DRUG & ALCOHOL FINDINGS *Matrix cell*

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Alcohol Treatment Matrix cell E2

Treatment systems; Generic and cross-cutting issues

Seminal and key studies on local, regional and national systems for effectively and cost-effectively providing treatment. Explores whether payment by results stifles patient-centred practice or stretches services beyond comfort zones, the surprising results of a randomised trial of service-improvement mechanisms, and the multiple answers to how many drinkers should be in treatment. See the remaining four cells in row 2 of the matrix for more on generic features of medical and psychosocial therapies.

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

S Organise chronic care for chronic conditions (2002; alternative free 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 and judging services on how the patient fares *during* treatment, not after they leave. For the benefits of continuing care see cell A2 and how to organise cell D2. For related discussion in this cell click and scroll down to highlighted heading.

K Need for alcohol treatment in England (prepared for Public Health England, 2017). Estimated that nearly 600,000 adults in England were dependent on alcohol in 2014/15, implying that the treatment caseload was equivalent to 19% of the in-need population. For similar estimates for Scotland see a technical report (prepared for the English Department of Health, 2016) from the same research team and a needs assessment (NHS Health Scotland, 2014) from the Scottish NHS. For discussion click and scroll down to highlighted heading.

K Local area strategies in England lack vision, clarity and commitment ([UK] Department of Health, 2011). When from 2006 to 2011 government alcohol policy support teams made more than 480 visits to local strategic partnerships, they found improving attempts to promote public health through alcohol-related interventions, but attempts which were often muddled and uncoordinated and lacked consistent commitment.

K What the treatment system feels like for the patient (2015). Interviews with patients being treated for problem drinking at an NHS addiction service in England revealed that for them the treatment journey was often "fragmented, with input from a number of different staff in different settings and an overall lack of clarity around the role and remit of each".

K Randomised trial proves that bedside outreach can dramatically improve continuity of treatment after detoxification (2018, free source at time of writing). In Denmark engagement in long-term treatment virtually doubled from 24% to 47% when a nurse from the outpatient alcohol treatment clinic met detoxification patients at the hospital to explain the importance of outpatient treatment, present an 'attendance contract', and offer a first appointment, helping to transform an acute-care episode into a programme which could tackle the roots of the problem.

K Service improvement system helped extend access to and retention in treatment (2008). US NIATx programme halved waiting times and extended retention partly by fostering a self-sustaining improvement network linking treatment services and a performance assessment 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'. These studies showcase the gains possible when a central authority engages services in its quality-improvement mechanisms. Related NIATx study and web site listed 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 promoted by the US NIATx quality-improvement resource (referred to in the listing below of their web site). 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 'coach'. Related NIATx study listed above and web site below. For discussion click and scroll down to highlighted heading.

K Independent evaluation of English payment-by-results schemes finds no overall benefits and increased costs (2017). In England from 2012 the government piloted eight schemes which paid substance use treatment services for achieving desired outcomes, evaluated in this study by comparing changes in scheme versus non-scheme areas from two years before the schemes started to the following two years. It found no overall benefit but some rebalancing to treating alcohol patients as opposed to users of illegal drugs, and even for alcohol patients the key recovery indicator of successful treatment completion and no return within a year appeared adversely affected and costs increased. Similar

results in government report ([UK] Department of Health, 2013) on the schemes' first year. Related US study and review below. For discussion click and scroll down to highlighted heading.

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 did just 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 Embed recovery from addiction in the community (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*", shifting the focus from the treatment clinic to the surrounding social systems within which the patient must eventually reshape their life. For discussion click and scroll down to highlighted heading.

R Evidence for key features of a recovery system ([US] Substance Abuse and Mental Health Services Administration, 2009). Turn to chapter 7 starting page numbered 22 for evidence for key elements of recovery-oriented systems of care for problem substance use, including continuity of care anchored in the community and delivered by an integrated network of services centred on the individual's need. See also associated implementation case studies ([US] Substance Abuse and Mental Health Services Administration, 2009). 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 in the UK and the USA set out the options for improving treatment systems. For related 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 outcomes after treatment for problem alcohol or drug use. Part 2 makes recommendations for service planning and commissioning which may be applicable to the UK. Related UK and US studies above. For discussion click and scroll down to highlighted heading.

