pilot

The SE region conducted a pilot to increase compliance on opioid medication induction following identification that some service users were not reaching Orange Guidelines recommended doses during induction due to high drop-out and re-presentation rates during this phase. A formal contingency management pilot was conducted using small financial rewards for compliance with induction regimes. The pilot resulted in a greater percentage of service users completing induction and complying with titration regimen to OG doses. Staff concluded that the project was cost-effective as the contingency management programme increased completion of the induction phase and the efficiency of induction versus costly failed induction and repeated re-presentation.

7.2 Improving detoxification and recovery management

We wish to improve MAT 4 detoxification, increasing the numbers who come off opioid medication and supporting them better with recovery management interventions to prevent relapse. This will include reducing use of non-evidence-based, inefficient 'slow reduction' regimes.

7.2.1

Data

Detoxification is defined as the percentage and number of service users in MAT 4 as measured by those reducing OST prescription to 0 within three months. In March 2019 we will provide data on MAT 4 detoxification including: mean doses entering MAT 4 and numbers detoxing within three months.

7.2.2

What we know

- Enforced detoxification is unethical, leads to relapse and should not be undertaken.
- Slow reducing regimens, although commonplace, have little evidence and often result in sub-optimal dose maintenance and illicit opioid use 'on top'.
- Community detoxification from opioid medication should be undertaken in three months or less from a maintenance dose.
- There is no evidence-based need for a service user to reduce opioid prescriptions to 30mg methadone prior to commencing detoxification.
- Those who wish to detoxify from opioids who cannot do so in the community should be offered in-patient detoxification.
- Service users should receive at least six months recovery support after detoxification. This may include community-based support and a minority may require residential rehabilitation followed by community-based recovery support.

7.2.3

Actions for services

We will ask services via Improving MAT groups to examine the data they are given on induction, reflect on whether their service has efficient and effective induction processes and how can they be improved.

8. Acknowledgements

The Project Sponsors and Lead would like to thank the following individuals and teams for their invaluable contributions to and support of this project:

- National Service User Council: Mark Pryke and colleagues for inputting into the plan and priorities, as well as informing the service user materials.
- Annette Dale-Perera: for pulling together and shaping the first drafts of this toolkit, and supporting the Project group in the development of the overall plan.
- The National Data Team: Jeff Crouch, Jordan Kirby and Sue Kelly for their collaboration to adapt the CRIiS system and develop the data required to inform the project.
- Inspire, Blackburn with Darwen: Danielle McGovern, Gary Howarth, Claire Hill, Robert Airey, Waheed Wilayat, Christopher Dignan and Abhi Gholi – for field-testing the Improving MAT Toolkit and providing essential feedback to improve and refine the document.
- The Quality team: Bec Davison and Nicky Knowles for guiding the team through the Continuous Improvement Plan methodology, and creating the summary information document to support front-line staff.
- Marketing team: Russell Booth, Tom Sutton and Francesca Roy for developing the service user posters, online resources, and putting together the final document.
- New Directions, Bradford: Emma Nicklin for providing examples of service user information leaflets to support MAT optimisation, and Colin Stansbie of City of Bradford Metropolitan District Council for allowing us to use and adapt them for our requirements.

9. Appendices

A. Improving opioid MAT: a whole organisation learning and improving together

Links with organisation priorities

This programme of work links to the following organisational priorities and programme of work:

- Reducing drug-related deaths
- Improving entry into treatment
- Enabling bottom-up solutions

How central teams will support this work

Central teams will support this work in the following ways:

- **Executive Leadership Team (ELT)**
  - Oversee and monitor progress
  - Information team
  - Provide monthly data on improving MAT from September
  - Ad hoc support to data managers as agreed with Jeff Crouch
- **Clinical team**
  - Revised Medications in Recovery training resource
  - New opioid prescribing policy and guidelines
  - Journal clubs for prescribers and regular meetings to update on progress
- **Quality team**
  - Advice to services on 'plan, do, study, act' (PDSA) methodology
  - Collation of Service Response Plan and creation of case studies (Nicky Knowles)
- **Service User Council**
  - Provide advice and expertise into Improving MAT project team
  - Co-produce Improving MAT materials for service users
  - Support service user representation in local Improving MAT groups
- **Communications**
  - Update and brief on progress
  - Publish and disseminate good practice
- **University of Manchester**
  - Advise on data collection and publication

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B. Using TOP to support Improving MAT

Using the TOP Tracker in CRIiS

"The Treatment Outcome Profile (TOP) measures change and progress in important areas of the lives of users of drug and alcohol treatment services. It consists of a series of simple questions focusing on the areas that can make a real difference to patients' lives." – PHE[4].

