DRUG & ALCOHOL FINDINGS *Matrix cell*

S Seminal studies **K** Key studies **R** Reviews **G** Guidance **MORE** Search for more studies
Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text

Drug Treatment Matrix cell E3: Treatment systems; Medical treatment

K Advancing recovery in US states (2012). In the US homeland of competition and private health care, it was cooperation and coordination which led to the introduction of new medications and innovations to promote continuing care – plus the exercise of regulatory and financial muscle and the salutary experience of senior staff who placed themselves in the patient's shoes.

K No use-reduction effect after detoxification from stimulants (2014). Free source at the time of writing. Australian study finds a typically five-day inpatient detoxification no more effective than no treatment at all at reducing methamphetamine use among dependent users, most of whom injected the drug.

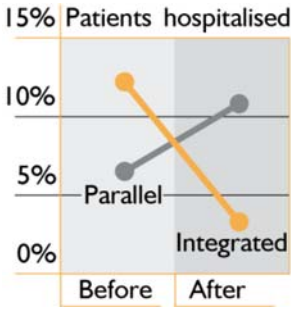
K Case management links detoxification to treatment (2006). Siting case managers there transformed detoxification services in to gateways to longer term treatment and reduced repeat detoxifications. The initiative was part of a broader 'recovery revolution' in Philadelphia. Transitioning detoxification patients to follow-on treatment is associated (2014; free source at time of writing) with fewer readmissions and may be dependent on the links clinics have to follow-on services. For discussion click and scroll down to highlighted heading. Related discussion also in cell A3.

K No need to start methadone in specialist clinic before transfer to primary care (2014). From France the first study to randomly allocate patients to start methadone maintenance either in primary care or at a specialist centre found primary care more attractive to patients, and no less effective at reducing street-opioid use and promoting engagement and retention.

K Commission to enhance adherence to clinical guidelines (2008). Two sets of US methadone clinics selected for high versus low adherence to clinical guidelines provided evidence that in everyday practice, the recommended high doses and intensive psychosocial services really do make the intended difference to substance use and perhaps also to other outcomes. Findings suggest that commissioning to strengthen adherence to guidelines will improve outcomes. More on dose and psychosocial services in cell cell C3.

K Dual diagnosis provision in England ([UK] Care Services Improvement Partnership, 2008). First national assessment for England of progress towards implementing the good practice guidelines set out by government in 2002. Regional reports also available. For discussion click and scroll down to highlighted heading.

K Integrated dual diagnosis teams help prevent crises (2006). Rare randomised trial of truly integrated substance use and mental health care for severely mentally ill problem substance users found these arrangements reduced the frequency of psychiatric and legal crises. Chart shows reduction in psychiatric admissions from before to the year after allocation to integrated versus parallel care. Related review below. For related discussion click and scroll down to highlighted heading.



R Build opioid treatment system on buprenorphine to minimise medication-related deaths (2015). In England and Wales from 2007 to 2012, per prescription the overdose death rate involving buprenorphine was one sixth that of methadone. Implication is that a treatment system built on buprenorphine will be safer – as long as it attracts and retains enough patients.

R Weak evidence for integrating addiction and mental health treatment (2013). Synthesis of research finds some evidence that integrating substance use and mental health treatment improves psychiatric symptoms and (in residential settings) drinking, but none of the slight advantages approached statistical significance, and only one of the studies assessed whether treatment truly was integrated. Study not included in review above. For discussion click and scroll down to highlighted heading. See also Effectiveness Bank hot topic on 'dual diagnosis'.

R Pay-for-performance systems an evidential leap in the dark (Cochrane review, 2011). Overview of reviews on financial incentives for healthcare professionals in general could find no evaluations which reported on patient outcomes. Also conducted under rigorous Cochrane procedures, a similar review (2011) but of individual studies found "insufficient evidence to support or not support the use of financial incentives to improve the quality of

primary health care". A review (2014) specific to drug and alcohol treatment could find "no peer-reviewed evidence that [pay-for-performance] … improves client outcomes post-treatment". Discussion in cell E2 and related discussion below – click and scroll down to highlighted heading.

R G Methadone maintenance as spine of a recovery-oriented treatment system (2012). From authoritative US recovery advocate William White, a humanistic interpretation of what makes an opioid maintenance treatment system recovery-oriented, including features of the treatment and its links with the community and other services. Based on freely available monograph (2010). For discussion see cell D3.

