issue 13 summer 2005

DRUG & ALCOHOL FINDINGS

linking practice to research research to practice

what works
what doesn't
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DRUG & ALCOHOL FINDINGS

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DRUG & ALCOHOL FINDINGS

Objectives To improve Britain's response to drug and alcohol problems by disseminating practice-relevant evaluation findings on the effectiveness of interventions including prevention, community safety and treatment.

Readers Workers involved in a specialist or non-specialist role in interventions addressing drug or alcohol problems in the United Kingdom, including drug and alcohol service practitioners, planners, managers, and commissioners, those whose responsibilities include these functions, and researchers working in these fields.

The FINDINGS partnership Alcohol Concern • National Addiction Centre • DrugScope • Mike Ashton

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Tales of the unexpected

It was so much against the grain that at first we doubted our eyes. By our reading of the literature, motivational interviewing had worked best when done without a manual, contrary to the dominant view that manualised therapy is the gold standard page 23. But then we sent the draft to the therapy's originator Bill Miller. He told us about a new synthesis of the research he and other colleagues had just published which confirmed our conclusion. In a way, we were not surprised. The *Manners Matter* series is built on the realisation that the vision of addiction as a technical medical or psychological problem susceptible to technical solutions is at best incomplete, at worst, a diversion from what really helps people recover.

The FINDINGS Editorial Board records its gratitude to Richard Phillips, now Director of Policy and Services at Phoenix House. As Alcohol Concern's representative on the board Richard was a committed and enthusiastic supporter who gave his own time to give the project a vital presence on the World Wide Web. We owe him a considerable debt.

It's also a good time to record our debt to our readers. Without you this project would be pointless and without your financial support, impossible. In a real way you create FINDINGS. How much this creation is valued was recently expressed by Dr Thomas McLellan, leading US researcher and editor of the *Journal of Substance Abuse Treatment*: "I am ashamed to say I did not know of this journal but I am going to subscribe. I don't think I have ever seen so much useful and well integrated information in one place. I just started at the front and couldn't put [it] down."

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issue 13 summer 2005

Nuggets

Recent evaluations of interventions selected for their particular relevance to UK practice

NUGGETTES

Evaluations that didn't quite make it as Nuggets; mini-jewels

Self help

don't leave it to the patients

Self-help is so important that professionals should intervene to promote and support it and can do so without undermining self-help principles, argues a team of experts convened by the US government. They offer an agenda for services and policymakers to make the most of a powerful free resource.

by Keith Humphreys, Stephen Wing, Dennis McCarty, John Chappel, Lewis Gallant, Beverly Haberle, A. Thomas Horvath, Lee Ann Kaskutas, Thomas Kirk, Daniel Kivlahan, Alexandre Laudet, Barbara S. McCrady, A. Thomas McLellan, Jon Morgenstern, Mike Townsend, & Roger Weiss.

Contact Professor Keith Humphreys, Stanford University, Program Evaluation and Resource Center, VAPAHCS (152-MPD), 795 Willow Road, Menlo Park, CA 94025, USA, knh@stanford.edu.

Adapted from Humphreys K. *et al.* "Self-help organizations for alcohol and drug problems: toward evidence-based practice and policy." *Journal of Substance Abuse Treatment*: 2004, 26(3), p. 151–158, with permission from Elsevier. A free version of the original report is available at www.chce.research.med.va.gov/chce/pdfs/VAsma_feb1103.pdf.

Preparation of the original paper was supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Dept. of Health and Human Services, and the Mental Health Strategic Healthcare Group and Health Services Research and Development Service, US Dept. of Veterans Affairs (VA). Conclusions do not necessarily represent official views of SAMHSA, the VA, or the organisations to which any author or commentator is affiliated. For their comments we are grateful to: Sonya A. Baker, T. Robert Burke, Herman Diesenhaus, Dona M. Dmitrovic, R. John Gregrich, Tom Hill, Mike Hilton, George Kosniak, John Mahoney, Kate Malliarakis, J. Paul Molloy, Harold Perl, Rick Sampson, and Richard Suchinsky.

BASED PRIMARILY ON THE CONCLUSIONS of a work-group of US experts on substance abuse self-help organisations convened in Washington in November 2001,[6] this paper summarises key research findings on addiction-related self-help groups and assesses their implications for services, government agencies, and policymakers.

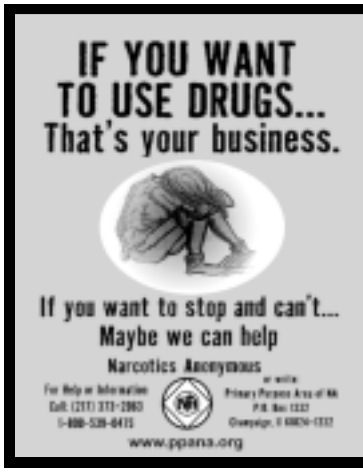
A substantial minority of Americans participate in self-help groups for chronic health problems,[13] but addiction-related groups are most common.[12 20] The largest and best known is Alcoholics Anonymous or AA, a 12-step organisation founded in 1935 which inspired many similar organisations. Others are also abstinence-based but eschew any spiritual content, or conceptualise addiction not as a disease but as maladaptive behaviour. At least one US organisation targets drinking reductions rather than abstinence. Rather than the 12 steps, some groups adopt cognitive-behavioural or feminist strategies.

As well as varying in approach, philosophy, and size, self-help organisations also vary in their governance, traditions (eg, willingness to accept outside financial support, encouragement of lifetime membership) and racial and ethnic diversity. However, none charge fees, require appointments, or limit the number of visits. Members can attend indefinitely, critical in light of the emerging view that, like diabetes and hypertension, addiction is best treated as a chronic health problem.[16] Acute care interventions (eg, hospitalisation) are important for immediate medical needs, stabilisation, and encouraging continuing care, but are not a cure. Rather, chronic health problems are managed by extended, lower intensity support.[11] Self-help groups are an important, enduring support for recovery from substance dependence, complementing rather than competing with acute care interventions.

A final important point about self-help organisations is that their growth can be fostered or limited by external forces. For example, AA experienced a major increase in membership in 1941 following a highly favourable magazine article. Non-profit, self-help clearinghouses have referred many potential members to self-help groups and helped found many groups. Many members affiliate after being referred by a clinician, while negative clinician attitudes can discourage participation. Countries including Australia, Canada, Germany, Poland, and Japan have funded the infrastructure of self-help organisations and promoted their growth.[7]

For clinicians, agencies and policy makers, the important messages are that:

- a diverse set of self-help organisations has developed for all substances of significant public health concern;
- collectively, these are both appealing and affordable to a broad spectrum of people;
- clinical, agency, and governmental procedures and policy influence the prevalence, stability, and availability of addiction-related groups.



A cost-effective continuing care resource

The effectiveness of any intervention for substance abuse must be understood in light of two facts. First, like other chronic health problems,[16] addictive disorders are difficult to resolve and no intervention produces complete and permanent abstinence in all cases, or even in most. Second, given constrained financial resources, any judgment about an intervention needs to factor in costs as well as effectiveness.

The 'effectiveness' of a self-help organisation can be conceptualised in a number of ways, including how fast it grows, how it handles change, and member satisfaction, but clinicians, agency managers and policy makers are primarily interested in three issues. Does self-help group participation reduce substance abuse? If so, at what fiscal cost? Do self-help groups produce other benefits for their members and for society?

Research is limited in the degree to which can answer these questions. Most work has focused on AA and to a lesser extent NA. Groups outside the 12-step tradition have rarely been studied. Also, nearly every study has been conducted on adults, leaving the possible effects of groups on adolescent substance users much under-studied.

RANDOMISED CONTROLLED TRIALS

Considered by some to be the most rigorous test of effectiveness, there have only been three randomised controlled trials of community-based self-help groups. All involved AA and people coerced in to treatment. In the late 1960s, the first showed that, compared with individuals assigned to treatment or to no treatment, a court order to attend five AA meetings did not reduce arrests for chronic drunkenness.[3] Unfortunately, there was no information on alcohol use *per se*. The other two trials documented a range of outcomes and compared AA alone to professional treatment combined with AA attendance.[2,22] Both suggested worse clinical outcomes for AA alone: in one, more individuals dropped out; in the other, more relapsed. But in both, individuals assigned to AA alone improved in absolute terms and incurred significantly lower health care costs than those assigned to treatment plus AA.

OTHER CONTROLLED TRIALS

Because randomised trials usually enrol only a small, unrepresentative subset of addicted patients, some researchers have instead compared outcomes among otherwise similar individuals who did or did not become involved in mutual help groups.

One study compared two sets of 887 substance dependent patients treated in inpatient programmes which either did or did not stress 12-step self-help group involvement.[9] At treatment intake, the two sets were comparable on treatment history, alcohol, drug and psychiatric problems, demographic variables, and motivation. A year later, those encouraged to join groups were significantly more likely to abstain from drugs and alcohol. They also relied more on self-help groups and less on treatment services for support after discharge, reducing health care costs by almost $5000 a year per patient. This study was confined to men, most of whom were African-American or Hispanic. However, very similar outcomes and cost-offset findings were found in a study of alcohol abusers, most of whom were Caucasian and about half women.[10]

HEALTH COSTS WERE CUT BY ALMOST $5000 A YEAR WHEN PATIENTS WERE ENCOURAGED TO JOIN 12-STEP GROUPS

CORRELATIONAL STUDIES

A third type of study simply observes whether becoming involved in self-help groups is related to substance use. These may have lacked a comparison group of non-participants and sometimes did not track changes over time. Almost all link AA attendance to better alcohol-related outcomes, and NA or Cocaine Anonymous attendance to better drug-related outcomes.[7] They also show that members who engage in other group activities in addition to attending meetings – reading programme literature, sponsoring new members, applying the 12 steps to daily life – are more likely to abstain than individuals who do not. However, such studies cannot prove that self-help participation *caused* the positive outcomes.

SELF-HELP INFLUENCED TREATMENTS

Although treatment is not self-help, studies of treatments *influenced* by self-help principles provide relevant evidence.

Best known is Project MATCH, which for three months randomly assigned US alcohol-dependent patients to 12-step facilitation, cognitive-behavioural, or motivational enhancement therapy.[1,19] In terms of increased days of abstinence and fewer drinks per day, outcomes over the following year were broadly similar after all three treatments. However, individuals treated in 12-step facilitation therapy attended more 12-step self-help meetings and were more likely to have maintained continuous abstinence. Over the three years after treatment, more continued to maintain abstinence and, compared to cognitive-behavioural patients, they abstained on more days. Regardless of assigned treatment condition, attending more 12-step self-help groups was associated with better outcomes.

Encouraging results were also found in a major US study of cocaine dependent patients. Those randomly assigned to counselling which strongly encouraged participation in self-help groups showed more consistent attendance, and more consecutive months of cocaine abstinence during follow-up, compared with patients treated only by professionally administered therapies.[23,24]

Three other studies warrant mention. In one, compared with usual aftercare, drug dependent patients randomly assigned to a programme incorporating a self-help style group and a network of supportive former patients were about 40% less likely to relapse over the next six months.[15] A second found that alcohol dependent patients randomly assigned to a treatment which emphasised peer responsibility and mutual help engaged more with treatment and incurred dramatically lower health care costs at one-year follow-up.[5] A third involved adult substance dependent patients who had been raised by substance dependent parents. They were randomly assigned either to 12-step self-help groups for adult children of alcoholics or to substance abuse education classes.[14] Self-help group patients were significantly less likely to use drugs and alcohol after leaving treatment.

These studies suggest that self-help group involvement reduces substance use and also lowers health care costs. With other studies, they also document benefits relating to self-efficacy, social support, depression and anxiety, and coping with stress.[7] However, the research has focused on AA and NA. Findings may generalise to other mutual help organisations but relevant research is lacking ◤ *What the research tells us*, p. 6.

With varying degrees of certainty, 12-step groups appeal to their effectiveness. Evidence is positive but limited.

GOLDEN BULLETS Key points and practice implications

- Research on 12-step self-help groups documents substance use reductions, other psychological benefits, and cost-effectiveness relative to professional support.
- Such groups provide an important long-term anti-relapse support of the kind rarely available through treatment services. As such they complement rather than replace time-limited professional treatments.
- How therapists behave, their beliefs and their attitudes, affect how many of their patients participate in self-help groups. Training and incentives should be implemented to extend the use of evidence-based methods to promote participation.
- Policymakers can promote and support self-help organisations without compromising their traditions or independence, improving health outcomes while containing costs.

How services and policymakers can promote self-help groups

Given their likely health and cost benefits, clinicians, treatment providers, and policymakers may wish to increase the likelihood that addicted individuals seek out mutual help organisations and that they spread and become accessible to a broad array of people. What follows are some potential courses of action for different constituencies.

