

# DRUG & ALCOHOL FINDINGS *Matrix cell*



## Drug 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 drug addiction treatment. Commentary focuses on payment-by-results funding mechanisms, crime-reduction as a justification for treatment, and ways to improve treatment systems, especially the core care planning process.*

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 [Chronic care for chronic conditions](#) (2002). [Alternative 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 (on which see [guidance and associated reviews](#) below) and judging services on how the patient fares *during* treatment, not after they leave. Discussion of the need for continuing care in [cell D2](#). For related discussion in this cell [click](#) and scroll down to highlighted heading.

K [£3 for £1 claim offers treatment investment rationale for commissioners](#) (1999). [NTORS](#) recruited its national English treatment sample in 1995 when all the [modalities](#) it studied were under threat. [It estimated](#) that within one year they had reaped benefits which greatly outweighed their costs, an estimate analysed by the Effectiveness Bank in the listed report and in a [presentation](#). An [NTORS analysis](#) (2004) for the two years after treatment entry came up with an even greater ratio of savings to costs. The later [DTORS study](#) (2009) of a similar sample calculated an almost identical savings:costs ratio for the year after treatment entry, but on shakier grounds. For related discussion [click](#) and scroll down to highlighted heading.

K [Challenge to Scottish treatment system](#) (2006). Recruiting its sample in 2001, [DORIS](#) was the Scottish equivalent to the English [NTORS](#). It challenged the Scottish treatment system to forefront abstinence as an aim because this is [what the patients want](#) (see analysis in [cell A2's bite](#)) and because it promotes social integration. Both may be true, but neither was proved by [DORIS](#). See also these reports on [employment](#) (2008) and [crime](#) (2007) outcomes, and an [omnibus report](#) (2008) on the project's findings.

K [Successful completion indicator of lasting remission in England](#) ([UK] National Treatment Agency for Substance Misuse, 2010). Support for the contention built in to national policy and funding criteria that leaving treatment after having '[successfully completed](#)' is an indicator of lasting remission. However, the same analysis (and [another](#) published in 2012) suggests staying in treatment for at least a few years is even better. For related discussion in this cell [click](#) and scroll down to highlighted heading.

K [Disappointing results from English payment-by-results schemes](#) (2017) Study funded by the UK Department of Health found the schemes reduced rates of successful completion of treatment, seen as ([above](#)) a critical indicator of successful treatment. See also [research report](#) from the same study including data from interviews with people involved in the schemes, and an [official evaluation](#) ([UK] Department of Health, 2013) and [study](#) (2015) of the pilots during their first year. These also found that the proportion of patients exiting treatment free of dependence was worse than in other areas and in the pilot areas before the schemes. Related [study](#) and [review](#) below. For discussion [click](#) and scroll down to highlighted heading.

K [Foundations of high-quality care planning in English commissioning areas](#) ([English] National Treatment Agency for Substance Misuse, 2007). In 2005/06 every treatment-providing area in England was assessed for the quality of its care planning, and an attempt made to identify the distinctive characteristics of high-performing areas. The result was a menu of potentially performance-improving features of local treatment systems. For discussion [click](#) and scroll down to highlighted heading.

K [Systems change helped improve access to and retention in treatment](#) (2008). US NIATx programme halved waiting times and extended retention partly by fostering a self-sustaining inter-service improvement network and a performance analysis 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'. Related NIATx [study](#) and [web site](#) 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](#) developed by the US NIATx quality improvement resource. 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 expert to individually

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‘coach’ them through the process. Related NIATx [study](#) above and [web site](#) below.

**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 focused on doing 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 Recovery-oriented systems of care** (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*”. 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). Evidence for key elements of recovery-oriented systems of care such as continuity of care anchored in the community and delivered by integrated services on the basis of system-wide education and training. See also associated [implementation case studies](#). 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 set out the options for improving treatment systems. For 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 post-treatment alcohol or drug client outcomes. Part 2 of the report makes recommendations for Australian service planning and commissioning which may in parts be applicable to the UK. Related [UK](#) and [US](#) studies above. For discussion [click](#) and scroll down to highlighted heading.