G Commissioning for recovery ([UK] National Treatment Agency for Substance Misuse, 2010). From what was England's special health authority tasked to improve the availability, capacity and effectiveness of drug misuse treatment, guidance for funding authorities on how to construct a local pattern of services.

G UK consensus on medications as a route to recovery ([UK] National Treatment Agency for Substance Misuse, 2012). How medications fit into a treatment system oriented to long-term recovery. While protecting the gains of the harm-reduction era, attempts to show that methadone maintenance and allied treatments can be part of the recovery agenda, despite that agenda's associations with abstinence from all drugs (no methadone) and with leaving treatment (no or curtailed maintenance).

G Opioid substitute prescribing and recovery-oriented treatment in Scotland (Scottish Drug Strategy Delivery Commission, 2013). Expert group's vision of what a recovery-oriented treatment system should look like, progress towards it in Scotland, and the role of methadone maintenance and allied treatments within such a system.

G Integrated care for substance users in Scotland (Report produced for the Scottish Advisory Committee on Drug Misuse, 2008). Guidance on how to construct a treatment system that combines and coordinates all the services required to meet the assessed needs of the individual. Includes care pathways and responding to mentally ill patients. For related discussion click and scroll down to highlighted heading.

G Expert advice on commissioning drug and alcohol treatment ([UK] Joint Commissioning Panel for Mental Health, 2013). Co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists, a collaboration of leading organisations and individuals with an interest in commissioning mental health services explains the rationale for and offers practical advice on commissioning effective addiction services. For discussions click here and here and scroll down to highlighted headings.

G Build opioid treatment system on maintenance (World Health Organization, 2009). Unequivocal backing from UN agencies for methadone and other long-term maintenance treatments as the prime modalities treating dependence on heroin and allied drugs. In contrast, says the report, detoxification results in poor long term outcomes. Related discussion in cell A3.

G Pharmacy-based services for drug users ([UK] National Treatment Agency for Substance Misuse, 2006). Commissioning pharmacy services to contribute to treating and reducing harm from problem drug use.

G What UK specialist addiction doctors should do and be able to do ([UK] Public Health England, Royal College of Psychiatrists, Royal College of General Practitioners, 2014). Guidance for commissioners and others from body overseeing addiction treatment in England and from UK professional bodies on the part addiction specialists are expected to play in promoting recovery and the importance of retaining their expertise in the sector.

G How to assess the performance of specialist doctors ([US] American Society of Addiction Medicine, 2014). Criteria designed to be used as the basis for local reimbursement and quality-control systems which evaluate performance against the standards ([US] American Society of Addiction Medicine, 2014) expected of specialist addiction physicians. 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). The 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 mentally ill substance users, and their care should be led by the mental health service. Another NICE guideline has dealt specifically with psychosis and substance use. See also earlier guidance ([UK] Department of Health, 2002). Related review and study above. For discussion click and scroll down to highlighted heading.

MORE Search for all relevant analyses or for sub-topics go to the subject search page or hot topics on commissioning and dual diagnosis.

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- Comment/query to editor
- Suggest a new document to add to this cell
- Return to/go to Drugs Matrix
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Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text

What is this cell about? The roles of medical services and interventions within treatment systems implemented across an administrative area; in particular, their role in creating an effective and cost-effective mix of services which offers patients/clients attractive access points and appropriate options for 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: assessing the need for different kinds of services; 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.

Research on these functions is rarely of the 'gold standard' randomised-controlled-trial format, and work focusing on medical services is rare, but we can fall back on the studies and reviews in cell E2 which deal with the same topic across drug dependence treatment systems as a whole.

Where should I start? Perhaps with guidance listed above from the Joint Commissioning Panel for Mental Health, a collaboration led by England's colleges for general practice and psychiatry. Published in 2013, it offered commissioning advice geared to the recovery and outcome-funding era, taking into account England's national drug strategy, guidance and standards from NICE, the UK's health intervention assessors, an expert consensus for the UK on medications as recovery aids (listed above), and guidance for England (listed above) on commissioning for recovery.

For the Joint Commissioning Panel, commissioning should be "outcome based" and "recognise recovery as central". They also boldly specified what in their opinion a good drug and alcohol service would look like – of which more below.