TREATMENT SERVICES: COULD DO BETTER

Much can be done to make treatment better at facilitating self-help group involvement. Practitioners who describe themselves as '12-step oriented' commonly see only a subset of 12-step processes as important. Few report operating a pure 12-step approach, preferring instead a mix of, for example, 12-step, cognitive-behavioural, motivational, psychodynamic, and family systems approaches. These findings have been confirmed in video studies revealing that counsellors emphasise some aspects of the 12 steps (such as AA affiliation) but not others (such as spirituality).[17] When counsellors do support 12-step group involvement, they rarely use evidence-based methods. Finally, many clinicians are not aware of alternatives to 12-step groups.

Research clearly shows that when clinicians use empirically validated techniques to support mutual-help group involvement, it is far more likely to occur.[18 21 23 24] Educating clinicians about such techniques may sometimes be helpful, but merely providing guidelines rarely changes practice significantly. Provider interventions must address attitudes, beliefs and behaviours.

Clinicians' beliefs influence their patients' transitions from treatment to self-help groups. Some believe self-help groups foster unhealthy dependence or detract from personal autonomy, others that AA is the only self-help organisation, or the only one of any value. Other misconceptions are that all self-help organisations have a spiritual component, or that spirituality must be central for every member. In reality, there are many pathways to recovery involving a variety of self-help groups and treatments.[4]

Any provider intervention strategy must recognise two points. First, most investigations have focused on specialist substance abuse treatment providers. Little is known about whether or how non-specialists (eg, emergency unit doctors) refer addicted patients to self-help groups. Second, due to cultural differences (such as spiritual beliefs, expectations about self-disclosure) and other diversity issues, all self-help organisations may not be equally appealing or helpful to all patients. Some (for example, SMART Recovery, Women for Sobriety, and Moderation Management) are almost entirely Caucasian and middle class. AA and NA have a higher proportion of people of colour, but individual chapters may not be diverse. Clinicians should be sensitive to potential discomfort among patients going to a self-help group with few or no people of their racial or ethnic background. Similarly, gay and lesbian patients may prefer special meetings, such as AA offers.

AS AN ENDURING SUPPORT, SELF-HELP GROUPS COMPLEMENT RATHER THAN COMPETE WITH ACUTE TREATMENT

EFFECTIVE REFERRAL TO A MENU OF CHOICES

The following strategies could be employed by clinicians, clinical supervisors, and service managers.

- Clinicians should use empirically validated methods (eg, 12-step facilitation counselling, motivational enhancement) to foster self-help group engagement.
- Given the variety of pathways to recovery, clinicians should have available a menu of alternative treatments and self-help groups to select from in consultation with the client and other stakeholders.
- Efforts to train clinicians about facilitating self-help group involvement should include incentives for changing clinical practice and be sensitive to cultural diversity among clients.
- Effective referrals to self-help groups should occur in both specialist and non-specialist health care programmes.
- Clinicians should recognise and communicate to patients that many individuals recover through AA, but also that others recover through alternative self-help groups, or without attending any.
- Even treatment programmes which see themselves as '12-step oriented' should evaluate whether their current practices actively promote involvement in 12-step groups.

POLICYMAKERS CAN MAKE A DIFFERENCE

Several countries have implemented policies to foster the growth of mutual help organisations.[7] Beyond the usual challenges, one is peculiar to this area: by tradition, 12-step organisations do not accept direct outside financial support. Even for self-help organisations which do, it is important not to bureaucratise or co-opt an essentially grassroots movement.

Like the organisations themselves, the infrastructure supporting self-help varies in strength and structure. In some areas, non-profit self-help clearinghouses provide information about, referrals to, and technical support for, mutual help organisations for addictions and other health problems. Helplines and welfare agencies may also provide information.

'Recovering' counsellors and groups of former patients at addiction treatment centres are another important component of the self-help infrastructure. Whether individuals who are not in recovery typically have the knowledge and skills to facilitate connections between addicted patients and self-help groups is unknown.

INFRASTRUCTURE ENHANCEMENT

Given the above context, it may be desirable to implement policies to strengthen the infrastructure supporting mutual help. The following have been implemented in some areas and might be replicated elsewhere.

- Invest in self-help clearinghouses. These can support a broad variety of alcohol and drug-related self-help groups without violating the traditions of those which do not accept funding.
- Make public facilities and institutions 'self-help group friendly' – not only allowing groups space for meetings, but also inviting them to hold groups where they may not have a historical presence, for example, in some clinics, hospitals, and religious or community centres.
- Disseminate information on self-help groups. Government and other relevant agencies could display lists of self-help organisations, post them on their web sites, and/or provide links to sites operated by self-help organisations. They could also provide information on evidence-based practices related to self-help groups as a recovery resource.
- Adopt the principle of 'informational parity'. All dissemination efforts should include information on the full range of mutual help groups as long as they are voluntary in nature, respect the civil rights of participants, address substance abuse, are not mislabelled professional treatments, and have some evidence of effectiveness.

WHAT THE RESEARCH TELLS US

Many improvements remain to be made in self-help group research, but the following represent reasonable conclusions based on research so far.

- Longitudinal studies associate participation in AA and NA with a greater likelihood of abstinence, improved social functioning, and greater self-efficacy. Participation seems more helpful when members engage in other group activities in addition to meetings.
- Twelve-step self-help groups significantly reduce health care utilisation and costs, relieving demand on the health care system.
- Self-help groups are best seen as a form of continuing care rather than as a substitute for acute treatment services.
- Randomised trials with coerced populations suggest that AA combined with professional treatment is superior to AA alone.
- Self-help groups outside the 12-step fold have not been subjected to longitudinal evaluation, but it is reasonable to suspect they also benefit members.

Alcoholics Anonymous

THREE MEN sat around the bed of an alcoholic patient in the psychopathic ward of Philadelphia General Hospital one afternoon a few weeks ago. The man in the bed, who was a complete stranger to them, had the drawn and slightly stupid look the inebriates get while being defogged after a bender. The only thing that was noteworthy about the callers, except for the obvious contrast between their well-groomed appearances and that of the patient, was the fact that each had been through the defogging process many times himself. They were members of Alcoholics

Anonymous, a band of ex-problem drinkers who make an avocation of helping other alcoholics to beat the liquor habit ...

THEY MADE it plain that if he actually wanted to stop drinking, they would leave their work or get up in the middle of the night to hurry to where he was. If he did not choose to call, that would be the end of it. The members of Alcoholics Anonymous do not pursue or coddle a malingering prospect, and they know the strange tricks of the alcoholic as a reformed swindler knows the art of bamboozling ...

Jack Alexander
The Saturday Evening Post
March 1, 1941

This famous article in a popular US magazine helped propel Alcoholics Anonymous into a major national network, proving that access to self-help can be altered by publicity.

William Griffith Wilson (Bill W), co-founder and driving force behind AA and author of the 'Big Book' with its 12 steps "suggested as a Program of Recovery".

- Create and support innovative services that promote self-help group involvement. Examples include the 'recovery coaches' funded by Arizona Medicaid, and funding in Philadelphia for an organisation with responsibility for transitioning individuals into self-help groups. Similarly, the US Center for Substance Abuse Treatment launched the Recovery Community Services Program to fund groups developing innovative peer-to-peer services. Examples include: recovery coaching and mentoring; peer case management; peer education in health topics and life skills; and assistance and referral with housing, employment, education, and related activities.
- Certificate and train health care professionals in linking patients to self-help groups. Staff with strong connections to local self-help groups may not always be available, so all health professionals should know how to effectively refer patients to groups.
- Foster self-help organisations for underserved populations. New York State's Mental Health Empowerment Project successfully assisted mental health service users to organise self-help groups for dually diagnosed people. Similar programmes which provide support without professionalising or bureaucratising might be tried with other underserved populations, such as adolescents and people living in rural areas.
- In conjunction with treatment, expand opportunities for self-help organisations in criminal justice settings. For example, groups might be invited to hold meetings in youth detention centres, prisons, and probation facilities.
- Discourage the use of self-help groups as a replacement for treatment. Many clients require support from both. Using the success of self-help groups as a pretext for delaying or withdrawing support for treatment is therefore inappropriate. Addiction self-help organisations typically see themselves as allies rather than competitors to professional treatment. Other stakeholders should do the same.
- Expand the research base. This includes research on the outcomes of 12-step and other self-help groups, on how self-help groups effect change, and on policy interventions to promote effective practices and self-help group involvement. A national centre could provide an important focus for such activities.
- Expand residential self-help options. We already have some successful models for peer-managed residential services for addicted individuals. Fostering the development of more self-help based housing could be a cost-effective strategy for providing recovery-supportive environments, including for homeless clients.
- Support opportunities for the families of addicted people to be involved in mutual help organisations. One of the discoveries of the Recovery Community Services Program was that families do not always feel part of the recovering person's self-help involvement. Accordingly, all the above efforts should include a focus on family members and family-focused mutual help organisations.

SUPPORT WITHOUT CO-OPTION

Addiction self-help organisations are a major resource for addicted individuals, as well as for those who treat, work with, or care about them. Research suggests that self-help groups can be beneficial, but also cautions that we have much more to learn about how they work and how they can be supported. The strategies presented here are a set of initial steps but are neither the final word nor a panacea. Yet they do hold significant promise for strengthening addiction self-help groups and thereby helping more individuals recover from drug and alcohol problems.

REFERENCES

1 Babor T. *et al*, *eds*. *Treatment matching in alcoholism*. Cambridge University Press, 2002.
2 Brandsma J.M. *et al*. *Outpatient treatment of alcoholism: A review and comparative study*. Baltimore, MD: University Park Press, 1980.
3 Ditman K.S. *et al*. "A controlled experiment on the use of court probation for drunk arrests." *American Journal of Psychiatry*: 1967 124, p. 64–67.
4 Fletcher A. *Sober for good: new solutions for drinking problems*. Houghton Mifflin, 2001.
5 Galanter M. "Self-help large group therapy for alcoholism: a controlled study." *Alcoholism: Clinical and Experimental Research*: 1984, 8, p. 16–23.
6 SAMHSA/Veterans Health Administration Workgroup on Substance Abuse Self-Help Organizations, c/o Program Evaluation and Resource Center, Veterans Affairs Health Care System (152-MPD), 795 Willow Road, Menlo Park, CA 94025, USA.
7 Humphreys K. *Circles of recovery: self-help organizations for addictions*. Cambridge University Press, 2004.
8 Humphreys K. *et al*. "Can targeting non-dependent problem drinkers and providing internet-based services expand access to assistance for alcohol problems? A study of the Moderation Management self-help/mutual aid organization." *J. Studies on Alc.*: 2001, 62, p. 528–532.
9 Humphreys K. *et al*. "Can encouraging substance abuse inpatients to participate in self-help groups reduce the demand for outpatient aftercare? A quasi-experimental study." *Alcoholism: Clinical and Experimental Research*: 2001, 25, p. 711–716.
10 Humphreys K. *et al*. "Reduced substance abuse-related health care costs among voluntary participants in Alcoholics Anonymous." *Psychiatric Services*: 1996, 47, p. 709–713.
11 Humphreys K. *et al*. "Towards more responsive and effective intervention systems for alcohol-related problems." *Addiction*: 2002, 97, p. 126–132.
12 Kessler R.C. *et al*. "Differences in the use of psychiatric outpatient services between the United States and Ontario." *New England Journal of Medicine:* 1997, 326, p. 551–557.
13 Kessler R.C. *et al*. "Patterns and correlates of self-help group membership in the United States." *Social Policy*: 1997, 27, p. 27–46.
14 Kingree J. *et al*. "Mutual help groups, perceived status benefits, and well-being: a test with adult children of alcoholics with personal substance abuse problems." *American Journal of Community Psychology*: 2000, 28, p. 325–342.
15 McAuliffe W.E. "A randomized clinical trial of recovery training and self-help for opioid addicts in New England and Hong Kong." *Journal of Psychoactive Drugs*: 1990, 22, p. 197–209.
16 McLellan A.T. *et al*. "Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation." *Journal of the American Medical Association*: 2000, 284, p. 1689–1695.
17 Morgenstern J. *et al*. "Cognitive processes and change in disease-model treatment." In: McCrady B.S. *et al, eds*. *Research on Alcoholics Anonymous: opportunities and alternatives*. Rutgers Center of Alcohol Studies, 1993, p. 153–166.
18 Nowinski J. *et al*. *Twelve-step facilitation therapy manual: a clinical research guide for therapists treating individuals with alcohol abuse and dependence*. National Institute on Alcohol Abuse and Alcoholism, 1995.
19 Project MATCH Research Group. "Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*: 1997, 58, p. 7–29.
20 Room R. *et al*. "Alcoholics Anonymous, other 12-step movements and psychotherapy in the US population, 1990." *Addiction*: 1993, 88, p. 555–562.
21 Sisson R.W. *et al*. "The use of systematic encouragement and community access procedures to increase attendance at Alcoholics Anonymous and Al-Anon meetings." *American Journal of Drug and Alcohol Abuse*: 1981, 8, p. 371–376.
22 Walsh D. *et al*. "A randomized trial of treatment options for alcohol-abusing workers." *New England Journal of Medicine*: 1991, 325, p. 775–782.
23 Weiss R.D. *et al*. "Self-help group attendance and participation among cocaine dependent patients." *Drug and Alcohol Dependence*: 2000, 60, p. 169–177.
24 Weiss R.D. *et al*. "Self-help activities in cocaine dependent patients entering treatment: results from the NIDA collaborative cocaine treatment study." *Drug and Alcohol Dependence*: 1996, 43, p. 79–86.

