DRUG & ALCOHOL FINDINGS *Matrix cell*

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Alcohol Treatment Matrix cell D2

Organisational functioning; Generic and cross-cutting issues

Key studies on the how the characteristics and functioning of treatment organisations affect implementation and effectiveness. Learn to see organisational context as part of treatment and about two evidence-based US quality improvement resources, and consider what makes treatment services engaging and how they could extend engagement into long-term continuing care. See the remaining four cells in row 2 of the matrix for more on generic features of medical and psychosocial therapies.

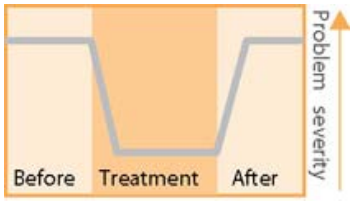
S Seminal studies **K** Key studies **R** Reviews **G** Guidance **MORE** Search for more studies

Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text

S Support and experience at work needed for training to strengthen commitment to working with drinkers (1980). English studies showed that without being able to experience working with problem drinkers, the support of experienced colleagues, and work settings which value, prioritise, and provide time for this work, training alone is of limited value in generating positive therapeutic attitudes. For discussion click and scroll down to highlighted heading.

S Goal-oriented, well organised and supportive workplaces maximise patient progress (1998). US services which were effectively mission-oriented, clear what they expected from staff, and which generated staff involvement and commitment, had more engaged patients who made greater progress and were more likely take up aftercare. Same research stable found (1997) patient participation and outcomes best in residential services which communicated high expectations for patient functioning, emphasised clear rules and procedures, and had a psychosocial treatment orientation; a strong treatment philosophy was "more important [than] the particular theory underlying that orientation". For discussion click and scroll down to highlighted heading.

S Chronic care for chronic conditions (2002; alternative free source at time of writing). Truly seeing addiction of the kind managed by specialist services as analogous to a chronic disease means evaluating success by what happens *during* treatment, not after it has ended (▶ figure), and demands continuing care which is attractive to and manageable by the patient and elicits their cooperation. For discussion click and scroll down to highlighted heading.



Is this evidence treatment failed – or that it worked?

K UK services which are 'open to change' have more engaged patients (2009). Clients engaged best when substance use services fostered communication, participation and trust among staff, had a clear mission, but were open to new ideas. The Organizational Readiness for Change or 'ORC' questionnaire used in this study formed the basis for a study and reviews (1 2) listed below. For discussions click here and here and scroll down to highlighted headings.

K Improvement initiatives 'stick' best in client-centred services (2017). Follow-up of a US trial of the 'improvement collaborative' model developed by the NIATx resource listed below. Focused on what is about some treatment organisations which helps sustainably embed improvements; one factor was commitment to client-centred practice. See also study (2015; free source at time of writing) of what influences enrolment and participation in the same kind of change programmes; management support and concordance with organisational aims emerged as factors. For discussion click and scroll down to highlighted heading.

K Place your agency in front of a potentially unflattering mirror (2007; free source at time of writing). US study found that feeding back scores from an organisational 'health' assessment motivated less well functioning agencies to commit to an improvement programme. The Organizational Readiness for Change or 'ORC' questionnaire used in this study formed the basis for a UK study listed above and reviews (1 2) listed below. For discussion click and scroll down to highlighted heading.

R A team of reviewers based in Ireland and the UK investigated relationships between a substance use treatment agency's organisational health and: 1. the adoption of innovations (2017; free source at time of writing); 2. outcomes for patients and clients (2017; free source at time of writing). Implications included: organisational health partly determines whether improvement attempts succeed; in particular, that a positive organisational climate is important in determining the success of innovations in staff training and treatment methods and is associated with good staff/client relationships, less substance use, and stronger engagement with treatment; and that organisational deficits revealed by such assessments can motivate change, but may need to be rectified before it is successful. All the studies in the

review used the ORC questionnaire used in studies from England and the USA listed above. For discussions click here and here and scroll down to highlighted headings.

