DRUG & ALCOHOL FINDINGS *Matrix cell*

S Seminal studies **K** Key studies **R** Reviews **G** Guidance **MORE** Search for more studies
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Drug Treatment Matrix cell D3: Organisational functioning; Medical treatment

S Vision counts in US methadone maintenance clinics (1991). US clinics oriented to rehabilitation and long-term maintenance and which delivered more counselling had the best outcomes. Results later partially confirmed in a replication study (1999) of a larger set of US clinics. For discussion click and scroll down to highlighted heading.

S Abstinence-oriented ethos undermines methadone services (1995). Australian study of two clinics allocated patients purely on the basis of their home address, one oriented to abstinence, the other to indefinite maintenance. At the former this ethos led to lower doses and time-limited treatment, adversely affecting retention and substance use. For discussions click here and here and scroll down to highlighted headings.

S Ethos, dose and organisation in methadone services (Australian Government, 1995). Comparison of three Australian clinics highlights the importance of good organisation and an ethos of individualised treatment, rather than acting as a more or less efficient 'methadone dispenary'. For discussions click here and here and scroll down to highlighted headings.

K Guideline-adherent methadone clinics do best for their patients (2008). Eight US clinics paired together in four sets for their contrasting adherence to clinical guidelines provide evidence that the relatively high dosing and intensive psychosocial services recommended in the guidelines really do make a difference. For discussion click and scroll down to highlighted heading.

K Waiting time for methadone prescribing (National Treatment Agency for Substance Misuse, 2004). British studies show rapid entry enables more referrals to engage with treatment and cuts time at risk from illegal heroin use.

K Methadone programme loosens up, increases capacity, patients do just as well (2004). Canadian study documents what happens when you 'deregulate' methadone prescribing and permit greater patient choice in treatment and treatment goals. Result: room for more patients, less conflict and no decrease in effectiveness. Free sources at the time of writing are linked to in the Effectiveness Bank analysis. For discussions click here and here and scroll down to highlighted headings.

K Integrated 'chronic disease management' model does not improve on usual primary care (2013). Chronic medical conditions requiring long-term behaviour change respond well to chronic disease management models based in primary care but integrated with specialised services, which support the patient in managing their illness. Expectations (2008; free source at time of writing) that the same would apply to addiction were confounded when researchers found little or no extra benefit compared to usual primary care, and no sign (2012; free source at time of writing) that increasing the quality of, or engagement with, the intervention would improve things.

K British GPs as effective as specialist methadone clinics (2003). A two-year follow-up of opiate-dependent patients sampled in 1995 by the national English NTORS study showed that experienced or supported GPs can provide methadone maintenance treatment at least as effectively as specialist clinics.

K Case management links detoxification to treatment (2006). Siting case managers at detoxification services transformed them into gateways to longer term treatment, part of a broader 'recovery revolution' in Philadelphia.

K Specialist and inpatient opiate detoxification improve completion rates (2000). Cost-effectiveness and cost-benefit analysis based on two UK studies, one of which showed that far more patients who choose or are randomly allocated to an inpatient setting complete detoxification, the other that the most effective inpatient setting is a specialist drug addiction ward rather than a general psychiatry ward.

K No long-term benefit from conducting opioid detoxification on an inpatient basis (2011). Randomly allocating methadone-maintained patients in Birmingham (UK) to an inpatient v. outpatient setting for their lofexidine-based detoxification may have improved completion rates, but not the low opioid-abstinence rate (16% – 11 of 68) just a month after discharge, a rate which fell to 12% five months later.

K High quality primary care helps control substance use after detoxification (2007). Free source at the time of writing. The substance use of US patients (most with both drug and alcohol problems) referred to primary care after

detoxification was found to be related to the general quality of primary care. Factors associated with greater problem reduction included how easy the practice makes it to get in touch and visit and whether patients see the same doctor each time. Other findings from this study in cell B3.

K Not just a methadone patient (2013). When some Australian methadone clinics started offering treatment for hepatitis C the unexpected effect was to improve relationships with patients who felt they were no longer there just to be dosed with methadone but to be cared for as a (whole) person. Related discussion in cell B3.

R Pharmacotherapies for opioid dependence (2009). Book by leading Australian authors includes evidence on how best to organise and orient pharmacotherapies.