Mined, refined, assayed and set in context – nuggets of data with important practice implications

Nuggets are new evaluations of interventions selected for their particular relevance to UK practice relating to alcohol and illegal drugs across prevention, community safety, and treatment. Studies are sourced mainly through Britain's national drug and alcohol information services, DrugScope and Alcohol Concern.

Entries are drafted after consulting related papers and seeking comments from the lead authors and members of FINDINGS' advisory panel or other experts. They generously enrich our understanding but bear no responsibility for the published text. Though not individually acknowledged, we particularly thank the study authors for their work and for helping us to interpret it.

Each entry is structured as follows:

Findings The most practice relevant findings and the main methodological characteristics of the featured study or studies.

In context Brief comments on the featured study's methodology and findings set in the context of related studies.

Practice implications Suggestions about how the implications of the featured study might be put into practice in the UK taking into account related research and the UK policy and practice context. The suggestions are intended to inform decisions over policy and practice but *do not constitute a sufficient basis for taking those decisions*, which should be more widely based on research, experience and expert opinion.

Featured studies References to the evaluation(s) described in **Findings**.

Additional reading Optionally, key related documents. Full references on request.

Copies of cited documents may be available from the author ◤ **Contacts** or for a fee from
AC Alcohol Concern (020 7928 7377);
DS DrugScope (0870 774 3682); or
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Check before ordering. In case of difficulty contact da.findings@blueyonder.co.uk

Contacts Where available, contact details of the author of the featured study. These may not be current and do not imply that the author has agreed to enter into correspondence over the study.

Links Cross reference to related items in current or past issues of FINDINGS. A Nugget entry referred to as '**1.2**' is the second entry in FINDINGS issue 1.

13.1 Aftercare calls suit less relapse-prone patients

Findings For less relapse-prone patients, a flexible aftercare regime mixing initial support groups with regular phone calls is at least as effective as entirely face-to-face contact, yet far less time-consuming.

Cocaine and/or alcohol dependent patients who completed treatment and achieved at least a week's abstinence during four weeks of intensive outpatient group therapy in Philadelphia were randomly referred to one of three aftercare regimes. The first stepped down group therapy to twice weekly counselling/12-step sessions, a typical US regime. The second was also twice weekly, but one session was individual and both offered cognitive–behavioural relapse prevention training. The third began with a one-to-one meeting during which the therapist asked patients to phone them at set times once a week. To ease the transfer, phone patients were also offered at least four weekly support groups. Before the 15-minute calls they used a workbook to record their substance use and recovery activities over the past week. These were reviewed with the therapist and plans made for progressing towards agreed goals over the following week. Therapists attempted to contact patients after missed calls. After 12 weeks all patients reverted to the centres' usual weekly aftercare groups.

At about seven hours per patient, total therapeutic contact time in the phone option was half that of the other two, yet over the two years after treatment intake it tended to result in better substance use outcomes. On some measures (sustained abstinence from both alcohol and cocaine, biochemical markers of heavy drinking, rapid move to cocaine-negative urine tests) the advantages over the typical regime were statistically significant. However, this near equivalence masked (in terms of abstinence) a more favourable reaction to typical aftercare among the fifth of patients most vulnerable to relapse, balanced by a more favourable reaction to phone care among the less vulnerable majority.

LINKS Nuggets **11.7 4.3** • *The power of the welcoming reminder*, issue 11 • *Gone but not forgotten*, issue 3

In context Previous research from the same group found little overall difference in outcomes between the two face-to-face aftercare options, but that relapse prevention training is preferable for patients still dependent at the end of the initial treatment. The present study confirms that these approaches differ little for other, more successful patients. The novel finding is that for these patients, relegating most aftercare contacts to phone calls usually achieves outcomes at least as good. Duplicate findings at the two study sites suggest that this might apply more broadly to similar services and populations.

Patients with the best prognosis seemed somewhat hampered by the more demanding face-to-face aftercare options, perhaps because these conflicted with the resumption of family and employment obligations. However, the applicability of phone-only aftercare does have limits. Phone patients first had (usually several) face-to-face contacts with their therapist. A third were judged to need and received more than the initial four support groups. And the study excluded patients who ended initial treatment without a week's abstinence, yet the most relapse-prone fifth still benefited more from typical aftercare groups.

Practice implications Reduced workload and less disruption for the patient make phone-based aftercare well suited to the long-term monitoring now being recommended. The very limited evidence base suggests that is also preferable for less relapse-prone patients but that face-to-face care should be retained for the more vulnerable. In this study such patients were identified on the basis of an indicator combining dual alcohol/cocaine dependence, drug use and poor self-help group attendance during prior treatment, lack of social support, and a less than absolute commitment to abstinence and belief in one's ability to achieve it. Where such indicators can be identified, vulnerable patients can be engaged in a relatively intensive aftercare regime while the remainder can step down via initial face-to-face sessions to brief phone contacts. A step back up can be taken if problems develop. This strategy is likely to be both more effective and more cost-effective than standard face-to-face care for all.

Featured study McKay J.R. *et al*. "The effectiveness of telephone-based continuing care for alcohol and cocaine dependence: 24-month outcomes." *Archives of General Psychiatry*: 2005, 62(2), p. 199–207 DS

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13.2 Abused women gain from holistic counselling

Findings Women with substance use and mental health problems and traumatised by sexual or physical abuse benefit most from counselling which addresses all these issues.

In nine areas the US government-sponsored Women, Co-occurring Disorders, and Violence project compared usual services to a comprehensive service tailored for these women. Project services embraced outreach, assessment, addiction treatment and specialist inputs such as parenting skills, psychological trauma care, and crisis intervention. Mental health, substance use, and the legacy of abuse were to be addressed simultaneously and in coordination. Empowerment as a therapeutic principle and awareness of the needs and sensitivities of women traumatised by abuse were to underpin all the work.

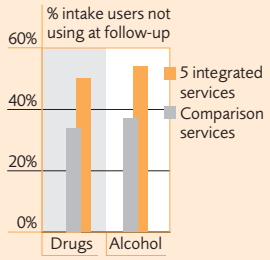
2006 of the 2729 women in the study completed a six-month follow-up interview. Those in project services had made greater gains in the remission of their drug, trauma and mental health symptoms, but the differences were slight and there was no extra improvement in drinking problems. Report ❶ showed this was partly because project agencies varied in the extent to which they did differ in the intended ways from their comparison services. When the focus was sharpened to how the projects had *actually* affected the treatment experiences of the women, consistent and substantial relationships with outcomes emerged, and these extended to alcohol as well as drug problems.

Accounts given by the women three months after study intake indicated that, compared to comparison sites, five project services had provided integrated counselling which, as intended, was significantly more likely to have addressed all three major problem areas. Their clients too had improved more in all these areas. For example, around half using drugs at the start of the study were no longer doing so but just a third at comparison services ◤ *chart*. The remaining four project services were no more likely to have addressed these issues than their comparison services; on most measures, their clients did *worse* than in treatment as usual. Report ❷ broadly confirmed these findings using different statistical methods, and established that the most important thing in improving outcomes for a woman was whether the service *as a whole* was characterised by integrated counselling rather than whether she in particular had experienced this.

In context The featured study is unique in testing integrated treatment tailored for its triple diagnosis subjects. Giving confidence in the findings is the large sample, its derivation from differing sites across the USA, and convergent conclusions from two sophisticated statistical analyses. A major weakness is that many of the women had been in treatment for some time before they enrolled in the study and had potentially already benefited from the new services. However, this would have tended to obscure their benefits, as would the fact that comparison sites learnt from what was happening at the project's services. The finding of a clear and consistent positive relationship between integrated counselling provision and better outcomes accords with US studies of typical addiction treatment caseloads. For women in particular, unresolved present or past physical or sexual abuse have been found to undermine treatment success.

Evidence from other studies of integrated treatment of mental health and substance misuse problems is equivocal. One found that combining care targeted at physical or sexual abuse and substance dependence did not generally improve on cognitive-behavioural addiction treatment. However, the evidence base is compromised by methodological flaws, confined mainly to the addition of substance misuse components to mental health treatment, and confused by differences over what counts as 'integrated'. Even simultaneous provision within the same agency is not truly integrated if substance misuse and mental health components run in parallel rather than being adapted to the joint nature of the patient's condition. This degree of integration has rarely been specified and tested.

Practice implications The combination of needs addressed in this US study is also very common in Britain. It suggests these are best responded to by agencies whose staff holistically counsel women with prolonged histories of abuse and substance and mental health problems. In turn this implies a client-centred organisational ethos rather than one focused on treating a particular condition such as addiction. Achieving integration by coordinating the agencies which specialise in each of the issues presented by these clients is difficult and can take years to produce benefits. Substantial benefits may be gained from the more modest approach of leaving service structures as they are, but ensuring that counsellors (whether in mental health or drug and alcohol agencies) understand and feel able to address these issues. Nevertheless, getting to this point took several years in the featured study and some agencies were clearly more successful than others. Given the paucity of research and equivocal findings on integrated therapies, initiatives along these lines should be carefully monitored to test whether they improve on usual counselling.



Featured studies ❶ Cocozza J.J. *et al*. "Outcomes for women with co-occurring disorders and trauma: program-level effects." *Journal of Substance Abuse Treatment*: 2005, 28(2), p. 109–119 DS ❷ Morrissey J.P. *et al*. "Outcomes for women with co-occurring disorders and trauma: program and person-level effects." *Journal of Substance Abuse Treatment*: 2005, 28(2), p. 121–133 DS

Additional reading ❶ Department of Health. *Dual diagnosis good practice guide*. 2002. Copies: www.dh.gov.uk ❷ Scottish Advisory Committee on Drug Misuse [etc]. *Mind the gaps. Meeting the needs of people with co-occurring substance misuse and mental health problems*. Scottish Executive, 2003. Copies: www.scotland.gov.uk.

LINKS Nuggets **12.4 11.3 4.9 2.12**

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NUGGETTE 1

With no specific treatment like methadone for opiate addiction, researchers have cast around for ways to treat cocaine dependence. So far no drug has convincingly fit the bill. Acupuncture is a popular alternative, but a new synthesis of the research has questioned its efficacy. ❶ A team including researchers from the Canadian College of Naturopathic Medicine and the London School of Hygiene and Tropical Medicine identified nine studies which randomly allocated cocaine dependent patients either to a recommended acupuncture procedure or to comparison treatments. In all but one, the comparison used was 'sham' acupuncture during which needles are inserted at supposedly inactive sites. Seven used biochemical tests to confirm cocaine abstinence at follow-up. When their results were pooled, there was no evidence that acupuncture helped patients stop using cocaine. This verdict statistically confirms previous expert reviews, but 'no evidence' does not mean acupuncture has been proved to have no value. On average half the subjects who started the trials could not be followed up, weakening their ability to detect any effect. Neither could the studies test whether offering acupuncture attracts people to services, a potential benefit even if it does not augment subsequent treatment. And for practitioners, perhaps the most important issue is not whether 'real' acupuncture is better than sham, but whether offering acupuncture as a supplement to normal treatment improves outcomes. As the research stands there is no basis for acupuncture as a primary treatment for cocaine addiction but it may aid retention in the primary treatment and, offered as an option, might attract some patients to treatment who would otherwise not attend.

LINKS Nuggets **5.7 3.8** Nuggette p.10 issue 6

❶ Mills E.J. *et al*. "Efficacy of acupuncture for cocaine dependence: a systematic review and meta-analysis." *Harm Reduction Journal*: 2005, 2(4). Copies: www.harmreductionjournal.com/content/2/1/4.

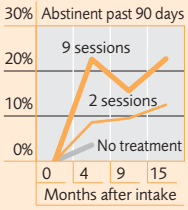
13.3 Brief interventions short-change some heavily dependent cannabis users

Findings A large US study showed that dependent cannabis users can benefit from individualised therapy which extends beyond the brief approaches previously found to produce equivalent outcomes.

The study recruited 450 cannabis-dependent adults at three services in different US regions. Most had responded to adverts. Typically they were single, employed, white men in their thirties. On average they used cannabis three or four times a day and were intoxicated for at least six hours. Over 9 in 10 saw themselves as dependent. Most had been using heavily all their adult lives.

