DRUG & ALCOHOL FINDINGS Matrix cell

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Drug Matrix cell E2: Treatment systems; Generic and cross-cutting issues

S Chronic care for chronic conditions (2002). Alternative source at time of writing. Implications of truly treating addiction of the kind seen by public treatment services as analogous to a chronic disease include organising long-term monitoring and care (on which see guidance and associated reviews below) and judging services on how the patient fares *during* treatment, not after they leave. Discussion of the need for continuing care in cell D2. For related discussion in this cell click and scroll down to highlighted heading.

K £3 for £1 claim offers treatment investment rationale for commissioners (1999). NTORS recruited its national English treatment sample in 1995 when all the modalities it studied were under threat. It estimated that within one year they had reaped benefits which greatly outweighed their costs, an estimate analysed by the Effectiveness Bank in the listed report and in a presentation. An NTORS analysis (2004) for the two years after treatment entry came up with an even greater ratio of savings to costs. The later DTORS study (2009) of a similar sample calculated an almost identical savings:costs ratio for the year after treatment entry, but on shakier grounds. For related discussion click and scroll down to highlighted heading.

K Challenge to Scottish treatment system (2006). Recruiting its sample in 2001, DORIS was the Scottish equivalent to the English NTORS. It challenged the Scottish treatment system to forefront abstinence as an aim because this is what the patients want (see analysis in cell A2's bite) and because it promotes social integration. Both may be true, but neither was proved by DORIS. See also these reports on employment (2008) and crime (2007) outcomes, and an omnibus report (2008) on the project's findings.

K Successful completion indicator of lasting remission in England ([UK] National Treatment Agency for Substance Misuse, 2010). Support for the contention built in to national policy and funding criteria that leaving treatment after having 'successfully completed' is an indicator of lasting remission. However, the same analysis (and another published in 2012) suggests staying in treatment for at least a few years is even better. For related discussion in this cell click and scroll down to highlighted heading.

K Disappointing results from English payment-by-results schemes (2017) Study funded by the UK Department of Health found the schemes reduced rates of successful completion of treatment, seen as (above) a critical indicator of successful treatment. See also research report from the same study including data from interviews with people involved in the schemes, and an official evaluation ([UK] Department of Health, 2013) and study (2015) of the pilots during their first year. These also found that the proportion of patients exiting treatment free of dependence was worse than in other areas and in the pilot areas before the schemes. Related study and review below. For discussion click and scroll down to highlighted heading.

K Foundations of high-quality care planning in English commissioning areas ([English] National Treatment Agency for Substance Misuse, 2007). In 2005/06 every treatment-providing area in England was assessed for the quality of its care planning, and an attempt made to identify the distinctive characteristics of high-performing areas. The results was a menu of potentially performance-improving features of local treatment systems. For discussion click and scroll down to highlighted heading.

K Systems change helped improve access to and retention in treatment (2008). US NIATx programme halved waiting times and extended retention partly by fostering a self-sustaining inter-service improvement network and a performance analysis system linked to funding. See also this later extension (2012) to the programme and a similar study (2010) (free source at time of writing) of the NIATx method in Los Angeles treatment services which recorded substantial improvements in waiting times, retention, and 'no-shows'. Related NIATx study and web site below.

K Expert coaching helps services improve patient access and retention (2013). Free source at time of writing. Randomised trial tested the improvement collaborative model developed by the US NIATx quality improvement resource. Arrangements for services to learn from each other were less effective and less cost effective at improving patient access and retention than assigning each clinic an NIATx-trained quality improvement expert to individually 'coach' them through the process. Related NIATx study above and web site below.

K Pay for results, not for trying (2008). Rather than specifying treatment inputs like numbers of counselling sessions, the US state of Delaware incentivised patient recruitment, engagement, and drug- and alcohol-free treatment completions; the result was more patients, more engaging treatment, and a rapid increase in satisfactory treatment completions. But there were signs too that services focused on doing enough to earn the rewards without seeking to excel in these or in other ways. Related UK study above and review below. For discussion click and scroll down to highlighted heading.