G Evidence-based principles for commissioning alcohol treatment systems in England (National Institute for Health and Care Excellence, 2011). From the UK's authority on medical and social care, organising and procuring treatment services across an area which implement national guidance and satisfy policy requirements. Reflected in associated quality standards (National Institute for Health and Care Excellence, 2011) and incorporated in more nuts-and-bolts guidance from Public Health England listed below.

G Practical guidance on commissioning integrated alcohol harm-reduction systems in England (Public Health England, 2018). Key strategies and action-prompts for developing an integrated local system to reduce alcohol-related harm, including treatment services which meet NICE standards. One of a suite of commissioning guidance and resources. Supported by 'return on investment' resources (Public Health England, 2016) enabling commissioners to estimate the social benefits of various interventions and their impacts on performance indicators. See also associated guidance (Public Health England, 2019) for strategic planners and commissioners.

G Scottish Government on what 'quality' consists of in substance use service provision (Scottish Government and Convention of Scottish Local Authorities, 2014). Aims to ensure commissioning of integrated service delivery of sufficient quality to meet the needs and aspirations of a local population. An evaluation ([Scottish] Care Inspectorate, 2017) judged that these principles "are being embedded and beginning to show some impact in more person-centred treatment, care and support"; summaries remain available (1 2). See also earlier guidance (produced for the Scottish Advisory Committee on Drug Misuse, 2008) on implementing an integrated care system, which includes action points to inform development of a plan to address local weaknesses or gaps.

G Impact of funding cuts on commissioning substance use services in England ([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, "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 a survey (2017) of treatment services in 2016–2017 which found "worrying signs that damage has already been done and the capacity of the sector to respond to future cuts has been eroded". For related discussion click and scroll down to highlighted heading.

G Organising to address problem drinking in NHS hospitals (undated). Guidance and advocacy from London's Health Innovation Network on the steps that need to be taken in NHS hospitals to tackle alcohol-related harm, including commissioning and models for service delivery systems.

G Case studies of how local areas in England reorganised to create more responsive and engaging alcohol services ([English] Local Government Association, 2019). From the body representing the local authorities responsible for substance use services in England, practical examples of how their members have reorganised local treatment systems in diverse ways to better meet the needs of their populations.

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 US system-change resources ([US] NIATx, accessed 2020). Web-based service provided by the University of Wisconsin offering practical strategies for commissioners and planners to promote quality-improving change across a treatment system, including engaging services in mutual learning and support, a tactic tested in a study listed above. Objectives include reducing waiting times and improving retention (example study listed above) and increasing admissions and reducing 'no-shows'. For discussion click and scroll down to highlighted heading.

MORE Search for all relevant Effectiveness Bank analyses or search more specifically at the subject search page. Also see hot topics on evidence-based commissioning and recovery as a treatment objective, and William White's on-line library of papers related to recovery-oriented systems of care.

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- ▶ Comment/query
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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? 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 services or re-tendering; 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 are just two in this cell: 1 2). 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 establishing which (if any) of the measured influences was cause, and which effect.

Applicability of evaluation research to the real world is always a concern, but one sharpened in the current era by the fact that rather than 'getting better', services are focused on 'getting by'. In this context, evidence and evidence-based guidelines may not be able (report listed above) to adequately influence practice. Research may, for example, indicate the desirability of local treatment systems being able to detoxify patients in hospital if needed and refer them to the shelter of a residential facility to solidify their recovery, but in 2017 a survey of alcohol services and alcohol-involved professionals in England found most could not say there was sufficient local access to these services. The main reason was the squeeze on funding: "In comments, respondents repeatedly said there was simply no money, especially for [rehabilitation] services." The same year a survey of substance use services in England warned that "the capacity of the sector to respond to further cuts has been seriously eroded". Instead of targeting the "comprehensive and high quality services" needed to actualise the government's recovery agenda, service providers were concerned about being able to maintain the basics of "safety and quality in an environment where the pace of change has not yet steadied".