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

**G Commissioning integrated drug treatment systems in England** (Public Health England, 2018). Key principles and associated action-prompts for developing an integrated local system to reduce drug-related harm, including treatment. One of a [suite](#) of commissioning guidance and resources. Supported by ‘return on investment’ [resources](#) (Public Health England, 2016) enabling commissioners to estimate social benefits and effects on performance indicators of various interventions.

**G Scotland’s vision of a high quality treatment system** (Scottish Government and Convention of Scottish Local Authorities, 2014). What for the Scottish Government ‘quality’ consists of in substance use services. Intended to ensure commissioning of services of sufficient quality to meet the needs and aspirations of a local population. An [evaluation](#) ([Scottish] Care Inspectorate, 2017) reported that “Overall, the Quality Principles are being embedded and beginning to show some impact in more person-centred treatment, care and support”. The report seems no longer available but there are summaries ([1](#) [2](#)). See also more provider-oriented English guidance for [NHS](#) and [independent](#) substance use services.

**G Commissioners in England face challenge of funding cuts** ([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, in England “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 sector-led [survey](#) of treatment services in England in December 2016 to March 2017 which “uncovered worrying signs that damage has already been done and the capacity of the sector to respond to future cuts has been eroded”.

**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 Integrated care for drug or alcohol users** (produced for the Scottish Advisory Committee on Drug Misuse, 2008). Guidance for Scotland on implementing a treatment system which combines and coordinates all the services required to meet the assessed needs of patients.

**G Strategies to promote continuing care** (2009; [free source](#) at time of writing). Expert US consensus on practical strategies to promote continuing care based on a [review](#) (2009) which was [later updated](#) (2014; [free source](#) at the time of writing) and the data reanalysed, with results still supportive of continuing care/aftercare but less strongly. Related seminal paper [above](#). More on continuing care in [cell D2](#).

**G US NIATx system change resources** ([US] NIATx, accessed 2018). Web-based service provided by the University of Wisconsin and supported by US government, offering practical strategies for commissioners and planners to promote change [across a treatment system](#) including engaging services in mutual leaning and support, tested in a study [listed above](#). Specific aims include reducing waiting times and improving retention (see [this example](#) listed above), and increasing admissions and reducing no-shows (see [this example](#)). For discussion [click](#) and scroll down to highlighted

heading.

**G Planning and implementing treatment and rehabilitation** (United Nations, 2003). Strategic framework, integrating services, and evaluation.

**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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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 intended 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 getting services to learn from each other. That way you will at least give more patients a *greater chance* of getting better, though whether the process *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' 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. Within each 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 interest across collaborating clinics.

## Issues to consider and discuss

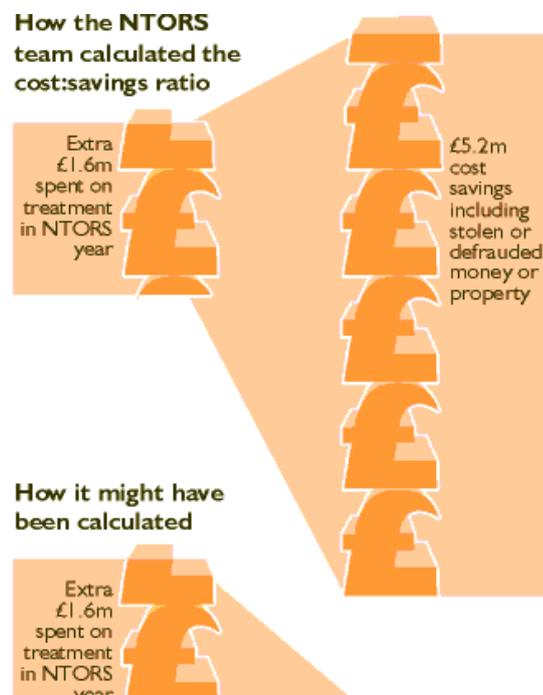
► **Were cuts in crime ever the justification they seemed for treatment?** In the 1990s post-treatment cuts in crime resulted in an estimate that society saved £3 for every £1 spent on treatment, helping to rescue UK drug services from an attack by the then Conservative government (for which see [cell A2's bite](#)). The same finding became the subsequent Labour government's main rationale for expanding provision.

