

Your toolkit for advocating
in drug treatment :

ADVOCACY GUIDE

PART TWO: THE MANUAL

Release
Drugs, The Law & Your Rights

Release

Drugs, The Law & Your Rights

Release is the national centre of expertise on drugs and drugs law. The organisation, founded in 1967, is an independent and registered charity.

Through our services the team provides free non-judgmental, specialist advice and information to the public and professionals on issues related to drug use and to drug laws.

The organisation campaigns directly on issues that impact on our clients - it is their experiences that drive the policy work that Release does and why we advocate for evidence-based drug policies that are founded on principles of public health rather than a criminal justice approach.

Release believes in a just and fair society where drug policies should reduce the harms associated with drugs, and where those who use drugs are treated based on principles of human rights, dignity and equality.

The organisation is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations, as well as being part of the Vienna NGO Committee on Narcotic Drugs (VNGOC) and the New York NGO Committee on Drugs (NYNGOC).

WELCOME
TO
PART
TWO
OF
THE
RELEASE
ADVOCACY
TOOLKIT,
AKA
“THE
MANUAL”



WHAT IS THIS FOR?

This booklet is a manual for advocating in different drug treatment situations. All of these situations are derived from common requests to the Release helpline and the steps that Release advocates would commonly take.

It continues on from part one of the Advocacy Toolkit, which provides more general principles, advice, and strategies for people wanting to advocate for themselves or others in drug treatment.

This booklet should be helpful to:

- **People in drug treatment**, particularly those receiving or wanting to receive Opioid Substitution Therapy (OST), which make up the bulk of our specific scenarios.
- **Friends, family, peer supporters, and professional advocates** who are supporting somebody in drug treatment.
- **Workers in drug treatment services.**

It aims to:

- **Support** people in treatment, and their advocates, to exercise their treatment rights.
- **Protect** individual consent, preference, and active involvement in treatment.
- **Outline** the different steps an advocate might follow to challenge decisions.
- **Present** the relevant guidelines in an accessible and concise format.

HOW TO USE IT:

The Guide includes:

- **Advice for advocating** in specific situations in treatment.
- **Template letters**, which you can use and adapt for your advocacy efforts.
- **A library of resources** including internet links and further readings.

We would always recommend that you get in touch with us if you need us or want support, either by emailing ask@release.org.uk or by phoning our helpline at **020 7324 2989**.

How we use Government guidelines:

You will find lots of references to “U.K. guidelines” or “guidelines for drug services”. This is the U.K. Department of Health and Social Care’s guidelines on drug treatment, titled ‘Drug misuse and dependence: U.K. guidelines on clinical management’. These guidelines are also known as the ‘Orange Book’ or ‘Orange Guidelines’.

The Orange Book contains the most important guidelines for treatment services: the Guidelines generally emphasise the importance of an individual’s involvement in, preferences about, and ongoing consent to all treatment decisions.

The Orange Guidelines are not law, and so services can choose to not follow them and that won’t necessarily mean they have done anything wrong. However, they are based on current evidence and professional consensus, and while there may be good reasons for not following them your service should always be able to explain to you what their reasons for this are. If they can’t, or you are unhappy with the treatment you’ve received, these may be grounds for complaints, referral to independent regulators like the GMC, or legal redress.

You will find that they are a helpful anchor for your arguments and advocacy. We provide short summaries of the relevant sections of these guidelines to support the advocacy steps we suggest for each common situation detailed in this booklet.

You can find the full text for these guidelines online at <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management>

If you need help accessing the full resource, contact us by phone or email address and we will support you with this.

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1

I WANT TO ACCESS TREATMENT



Accessing drug treatment should be a simple case of self-referral (or your GP can refer you).

However, over the years people have reported barriers to accessing treatment, such as being told you have insufficient “motivation,” that the service only supports people who require OST for heroin use, or that someone else is responsible for your care (such as your GP, a pain specialist, or a mental health service).

Regardless of the reasons, get a clear and written reason from the drug treatment service for turning you away.

In a response, outline the risks of turning you away from treatment - whether that’s buying drugs that you can’t test, withdrawal, and any other impact on your life. You should also ask follow-up questions about the decision. For example, how does the service measure motivation? Why can the drug treatment service only provide OST to people who use heroin, not other opiates? Can a multi-disciplinary team meeting be arranged with all relevant services and with you at the centre?

An Advocate should show why you need the support of drug treatment *specifically*.

Key points:

1. Services should have a low threshold for people accessing drug treatment.
2. You should focus on getting clear info on the reasons for exclusion and giving clear info on the risks.
3. Remember that accessing one service (e.g. mental health) should not exclude you from another.

What do the guidelines say?

Chapter 2: 2.6

People in drug treatment will often be receiving support elsewhere.

Chapter 7: 7.9.5

Those receiving support from mental health services should not be blocked from also accessing drug treatment and vice versa.

Chapter 7: 7.9.5

'Sequential' models of treatment are not recommended; in fact, people may need to receive treatment for mental health conditions and drug dependency at the same time (meaning they may be accessing several services at once).

Chapter 7: 7.2.6.3

Those who initially received opioids for pain management should not be blocked from accessing drug treatment. Where someone has chronic pain, there should be clarity on what the opioid prescription is primarily prescribed for, whether for pain or dependency or both. Efforts should be made to collaborate between the different clinicians and services.

The National Institute for Health and Care Excellence (NICE) also sets the following standard in their 'Coexisting severe mental illness and substance misuse Quality standard': this may be relevant if you are seeking mental health support alongside drug treatment:

"People aged 14 and over are not excluded from mental health services because of coexisting substance misuse or from substance misuse services because of coexisting severe mental illness".



If you are being refused OST, find out why. Have you been told that you have not shown enough motivation? Have you been told that OST is only provided for people using heroin, as opposed to other opioids? Is it due to your immigration status?

Whatever the reasons, tell the service, in writing, what the risks are of denying you treatment. Those reasons might include: recent overdoses, recent alerts about your local drugs supply, or ongoing effects on your mental and physical health.

If you are being denied treatment you could:

- Appeal to senior figures in the treatment service (such as the head office of the treatment service) or the Local Authority.
- Book a GP appointment, to see if they will support you to access treatment.

Motivation

Entry to services should be 'low threshold', meaning that access to OST should primarily just require confirmation of opioid dependence. If you have been told you need to show motivation, ask your service what is meant by this and what it involves.

OST for non-heroin opioid use

People have previously contacted Release about being denied OST as non-heroin opioid users. This may be related to the contract that services have with the Local Authority, if their contract focuses on people who use heroin. This, however, very rarely means that services are prevented from assisting other opioid users. All that the service should require from you is opioid dependence.

If your service is questioning whether you need OST, describe your drug-taking

behaviours and withdrawal symptoms. You could offer to do a drugs test or a Clinical Opioid Withdrawal Scale test to demonstrate your need.

Immigration status

You can have OST regardless of immigration status. Primary medical services (which include community drug treatment services) are freely available to anyone from overseas under Section 4 of the NHS Act 2006. However, if there are any issues with costs, you can also apply for a health costs certificate, named HC2 or HC3, by filling out the HC1 form. In-patient and residential services, however, might not be freely available to you. For more information, contact Release.

What do the guidelines say?

Chapter 4: 4.2.2

When deciding whether to prescribe, a prescriber should normally only consider OST if the following apply: opiates (not heroin specifically) are being taken regularly, usually daily; there is evidence of dependence and drug use; the prescriber believes the patient will follow the prescribing regimen (e.g., attend the pharmacy); and the patient is not already receiving OST.

Chapter 4: 4.2.2

For safe prescribing, a patient will need to engage in at least a “minimum level” of keyworking and attend prescribing reviews.

3

MY OST IS BEING REDUCED AND I'M NOT COMFORTABLE



Your dose should only be reduced if (1) you have consented to this or (2) there is evidence that your dose alone could result in an overdose. Any reduction should be led by you.

If your dose is being reduced as a punishment or consequence of missing appointments, missing pickups, or using other substances other than those you are prescribed, then that decision should be challenged, as none of those reasons are clinical justifications for altering your treatment plan in that way. In fact, if you are using on top, it likely means that an increased OST dosage would be appropriate to offer. In this case, you could use an opiate withdrawal measurement scale or tool such as the online SODA tool (<https://mydose.digital/>) to support that a maintained or increased OST dose is called for in your circumstances.

Key points:

Whatever the reasons for the reduction, you can emphasise that:

1. These reductions will risk your success and engagement in treatment, by increasing the odds that you will need to buy street drugs, or cause you to be sick, then jeopardising your employment, housing, or relationships.
2. You do not consent to the decision.
3. Your current dose, or a higher dose, is what you need.
4. The guidelines strongly advocate against forced reductions.

As early as possible, you should put these items, particularly that you do not consent to the change in treatment plan, in written form to your drug service.

What do the guidelines say?

Chapter 4: 4.8.1

The research and evidence do not support clinicians requiring or forcing patients on maintenance dose to gradually reduce.

Chapter 4: 4.6.3.3

If patients have missed pick-ups, it is sometimes appropriate to reduce the dose, but this should then be monitored and titrated up to the right dose for you.

My dose is being reduced and I'm not comfortable

Change this depending on whether you are advocating for somebody else or yourself.

Dear Treatment Service,

YOUR INTRODUCTION

Introduce yourself

Provide a brief summary of the issue and the solution you want to see

My name is Mo and I am a patient of the drug & alcohol service. A recent decision was made in relation to my Opioid Substitution Therapy medication, which has been causing me significant worry. I am hoping that I can reach a better, more collaborative treatment plan with the support of the service and my prescriber: I am writing to you with this purpose in mind.