R Policy strategies for improving outcomes (2011). Two of the world's most respected addiction researchers, each also with top-level policy experience, explore the evidence that patients' prospects are improved by organisational changes like strengthening managerial capacity and business practices and submitting the organisation to external scrutiny. For related discussion click and scroll down to highlighted heading.

R Organisational dynamics of the change process (2011). Structures findings from the most comprehensive and systematic attempt yet (see studies 1 2 from the same team listed above) to map the processes involved in effective treatment, including the organisational dynamics of implementing and sustaining innovations. As in a study and guidance from England, openness to change ("general readiness to embrace innovation") emerged as an important quality. For discussion click and scroll down to highlighted heading.

R Implementing long-term care/aftercare (2011). Since "People treated for substance use often remain precariously balanced between recovery and relapse", argues for "Assertive linkage to continuing care" and promoting engagement and retention in recovery resources such as mutual aid groups. Another review (2009) advocated the direct and proactive provision of aftercare – taking it to the patient rather than relying on them to attend a clinic and/or determinedly contacting patients and making aftercare easy to access. Related guidance below. For discussion click and scroll down to highlighted heading.

G Strategies to promote continuing care (2009; free source at time of writing). Expert US consensus on practical strategies to promote aftercare/continuing care based on official US statement of the principles of addiction treatment. Recommendations have implications for organisational structure and coordination with other services. Related review above. For discussion click and scroll down to highlighted heading.

G English inspectorate's criteria for quality services (Care Quality Commission [CQC], accessed 2020). Official inspector of health and social care services in England asks five key questions of specialist NHS and independent substance use services: whether they are safe, effective, caring, responsive to people's needs, and well-led. More on these criteria in appendices to prior consultation. Standards based on the CQC's requirements are listed below.

G English drug services define their own quality standards (2016). From bodies representing the addictions treatment sector in England, standards to guide services in assessing how they support people into and through recovery and the quality of vital aspects of their organisations. Can act as a check list for provider organisations as well as managers and commissioners. Consists of: standards for non-residential services (2016); implementation guide (2016) for these standards; and standards for residential rehabilitation (2016). Based partly on the CQC's requirements listed above.

G Scottish government's vision of a high quality substance use service (Scottish Government and Convention of Scottish Local Authorities, 2014). Sets out what patients can expect, what services should provide, and how they should relate to patients. "At [the guidelines'] heart is a person-centred, holistic, recovery-focused approach where services and those seeking to address their problematic substance use work in partnership to achieve agreed outcomes."

G Quality standards for alcohol and drug services ([Irish] Health Service Executive and Ana Liffey Drug Project, 2013). Update adopted by the Irish government of the QuADS standards developed for UK drug and alcohol services. Consists of a checklist of practices which for different types of services constitute quality in management, service delivery, and upholding service users' rights.

G Assessing readiness for change and the implementation process ([US] Substance Abuse and Mental Health Services Administration, 2009). Practical, hands-on guide to how to assess an organisation's capacity to identify priorities, implement changes, evaluate progress, and sustain quality-improvement programmes, plus how to implement these programmes.

G Organisational features underlying successful improvement programmes ([US] NIATx, accessed 2020). Web-based service whose model for improving addiction treatment services is based on five principles such as involving the customer and seeking ideas from other fields. See also case studies (2012; free source at time of writing) of the principles' roles in improving US services and the attributes which experts say (2011; free source at time of writing) determine whether an organisation will not just implement, but sustain improvements. Specific aims include cutting waiting times and the number of 'no-shows', for which see cell C2. Related study above. For discussion click and scroll down to highlighted heading.