Where should I start? William White's monograph (see our analysis listed above) could form not just the start, but the middle and end of your investigation of the recovery transformation in treatment. Apparent in his writings and multiple awards, 'Bill' White is an authority who more than any other has promoted the 'recovery era' in addiction policy and provided its scholarly underpinnings. Rather than isolated bouts of professional care for a problem which has become intolerably severe or attracted attention, his understanding of 'recovery' entails a shift on the one hand to intervening before things have got this bad, and on the other to seeing treatment as often merely the first step to an extended programme of monitoring and care – the "recovery maintenance" advocated by another US expert in a document listed above. This broader vision embraces formal treatment, but shifts the focus from inside the clinic to the systems around the clinic within which the patient must 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.

In its breadth as a strategy and an aim, 'recovery' 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, encouraging 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 escape continuing to satisfy a core diagnostic criterion for addiction – the narrowing of interests and activities to substance procurement and use. Neither does this focus necessarily address the patient's most disabling, troubling or fundamental problems. A recovery orientation uncontaminated by an undue emphasis on abstinence can widen perspectives to relationships, family, work, interests, housing, mental health, the home environment and social networks, elevating these to at least the salience of substance use in identifying the need for recovery and in moving towards it.

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 recovery-based policy in the UK), a seeming demand

that people whose lives have made them vulnerable to and been further damaged by problem substance use develop new lives more fulfilling than many who never had these problems, and a tendency to elevate abstinence as the prime objective and relegate reducing harm to secondary importance. In the UK, however, these downsides have been targeted more at the treatment of problem drug use than the less politically sensitive treatment of problem drinking.

Highlighted study Our highlighted study listed above tested a core methodology of the US NIATx resource listed above and featured in cell D2. The study evaluated NIATx's 'learning collaborative' model, a strategy expected to improve patient access and retention across a treatment system by enabling services to learn from each other. In the process it revealed the great strength of randomised trials: that they can generate truly surprising results which by eliminating extraneous influences, also eliminate possible 'excuses' for an intervention not working as intended, forcing 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 meant 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.

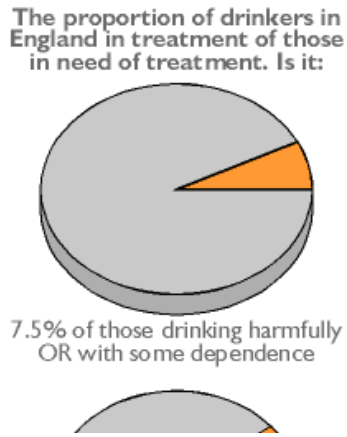
The message for commissioners seems inescapable: if you are responsible for treatment provision across an area, employ a quality-improvement expert and set them to work with each service; don't waste money trying to get services to learn from each other. That way you will at least give more patients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

You might counter that in the US context the clinics were probably profit-making businesses hardly likely to share tips, but in fact, none were. Apart from the usual caveats, notice that the 'collaboratives' tested in the study 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. Instead of grouping by common interests, within a US state each clinic was *randomly* allocated to the different improvement methods.

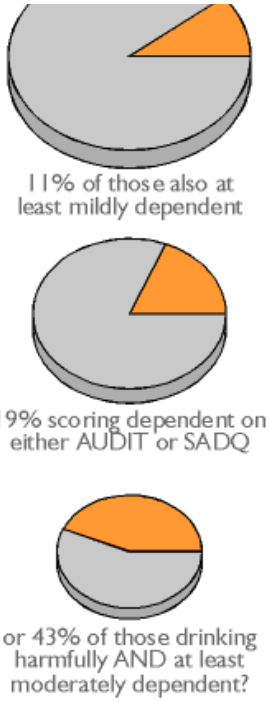
And there you have the great *weakness* of this kind of randomised trial: by eliminating 'extraneous' influences, it risks eliminating some which are not extraneous at all, but essential to the intervention working – perhaps in this case, a common set of issues and of possible solutions across collaborating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

