



DRUG & ALCOHOL FINDINGS

A collaboration between DrugScope, Alcohol Concern, the National Addiction Centre and the editor Mike Ashton devoted to communicating 'what works' research findings to British practitioners and policy makers. Findings is supported by grants from the J. Paul Getty Jr. Charitable Trust and Alcohol Research UK.

The matrices were commissioned by the Substance Misuse Skills Consortium.

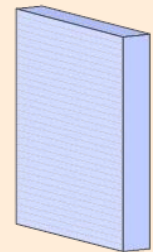
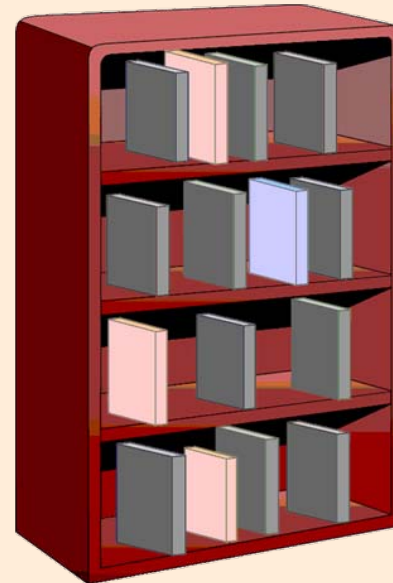
Further information at <http://findings.org.uk> or from editor@findings.org.uk

A funnel of increasing select(subject)ivity

From a library of about 17,000 documents

Via a hyper-selection of two or three seminal studies,
key studies, reviews and guidelines – the matrices

Finally to one sample seminal study

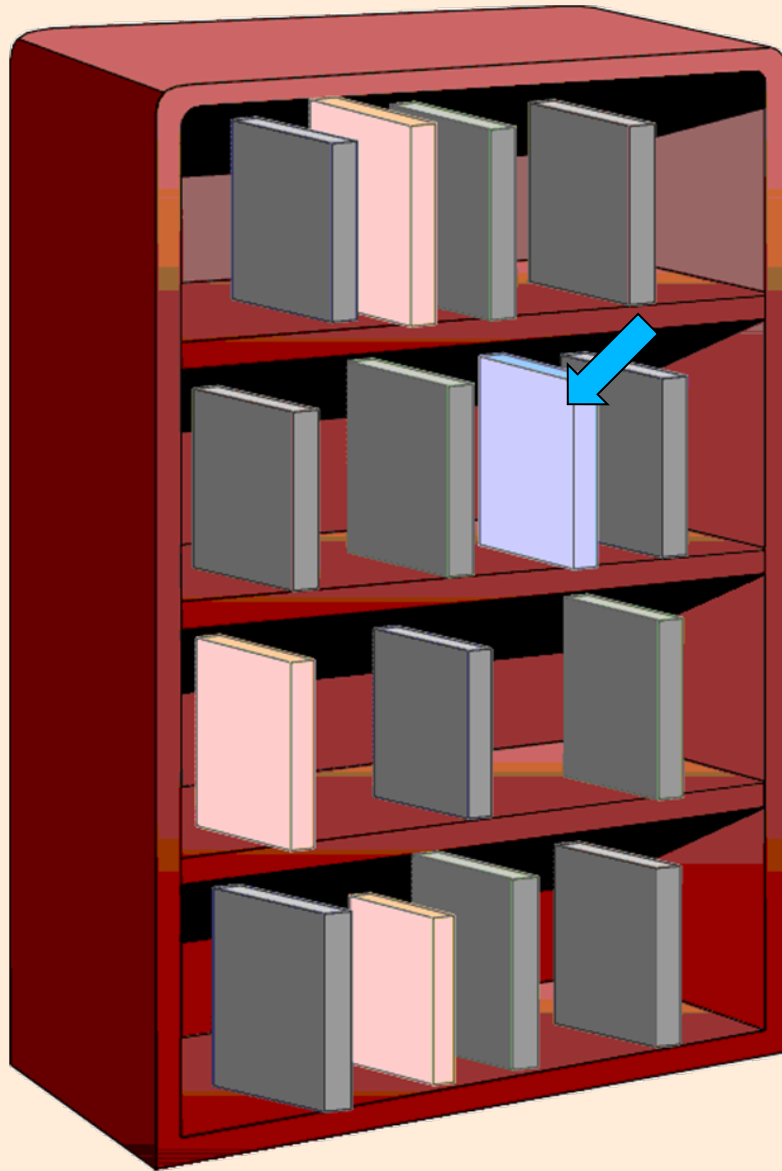




Stage I: the library

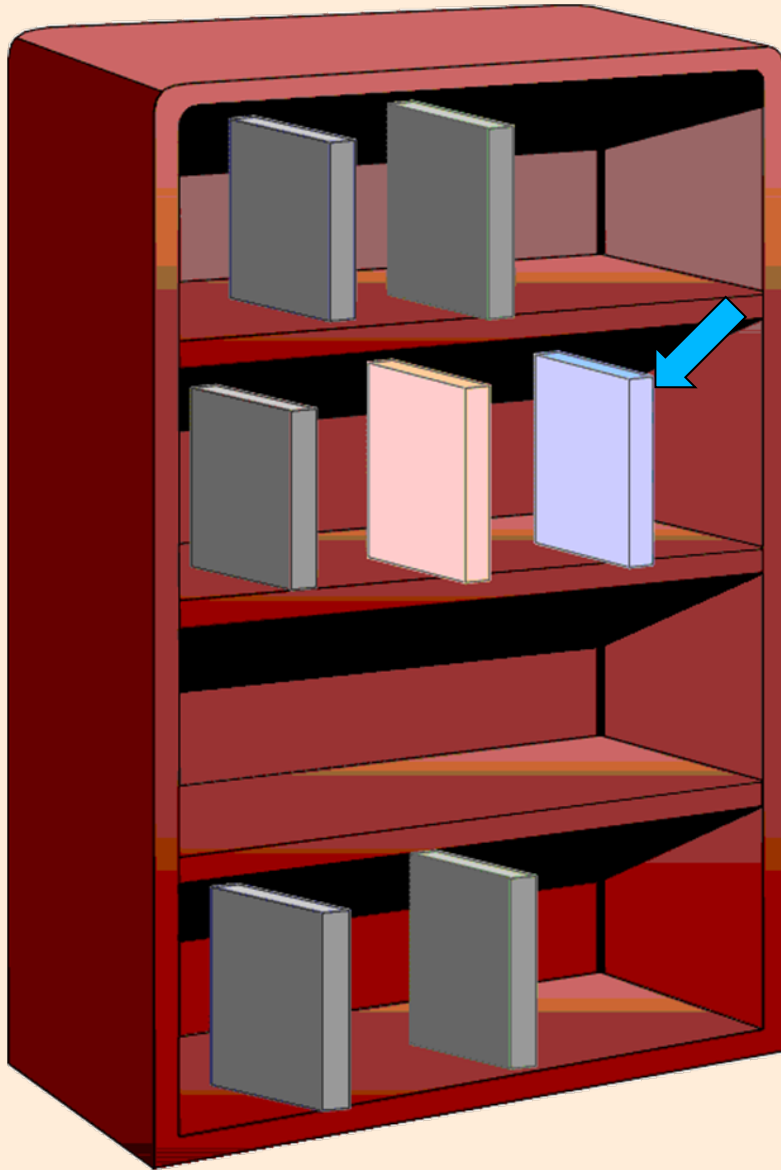
A library of about 17,000 documents, the largest live drug and alcohol library in Britain, housed in a back room in Tottenham.