EXPLAIN WHY YOU ARE WRITING AND WHAT YOU WANT TO CHANGE

What dose were you on before this started?

What are the most relevant recent events relating to the reduction? For example, has this been threatened or has it already started?

Summarise if you consented to this reduction or not. It may be that you voiced you would potentially want to detox eventually but didn't mean for it to happen immediately

What do you want to change?

Give a brief summary of what doses you have been on

I am writing about the reduction of my script; I was on a stable dose of 120mg/ml of methadone. I was told last week that my dose will be reduced at a rate of 20mg/ml per week, and a reduced prescription was at the pharmacy for me yesterday. I had not agreed to this reduction, nor did I indicate a wish to reduce my maintenance dose or begin a detoxification. The service should be aware that forced reduction or detoxifications are entirely contrary to the U.K. Guidance on Clinical Management for drug misuse and dependence, and that these practices are shown to reduce patients' retention in treatment and increase their risk of physical and mental harm. For those reasons, and further reasons I outline below, I am writing to ask that the reductions of my dosage stop. I wish to return to my original dosage with immediate effect, given the severity of the situation.

I have been on my prescription for 2 months and in OST treatment for 6 months. My dose was increased to help me to achieve my desired outcomes from

Give a brief summary of why your dose was increased e.g., it wasn't holding you, you were withdrawing

When was the decision made?

Did anything else happen in the appointment that felt relevant?

What happened during the appointment? Did you voice that you did not agree with the decision? Did you voice any concerns? Have you done anything since the appointment?

treatment, including those mentioned in the clinical guidelines as common goals of treatment:

- **“Break completely with all illicit opioid drug use [and...]”**
- **Reduce illicit opioid use with positive change in drug taking and risk behaviour” (Chapter 4: 4.2.2).**

At lower doses I experienced withdrawal symptoms and was regularly using oxys (despite hoping to stop).

I was informed of the reduction last week: this was a sudden decision during my medical review. The decision followed my request for harm reduction advice when it comes to using oxys and methadone, which I am concerned led to the decision to reduce me. Before the decision was made, there was no mental or physical examination, and I was not asked if a reduction was what I wanted or needed. During and after the appointment, I expressed my serious concerns about a reduction, namely that my drug use will increase and that I will be very unwell. I've asked several times for a review of the decision, however my emails have been ignored. According to the U.K. guidelines on clinical management, it is the responsibility of the prescriber to be continually **“obtaining informed consent” (Chapter 4: 4.2.1)**. Treatment decisions, including pharmacological ones, must not only be consented to by patients, but must **“reflect patient preference” (chapter 2: 2.2.4.2)**. The principles of the guidelines are that patients should be involved in all decisions in their treatment.

OUTLINE THE CLINICAL ARGUMENT

Unnecessary reductions to dosages are not recommended practice. Often, services begin



such reductions with the aim of detoxifying patients: as is well-documented, this is not an appropriate goal for many patients:

“It may seem to some observers that, in all cases, progress in treatment should lead towards detoxification and ultimately abstinence. Patients and their families (as well as some clinicians) may hold the view that this progression is required for treatment to be deemed to have succeeded. Complete abstinence from all drugs (prescribed and non-prescribed) may not be a realistic or preferred goal at various times in a patient’s treatment journey [...] It is important to emphasise that this is not a failure” (Chapter 4: 4.7.2).

Similarly:

“There is clear evidence that coerced detoxification against a patient’s will is likely to lead to relapse and increased risks of harm such as overdose and blood-borne viruses [...] The research evidence does not support the case for clinicians requiring, coercing or encouraging patients who are on stable maintenance doses of OST to start a very gradual reduction” (Chapter 4: 4.8.1).

A script reduction against a patient’s consent often means that the patient will have to supplement their prescription with drugs from the street market. A ‘higher’ dose, in contrast, can support a patient to reduce their drug use or stop:

“Higher methadone doses can help to reduce and stop heroin and other opiate consumption” (Chapter 4: 4.7.3).

Except where there are clear signs of intoxication due to dosage level, clinicians should not discontinue or reduce doses if the stabilised dosage has been shown to have beneficial impacts on a patient. Even in cases where the stabilised dosage is not resulting in benefits, the guidance does not advocate

reduction. One recommended response to 'opioid use on top of opioid use,' described in the guidelines, is to increase the dose (Chapter 4: Table 3). Similarly, the guidance warns against reduction if there has been alcohol/benzodiazepine use; instead, the guidelines encourage a review of the patient's tolerance to their medications (Chapter 4: Table 3).

Reduction is rarely the correct clinical approach where a patient is not instigating this for themselves: instead,

“Clinicians should aim to optimise treatment interventions for patients who are not benefiting from them, by intensifying support (pharmacological and psychosocial) rather than reducing it” (Chapter 4: 4.1).

As you will be aware, drug services should meet the standards set by these guidelines. I am concerned to see that these standards have not been met in my case.

OUTLINE YOUR FEELINGS ABOUT ANY OF THE REASONS FOR THE REDUCTION (IF YOU KNOW THE REASONS)

Outline why you believe the decision has been made (including if you have not been told any reason yet)

In this example, Mo has been reduced because of drug use. But there may be other reasons, such as missed appointments or missed pick-ups from the pharmacy (see Chapter 4: 4.6.3.3 of the Guidelines)

Although no reason has been provided by the service, I am concerned that the reduction was a result of my requesting harm reduction advice and my honest communication about drug use. As I understand it, punitive responses to drug use are not considered acceptable clinical practice according to U.K. clinical guidance. As I have already mentioned, the desired outcomes of treatment may not always be to end all additional drug use but reduce it. On top drug use is a reality of treatment and does not dismiss equally important elements of treatment, such as attendance



Give some brief information about positives in treatment

at appointments and the pharmacy, which I have done. As the guidelines state:

“Eliminating all drug and alcohol misuse may take months or years. Often, this ongoing drug use is balanced by improvements in other domains” (Chapter 4: 4.6.1).

I have communicated regularly with my keyworker and reported significant improvements in my use of oxys (now using them only at the weekend): I feel that my request for harm reduction information should be treated as a positive sign of engagement in treatment.

Make sure to repeat what you want to happen next

This use of additional drugs, if anything, can suggest a need for a dosage to be ‘optimised’, which usually requires an increase in dosage and/or the possibility of psychosocial interventions and greater support. I cannot see a clinical rationale behind these current reductions, which will only increase the necessity of additional drug use. With this in mind, I feel it is extremely important to stop the reduction regime and return me to my original dose.

EXPLAIN HERE WHAT HAS BEEN THE IMPACT ON YOU, OR WHAT YOU ARE WORRIED WILL HAPPEN

What have been the mental and physical effects of the reduction?

The reduction has already had serious effects on me, causing significant stress and worry for the future. It also risks undermining the therapeutic relationship between me and my prescriber, which is essential to good outcomes in treatment. I have felt much more anxious and, since the 20mg reduction, I am experiencing symptoms of withdrawal, including cramps, nausea, and insomnia. As a result, I have ended up staying in my house for several days on end and am also struggling to eat. Because of anxiety and withdrawal, I have only slept a few hours in the last week. I am afraid I will have to return to regularly

If you can, give specific examples of how it has affected your daily routine; for example, not being able to get out of bed, not sleeping, becoming more isolated, having to buy street drugs to deal with withdrawal or the emotional effect of the events

Are there examples of more positive improvements that were happening when on your normal dose? Were you feeling better physically or mentally? Were there any changes to your drug use that you felt positive about? Were you able to pursue things you are interested in, like friends, work, or volunteering?

using the street market within the next few days, and certainly if the next reduction goes ahead: this current dose is already not holding me. For the last two months on 120mg/ml, I have established hard-earned stability: for example, I have left my house more regularly than before (at least every other day), feeling more able to manage my agoraphobia. Relatedly, I had started to see my daughter more regularly. Through this, I have kept in regular contact with my keyworker. I have explained that I have found it easier to manage when on my OST dose of 120mg/ml and that it has enabled me to reduce use of street benzos also. The change to my treatment plan threatens to put these achievements in jeopardy.

REPEAT AGAIN WHAT YOU HOPE TO SEE CHANGE, AND WHAT IMMEDIATE NEXT STEPS YOU ARE ADVOCATING FOR

Summarise here what you want to happen (best case scenario)

Summarise here what you would like to happen (if the best-case scenario doesn't happen)

For the reasons above, I am asking for this decision to be reversed immediately, as I am not aware of any therapeutic, clinical, or safety benefit to be gained from reducing my prescription against my consent. I would like the reduction to be stopped and to return to my previous prescription, with an apology from the Service. I believe that actioning this request immediately is the most appropriate course of action. However, if that cannot be done, I would ask for a written response from the service explaining their decision and a copy of your complaints policy. I would appreciate a response to this letter within 5 working days.

I look forward to your response.

Yours Sincerely,
Travis

4

MY KEYWORKER WANTS ME TO DETOX BUT I DON'T WANT TO



You should not be forced to detox. If you have chosen to initiate detox and it is not working, you should not be forced to continue either. This process should be led by you throughout.

If your keyworker is frequently talking to you about detox, you could make your own 'care plan', which indicates that you have no plan to detox. If the pressure is causing you distress, you are able to ask for a different keyworker.

Key points:

If a reduction or detox is initiated without your consent:

1. Write to your service to state you do not consent to this.
2. Ask for the reasons for the decision.
3. Explain the risks, such as having to buy your own OST.
4. Ask for an urgent appointment.
5. Point them towards relevant sections of the guidelines (see next page).

What do the guidelines say?

Chapter 2: 2.7.6

“It is inappropriate, in providing ethical, evidence-based treatment, for services to create a sense that those opting for OST maintenance are making a poorer choice than those opting for an abstinence-oriented or abstinence-based treatment”.