K How much should treatment systems rely on residential rehabilitation? (2007). Rare randomised trial confirmed that unless there are pressing contraindications, intensive day options deliver outcomes equivalent to residential care. Often of course, there *are* pressing contraindications. See also this informal Effectiveness Bank review.

R Recovery-oriented systems of care (2008). Creating a recovery-friendly environment is the best way to sustain resolution of substance use problems argues this (as we described it) "sweeping, learned but practice-oriented *tour-de-force*". For discussion click and scroll down to highlighted heading.

R Research supporting components of a recovery system ([US] Substance Abuse and Mental Health Services Administration, 2009). Evidence for key elements of recovery-oriented systems of care such as continuity of care anchored in the community and delivered by integrated services on the basis of system-wide education and training. See also associated implementation case studies. For related discussion click and scroll down to highlighted heading.

R Policy strategies for improving outcomes (2011). Two of the world's most respected addiction researchers also with top-level policymaking experience set out the options for improving treatment systems. For discussion click and scroll down to highlighted heading.

R Funding mechanisms for substance use treatment (Report for the Australian Department of Health, 2014). Chapter 6 comprehensively reviews funding mechanisms including payment by results, for which it finds no peer-reviewed evidence that it has improved post-treatment alcohol or drug client outcomes. Related UK and US studies above. Part 2 of the report makes recommendations for Australian service planning and commissioning which may in parts be applicable to the UK. For discussion click and scroll down to highlighted heading.

G Commissioning for recovery ([UK] National Treatment Agency for Substance Misuse, 2010).

G Commissioning integrated drug treatment systems in England (Public Health England, 2017). Key principles and associated action-prompts for developing an integrated local system to reduce drug-related harm, including treatment. One of a suite of commissioning guidance and resources. Supported by 'return on investment' resources (Public Health England, accessed 2018) enabling commissioners to estimate social benefits and effects on performance indicators of various interventions.

G Scotland's vision of a high quality treatment system (Scottish Government and Convention of Scottish Local Authorities, 2014). What for the Scottish Government 'quality' consists of in substance use services. Intended to ensure commissioning of the quality of treatment and support services needed to meet the needs and aspirations of a local population. An evaluation ([Scottish] Care Inspectorate, 2017) reported that "Overall, the Quality Principles are being embedded and beginning to show some impact in more person-centred treatment, care and support". See also more provider-oriented English guidance.

G Commissioners in England face challenge of funding cuts ([UK] Advisory Council on the Misuse of Drugs, 2017). Based on research, financial data and stakeholder surveys and testimonies, the UK government's official drug policy advisers warn that without significant efforts to protect investment and quality, in England "loss of funding will result in the dismantling of a drug misuse treatment system that has brought huge improvement to the lives of people with drug and alcohol problems". Supported by sector-led survey of treatment services in England in December 2016 to March 2017 which "uncovered worrying signs that damage has already been done and the capacity of the sector to respond to future cuts has been eroded".

G Elements and procedures of an effective local treatment system (2016). The Obama administration's extension of health care and in particular substance use treatment to more of the US population generated a need for guidance on how local areas should set up addiction treatment systems. This clear US guidance covers the types of services to be provided, the links between them, and how to assess need and maintain quality.

G Integrated care for drug or alcohol users (produced for the Scottish Advisory Committee on Drug Misuse, 2008). Guidance for Scotland on implementing a treatment system which combines and coordinates all the services required to meet the assessed needs of patients.

G Strategies to promote continuing care (2009). Free source at time of writing. Expert US consensus on practical strategies to promote continuing care based on a review (2009) which was later updated (2014; free source at the time of writing) and the data reanalysed, with results still supportive of continuing care/aftercare but less strongly. Related seminal paper above. More on continuing care in cell D2.

G US NIATx system change resources ([US] NIATx, accessed 2018). Web-based service provided by the University of Wisconsin and supported by US government, offering practical strategies for commissioners and planners to promote change across a treatment system including engaging services in mutual leaning and support, tested in a study listed above. Specific aims include reducing waiting times and improving retention (see this example listed above), and increasing admissions and reducing no-shows (see this example). For discussion click and scroll down to highlighted heading.