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

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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? As well as concrete things like staff, management committees, resources, and an institutional structure, organisations have links with other organisations, histories, values, priorities, and an ethos, determining whether they offer an environment in which staff and patients/clients can realise their potential. For these and other reasons, agencies differ in how keenly and effectively they seek and incorporate knowledge and implement evidence-based practices. The best might, for example, have effective procedures for monitoring performance and identifying where improvements are needed, facilitate staff learning from each other and from research, and forge learning or service-provision links with other organisations. Openness to change, and encouraging stimulants to change such as research and feedback from staff and patients, emerge as key attributes; for example, see our commentary on a study listed above.

In the treatment of conditions affected by thoughts and emotions, it is "the meaning the client gives to the experience of therapy that is important," and that meaning is constructed from the context within which an intervention is delivered. Forming part of that context is the setting provided by the organisation, its administrative procedures, and its clinicians, whose intervention style, optimism and expectations of treatment will be affected by the organisation within which they work. "Patients may improve simply because they are placed in places that are symbols of competent care," reviewers have concluded. Rather than seeing the *intervention* as the treatment, arguably it is more realistic to see treatment as a package of interacting elements, including (among other factors) the patient's predispositions, responses, and how they manage their condition, the way the therapist relates to them, the intervention, and the credibility of the context as a healing environment.

Where should I start? Arguably no body has done more to promote evidence-based improvements in addiction treatment at the level of whole organisations than the US NIATx collaboration. The name recalls its origin as the Network for the Improvement of Addiction Treatment; it has moved beyond that, but addiction remains a major focus. Study after study under the NIATx banner has examined how addiction treatment organisations can become more receptive to improvements and more successfully implement them, work available on the NIATx web site featured above.

Loosely based on findings from industry, most relevant to this cell are NIATx's "five principles" found to have "consistently influenced efforts to overcome barriers to process improvement", explained by Director Dave Gustafson in a short video. Note his stress on organisations putting their staff in the customers' shoes – not *assuming* they know what they need and want, but actively finding out.

The NIATx logo signifies 'rapid-cycle testing': implement an idea on a small scale, test the change, modify it, test again, and repeat this cycle until the change meets the needs of customers.

Ask yourself, 'What kind of organisation does that?' – especially when its clients are among the most stigmatised in society. 'Alcoholics' and 'addicts' are *by definition* seen as incapable not just of doing, but even of consistently *wanting* what is best for them. The default position is surely to assume that as an expert, and/or someone who has already extricated themselves from these problems, you know best.

One answer is that it is an organisation led by someone open-minded enough to think they can learn from such patients, who takes steps to imbue that ethos across the service, and who is allowed – perhaps encouraged – by the organisation to make the required changes. An example comes from the late 1950s when Morris Chafetz's leadership transformed intake and retention at the alcohol clinic of the Massachusetts General Hospital, documented in studies explored in cell A2 of the Alcohol Treatment Matrix. Part of that process was a proto 'walk-through' (see cell C2 for more on walk-throughs) of the intake process to identify barriers from the patient's point of view. This procedure entailing senior staff role-playing a new patient is now seen by NIATx as a key tactic.

Understanding and involving the customer is just one of NIATx's five principles. Take a look at the others, see if to you they make sense. Ask yourself if your organisation embodies these principles in its day-to-day work and its change efforts. Look too at the freely available results of a study listed above investigating why some treatment organisations have been able to sustainably embed NIATx-generated improvements, and ask yourself if according to these criteria, the services you know have a good chance of incorporating quality-improvements within their operations. Resources were one of the sustainability factors: there had to be some perceived 'elbow room' to enable staff to make the effort to improve, especially when improvements might increase workload by engaging and retaining more clients. High staff turnover was

found “inconsistent with sustainment”. Concordance between the intended improvements and bottom-line organisational objectives was also important, as was institutional commitment to client-centred practice, staff and management commitment to the improvement process, and having the data needed to find out when things need improving, and whether attempts to rectify these deficiencies have worked. Some of the same influences seemed to (study listed above) promote or hinder services’ initial enrolment in and subsequent participation in the same kind of change programmes.