Issues to consider and discuss

▸ **How many drinkers should be in treatment?** A complex issue to which we have devoted a hot topic essay. Abridged here, it offers more detail, an analysis of whether funding cuts have obstructed the path leading from need to demand and then to treatment access, and a critique of an officially accepted yardstick for what counts as an acceptable treatment-access rate. In it we argued that depending on where you draw the line, England's performance in ensuring a high proportion of drinkers in need of treatment actually receive it can look from an abysmal 7.5% to an excellent 43% – and under some assumptions, even 100%. Those proportions may be wrong, but the point here is to show how they differ under different assumptions about what counts as being 'in need of treatment'. It's a statistic which matters, because the more of the in-need population we treat, the smaller the alcohol-dependent population, and the less the related harm. Our analysis focuses on England and the year 2014, because this is where data and estimates are most complete.



Let's start with how many people *are* in specialist treatment, In England, 114,920 adults aged 18 or over were recorded as having been in specialist treatment primarily for the treatment of their drinking problems at some time during the year 2013/14, the last time the figures were presented in this way. Extrapolating that to 2014/15, it can be estimated with some degree of confidence that the corresponding figure was about 111,573 – our best estimate for the top element of the needs-met versus total-needs fraction in 2014. Now we are in a position to plug in various total-needs estimates to calculate what proportion the caseload represents of the population in need of treatment.



> **Key source**
> Listed above, the key source for estimates of alcohol treatment need in England is a report commissioned by Public Health England from researchers at the University of Sheffield and King's College, London. Among other things, it was intended to establish the extent of the need for specialist treatment of problem drinking in England in 2014/15 based on the estimated alcohol-dependent population in 2014. In turn it drew its data on the alcohol-dependent population from a survey of the mental health of the English population conducted in 2014, the Adult Psychiatric Morbidity Survey 2014.

Is it 7.5%? The Adult Psychiatric Morbidity Survey 2014 found that 3.1% of people aged 16 or over scored at least 16 on the AUDIT screening questionnaire. Based on this finding, our key source for treatment-need figures (▸ panel above) estimated that in 2014/15, about one-and-a-half million adults were harming themselves with their drinking or at least mildly dependent. That year treatment had captured the equivalent of 7.5% of this total, seemingly a poor record.

Is it 11%? Using the same key source (▸ panel above) we can narrow the one-and-a-half million estimate down to the roughly a million adults who, in addition to the AUDIT 16+ criterion, *also* scored as at least mildly dependent on alcohol on the 'community' version of the Severity of Alcohol Dependence Questionnaire (SADQ). According to NICE, Britain's official authority on health interventions, drinkers who meet these criteria should be considered for less intensive forms of treatment. On this basis, the specialist treatment caseload in 2014/15 was equivalent to about 11% of the at least mildly dependent drinkers whose drinking was causing harm and who might qualify for some form of treatment.

Is it 43%? Results from the SADQ gathered by the Adult Psychiatric Morbidity Survey 2014 can be used to narrow down further to the cohort who perhaps really ought to be in treatment. In 2011 NICE calculated that in England 260,000 adults were not just harmfully drinking and perhaps mildly dependent, but "moderately" dependent, indicated by their also scoring at least 16 on the Severity of Alcohol Dependence Questionnaire. Our key source (▸ panel above) updated that figure to 257,626 for 2014/15, suggesting that in 2014 the treatment caseload was equivalent to 43% of adults whose harmful and dependent drinking 'really' justifies specialist help, probably extending to comprehensive assessment, managed community withdrawal, and definite consideration of anti-relapse medication and aftercare.

Is it 19%? But the key source (▸ panel above) itself used a wider bracket to estimate potential treatment need. To the total described in the previous paragraph, it added 337,505 people who though they may have scored as mildly dependent on the Severity of Alcohol Dependence Questionnaire (score 4–15), registered an AUDIT score of at least 20, indicative of probable dependence. Put another way, this method includes anyone who scores as a high-risk and probably dependent drinker on AUDIT *unless* that 'probability' is flatly contradicted by a SADQ score variously described as indicative of no dependence at all or a severity not even rating the term 'mild'. It then adds in anyone with a lesser AUDIT score of at least 16 (indicative of harm from their drinking and possibly mild dependence) *as long as* this is bolstered by a SADQ score of 16 or more, indicative of at least moderately severe dependence. The result was a total of 595,131 "adults in England with alcohol dependence", a figure accepted by Public Health England as the population who "may need treatment". The rationale was that due to their dependence, these drinkers could not be expected to respond to a brief intervention and needed fully-fledged treatment, while for less severely affected drinkers brief intervention might suffice. Setting aside doubts about this rationale, the implication is that the 2014/15 alcohol treatment caseload was equivalent to 19% of the alcohol-dependent adult population.