Since 2010 crime-reduction has been subsumed under the broader recovery agenda, but the economic bottom line remains the same: **in terms** of hard-nosed return on investment, the main justification is still cuts in crime linked to the reduced need for overwhelmingly poor and unemployed patients to raise money for illegal drugs. This is the case not just in Britain but **also across** US cost-benefit studies, in which reduced crime usually accounted for most of the cost-savings for society from addiction treatment. In contrast, savings in health service costs and gains due to increased employment were minor.

Crime reductions after treatment entry are real enough, but did society really save as a result? The '£3 for £1' estimate came from the [NTORS study](#) of patients newly attending drug treatment services in England in 1995. From that data it was calculated that £5.2 million crime-related savings resulted from an extra £1.6 million spent on treatment – roughly the 3:1 ratio ► figure.

Look at the [Effectiveness Bank analysis](#) and the [presentation](#) cited [above](#). They explain that:

- Unusually, the £1.6 million was not the full cost of treatment during the follow-up year, but how much this exceeded the £1.4 million spent the year before; add in the full costs and arguably assume previous treatment helped too, and costs could rise to £4.4 million – close to the calculated savings.
- A large proportion – probably nearly half – of the savings related to stolen or defrauded property and money, from which the calculations unrealistically



assumed no one benefited. Eliminate these (as some economists would) from the calculations and savings might drop to £2.9 million.

Already these alternative assumptions result in treatment costing more than it saved, implying that in these terms, it was a bad deal for society. But there was more. Plausibly (as [NTORS](#) itself [suggested](#)), criminal activity peaked before treatment entry and then progressively fell. If this was the case, the [study's methodology](#) would have inflated the before-to-after crime reduction and in turn the cost-savings estimate.



In any event, among [NTORS'](#) [caseload](#) crime reduction justified treatment only for the **1 in 10** patients highly criminally active before treatment, among whom reductions in acquisitive crime were concentrated. And whatever the true figures, criminal justice savings may not be an incentive to health services, which bear the costs not only of addiction treatment, but [sometimes also](#) of responding to the medical needs revealed when patients enter treatment.

But a failure (if that's what it was) to *demonstrate* net benefits is not the same as there being none. Benefits there almost certainly were in terms of saved and improved lives. These were not included in [NTORS'](#) economic estimates, leaving crime as the main component.

This crucial episode in the survival and expansion of treatment provision in the UK raises some fundamental issues. Most of all, how precarious it is to justify treatment as *saving* money, rather than seeing it as money *well spent* to save lives and alleviate distress and illness. Ask yourself, does anyone question cancer treatments on the grounds that they fail to save more money than they cost? Instead the traditional yardstick is how much the treatment costs per year of good quality life it gains. Unfortunately, drug addiction treatment also [appears to](#) perform poorly on this [incomplete](#) yardstick; addiction to illegal drugs spreads diminished quality of life well beyond the patient.

You might also ponder whether the researchers should have presented alternative cost:savings scenarios, even if they showed costs exceeding savings. And if they had, given the scepticism over treatment [which generated](#) the study, whether that would have meant a funding standstill or a shrinking treatment system incapable of helping all but a small proportion of those in need. In the end, was this limited and questionable analysis a 'good thing'?

► **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 influence and scrutiny. Setting *process* targets/incentives for them may persuade them to improve that process (such as retention), but this may bear little relation to improved patient welfare and reductions in problem substance use. It seems to make more sense to pay services to achieve those desired outcomes, rather than to do things expected to lead to that way, but which may not.

