RESPONSE TO COMMENTARIES

Measurement-based care using DSM-5 should be embedded in services now with scope for further development following efficacy and implementation trials.

We are grateful to Kathy Bradley and her colleagues [1] and Dennis McCarty [2] for their helpful comments on our article on measurement-based care (MBC) [3]. They draw on a wealth of applied experience in efficacy and implementation research in primary care (PC) and substance use disorder (SUD) treatment programmes. Their reflections emphasize the challenge of embedding sustainable clinical measurement of patient progress.

Bradley and colleagues illustrate the way PC clinicians' use of open-ended questions about SUD symptoms can facilitate discussions with patients, beginning with topics and experiences which are important to the person. This is an ideal way to help the patient feel understood, to build therapeutic alliance and review interventions offered. We had this in mind when envisaging DSM-5 criteria as the springboard to a collaborative discussion on the patient's specific SUD-related thoughts, emotions and behaviours. The aim is that treatment goals reflect personal priorities.

We agree with Bradley's group that we must ensure the MBC administrative burden is minimized. This has been a priority for all contemporary developers of screening [4] and clinical instruments [5], reflecting a move away from unwieldy scale batteries and a focus on selecting items which provide the most useful information. As a minimum, we think drug craving and substance use should be monitored during the first 2 weeks after medication stabilization and regularly thereafter, to guide decisions as to whether treatment should be maintained, adjusted or switched. Brief items and scales are likely to correlate with DSM-5 SUD criteria but, importantly, they do not confirm remission.

McCarty offers insight on his work with providers striving for process improvements in patient retention and engagement [6]. He reports how managers stopped asking therapists to complete the brief Session Rating Scale and Outcome Rating Scale [7,8] after inconsistent use and difficulties with data capture and feedback. This demonstrates how even a very brief measure can flounder in busy clinics. We agree that inconsistent completion confounds validity. Less frequent, consistent completion would be sufficient—and there are also other options. As we discussed, the PHQ-9 is commonly used to monitor symptoms for depression and inform treatment decisions. It is usually self-completed, so it does not compete with session time. Digitally enabled adjunctive psychological therapies can now be offered on-line or through mobile applications to help patients engage in self-monitoring of craving and self-study with discussion face-to-face with a therapist [9,10].

We appreciate that PC providers may query the cost of MBC, but in our view it is clearly warranted by the urgent need for improved treatment outcomes, especially in the context of the OUD epidemic. Clinical trials are needed to study MBC efficacy and implementation. Indicators that guide the way will emerge as a standard—but the objective must always be to help patients access and remain in effective, personalized treatment for as long as is needed. In our view, DSM-5 (or ICD-11) diagnosis and ongoing remission assessment, with interventions matched to symptoms, should be included as the standard of care in all out-patient and PC settings.

Declaration of interests

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Keywords Implementation, interventions, measurement-based care, medications, opioid use disorder, tailored.

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