DRUG ALCOHOL FINDINGS *Hot topic*

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Individualising treatment: an obviously 'good thing'?

Individualisation of treatment is the deliberate attempt to ensure that treatment is adapted to each clients' preferences and characteristics, an attempt which if successful is expected to make treatment more attractive and more effective. Not quite the same as matching, which is about determining the best treatment package for groups of patients sharing the same characteristic, individualisation implies that each patient is treated as a unique treatment challenge. Substance use treatment tailored to the needs of individuals can be achieved by patients and practitioners working together to set goals, the ongoing monitoring and assessment of a wide range of psychosocial issues, and by integrating treatment for problem substance use with addressing underlying medical or mental health issues.

Individualisation might seem an obvious and basic prerequisite to substance use treatment, but in fact services have often striven for uniformity. Early heroin addiction treatment clinics in Britain sought to homogenise their prescribing in order to avoid patients arguing for alternatives (like injectables) on the grounds that other patients were being prescribed them. Similarly, therapeutic communities rigidly implemented traditions, procedures and hierarchies, seeing any attempt to tailor these to the individual as invitations to (or indications of) denial or avoidance.

Among the influences generating greater individualisation was the advent of HIV, which in the 1980s led some British therapeutic communities to relax their regimens and to take more account of individual needs, particularly those of patients infected with the virus. There are other examples of therapeutic communities modifying services to accommodate the individual needs of adolescents, women, and people with co-occurring disorders, without compromising their traditional ethos. In the late 2000s the emergence of the recovery agenda encouraged British methadone maintenance services to more holistically assess and respond to each patient in order to progress their individual journeys out of addiction, but also, as discussed below, introduced new pressures towards de-individualisation.

Understood as a failure of treatment rather than the patient, another strong influence has been the sight of the backs of patients and potential patients leaving or rejecting treatment in large numbers. Motivational interviewing was introduced to avoid this rejection by systematising the imperative to start from where the patient 'is at', not where the therapist thinks they should be at, or where they need to be at in order to benefit from the fixed treatment package on offer. Researchers and clinicians have stressed that healthcare structures for treating substance use problems must provide a continuum of different types and intensities of interventions tailored to the different needs of individual patients and their families. Continuity of therapy, inter-professional networking, and flexible conceptualisations of recovery are considered essential elements in providing this type of individualised treatment. Recovery "should not be obsessively characterised by achieving an immediate alcohol-free state, which considering the psychopathological profile of the alcoholic will certainly result in treatment failure in some individuals".

Choice of drinking goal for problem drinkers – specifically, abstinence versus moderation – has for decades been a controversial issue. The fascinating history is outlined in this hot topic. Findings from a major UK study and from most others support arguments that treatment programmes for dependent drinkers should not be predicated on abstinence or controlled drinking goals, but offer both. Nor does the literature offer much support for requiring or imposing goals in the face of the patient's wishes. In general it seems that (perhaps especially after a little time in treatment) patients themselves gravitate towards what for them are feasible and suitable goals, without services having to risk alienating them by insisting on a currently

unfavoured goal.

What do we mean by recovery?

Since the late 2000s the emphasis on holistic recovery, accompanied by a turn towards dependence-free treatment exit as its main signifier, should have further individualised treatment in line with the mantra that for each dependent drinker or drugtaker, recovery is an individual and unique journey. According to experts convened in 2008 by the UK Drug Policy Commission, recovery from substance use problems is "characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society", producing an "accrual of positive benefits … a satisfying and meaningful life". This broad conceptualisation left room for many forms of recovery depending on what for that patient was "satisfying and meaningful".

However, in practice policies and initiatives introduced in the name of recovery have not always lived up to that vision. The contradiction was sharpest in the 2012 UK Government's policy document *Putting Full Recovery First*, which placed opiate maintenance prescribing outside of the remit of the recovery agenda by promising to bring "an urgent end to the current drift of far too many people into indefinite maintenance, which is a replacement of one dependency with another". The controversial nature of long-term maintenance prescribing and Government recovery objectives for substance use issues are discussed further in the respective hot topics.

A particularly risky manifestation of certain understandings of recovery is the drive to set time limits to, and to withdraw patients from, opioid substitute prescribing programmes like methadone maintenance, accompanied by the denigration of in-treatment gains short of 'full recovery' like relative stability, harm reduction and moderation in opiate use. This trend, however, predates the recovery agenda and has been particularly prominent in US discourse. US experts have explored how philosophies and ideologies can bias treatments strategies and definitions of treatment success, asking why maintenance prescribing for substance use disorders (and for opioid use disorders in particular) is "often perceived as substituting one addiction for another". The authors suggest that chronic disease models of treatment should be constructed by building patient-focused networks of professionals, and integrating care for substance use disorder *and* underlying medical or behavioural health issues. They argue that medication-assisted therapy is an important component for some patients, keeping them safer by reducing rates of overdose and overdose death, and increasing compliance and adherence to other medical services, valid markers of successful treatment.

Individualisation can be systematised

Though this might seem contradictory, individualisation can be systematised. An example was implemented at a Dutch inpatient programme for drug and/or alcohol dependent patients in need of further help after outpatient treatment. It involved patients and clinicians using standard surveys and cards and a standard procedure to prioritise goals in relation not just to drinking and drug use, but also other issues such as physical and mental health, psychological distress, housing, eating, relationships, social life, and daytime activities. Patients and clinicians compared their choices, typically generating dialogue over the feasibility and benefits of the various treatment goals and expectations. Later they evaluated progress and reviewed the goals. There was some positive impact on psychological health and some limited impact too on substance use.