After research assessments they were randomly allocated to a four-month delay before treatment or to one of two therapies. Both married a manual-guided programme with flexibility to tailor this to the individual (including abstinence versus moderation objectives), and specific therapeutic techniques with building relationships and communicating optimism. The briefer treatment consisted of two motivational enhancement sessions a month apart. The first two sessions of the longer treatment were similar but a further seven individual sessions focused on cognitive-behavioural anti-relapse skills whilst also addressing issues such as housing, transport and childcare which might impede progress. Throughout therapists adopted a motivational interviewing style.

Over the first four months those waiting for treatment changed little. In contrast, groups offered therapy moderated their cannabis use to a significantly greater degree and experienced fewer cannabis-related problems. Improvements from intake to the last three months of the follow-up were greatest in those offered the fuller therapy, but this could have been because around half and perhaps more had spent most of this time in treatment. The nine-month follow-up reflected a time when both groups were out of treatment, yet the advantages of the longer therapy were still apparent. The brief therapy group was using on average about six days in every ten, those offered longer therapy just four, and they had experienced greater reductions in symptoms of dependence and abuse. Though attenuated, the advantages of the longer therapy persisted to the 15-month follow-up. At each follow-up many more of the longer therapy group had sustained abstinence over the past three months ◤ *chart*.



In context Until the featured study, none had consistently found significant advantages for longer versus briefer therapies for cannabis dependence, except when the longer therapy had been supplemented by material rewards for abstinence. However, previous studies each had features which could have obscured any extra benefits such as small samples, less experienced therapists for the longer therapies, conducting these in groups, research requirements which could have filtered out all but the most promising clients, and inflexible regimes exclusively focused on abstinence.

The featured study avoided these features and for the first time found a clear advantage for a longer therapy. The difference between the therapies is the obvious explanation, but it is also conceivable that clients and therapists (all had been trained in the longer therapy) saw the two-session option as an incomplete response, diminishing confidence and affecting outcomes. The study also confirmed that even brief therapies lead to improvements and that moderation rather than abstinence is the usual outcome. Outcomes were similar at all three sites, raising the chances of similar results at other clinics and with other clients.

LINKS Nugget **5.11**

Practice implications Studies such as this reveal a substantial potential caseload of very heavy cannabis users who feel a need for help in curtailing their use. Despite a focus on heroin and cocaine, in Britain cannabis is the second most common primary problem drug among new addiction treatment clients, accounting for around 1 in 10. Many more might be attracted by cannabis-specific publicity. Given these new findings, it seems appropriate to offer such patients a course of cognitive-behavioural therapy and motivational counselling, for which moderation should be considered an acceptable objective and outcome. This could begin with one or two sessions combining motivational interviewing with an introduction to techniques for moderating use, which could act as a standalone therapy for those who do not need more or do not return. The manual from the study should make a good starting point ◤ *Additional reading*.

Featured study The Marijuana Treatment Project Research Group. "Brief treatments for cannabis dependence: findings from a randomized multisite trial." *Journal of Consulting and Clinical Psychology*: 2004, 72(3), p. 455–466 DS

Additional reading Steinberg K.L. *et al*. *Brief marijuana dependence counseling. A manual for treating adults*. US Department of Health and Human Services [etc], in press. Copies will be available through www.health.org.

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Thanks to Professor Neil McKeganey of the Centre for Drug Misuse Research, University of Glasgow, for his comments.

NUGGETTE 2

Despite successes with schoolchildren, recent studies have shown that normative education often fails to reduce drinking at colleges, where heavy drinking is both more common and more valued. The approach contrasts real drinking rates with a student's perception of how much their peers drink and with their own drinking. Correcting 'everyone's doing it' misconceptions is expected to reduce drinking closer to the real norm.

One of the largest and most carefully controlled studies of its kind randomised over 1000 US college students to usual peer-led alcohol education in small groups, or to this plus feedback comparing the real extent of drinking at the college to their own drinking and their estimates of how much their fellow students drank.❶ Before and after surveys available from 874 students showed that, as intended, normative education had reduced estimates of how much students drank. However, these were only very weakly related to changes in the individual's drinking. The net result was that normative education slightly reduced the frequency of drinking but did nothing to reduce the amount drunk on each occasion, the more relevant measure if 'binge' drinking is the major concern.

LINKS Nuggets **7.9 6.9 6.8**

The first national US study of normative education in colleges used a different research design and studied media campaigns as opposed to face-to-face interventions, but the results were similarly negative.❷ Colleges which had implemented normative campaigns between 1997 and 2001 had more consistent evidence of *increased* drinking over this period than colleges which had not. Another analysis from the same study showed that colleges which have adopted a social norms approach did less to limit access to alcohol through means such as an alcohol-free campus. The suspicion has been voiced that the drinks industry supports social norms campaigns precisely because these are less effective and divert colleges from imposing restrictions which could cut consumption.

❶ Stamper G.A. *et al*. "Replicated findings of an evaluation of a brief intervention designed to prevent high-risk drinking among first-year college students: implications for social norming theory." *J. Alcohol and Drug Education*: 2004, 48(2), p. 53–72 AC

❷ Wechsler H. *et al*. "Perception and reality: a national evaluation of social norms marketing interventions to reduce college students' heavy alcohol use." *Journal of Studies on Alcohol*: 2003, 64, p. 484–494 AC

13.4 Anaesthesia during rapid opiate detoxification raises costs but does not improve outcomes

Findings Anaesthetising patients during accelerated opiate withdrawal is expensive and introduces new risks, but does not help patients complete detoxification or sustain drug use reductions.

The first study to directly make this comparison recruited 272 opioid dependent patients at four Dutch addiction services who wanted to stop using heroin and other opioids despite prior (average eight) unsuccessful detoxifications. After stabilising on methadone they spent a week in inpatient detoxification where naltrexone to precipitate withdrawal was followed by medication to mitigate the symptoms, including diazepam for anxiety. For the the day of precipitated withdrawal a randomly selected half were transferred to hospital where as soon as withdrawal symptoms became apparent they were anaesthetised for four hours. After completing detoxification all patients began daily naltrexone plus therapy to sustain abstinence.

The course and severity of withdrawal and of craving for heroin were similar in the two groups, though slightly more severe at first after anaesthesia. Complications in five anaesthesia patients required short periods of hospitalisation. In each group all but a few completed detoxification and a month later compliance with treatment and drug use outcomes were virtually identical. Around 85% were still taking naltrexone, 46% had resumed heroin use, and on average heroin or methadone use had fallen from around 20 days a month before treatment to three afterwards. Anaesthesia elevated the average cost of detoxification from 2517 Euros to 4439 plus about 15 extra days in hospital for the treatment of complications.

In context Compared to conventional procedures, rapid detoxification under anaesthesia or deep sedation enables more patients to complete the procedure and start naltrexone therapy. Whilst in the short-term this means more are heroin-free, no study has yet found that significantly more remain so up to 18 months later.

The featured study shows that even these short-term advantages can be equalled by less radical procedures. Its significance is that it compared two approaches identical except that one used anaesthesia, the other light sedation. Relevant factors were probably a relatively stable set of patients, the shelter of an inpatient setting, and, perhaps crucially, acceleration of withdrawal using naltrexone and its comprehensive control by the same array of medications used during and after anaesthesia. Given these supports, nearly all the patients completed without needing deep sedation or anaesthesia.

The study also confirms British and US findings that inpatient detoxification completion rates improve (to over 80%) when detoxification is accelerated using naltrexone, and adds to the evidence that deep sedation or anaesthesia do not eliminate withdrawal discomfort.

Practice implications Whether detoxification under anaesthesia (and by extension, deep sedation) confers any benefits, let alone any sufficient to justify the added risks, is the issue posed by the study. The reason for retaining these options would be that some patients would only countenance or complete detoxification if rendered unconscious for the first few hours, and that this is the best way to reduce the risks they run from continued opiate use. Whether there are such patients and how many is unclear. Studies like the featured study cannot answer this question because they can only recruit subjects prepared to detoxify either way. However, if adding anaesthesia/sedation to inpatient accelerated withdrawal does not compress the process, reduce discomfort, or improve completion and long-term remission rates, it seems likely that very few well informed patient would insist on the more risky procedures.

Long-term recovery depends less on the detoxification technology than on what follows, particularly whether a suitable friend or relative is on hand to help ensure naltrexone is taken and on the quality and intensity of continuing monitoring and therapeutic support.

LINKS Nuggets **9.1 7.1** • Nuggettes p. 13 issue 10, p. 9 issue 9

Featured study De Jong C.A.J. *et al*. "General anaesthesia does not improve outcome in opioid antagonist detoxification treatment: a randomized controlled trial." *Addiction*: 2005, 100, p. 206–215 DS

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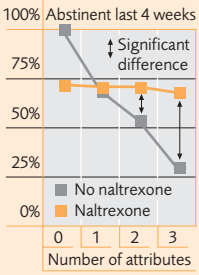
Thanks to Linda Gowing of the University of Adelaide for her comments.

13.5 Naltrexone specially helps poor prognosis patients avoid relapse to heavy drinking

Findings Two European studies have confirmed that the opiate-blocking drug naltrexone particularly helps alcohol-dependent patients who respond least well to therapy, elevating in-treatment outcomes to those of more promising clients. In both studies, after completing detoxification patients were randomly allocated to group therapy and clinical care with or without naltrexone.

Study ❶ conducted in Madrid involved 336 patients treated for three months. Mimicking normal practice, there were no placebos, patients and doctors were aware whether or not naltrexone was prescribed and free to supplement the treatments. Patients prescribed naltrexone drank heavily on significantly fewer days and more (71% v. 59%) sustained abstinence during the last four weeks of the trial. Subdividing the sample revealed that naltrexone only boosted abstinence among patients aged under 25 when they started problem drinking, with an alcoholic near blood relative, or who abused other substances. Without naltrexone, each of these attributes was linked to poorer outcomes and when all three were present, just 30% of patients sustained abstinence. With naltrexone, around 70% of patients stopped drinking whether or not they shared these attributes ◤ *chart*.



Patients who did well on naltrexone in Madrid (early onset, family history, other drug use) also typify 'type 2' alcoholics in Cloninger's schema. In Hamburg (study ❷) they were identified by alcoholism onset before age 25. Given just placebo pills, on average these patients relapsed to heavy drinking within about a week. Given naltrexone, they lasted over five weeks, near the seven managed by patients with a later onset of alcoholism.

In context Unusually, the Madrid study included patients dependent on other drugs, exposing the relevance of this indicator. The main limitation was that all the patients were men; naltrexone may be less effective for women. While partially confirming study ❶, study ❷ also raised a question over whether it is naltrexone which suits early onset alcoholics, or relapse prevention medication in general, since similar results were found with acamprosate.

As in the featured studies, in US studies naltrexone has improved the drinking outcomes of patients who would otherwise have done worst, but those with a better prognosis have been unaffected. The effect is to even out response to treatment. In one study (echoing study ❶) the medication countered poor outcomes associated with a family history of alcoholism. In this study and in two others, it also countered poor outcomes associated with a high craving for alcohol at the start of treatment and in another it helped patients still drinking when they started treatment reduce to about the same level as other patients.

LINKS Nuggets **12.1 11.4 9.8 7.2 5.1** • *Interesting times in the pharmacotherapy of alcohol dependence*, issue 8

Practice implications Based on these and other studies, naltrexone seems particularly worth trying for patients with one or more of the following attributes: early onset (pre-25) alcohol problems; family history of alcoholism; abuse of other drugs; strong urge to drink even in the absence of withdrawal symptoms; unable to initiate abstinence at the start of treatment or sustain it during treatment. The effect is to counter an otherwise poor prognosis, but this can only happen if these patients stay in treatment and take the pills. It may help that naltrexone is particularly suited to programmes which do not demand abstinence, since its main effect is to prevent lapses becoming relapses. Adherence to treatment can be improved by motivational counselling, advice on minimising side effects, and engaging relatives or friends to monitor consumption of the pills. Side effects are more troubling (though rarely severe) than from acamprosate, the main alternative, and naltrexone is contraindicated in patients with certain liver problems or dependent on opiates.

Featured studies ❶ Rubio G. *et al*. "Clinical predictors of response to naltrexone in alcoholic patients: who benefits most from treatment with naltrexone?" *Alcohol & Alcoholism*: 2005, 40(3), p. 227–233 AC ❷ Kiefer F. *et al*. "Pharmacological relapse prevention of alcoholism: clinical predictors of outcome." *European Addiction Research*: 2005, 11, p. 83–91 AC

Contacts ❶ Gabriel Rubio, Alcoholism Research Programme, "Retiro" Mental Health Centre, Doctor Castelo, 60, 28009, Madrid, Spain, garuva@inicia.es ❷ Falk Kiefer, Central Institute of Mental Health, University of Heidelberg J5, DE-68159 Mannheim, Germany, kiefer@zi-mannheim.de.