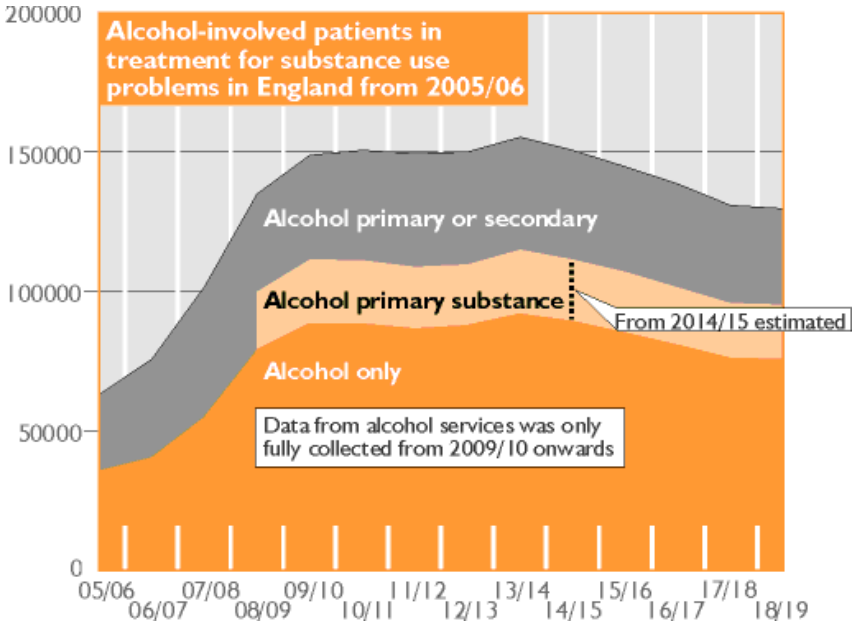
Could it be around 100%? All these estimates assume that if a research or clinical assessment judges you to be experiencing harm and dependent on alcohol, then you should be in treatment, regardless of how you feel about it. What happens if we take into account whether *the drinker* themself wants or intends to reduce their consumption/harm and take a treatment route to achieving their goals?

Fortunately, our key source (▸panel above) addressed this issue. Based on surveys mounted by the Alcohol Toolkit Study, it refined its 'best guess' (▸above) of 595,131 adults in need of treatment down to around 341,376 who also wanted to cut down on their drinking, or 245,614 who additionally intended to do so in the near future. Respectively these estimates suggest that instead of 19%, the treatment caseload in 2014 was equivalent to 33% or 45% of adults who both needed and might consider treatment, based on their desires and intentions to cut down on their drinking.

In principle, similar calculations could be applied to other estimates of treatment need, including the one (▸above) which suggested that in 2014 the treatment caseload was equivalent to 43% of the in-need population. What the resulting figure would be is not known, but if the same degree of narrowing applied, the 257,626 in-need population which generated the 43% estimate would be reduced to either 147,877 or 106,400, very close to the estimated treatment caseload.

The population in need of treatment would be further constricted if we accepted the view that diagnosing an alcohol use disorder requires not just alcohol-related harm, but evidence of a pathologically impaired ability to control drinking – that repeated, heavy drinking was not a rational choice made because perceived benefits were greater than perceived harms, but an addiction-driven non-choice. Compared to standard clinical criteria, applying this 'harmful dysfunction' diagnosis to US figures slashed the proportion potentially in need of treatment from about 12% in the past year to about 2%, and the proportion whose supposed need had not yet been met from 34% over their lifetimes to just 4%.