R Implementing evidence-based innovations ([Australian] National Centre for Education and Training on Addiction, 2008). Lessons from health promotion and medical care on how to improve addiction treatment, including the use of organisational and administrative quality-improvement strategies.

R Weak evidence for integrating addiction and mental health treatment (2013). Synthesis of research findings finds some evidence that integrated treatment for substance use and mental health problems improves psychiatric symptoms and (in residential settings) reduces drinking more than non-integrated care, but none of the slight advantages approached statistical significance. See also Effectiveness Bank hot topic on 'dual diagnosis'. Related guidance below.

G Making recovery the paradigm for medication-based treatment ([UK] National Treatment Agency for Substance Misuse, 2012). Clinical consensus developed for UK government on how medication-based treatment for heroin addiction can be made more recovery-oriented, focusing on methadone maintenance and allied programmes. Constructed with the aid of the US recovery advocate whose work is listed below and who co-authored a commentary on the UK report. For related discussions click here and here and scroll down to highlighted headings.

G US vision of methadone maintenance as a recovery vehicle (2012). From authoritative US recovery advocate William White, a humanistic interpretation of what makes for recovery-oriented opioid maintenance, including long-term, flexible, prescribing with no pressure (but with opportunities) to reduce doses or detoxify, allied with support if wanted to develop a more satisfying and pro-social life. Based on freely available monograph (2010). For discussion click and scroll down to highlighted heading.

G NICE advises against specialist 'dual diagnosis' services ([UK] National Institute for Health and Care Excellence, 2016). UK's official health intervention assessor says that rather than creating specialist 'dual diagnosis' services, health and social care (including substance misuse) services should adapt to seriously mentally ill substance users, and their care should be led by the mental health service. Other NICE guidance (2011) has dealt specifically with psychosis and substance use. Related review above. See also Effectiveness Bank hot topic on 'dual diagnosis'.

G Getting your organisation fit to implement change ([US] Substance Abuse and Mental Health Services Administration, 2009). How to assess an organisation's capacity to identify priorities, implement changes, evaluate progress, and sustain effective improvement programmes, and how to actually implement these changes: "If your organization is troubled, you need to build a healthier work culture before change will be possible." For related discussion click and scroll down to highlighted heading.

G Theory into practice strategies ([Australian] National Centre for Education and Training on Addiction, 2005). Chapter on organisational change includes the organisational factors which impede or promote change and how to manage them. For discussion click and scroll down to highlighted heading.

MORE Search for all relevant Effectiveness Bank analyses or for sub-topics go to the go to the subject search page. Also see hot topic on why some treatment services are more effective than others.

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What is this cell about? About the treatment of drug dependence in a medical context and/or involving medical care, typically by GPs or at specialist drug treatment centres or clinics. Clinical staff are responsible for medications, so the centrality of these to an intervention distinguishes it most clearly as medical. But drugs are never all there is to medical care. Even when drugs are prescribed, the clinician-patient relationship influences whether they are taken, and this relationship can be therapeutic in its own right. In turn, clinicians work in a physical and social context which more or less legitimises and supports their work, generally taking the form of a service run by a distinct organisation. As well as concrete things like staff, management committees, resources, and an institutional structure, organisations have links with other organisations, histories, values, priorities, and an ethos, determining whether they offer an environment in which staff and patients/clients can maximise their potential. For these and other reasons, agencies also differ in how keenly and effectively they seek and incorporate evidence-based practices.

It is not easy for researchers to manipulate these qualities in order to test their roles in the implementation of evidence-based practices or their effects on outcomes for patients. Instead, observations of real-world practice look for links between organisational qualities and practice and outcomes which *may* derive from a causal effect of one on the other, but may be due to something else. As a result, rigorous research is scarce, and generic sources beyond the scope of the matrices become more important. If research on an issue which interests you does not specifically relate to medical treatment services, you may be able fall back on cell D2, which deals with similar issues across treatment.