All relevant to evaluating interventions to prevent or reduce drug or alcohol use or problems in the UK.



Stage 2: the Effectiveness Bank

An accumulating selection now of about 900 documents whose findings have been described and usually analysed and commented on, mainly chosen for their combination of rigour and relevance. These analyses are uploaded to a database which serves the Effectiveness Bank site. Each analysis looks something like ...



Stage 3: the matrices

“A godsend for practitioners and commissioners”

“Just awesome”

“Brilliant”

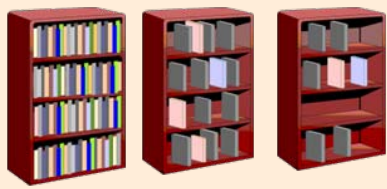
“You are a freaking legend”

“A real *tour de force*. Brilliant”

“Wow – this is terrific stuff”

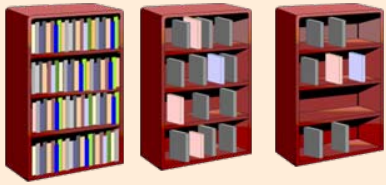
“Wow!! This is simply too good”





Organisational level	A Interventions	B Practitioners	C Management/ supervision	D Organisational functioning	E Treatment systems
Intervention type					
1 Screening and brief intervention					
2 Generic and cross- cutting			C2		
3 Medical treatment					
4 Psychosocial therapies					
5 Safeguarding the community					





Where available, each cell includes links (or links to corresponding Effectiveness Bank analyses) to a few:

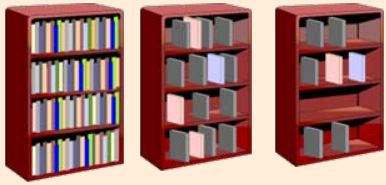
Seminal studies from the past of lasting relevance

Key studies; usually more recent studies of particular importance

Reviews of the research on this topic

Guidance on practice based on the research

Searches for other relevant documents on the Effectiveness Bank web site



Matrix Bites

“Let me take you by the hand ...”

A weekly cell-by-cell ‘bite-size’ introduction to the Alcohol and Drug Treatment Matrices, cumulating to a year-long foundation course on the evidence base for treatment and allied interventions. Each offers an overview of the cell, shows you where to start with it, and highlights a particularly crucial study. To stimulate further learning and discussion, each also points to further reading on some key questions.

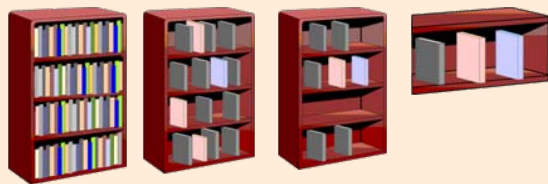




Now we can have a look at the

Alcohol Matrix

Intervention level ► Intervention type ▼	A Interventions Techniques, programmes, equipment, therapies or medications ... more	B Practitioners Staff attributes, training, skills, qualifications, and competencies ... more	C Management/supervision Selecting, training and managing staff and managing interventions ... more	D Organisational functioning What kinds of organisations foster effectiveness at levels A, B and C ... more	E Treatment systems Fostering effective organisations and an appropriate mix and quality of services across an area ... more
1 Screening and brief intervention Identifying and advising people not seeking help for their drinking but who might benefit from it ... more	Effectiveness of alcohol screening and brief intervention	Impact of the practitioner in brief interventions	Role of management and supervision in screening and brief intervention	How organisational functioning affects impacts of screening and brief intervention	Local, regional and national systems for implementing screening and brief intervention
2 Generic and cross-cutting Affecting medical and psychosocial treatments and criminal justice work ... more	Aspects of interventions relevant both to therapy and medical treatment	Impact of the practitioner across therapy and treatment	Role of management and supervision across treatment and therapy	How organisational functioning affects treatment and therapy	Influence of treatment systems on impacts of therapy and treatment
3 Medical treatment Treatment in a medical context involving medical care, usually medications ... more	Medical interventions and treatment in medical settings	Impact of the practitioner in medical settings and treatments	Role of management and supervision in medical treatments and settings	How organisational functioning affects impact of medical treatment	Influence of treatment systems on impacts of medical treatment
4 Psychosocial therapies 'Talking therapies' in which human interaction is the main active ingredient ... more	Psychosocial therapies: general principles and specific interventions	Impact of the practitioner in psychosocial therapies	Role of management and supervision in psychosocial therapies	How organisational functioning affects impact of psychosocial therapies	Influence of treatment systems on psychosocial therapies
5 Safeguarding the community Funded or ordered to safeguard the wider community, or studies of these impacts ... more	Effectiveness of treatment intended to safeguard the community	Impact of the practitioner in criminal justice and allied work	Role of management and supervision in safeguarding the community	How organisational functioning affects treatment's impact on the community	Influence of treatment systems on treatment's impact on the community



Alcohol matrix cell C2

Management/supervision; Generic and cross-cutting



S [Organised caring transforms alcohol clinic](#) (1970): Remarkable series of US studies from the late 1950s proved that an alcohol clinic's intake and attendance can be transformed by being responsive to need and systematically and caringly keeping in touch with patients.

K [Identifying rapport-generating counsellors](#) (2002): From responses to written counselling scenarios it was possible to identify which counsellors would best generate retention-enhancing rapport at a Finnish outpatient alcohol clinic.

K [Walk in their shoes](#) (2008): Getting staff to simulate being a new client helped halve waiting times and extend retention in non-medical services. See also this [extension](#) (2012) to the programme and [this account](#) (2007) of the 'walk-through' procedure.

K [Matching resources to needs](#) (2005): Automatically linking assessed problems at treatment intake to local services transformed assessments from redundant paperwork into a practical route to needed services.

R [Implementation strategies](#) ([Australian] National Centre for Education and Training on Addiction, 2008): Lessons from health promotion and medical care on how to improve addiction treatment practice by introducing research-based innovations.

R [The power of the welcoming reminder](#) (2004): In seemingly mundane tasks like reminding patients of appointments and checking how they are doing after they leave, individualised and welcoming communications characterise retention-enhancing services.

G [Staff development toolkit](#) ([UK] National Treatment Agency for Substance Misuse, 2003).

G [Competencies and training needs for Scotland's substance misuse workforce](#) (NHS Health Scotland, 2011): Desired competencies for staff dealing with alcohol and drug problems at all levels including criminal justice settings.

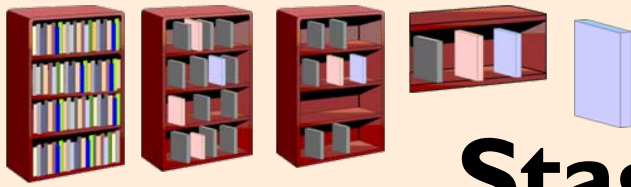
G [Theory into practice strategies](#) ([Australian] National Centre for Education and Training on Addiction, 2005). Workforce development strategies.

G [Managing non-residential programmes](#) ([US] Substance Abuse and Mental Health Services Administration, 2006): US consensus guidance.