G Planning and implementing treatment and rehabilitation (United Nations, 2003). Strategic framework, integrating services, and evaluation.

MORE This search retrieves all relevant analyses.
For subtopics go to the subject search page and hot topics on evidence-based commissioning and recovery as a treatment objective. See also this on-line library of papers related to recovery-oriented systems of care.

Close Matrix Bite

Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text

What is this cell about? How across an administrative area to engineer an effective and cost-effective mix of services which offers patients/clients appropriate options for entering and moving between services or using them in parallel. Involves commissioning, contracting and purchasing decisions to meet local needs in the context of resource constraints and national policy. Activities include: needs assessment; restructuring or re-tendering services; contractual requirements on services to demonstrate evidence-based practice, meet standards, and implement performance monitoring; and financial or other rewards/sanctions linked to activity, quality or outcomes.

At this distance from the preoccupation with intervention effectiveness, research is scarce and rarely of the 'gold standard' randomised controlled trial format (there is just one example in this cell). Instead researchers often have to interpret how things happen in the messy real world, attempting to isolate what may have been the active ingredients among a complex set of variables not under their control. The key limitation of such methodologies is the difficulty of being sure what (if anything) was cause, and what effect.

Where should I start? William White's monograph could form not just the start, but the middle and end of your investigation of the recovery transformation in treatment. It comes from (see his collected writings) an authority who more than any other has promoted and provided the scholarly underpinning to the new recovery eras in both the UK and the USA. For him 'recovery' entails a shift from isolated bouts of professional care for a problem which has become intolerably severe or attracted attention, to on the one hand, intervening before things have descended to this point, and on the other, locating treatment as often merely the first step (as advocated by a US expert) to extended monitoring and care – "recovery maintenance". Accordingly the focus shifts from inside the clinic to systems around the clinic within which the patient must eventually reshape their life in community with others who have done or are trying to do the same, sustained by ties to family, community, and productive activities. Explore this monograph to appreciate what this means for the roles of commissioners, services and treatment staff.

The recovery model has the potential to at least partially sidestep a 'Catch 22' in the provision of an 'addiction' treatment system: that by its very nature it identifies the substance use aspects of a person's difficulties as primary and the focus for intervention, and leads both patient and service to collude in this identification as a ticket to state-funded help. Making substance use central to a person's identity is not necessarily the best way to help them de-centralise from substance use and overcome a core diagnostic criterion for addiction – the narrowing of interests and activities to substance procurement and use. Nor does this necessarily focus on the key problem(s). A recovery orientation uncontaminated by an undue emphasis on abstinence can widen perspectives to relationships, family, work and interests, housing, mental health, the home environment, and so on, elevating these to at least the level of substance use in the diagnosis of the

need for recovery and in the recovery journey.

Optimistic and enthusing though it is, some interpretations of 'recovery' have their less clearly positive sides, including the implication that only patients who have left treatment can be recovered, an associated push to limit treatment durations (one of the roots of the current recovery phase in the UK) rather than letting patients and clinicians decide, a seeming demand that problem substance users develop lives more fulfilling than many who never had these problem, and a tendency to elevate abstinence as the prime objective and to relegate harm reduction to secondary importance.

There are also competing paradigms, including the contention that "Harm Reduction is the goal – not a step along the 'road to recovery' or the path to 'freedom from dependence'."

Highlighted study Our highlighted study tested a key methodology of the US NIATx partnership (featured in cell D2's bite) intended to improve patient access and retention across a treatment system – the learning collaborative model. In the process it revealed the great strength of randomised trials; they can generate truly surprising results which by eliminating extraneous influences also eliminate alternative explanations. The result can be to force the researcher to re-evaluate the expectations which led to the study. Lead researcher in this case was NIATx director Dave Gustafson, whose organisation promotes the model he tested.