Key message is that not all organisations are ready to take on, engage, and stay engaged in improvement programmes, even programmes sdesigned to be at the easier end of the spectrum. Some of these factors can only be countered but not changed. For example, in the UK there are fundamental differences in how public versus private addiction treatment services conceive of ‘quality’ and how to achieve it, conceptions which to a degree seemed inherent in the nature of private and public services, making them hard to alter. Such differences are bound to affect the acceptability and feasibility of improvement programmes predicated on these conceptions.

Highlighted study Exceptionally seminal were the British studies listed above from Alan Cartwright and colleagues of the Mount Zeehan alcohol treatment unit in Kent, whose findings have since repeatedly been confirmed. From the early 1970s their government-funded Maudsley Alcohol Pilot Project opened up an agenda centred on the therapeutic alliance between patient and helper. In this and other work, the researchers found that the helper’s commitment to working with drinkers (a key factor in alliance formation) depended on the workplace environment, including whether it engendered the feeling that working on drinking was a legitimate role supported by their organisation. Cartwright and colleagues discovered that staff who felt that working with drinkers was ‘not their business’ in the environment within which they worked could not be ‘trained’ into being committed therapists. Their studies turned the focus instead on the messages staff received about the organisation’s priorities expressed in its policies, resource allocation and the perceptions induced in staff about whether working with drinkers was a valued and worthwhile use of their time.

Most critical it seemed – and inevitably related to the organisation’s procedures and priorities – were opportunities to gain support from colleagues, and experience in working with problem drinkers on return to work after training. Without these, formal training alone was of limited value in strengthening commitment to working with problem drinkers. Experience and support might be expected to be a given in specialist alcohol services, and the lack of these in non-specialist sectors such as social work and nursing partly accounted for lack of commitment among practitioners. Among social workers in particular, these deficits plus organisational constraints and competing priorities meant training per se would have little effect on their rejection of anything but a minimal therapeutic role with problem drinkers.

Cartwright’s work sets a context both for the difficulty of engaging non-specialist workers in screening for risky drinking and offering brief advice or referral (on which see cell E1), and the obstacles to extending the treatment of more seriously problematic drinking by rooting it in non-specialist services such as primary care, one way to bridge the need–provision gap in treatment discussed in cell E2.

Issues to consider and discuss

What do we know about the ‘engaging organisation’? Over decades of systematic research, Dwayne Simpson and colleagues at the US Institute of Behavioral Research developed a model of the treatment process, then moved on (study listed above) to assessing an organisation’s capacity to improve this process as reflected in staff perceptions of the service and of their own professional functioning and needs. The practical fruits of this work in the form of assessment forms, manuals, and evidence-based advice are available on the institute’s web site. Look specifically for the form assessing a treatment organisation’s readiness to implement change, including its ability to embrace, absorb and sustain evidence-based improvements.

In 2006 the institute teamed up with what was then England’s National Treatment Agency for Substance Misuse to conduct what remains the most wide-ranging investigation of the organisational health of British drug and alcohol treatment services (study listed above). Clear relationships were found between on the one hand the degree to which patients engaged with treatment, and on the other organisational features such as team-working and mutual trust, whether the service fostered open communication between staff, was receptive to their ideas and concerns, adequately resourced, and had a clear mission and programme. Like a more or less coherent, well organised department store, all these and other features funnelled to a head in the interaction between staff and ‘customer’, affecting whether that

customer wanted to stay and buy (enter and engage in treatment), or preferred to move on to another store or abandon the attempt to improve their lives.

This is how our analysis summed up the findings: "Staff working in an atmosphere of support and respect for their views, and concern for their development, tended to have clients who also felt understood, respected, supported and helped … also influential was the degree to which a service was clear about what it was trying to do and how it was trying to do it, and communicated this to its staff." Similar messages had emerged from the USA in the mid-1990s from the first study (listed above) to investigate these issues.