G [Clinical supervision and professional development of counsellors](#) ([US] Substance Abuse and Mental Health Services Administration, 2009).

MORE This search retrieves all relevant analyses.

For subtopics go to the [subject search](#) page and hot topics on why some treatment services [more effective](#) than others, [matching](#) alcohol treatments to the patient, and [individualising treatment](#).



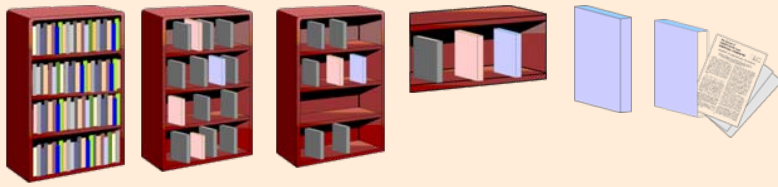
Stage 5: a single entry

S [Organised caring transforms alcohol clinic](#) (1970): Remarkable series of US studies from the late 1950s proved that an alcohol clinic's intake and attendance can be transformed by being responsive to need and systematically and caringly keeping in touch with patients.

Clicking on the title brings up in this case the Findings analysis from the Effectiveness Bank database; in other cases it will be the abstract from the journal's web site or the full original document if available.

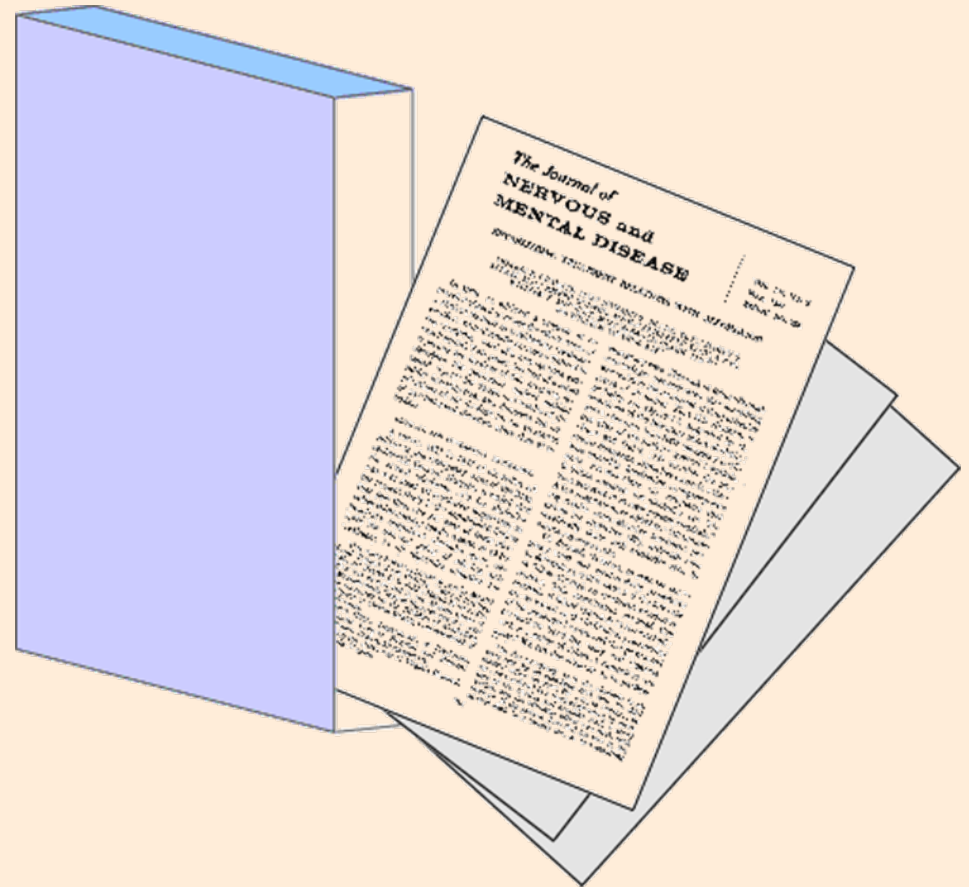
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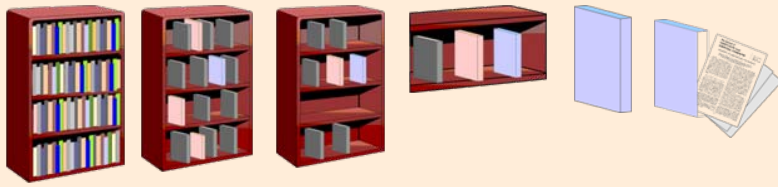
Findings analysis
Journal abstract
Full original document



Stage 6: unpacking the entry

The entry refers to a remarkable series of studies begun in the late 1950s at the emergency department and alcohol clinic of Massachusetts General Hospital in Boston. When we unpack it we encounter not just remarkable studies, but a remarkable man.

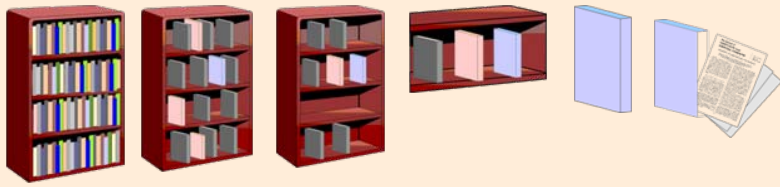




The alcohol clinic was run by Morris Chafetz, later to become founding director of the US National Institute on Alcohol Abuse and Alcoholism. This is him with his wife of 65 years.



Marion and Morris Chafetz



To envisage and conduct such remarkable studies required a remarkable person capable of seeing humanity where others saw dirty drunks.

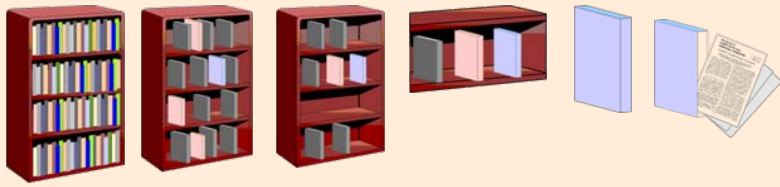
“At that time ... people with alcohol problems were reviled,” said Howard Blane, Chafetz’s co-author and colleague.

“Criminalised ... put in hospitals ... left to lie in the streets ... very little in the way of humane treatment.”

Chafetz was not immune: “I did not think much of alcoholic people. I did not like them.”

“Having experienced the extent of my own prejudices and my own ignorance of the issue, I was bound and determined to turn the country around and to treat alcoholics as ill human beings who needed treatment, not as bad people who should be ignored and neglected.”



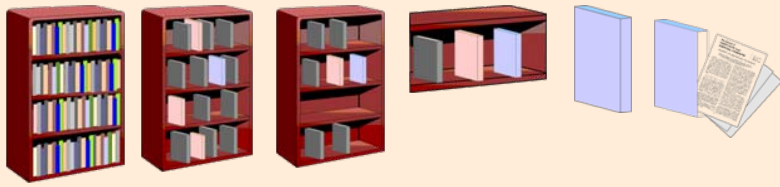


On one occasion, he proposed that schools teach children how to drink responsibly, starting with heavily diluted sherry in grade school. “Alcohol is here to stay, and people must learn to develop a healthy attitude toward it.”

He emphasized scientific findings showing the health benefits of moderate drinking, opposed total abstinence as a social ideal, and promoted the Mediterranean approach to alcohol consumption: in company, with food and never with the goal of intoxication.