13.6 Not just for drinkers: screening and motivational interviews help heroin and cocaine users

Findings Substantial minorities of heroin and cocaine users identified while visiting a hospital for medical care cut back after assessment and brief motivational counselling, extending the potential of this approach beyond heavy drinkers.

The study took place at walk-in clinics offering a 'safety net' service to a diverse inner-city Boston population. Research and screening/intervention were conducted by former drug users with outreach experience drawn from the same populations. Questions embedded in a general health needs assessment were used to screen nearly 24,000 patients for past-month heroin or cocaine use plus at least moderate substance use problems. 1232 screened positive, 1175 joined the study. Nearly half had been treated for substance misuse, just under half were homeless, and over 80% were not working.

After a baseline research assessment including a hair test for drug use, patients were randomly allocated either to a comparison group simply given a handout advising them to seek help plus a list of services, or to an intervention group. This group additionally participated in a motivational interview incorporating (if agreed) referral to treatment, ended by scheduling a check-up phone call for a week's time (though in the event, only a third could be recontacted).

About 80% of both groups were reassessed six months later. The analysis was confined to the 778 who tested positive for heroin or cocaine at baseline and for whom there were follow-up hair tests. The comparison group had cut their drug use substantially, but the intervention group had done so to a significantly greater degree: 17% versus 22% of former cocaine users and 31% versus 40% of heroin users now tested negative, and cocaine hair levels had fallen by 4% versus 29%. There was no difference in treatment uptake.

In context Even without a motivational interview, the 40-minute research assessments and simple advice had prompted many patients to reflect on the extent and costs of their drug use and to reduce both. An extra 20 minutes of motivational interviewing further improved outcomes, most notably cocaine use levels. Whether a simple clinical consultation and recommendation to cut back might have done as well is unclear. Failure to improve treatment uptake may have been due to health insurance rules which obstructed access.

The study is the only controlled study to have screened for illicit drug problems in a medical setting and followed this with a brief motivational intervention. Among heavy drinkers this approach has been found to encourage drinking reductions more effectively than usual clinical advice. A few other studies have identified alcohol/drug misusers from hospital records or by referral from staff, and others during street outreach, but none has found motivational interviewing improves treatment uptake more than simple advice. However, motivational interviewing does have a positive record with drug users seeking help rather than those identified through screening.

Practice implications In settings and areas where drug problems are common, it makes sense to screen for these along with heavy drinking. Psychiatric facilities, emergency departments, homeless centres, and clinics treating complaints linked to drug use, are among the candidate settings. The featured study's model of using former drug users from the same backgrounds as the patients is intended to avoid defensive denial. In conversation with these peers/role models, the assessment process itself appeared to motivate change which was augmented by further counselling. To avoid offending other patients and to make the most of the encounter, drug screening could be conducted as part of a wider health screen. Patients who screen positive can be assessed further and offered an immediate brief motivational interview aimed at reducing drug use and, if appropriate, facilitating treatment entry. Even if few do seek treatment, this intervention is itself likely to lead many to cut back or stop using.

Featured study Bernstein J. *et al*. "Brief motivational intervention at a clinic visit reduces cocaine and heroin use." *Drug and Alcohol Dependence*: 2005, 77(1), p. 49–59 DS

LINKS Nuggets **12.6 10.5 9.5 8.5 8.3 6.1 3.10**

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Thanks to David Robertson of Camden and Islington Substance Misuse Services for his comments.

13.7 Syringe sharing cut by two-thirds after injecting room opens

Findings Having shown that the safer injecting facility in Vancouver benefited residents by reducing public injecting and injection-related litter (◤ *Links*), researchers have now shown that it also safeguarded its users by cutting the number who shared syringes by two-thirds.

The study drew on another study which since 1996 has regularly sampled injectors in the city. Earlier this had found that Vancouver's high-volume needle exchanges had not curbed the spread of blood-borne diseases among their users nor markedly reduced their risk behaviour. Faced with epidemics of HIV and hepatitis C, in September 2003 the city opened North America's first facility offering both injecting equipment (left on the premises after use) and a medically supervised place to inject.

For the featured study, injectors were asked whether they had passed on or received a used syringe during a six-month period after the facility had opened. Of the 431 questioned, 90 had injected at least some of the time at the facility while the rest had visited infrequently or not at all. After other influences were taken into account (such as drug use patterns and age), visitors were 30% as likely to have shared syringes as injectors who rarely used the service. Crucially, the study was able to exclude the possibility that visitors had been sharing less even before the service had opened. In contrast, there was no significant link between using needle exchanges and sharing syringes.

In context There are over 50 drug consumption centres in mainland Europe as well one in Australia and now Canada. Research and experience consistently reflect benefits for the local environment. Centre users also benefit by being protected from overdose death and from complications due to poor or hurried injecting practices. However, the evidence for reduced syringe sharing is inconsistent and no study has yet been able to demonstrate an impact on viral infection, perhaps because such studies are hard to construct.

The featured study adds substantially to this research, demonstrating that even where needle exchanges cannot be shown to have made a difference, safer injecting facilities can dramatically reduce syringe sharing among their users. But it also suggests that this single facility lacked the capacity to affect the spread of blood-borne diseases across the city, since just a fifth of the sampled injectors customarily used it. The same limitation applies to centres elsewhere. Even where centres are accessible, some injectors would not use them because this would delay drug consumption or because they prefer to inject in less regulated environments or in greater privacy. Nevertheless, where authorities have been prepared to allow multiple centres, a community-level health impact has been seen on overdose deaths. Their potential to make this impact arises partly from the fact that they attract high-risk injectors, in particular, people who inject in public, who also tend run the greatest risks. They also eliminate sharing for the injections that occur on their premises, a guarantee which cannot be made by needle exchanges.

LINKS Nugget **12.8**

Practice implications ◤ *Links* for further details. In themselves injecting rooms are not illegal in Britain and have some political, medical and academic support. How far they are supported by drug services is unclear, but in harm reduction circles they are seen as an important way to tackle blood-borne viruses and overdose. To deliver these benefits at a population level, many centres will be needed with sufficient capacity to cater for a high proportion of injectors. Public health benefits will not emerge if centres are isolated venues designed to tackle particular hotspots of injection-related nuisance. The balance between nuisance-reduction and public health aims could change if hepatitis C and HIV rates among injectors continue to rise in parts of Britain despite needle exchange provision. If centres are opened they should supplement rather than replace exchanges.

Featured study Kerr T. *et al*. "Safer injection facility use and syringe sharing in injection drug users." *The Lancet*: published online 18 March, 2005. Copies: http://image.thelancet.com/extras/04let9110web.pdf.

Additional reading Hedrich D. *European report on drug consumption rooms*. EMCDDA, 2004. Copies: www.emcdda.eu.int.

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Thanks to Neil Hunt for his comments.

13.8 Continuity vital after prison treatment

Findings Though the original regimes were diametrically opposed, two long-term follow-up studies have confirmed that post-release continuity is vital to sustain the benefits of treatment in prison.

An earlier report on study ❶ had found that while in prison in Australia, far fewer opiate-dependents randomly allocated to immediate methadone maintenance continued to use heroin compared to those who had to wait four months. For the featured study, two-thirds of the 365 surviving prisoners (17 had died – all while out of methadone treatment) were re-interviewed about four years later. The longer someone had stayed on methadone, the less likely they were to have been re-imprisoned or become infected with hepatitis C. The researchers concluded that it was important to use prison to provide methadone treatment which continued unbroken on release.

In California, the Amity prison therapeutic community offered a nine to 12 months programme followed after release by up to 12 months in a similar residential regime. Applicants were randomly allocated to free beds until they had nine months left to serve. Then they were dropped from the waiting list, forming a comparison group who wanted and qualified for treatment, but did not receive it. Five years after their release, records on all 715 prisoners were reviewed and 80% were re-interviewed. 76% of former Amity residents had been re-imprisoned compared to 83% of the comparison group, and on average they had stayed out six months longer. This advantage was largely due to prison treatment increasing treatment uptake on release, mostly in Amity's aftercare programme.

In context Usually modestly beneficial in its own right, prison treatment makes its greatest contribution to reducing recidivism when it paves the way for continuing treatment on release. Take up of, retention in, and outcomes from follow-on treatment are improved if it is compatible with the prison regime.

The featured studies exemplify these findings. In study ❶, without transfer to methadone programmes outside prison, programmes inside would usually have constituted a start-stop response ineffective in preventing infection or re-imprisonment and creating windows for overdose fatality. In study ❷, without compatible aftercare to which prisoners could seamlessly transfer, Amity would have been considerably less effective and less cost-effective in preventing re-imprisonment. In each case, the ex-prisoners were free to enter follow-on treatment or not and probably the most motivated did so, but without this option their motivation may not have been enough.

Practice implications Clear implications are that follow-on treatment should be made easily and immediately available on release, that (assuming prison treatment had been well targeted) this should be compatible with the previous treatment, and that investment in link-up services is vital to encourage transfer. But ensuring continuity requires prodigious feats of coordination. Transfer is maximised by pre-release contact and prison gate pick-up of released prisoners for escorting to aftercare services. The main blockages in Britain include short sentences which afford little time for planning, problems arranging housing, waiting lists for community treatment, poor coordination, and the lack of specific funding. As a result, in recent research aftercare arrangements rarely took the form of a particular service and programme arranged in advance.

LINKS Nuggets **11.5 10.8 4.12 3.13**

Each of these issues is being addressed by new or reshaped agencies, including in England and Wales the Drug Interventions Programme and the newly combined prison and probation service, and in Scotland the new National Addiction Throughcare service to be run by local authorities, replacing a linkage initiative whose workers were unable to meet up with most prisoners on release or to make a difference to those they did meet. Across the UK there are plans to shift the balance from detoxification of opiate dependent prisoners towards maintenance and to ensure its continuation on release, and some evidence that a start is being made. Progress might be aided by regulations allowing prisoners to 'trade' part of their time in prison for supervised treatment on release and preferential access to and funding for the treatment of released prisoners as a group at high risk of relapse and death through overdose.

Featured studies ❶ Dolan K.A. *et al*. "Four-year follow-up of imprisoned male heroin users and methadone treatment: mortality, re-incarceration and hepatitis C infection." *Addiction*: 2005, 100(6), p. 820–828 DS ❷ Prendergast M.L. *et al*. "Amity prison-based therapeutic community: 5-year outcomes." *Prison Journal*: 2004, 84(1), p. 36–60 DS

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Thanks to Russell Webster and to Peter Mason of the Centre for Public Innovation for their comments.

NUGGETTE 3

For over a decade many US states have mandated especially severe penalties for drug dealing near schools. Just as the UK is embarking on a similar strategy, the only US study of its effectiveness has found it did nothing to drive dealing away from schools.

In Britain the Drugs Act 2005 now obliges courts to treat drug supply as a more serious offence when it occurs on or in the vicinity of school premises and within an hour either side of that school being in use. Since 1989 Massachusetts has enacted a similar but more specific provision in relation to dealing within a thousand feet of a school. In three of its cities, researchers mapped these school zones and superimposed the location of drug dealing incidents dealt with by the courts. ❶ Had the law deterred school-zone dealing, offences should have been thicker on the ground outside the zones. In fact, the reverse was the case. This was because dealers tended to do business near their homes which also tended to be near schools, both concentrated in the densely populated poorer areas of the cities. Even a conscientious dealer would have found it difficult to tell if they were inside or outside the often overlapping zones.

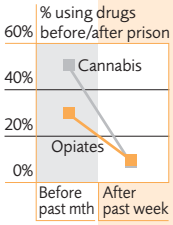
Though the best evidence to date of the impacts of such laws, the detail of the laws in the UK and Massachusetts and the judicial systems differ substantially. In particular, the prevalence of plea-bargaining in the USA meant the most common impact of a school zone charge was to persuade defendant and prosecutor to agree to a guilty plea to a less serious drug supply charge, especially if the offence involved cannabis rather than heroin or cocaine.

❶ Brownsberger W.N. *et al*. "An empirical study of the School Zone Anti-Drug Law in three cities in Massachusetts." *J. Drug Issues*: 2004, 34(4), p. 933–950 DS

NUGGETTE 4

The Scottish Prison Service is reconsidering random drug testing with a view to refocusing on treatment rather than punishing inmates who test positive. Officials are concerned that testing has failed to curb drug use and led prisoners to replace cannabis with heroin, detectable in urine for only a fraction of the time. New research in England and Wales partially substantiates these concerns.