There are also (see the hot topic essay from which this section was abridged) other reasons to expand estimates of treatment need, and of the numbers accessing some kind of treatment-like response to their problem drinking. So while we may suspect that in 2014, capturing about 112,000 of England's problem drinkers in treatment was not enough, there is no clear way to determine the degree to which this is the case.



What we do know from Scotland, is that England could be doing much better at meeting treatment need (1 2). We also know that in England the alcohol treatment caseload has been falling consistently since 2013/14 (see chart to the right) despite little change in estimates of the alcohol-dependent population, and that the main frontline medical care portals to specialist treatment had referred fewer and fewer of the treatment caseload, suggesting an increasingly less effective channel into specialist care.

Where would you draw the treatment-need line: harmful drinking; at least mildly dependent; moderately dependent; or severely dependent? If for the benefits they feel they get, the drinker has freely chosen to shoulder the harm they experience and their dependent state, can they be considered in need of treatment? Does where you draw the line depend on whether you *want* to portray Britain's treatment-access performance as abysmal or excellent, perhaps depending in turn on whether you wish to argue for more resources or to contain expenditure? Is severity (of drinking and/or dependence) the right criterion? How about the *duration* of heavy drinking, whether the drinker *wants* treatment, how many patients we want to *afford* to treat, or whether the drinker is likely to benefit from the kinds of treatment we have on offer?

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 scrutiny and learning. Common strategies are to set services 'stretch' objectives for treatment activity, or to offer incentives for engaging patients in therapies or for intermediary aims such as adequate retention. However, these strategies may boost whatever is targeted, but without improving patient welfare or reducing problem substance use, and even risk defocusing from those desired end-points and making the targeted criteria ends in themselves. It seems to make more sense to directly incentivise services to achieve those desired end-points, rather than to do things expected to lead to them, but which may not – 'payment by results'.

Certainly it made sense to the UK government, which advocated this mechanism and set up 'payment-by-results' pilot schemes in eight areas to test it, and which after evaluations remained enthusiastic, at least in respect of probation services. Also not to be lightly dismissed is the hunch (document listed above) of two of the world's most respected addiction experts (one of whom had been appointed to advise on addiction treatment in England) that payment-by-results is among the most promising strategies for improving treatment outcomes. Are they all 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 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 – criteria services cannot afford to ignore.

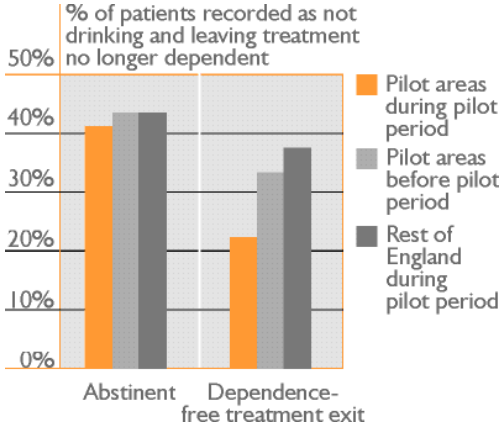
Another possible downside of what seems a no-brainer strategy emerged from a US study listed above: that (like contingency management incentives for patients) payment-for-performance systems engender a mentality of doing just enough to get the money, but no more. And even if outcomes could be directly 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. Giving all the credit to the episode immediately before they sustainably overcame dependence ignores the contribution of 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 authoritative conceptions (listed above) of recovery and associated understandings (listed above) of addiction, but on discharging patients who then are not seen again for at least a year – a metric similar to the national indicator for England recording "Successful completion of alcohol treatment" as the proportion of patients who leave treatment when no longer dependent and do not return within six months. Do these assessments 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? As explored in cell D2, should we instead incentivise long-term support?

Research to help answer these questions is almost entirely lacking; in evidence terms, payment-by-results in health and social care of any kind is a leap in the dark. Across these sectors, in 2011 a review of reviews could find no evaluations which reported on patient outcomes. Specifically in respect of substance use treatment, in 2014 another review (listed above) could find "no peer-reviewed evidence that [payment for performance] … improves client outcomes post-treatment". After analysing the literature, a leading UK commentator on such schemes discerned "consensus" about the evidence base – consensus that is "not able to give a clear indication as to whether payment by results works", and also that "unexpected, often perverse, consequences are commonplace".