Chapter 4: 4.8.1

Evidence shows that forced detox will likely lead to negative consequences, such as overdose, BBVs, and return to more problematic drug use.

Chapter 4: 4.7.2

Complete abstinence from all drugs (whether prescribed or not) is not everyone’s goal: maintenance OST for long periods, including for someone’s whole life, will sometimes be the right way forward for an individual.

Chapter 4: 4.10.1.2

Simultaneous detoxes of opiates and benzos are not recommended in a community setting.

MY DOSE IS NOT HOLDING ME, BUT AN INCREASE HAS BEEN REFUSED



Your dose should make you comfortable. If you are experiencing symptoms of withdrawal or having to use on top, those are clinical reasons to consider an increase.

People often report being told that their dose is already 'too high' or that it is not the service's policy to prescribe above a certain level. But a 'one size fits all' approach might not be right for you.

The daily dose of buprenorphine usually falls somewhere between 12mg and 16mg, whilst the daily dose of methadone usually falls between 60mg and 120mg. These doses are what's typically offered; however, clinicians are not barred from prescribing above or below these amounts.

If there are safety concerns, ask the service why they are not considering a safety plan to mitigate the risk. This can involve negotiation on your end, such as agreeing to ECGs or receiving an increased dose supervised for a period of time.

Key points:

If you are being denied an increased dose, you should:

1. Ask your service to put their reasons in writing.
2. Use an opiate withdrawal measurement scale, such as the Stability of Opioid Dose Assessor (**SODA** - <https://mydose.digital/>) tool, to evidence that your current dose is not holding you.
3. Keep evidence of any withdrawal symptoms.
4. If you are willing, suggest arrangements that mitigate any perceived 'risk'.

What do the guidelines say?

Chapter 4: 4.7.3

Doses outside the usual recommended buprenorphine/methadone doses can be offered where somebody's tolerance is especially high.

Chapter 4: 4.7.3

Evidence clearly indicates that lower, sub-optimal doses are less effective: meanwhile, optimal doses can result in better clinical outcomes, allow you to disengage with the street market if you want, and result in better retention in treatment.

Chapter 5: 5.4.1

Treatment should be regularly reviewed: you should not just be 'parked' on one dose with no chance to change.



You may want to reduce because you want a lower maintenance dose, or because you are hoping to taper off your meds. Either way, your treatment plan should be steered by you.

Most people report feeling that a gradual reduction of their OST works best for them, and this is also what the guidelines recommend for safety. If the reduction is going too fast, tell your service you want to pause or reverse.

Your treatment service should support you in your reduction, and you will want to make sure your keyworker is being proactive with you and getting you regular and timely medical reviews, perhaps arranging ahead of time a timeline of check-ins for the next few weeks.

Sometimes detox prescribing is discharged to a GP. If you move to your GP, make sure that they also make time for medical reviews.

You might still wish to remain in the drug service for other support, or your preference may be that your prescribing remains there.

If that is the case, ask that whoever supports you at the drug service helps you to build a case to stay within the service, either for prescribing or psychosocial support.

¹ For advice about benzodiazepine tapering, look at the [Ashton Manual](#) or the 2014 document, '[Guidance for the use and reduction of misuse of benzodiazepines and other hypnotics and anxiolytics in general practice](#)'. If you want advice on advocating for a benzodiazepine tapering regimen, contact Release.

Key points:

1. Advocate for regular check-ins.
2. Keep in regular contact with your keyworker or prescriber.
3. Make sure your reduction happens where you want it to happen.
4. For detoxes, your meds are sometimes changed (e.g., from methadone to buprenorphine): this is your decision.

What do the guidelines say?

Chapter 4: 4.8.1

There should never be a mandatory reduction regimen policy at a service: you should not be forced to reduce.

Chapter 4: 4.8.1

Any detox or reduction regimen should go at the pace that the patient needs, rather than a 'one size fits all' approach: it must aim, first and foremost, to reduce your withdrawal symptoms.

Chapter 4: 4.8.2.1

The recommended reduction regimen of methadone lasts around 12 weeks, but it depends on the person.

Chapter 4: 4.8.2.2

The recommended reduction regimen of buprenorphine is usually 2mg every two weeks. In the final stages of the reduction regimen, the reductions will be smaller (around 400 micrograms).

7

I'M ON SUPERVISED CONSUMPTION AND WANT TO MOVE TO AN UNSUPERVISED SCRIPT



Treatment often begins with daily collections of medication, where the pharmacist dispensing your medication will 'supervise' the taking of that medication.

Supervised consumption should be proportionate to actual risks. It shouldn't go on indefinitely and shouldn't be a barrier to doing things in the rest of your life, like spending time with loved ones or going to work.

You might have been put back on supervised consumption if there are concerns about your likelihood of overdosing or not taking meds as prescribed.

If you want to stop supervised consumption, start with making this request to your keyworker or clinician. If a request has been rejected, get their reasoning in writing.

In your response, outline the effects on you, such as:

- The negative impacts of supervised consumption on your mental and social life
- Any risk that the continuation of supervised consumption will result in you having to stop treatment

Equally, include any positive examples of any times you've taken home medication without issue. For example, many people will have been given some take-home meds over bank holidays or weekends.

Key points:

In any event:

1. Ask what the service's criteria is for a change from supervised to take-home medications.
2. Carry out an assessment on yourself: the guidelines provide a general example for prescribers.

What do the guidelines say?

Chapter 4: 4.5.1

There must be a *clinical* need for supervised consumption, and this must be regularly reviewed as the situation develops and based on individual risk assessment.

Chapter 4: 4.5.1

A prescriber should consider that supervised consumption may not be appropriate for your life routine. For example, if you are in full-time work, a full-time carer, or in education.

Chapter 4: 4.1

Supervised consumption is normally involved in the *induction of new patients*, but it should have an end-date beyond this, with relaxation of pharmacy attendance being a key goal of treatment.

Chapter 4: 4.5.2

Chapter 4: 4.5.2

The guidelines provide a general assessment for prescribers who are considering reducing someone's supervision, including 'compliance' with drug treatment, abstinence from or change in drug use, and change in drug-taking behaviours.

I'm on supervised consumption and want to move to an unsupervised script

Change this depending on whether you are advocating for somebody else or yourself.

Dear Treatment Service,

YOUR INTRODUCTION

Explain here how you know the person you are advocating for. In this example, Allie and Louise are in a drug user union together: if this applies to you, use your judgement when it comes to how comfortable you would be disclosing this to your treatment service. If you are not comfortable disclosing this, you could say you are in a community organisation or just a friend to Allie

Outline any relevant experience (you don't have to have any)

My name is Louise and I am writing on the behalf of Allie, who has asked that I advocate on their behalf. I know Allie through our local drug user union, where we provide support and advice to one another, and work jointly to ensure that the voices of people who use drugs are represented and heard in treatment. I also worked for many years as a keyworker in drug treatment services, and now continue to work in an advisory capacity for a treatment service in London. As you know, patients often ask that advocates support them in issues around their prescribed medication.

EXPLAIN YOUR REASONS FOR WRITING AND WHAT YOU WANT TO SEE CHANGED

Change to fit the situation of the person you are advocating for

Make sure to check if the person you are advocating for already has an arrangement for taking home some medication

Outline what your plan is (you may want to move to weekly immediately)

Allie is currently on daily supervised consumption of their oral methadone (80mg/ml). Allie gets take-home medication for Sundays and bank holidays, when their pharmacy is closed. Allie is hoping to change from supervised consumption to take-home medication twice a week, with the aim of gradually reducing the frequency of pick-ups to once a week. This is recommended practice by U.K. clinical guidance, 'Drug Misuse and Dependence: Clinical Guidance on Management'.

PROVIDE SOME RELEVANT BACKGROUND FOR THE SITUATION

Change to fit the situation of the person you are advocating for

Explain any relevant recent events or conversations with the treatment service: Has a request been made to reduce supervision already? What was the response of the keyworker or prescriber?

Allie is on a prescription of 80mg/ml methadone and has been for 5 months. They recently asked their keyworker if they could put in a request for an unsupervised prescription, however their keyworker was then informed that the Service's policy is that patients remain on supervised prescriptions unless their dose is below 60mg/ml. Allie was not aware of this when they first began treatment and is concerned that this policy would be contrary to the principle of individualised assessment. When Allie started treatment, they were told that supervision would not be required beyond the initial stages of treatment. As you will be aware, the Orange guidelines state that the **"clinical need for supervised consumption should be reviewed regularly"** (chapter 4: 4.5.1) and, moreover, that **"the patient is a key partner in decisions on the appropriate level of supervision"** (chapter 4: 4.5.1).

LAY OUT THE RELEVANT GUIDELINES AND HOW THEY APPLY TO THE PERSON YOU ARE ADVOCATING FOR

As defined in the clinical guidelines, supervised consumption is primarily "appropriate for new patients" (Chapter 4: 4.5.1) and "to support induction on to opioids" (Chapter 4: 4.1). Unless there are specific risks to take-home doses, the change from supervised to unsupervised consumption is not only an achievable step in a treatment, but an important one:

"Relaxation of supervised consumption and instalment dispensing should be a stepped process in



which a patient normally remains on daily dispensing with reduction or cessation of supervision and progression to less frequent instalment collection. The relaxation of supervision and collection is an important component of support further recovery in stable patients” (Chapter 4: 4.5.2).

In line with this, good clinical practice must avoid “arbitrary” use of supervision (Chapter 4: 4.5.1), or risk causing patients who are stable to be “over-treated or over-supervised”. Whilst there are heightened risks when a patient enters treatment, these risks naturally reduce with time, and sometimes reduce quickly, meaning that supervision may only be “needed for a short period” (chapter 4: 4.5.1).