Individualisation does not prohibit the standardisation of care to achieve consistently high quality, so long as uniformity in the face of patient differences is understood as the opposite to quality care. Where there is evidence of common mechanisms of change, these can be incorporated into treatment plans, alongside known therapy-specific mechanisms of change, and the individual requirements and goals of patients. For example, common mechanisms of change for adolescents accessing treatment include supportive (therapeutic) relationships, increasing motivation to reduce substance use, improving coping skills, increasing self-efficacy to reduce use, and improving the self-regulation of emotions.

The risks of rigidly sticking to therapy-specific guidelines have become apparent in studies of motivational interviewing. Its dos and don'ts (ask open questions, reflect back the client's comments, don't argue, don't warn, etc.) were intended to avoid the traps which provoke clients to defensively dig in their heels, but in certain circumstances adhering to these rules seems to make therapists seem less than genuine, a quality long recognised as one of the keys to effective therapy. Allied findings are that motivational interviewing has actually worked best without a manual for the therapist to follow. This was the conclusion of a review by Findings which was then confirmed by a synthesis of research co-authored by the approach's originator, William Miller. He and his colleagues found that of all the differences between motivational approaches including duration, how many motivational-style principles and techniques were said to have been deployed,

and therapist training and support, only one was related to outcomes – whether the study had made its therapists follow a manual. Unexpectedly, the relationship was in the 'wrong' direction: manualised therapy had less impact.

Fostering a collaborative environment

In the same vein as motivational interviewing, shared decision-making aims to foster true collaboration between patient and practitioner, by informing patients and promoting their sense of autonomy. The relationship in the Dutch programme cited above between patient and clinician can be likened to coproduction – a relatively new term within substance use literature. Coproduction is increasingly being applied in social care settings, characterised by the equal power, status and influence of people who use services and of the practitioners who work with them – designing, delivering, evaluating and making decisions about services together, rather than practitioners guiding and instructing people who use services (the traditional dynamic), or people who use services being merely consulted (as with a participation approach).

Coproduction is a challenge for public services, particularly because many typical characteristics of public service are themselves a barrier to innovative types of service design such as coproduction. One of these is centralised decision-making, which has introduced complex and time-consuming compliance and auditing mechanisms. In this report, one former member of the Bristol drugs action team estimated that he and his service colleagues spent less than 40% of their time tackling drugs. He warned that there is a "demand for quick hits and early wins … driven by a central desire analogous to the instant gratification demands made by drug users themselves". This presents a dilemma: if we neglect to collect outcomes and to define what success means in substance use treatment, we miss the opportunity to recognise positive changes. But, if we standardise measures of success, we risk neglecting people's individual lived experiences. In this Effectiveness Bank analysis you can read about a study which found that patient-defined outcomes and barometers of success are compatible with harm-reduction treatments, but that this means accepting that patient-defined success (in this case de-marginalisation, engagement in the programme, quality of life, social functioning, changes in substance use, and changes in future goals and plans) might differ from traditional notions of success in substance use treatment.

Across psychotherapy, one strand of substance use treatment, the evidence is strongly in favour of patients and therapists collaboratively agreeing goals and how they will go about reaching them, underscoring the importance of having empathic, client-centred staff capable of and willing to incorporate patient preferences when making treatment decisions. These qualities can be expressed in simple ways like individualised, handwritten reminder letters, or in more sophisticated attempts to ensure the client's preferences and characteristics are acted on in ways which improve the effectiveness of talking therapies. So important has this become that a high-level US psychology task force has comprehensively reviewed what works best not just for substance using clients, but for psychotherapy clients in general. Visit this Effectiveness Bank analysis as a gateway to all eight reviews, each focusing on a particular client characteristic.

Supporting ongoing progress

The key to individualising treatment in the long-term may lie in comprehensive assessment and monitoring measures – increasing the capacity of practitioners to detect early signs of relapse (in line with chronic disease models of addiction), and keeping the door open for re-intervention. This approach emphasises "regular recovery status checkups as an essential tool for achieving and sustaining recovery", supported by computerised measures which reduce the burden on both patients and practitioners, such as those currently found in the Patient Reported Outcomes Measurement Information System (PROMIS), funded by the US National Institutes of Health.

While the above study suggests that assessment and monitoring may help to prevent relapse and to sustain recovery, this small pilot study indicates that assessment and personalised feedback may increase early engagement with treatment. Patients enrolled in a 90-day residential programme were randomly allocated to either a therapeutic assessment intervention or a comparison group. Patients in the intervention worked with an assessor to develop questions based on what they would like to learn about themselves from a personality assessment. During a feedback session, they were encouraged to assist with interpretation of the results of the personality assessment – explaining how well the test's description of their personality matched their experiences in the residential setting and of their lives more generally. Although no differences were observed between intervention and comparison in treatment outcomes, those in the intervention group had a longer length of stay in the programme than those in the control condition, and were also more likely to report positive relations with other residents.

Ceding control to the patient need not be dangerous

National professional and clinical guidelines can present a barrier to individualised care, particularly when it comes to prescribing services. Fear of stepping beyond guidelines can generate a climate in which professionals prioritise implementing guidelines and accepted practices rather than the patient’s needs and preferences, despite evidence that meeting needs and preferences may be a more effective strategy.

When it was tried, opiate-addicted patients were found capable of being supported to initiate buprenorphine/naloxone treatments at home, rather than all doses having to be supervised and adjusted at the clinic. Another tactic successfully tried several times is to (within safe limits) let patients set their own doses of substitute drugs. Results were equally good when staff retained control yet were flexible and patient-oriented, underlining the importance of empathic and understanding staff centred on the needs and reactions of the patient.

For some patients, regular attendance at the prescribing clinic to take medication could aid individualisation by permitting fine adjustment of doses and an opportunity for frequent medical and psychosocial interventions, whilst for others regular attendance could impede wider personal goals for recovery.

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