Think of the services you know. Do these findings ring true? Look at our analysis of the British study and of the studies cited in the commentary to that analysis. Consider whether these studies are methodologically strong enough to support the implications of their findings about links between organisational health and patient engagement. Generally they could only discover *associations* between organisational features and engagement, not determine whether one actually caused the other. If they were merely associated, then improving organisational health would not have the desired impact on engagement. The classic way to determine causality would involve randomly allocating patients to treatment services engineered to differ only on the dimensions thought to affect engagement. But on issues such as these, demanding randomised-controlled-trial proof is unrealistic. Services which differ, for example, in the degree to which they supportively develop their staff are likely to differ in other potentially important ways, so what actually caused any improvements in engagement would remain unclear. In any event, it would be unethical to deliberately create and allocate patients to a poorly functioning service just to see how badly they do. So in practice, causal links can be presumed, but not proven; engagement *may* have been affected by the measured organisational variables, but it will never be possible to eliminate alternative explanations.

At a deeper level, searching for simple and universal links may be a flawed enterprise; attributes linked *on average* to greater engagement may not always be linked in this way, and not always a positive influence on patients. For example, a service may have a "clear mission and programme", but both may be misguided, or at least believed to be so by some experts. Similarly, being receptive to staff ideas seems fine – but what if those ideas are at odds with what patients want and need?

> *Does it matter if a service's philosophy is 'wrong' as long as it provides structure, clarity and hope?*

Think more about one of these examples – the influence of a service having a clear mission and programme. We have suggested this may not be a good thing if both are misguided – but perhaps this concern is itself misguided. Does it matter if (perhaps within reasonable limits) a service's philosophy of addiction and of its treatment are unsupported by theory and evidence and contested by experts, as long as to staff and patients these convictions provide structure, clarity and hope, and in doing so foster engagement with the treatment? Note that in a seminal US study listed above, it was not scientific understandings of addiction which seemed to underpin these positive results, but a strong belief in a treatment philosophy developed outside scientific processes and strongly contested by some experts – the 12-step model. Even in the USA, in this the 12-step model is not unique. A companion study also listed above suggested that to the degree that they are strongly held, other philosophies are also associated with positive consequences. It found that a strong orientation to a distinct treatment philosophy was positively associated with patient participation and outcomes, and that "the strength of an orientation is more important [than] the particular theory underlying that orientation".

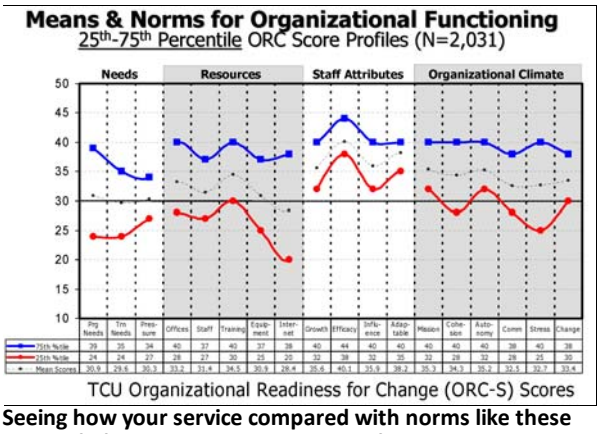
Then play devil's advocate and ask yourself whether – however important they seem – the dimensions of organisational culture described above trump concrete performance-enhancing procedures. Perhaps, for example, the most important thing is not for an agency to understand, respect and support staff, but to incentivise them to achieve/do what the agency wants – as with Scottish GPs incentivised to offer brief advice to risky drinkers. Another concrete way to enhance performance is to let clinical staff know when their patients are doing poorly and suggest remedial action, trialled in a US study of three substance use therapy centres discussed in cell C4.