For good clinical practice, the decision to continue supervision should be the result of an **“ongoing risk assessment” (Chapter 4: 4.5.1)**. If treatment is to be successful and fair, this risk assessment must be updated as the individual patient progresses. When treatment decisions are unchangeable, the service ends up imposing unnecessary requirements creating negative effects for the patient. Thus, we would refer to the following guidance:

“the level of supervision and the frequency of collection should be based on individual assessment of patient needs, including the risk assessment, and should be sufficiently flexible to respond to changing circumstances” (Chapter 4: 4.5.1).

I believe the above is especially relevant to Allie’s case.

STRENGTHEN YOUR CASE BY THINKING THROUGH A 'RISK ASSESSMENT'

We are aware that the change to unsupervised consumption can only be made once there has been an appropriate risk assessment. The Orange guidelines explain that an assessment should **"include a review of compliance and individual circumstances"** (Chapter 4: 4.5.1). We take these two limbs of the assessment in turn, starting with Allie's 'compliance' with treatment. According to the U.K. guidelines, an assessment of compliance should cover:

- **Compliance with prescribed drug treatment,**
- **Abstinence from or significant change in heroin or other drug misuse,**
- **Changes in drug-taking behaviours (such as cessation of injecting),**
- **Compliance with other elements of the treatment and recovery care plan, for example, attendance at appointments"** (Chapter 4: 4.5.2).

Describe attendance at appointments, contact with keyworker, or any other relevant changes (such as joining groups)

Acknowledge any times that the person in treatment may have missed appointments or pick-ups and explain the reasons where possible

Many of these apply positively to Allie. Allie has engaged in treatment, speaking regularly with their keyworker and forming a good relationship: over the last 5 months, they have spoken with their keyworker at least once a week on the phone and gone to the Service in person for appointments with their prescriber; Allie has also joined a local art-class that their keyworker referred them to. Allie told me that on occasion they've missed appointments, but that this has happened, they would estimate, only 3 or 4 times in 5 months of treatment, and for understandable



You may want to include this if appointments and regular pick-ups are making it difficult to keep on top of everything

If you or the person you are advocating for have spoken with the service about drug use, are there still important changes to note? For example, safer drug use, feeling drug use is more under control, changes in other areas like housing or mental health?

reasons. Similarly, they have missed pharmacy attendance only once and have otherwise followed their prescribed drug treatment plan.

Allie feels that the times they have missed appointments or pick-ups has been due to lack of flexibility around pharmacy attendance, which Allie says they struggle to always fit into their routine. The U.K. guidelines recognise that practical challenges, rather than 'non-compliance', are often the primary reason for difficulties during treatment: **"sometimes, simple practical challenges, such as accessing the pharmacy, are the issue and may be resolved"** (chapter 4: 4.6.3.3).

Allie has shared with their keyworker that they are continuing to use heroin on occasion; they estimate once a fortnight currently. There has been no evidence of over-sedation and, as stated in the U.K. guidelines, **"this ongoing drug use is balanced by objective improvements in other domains"**. This should equally inform treatment decisions and revisions (chapter 4: 4.6.1). In addition, it is **"changes"** in drug use that are relevant to a risk assessment. In Allie's first months of treatment, they continued to use heroin alongside methadone every few days; this has changed significantly. There have also been positive changes to their drug-taking behaviours: their prescription has allowed them to engage regularly with the needle exchange, which they had not done before, and Allie has expressed feeling that they are achieving the goals they set for themselves in treatment. They have, for example, started to pick up foil from the needle exchange to smoke heroin, as the reduction in their heroin use has made this an option that is affordable.

Considering each factor listed in the Orange Book's review of compliance, Allie believes that a change to unsupervised consumption would be safe and beneficial.

STRENGTHEN YOUR CASE BY THINKING THROUGH A 'RISK ASSESSMENT', NOW FOCUSING ON THE INDIVIDUAL CIRCUMSTANCES

Just as important in any assessment are Allie's individual circumstances. According to the guidelines, supervised consumptions is **"provide[d] for a length of time appropriate to [the patient's] individual needs and risks"** (Chapter 4: 4.1). The guidelines give some examples of certain such needs and circumstances to be taken into consideration, including whether a patient's home environment is suitable for safe storage of medications (Chapter 4: 4.5.1), **"local pragmatic factors, such as geographical availability of supervised consumption"** (Chapter 4: 4.5.1), and patients in **"full-time work or education"** (Chapter 4: 4.5.1). The guidelines make clear that there are many circumstances that make supervised consumption inappropriate for patients beyond induction and/or when an ongoing assessment shows it is no longer necessary. Arbitrary supervision risks undermining the treatment process and becoming a barrier to recovery, preventing patients from beginning a daily dispensing regime and eventually reducing pharmacy pick-ups.

What are the main things supervised consumption impacts negatively? It might be social life, caring responsibilities, work, or finances

Daily supervised consumption is difficult for Allie to manage alongside their employment, wellbeing, mental health, and vital community work. Daily

Explain the practical difficulties of supervised consumption, such as journey times and costs

supervised consumption means Allie must spend her lunch-breaks at work travelling to the pharmacy; this means they miss out on valuable time getting to know colleagues and sometimes results in Allie spending money on a taxi to the pharmacy (if their work-day is too busy to allow for the 25-minute walk). This is not financially sustainable for them and causes significant stress. Allie also has anxiety and depression: they have had panic attacks several times because of anxiety at the thought of supervised consumption, particularly when the pharmacy has been very busy, allowing little privacy.

What are the impacts on the mental health of the person you are advocating for?

Are there any effects on social or caring responsibilities? Or does supervised consumption make it difficult to do other positive things in life? What has the person you are advocating for told you about the effect on their life?

Allie is also very active in their community, supporting other people in treatment through community-groups. Particularly relevant is that Allie usually helps out another service user, who uses a wheelchair, with the weekly delivery of their medication. Allie has said they have found it stressful to balance their daily supervision with these responsibilities: their community-work is hugely fulfilling and it would upset them deeply if they had to stop any of this work.

SUMMARISE WHAT YOU HOPE WILL CHANGE AND NEXT STEPS

Outline what you want to happen next. If the person you are advocating for has been on daily supervised for a very long time, they may not feel that a stepped reduction of supervision is appropriate any more

I share Allie's concerns regarding the impacts on their life of daily supervised consumption. A change to an unsupervised prescription, as well as a reduction to pick-ups, would be a very positive step for them. Actioning this request with immediate effect, we believe, is the most appropriate course of action. However, if that is not deemed clinically appropriate, we would ask at the very least that Allie moves to daily take-home medication, with the expectation

Depending on how far along negotiations with the service are, you may wish to indicate a potential 'fall-back' position here. However, for initial letters especially, it would be best to keep suggestions like this in the back-pocket until necessary, given that they are still significant compromises for the person in treatment

Make sure to get a written response

that there be a medical review to discuss reducing pharmacy attendance at the end of a trial period, the duration of which should be jointly decided]. We would appreciate a response to this letter in time for Allie's next medical review in a week's time: Allie is happy for a written response to be shared with them during the review.

I look forward to your response.

Yours Sincerely,

Louise

I WOULD LIKE TO REDUCE PICK-UPS



Like supervised consumption, daily pick-up should generally only be a part of the initial stabilisation period when you start OST, or used in situations where there are real concerns about inability to store medication. If daily pick-up is reinstated during treatment, its continuation should be down to an ongoing review of risk.

Daily pick-up can make it hard for people to keep down a job, lead to expensive travel costs, or be a significant barrier to staying in treatment for people who struggle to leave the home regularly. If you've been told by your treatment provider that you cannot reduce pick-ups, ask for their risk assessment, and examine it for the following:

- Have they considered progress you have made thus far?
 - Have you reduced your drug use to a manageable level, or stopped?
 - Are you using more harm reduction approaches?
 - Are you in contact with your keyworker regularly?
- Have they considered the negative impacts on you? For example, are your finances or employment put at risk by daily pick-up?

There is a general assessment for reducing supervision in the guidelines, which you can apply to your own situation: do this on yourself if your service hasn't.

There should be clear, clinical reasons for continuing daily pick-up: these should be individual to you. If you find yourself bartering over your treatment – for example, being offered reduced pick-ups in exchange for agreeing to reduce your dose – then contact Release.

Key points:

1. Daily pick-up is not supposed to last forever; it should be a step towards more independence.
2. Stopping all drug use is not the only factor in fewer pick-ups. Your life circumstances matter too.

What do the guidelines say?

Chapter 2: 2.7.4

Over-supervision can have a more negative effect on people; attendance requirements should not be arbitrary and must respect individual circumstances.

Chapter 4: 4.5.1

Services must be carrying out an ongoing risk assessment, which will in turn affect whether such regular pick-up arrangements are necessary.

Chapter 4: 4.5.2

The guidelines provide an exemplar general assessment for prescribers considering reducing someone's supervision, including 'compliance' with drug treatment, abstinence from or change in drug use, and change in drug-taking behaviours.

I want to reduce frequency of pick-ups

Change this depending on whether you are advocating for somebody else or yourself.

Dear Treatment Service,

YOUR INTRODUCTION

Explain your relationship

Include any relevant experience, such as working in the drugs sector or supporting your local community

My name is Fenella and I am writing on the behalf of Eve Adams, who has asked that I advocate on her behalf. I am a close friend of Eve and have supported her for nearly a decade. As well as this, I am on a methadone prescription and have also worked as a peer supporter within the community for many years, acquiring significant experience providing advice and support to people who use drugs. As you know, patients often request that advocates support them in issues relating to their prescribed medication.

