Drug Matrix cell E3: Treatment systems; Medical treatment

S Seminal studies | K Key studies | R Reviews | G Guidance | MORE Search for more studies

K Advancing recovery in US states (2012). Implementing medication-assisted therapies required regulatory, financing and contractual levers to overcome staff resistance.

K Case management links detoxification to treatment (2006). Siting case managers at detoxification services transformed them in to gateways to longer term treatment, part of a broader 'recovery revolution' in Philadelphia. Link is to Findings analysis; original article also freely available.

K Dual diagnosis provision in England ([UK] Care Services Improvement Partnership, 2008). First national assessment for England of progress towards implementing government guidelines. Regional reports also available.

K No impact of dual diagnosis training for UK mental health workers (2007). Tests guidance that mental health teams should lead care of dual diagnosis patients. Found no evidence that training staff to deliver integrated dual diagnosis care improved substance use outcomes for psychotic patients. Article freely available.

K Truly integrated dual diagnosis care does work (2006). Rare test of truly integrated substance use and mental health care for severe mental illness found it reduced the number of subsequent psychiatric and legal crises.

R Link methadone maintenance with recovery resources (2010). Review and guidance on reorienting methadone maintenance to recovery objectives from leading US author; includes enhancing treatment's benefits through linking to/developing community resources, plus local campaigns and advocacy to reduce stigma and generate support for methadone programmes.

R Inconsistent benefits from integrated mental health/substance use treatment (2013). Meta-analytic synthesis of US studies finds integrated treatment modestly helps resolve psychiatric symptoms, but alternative treatments focused on this issue are more effective in reducing drug use, especially when delivered in outpatient settings. Only one of the studies assessed whether treatment truly was integrated.

R Paying health professionals to do better (Cochrane review, 2011). Some evidence that financial incentives for workers or provider organisations can affect processes of care, but no evidence of improved patient outcomes. Reviewed studies not specific to substance use. Similar message from review (Cochrane review, 2011) of paying primary care doctors or teams. None of the smoking studies found payment led to significantly more patients giving up, including this German study (2007) which paid GPs for each patient no longer smoking 12 months later.

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

G UK consensus on medications as a route to recovery ([UK] National Treatment Agency for Substance Misuse, 2012). UK clinical consensus, including how medications fit in to an overall treatment system oriented to long-term recovery.

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

G Integrated care for substance users in Scotland (Report Produced for the Scottish Advisory Committee on Drug Misuse, 2008). Treatment system guidance including care pathways and dual diagnosis.

G Guidance for commissioners from British medical colleges ([UK] Joint Commissioning Panel for Mental Health, 2013). Collaboration of leading organisations and individuals involved in commissioning for mental health offers practical advice on commissioning effective and efficient drug and alcohol treatment services. Group was led by England's Royal College of General Practitioners and the Royal College of Psychiatrists.

G Pharmacological treatment of opioid dependence (World Health Organization, 2009). Recommends that opioid maintenance (eg, using methadone) should form the backbone of treatment systems for addiction to opiate-type drugs like heroin.

G Pharmaceutical 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 Systems for treating mentally ill problem substance users ([UK] Department of Health, 2002). Key message is that mainstream mental health services should lead on treating 'dual diagnosis' patients, coordinating care with specialist substance misuse services. Later reiterated in guidance ([UK] National Institute for Health and Clinical Excellence, 2011) issued by NICE specific to substance using psychotics.

MORE This search retrieves all relevant analyses.
For subtopics go to the subject search page and hot topics on commissioning and dual diagnosis.

Matrix Bite a commentary on this cell from the cell-by-cell Matrix Bites course funded by the Society for the Study of Addiction

Click underlined text to highlight text/link in cell

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: 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. Work focusing on medical services is rarer still, but we can fall back on the studies and reviews which deal with similar issues across drug treatment, to be found in cell E2

Where should I start? Perhaps with this recent guidance from a collaboration led by England's general practitioner and psychiatry colleges. It offers commissioning advice geared to the recovery and outcome-funding era. Among other reports it takes in to account the current national drug strategy for England, NICE guidance and standards, the latest UK expert consensus on medications as recovery aids in drug addiction, and guidance for England on commissioning for recovery. Commissioning should, said the expert group, 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 Here's a simple idea from Philadelphia, noted for the recovery-oriented transformation of its treatment system. The study was concerned with Philadelphia's detoxification centres, whose patients typically experienced multiple drug problems, usually cocaine, alcohol, and cannabis, though around a third were problem heroin users. The issue addressed was that too often detoxification was an isolated episode of care followed by relapse and then another detoxification. The attempted solution was to site clinical case managers at the detoxification centres and task them with contacting 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 initiative transformed these revolving-door patients in to 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 proportions of admissions accounted for by repeated detoxifications, and more successful referrals to longer term care following detoxification. This simple tactic offers one way to make a reality of the continuing care advocated by experts convened by UK medical colleges and now seen as an essential element of recovery-oriented treatment which matches the chronic nature of the kinds of dependence/patients seen by treatment services.

Issues to think about

▶ **What would a good quality drug service look like?** The vision presented in this report of what commissioners should be looking for in a drug (and alcohol) treatment service is not to be taken lightly, coming as it does from a heavyweight collaboration led by England's general practitioner and psychiatry colleges. Take a look at the specifications on page 14 of the report. Note that the list is subheaded, "Key components of a good quality service". The experts presumably saw these attributes as the *minimum* to justify a 'good quality' tag. On the following page of the report you will find their recommended "Model of service delivery and core principles." Take a look at both. Is this also your vision of what a treatment service should look like and how it should work?

You could discuss the criteria with colleagues and benchmark services in your area against them, checking whether the criteria seem relevant and appropriate. Here's some suggested starter questions: Are these the attributes to be expected of each individual service, or (perhaps more realistically) of the local service network? Services which meet these criteria can be expected to deliver good outcomes for patients, but why not simply recognise what is or is not a good quality service by how well its patients do, regardless of how it is organised and staffed? 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 a universally applicable vision, or one particular to a certain kind of service – the "specialist integrated" teams staffed by "professional health and social care staff" which the 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? Of course, medical competence is essential, but is it a driver of recovery? Look back at the 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 patients of different methadone service counsellors could not be accounted for by the counsellors' qualifications. Important instead were being administratively well organised and diligent, and building on this by being actively problem-solving and therapeutic.

▶ **Are we making progress on systems for treating 'dual diagnosis'?** According to commissioning guidance from UK medical and other experts (see *What would a good quality drug service look like?*), one sign of a good 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 stressed that when the mental 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 NICE echoed that advice. Yet we know that when assessed in 2007, mental health services had not been able to adequately gear up for problem substance users among their caseloads. At a micro level, some of the reasons why became apparent in interviews with mental health nurses. Though experienced in working with substance using clients, to them these patients often seemed to pose an "impossible challenge" for which they lacked both skills and support. In this organisational context (see *Where should I start?* in Alcohol Matrix cell D2), training the individual workers may not lead to improved practice and outcomes, the finding in a study in London which tested a substantial training and supervision investment in dual diagnosis for mental health case managers. Are things better now – do substance users find welcoming and effective care in mental health services? Should substance use services take a more prominent role in aiding mental health services, perhaps even expanding their remit and skilling up to themselves deal with the severe psychiatric problems so common among their caseloads? Or would that be counterproductive and possibly dangerous in cases of severe illness? The issue of how to deal with these crossover patients just does not seem to go away.

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