The researchers marshalled existing data and new data from interviews in 2001 and 2002 with over 2200 prisoners which clearly demonstrated that whilst testing may deter opiate use to some extent, its major impact is to deter cannabis use. ❶ In their current prison about 4 in 10 prisoners had used an illegal drug. More had used cannabis than opiates (32% v. 21%) but for each about 1 in 10 had used in the past week and opiates were used slightly more often than cannabis. Since more prisoners were using cannabis than opiates before prison (51% v. 30% in the month before), this represents a greater reduction in cannabis than opiate use ◤ *chart*. There was a strong tendency for dependent opiate users to continue to use regularly in prison but also a few started or renewed their opiate use, particularly if prison had interrupted methadone treatment, yet at the time of the study test results were rarely used to direct prisoners into treatment. Since random drug testing started, cannabis positives have steadily declined while opiate positives have remained stable.



❶ Singleton N. *et al*. *The impact of mandatory drug testing in prisons*. Home Office online report 03/05, 2005. Copies: www.homeoffice.gov.uk/rds.

FEATURE NUGGET

13.9 High-risk youngsters respond to coherent, consistent and interactive after-school activities

Findings Analyses of 48 US government-funded projects for 9–18-year-old children at high risk of drug problems found that only interactive, well structured projects with supported and engaged staff curbed progression to more frequent substance use.

The projects varied in setting (most were after or out-of school projects), approach, intensity and length (eight weeks to three years), but conformed to the same evaluation methodology, enabling impacts to be compared. The key measures were how far children in each project changed their cigarette, cannabis and alcohol use in relation to a local comparison group of similar children. At the start the 6031 project and 4579 comparison children were using these substances far more often than the US norm. Overall, the projects retarded further increases in frequency of use by around 10% and were particularly effective among the quarter of youngsters already using.

Report ❶ sought to identify which projects had done most to curb substance use between the time they started and after they had ended. By this yardstick, the most effective had focused on substance-free recreational activities or used these and other means (eg, academic and vocational support) to develop personal and social lifeskills such as anger management and conflict resolution. Children in projects which instead focused on knowledge or boosting self-esteem actually did worse than comparison children. However, a lifeskills orientation only helped when the project *also* implemented this using interactive or experiential learning methods rather than passive lecture-style approaches. Interactive methods were particularly effective when they fostered 'connectedness' between children and adults through collective activities, mentoring and other social interactions, but were also effective when they helped youngsters examine the effects of their own attitudes and behaviours through role plays, group discussion, and the challenges of pursuits such as wilderness training. School projects were less effective than after-school activities, seemingly because a classroom setting constrained the extent to which projects could incorporate these positive features.

How projects were managed was also important. Those with an explicit rationale around which staff and activities could cohere were most effective, markedly so when this conceptual coherence was combined with consistent delivery of planned activities at set times. But (reports ❷) even positively featured projects were only effective when their staff felt reasonably supported and satisfied with their work, and the greatest impacts emerged from projects whose staff felt empowered to work effectively with the youngsters.

Compared to these qualitative dimensions, the projects' duration and intensity were less important, though the half active for the most hours per week (at least 3.3) were most effective.

The few projects which combined most of these positive features curbed the growth of substance use substantially more than whatever usual responses were being made to comparison children; the remainder were ineffective. Moreover, children who had experienced these projects continued to use cannabis, cigarettes and alcohol less frequently six months (25% less than comparison children) and 18 months (14% less) after the projects had ended.

In context Despite lacking detail on how the children were selected and on recruitment rates, this work represents a major advance on the previously patchy research on intervening with high-risk youngsters. It confirms the importance of enabling children (whether high risk or not) to participate and interact with each other and with adults rather than being passive recipients of adult messages, and also confirms that the ability or willingness to run such programmes is more often found outside than inside formal schooling. Other effective work with high-risk youngsters has involved interactive family skills training for both parents and children, bringing them together to practise more constructive interactions. In Britain, interactive youth work projects which respond to young people's priorities and which, rather than focusing on drugs, address broader vocational, lifeskills and health issues, have been found to be most attractive to high-risk teenagers.

Practice implications Though relevant to prevention in general, the lessons of this study are particularly relevant to initiatives such as the Positive Futures projects in England and Wales, which offer marginalised 10–19-year-olds mainly sports-based activities intended to prevent substance misuse and reduce social exclusion. Lessons relating to content (lifeskills) and teaching methods (interactive) are familiar from programmes aimed at children in general. Equally important is the less familiar lesson (but one also found in school drug education) that these will not be effectively delivered unless staff understand and feel comfortable with the underlying approach, are adequately supported, and given the resources to mount coherent, consistent programmes.

Featured studies ❶ Springer J.F. *et al*. "Characteristics of effective substance abuse prevention programs for high-risk youth." *Journal of Primary Prevention*: 2004, 25(2), p. 171–194 DS ❷ [US] Substance Abuse and Mental Health Services Administration. *The national cross-site evaluation of high-risk youth programs*. 2002. Series of monographs available at: www.health.org/govpubs/FO36.

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Thanks to the health education consultant Blaine Stothard for his comments.

LINKS Nuggets **11.9 7.10 7.8 2.14** • Offcut 2, issue 11 • *Doing it together strengthens families and helps prevent substance use*, issue 10 • *Prevention is a two-way process*, issue 5

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NUGGETTE 5

Offenders ordered to the same treatment stay longer and then commit fewer crimes if sent by criminal justice programmes which have credible sanctions and ensure offenders understand this and know they are being monitored.

The latest report on the Drug Treatment Alternative to Prison (DTAP) programme in New York compared problem drug users (mainly daily heroin and/or cocaine users) sent to the same four residential therapeutic communities from three types of criminal justice sources. ❶ The first was DTAP itself, which allowed dealers with previous convictions to opt for treatment instead of probable conviction and prison; the second, another structured diversion programme (TASC) for offenders who have pleaded guilty. The third was normal criminal justice sources rather than a structured programme. Both structured programmes took care to ensure offenders were made repeatedly aware that they were being monitored and that failure to comply with treatment would attract legal sanctions usually amounting to several years in prison. After taking caseload differences into account, offenders supervised by these programmes were under a third as likely to be rearrested or reconvicted in the following three to four years, and whilst free were arrested fewer times. Previous reports had established that DTAP and (non-significantly) TASC offenders stayed longer in treatment and that retention was strongly related to offenders' perceptions that they were under legal pressure. Both structured programmes were more successful than usual criminal justice sources in instilling the particular perceptions related to retention: that the offender had been made aware of the programme's rules by several criminal justice agencies; had been made to understand the consequences of breaking rules or not completing treatment; that they would swiftly and surely be rearrested for absconding; and that the consequences would be severe. Though further analysis would be needed to confirm this, the presumption was that by fostering these perceptions, DTAP and TASC had persuaded offenders to stay longer in treatment and that this had reduced later recidivism.

LINKS Nugget **8.11**

❶ Young D. *et al*. "Criminal recidivism in three models of mandatory drug treatment." *J. Substance Abuse Treatment*: 2004, 27(4), p. 313–323 DS

NUGGETTE 6

A simple system enabling police to target licensed premises associated with alcohol-related crime has been implemented across New South Wales after a trial showed it was feasible, acceptable to licensees, and resulted in a drop in alcohol-related incidents. The Alcohol Linking Programme systematised enforcement of a new law requiring responsible alcohol service. It was developed in partnership with police after an assessment of gaps in their procedures. A similar approach has been successfully tried in Wales ◤ *Nugget* 10.9. These procedures could provide a mechanism for implementing new British licensing laws and strategies aiming to curb crime and disorder.

LINKS Nuggets **11.10 10.9 1.10** *Just say, 'No sir'*, issue 9

In the Australian programme, police attending an incident involving drinking record just four extra bits of information, including where the suspect last had a drink. ❶ If this was a licensed premises, the incident is considered 'linked' to those premises. Licensees are sent written feedback comparing the number and type of incidents linked to their premises with the local average, together with notification of a police visit the following week for a 30-item responsible service audit. At a further meeting the result is presented to the licensee with advice on reducing alcohol-related harm. Licensees with a 'clean' record are instead sent a congratulatory letter. In the initial trial nearly 400 premises were randomly allocated to these interventions or to normal policing. ❷ Incidents linked to intervention premises fell by 36% compared to 21% after normal policing, narrowly missing statistical significance. Most involved assault or drink driving but the intervention was also followed by large drops in domestic violence, malicious damage and drunkenness. After state-wide adoption, audited premises accounted for up to 22% fewer alcohol-related incidents than before.

❶ Wiggers J. *et al*. "Strategies and outcomes in translating alcohol harm reduction research into practice: the Alcohol Linking Program." *Drug and Alcohol Review*: 2004, 23(3), p. 355–364 AC

❷ The Linking Project. *Hunter & Northern Metropolitan Regions of NSW 1996–1999. Final report*. April 2002. Copies: www.hunter.health.nsw.gov.au/docs/HCHA_LinkingFinal.pdf.

NUGGETTE 7

A rare opportunity to test whether drug prevention is best done by outside specialists or a school's own teachers came down on the side of the teachers.

The US All Stars programme for early secondary school aims to retard growth in substance use by fostering a belief that this is incompatible with desired lifestyles, correcting over-estimates of how many age-mates are using drugs, strengthening bonds with the school, and providing an opportunity to make a public commitment to avoid drugs. These 'mediating variables' are targeted through interactive classroom activities supplemented by one-to-one sessions to help children integrate with the school. In five schools the programme was delivered by specialists with teaching experience drafted in for this task and given 30 hours training. In three, the school's own teachers took it on after just half a day's training. Another six schools implemented their normal lessons. Only when teachers led the programme did it significantly retard substance use (drinking, smoking and solvent abuse). ❶ This was because the teachers created greater positive change in all four mediating variables, only one of which was significantly affected by the specialists. Further analyses found that the pupils enjoyed the programme more and became more involved when it was led by their teachers, which in turn was related to greater change in the mediating variables. However, observers judged the teachers to have delivered the programme slightly *less* well than the more highly trained and experienced specialists. That nevertheless they were more effective may have been due to their continuing relationships with pupils, enabling them to tailor and reinforce the programme's messages. Since their schools were prepared to devote in-house resources to the programme, they may also have been relatively well supported and comfortable with interactive teaching.

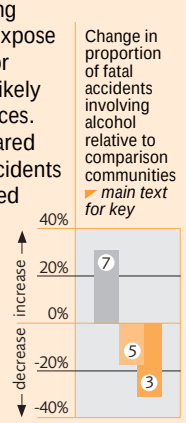
❶ McNeal R.B. *et al*. "How All Stars works: an examination of program effects on mediating variables." *Health Education & Behavior*: 2004, 31(2), p. 165–178 DS

13.10 Communities can reduce drink-driving deaths

Findings A multi-million dollar attempt to equip US communities to tackle substance misuse only succeeded in reducing alcohol-related traffic deaths when treatment initiatives were supplemented by measures to limit the availability of alcohol.

Between 1990 and 2002 the *Fighting Back* initiative funded 14 community coalitions to develop community-wide prevention and treatment systems. Each could devise its own strategies as long as these included public awareness campaigns, preventive measures aimed at young people, early intervention, treatment, and 'environmental' changes intended to make the area and the community more resistant to substance misuse problems. Trends at 12 of the sites could be compared against matched communities but the results were disappointing. Surveys of residents revealed no positive relationships between the initiatives and drug, tobacco or alcohol use, problem use, or community awareness, either overall or for the outcomes expected from particular types of interventions.

But a later analysis (◤ *Featured study*) of traffic accident records showed that there had been substantial benefits in five of the communities. Overall their coalitions had not been markedly more vigorous, but they had made more extensive efforts improve access to treatment (including screening emergency patients for substance misuse) and allied this with a much greater focus on restricting alcohol availability. They had mounted 'sting' operations to expose illegal sales, conducted responsible service training, closed or blocked the opening of alcohol outlets, and were also more likely to have limited advertising and established city-wide task forces. When the decade before these projects went live was compared with the following ten years, the proportion of fatal traffic accidents involving alcohol had fallen by 22% more than in their matched communities ◤ *chart* 5. The three projects which had operated on a city-wide basis recorded particularly large relative reductions, from 31% at the lowest blood alcohol level to 39% at the highest ◤ *chart* 3. In contrast, the remaining seven *Fighting Back* communities which had focused less on treatment and availability had seen relative *increases* (albeit not statistically significant) in the proportions of fatal accidents involving alcohol ◤ *chart* 7.



Change in proportion of fatal accidents involving alcohol relative to comparison communities ◤ *main text for key*

In context Apart from in one community, these results were achieved without including roadside police sobriety checks in the campaigns, the most direct way to reduce alcohol-related accidents and one with a positive research record. Availability restrictions were probably the major active ingredients. These most clearly distinguished the five successful communities from the remaining seven, and previous research has demonstrated their potential to reduce heavy drinking, drink driving, and alcohol-related accidents, injuries and deaths. Without a focus on regulatory action and availability restrictions, media campaigns and community mobilisation are less effective. However, these can help generate and sustain support for intensified regulation and may in their own right reinforce social norms against drink driving. Improvements in treatment access may also have helped. Treating people seeking help for their alcohol problems and screening and intervention among emergency patients both reduce accidents among the patients concerned. Though yet to be clearly demonstrated, such effects may cumulate into public health benefits visible at a community level, including impacts on accidents and drink-driving.