STATE YOUR REASONS FOR WRITING AND GOAL

List the 2 or 3 most important reasons that the person you are supporting need a reduction of pick-ups

Lay out here how many pick-ups are wanted, or if a stepped reduction to pick-ups is desired

I am writing in regard to the current frequency of Eve's pharmacy attendance; Eve is required to attend the pharmacy daily. We would ask that Eve now progresses from these current arrangements, as is recommended by the clinical guidelines. We are requesting an updated pick-up arrangement, which is more conducive with Eve's wellbeing, voluntary work, and caring responsibilities for her Mother. We request a change to maximum 3 pick-ups per week, with the aim of moving to weekly pick-up.

PROVIDE BACKGROUND ON THE PICK-UP ARRANGEMENTS ALONGSIDE SOME CLINICAL GUIDELINES

Edit the factual details about your person's meds and time in treatment

Include any information about previous treatment plans described in earlier appointments

Give some context about the more recent history and impact on the individual. This is one example: their story may be different

Eve is on a prescription of 60ml oral methadone (1mg/1ml) and has been since for over 14 months. At the beginning of treatment, Eve was informed that she would work down from daily pick-ups, and that she could expect to increase her take-home supply within several months. However, no change has taken place. Eve has informed her key worker that she would benefit from a relaxation in pick-up times but, in the past fortnight, has been told by the service that a relaxation in pharmacy attendance is not possible. No justification was provided for why this, leaving Eve in a place of uncertainty about her own treatment plan and progress. As you will be aware, the 'U.K. Guidelines on Clinical Management' for drug misuse and dependence states that treatment and recovery care plans should be 'regularly reviewed' (chapter 2: 2.1) and that 'good treatment...should reflect patient preference' (chapter 2: 2.2.4.2).

EXPLAIN THE IMPACTS OF THE PICK-UP ARRANGEMENTS ON THE PERSON

Amend accordingly

The continued expectation to attend the pharmacy 7 days per week has detrimental impacts on Eve's personal, physical, and mental wellbeing. To quote the 'Orange Book', unnecessary attendance at the pharmacy can be detrimental to the patient and should, then, be avoided where possible –

'More stable service users, who do not have a clinical need for such frequent attendance, can be



Describe the specifics of the demands of regular pick-ups, such as time constraints and costs

Describe any impacts on their routine, such as having to stop work, volunteering, seeing friends and family

What are the mental health impacts on the person?

If they have any caring responsibilities or medical conditions that make pick-up more difficult, emphasise these here

over-treated or over-supervised. This can have a detrimental effect on their ability to return to, or sustain, a more conventional or stable lifestyle...It is important, therefore, that attendance requirements are not arbitrary and that they respect individual circumstances' (chapter 2: 2.7.4)

Eve is struggling with the precise difficulties that the guidelines describe: sustaining a 'conventional or stable lifestyle' alongside the ongoing high attendance requirements. On a daily basis, pick-up takes up at least 2 hours, with a 55-minute bus ride to and from the pharmacy (in good traffic). As well as the time constraints, the cost of these regular trips has also become a constraint, costing up to £20 each week. Thus, after several months of trying to manage the daily pick-up, Eve has now had no choice but to reduce her three days of remote volunteering work to one day. Her volunteering previously provided her with routine and stability, and was a positive boost to her mental wellbeing. As a result, the daily pick-ups have had an increasingly negative impact on Eve. Eve has reported increased anxiety, stress, and symptoms of depression, as she struggles to balance her life alongside such a disruptive daily demand. In addition to this, Eve's 'individual circumstances' have been exacerbated by such stringent pharmacy attendance and necessitate a revision of current arrangements: Eve is a full-time carer for her Mother, who, in her 90s, is clinical vulnerable. This makes daily visits to a busy pharmacy especially concerning.

FLESH OUT THE CLINICAL GUIDELINES

The guidelines warn against 'arbitrary' attendance requirements; it is recommended that patients work towards fewer pick-ups and higher supplies of take-

home medication, encouraging self-reliance and independence.

'The professional should encourage the service user to take control of their own recovery plan and to become independent of professionals. For those on substitute medication, this progression will normally be reflected in the degree of supervision and flexibility of prescribing and dispensing arrangements' (chapter 4: 4.5.2)

For that reason, beyond the stabilisation period, it is standard and encouraged practice to reduce pharmacy attendance. Having been in treatment for 14 months now, Eve is well beyond the stabilisation period.

Amend accordingly: if they have been in treatment for a much shorter time (for example, less than a month), you may need to include evidence of their fast stabilisation and/or explain why an exception should be made

FINAL POINTS AND THEIR ENGAGEMENT IN TREATMENT

If the service has provided reasons, you may want to change this to "the service has provided reasons which Eve does not feel are fair or reflective of her needs"

Include here any issues that have been raised about their engagement, and the reasons why this happened: for example, if they missed pick-ups, why?

There is no reason to believe that this trajectory should not be followed for Eve, and the service has not provided one. Eve has not mismanaged her prescription or been at serious risk of overdose, complying with demanding pharmacy attendance requirements as far as possible. Although Eve missed 2 pick-ups, this is across a time-span of, in total, fourteen-months, and coincided with an acutely difficult period of caring for her Mother. Again, the U.K. guidelines make allowances for such events, recognising that the practical challenges of meeting strict attendance requirements are often the only reason for apparent non-compliance with treatment: 'sometimes, simple practical challenges, such as accessing the pharmacy, are the issue and may be resolved' (chapter 4: 4.6.3.3). Missing pick-ups on occasion is not a sufficient reason to divert a patient from the standard, recommended practice of reducing pick-ups.

Include this if there have been concerns raised about drug use: provide details of when and why you feel this should not prevent a reduction to pick-ups

Eve confided in her keyworker that she had used drugs on-top of her script last month, specifically using heroin on 2 occasions at a weekend. However, again, the Orange guidelines, which make clear that the response to illicit drug use should not be “punitive” (chapter 4: 4.6.2). Additional drug use is a reality of drug treatment, including successful drug treatment. As stated in the U.K. guidelines, **“this ongoing drug use is balanced by objective improvements in other domains,”** which should equally inform treatment decisions and revisions (chapter 4: 4.6.1).

CONCLUSION AND REQUEST FOR NEXT STEPS

Amend accordingly

I share Eve’s concerns regarding the impacts on her life of pharmacy attendance 7 days per week. We therefore re-state our request for a maximum a 3-days a week pick-up, with the intention of moving to weekly pick-up. Actioning this request with immediate effect, we believe, is the most appropriate course of action. However, if that cannot be done, we would ask for a review with clinical staff to provide the rationale for rejecting the request in the light of what is included in this letter, and ideally to arrange a meeting with us.

Include here what next steps they would like to see

I look forward to your response.

Yours Sincerely,
Fenella

THE TYPE OF OST MEDICINE I'M PRESCRIBED IS BEING CHANGED WITHOUT MY CONSENT



There are situations that might mean you and your prescriber consider changing your OST medicine. For instance, if your OST medicine is not working or making you very unwell, or if there is a temporary shortage of your usual medication.

A change to medication should not be forced on you. Medicine changes should be about improving your wellbeing and based in clinical judgement on how best to do that. Practical obstacles, such as a prescriber retiring or a medication shortage, should not be used as reasons for a permanent change to your OST, as these are not clinical reasons pertaining to your health.

If your medication has been changed and you are not comfortable, tell the service in writing that you do not consent to the decision.

It is essential to get a clear summary of the clinical reasoning behind any OST medication change if it is happening without your consent. If a summary is not provided, you may have to get it via a Subject Access Request for your case-notes or aim to take thorough notes of the reasons given during your appointment.

Use the reasons that your service has given to structure a response to the decision. Draw on your personal experience, but also cross-reference the service's summary with the guidelines (see next page).

Key points:

If your medication is being changed then:

1. Focus on getting a written summary of the reasons.
2. Ask your GP or any other health professionals to support you in your advocacy.
3. Ask your service for their policies; for example, their policy on prescribing various OST options.
4. Remember that practical barriers to getting your medication are not good reasons for a long-term change.

What do the guidelines say?

Chapter 4: 4.3.1

Patients should be empowered to make their own decision about medication choices.

Chapter 4: 4.3.1

A person's existing preference for either methadone or buprenorphine, as well as evidence of previous benefit from a certain medication, are two of seven key clinical factors in prescribing decisions.

Chapter 4: 4.6.1.2

If someone is struggling in treatment, changing their OST med is just one option: optimising the dose, increasing keyworking support, and supervised consumption are also options.

Chapter 7: 7.1.11.4

Older patients (who are sometimes on more unusual maintenance scripts) **should not have their medication taken from them simply because of a change of prescriber or service provider:** decisions must be made on individualised assessment.

My medication is being changed and I'm not comfortable

Change this depending on whether you are advocating for somebody else or yourself.

Dear Treatment Service,

YOUR INTRODUCTION

Explain your relationship to Eli

Explain any experience or insight you have that you feel is relevant

My name is Amirul and I am writing on the behalf of Eli, who has asked that I advocate on her behalf. I am Eli's carer and I have supported her for 5 years. I do not have direct experience of drug treatment myself, however I have seen the difficulties Eli has suffered as a result of the Service's recent decisions, and have been the person to support her through them. I have also known Eli for many years and have seen how she was before the recent decision was made about her treatment. As you know, patients often ask that advocates support them in issues around their prescribed medication.

SUMMARISE WHAT HAS HAPPENED AND WHAT YOU WANT TO HAPPEN NEXT

What was their prescription before?

What was changed, or is going to change, and in what time-span?