In the UK and US context, and in particular for treatment based in primary care, the kinds of services which choose to treat addiction and are selected for or volunteer to join studies are unlikely to be typical of practices in general. These studies demonstrate the potential of GP practices to offer treatment as safe and effective as specialist clinics and to greatly extend access, but there will be other less experienced or well supported GPs who would not do so well. There is some evidence, for example, that in normal practice in the UK, starting methadone treatment in primary care is not as safe as at specialist clinics, while going back to 1960s Britain, "The drug problem … was seen as the result of inappropriate prescribing by GPs," leading to the establishment of a network of specialist clinics and limits on the prescribing of all but specially licensed doctors. Clinics too can and have provided sub-optimal treatment, in the 1970s deterring treatment entry by turning way from maintenance prescribing. In the end, it seems quality counts more than the particular medical setting.

Where should I start? We suggest UK guidance from 2012 (listed above) on how methadone clinics and other medication-based treatment services can be (re)oriented to long-term recovery. Turn to the Effectiveness Bank analysis and click the title to download the report. Then turn to pages 8–9 and the "FOR SERVICES" section of a table on how to recognise whether your service *is* recovery-oriented and on what it would take to fill in any gaps. These two pages operationalise the guidance's vision of treatment as a dynamic, goal-orientated movement, ideally towards sustainably drug-free treatment exit – the opposite of the 'parking' accusation then being levelled at opioid substitute prescribing services, envisaging de-energised, methadone-dosed patients making no further progress in their lives. If implemented, the table's recommendations would replace ad hoc service provision which may miss or be unable to capitalise on opportunities for progress, with services clear about their aims, which systematically monitor progress towards them, gear staff and programmes up to promote this progress, and reach out to other resources which can accelerate, broaden and solidify progress.

Note that the vision here is rather different from the maintenance/harm reduction vision which animated the Toronto clinic featured in the *Highlighted study* section below, and to the commitment to indefinite/long-term maintenance which characterised the most effective clinics in seminal US and Australian studies listed above (1 2). Whatever it is, a third seminal study listed above highlights the importance of having some kind of "rationale" for treatment to weave the strands into a coherent, goal-oriented programme – in the UK guidance, "A clear and coherent vision and framework for recovery that is visible to people in treatment, owned by all staff and maintained by strong clinical leadership."

Compare also the UK guidance's criteria for recovery-oriented opioid substitute treatment with the corresponding US criteria found on page 203 of a journal article listed above, based on pages 9–10 of a freely available report. Parallels are expected because this work influenced the UK guidance, but you may discern a

greater emphasis on community involvement and engagement in the US version and also on the patient co-directing their treatment and directing their recovery plan. Interesting too is the explicit US call to "ensure minimum (at least one year) and optimum (individualized) duration of treatment via focused retention strategies and assertive responses to early signs of disengagement" – a stronger commitment to long-term treatment than in the UK version, and from arguably the world's most respected thinker on 'recovery' in the addictions, a flat contradiction of visions of recovery which hinge on the earliest feasible treatment exit. Going in this respect further than the report, the journal article also offers a forceful repudiation of what recovery-oriented methadone maintenance may "stereotypically" be assumed to be, but "is not". The article is not freely available, so this passage is reproduced in the unfoldable supplementary text.

> Close supplementary text
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> "Recovery-oriented methadone maintenance is not, as some will stereotypically assume from its name, a call to: (1) raise the bar of admission to medication-assisted treatment programs, (2) set arbitrary limits on medication dosages or the duration of medication-assisted treatment, (3) impose pressure for patients in medication-assisted treatment to end their medication, (4) deny patients in medication-assisted treatment access to harm reduction information or services, (5) force counseling or peer support services on patients who do not need or want such services, (6) extrude patients who do not adopt the goal of full recovery, (7) deny patients access to other drug treatment modalities or recovery support services (based on the rationale that these services are now provided by medication-assisted treatment programs), (8) deny stabilized patients access to interim or office-based treatment, or (9) impose remission or recovery criteria on medication-assisted treatment patients different than the remission or recovery criteria applied to all individuals with substance use disorders."
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> Close supplementary text

In 2015, at the request of the UK government their official drug policy advisers on the Advisory Council on the Misuse of Drugs reviewed the issue addressed in the 2012 UK guidance, and looked for evidence that the guidance had been implemented. They found anecdotes only, indicative of a varied response "with some services not adopting a 'recovery approach', others trying … and some commissioners re-procuring services in order to push for a 'culture change'." While recognising these entailed a "higher risk of relapse, overdose and subsequent return to drugs and crime," the Advisory Council was concerned there was a deficit in "abstinence pathways" to recovery via detoxification and recovery support, both for patients presenting for treatment and those already in opioid substitute treatment.