Can such procedures work well, whatever the organisational culture, or will they only be implemented and effective in conducive environments? In the US study, of the three centres, the feedback system worked only at one, being strongly associated there with improved psychosocial functioning among patients whose counsellors had been warned they were not doing well. At the other two centres, there was virtually no such relationship.

▸ **Do we know how to *make* an organisation engaging and effective?** The preceding section

was about what kind of treatment organisations are *naturally* more effective. Can we build on these findings to go a step further, and actually *engineer* more effective organisations? Australia's addictions workforce development agency alerts us to a potential 'catch 22'. Under the heading, "First things first: Is a change needed?", chapter 7 of their workforce development guidance points out that first an organisation has to accept the need to change – yet the very agencies most in need of improvement may be the ones least likely to acknowledge and act on their deficiencies. This dilemma emerged also in a review listed above. It found that adverse working conditions could motivate staff to recognise the need for training, but also that "the opportunities for training in these programs is often limited". Similarly in respect of adopting new treatments, services whose staff felt a greater need for organisational change also perceived "greater barriers in their implementation".

One way to square this circle has been trialled by the US research stable whose work was highlighted in the preceding section: alerting the service to how its staff see it and how this compares with other services. Faced with the graphically presented evidence (▸ illustration), senior staff from agencies which scored as less open to change and suggestions from staff became the ones most likely to commit to change.



Seeing how your service compared with norms like these persuaded US services to commit to change

Another way agencies can open themselves to an awareness of the need to change is to submit themselves for approval by accreditation agencies, but two of the world's most respected addiction experts judged this (review listed above) a flaccid lever for improving outcomes. More promising are the 'walk-throughs' advocated by the US collaboration featured in the "Where should I start?" section. These involve senior staff acting the role of a patient to (for example) experience their service's intake and induction procedures as the patient experiences them. But again, there may be a 'catch 22': would the poorly functioning services most in need of this spur to improvement consider mounting such an exercise? After assessing the evidence, the US experts favoured subjecting agencies to market forces, of which in the UK the most prominent models are payment-by-results schemes. In cell E2 of the Alcohol Treatment Matrix we learn that such schemes can force change, but that rather than maximising outcomes for clients, sometimes this is limited to the adjustments required to gain externally imposed carrots or avoid the sticks.

It will be apparent that we have argued ourselves into an apparent bind: ideally health services and charities whose mission is to serve patients and clients would willingly open themselves to influence and scrutiny and embrace improvements, but the ones most notably failing in that mission are probably also the ones least likely to take those remedial steps. External pressure seems the solution, yet the same organisations may react by doing just what is needed to satisfy their funders or inspectors (which may bear a loose relationship to patient welfare) rather than engaging in a sustained improvement programme focused not on external requirements, but on the needs and aspirations of their actual and prospective patients. Sometimes the market mechanism of patients voting with their feet has been an option, but one which being eliminated as mega-services take over in local areas, offering to do everything for the commissioners.

Is this bind real, is there a 'best' way round or through it, or must it be worked out anew each time? Are some services *right* not to be *too* open to change – even to resist it? After all, every change has a cost in terms of at least short-term disruption, use of resources, and perhaps alienating or confusing staff and patients. As with fixing the roads, in principle improvement is good, but if you have so much of it that drivers are constantly frustrated by one set of road works after another, it starts to obstruct rather than promote progress. And in the real world, is change normally the result of a deliberate improvement process, or forced on organisations as an emergency response to cope with events (like budget cuts or staff/patient welfare scandals) which render the status quo unsustainable?

▸ **How should services gear up for long-term care/aftercare?** From cell A2 we know that offering patients aftercare or continuing care following a period of more intensive treatment does (modestly) help sustain reductions in drinking. In turn that raises the issue of what kinds of aftercare work best, and how to organise them.