Give a brief summary of whether the person agreed to these changes

I am writing about the recent decision to change Eli's prescription to a different Opiate Substitution Therapy medication; Eli was on a prescription of 150mg MXL (5 x 30mg capsules) and 70mg/ml methadone. A month ago, Eli was informed of a potential plan to change her prescription to 100mg/ml methadone, with no MXL, across a period of 3 weeks. Eli voiced that she would not be comfortable with this plan, as she struggles to take more than 70mg/ml of methadone and has a preference for MXL, which Eli stated clearly. Despite this, a week after the appointment Eli was told by her keyworker that the plan would in fact be going ahead. Eli has not consented to this change and this abrupt switch is contrary to U.K. Guidance on Clinical Management for drug misuse and dependence.

State what they want to happen

Due to the stress caused by the situation, Eli has not felt able to engage with the Service to communicate how unhappy she is with the situation. We ask that Eli returns to her original prescription with immediate effect given the severity of the situation. According to the U.K. guidelines on clinical management, which set the standards for a 'reasonable' prescriber, it is the responsibility of the prescriber to be continually **"obtaining informed consent"** (Chapter 4: 4.2.1). Treatment decisions, including pharmacological ones, must not only be consented to by patients, but must **"reflect patient preference"** (chapter 2: 2.2.4.2).

EXPLAIN THE CLINICAL ARGUMENT AGAINST MEDICATION CHANGES THAT PATIENTS ARE NOT COMFORTABLE WITH

Only include this section if relevant: for example, if you or the person you are supporting have heard comments about their prescription being 'more expensive' or if they have just changed from one prescriber to another

It is highly irregular for patients to be switched to a different prescription if they have stabilised on a dose already and have not initiated the switch, due to the distress it can cause to the patient and the disruption to their treatment. Unfortunately, services have been known to make changes to medication because of practical issues faced by the service, such as concerns about costs, resources, and changes of prescribers. In the absence of any clear clinical reasons for the change, Eli is concerned that these factors have played a role in the medication change. The U.K. guidelines are clear these are not appropriate factors in clinical decisions:

"[Patients] should not be faced with arbitrary withdrawal of such treatments simply due to change of prescriber or change of service provider" (Chapter 7: 7.11.4).



How do they feel the decision has gone against their treatment history or preferences?

The primary clinical factors in prescribing decisions are **“a patient’s pre-existing preference for either drug”** and the patient’s own history of treatment - any **“previous substantial benefit on either medicine” (Chapter 4: 4.3.1)**. The patient’s own current assessment, and reported history, should inform the treatment decision first and foremost. This has not happened in Eli’s case: a decision has been made contrary to the many years of substantial benefit on her medication and her voiced preference for MXL. There have been no recent changes to indicate that Eli’s medication should be changed.

OUTLINE WHAT THE IMPACT OF THE DECISION HAS BEEN

What was life like on their previous prescription? How was their mental and physical health compared to now? Are there examples of this, such as returning to work or education, pursuing personal projects, building friendships and family relationships, reducing or stopping other drugs, taking care of themselves or others?

How are things at the moment? What are the mental and physical effects? For example, heightened symptoms of existing conditions, stress about the future, or withdrawal

Explain any reasons for their preference of one med over another

Eli has suffered a great deal as a result of the decision, which has risked undermining the therapeutic relationship of prescriber and patient. When on her previous prescription, Eli did not need to buy street drugs for several years and reported much better mental and physical health. Being stable on her OST also allowed her to engage in physiotherapy for arthritis, which Eli had not felt able to do for many years before. Since the medication change, Eli has said she feels much more worried and is also in severe withdrawal, as she has not been able to drink the additional 30mg/ml of methadone and is therefore very under-dosed. Eli struggles to drink much more than 70mg/ml methadone due to the effect of the medication on her stomach (it makes her feel very nauseous). The consequences of this has been severe illness, meaning that Eli has missed physiotherapy appointments as well as a mental health assessment with the community mental

What are the impacts of the change on their routine? For example, have they been more isolated, missed important commitments, or needed more support?

health team. I have also needed to provide more care to Eli since the change: for example, where Eli would usually still go to pick up her own medication, I have started to do this for her, as the effect of the medication change has been so severe. Eli has said several times that she is worried she will have to buy heroin for the first time in 5 years because of being under-dosed. In short, the change has caused Eli severe distress and the decision has been forced without appropriate consideration of its impacts.

YOUR CONCLUSION: SUMMARISE THE ISSUES AND WHAT NEXT STEPS YOU WANT TO SEE

State what you want to happen (the best case scenario)

State what you would like to happen if an immediate reversal does not happen

I am asking for this decision to be reversed immediately, as I am unaware of any therapeutic or clinical benefit to be gained from this change to Eli's medication. As Eli's carer, I echo her concerns about how her life will be on this different prescription. I therefore re-state her request for a return to the previous prescription. I believe that actioning this request immediately is the most appropriate course of action. However, if that cannot be done, I would ask for an urgent medical review with Eli's prescriber, the clinical director of the Service, and myself to discuss what has happened, so that Eli's perspective on the situation can be listened to properly. We would appreciate a response to this letter within 5 working days.

I look forward to your response.

Yours Sincerely,
Amirul

MY TAKE-HOME DIAMORPHINE IS BEING REMOVED¹



Take-home injectable diamorphine is no longer available in drug treatment services. But a small group of patients remain on their diamorphine, having started on it over a decade ago. These people are referred to as 'British System' or 'Old System' patients.

If you are one of these patients and have been told that your diamorphine prescription is being withdrawn:

- Has there been a change in prescriber recently that may have prompted the withdrawal? Diamorphine prescriptions require prescribers to hold a Home Office licence. Services should find a new prescriber with a licence if one leaves.
- Was there a shortage of diamorphine recently? Has this led to you losing diamorphine permanently?

If you don't know how to find the answers to those questions, contact Release.

If your diamorphine has been withdrawn, get your service to give you the reasons in writing. Are the reasons clinical and individual to you, or are they practical issues, such as a shortage?

In your response, focus on the evidence you have of how your diamorphine treatment has benefitted you. That could be doing educational courses, looking after family and friends, reducing street drug use, going to work, or simply feeling much better.

Equally, if you have lost your diamorphine, make sure your service knows how this is affecting you.

¹ If you are a patient receiving supervised diamorphine assisted treatment (D.A.T., also known as heroin assisted treatment or H.A.T.) and your medication is in jeopardy, please contact Release.

Key points:

1. Find out the reasons and circumstances that have led to the decision.
2. Get your service's policy on injectable prescribing.
3. Try to get supporting letters from people, such as friends or other professionals.
4. Stay in touch with your keyworker so that they can confirm the impacts the decision is having.

What do the guidelines say?

For patients receiving unsupervised injectable opioid treatment:

Chapter 4: 4.7.5.2

The quality of care for such patients should be reviewed regularly. Where there is clear evidence of benefit, treatment should continue and be improved for these patients. They should not have their treatment withdrawn but should be reviewed to consider whether their current treatment meets their needs.

Chapter 7: 7.11.4

Older patients who have been on long-term maintenance should not lose their treatment because of practical issues, such as changes of prescriber or service providers.

My diamorphine is being removed/changed and I'm not comfortable

Change this depending on whether you are advocating for somebody else or yourself.

Dear Treatment Service,

STATE YOUR REASON FOR WRITING AND GOAL

Explain your relationship to Jose and any relevant experience you have (don't worry if you have none!)

My name is Jen and I am writing on the behalf of Jose, who has asked that I advocate on their behalf. I am Jose's close friend and have supported them for many years. I am also a peer support worker for people who use drugs, so am familiar with the way treatment works. As you know, patients often ask that advocates support in issues around prescribed medication. My aim to work with the Service and Jose to reach a more suitable treatment plan.

Amend details of your dose and situation

I am writing about the recent decision to withdraw Jose's prescription for injectable diamorphine; Jose was on a prescription of 200mg daily until last month when he was changed to a prescription of oral methadone. Jose has not agreed to this change. The decision is contrary to U.K. Guidance on Clinical Management for drug misuse and dependence. We would ask that Jose returns to their original prescription with immediate effect given the severity of the situation.

RELEVANT BACKGROUND

Amend details of the timeline

Jose has been on a diamorphine prescription for 15 years. However, last month, Jose learned that their long-standing diamorphine prescription had been ended by the prescriber. Jose was informed about this by their pharmacist after no contact from their keyworker or prescriber. Jose was switched suddenly and not gradually titrated onto alternative medication.

Describe here if there were issues with how the decision was communicated or how titration went. For example, were they left without any meds?

What was the reason they were given? Was it use 'on top'? A prescriber retiring? (Clinical reasons? Were they given any reason?)

Evidence how they were excluded from the decision. For example, did the prescriber speak to them before? Did they have any physical examination? Was a keyworker involved?

Jose was told that the reason they were taken off diamorphine was that it was no longer clinically viable and there had been heroin use 'on top'. Before the decision, Jose had not had any appointment with a prescriber for several weeks. Jose did not agree to the decision. According to the U.K. guidelines on clinical management, which set the standards for a 'reasonable' prescriber, it is the responsibility of the prescriber to be continually **"obtaining informed consent"** (Chapter 4: 4.2.1) and treatment decisions, including pharmacological ones, must not only be consented to by patients, but must **"reflect patient preference"** (chapter 2: 2.2.4.2).

CLINICAL ARGUMENT

Removing diamorphine patients from their prescriptions is not recommended practice in the U.K.'s 'Drug misuse and dependence: Guidance for Clinical Management'. Removing diamorphine can cause immense disruption and distress to patients who have stabilised on a regular dose, often for many years. The guidelines give the following recommendation to services caring for patients already receiving unsupervised injectable opioid treatment:

"The quality of care for such patients should be reviewed regularly. Where there is clear evidence of benefit, treatment should continue and be improved for these patients. They should not have their treatment withdrawn but should be reviewed to consider whether their current treatment meets their needs" (Chapter 4: 4.7.5.2).