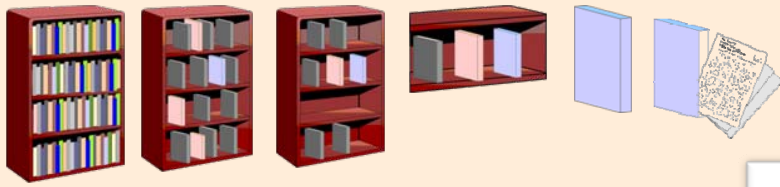
Some thought him too close to the alcohol industry.





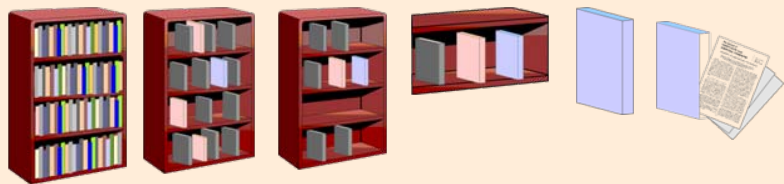
Massachusetts General Hospital in Boston





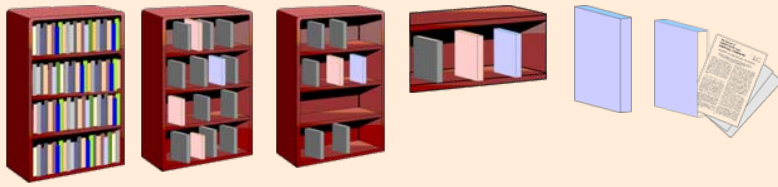
Typically the 'skid-row' alcoholics seen by the hospital's emergency department were in crisis, dirty, disturbed and disturbing. Worst of all they refused to be patients, refused treatment. The effect was to evoke outright hostility and rejection on top of underlying moralising and punitive attitudes. The implicit message from the carers was ...





**You are not
wanted!**





Not surprisingly most left as soon as they could, rejecting referral to the alcohol clinic. This looked a decidedly

unreachable moment

and an intractably

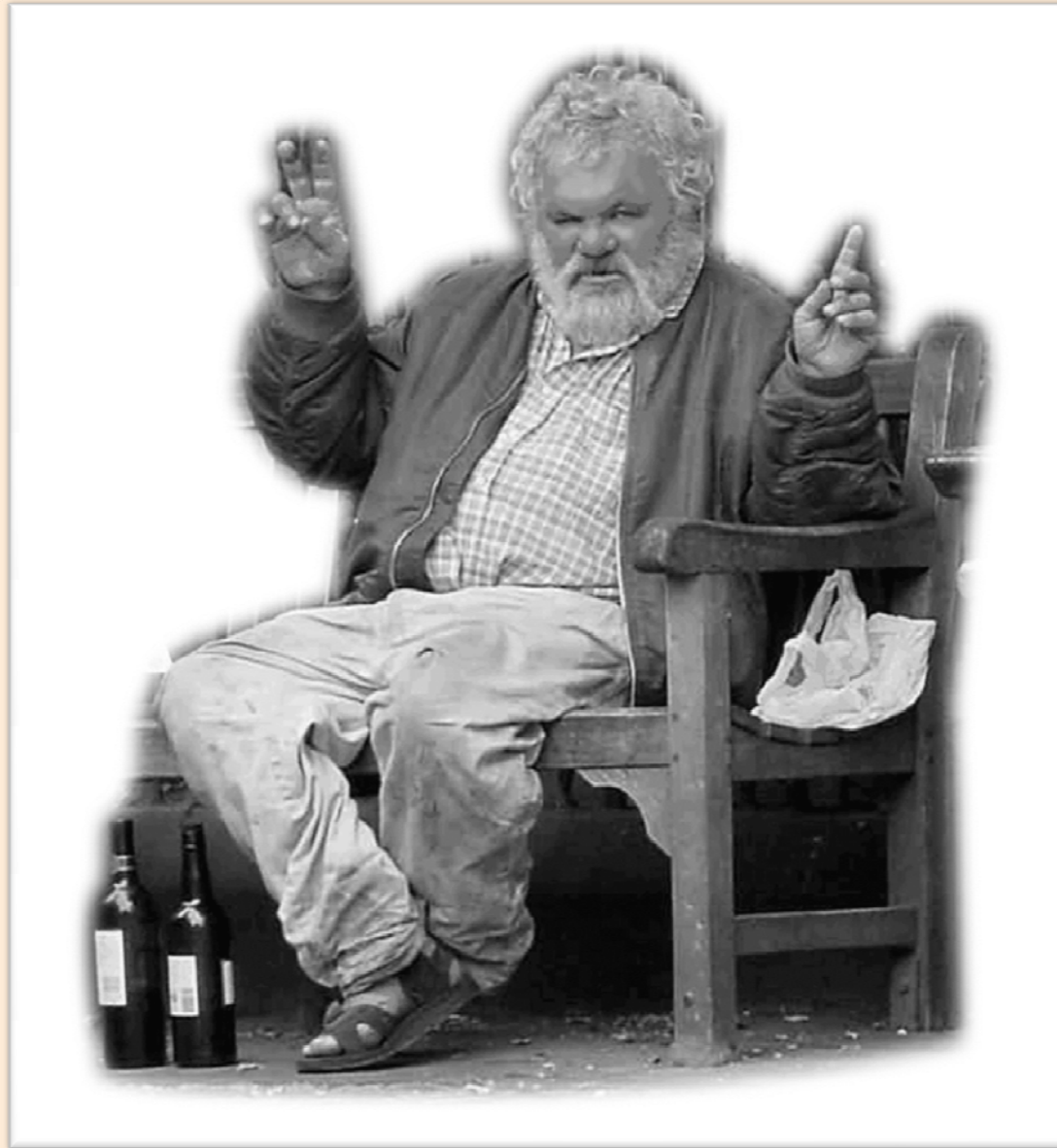
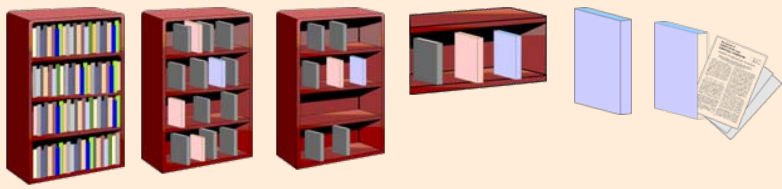
treatment **resistant**

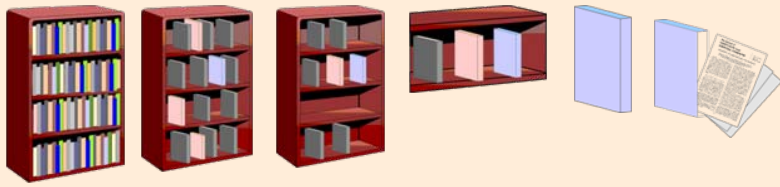
set of

patients from **hell**

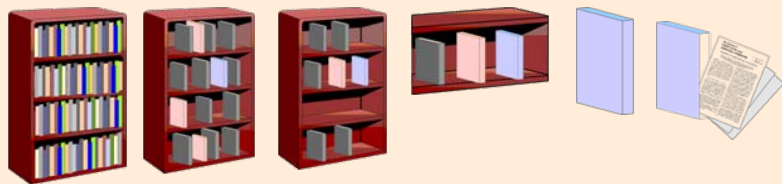
but ...