As an evidence-based tool, we have fully embedded TOPs into our working practice and have developed functions in CRIiS to support its effective use.
This includes the ability to track progress using an automated tracker within the system.

Where to find the TOP Tracker

On the CRIiS 'Recovery Assessment', a 'TOP-TPT' link is available which allows the worker to select which episode of treatment and which TOPs to analyse.
The example below (Figure 12) shows the change in opiate use for a service user:

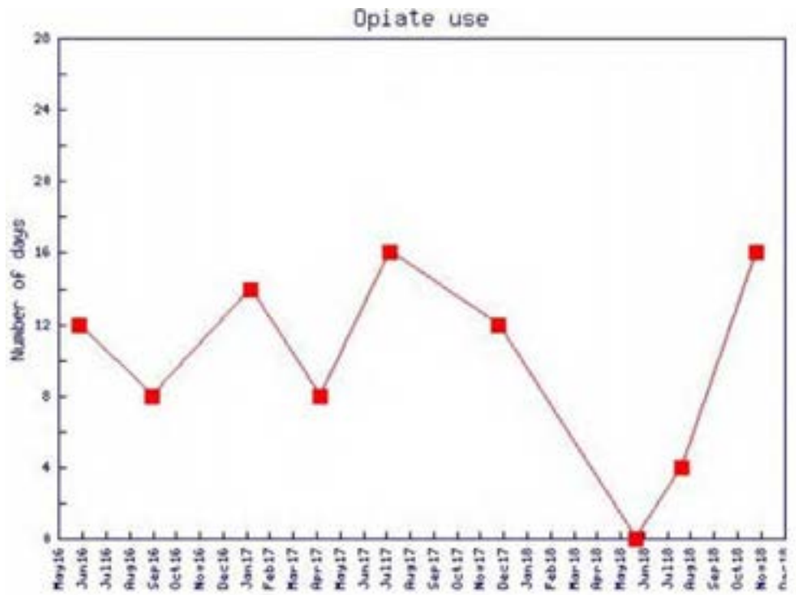

Figure 12: TOP-TPT

[4] *https://www.gov.uk/government/publications/drug-and-alcohol-treatment-outcomes-measuring-effectiveness/collecting-drug-and-alcohol-treatment-outcomes-information*

C. Project timeline

ELT identify priority, project continuous improvement plan developed, development of data set, toolkit, opioid prescribing policy rewrite etc.

ELT, INFO TEAM, PROJECT TEAM

Plan 1: services explore issues around opioid maintenance and develop solutions

SERVICES

Study 1: bi-monthly data to track improvement in MAT 2 and give case studies

March - assess improvement, identify and share good practice across the organisation

INFO TEAM, QUALITY, ELT

Act 1: implement any whole organisational change re MAT 2: maintenance

ALL

Study 2 & 4: bi-monthly data to track improvement in MAT 1 & 4 and give case studies. Data on MAT 2 & 3 (maintenance will continue to be provided)

Assess improvement, identify and share good practice across the organisation

INFO TEAM, ELT, QUALITY

Act 2 & 4: implement any whole organisational change re MAT 1 & 4: induction and detoxification

ALL

JUN – AUG 2018 | **SEPT 2018** | **OCT 2018** | **NOV 2018** | **MAR 2019** | **APRIL 2019** | **MAY 2019** | **SEPT 2019** | **NOV 2019**

ELT, INFO TEAM

Launch of data, toolkit and services planning to improve MAT

SERVICES

Do 1: services develop and implement Service Response Plans for MAT 2: opioid maintenance

INFO TEAM, SERVICES

Plan 2 & 4: services provided with data on MAT 1: induction and MAT 4: detox to explore and develop solutions