Check the free source for the study and you will see that the model's cheapest method – monthly, expert-led teleconferences between staff from different clinics – made no significant difference to any of the processes it was intended to improve. The other way services could learn from each other – face-to-face versions of the teleconferences – were associated with improvements in waiting time for treatment, but not in retention or patient numbers. Given the weak performance of these methods, it comes as no surprise that adding them to the mix did not improve on just having an expert quality improvement coach to support and guide clinic staff. In other words, the *collaborative* bit of the learning collaborative model rarely generated improvements, and created no added value over and above the non-collaborative approach of assigning each clinic an expert guide. Coaching was also much cheaper than both face-to-face conferences and the combined intervention.

The message for commissioners seems inescapable: if you are responsible for treatment provision across an area, employ a quality-improvement expert and set them to work with each service; don't waste money getting services to learn from each other. That way you will at least give more patients a *greater chance* of getting better, though whether the process *actually* improved substance use outcomes is unknown.

You might counter that in the US context, the clinics were profit-making businesses hardly likely to share tips, but in fact, none were. Apart from the usual caveats, notice that the 'collaboratives' were not natural networks, like services working in the same catchment area, doing the same kind of work, or seeing the same kinds of patients. Within each US state, each clinic was *randomly* allocated to the different improvement methods.

And there you have the great *weakness* of this kind of randomised trial: by eliminating 'extraneous' influences, it risks eliminating some which are not extraneous at all, but essential to the intervention working – perhaps in this case, a common interest across collaborating clinics.

Issues to consider and discuss

▸ **Were cuts in crime ever the justification they seemed for treatment?** In the 1990s post-treatment cuts in crime resulted in an estimate that society saved £3 for every £1 spent on treatment, helping to rescue UK drug services from an attack by the then Conservative government (for which see cell A2's bite). The same finding became the subsequent Labour government's main rationale for expanding provision.

Since 2010 crime-reduction has been subsumed under the broader recovery agenda, but the economic bottom line remains the same: in terms of hard-nosed return on investment, the main justification is still cuts in crime linked to the reduced need for overwhelmingly poor and unemployed patients to raise money for illegal drugs. This is the case not just in Britain but also across US cost-benefit studies, in which reduced crime usually accounted for most of the cost-savings for society from addiction treatment. In contrast, savings in health service costs and gains due to increased employment were minor.

Crime reductions after treatment entry are real enough, but did society really save as a result? The '£3 for £1' estimate came from the NTORS study of patients newly attending drug treatment services in England in 1995. From that data it was calculated that £5.2 million crime-related savings resulted from an extra £1.6 million spent on treatment – roughly the 3:1 ratio ▸ figure.

Look at the Effectiveness Bank analysis and the presentation cited above. They explain that:
• Unusually, the £1.6 million was not the full cost of treatment during the follow-up year, but how much this exceeded the £1.4 million spent the year before; add in the full costs and arguably assume previous treatment helped too, and costs could rise to £4.4 million – close to the calculated savings.
• A large proportion – probably nearly half – of the savings related to stolen or defrauded property and money, from which the calculations unrealistically assumed no one benefited. Eliminate these (as some economists would) from the calculations and savings might drop to £2.9 million.