But when for the Advisory Council's report, opioid substitute patients were asked what outcomes they thought services expected of them, their responses suggested a recovery orientation was common. Just under 8 in 10 said these objectives included coming off the treatment in the future, and the same proportion endorsed working towards being abstinent. Improved mental and physical health and good relationships with family/friends were about as prominent, and just over half each felt they were expected to train or volunteer, or to find work or come off benefits. Harm-reduction objectives too were prominent, but no more so than these elements of what is normally thought a recovery orientation. However, it seems from the patient's perspective, this effort was generally under-resourced. In the same survey, 64% felt they did not get enough psychosocial and recovery support, while only 22% felt they got enough.

Highlighted study An object lesson (listed above) from a methadone clinic in Toronto in Canada shows that a limited pot of money can be stretched to double the caseload by loosening up the programme and making it more flexibly patient-centred – very relevant in these relatively resource-constrained times. The changes took place in 1995 and 1996 at a clinic run by Ontario's highly respected clinical and research centre. The Effectiveness Bank analysis gives the essential findings and access to (at the time of writing) free sources for the two original papers.

In sum, at first the clinic's intake was capped to 100 patients. A long waiting list developed, but was rarely whittled down. Only 'high-risk' patients could be accommodated. The philosophy was described as "abstinence-based". From the description of how it changed, we can assume it: expected patients to rapidly cease illegal drug use; discharged them when frequent urine tests showed they hadn't; enforced long-term supervised consumption at the clinic; set doses with little reference to the patient in a largely arbitrary manner and capped them at 100 mg/day; and whether or not needed or desired, required attendance at counselling sessions.

After extensive consultations including with patient advocates, during 1995 and 1996 a patient-centred regimen was introduced which reversed or relaxed these constraints. Patients could decide whether they wanted counselling, had a greater say over doses (which were no longer capped), urine tests were cut down, more take-home doses were allowed, continued illegal drug use was treated as a sign more treatment was needed, not that it should end, and the clinic accepted goals short of abstinence from illegal drugs. More front-line doctors and therapists were employed, funded by budgetary and 'back-office' efficiencies, and integration of mental health and addiction treatment was considered a priority.

Check our analysis and you will see that patient numbers more than doubled, the waiting list was eliminated, the case-mix diversified to include users of opioids other than heroin, and average doses rose from sub-optimal (below 60 mg/day) to over 90 mg/day and the range widened, a sign of greater individualisation.

What were the consequences? Even when like-for-like patients were compared, allowing them to set their own pace in reducing illegal drug use did not mean more used 'on top'; within six months of starting treatment half the patients were no longer using illegal opioids. Patients also attended as many therapy sessions as when these were mandatory, doctors were seen more often, confrontations over continued illegal drug use could give way to potentially more productive interactions, and generally there were no signs that widening access and relaxing the regimen had attracted patients more interested in getting drugs than getting treatment. If you have explored the preceding cell of the matrix – cell C3 – you will not be surprised that greater user involvement in dosing and relaxing counselling and supervised consumption requirements did not affect outcomes.

Issues to consider and discuss

Ethos, dose, organisation: the three pillars of a pharmacological intervention An Australian study listed above painted a vivid picture of the 'characters' of three methadone clinics – their ethos and working environments – and related these to impacts on 304 patients documented through repeated interviews over a 12-month period. The 'characters' of the three clinics seem common and important prototypes, probably familiar to many who have visited or worked in methadone maintenance clinics. The by-line of the original study included several internationally respected Australian researchers, of whom one (James Bell) gave an account of the study in what at the time was and arguably still is the most informative book ever on methadone maintenance and allied therapies. His account supplemented the original research report with practice lessons from the findings, and is reproduced in the Effectiveness Bank entry, which also links to the freely available original research report.

Dr Bell deduced three success factors from his work, but implicitly there was another, higher order factor – that a service should have *some* guiding vision, whatever that might be. In all three clinics, treatment "was something of a ritual, with little clear rationale for what was occurring. The absence of a frame of reference for approaching methadone treatment was apparent, not just in the differences between the clinics, but in the interaction between staff and patients."