Certainly it made sense to the UK government, which has advocated this mechanism and set up 'payment-by-results' pilot schemes in eight areas to test it, and which [remains](#) enthusiastic, at least in respect of probation service providers. 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 was appointed to advise on addiction treatment in England) that payment-by-results arrangements are among the most promising strategies for improving treatment outcomes. Are they 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 – and set these criteria in a way services cannot afford to ignore.

A [US study listed above](#) hints 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.

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 before sustainably overcoming dependence. 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 of recovery (see [leading US version listed above](#)) and [associated understandings](#) (document [listed above](#)) of addiction, but on discharging patients who then are not seen again for at least a year. Does that 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? Should (as [explored](#) in cell D2) 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, a [review of reviews](#) could find no evaluations which reported on patient outcomes. Specifically in respect of substance use treatment, [another review](#) ([listed above](#)) could find "no peer-reviewed evidence that [payment for performance] ... improves client outcomes post-treatment". When a leading UK commentator on such schemes [reviewed the literature](#), he found "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. Funded by the UK Department of Health, a [study listed above](#) compared results in the eight pilot scheme areas in the two years before and after the schemes started with corresponding results from comparison areas. Fewer clients in payment-by-results areas met the three-weeks-or-under waiting time target, fewer started treatment after their initial assessments, more left treatment as an unplanned discharge, and fewer successfully completed their treatment or completed without later having to return.

*Could the pilot's payment-by-results mechanisms actually have made things worse?*

There were countervailing gains in abstinence and non-injecting *during* treatment, but successful treatment completion, exit and non-return is the UK government's [key indicator](#) of recovery from substance use problems, and on this measure the pilots seem to have made things worse – findings which contributed to the researchers' verdict that the pilot areas had "performed worse in

a number of these recovery-specific outcome domains, despite their apparently greater emphasis" on recovery. In other words, the attempt to promote recovery by 'paying' for it, seemed to have backfired.

The study showed that earlier similar findings from two studies of the first years of the schemes were not just due to short-term implementation difficulties; [unfold](#)  [supplementary text](#).

 [Close supplementary text](#)

The Department of Health's own evaluation found [consistent](#) gains only in the proportion of drug using patients who *while in treatment* said (via forms completed by staff) they had stopped using their problem substance(s), while the proportion exiting treatment free of dependence was lower in the pilots – findings which persisted to the later evaluation. "Mixed" was the document's characterisation of the results; "disappointing" might also have been justified – but these were early days.

Next the Department funded independent researchers to evaluate the schemes, including some involved in creating and maintaining the key data source, the [National Drug Treatment Monitoring System](#). Their peer-reviewed [journal article](#) [listed above](#) was based mainly on patients with heroin and crack cocaine problems treated in payment-by-results areas in the first year of the schemes compared to earlier years and other areas. The analysis confirmed that the proportion of patients successfully exiting treatment (no longer using heroin or crack and no longer dependent) was lower in scheme areas. The difference was slight but statistically significant and consistent across various comparisons. Also slight but significant was the higher rate of patients declining to start or engage with treatment after contact with the treatment system.

 [Close supplementary text](#)

Across all three studies there is a consistent picture of fewer successful and lasting treatment exits, but some greater gains during treatment in abstinence and also in the remission of injecting. Speculations made by the researchers to account for these results included an unintended focus on in- rather than post-treatment performance indicators (easier to achieve and measure), and keeping patients longer in

treatment to cut down the number who return to treatment after leaving.

Why more potential patients did not start treatment after being assessed is even less clear, but [it seems](#) this finding was due to the performance of just one of the eight pilot sites, whose central assessment unit assessed “clients for interventions other than structured treatment”. Together with more waits of over three weeks, the findings suggest that ([as feared](#)) the pre-treatment assessments needed to set payment-by-results tariffs can (but not necessarily) act as a barrier to starting treatment. Set against this are some perceived benefits, [including](#) more consistent and more comprehensive assessments and better data on treatment demand.

You will have your own questions about payment-by-results and their English implementation, so critical to the future of treatment in the UK. Here are some starters. 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? 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 ‘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? Could the pilot’s payment-by-results mechanisms actually have made things worse, causing a deterioration in the main outcomes they were intended to improve?