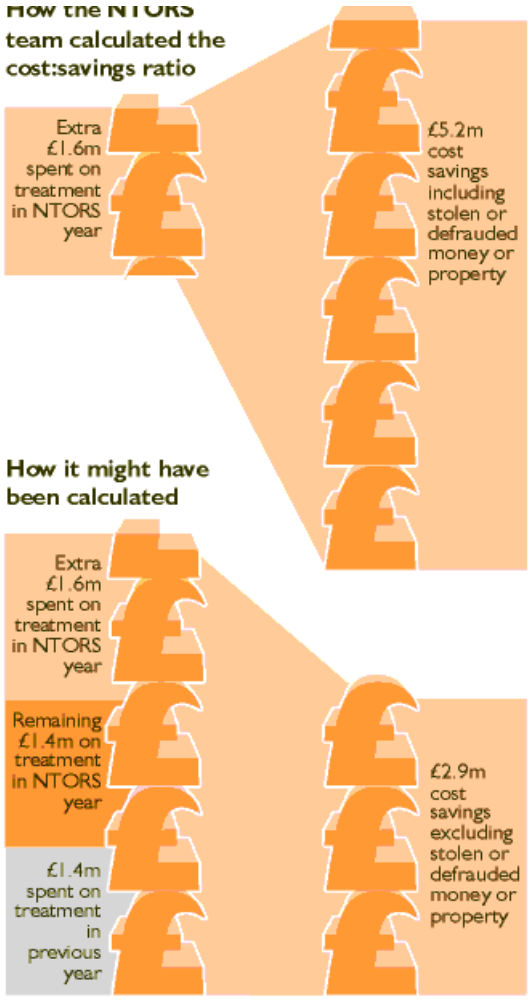
Already these alternative assumptions result in treatment costing more than it saved, implying that in these terms, it was a bad deal for society. But there was more. Plausibly (as NTORS itself suggested), criminal activity peaked before treatment entry and then progressively fell. If this was the case, the study's

methodology would have inflated the before-to-after crime reduction and in turn the cost-savings estimate.

In any event, among NTORS' caseload crime reduction justified treatment only for the 1 in 10 patients highly criminally active before treatment, among whom reductions in acquisitive crime were concentrated. And whatever the true figures, criminal justice savings may not be an incentive to health services, which bear the costs not only of addiction treatment, but sometimes also of responding to the medical needs revealed when patients enter treatment.

But a failure (if that's what it was) to *demonstrate* net benefits is not the same as there being none. Benefits there almost certainly were in terms of saved and improved lives. These were not included in NTORS' economic estimates, leaving crime as the main component.

This crucial episode in the survival and expansion of treatment provision in the UK raises some fundamental issues. Most of all, how precarious it is to justify treatment as *saving* money, rather than seeing it as money *well spent* to save lives and alleviate distress and illness. Ask yourself, does anyone question cancer treatments on the grounds that they fail to save more money than they cost? Instead the traditional yardstick is how much the treatment costs per year of good quality life it gains. Unfortunately, drug addiction treatment also appears to perform poorly on this incomplete yardstick; addiction to illegal drugs spreads diminished quality of life well beyond the patient.



You might also ponder whether the researchers should have presented alternative cost:savings scenarios, even if they showed costs exceeding savings. And if they had, given the scepticism over treatment which generated the study, whether that would have meant a funding standstill or a shrinking treatment system incapable of helping all but a small proportion of those in need. In the end, was this limited and questionable analysis a 'good thing'?

▸ **Is payment by results the way out?** Out that is, of the apparent bind described in cell D2 – that treatment organisations doing least well are probably also the ones least likely to open themselves to influence and scrutiny. Setting *process* targets/incentives for them may persuade them to improve that process (such as for example retention), but this may bear little relation to improved patient welfare and reductions in problem substance use. It seems to make more sense to pay services to achieve those desired outcomes, rather than to do things expected to lead to that way, but which may not.

Certainly it made sense to the UK government, which has advocated this mechanism and set up 'payment-by-results' pilot schemes in eight areas to test it, and which remains enthusiastic, at least in respect of probation service providers. Also not to be lightly dismissed is the hunch of two of the world's most respected addiction experts (one of whom was appointed to advise on addiction treatment in England) that payment-by-results arrangements are among the most promising strategies for improving treatment outcomes. Are they are on the right track?

Look at the discussion of the schemes in our commissioning hot topic. It points out that such schemes have to be consistent, concrete and prescriptive about what they expect from treatment services, seemingly at odds with the individualisation stressed by recovery advocates. In theory local schemes could create a space for the patient's ambitions in their payment criteria, but this is not a required element or one included in the national criteria, nor one which sits easily within a system predicated on observable outcomes the public and their representatives recognise and are willing to pay for. Instead, schemes pre-set what counts as success without reference to what the individual patient wants – and in a way services cannot afford to ignore.

A US study listed above hints that (like contingency management incentives for patients) payment-for-performance systems engender a mentality of doing just enough to get the money, but no more.