Highlighted study Listed above is our account of a simple idea from Philadelphia, noted for the recovery-oriented transformation of its treatment system. The issue was how to make the most of the city's detoxification centres, whose patients typically experienced multiple overlapping drug problems. Usually these involved cocaine, alcohol, and cannabis, though around a third were using heroin.

The problem was that all too often detoxification was an isolated episode of care followed by relapse and then repeat detoxifications. The solution was to site clinical case managers at the centres to make contact with patients who had been cycling repeatedly through withdrawal, seemingly getting nowhere in terms of sustainably overcoming dependence. Case managers sought to motivate these patients to complete detoxification and (for at least a year) offered to guide and support them through the follow-on services needed to sustain their recovery. The effect was to transform these revolving-door patients into patients with typical treatment admission patterns. Benefits were apparent across the entire caseload of the detoxification centres in increased capacity (the number of patients treated rose by well over a half), a halving in the proportion of admissions accounted for by repeated detoxifications, and an increase in successful referrals to longer term care.

The authors explained why their results mattered not just from a clinical perspective, but also from a health systems management perspective: "… repeated use of these expensive acute-care services was a major source of system inefficiency. Moreover, because detoxification and stabilization is a necessary first step for most publicly supported patients in their treatment episodes and some of these scarce detoxification beds were being re-occupied multiple times by a small group of [multiple-detoxification] patients, this inefficient, expensive utilization of the system had the additional perverse effect of reducing treatment access for other patients."

This simple tactic offers one way to make a reality of the continuing care advocated by experts convened by UK medical colleges (listed above), seen as an essential element of recovery-oriented treatment which matches the chronic nature of the kinds of dependence/patients who present to treatment services. It would also improve a treatment system's standing on the single performance measure recommended by (section below) the American Society of Addiction Medicine.

Issues to consider and discuss

What would a good quality drug service look like? Coming as it does from a heavyweight collaboration led by England's colleges for general practice and psychiatry, a portrait painted in 2013 of what commissioners should look for in a drug (and alcohol) treatment service is not to be taken lightly. Take a look at the specifications on page 14 of the report listed above. Note that the list is subheaded, "Key components of a good quality service"; presumably the experts saw these as the *minimum* needed to justify a 'good quality' tag. On the following page you will find their recommended "Model of service delivery and core principles," including: comprehensive assessment of patients' needs going well beyond substance use problems; NICE-recommended substance use interventions and broader intervention to safeguard children and vulnerable adults and promote the welfare of carers and families; and assuring a competent and appropriately qualified workforce.

Is this also your vision of what quality consists of? It might help to look at the alternative set of criteria listed above (turn to pages 15–16 of the document) selected by a US expert panel as feasible, scientifically valid and unlikely to have unintended adverse consequences. Among the list are 'process' and 'context' measures like screening for related complaints and the proportions of patients prescribed medication and followed-up after detoxification. The effectiveness of these measures is assessed by a single 'performance' measure – the proportion of patients readmitted within three months of discharge for a further episode of inpatient or residential care. It was selected as an easily collected indicator of relapse or complications after initial treatment, interpretable as a direct outcome of poor coordination of services and/or an indirect outcome of poor continuity of services. Reducing this kind of readmission was the aim in the *Highlighted study* discussed above from Philadelphia.

Discuss with colleagues, size up existing services in your area against these criteria, test them against your experience of what makes for a good service. Here are some starter questions. Are these the attributes to be expected of each individual service, or (perhaps more realistically) of the local service network? Can we specify what constitutes a good quality service in isolation from the local service and case-mix context? Could good quality in one area be poor in another? Is this vision universally applicable, or particular to a certain kind of service – the "specialist integrated" teams staffed by "professional health and social care staff" which the English report (page 15) sees as the best model for addiction treatment? Do you also see a specialist, professional, and multidisciplinary team as the ideal? What of the GP-led services which in the national English NTORS study matched specialist clinics for outcomes?

The report's focus is on professional competence – obviously essential for safety, but is it a driver of recovery? Look back at the cell B3's bite on practitioners in medical treatment. There we cite this advice from a review of why patients do better with one clinician than another: "Select and evaluate clinicians based on their 'track record' … assumptions that levels of training, experience, or other simple therapist variables could account for such differences [in effectiveness] does not hold." In the same cell the *Highlighted study* section notes that the varying progress made by the patients of different methadone service counsellors could not be accounted for by their qualifications. Important instead were being administratively well organised and diligent, and building on this by being actively problem-solving and therapeutic.