SERVICES

Do 2 & 4: services develop and implement improvement action plans for MAT 1: induction and MAT 4: detoxification

Sept 2018

- Field testing of toolkit
- Project launch
- Opioid MAT data to services (bi-monthly thereafter), plus this ‘toolkit’ and other resources

October 2018

- Each service implements an Improving MAT project group including: manager; data analyst; clinician; recovery worker; service user representative; peer support worker
- Project groups discuss the MAT maintenance, mean opioid doses and opioid use ‘on top’ data, identify key issues and solutions and devise improvement plans

Nov 2018 – Feb 2019

- Services implement improvement plan
- Central teams provide bi-monthly data, collate improvement plans and identify case studies

March 2019

- Review of progress in improving use MAT maintenance, mean opioid doses and levels of ‘use on top’
- Publication of best practice and changes made to our systems and processes as required.

April 2019

- Launch of improving opioid phase 2: improving MAT induction and detox
- Data on MAT induction and detoxification to services and updated toolkit to services and other resources
- Service Improving MAT project groups discuss MAT induction and detoxification data identify key issues and solutions and devise improvement plans

May – August 2019

- Services implement improvement plan
- Central teams provide bi-monthly data, collate improvement plans and identify case studies

September 2019

- Review of progress in improving use MAT induction and detoxification
- Changes made to national systems and processes as required.
- National/international publication of Improving MAT and ‘best practice’ findings.

D. Setting up a service Improving MAT project group

We would like each service to set up an Improving MAT project group.

Improving MAT project group membership

Your Improving MAT project group should consist of: the service manager; the clinical lead; a recovery worker Improving MAT champion; service user representatives; peer support worker representative; and the service data analyst. Other members of the team can be included as required.

Improving MAT terms of reference

- Improving MAT is a short-life project group which should meet for one year.
- Ideally your Improving MAT project group should meet monthly for the duration of the project (for next year).
- The overall aim of your Improving MAT project group is to champion and drive improvements in MAT in your service.
- The specific tasks of your Improving MAT project group are to:
  - Examine initial data and your service quality and performance on MAT.
  - Develop 'bottom-up' solutions to the Phase 1 priority areas, as required.
  - Share your action plans with the Quality team.
  - Receive monthly data on MAT that will enable you to track changes.
  - Share learning and 'good practice' case studies with Quality team.
  - Repeat these steps for Phase 2 priority areas after six months.

E. Recommended responses to drug and alcohol use on top of opioid prescriptions[5]

Scenario	Risks	Possible responses
Opioid use 'on top' of an opioid prescription	• Overdose • Blood borne viruses and other infections if injecting • Continued offending and involvement in drug use • Impaired engagement	• Reinforce overdose prevention interventions • Ensure access to safer injecting advice and NEX • If on a reducing regime, re-stabilise on a higher dose, review goals and support • Increase doses if inadequate • Divide dose, in addition, if fast metaboliser • Change MAT medication • Daily supervised consumption if appropriate, then monitor successful progress before relaxing • Increase medical review and PSI: key work, motivation, contingency management, etc. • Review medication collection arrangements
Cocaine or crack cocaine use 'on top'	• Blood borne viruses and other infections if injecting • More chaotic drug use • Continued offending • Psychological problems • Overdose	• Reinforce overdose prevention interventions • Ensure access to safer injecting advice and NEX • Confirm adequate stability on current dose of MAT – increase dose if inadequate • Review level of instability and need for daily supervised consumption • Provide PSI for stimulant use • Increase frequency of medical review, key work or PSI • Review for comorbid mental health problems
Harmful or dependent alcohol use or benzodiazepine use	• Overdose or 'near misses' • Drug interactions • Alteration of methadone metabolism • Deterioration of liver function in those with Hep C • Intoxicated presentations	• Assess alcohol/benzodiazepine dependence and need for assisted withdrawal from alcohol/benzodiazepine • Increase medical review • Increase key work, alcohol PSI or other PSI • Daily supervised consumption if appropriate, then monitor successful progress before relaxing • Consider breathalyser testing to monitor progress

[5] *Orange Guidelines 2017*

F. Notes