LINKS Nuggets **10.9 4.13 3.4 3.3**

Practice implications In England and Wales, transfer of licensing powers from magistrates to local authorities has paved the way for increased community involvement in the regulation of alcohol availability. Though powers to regulate at a neighbourhood level (as opposed to an individual site) are limited, the kind of mobilisation and actions trialed in the featured study are feasible in Britain. They are likely to have their greatest impact when implemented across a circumscribed community, particularly if the alcohol-related accidents in that area mainly involve residents drinking in local venues.

Featured study Hingson R.W. *et al*. "Effects on alcohol related fatal crashes of a community based initiative to increase substance abuse treatment and reduce alcohol availability." *Injury Prevention*: 2005, 11, p. 84–90 AC

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Thanks to Professor Mike Maguire of Cardiff University for his comments.

Care Control Challenge

WET DAY CENTRES IN BRITAIN • PART 2

A wet day centre can only cohere into an effective force for change when seemingly contradictory elements are made to interlock – when challenge and control promote care rather than exclusion and care enables challenge rather than encouraging stagnation.

WET DAY CENTRES offer drinkers a place to stay during the day where they don't have to stop drinking, a vital first point of contact for people who would otherwise be excluded from services. But these centres are inherently fragile and difficult to run. They must be welcoming, yet proactively address anti-social and self-harming behaviour, and do both with low paid and at times inexperienced staff.

Part one of this series (◤ issue 12) dealt with how to plan and set up a service. This final part takes up the story when a centre has become a reality, and its management and staff face the demanding task of maintaining order yet retaining focus on the more challenging objectives: helping clients control their drinking, and maintaining good community relations. First we describe how centres engage and work with their clients, then the management structures needed to keep the work on track.

by Maureen Crane & Tony Warnes
of the Sheffield Institute for Studies on Ageing at the University of Sheffield. Article adapted with permission from *Wet Day Centres in the United Kingdom: a Research Report and Manual* published by the Sheffield Institute for Studies on Ageing in 2004. The research was commissioned by the King's Fund and the Homelessness Directorate. We are grateful to the commissioners, publishers and authors for permission to adapt their work.

Working with the clients: safety, welcome and challenge

To describe the work that needs to be undertaken with wet-centre users we draw on interviews with clients and staff at the four British centres that we studied closely and the experiences of other centres ◤ *The research behind the report*, p. 20.

EMBRACE NEWCOMERS (BUT NOT TOO TIGHTLY)

It is important that a centre's environment is attractive, safe, free from intimidation, and welcoming to new clients. Ideally rooms are bright and spacious, so clients who normally have little close contact with others do not feel cramped. Front-line staff should welcome new clients (one might be designated for this role), explain what the centre offers, and take every opportunity to sit with and get to know them. Staff at the Booth Centre find the wet garden a relaxing 'half-way step' in to the centre for the more wary. Volunteers can play important roles in engaging clients and making them feel at ease.

First contacts have to be handled tactfully, eliciting any pressing problems without probing so insensitively that the client is scared off. Some wish to talk, others initially to be left alone. Staff need to be aware and respond accordingly. More information can be collected once they have engaged with the centre. Women may have particular issues they wish to discuss, and a women's group might be useful.

CONDUCT A BROAD, PHASED NEEDS ASSESSMENT

Most centres collect basic personal information from a client when they first attend, but not all later undertake a detailed assessment of problems and needs. To best help a client, information is required about:

- recent housing, including tenancies, temporary accommodation, or rough sleeping; recent and current problems with tenancies, including rent arrears; and experiences of homelessness;
- family and social contacts, and contact with drinkers and non-drinkers;
- income, state benefits, and financial problems;
- physical health problems and nutrition;
- morale and indications of depression, mental illness, unresolved stresses or memory difficulties;
- alcohol consumption, including types, drinking pattern, drinking history, reasons for heavy drinking, and involvement in alcohol treatment;
- use of illegal substances and involvement in drug treatment programmes;
- recent history of offending and contact with the probation service;
- daily living, personal care, literacy and social skills;
- activities and engagement in community, work and training schemes.

Given this list, the assessment cannot be completed at a single interview. Moments will have to be sought when a client is fairly sober and willing to talk. Mental health or cognitive problems will leave some unable to give accurate details, while others will be reluctant or deliberately mislead. If the client consents, information should also be sought from other agencies. Needs, abilities and attitudes will change as problems are resolved or ameliorated, so assessments have to be frequently updated. There needs to be a thorough assessment of a client's daily living skills as a basis for determining their suitability for different types of housing. Even among those who are housed, many struggle to cope at home.

PROFILE RISK TO SELF AND OTHERS

Most clients are vulnerable and some have challenging behaviour, so it is essential that risk assessments are undertaken and updated. These assess whether someone poses a risk to themselves or others and whether the risk can be managed within a service. A

comprehensive guide, *Risk Management Policy and Procedure*, is available from www.serviceaudit.org. Such assessments are not normally used to exclude people but to ensure they receive the best possible service.

Risk assessments need to consider:

- behaviour, including violence, abuse, harassment, likelihood of dangerous accidents linked to substance misuse or smoking, and persistent provocative behaviour;
- physical health, and risks from mobility, weight, self-neglect and substance misuse;
- mental health, and the risks of self-harm and of bizarre behaviour;
- daily living skills, including risks while preparing food and using appliances at home;
- the condition of clients' accommodation, including outstanding repairs, infestation, faulty appliances, furniture and flooring.

FIRST THINGS FIRST: FEED AND CLEAN

Many heavy drinkers have poor diets, partly because they spend their money on drink, and partly because they are prone to health problems which affect appetite and digestion. Most wet centres provide a free cooked breakfast or dinner, and the Brighton centre also gives out vitamin tablets. Meeting nutritional needs is important. Free hot and cold drinks should be available at all times and nutritious food served at least once a day. If there is a charge for food, it should be discretionary and dependent on circumstances. Some staff believe free food encourages attendance and ensures at least one meal a day, others that it enables clients to spend more on alcohol. Attention should also be paid to whether clients are eating; some may need encouragement. If there is cause for concern, clients should be referred to a primary care nurse or GP.

Some heavy drinkers neglect personal hygiene, do not launder clothes, and become incontinent when drunk. Skin infestations, especially lice and scabies, are common among those sleeping rough or in neglected tenancies. Most wet centres have showers and laundry facilities or are close to centres which do. Staff need to encourage personal hygiene. Clean clothing and toiletries may prompt some clients to shower and change, and leaflets about hygiene may encourage interest. A clear policy is needed for managing clients with skin infestations. For example, at Leicester's Anchor Centre, nurses treat clients with lice.

PLANNING FOR THE FUTURE

Only a few wet centres carry out individual casework with clients by a named worker, but most staff we interviewed recognised the value of assigning each client a named keyworker who is responsible for seeing they get the help they need. It ensures that interventions with clients are followed through and that the needs of the withdrawn or undemanding are not neglected.

Keyworkers assess needs, design a care plan with realistic goals, refer to specialist agencies, and coordinate the client's care. Care plans should be prepared and agreed with the client when they are sober and coherent, and regularly reviewed. They must address immediate problems, such as lack of income, poor nutrition, untreated illness, poor hygiene, and lack of accommodation, and more complex issues such as alcohol abuse and long-term housing and support needs. They should also seek to build confidence, self-esteem and motivation. What comes first will depend on the individual. Some rough sleepers will not consider temporary accommodation until their confidence and self-esteem has been boosted, and some heavy drinkers will not attend to personal hygiene until their drinking is controlled.

CENTRES MUST BE WELCOMING YET PROACTIVELY ADDRESS ANTI-SOCIAL AND SELF-HARMING BEHAVIOUR

Many clients have long-standing problems. Working with them will be slow and should be paced to the individual. The keyworker will be able to complete some agreed actions, such as filling in benefit forms. For others they will need the inputs of primary care nurses and mental health teams. In such cases, care plans should be coordinated by the keyworker with regular reviews and liaison across agencies.

Despite their problems, clients have often had little or no contact with services for some time. To address health and welfare problems, it is imperative that such contacts are made. At some wet centres, outside agencies hold regular sessions, and the keyworker should ensure that their clients are seen by these workers. In other cases they will need to arrange for the client to attend an outside agency – no easy task, as some fail to keep or forget appointments, or leave if they are kept waiting. Early appointments (before the person has drunk a lot) and escorting the client have proved useful.

HELP HOUSED CLIENTS STAY THAT WAY

Many heavy drinkers with tenancies live alone and find it hard to manage. They neglect to pay bills and clean and some live in squalid conditions. Rent arrears and tenancy failures are common. Home care services are difficult to arrange because staff refuse to go to flats where there are several drinkers, and the clients are often not at home or refuse to answer the door. To combat loneliness, some have their friends round, host 'drinking schools', and allow those without accommodation to stay. This can lead to noise, disruptive behaviour and complaints from neighbours. Some clients do not report problems or seek help until taken to court and evicted.

Given these problems, many housed clients need tenancy support – some for a long time – if homelessness is to be avoided. Centres have to decide whether to undertake this or to refer clients to tenancy support teams (if available). The advantages of wet centres being directly involved are that clients already know and are in frequent contact with the staff. Sorting out rent arrears, helping clients pay bills, intervening in neighbour disputes, and arranging for cleaning and furnishing, is, however, time-consuming work, and joint home visits may be necessary when there are safety concerns.

TAKE ACCOUNT OF THE SOCIAL DYNAMICS

There are many social relationships among clients at wet centres. The significance of these relationships is heightened among a group of people who in general lack

GOLDEN BULLETS Key points and practice implications

- A key management task is to provide a welcoming and reassuring service which does not neglect the more challenging role of prompting clients to move forward in their lives.
- It is essential to maintain order within the centre by enforcing clear boundaries, to minimise local nuisance, and to respond to community concerns.
- Detailed assessments of problems and needs should incorporate assessments of risk to self and others and of whether and how these can be managed by the centre.
- To address health and welfare problems, it is imperative that contacts are made and sustained with external agencies including (unless this is done in-house) those providing tenancy support.
- Clients who wish to tackle their alcohol problems commonly require detoxification followed by several months of rehabilitation.
- Staff should monitor clients' alcohol intake and intervene if someone drinks at unsafe levels.
- Meaningful activities provide opportunities for the constructive use of time and a platform for building skills, confidence and a sense of achievement and self-esteem.
- Staff have exceptionally challenging roles and require a high level of guidance and support. Job satisfaction is improved when they are enabled to witness client progress.
- Given attention to these priorities, wet day centres can make an impressive contribution to reducing unmet need among the most vulnerable people in our society.

intimate relationships and family contacts. Some have socialised for years on the streets and in hostels, and group camaraderie is usually strong. They share alcohol, lend each other money, visit each other at home, and generally support one another, if not always in constructive ways. Their lives are interlinked. When planning care, consideration has to be given to the individual's relationships with peers and how this might impact on the help that is given.

HOW TO ADDRESS ALCOHOL PROBLEMS

Little is known about how best to tackle alcohol problems in this client group. Most staff we interviewed believed that allowing clients to drink at wet centres is a positive move. It encourages people excluded from other services to use the centre, and it reduces tensions and facilitates communication between staff and clients, who no longer have to conceal their drinking.

It can, however, be extremely difficult (though not impossible) for clients to stabilise their drinking while attending a wet centre. They attend for just a few hours a day and mix with other attenders who drink heavily, and life away from the centre tends to revolve around other drinkers they have known for years. To control or reduce their drinking, they may need to stop attending, break away from drinking friends, and be referred elsewhere for help.

DETOXIFICATION AND REHABILITATION

Clients who wish to tackle their alcohol problems commonly require detoxification followed by months of rehabilitation. However, multiple episodes of alcohol withdrawal may (the evidence is contested) risk neurological damage and cognitive dysfunction. If this is the case, clients should be very carefully selected. Helping to control and reduce drinking may be more appropriate for those unlikely to sustain abstinence.

In some cities the wait for a detoxification place is up to 10 weeks but in Nottingham, Framework Housing Association runs both a wet centre (Handel Street) and a residential treatment project for heavy drinkers with a detoxification bed, providing a fast and efficient alcohol treatment service for wet centre users. Elsewhere, home detoxification services are available. These can start promptly and are more accessible than inpatient treatment, but are only suitable for stably-accommodated clients with strong social support.