Even if outcomes could be directly and accurately measured – a task which has expensively occupied teams of researchers – just what led to them would remain unclear, particularly since patients commonly traverse several treatment services and modalities before sustainably overcoming dependence. Giving all the credit to the last episode ignores the contribution of any predecessors which paved the way for 'its' successes.

To these in-principle issues can be added the particular criteria prioritised by the schemes. Though introduced in the name of recovery, UK schemes place a premium not on the long-term contact presupposed by the

recovery vision and associated understandings of addiction, but on discharging patients who then are not seen again for at least a year. Does that incentivise the achievement of lasting recovery, or tempt services to counterproductively place hurdles in the way of treatment re-entry? If addiction of the type seen at specialist services at least *behaves* like a chronic, relapsing condition, is it appropriate to punish services for post-treatment relapse?

Research to help answer these questions is almost entirely lacking; in evidence terms, payment-by-results in health and social care of any kind (1) and in particular in substance use treatment (1 2) is largely a leap in the dark, into territory strewn with "unexpected, often perverse, consequences".

Evidential uncertainty and the risk of counterproductive effects are presumably among the reasons why the English schemes were evaluated pilots. Funded by the UK Department of Health, a study listed above compared results in the eight pilot scheme areas in the two years before and after the schemes started with corresponding results from comparison areas. Fewer clients in payment-by-results areas met the three-weeks-or-under waiting time target, fewer started treatment after their initial assessments, more left treatment as an unplanned discharge, and fewer successfully completed their treatment or completed without later having to return.

Could the pilot's payment-by-results mechanisms actually have made things worse?

There were countervailing gains in abstinence and non-injecting *during* treatment, but successful treatment completion, exit and non-return is the UK government's key indicator of recovery from substance use problems, and on this measure the pilots seem to have made things worse – findings which contributed to the researchers' verdict that the pilot areas had "performed worse in a number of these recovery-specific outcome domains, despite their apparently greater emphasis" on recovery. In other words, the attempt to promote recovery by 'paying' for it, seemed to have backfired.

The study showed that earlier similar findings from two studies of the first years of the schemes were not just due to short-term implementation difficulties; unfold supplementary text.

Across all three studies there is a consistent picture of fewer successful and lasting treatment exits, but some greater gains during treatment in abstinence and also in the remission of injecting. Speculations made by the researchers to account for these results included an unintended focus on in- rather than post-treatment performance indicators (easier to achieve and measure), and keeping patients longer in treatment to cut down the number who return to treatment after leaving.

Why more potential patients did not start treatment after being assessed is even less clear, but it seems this finding was due to the performance of just one of the eight pilot sites, whose central assessment unit assessed "clients for interventions other than structured treatment". Together with more waits of over three weeks, the findings suggest that (as feared) the pre-treatment assessments needed to set payment-by-results tariffs can (but not necessarily) act as a barrier to starting treatment. Set against this are some perceived benefits, including more consistent and more comprehensive assessments and better data on treatment demand.

You will have your own questions about payment-by-results and their English implementation, so critical to the future of treatment in the UK. Here are some starters. Surely a charity or health service should not need external incentives to strive to do the best for its patients? Yet without these, would services stay un-stretched within acceptable-quality comfort zones? Are pre-set objectives desirable, pushing services to deliver on national and local priorities, improving comparability across services, and preventing them glossing over their shortcomings? Or do they stifle patient-centred practice, preventing treatment objectives being based on the *patient's* priorities? Maybe all the above? Does the no-return-for-a-year criterion incentivise services to ensure their patients' recovery lasts, or tempt them to counterproductively place hurdles in the way of treatment re-entry? Where does it leave long-term continuing care of the kind advocated by some authorities on recovery?

Other issues are raised in this blog from a keen observer of the process, of which perhaps the most worrying is the diversion of resources to administration and to the added step needed to assess the 'tariff' for each patient.