Less than one per cent of these alcoholics subsequently sought treatment at the hospital's outpatient alcoholic clinic, despite the nominal policy of offering such treatment to all alcoholics admitted for emergency care.



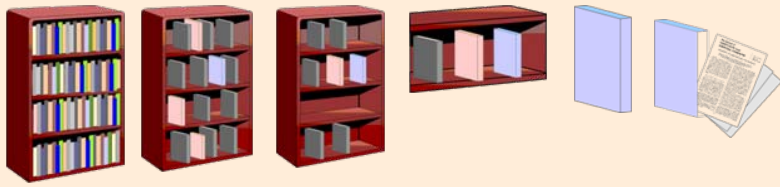


A miracle!



**You are not
wanted!**

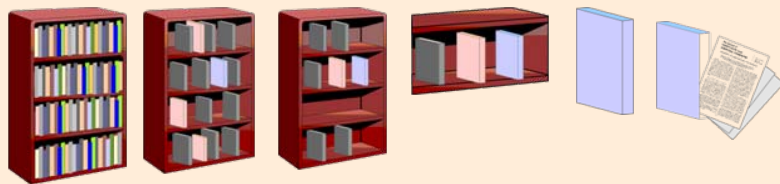




**You are ~~not~~
wanted!**

Another miracle!





Chafetz, M. et al. "Establishing treatment relations with alcoholics." *Journal of Nervous and Mental Disease*: 1962, 134, p. 395-409.

The Journal of **NERVOUS and MENTAL DISEASE**

VOL. 134, NO. 5
May, 1962
SERIAL NO. 954

ESTABLISHING TREATMENT RELATIONS WITH ALCOHOLICS¹

MORRIS E. CHAFETZ, M.D.,² HOWARD T. BLANE, Ph.D.,² HARRY S. ABRAM, M.D.,³ JOSEPH GOLNER, M.S.W.,² ELIZABETH LACY, M.S.W.,² WILLIAM F. McCOURT, M.D.,² ELEANOR CLARK, M.S.W.²
AND WILLIAM MEYERS, A.M.²

In 1959, we initiated a program of research designed to assess the effectiveness of a clinical method in establishing treatment relations with alcoholic patients admitted to the emergency ward of a metropolitan general hospital. This paper, the first of a series reporting the findings of this program, describes the particular clinical method tested, reports the design and results of the initial investigation, and discusses the implications of our findings for the treatment of psychological disorders other than alcoholism.

CLINICAL AND CONCEPTUAL BACKGROUND

A survey (27) in 1957 of alcoholics admitted to the emergency ward of the Massachusetts General Hospital revealed that the annual admission rate for alcoholics was over 1200. Of particular importance to the present study is the unpublished finding that less than one per cent of these alcoholics subsequently sought treatment at the hospital's outpatient alcoholic clinic, despite the nominal policy of offering such treatment to all alcoholics admitted for

emergency care. This lack of follow-through convincingly demonstrated that something was amiss in the treatment of this particular group of alcoholics. That this situation is probably not atypical is suggested by the scantiness of the literature about alcoholics seen in the more than 5000 emergency facilities (16) of the nation's general hospitals. Grout and Holub (15) mention the presumed disruption alcoholics cause in otherwise smoothly functioning emergency-care units. Brunner-Orne (5) complains that facilities adequate for alcoholics are "almost nonexistent in most general hospitals." A few hospitals have initiated, with promising results, comprehensive treatment programs for alcoholics (30), although none specifically deals with alcoholics seen in emergency-care units.

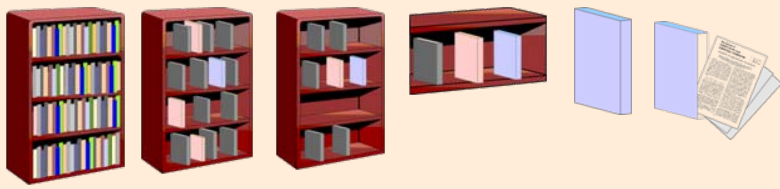
We decided, therefore, to examine emergency-ward and alcohol-clinic procedures to determine possible causes of the low rate of follow-through on treatment recommendations. This examination revealed that methods of initial approach to the alcoholic are as varied as the individual propensities of the personnel he sees, and that protracted evaluations involving delay and contacts with a number of different caretakers are usual.⁴ We felt this situation to be particu-

¹This research was supported in part by Mental Health Project Grant OM-218, National Institute of Mental Health, U. S. Public Health Service. The project was carried out in the Alcohol Clinic of the Massachusetts General Hospital, one of several clinics supported by the Division of Alcoholism, Department of Mental Health, Commonwealth of Massachusetts.

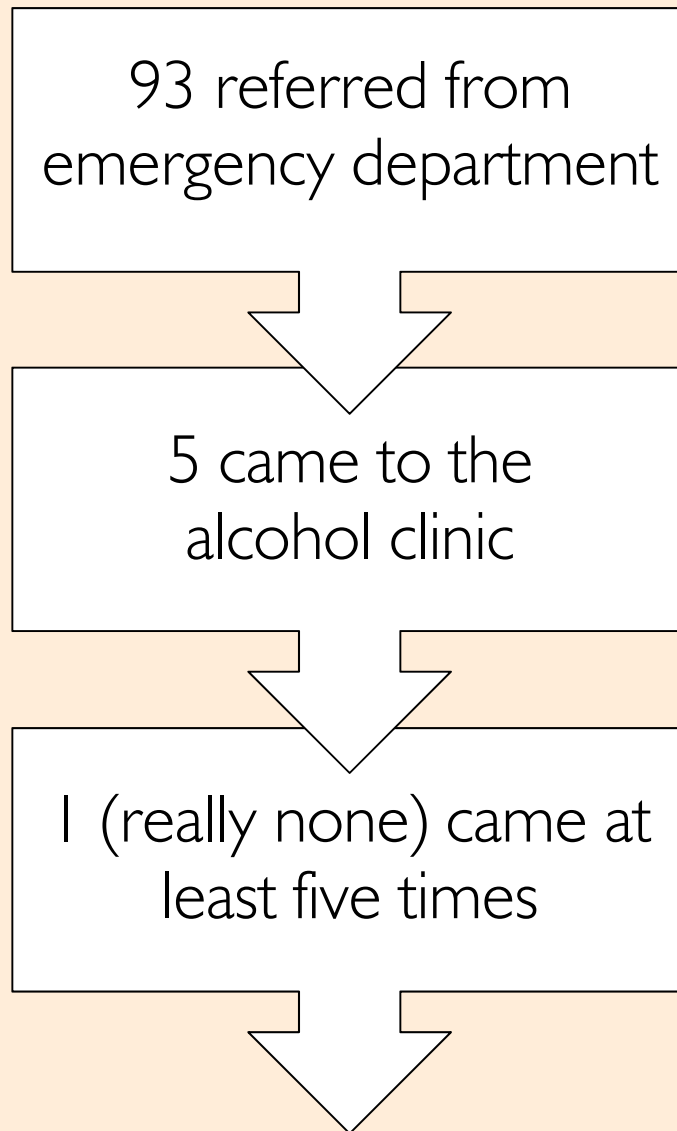
²Alcohol Clinic, Departments of Psychiatry, Massachusetts General Hospital and Harvard Medical School, Boston, Massachusetts.