Of the three success factors, most fundamental is a "treatment" ethos. If that seems obvious, look at the description of the working style of clinic one: "businesslike … with little attention to 'treatment'." For the author, a treatment ethos is a "framework in which all interactions with patients are understood as part of the care of the individual. Thus issues of anger, conflict and acting out become part of the material being worked with, rather than an irritation or obstacle to the smooth running of the clinic."

This ethos in turn affects the second success factor – dosing strategies and levels. A treatment ethos entails a patient-centred, individualised approach to doses rather than blanket limits or blanket ambitions to constrain or reduce. In another of the same author's studies (listed above), it was partly through its impact on dosing that ethos seemed to affect heroin use, leading to more use when an abstinence orientation restrained dose levels. That may also have been one of the mechanisms in action before the reforms at the Toronto methadone clinic featured above as the *Highlighted study*.

Finally, the organisation of the clinic forms the third pillar of effective methadone treatment. For the sake of both patients and staff, treatment should be "Structured and well-organised … with clear rationale and objectives." Lack of organisation meant the study's clinic three "was chaotic", and despite usual dose levels, the dissatisfied patients had poor outcomes.

Over a decade later, in the USA similar implications emerged from a study listed above which in each of four

regions had paired a methadone clinic ranking high in adherence to clinical guidelines recommending relatively high dosing and intensive psychosocial services, with one which ranked towards the bottom of the range. Whether the guideline-adherent clinics would generate the best outcomes for their patients was the question, one answered in the affirmative. In the terms of the Australian study, the guideline-adherent clinics were more 'treatment-oriented' and also more organised and efficient, and they met more of the criteria for a 'recovery orientation' listed (see above) by a US authority on recovery.

The researcher in Australia also contributed to the evidence review behind the UK guidance featured under *Where should I start?* Look at the review and you will see that nearly two decades later, the factors identified by his study in Australia remained supported by the evidence and relevant to a recovery focus. Ethos, dose, organisation: do these for you remain the three pillars of an effective medication-based service, and in particular of methadone maintenance, and are they sufficient in themselves?

▸ **Is (even evidence-based) innovation always a good thing?** Generally evidence-based organisational change is assumed to be a good thing, and resisting it a sign of a moribund organisation unable or unwilling to improve. But one caution in Australian guidance listed above stands out: "Organisational change can be a significant source of stress and job dissatisfaction. The experience of instability and frequent change can result in 'change fatigue', characterised by cynicism and exhaustion in response to change initiatives." The advice is to allow staff to consolidate and recuperate by spacing out change efforts – advice given extra salience by the current upheaval in Britain in commissioning and service-provision structures and by recommissioning cycles which disrupt services every few years; to ladle yet more change on top risks being a step too far.

But what about the mantra of 'continuous improvement', adopted by the UK's Department for Business, Innovation & Skills? And the similar recommendation for substance use treatment programmes in particular from the US health department (see guidance listed above): "a commitment to continuous quality improvement ensures the program's ability to respond to future changes in the needs of the client population and community". Would 'taking breaks' leave organisations lagging in a fast-changing world? On the other side are the possible negatives of change, including a demoralised workforce in no position to do their best for patients.

Among the reasons why this matters is that the 're-moralisation' and optimism engendered by new ways of working which promise to make a difficult job more satisfying could be a major factor in the effectiveness of innovations. Optimism that you *can* help even in unpromising circumstances seems a significant influence promoting recovery. But if unwanted or burdensome change instead *de*moralises staff, the reverse effect on recovery seems likely. There is also the possibility that (again to quote the Australian guidance listed above) staff may be *right* to resist change: "Change that has little obvious benefit or connection to organisational goals is likely to be met with reluctance from workers."

How would you balance these seemingly contradictory imperatives? Continuous improvement, or slow down to avoid continuous disruption? Will introducing new ways to do better for patients re-moralise staff and engender optimism, or demoralise staff by seeming to denigrate their current practice and overwhelming them with demands to change?

Thanks for their comments on this entry to Michael Gossop and on an earlier version to James Bell, both of the National Addiction Centre in London, England. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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