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Substance use treatment as part of a 'wrap-around' package of care

In the 'austere' UK financial climate, it seems unclear whether treatment services will be forced to bunker down and focus on substance use objectives, or instead be supported to expand into holistic providers of, or gateways to, the range of psychosocial services demanded by government reintegration and recovery agendas. Given the typically multiple, severe, and overlapping problems presented by treatment caseloads, it seems obvious that a holistic approach would help get patients back on a stable (recovery) footing, and similarly obvious that *just* focusing on substance use objectives would be setting some patients up to fail. Could 'wrap-around' care be the answer, and should treatment services have the flexibility to determine the extent to which this would be implemented in practice, or would this risk a lottery of comprehensive care?

In 2013, Scottish guidance called for addiction treatment patients to have access to a full range of psychological and psychiatric services, as well as services addressing employment and housing needs – reflecting understandings of wrap-around care as "psychosocial services that treatment programs may provide to facilitate access, improve retention and address clients' co-occurring problems". Although in England expectations have been similar, a survey of treatment services conducted in 2014 suggested that funding constraints had led both to a cutback in core services *and* the retraction of health, employment and education provision.

UK guidelines for the clinical management of drug misuse and dependence were updated in 2017, featuring a more explicit focus on individually-defined recovery journeys than previous versions, including an enhanced focus on keyworking and care planning that can integrate support for pharmacological and psychosocial interventions, peer engagement, and mutual aid. To address comorbid mental health and substance use problems specifically, the guidelines said that "suitable interventions [would be] needed for substance problem(s) in all mental health services, and for mental health problems in all substance misuse services, with competent staff available to deliver such interventions".

The flexibility of wrap-around care was described in the guidelines, with reference to three models of implementation:

> • **Integrated model:** Where feasible, it may be best to provide comprehensive care in one service. Almost all treatment services should have the capacity/ability to provide information, advice, and basic motivational skills. More specific interventions could be delivered by bringing in suitably skilled workers, particularly for patients who are unable or unwilling to engage with more than one service.
> • **Parallel model:** In more complex cases of comorbidity, where there is need for additional specialist interventions, such provision may only be practical as additional treatment from a specialist substance use or mental health treatment service. However, the emphasis should still be on adequate collaboration, good communication and "ensuring patients do not fall between gaps".
> • **Sequential model:** Sometimes treatment services may prioritise the treatment of one disorder over another until the first can be successfully stabilised. In the case of co-occurring mental health and substance use problems (where there is a recognised reciprocal relationship), this approach is not normally recommended. Untreated disorders can potentially limit the effectiveness of treatment for other disorders. Initial timing of treatment may be affected by the current severity and stability of one or other disorders.

In 2012, expert guidelines on drug-based treatments for addiction envisaged a division of labour which saw treatment services focusing on addiction treatment, and liaising with other services to help patients with needs such as relationships, work, life skills, and housing. Though perhaps more realistic to expect than fully integrated services, this model of joint working or coordination can still be challenging to implement, and leaves organisations with the perennial problem of how to ensure access to services for their clients when they are not provided by and/or at the addiction treatment service – explored in an Effectiveness Bank hot topic in the context of patients' dual mental health and substance use needs.

Seemingly supporting the philosophy of wrap-around care, was a study funded by the US government's drug misuse agency, which had previously asserted that "Effective treatment attends to multiple needs of the individual, not just his or her drug abuse," including any associated medical, psychological, social, vocational, and legal problems. Analysts amalgamated relevant studies, and calculated for each how many more 'ancillary' services were provided to patients than those in comparison groups. Though this could not determine whether clients' needs were actually addressed, the greater the number of additional services, the greater the scope for patients in focal treatments to receive extra services matched to their needs. From over 236 comparisons, each additional service was associated with a small but statistically significant further reduction in drug use.