³Now with the University of Virginia Hospital, Charlottesville, Virginia.

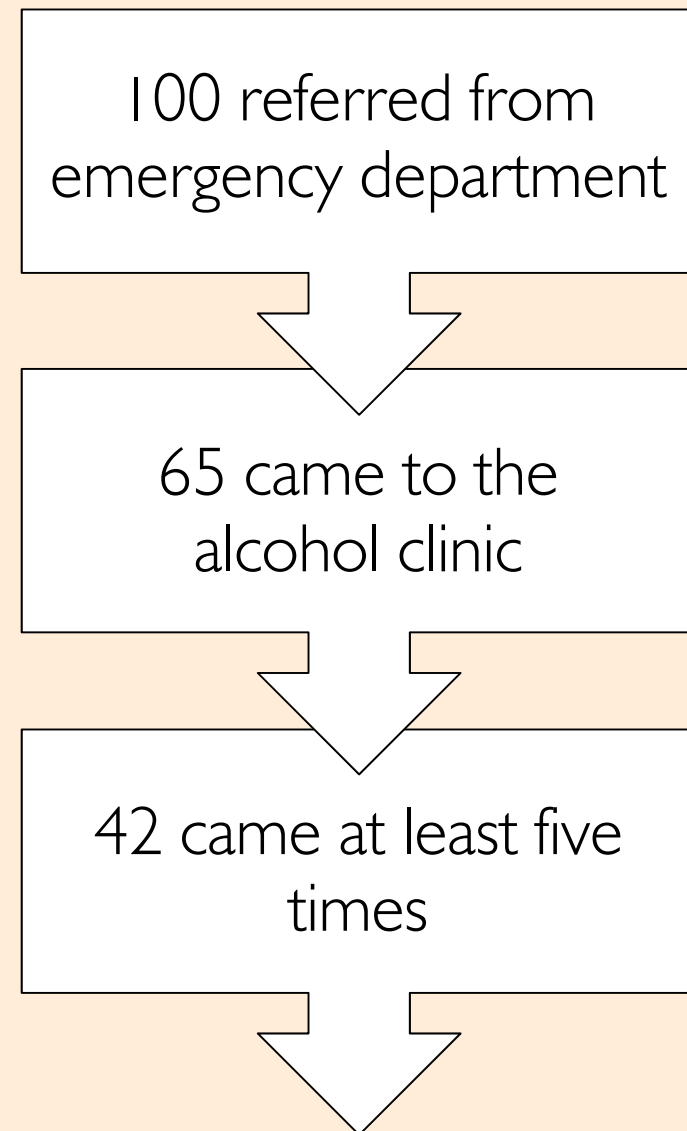
⁴In the emergency ward, the alcoholic is always seen by an admitting clerk and the chief medical officer on duty. He may, in addition, be seen by a resident in a medical specialty, by members of the nursing and ancillary staff, a social worker, and the discharge officer who deals with finances. If the patient does find his way to the alcohol clinic he is usually seen by two admitting