► **What makes a local treatment system excel?** For some possible answers we can roll back to the 2000s and the era of the National Treatment Agency for Substance Misuse ([NTA](#)), an unprecedented experiment in the central promotion and control of addiction treatment in England – and in particular, back to their work on care planning, the core process of planning, evaluating and adjusting a patient’s treatment plan.

With its leverage and data systems, the [NTA](#) was able to establish that commissioning areas differed in how well patients were worked with and in patient outcomes. For example, though generally in the same ball park, local areas [could substantially differ](#) (2012) in how completely their heroin-using patients manage to avoid heroin use during treatment, even after adjusting for caseload differences.

Those figures derived from patients starting treatment in 2008–2010. A few years before, in 2005/06 the [NTA](#) had found similar variation in the quality of care planning and prescribing, revealed by surveys responded to by nearly all 149 drug action teams in England, then responsible for planning and commissioning addiction treatment in their areas. Of the 148 which were rated, 106 scored as “fair”, 33 as “good” and seven as “excellent”

The assessments included data from client surveys and directly from treatment services in the areas, and it was when these were analysed that this generally rosy picture came most strikingly into question. For example, an analysis of the documents services used for care planning, triage, and assessment resulted in half the areas being scored as “weak”, while around two-thirds of clients either were unaware of their care plans or said they had not been reviewed in the last three months.

Unusually, a subsequent analysis went beyond identifying variation in performance to trying to account for this variation. The data was used to select eight areas to investigate further via interviews with staff. All eight had either scored well overall or on certain components of the assessment. Next the interviews were sifted to identify features thought to have had a positive influence on care planning. Starting on page 9, the [resulting report](#) ([listed above](#)) offered what could be seen as a list of features which might be addressed to improve care planning.

*The analysis went beyond identifying variation in performance to trying to account for this variation*

Take a look at these [22 features](#). Some, it has to be admitted, are expansions of the criteria used to assess that areas were good at care planning, rather than underlying reasons why these criteria were met. Some too are likely to have been compromised by the austerity era which began as the [NTA](#) neared its

absorption into Public Health England, accompanied by the transfer of responsibility for treatment to local authorities and the ending of the central fund reserved for treatment. Per-patient belt-tightening began (1 2) as long ago as the mid-2000s. Overall budget cuts followed, until by 2017 the government's advisers saw the achievements of the NTA as under threat, and with these not just the recovery but the health and lives of substance users. The same year a survey of treatment services in England "uncovered worrying signs that damage has already been done and the capacity of the sector to respond to future cuts has been eroded".

In this situation, how likely is it that patients will have access to "the full range of treatment services" (one of the features thought to improve care planning), including expensive options like residential rehabilitation and inpatient detoxification? What of the chances of clinical leadership by expensive specialist psychiatrists or other doctors supervising "skilled and competent" staff? Already in 2008 it was being said that consultant psychiatrists and clinical psychologists were being left out of re-tendering specifications for local treatment systems – and that from a base reckoned to be only a quarter of the number of addiction psychiatrists required in England.

These warnings were, it seems, not entirely taken to heart. In 2014 Public Health England and professional medical bodies remained concerned at feedback from commissioners and providers which "indicated that the number of specialists (many are addiction psychiatrists) in local treatment systems is reducing, due either to recommissioning of services or cutting of posts within existing services". By 2017 treatment services reported an increasing reliance on volunteers for work previously undertaken by professionals. On the other hand, local authority 'ownership' of the treatment system ought to improve the chances of "Good links with local partners responsible for wraparound services", another of the features thought to improve care planning.

Together with your colleagues, you might want to discuss whether you are convinced that these 22 characteristics really did at the time underpin high quality care planning, whether they remain relevant, and how many are malleable features which could be changed to improve performance, even in today's more straitened circumstances.

*Thanks for their comments on a draft of the original version of this cell to Professors A. Thomas McLellan, Keith Humphreys and Michael Gossop. Commentators bear no responsibility for the text including the interpretations and any remaining errors.*

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