Evidential uncertainty and the risk of counterproductive effects are presumably among the reasons why the English schemes were evaluated pilots. Analysed by the Department of Health, initial results (listed above) were not encouraging (▸ chart right), and neither were later findings (listed above) from independent researchers. In both cases areas with payment-by-results schemes had performed worse than areas without, including on outcomes reflecting the key indicator of recovery for the UK government – leaving treatment free of dependence and not returning so soon that treatment gains had clearly not 'stuck'. With no proven overall benefits for society or patients, some downsides, yet increased costs per patient, these findings gave little reason for continuing with the types of payment-by-results schemes tested in the English pilot areas. The main plus side was a rebalancing towards alcohol- rather than

drug-dependent patients, but this could have been achieved without payment by results. Unfold the supplementary text to read more about these unexpected findings.



On all four substance use comparisons things were worse in the pilot areas once the schemes had started

> Close supplementary text
>
> The Department of Health's analysis (listed above) used routinely collected treatment monitoring data to compare performance under payment-by-results in the pilot areas from April 2012 to February 2013 with the same months in the year before the pilot schemes had started. This before-after comparison was supplemented by a contemporaneous comparison between the pilot areas under payment-by-results and the rest of England.
>
> In pilot areas records were available for 3,081 patients whose substance use problems primarily involved alcohol. Against both comparators, the proportion recorded as no longer drinking (just over 40%) had worsened by 2% ▸ chart above. The proportion recorded as leaving treatment free of their dependence on alcohol or other drugs – for the government, the key indicator of recovery – was 15% lower than in the rest of England and 11% down on previous performance in the same areas, statistically significant differences. In other words, on all the substance use comparisons things were worse in the pilot areas once the schemes had started.
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> Beyond substance use, there was some indication that more patients with housing problems had resolved these, but none that patients' quality of life had been improved by introducing the pilot schemes. "Mixed" was the document's characterisation of the results; 'disappointing' might also have been justified. These were, however, early days, and the intention was that "This report will now be updated with the latest information every three months." If that happened, it has been kept very quiet.
>
> This analysis from the government was followed by that of independent researchers, including some involved in creating and maintaining the key data source, the National Drug Treatment Monitoring System. In 2017 they produced their final report (listed above) on the pilot schemes, extending the comparison windows to two years before they started in April 2012 versus the following two years. Outcomes were benchmarked against those in areas which had not implemented payment-by-results schemes.
>
> Again, the results were not encouraging: "Overall … the introduction of [payment by results] did not seem to be associated with the desired effects of outcome-based commissioning of drug and alcohol treatment services." Many of the results were similar for drug and alcohol patients. For both, the proportion of patients who had successfully completed treatment had fallen more in scheme than non-scheme areas, as had the proportion who successfully completed and did not return to treatment for at least a year – negative findings relating to a key metric used as a proxy for rates of recovery from dependence. Perhaps related to these findings was extended retention in treatment in the pilot areas, but greater rates of unplanned discharge indicative of unsuccessful treatment. Death rates had not significantly improved in the pilot areas, where the cost of treatment had increased significantly more than in non-pilot areas.
>
> There were also notable differences in how the introduction of payment by results had affected drug versus alcohol patients. Compared to non-pilot areas, more drug clients had to wait over three weeks before they could start treatment, and after assessment, more failed to start treatment, but neither was the case for alcohol clients – findings consistent with the views of commissioners, service managers and practitioners from pilot areas that "the provision of alcohol services [had] improved … partly as a result of greater emphasis and availability of funding for this support under [payment by results]". The new payment mechanism seemed to have levelled up the provision of alcohol treatment to nearer that for problems with drugs like heroin and crack, narrowing a gap long complained of in the alcohol sector.
>
> Close supplementary text

You will have your own questions about payment by results and its English implementation, so critical to the future of substance use treatment in the UK. Here are some of ours. 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 by choosing 'friendly' or more manipulable outcomes?

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 payment '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? Set against it is the suggestion that the pilot payment-by-results mechanisms actually made things worse, causing a deterioration in the main outcomes indicative of recovery they were intended to improve.

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