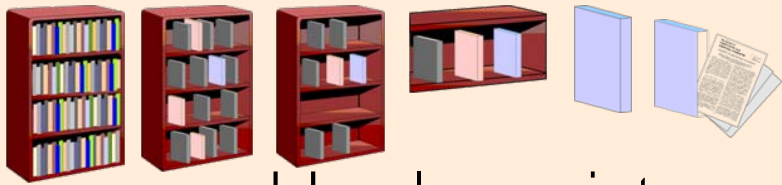


Usual care

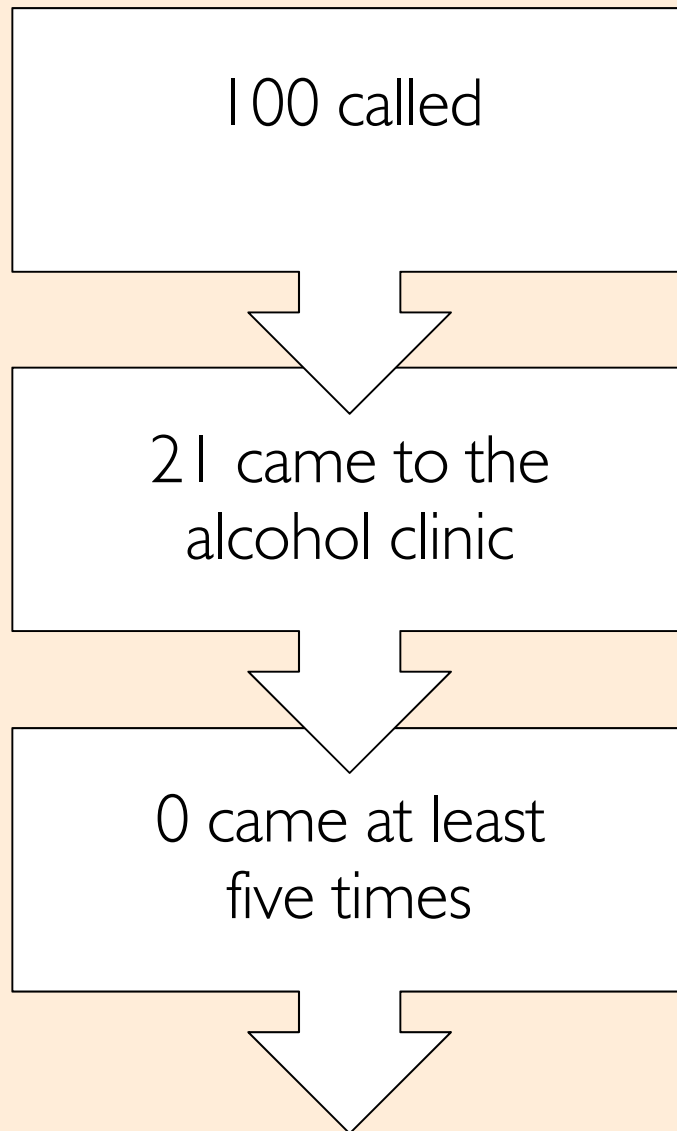


Treatment catalyst teams

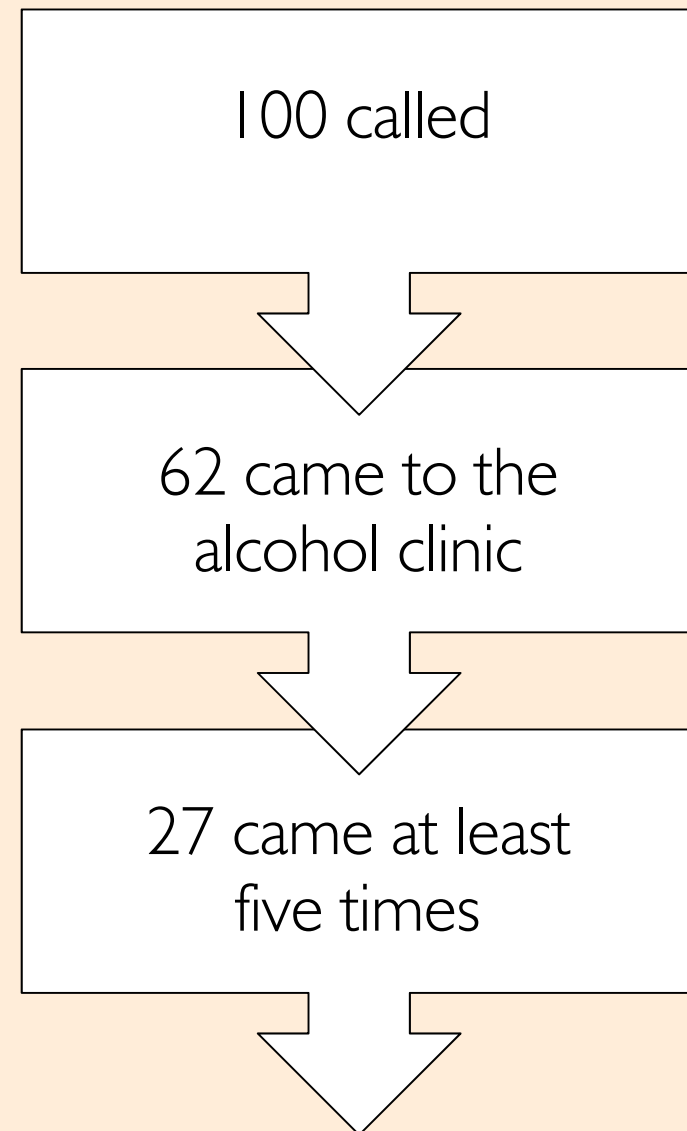


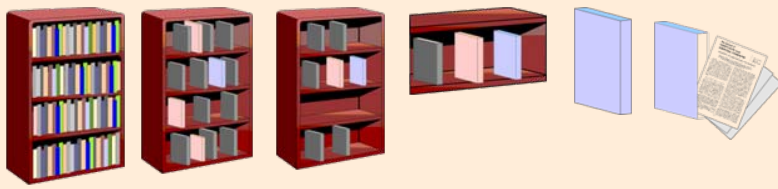


Usual appointment process

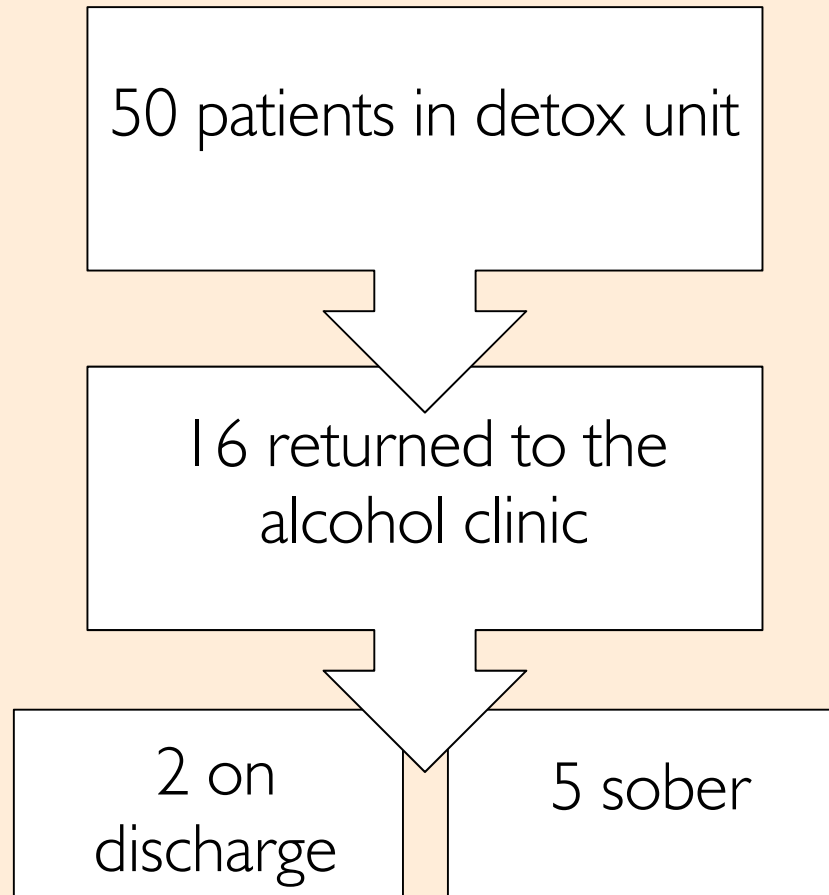


Same-day personal contact

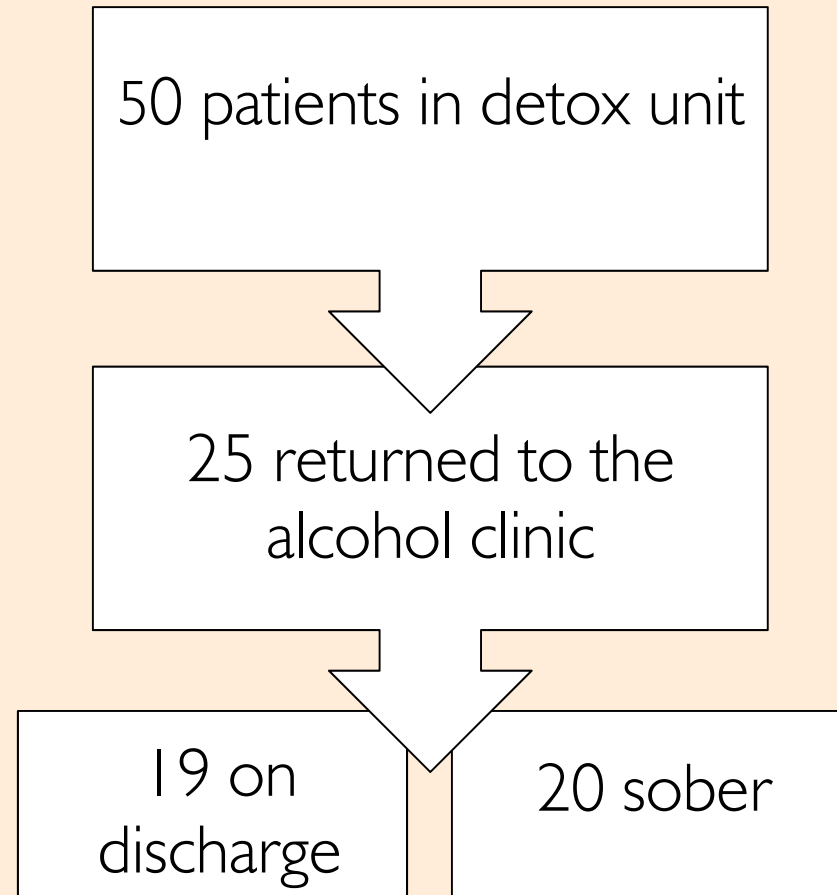




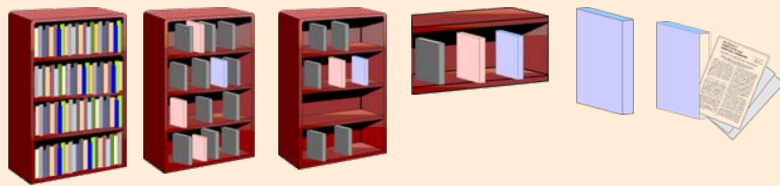
Usual recall process



Welcoming letter



Replacing the letter with a phone call to the unit had a similar impact. Within a week of discharge, 22 of the 50 called patients returned for outpatient care but just four of the 50 who were not called.