A major US study found that for patients most in need of ancillary services – in particular vocational and housing aid – receiving this help also helped them control their illegal drug use. A more stringent test was conducted in Philadelphia, where the directors of four private drug and alcohol services were asked to provide at least three professional vocational, family or psychiatric services to randomly selected clients with severe problems in these areas. Other clients with such needs received standard treatment. For these employed, privately insured patients, responding to need in this systematic way improved treatment retention and completion rates, and six-month outcomes in the targeted areas, as well as reducing arrests and the need for further treatment. This was a particularly stringent test because there was nothing stopping the other clients also receiving these services (which were available from service staff on-site) and many did, but to a lesser degree. However, the researchers cautioned against generalising their findings to other groups.

Among the most widely cited of addiction treatment studies, the classic 1999 trial at US methadone services suggested that only modestly increasing availability of counselling bought more abstinence per dollar than universally offering frequent daily access plus other services. Together these US studies suggest that targeting extra services only at those most in need will maximise cost-effectiveness without sacrificing benefits for patients less in need.

Targeting or matching services to needs is perhaps easier to accept than to implement – how do services routinely find out what their clients need, and then respond with appropriate services? We have one solution from Philadelphia, where intake assessments of patient needs were largely perceived as 'redundant paperwork', and led nowhere in terms of meeting those needs – until those assessments were linked to a computerised guide to local welfare and medical services, when they were transformed into a practical route to obtaining services matched to needs. The result was that treatment completion rates doubled. A more elaborate and extended version of a 'needs-services matching system' was also trialled in California. This carefully worked out strategy offered an unusually fully developed model for promoting recovery and judging the outcomes achieved by a service in the light of its patient profile.

Just as national policy and treatment services may aspire to holistic recovery, the ambitions of patients are not narrowly substance-focused. When asked what constitutes a good quality of life, the accounts of patients like those on methadone in Belgium are no different from those of the general population: satisfying social relationships, good psychological well-being, an occupation, being independent, and having a meaningful life.

But even where wrap-around service provision is strongly endorsed by a national government, in practice provision may fall far short. The US National Institute on Drug Abuse recommends a comprehensive treatment programme for people with substance use disorders, covering: health, mental health, HIV/AIDS, child care, education, vocation, family counselling, housing, transportation, finances, and legal needs. However, in 2016 a US study found that on average centres offered fewer than half of the wrap-around services endorsed. Client characteristics were significant predictors of wrap-around provision. The greater the proportion of adolescent clients, the more likely there were to be educational services, and the greater the proportion of female clients, the more likely there was child care. The proportion of clients referred from the criminal justice system, on the other hand, was negatively associated with the provision of multiple wrap-around services. Similarly, a nationally representative sample of 217 US community-based treatment programmes serving predominantly criminal offenders revealed that the average

number of wrap-around services was low, leaving offenders at risk of not receiving the services they need to succeed in treatment and establish crime- and drug-free lives, particularly child care and legal and housing assistance.

Women's substance use outcomes are known to be improved when treatment is delivered alongside services tailored to their specific (gendered) needs, for example child care, domestic abuse, employment, and mental health. From the above study, female offenders re-entering the community were likely to have access to more services if they went to women-specific treatment programmes. However, this seemed to be because such services tended to be larger in size, support rehabilitation, and offer a greater number of treatment approaches. When all the influences were taken into account together, it was these factors which remained associated with broader service provision. The authors speculated that larger organisations may be a prime location for the adoption of wrap-around services because of the presumed greater likelihood of there being 'slack' (extra) resources – time or money – which could be used to deliver training for new services (eg, HIV-testing), and to write applications for funding additional services (eg, provision of on-site child care).

The high prevalence of smoking among people in substance use treatment has led to repeated calls for integrating smoking cessation treatment into this setting, but numerous organisational barriers – limited training, inadequate resources, and cultural norms that don't recognise smoking cessation as part of the organisation's mission – have prevented it from happening on a wide scale. Smoking cessation services are more likely to be available in medically-oriented treatment settings, those offering other wrap-around services, and (again) larger treatment programmes. Greater size could be an indication that organisations have resources that can be directed toward implementing services beyond their core mission – which could help to account for the positive correlation between organisations offering a broader array of wrap-around services and tobacco treatment – but it could also be that in services with more clients, the ancillary needs are seen in enough clients to make it worth making specific provision for them rather than treating each on a case-by-case basis.

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