As the above quotation explains, taking patients off a stabilised dose is highly irregular, as well as catastrophic for patients. Ending diamorphine prescribing also ignores the many proven benefits of injectable opioid treatment. There has been extensive research into the benefits of injectable diamorphine treatment, including the 2009 RIOTT trial, which saw higher rates of retention, and lower rates of street heroin use, for those patients receiving pharmaceutical heroin over patients receiving injectable or oral methadone. Whilst the RIOTT trial looked at supervised HAT, the same benefits extend to patients such as Jose, who receive unsupervised injectable opioid treatment and, as a result, similarly disengage with the street market of heroin. Such outcomes are listed as the desired outcomes of treatment in the U.K. guidelines: treatment should aim to help patients to

- **“Break completely with all illicit opioid drug use [and...]**
- **Reduce illicit opioid use with positive change in drug taking and risk behaviour” (Chapter 4: 4.2.2).**

We would bring your attention to the fact that these desired outcomes include both a cessation of illicit opioid drug use and a reduction or change in behaviour.

CLINICAL ARGUMENT CONTINUED

This is one example: amend according to your situation!

I understand that the diamorphine prescription has been taken away because of Jose informing their keyworker openly that they had used heroin on several occasions in the last month, due to significant stress in their life. I am very disappointed to learn

Provide some details about what has happened

Explain here other ways that diamorphine treatment has helped you, whether it be employment, engagement in treatment, relationships, or general wellbeing

that this is the service's justification; as I understand it, this is not considered to be acceptable clinical practice according to U.K. clinical guidance. The desired outcomes of treatment may not always be to "break completely with all illicit opioid drug use" but to instead "reduce illicit opioid use". In total, Jose used street heroin 4 times in many years of treatment, a life-changing reduction of "illicit opioid drug use" compared to time before treatment. On top drug use is a reality of treatment and recovery and does not dismiss equally important achievements in treatment, such as attendance at appointments and the pharmacy, which Jose has done consistently. As the guidelines state:

"Eliminating all drug and alcohol misuse may take months or years. Often, this ongoing drug use is balanced by improvements in other domains" (Chapter 4: 4.6.1).

Patients should not be punished if they use drugs on top. This behaviour should be met with further support, not distressing changes. Nowhere in the guidelines for clinical management is a change of medication recommended if on top drug use is identified; at most, opioid use on top of an opioid prescription might prompt a prescriber to **"offer to change OST medication"** but it equally might prompt the prescriber to **"increase [current medication] dose"** and/or engage in important psychosocial interventions (Chapter 4: Table 3). I do not understand why this guidance should not apply to Jose's case.



IMPACT ON YOU

How were things when the person was on their chosen treatment? What were the positives? For example, talk about relationships, employment, debt, your safety, and your mental and physical health

How have things been since? What are the negatives? What other responsibilities does this person have which this decision will threaten?

Jose has suffered a great deal as a result of this decision: it has undermined their quality of life and the therapeutic relationship of prescriber and patient. Before this decision, Jose had been engaging on a weekly basis with local art classes, allowing them to build a support network and explore their interests. Jose had also got to a much more financially stable position, having worked with Citizens Advice to manage their debt after diamorphine OST allowed them to significantly reduce the money they spent on street drugs. Jose also reported improved mental and physical health, including being able to engage with their GP for referrals to mental health service. Since the removal of Jose's diamorphine however, they have reported worsened mental and physical health conditions, describing difficulties getting out of bed, getting dressed, and now stopping their art class. Jose has also had to return to using heroin daily, which they have not needed to do for nearly two decades. Jose is a full-time carer for their partner and the threat to their stability caused by the loss of their diamorphine has huge impacts, in turn, on their caring responsibilities. In short, the change has caused Jose enormous distress. Jose believes the decision has been made without appropriate consideration of its impact on their safety and stability.

CONCLUSION AND NEXT STEPS

I am asking for this decision to be reversed immediately, as I am unaware of any therapeutic or clinical benefit to be gained from taking away Jose's

Add here whatever is wanted as a next step. It might be a copy of their complaint policy or a new medical appointment

diamorphine. As Jose's friend, I am deeply concerned by their current wellbeing. I therefore re-state the request for a return to the previous prescription. I believe that actioning this request immediately is the most appropriate course of action. However, if that cannot be done, I would ask for a clear written answer from the Service to this letter and a meeting to review the situation. We would appreciate a response to this letter within the fortnight.

I look forward to your response.

Yours Sincerely,

Jen

I'M IN HOSPITAL AND THEY WON'T CONTINUE MY SCRIPT



People who receive OST are often concerned about whether their prescription will transfer easily, or at all, into a hospital setting. Difficulties getting your prescription in hospital can mean it's hard for you to continue staying there.

If you know you are going to hospital, you can prepare in advance: ask for a letter from your treatment service that confirms your OST dose and bring some recent prescription sheets. Make sure you have the phone-numbers of your pharmacy, keyworker, and treatment service so that you can pass that onto any hospital staff.

You should remain at your usual dose in hospital.

Key points:

If you find yourself in hospital unexpectedly, or at the weekend, staff may tell you that they need to 'verify' your dose. You could:

1. Ask that they try to contact your pharmacy (if it is open at weekends).
2. Ask that they carry out a Clinical Opiate Withdrawal Scale (COWS) assessment.
3. Offer to do a urine test, which should be positive for opiates if taking OST.
4. Emphasise the risks of withdrawal and likelihood of you having to discharge against medical advice if you do not have your OST.

A starting dose of methadone in hospital would normally be 10mg, titrated up to 30mg in the first 24 hours. **At the very least**, if you are showing symptoms of withdrawal, you should be provided this.

What do the guidelines say?

Chapter 7: 7.5.1

Provision of opioid substitution therapy in hospital should involve reassurance, rapid assessment and prescribing as soon as possible after admission.

The World Health Organisation lists methadone and buprenorphine in the WHO's 2021 'Model List of Essential Medicines': this list is guidance for national healthcare systems on the medications that should be available to all patients, particularly in hospital settings.

I'M IN PRISON AND CAN'T GET TREATMENT



Treatment in prison should be guided by the 'principle of equivalence,' meaning healthcare in and out of prison should broadly be the same. However, most will know that this is not the reality.

Although your OST treatment in the community should continue when you go to prison, people report being forced to detox too fast, or being switched onto a different medication against their will.

Before going to prison, gather evidence of your current treatment, such as supporting letters from your prescriber, keyworker, or pharmacist confirming your dose. You should be able to take these in with you to prison, but you may want to check in advance.

You could also ask friends or family to send you these letters once you are in prison but be aware of the delays to post.

You can call the Release helpline from prison.

Key points:

1. You are entitled to OST maintenance in prison (including if you were not on it before).
2. Aim to go to prison prepared with evidence of your OST.
3. Be mindful of the risks when leaving prison. When your sentence is finished, you should be released on a weekday other than Friday, so that community services are open and available. You should also be given naloxone.

What do the guidelines say?

Chapter 5: 5.4.5.1

Prison healthcare is guided by the ‘principle of equivalence’: individuals in and out of prison should get the same standard of care.

Chapter 5: 5.4.6.4

Prison healthcare systems should be joined up with the community service and pharmacy to mean there is continuity of care.

Chapter 5: 5.4.6.4

OST in prison will almost always be supervised.



Accessing and staying in treatment

When you are pregnant, you should not be blocked from getting treatment (at any stage). You also should not be detoxed out of treatment against your consent. If your treatment service is doing this, contact Release.

Take-home medication

Pregnancy might make daily pick-ups or supervised consumption more stressful.

When advocating for take-home meds:

- list anything you've done to prepare for a baby, such as having safe storage boxes for meds and sharps bins,
- remind your service that pharmacy attendance requirements, if not manageable, could put you and your baby at greater risk: it could result in you missing a dose and being left in withdrawal.

During labour

You will still need pain medication during labour when on OST. Contact the hospital in advance to make sure they know your meds and see if your keyworker can support you with this. You could ask your GP or service to write to the hospital directly or write you a letter to take with you.

Social services

You may be anxious about social services getting involved if you seek help for drug use. Though drug treatment services are not required to tell social services about drug use, social services might be alerted to you as part of the drug service's safeguarding procedure.

If something goes wrong, legal aid is available for child proceedings. We also recommend referring to the Resources page of Support Not Separation's website - <https://supportnotseparation.blog/resources/>

What do the guidelines say?

Chapter 7: 7.6.2

Pregnant people should be fast-tracked into treatment.

Chapter 7: 7.6.8

OST can begin at any time during pregnancy and is lower risk than street opiates.

Chapter 7: 7.6.14

Pain relief for people on OST going through labour needs extra attention and forward planning between services.

Chapter 7: 7.6.9

Detox during pregnancy must be very carefully managed and is not recommended for the last trimester. Any reductions should be stopped if it forces someone to buy street drugs again.

Chapter 7: 7.6.11

Pregnant people dependent on benzos should be stabilised on prescribed diazepam: this can be reduced if it does not trigger street benzo use.

I HAVE CHILDREN LIVING WITH ME



This should not block you from accessing treatment: treatment needs to fit into family life. As a parent in treatment, you may want to advocate for your service to:

- Help you to access childcare,
- Be flexible with pharmacy attendance regimes if they disrupt family routines,
- Help you to arrange safe storage and other ways to reduce potential risks,
- Help with housing or benefits.