It's the way you say it!

Milmoie S. et al. The doctor's
voice: postdictor of successful
referral of alcoholic patients.
Journal of Abnormal Psychology:
1967, 72(1), p. 78-84.

Journal of Abnormal Psychology
1967, Vol. 72, No. 1, 78-84

THE DOCTOR'S VOICE:

POSTDICTOR OF SUCCESSFUL REFERRAL OF ALCOHOLIC PATIENTS¹

SUSAN MILMOE AND ROBERT ROSENTHAL

Harvard University

HOWARD T. BLANE AND MORRIS E. CHAFETZ

Massachusetts General Hospital

IRVING WOLF

Boston University

9 physicians discussed their experiences with alcoholics in tape-recorded interviews. Feelings and attitudes conveyed in doctors' speech were related to their success in referring alcoholic patients for treatment to a special clinic. 10 judges (5 male, 5 female) rated the interview material presented normally (unfiltered tape recording); 10 rated it presented in a "tone-only" condition (content-filtered tape recording); and 10 rated it in a "content-only" condition (typed transcripts). Doctors judged less angry in the tone-only condition and more anxious in the normal condition were more successful in referring alcoholics for further treatment.

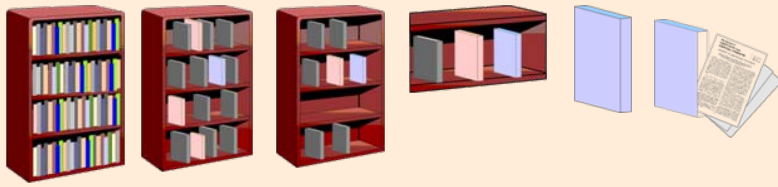
"It wasn't what he said; it was the way he said it." Investigators are paying increased attention to the intuitively long-recognized ability of people to pick up and utilize what Kauffman (1954) referred to as "expressive" cues in the language of others, and to the importance of these expressive cues as clues to personality and feeling states. The literature on nonverbal communication in speech has been reviewed by Kramer (1963), Mahl and Schulze (1964), and Starkweather (1961). For example, speech disruptions have been related to situational anxiety (e.g., Dibner, 1956; Eldred & Price, 1958; Feldstein, Brenner, & Jaffe, 1963; Kasl & Mahl, 1958; Mahl, 1956), and reliable "global" judgments have been related to emotions in speech (e.g., Davitz, 1964; Davitz & Davitz, 1959a, 1959b).

An important area for research has been emotion judged from "content-filtered" speech, in which a tape is rerecorded through

a low-pass filter to remove high-frequency sounds and thus render the words themselves unrecognizable. Starkweather (1956) found that content-filtered voices of hypertensives were judged to be higher on dominance than similarly presented voices of nonhypertensives. Kramer (1964), however, has observed that one of the problems in most studies which correlate paralinguistic ratings with independent variables is the weakness of the latter. Another difficulty is that studies of emotion in speech have primarily utilized speech elicited in an experimental situation in which the speaker is asked to "act out" the emotion in one way or another. An unpublished study by Starkweather (cited by Kramer, 1963), in which 12 clinical psychologists rated excerpts from the Army-McCarthy hearings, seems to be one of the first in which emotional content was rated globally in completely spontaneously elicited speech. Soskin and Kauffman (1961) demonstrated that listeners could agree to a significant extent about the emotional content of content-filtered spontaneously elicited speech samples gathered in a variety of situations—but they had no independent variables to which the ratings were related.

The purpose of the present study was to relate emotion communicated in spontaneous

¹ This study was supported by National Science Foundation Grants G S-177 and G S-714, by Mental Health Grant O M-210, National Institute of Mental Health, United States Public Health Service, and by the Division of Alcoholism, Massachusetts Department of Public Health. The first author was a participant in the National Science Foundation Program in Undergraduate Research during the period in which the data were being collected.



Nine of the 15 emergency doctors
who a year before had referred
patients in the referral study

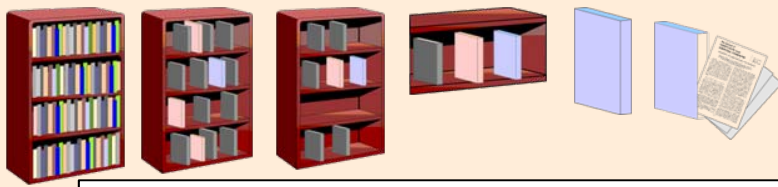
**“What has been your
experience with alcoholics?”**

Responses
taped

Normal recording

Filtered leaving
emotional tone

Transcript



Anger-Irritation

Normal recording	Filtered leaving emotional tone	Transcript
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Sympathy-Kindness

Normal recording	Filtered leaving emotional tone	Transcript
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Anxiety-Nervousness

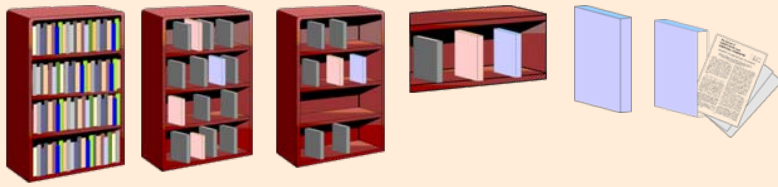
Normal recording	Filtered leaving emotional tone	Transcript
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Matter-of-factness-Professionalism

Normal recording	Filtered leaving emotional tone	Transcript
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Positive correlations green, negative black. Strong colours statistically significant; others $r=0.4$ or more.





His studies exemplified important themes of continuing relevance:

1. Caring and organised persistence are complementary
2. Is a crisis at least a 'reachable moment'?
3. Initial contacts are critical
4. Don't blame the patient; take responsibility; change your approach
5. Addiction is a relationship 'disease'; we can change it by changing ourselves and how we relate to the addict
6. This also means changing the social environment which relates to the addict outside the clinic





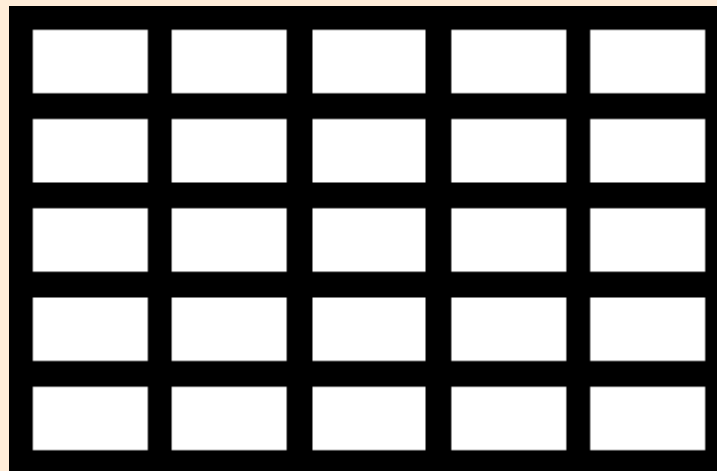
One of the gems we hope you will find in the

Alcohol Matrix

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Visit the Matrices page of the Effectiveness Bank web site for more on the Matrices and links to related articles, presentations, and a video of the developer explaining their genesis and construction.

<http://findings.org.uk/matrices.htm>





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Further information at <http://findings.org.uk> or from editor@findings.org.uk