These concerns must be judged against the backdrop of the usual funding mechanisms, which generated treatment systems widely criticised for failing to deliver recovery outcomes. Was that criticism justified? Could the pilot's payment-by-results mechanisms actually have made things worse, causing a deterioration in the main outcomes they were intended to improve?

▸ **What makes a local treatment system excel?** For some possible answers we can roll back to the 2000s and the era of the National Treatment Agency for Substance Misuse (NTA), an unprecedented experiment in the central promotion and control of addiction treatment in England – and in particular, back to their work on care planning, the core process of planning, evaluating and adjusting a patient's treatment plan.

With its leverage and data systems, the NTA was able to establish that commissioning areas differed in how well patients were worked with and in patient outcomes. For example, though generally in the same ball park, local areas could substantially differ (2012) in how completely their heroin-using patients manage to avoid heroin use during treatment, even after adjusting for caseload differences.

Those figures derived from patients starting treatment in 2008–2010. A few years before, in 2005/06 the NTA

had found similar variation in the quality of care planning and prescribing, revealed by surveys responded to by nearly all 149 drug action teams in England, then responsible for planning and commissioning addiction treatment in their areas. Of the 148 which were rated, 106 scored as “fair”, 33 as “good” and seven as “excellent”

The assessments included data from client surveys and directly from treatment services in the areas, and it was when these were analysed that this generally rosy picture came most strikingly into question. For example, an analysis of the documents services used for care planning, triage, and assessment resulted in half the areas being scored as “weak”, while around two-thirds of clients either were unaware of their care plans or said they had not been reviewed in the last three months.

Unusually, a subsequent analysis went beyond identifying variation in performance to trying to account for this variation. The data was used to select eight areas to investigate further via interviews with staff. All eight had either scored well overall or on certain components of the assessment. Next the interviews were sifted to identify features thought to have had a positive influence on care planning. Starting on page 9, the resulting report (listed above) offered what could be seen as a list of features which might be addressed to improve care planning.

The analysis went beyond identifying variation in performance to trying to account for this variation

Take a look at these 22 features. Some, it has be admitted, are expansions of the criteria used to assess that areas were good at care planning, rather than underlying reasons why these criteria were met. Some too are likely to have been compromised by the austerity era which began as the NTA neared its absorption into Public Health England, accompanied by the transfer of responsibility for treatment to local authorities and the ending of the central fund reserved for treatment. Per-patient belt-tightening began (1 2) as long ago as the mid-2000s. Overall budget cuts followed, until by 2017 the government’s advisers saw the achievements of the NTA as under threat, and with these not just the recovery but the health and lives of substance users. The same year a survey of treatment services in England “uncovered worrying signs that damage has already been done and the capacity of the sector to respond to future cuts has been eroded”.

In this situation, how likely is it that patients will have access to “the full range of treatment services” (one of the features though to improve care planning), including expensive options like residential rehabilitation and inpatient detoxification? What of the chances of clinical leadership by expensive specialist psychiatrists or other doctors supervising “skilled and competent” staff? Already in 2008 it was being said that consultant psychiatrists and clinical psychologists were being left out of re-tendering specifications for local treatment systems – and that from a base reckoned to be only a quarter of the number of addiction psychiatrists required in England.

These warnings were, it seems, not entirely taken to heart. In 2014 Public Health England and professional medical bodies remained concerned at feedback from commissioners and providers which “indicated that the number of specialists (many are addiction psychiatrists) in local treatment systems is reducing, due either to recommissioning of services or cutting of posts within existing services”. By 2017 treatment services reported an increasing reliance on volunteers for work previously undertaken by professionals. On other hand, local authority ‘ownership’ of the treatment system ought to improve the chances of “Good links with local partners responsible for wraparound services”, another of the features thought to improve care planning.

Together with your colleagues, you might want to discuss whether you are convinced that these 22 characteristics really did at the time underpin high quality care planning, whether they remain relevant, and how many are malleable features which could be changed to improve performance, even in today’s more straitened circumstances.

Thanks for their comments on a draft of the original version of this cell to Professors A. Thomas McLellan, Keith Humphreys and Michael Gossop. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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