Treatment services should never assume that a parent on OST is not capable of looking after their children. If a referral to social services happens, be prepared for any meetings in advance to help manage the stress that they might cause you. Start with using the questions below:

- Are you more or less involved in family routines now? If you are not, is this partly because of the demands of your drug treatment (e.g. daily pick-up)?
- Has drug treatment supported you to look after your children? If not, what would help (e.g. are you on the right dose)?
- Have you taken steps to reduce any risks to children? Examples could be buying a safe box for meds, engaging in treatment, seeking out help setting up benefits and better accommodation.
- Are there previous behaviours that had an effect on your family that you have since been able to stop?

You don't need to provide all of this information to social services upfront, but it is good to know, offhand, the answers to questions such as these in case you are asked. If you are struggling with Children's Services, check out the resources on Support Not Separation's website - [Section 1: *Top TIPS* – sns-self-help-guide.net](#)

What do the guidelines say?

Chapter 2: 2.2.2.3

Services should not be prejudiced against, or presumptuous about, parents using drugs or in drug treatment. If there is concern, a service should think specifically about any effects on children: are the parents intoxicated? Are children left unsupervised? Does your physical and mental health impact parenting? What's the effect on family routine? Are you able to access professional support? How are you storing any drugs?

The Government's May 2021 guidance on 'Parents with alcohol and drug problems: adult treatment and children and family services' advises that service providers consider how stigma, as well as fear of social work involvement, prevent parents from accessing treatment. To address this, it suggests involving parents and children in planning and being flexible in where treatment is offered (e.g., offering appointments where there is childcare available).



For holidays and travelling with controlled drugs, you'll need to:

- Try to keep any meds in their packaging,
- Try to give advance warning to your treatment service,
- Get a 'letter of proof' from your prescriber which confirms your name, where you are going, and what meds you have with you. This needs to be signed by the prescriber.
- Check if you can legally take your meds to wherever you are travelling.

However, for any travel longer than 3 months, the rules are different: you will need a licence from the Home Office.

You might need your service to prescribe you a longer take-home dose than you would usually get. If your request is refused, ask for the reasons, the risk assessment, and the service's policy on holiday doses.

When responding, you could refer to:

- Why you need to travel. Focus on how travel supports your treatment. Does it allow you to see friends, family, and your support network? Does it help you to build independence?
- When you've had unsupervised meds before without issue, such as over bank holidays or the Christmas period
- What the risks of not having a holiday prescription are, such as having to miss doses, withdrawal, and potentially dropping out of treatment

Key points:

1. Keep your keyworker up to date on travel needs.
2. Remember that decisions should be made on a case-by-case basis: there should be no blanket 'no' to holiday requests.

What do the guidelines say?

Chapter 4: 4.5.1

Patients need to give advance notice for holidays.

Chapter 4: 4.5.1

There needs to be a clinical rationale for why a holiday prescription is not provided: this rationale should be clearly explained to a patient. The guidelines give some examples of when holiday doses might not be possible, such as for people early in treatment or "significantly unstable".

Chapter 4: 4.4.7.3

You could request a change of medication for holidays: for example, methadone tablets can be used for travel to avoid taking lots of liquids in cabin bags.

Annex 4: A4.3

Normally, the maximum amount of OST that is dispensed is a week's total supply, but exceptions can be more for holidays.

I THINK I AM BEING PUNISHED BY MY SERVICE



Decisions relating to your treatment should be based on a clinical assessment of your needs, as well as risks and benefits of any decisions: if you are concerned you are being punished or victimised, it becomes even more important to ask for the clinical justification for any changes to your treatment plan.

If you are told by your service that changes are being made because of 'bad' behaviour or non-compliance, then point them towards the guidelines. These state clearly that all decisions should have a clinical rationale and that treatment is not successful when patients are punished.

If your service has dismissed your concerns, ask for the clinical reasons: do they add up?

For example, reducing your dose because of drug use is not what is clinically recommended, so how is your prescriber justifying the decision?

In this situation, you may be worried about making a complaint. If you are, is there someone in your service, locally or nationally, who you could trust to raise the issue? For example, a service user lead or patient advocacy service. You can also contact Release.

Key points:

1. Services should not punish patients, and doing so goes against guidance for services and makes treatment less likely to be successful.
2. Contact Release if you feel unsafe raising further concerns.

What do the guidelines say?

Chapter 3: 3.7.3.1

“Services should consider how the organisation and delivery of treatment can provide opportunities to acknowledge the positive changes that service users make. Shaping behaviour, through rewarding positive change, works better than punishing negative behaviours.”

Chapter 4: 4.5.1

Supervision should be used only to safeguard the patient, not as punishment.

Annex 3: A3.2

Young people, particularly, need dosages that keep them comfortable and safe: adjustments to doses should not be used as a punishment system.

I'VE BEEN ASKED TO SIGN A TREATMENT AGREEMENT



Coming to an agreement with a keyworker or your prescriber about your 'care plan' is a normal part of treatment; for example, at the beginning it may be a case of outlining expectations, such as regular appointment attendance.

However, any care plan should be:

- Made by the patient and prescriber together,
- Flexible to changing circumstances. For example, pick-up and supervision should normally change as time goes on.

Treatment agreements should not feel like binding contracts, made up of a series of conditions and punishments. Likewise, use of opioids, alcohol, or other drugs alongside your prescription should not result in a punitive reduction or loss of your prescription.

Key points:

1. State clearly any parts of the treatment agreement that concern you.
2. Ask for any agreement be made in collaboration with you, with enough flexibility and conditions that are appropriate to your goals and situation.

What do the guidelines say?

Chapter 2: 2.7.11

“Involving patients as active partners in their drug treatment is good practice and is associated with better outcomes”.

Table 3

The Guidelines provide possible responses when there is opioid use on top of an opioid prescription, such as increasing dose if inadequate or offering to change OST med: notably, none of these possible responses mention reducing somebody’s dose (Chapter 4: 4.6.5 - Table 3: Responses to drug and alcohol misuse on top of an opioid prescription).

I'VE BEEN ACCUSED OF SELLING OR SHARING MY PRESCRIPTION



Your treatment service may call this 'diverting' your prescription. It is a common occurrence that people share their prescriptions, often for entirely compassionate reasons, but services will respond strongly against it. You need to be aware that selling or sharing a controlled drug amounts to a criminal offence.

If you have been accused of sharing or selling your prescription, your service needs to give evidence of this; you have a right to ask for that evidence. If you do not agree with the accusation, state clearly why in writing.

If you are being threatened with exclusion from treatment, an appeal against this may be strengthened by support from other professionals, such as your GP, keyworker, or any other support worker.

Exclusion should be a last resort. There are alternatives to excluding someone from treatment, such as more supervision, drug testing, or more key-working, which may be something to advocate for.

If you are facing exclusion from treatment, contact Release.

Key points:

1. If you have been sharing your prescription, you may need to accept more supervision, but exclusion should be a last resort.
2. If you have been unfairly accused of selling or sharing your prescription, you may want to escalate your experience to a complaint, gather support from other professionals, and contact Release.

What do the guidelines say?

Chapter 4: 4.6.5

Patients should be warned if there is a risk of exclusion.

Chapter 4: 4.6.5

Temporary or permanent exclusions from drug treatment services are not decisions to be taken lightly: they require coerced detoxification, which the guidelines otherwise advise against. Exclusion also puts patients at greater risk of overdose, blood-borne viruses, and involvement in the criminal justice system.

Chapter 4: 4.6.5

Patients excluded from a service should, where possible, be offered treatment at an alternative local service.

Chapter 4: 4.5.2

Supervised consumption can be used where there are concerns about diversion of prescriptions (as an alternative to exclusion).

I'M BEING DETOXED OUT OF TREATMENT FOR BEHAVIOUR-RELATED REASONS



Exclusion from a service must be a last resort. However, it may be down to you or your Advocate to present the treatment service with every possible alternative to removal from treatment.

Alternatives to forced detox could be:

- Treatment at another local service,
- Remote key-working, rather than in person appointments,
- Care being switched to the most experienced workers,
- Increased supervision,
- Increased pharmacy attendance,
- Increased key-working or psychosocial support,
- Optimising treatment – for example, a change to a different medication, including the option of alternative opioids other than methadone or buprenorphine.

As usual, get the reasons for the detox in writing. In your response, you must emphasise the risks of the detox and the ways that treatment has helped you. Even if something has gone very wrong, there may be other ways your life has improved that are not being given full weight.

If you are being detoxed out of treatment and require additional advocacy support, contact Release.

What do the guidelines say?

Chapter 4: 4.6.5

Patients excluded could be offered treatment at another local service or in settings that minimise risk but still allow the person to remain in treatment.

Chapter 4: 4.8.1

There is clear evidence that coerced detoxification will lead to relapse and increased risks.



What's next?

Each and every situation will be, to some extent, context dependent. At Release, we recognise that there is no 'one size fits all' approach to drug treatment, and so similarly, there can't be a single solution which resolves every person's advocacy case.

Nonetheless, we hope that the steps and relevant guidelines in this booklet have given you a good starting point. Along with the specific advice given in this booklet, you should refer back to Part One of the Advocacy Toolkit, particularly to sections such as "How can I challenge treatment decisions?" in order to develop a strategy and escalation plan if your advocacy matter isn't resolved on first try.

Of course, if you are stuck or could benefit from outside support on your advocacy matter, the Release team is here to help. You can reach us by emailing ask@release.org.uk or by phoning our helpline at **020 7324 2989**.

For more information on Release and our resources, please visit [release.org.uk](https://www.release.org.uk).

Partners:



PART TWO: THE MANUAL

Release
Drugs, The Law & Your Rights