Following the lead given to evaluate practitioners by their track records, why not do the same for whole services, and simply recognise what is or is not a good quality service by how well its patients do, regardless of what the service does or how it is staffed? That sounds very simple, but the (see documents listed above) reality has proved complicated and of unproven value.

Are we making progress on systems for treating 'dual diagnosis'? According to commissioning advice for the UK from medical experts (discussed above), one sign of a high-quality substance use service is that it can "manage the full range of complexity of need, including … mental and associated physical health needs".

But back in 2002 official UK guidance listed above stressed that when mental health problems are severe, care "should be delivered within mental health services," which "have a responsibility to address the needs of people with a dual diagnosis". In 2011 and again in 2016, guidance from NICE listed above echoed that advice. Yet when assessed in 2007, mental health services in England had not been able to adequately gear up for problem substance users among their caseloads; the guidance might have made sense in theory, but in practice it was not working out.

Britain is not alone in finding this an intractable task. In 2013 a review listed above of international research

on treating serious mental illness and substance use sounded a "Mission impossible" warning in its title, explaining that "Treating adults with severe mental illness and substance use disorder has been considered 'mission impossible' [exemplifying] the challenges consumers confront in obtaining treatment for both disorders concurrently." "Yet the challenge must be met," was the next sentence, alluding to the high degree of overlap between these conditions, and the serious consequences of failing to respond effectively to their co-occurrence.

At a micro level, some of the reasons why the challenge is so steep became apparent in interviews with mental health nurses in the south of England. Despite their experience in working with substance using clients, that word 'impossible' – so prominent in the review – was also a prominent theme in their responses, prompted by a perceived lack of skills and support in the face of a hard-to-treat population: "Working with people who have a dual diagnosis was thought to be hard, not often rewarding and often seeming like an impossible challenge." Why "impossible"? Among the reasons were that "Clients were hard to engage and often appeared helpless and lacking in hope. Many clients are reluctant to accept help. Dually diagnosed people required long-term commitment in order to build trusting relationships and to establish enough contact with them over time. Community mental health nurses felt that they never had enough time to achieve their goals of care."

This is (see cell D2 of the Alcohol Treatment Matrix) a classic situation in which training is unable make a difference, the finding in a study in London published in 2007 of dual diagnosis training for mental health staff. Though mental health case managers had attended at least four days of a five-day course and been offered monthly supervision, their patients could not be shown to have further reduced their substance use or required less follow-up hospital care.

These studies date from several years ago. Are things better now – do substance users find welcoming and effective care in mental health services? For problem drinkers, a survey conducted in England in 2014 suggests that the "failure to meet the needs of the dually diagnosed" remains, and may be worsening because mental-health budgets have been cut and services are now commissioned separately from substance use services.

In 2015 Professor Liz Hughes, who has extensive clinical and academic experience in mental health, substance use, and dual diagnosis, gave her verdict under the banner, "The NHS is failing people with mental health and substance use problems." Things were, she warned, no better now than in the 1990s, and in some ways worse. Again, budget cuts and commissioning processes and structures were in the firing line: "Since the localism agenda of the coalition government, and now the Conservative government, and the cuts to government central budgets, many of the national programmes have disappeared. This is further complicated by the almost complete transfer of substance use services to the third sector and the absence of mental health staff in these new services. Currently dual diagnosis work is based on a postcode lottery, and is piecemeal at best."

Faced with this persistent and potentially highly costly inadequacy, should we change tack and help substance use services take a more prominent role in aiding mental health services, perhaps even skilling up to themselves deal with the psychiatric problems so common among their caseloads? Or would that be counterproductive and possibly dangerous in cases of severe illness? What can feasibly be done to help mental health services welcome and offer an appropriate response to patients whose condition is complicated by counterproductive substance use? Was NICE right to so firmly close the door ("Do not create a specialist 'dual diagnosis' service") on special services integrating substance use and mental health? Is the task really so impossible, or are we just not prepared to do what it takes to overcome the challenges? The issue of how to deal with these crossover patients just does not seem to go away.

Close Matrix Bite