We get strong clues from a review (free source at time of writing) of high quality, randomised aftercare

trials which focused on patients solely dependent on alcohol – a focus based on the argument that dependent drinkers who use other drugs materially differ from those who do not. Compared to usual approaches, its findings supported aftercare options which involve actively and regularly reaching out to the patient, rather than leaving it them to re-make contact. Effective interventions also targeted the patient's family network and sought to improve coordination between different healthcare sectors. Their findings led the reviewers to propose weekly telephone monitoring by a specialised nurse – calls the nurse will initiate if the patient fails to make contact. Home visits and specialist counselling would be an option if indicated, and in general the programme should be adapted to individual needs.

The benefits of active (and long-term) aftercare also emerged from an earlier review listed above, which raised the issue of where and by whom continuing care should be provided. One view from a review listed above is that "Assertive linkage to continuing care" and promoting engagement and retention in recovery resources such as mutual aid groups is the way to go. Is this enough, and does it prematurely let the treatment service off the hook of caring for patients they may (due to lost tolerance to opioids or other drugs) have left more vulnerable to overdose if they relapse? Devolving aftercare responsibility to local services such as primary care or mutual aid groups might maximise convenience for the patient and offer social reintegration opportunities, but perhaps risk the 'continuing' element by breaking with the initial approach to treatment. Devolved services may also be less able to rapidly resume intensive support if needed.

Alternatively, rather than linking the patient to other resources, the initial treatment service could directly take responsibility for extended monitoring and care. It could ensure it reinforced the original programme and seamlessly adapt and (de-)intensify in response to their experience of the patient. Some patients may, however, prefer to feel that their treatment is now successfully over and they no longer need the service's support, though in this they could be mistaken.

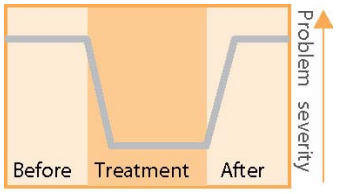
Underlying these practical issues are more fundamental ones about alcohol and drug dependence and how treatment services see themselves – for which unfold the supplementary text.

Close supplementary text

There is no need to buy into conceptualisations of addiction as a chronic neural disorder in order to argue for chronic care. The broad cross-section of drinkers who at some time become dependent commonly have the resources to extricate themselves from a phase not too deeply embedded in their lives, but some are too severely and multiply disturbed to 'bootstrap' themselves out of their troubles. These are the drinkers who tend to turn to or get directed to treatment. Despite this help, still they take longer than average to achieve remission.

For the typically multiply and deeply troubled treatment caseload, perhaps services should see themselves as offering chronic care for what *in the circumstances of these patients' lives and given the support society is prepared to offer them* often is a chronic condition, or one to which patients repeatedly gravitate. The implication is that rather than lasting post-treatment remission, services' performance should be judged on keeping the condition at bay *while the patient remains in their care*.

According to this vision, post-treatment relapse is a sign that treatment had been working, not that it had failed ▸ figure. That was the view (document listed above) of a US expert who had advised Public Health England on addiction treatment. In turn he said that meant lengthy treatment contact has to be palatable to and manageable by the patient, long-term monitoring of patients has to be a recognised and funded part of treatment, and staff are needed to manage continuing care who like case managers and GPs, are keyed into the broader spectrum of health and social services.



Is this evidence that the treatment worked – or that it failed?

Close supplementary text

The need for regular, frequent, and proactive aftercare – and possibly too, direct provision rather than just linkage – means that effective extended care is not going to be cheap or ad hoc; it has to be organised and funded. US experts strongly in favour of extended care had to admit (document listed above) that "effective interventions such as extended monitoring and incentives for good performance often come with an increased price tag". If services did extend treatment/aftercare contact, how would that square with the drive in Britain to contain costs and maximise the numbers completing and leaving treatment, a metric by which services and local areas are called to account? Would diverting resources to extended care mean fewer patients get a chance of any kind of treatment, or have the opposite effect by slowing the revolving door of treatment re-entry, releasing space for new patients? Is there a trade-off between

extending episodes of care, and extending care of some kind to more people?

Close Matrix Bite