Ideally, rehabilitation starts straight after detoxification, but this is difficult to arrange. Detoxification is funded and arranged by the NHS, rehabilitation by social services. Places are scarce (waits of six to nine months in some areas) and costly (£400–550 per week per client). Inadequate move-on services mean some return to a wet centre and resume drinking after detoxification.

RULES AND RESTRICTIONS

Wet centres have different rules about drinking on the premises. Some allow drinking only in a designated room or garden, others anywhere. Some restrict the amount of alcohol brought in, others monitor neither quantity nor types. It is important to remember that whilst monitoring can limit the 'import' of alcohol on to the premises, it cannot restrict the amount of consumed throughout the day. Many clients have drunk alcohol before arriving, some share drinks in the centre, and others go outside to drink.

On this issue, staff views were diverse. Some opposed restrictions because these affect relationships with clients and place staff in a 'policing' role. They also feared some clients might stop coming, though no instances were reported. Instead, they preferred other strategies for controlling alcohol consumption, including engaging clients in activities. Those in favour of restricting alcohol argued that:

- It improves behaviour and makes the environment more welcoming and safer for clients and staff. Some needy clients stay away if a centre becomes rowdy and volatile.
- The centre should aim to reduce the damage clients do to themselves through alcohol. It should not communicate that it is acceptable to drink irresponsibly.
- It is impossible to work constructively with highly intoxicated clients.
- It is irresponsible to allow clients to drink liberally on the premises. Their drink and drug use before coming to the centre is unknown, and heavy drinking can be lethal. Moreover, if clients become intoxicated, when the centre closes there are health and safety implications for neighbours and the public as well as for clients.

Despite mixed opinions, most staff agreed that it is irresponsible to allow clients to use the centre simply as a social drinking venue and to permit consumption of large amounts of alcohol. They also believed that there should be activities at the centre and other interests to engage the clients, so they do not drink because there is nothing else to do, and that staff should keep an eye on the amount being drunk and intervene when there is cause for concern.

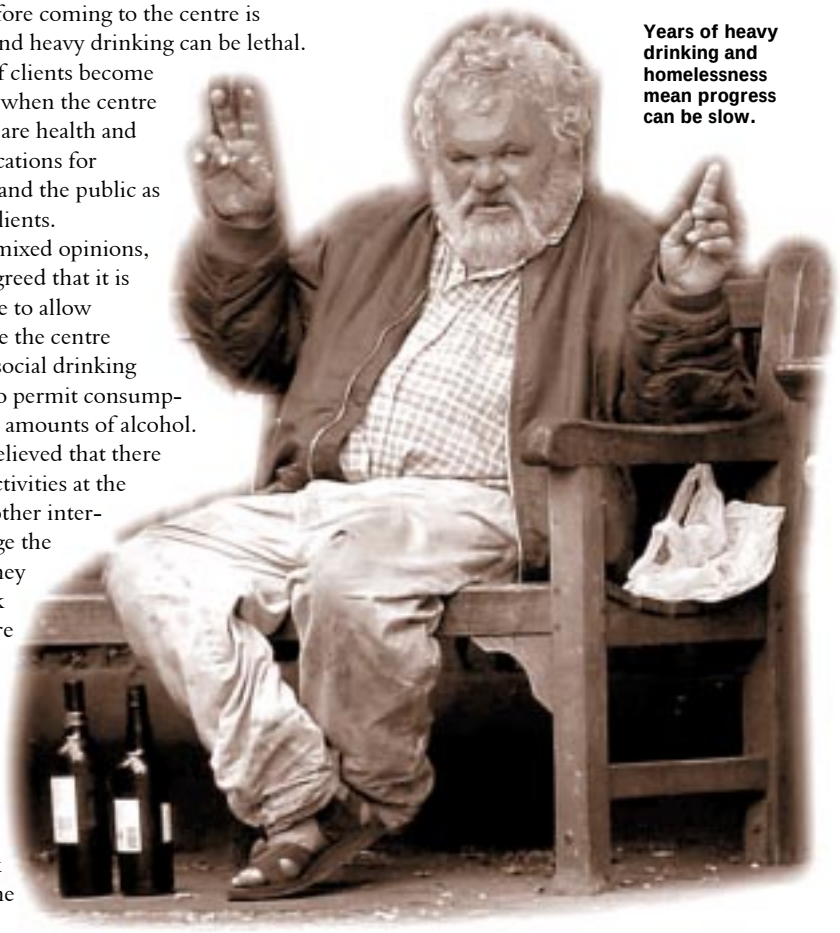
In summary, if rigid alcohol restriction rules are not imposed (and we do not recommend they are), then it is essential that staff integrate with the clients, observe their alcohol intake, and intervene if a person drinks excessively.

SOMETHING MEANINGFUL TO DO

The value of 'meaningful', structured activities for people with mental health problems has been well documented, stimulating the development of sheltered workshops and clubhouses to help build skills, confidence and self-worth.[1] These have spread widely in day centres for homeless people, particularly since the Rough Sleepers Unit was established in 1999.

Several wet centres promote activities, as exemplified by the Booth Centre. It has four activity workers and has secured education and health funding, the latter for sports and outdoor pursuits. Other activities include basic education and skills training (such as cookery and literacy courses), recreational and developmental pursuits (including computer use, art and gardening), and work and volunteer training schemes such as conservation projects. The Anchor Centre has secured education funds for an external agency to run activities. At Tollington Way, local college tutors run a literacy group.

Activities should be central to wet centre provision. They provide opportunities for



Years of heavy drinking and homelessness mean progress can be slow.

JOHN CHALMERS, ANCHOR CENTRE, LEICESTER

Recreation, rest and referral at the Anchor Centre in Leicester.

the constructive use of time, a diversion from drinking, and a platform for building skills, confidence, self-esteem and a sense of achievement. They promote decision-making, planning for the future, and social interaction and integration through group work. Activities may also compensate for the cognitive deficits and poor physical coordination suffered by many chronic drinkers.

Running activities is a complex task on which wet centres should seek expert help. Success depends to some extent on the ability of tutors or leaders to engage and inspire. A useful guide for working with homeless people has been commissioned by the Learning and Skills Development Agency.[2] It recommends that staff initially contact the community education coordinator at a further education college and the local authority's adult and community learning service.

Managing a wet centre: facing in, facing out; containing chaos, staying focused

Wet day centres have two linked and demanding roles: to engage with street drinkers and help them deal with their problems; and to reduce street drinking and associated anti-social behaviour and negative environmental impacts. This section details the most apparent problems of running a centre, how they arise, and how they have been contained and solved, drawing almost entirely on the experiences of the centres which contributed to this study.

ENOUGH OF THE RIGHT PEOPLE

A wet centre requires enough staff to:

- provide a safe setting for users and workers;
- provide basic services and constructive, rewarding activities;
- facilitate individualised work that involves care planning, support, monitoring, and liaising with other agencies;
- induct new staff and volunteers and cover for holiday and sickness absence;
- undertake routine performance recording and reviews;
- enable managers to develop and maintain contacts with other services, professionals and the local community; and
- allow time for staff to attend appraisal, supervision and training sessions.

At least one should be a trained first-aider as accidents and seizures are common, and one responsible person should have detailed, up-to-date knowledge about how to enlist emergency support from primary care and mental health services and police.

BALANCE FRONT-LINE AND CASE WORK

There are two main kinds of work with clients in wet centres. 'Front-line' work includes the day-to-day running of the centre and supporting clients when they first attend – delivering basic services such as drinks, meals, standard information and advice, and engaging, getting to know and building trust with attenders. Front-line workers need to be able to develop rapport with distrustful and disturbed clients, manage boisterous exchanges, and control unruly, threatening or disallowed behaviour. Staff and volunteers need a clear understanding of the situations in which they should intervene alone, only with support, or not at all. They also need a general awareness of what is happening on the streets and in the clients' lives.

The other type of work is individualised 'developmental' work with established clients to help them make positive changes in their lives. It includes assessing needs, and formulating, implementing and reviewing care plans. Workers require skills in carrying out these tasks but also in gaining the client's trust and cooperation. Caseworkers also need wide-ranging, up-to-date knowledge of the local welfare system and the roles and referral procedures of specialist agencies. Implementing care plans requires a great deal of work, not only to persuade other agencies to take on the clients, but also to promote the client's compliance, keep records, and to monitor and review progress.

There are also valuable forms of intermediate work with both 'front-line' and 'developmental' functions, primarily the activities provided and promoted through the centre. Many are organised as group activities and initially presented as such, but provide settings in which individualised 'assessment', advice, encouragement and plans can gradually be introduced, an approach specially suitable for wary clients.

Every wet centre needs staff who can deliver front-line work, gradualist engagement and casework. At some, all core staff take on these roles, at others, some are dedicated to front-line work and refer clients who have been engaged and who consent to dedicated caseworkers.

INTENSIVE STAFF SUPPORT IS ESSENTIAL

Working with this client group is intrinsically challenging; tensions, aggression, non-compliance and rejection are common – why many mainstream services bar the clients. To counter this, it is unusually important that, alongside a strong client-oriented ethos, line management functions are vigilantly applied. These have a vital role in supporting and retaining staff and ensuring that the more ambitious but difficult aims of the centre are pursued.

Challenging roles demand a high level of guidance and support for staff who in turn require an exceptional degree of professional responsibility and dedication. Persuading and enabling clients to make positive changes is far more difficult than being welcoming and reassuring. Without support and supervision, the former can lose out.

The temptation is to drift from optimal working methods in at least two ways. First, building relationships with clients can eclipse more reflective exchanges about problematic behaviour, leaving alcohol-dependent lifestyles and dependence on the centre unchallenged. Second, unsupported

staff may react to aggressive or argumentative clients by allowing an 'us' and 'them' ambience to develop, retreating to 'the office' and shunning maximum contact. They may come to see their jobs as primarily to maintain order and 'keep the lid' on latent problems.

TRAINING AND PEER EXCHANGE

Training is essential for staff and volunteers. They need to understand alcohol dependence and the needs of heavy drinkers, develop skills in managing aggressive and challenging behaviour, and learn how to work with people who have drug and mental health problems. Casework staff will also require training in assessment and care planning, those involved in activity groups will need group-work skills, and those undertaking tenancy support will require skills in assessing housing vulnerabilities and responding to difficulties.

Drugs and Alcohol National Occupational Standards (DANOS) describes the performance, knowledge and skills required of substance misuse workers and forms the basis of national vocational qualifications (NVQs). A government-sponsored handbook recommends that all staff working with homeless drug users are trained to DANOS standards;[3] the same could be said of staff working with alcohol misusers. Key skills relevant to wet centre workers include: assessment; helping individuals access services; supporting them in difficult situations; educating about substance use, health and social well-being; coordinating care; supporting rehabilitation; and providing a healthy, safe, secure and suitable environment for the delivery of services.

Training is one way to develop skills, peer contact is another. Wet centres are in their infancy, yet staff report little opportunity to meet and discuss working practices. It is strongly recommended that resources are made available to enable staff to share good (and bad) practice.

SEEING SUCCESS IMPROVES MORALE

Some wet centres have problems recruiting and retaining staff. Low wages, weekend work, and challenging and abusive clients are among the deterrents. Moreover, the work involves supporting people who have been drinking heavily for years. Some will make little or no progress. Clients who do make major progress are likely to stop attending and break away from the drinkers' network, while the less improved and more resistant stay in contact. Hence, staff may not see their successes. Not surprisingly, they describe their work using phrases such as: "emotionally draining"; "depressing to see the wasted skills of clients"; and "constantly faced with difficult behaviour; after a while it takes its toll". Job satisfaction is likely to be greater when staff are enabled to witness client progress.

To improve job satisfaction and staff retention, and to provide continuity of care, Handel Street extended the roles of its staff to tenancy support. It added variety to the work and enabled staff and volunteers to witness satisfyingly concrete client benefits. As a result, job applications increased. At the Booth Centre, job satisfaction is associated with being involved in activities, helping clients change, and seeing the changes. Staff support sessions are essential for discussing the positive and negative aspects of the work and improving morale.

MIXED VIEWS ON VOLUNTEERS

Wet centres vary in their use of volunteers. In addition to external volunteers, the Booth Centre's Supported Volunteering Project recruits clients to work at the centre one session a week. Staff believe that volunteers have an important role in engaging with clients for they have the time to talk to them. The Nottingham and Brighton centres also use volunteers, many of whom later obtain jobs working with homeless people. The Anchor Centre initially had volunteers but found them unreliable and the arrangement did not work.

AN IMPRESSIVE CONTRIBUTION TO THE REDUCTION OF UNMET NEED AMONG THE MOST VULNERABLE PEOPLE IN OUR SOCIETY

Three important considerations should govern the use of volunteers. First, they should not replace salaried staff but extend and improve service provision. Second, because of the nature of the clients, an unusually high level of systematic training, supervision and support is essential. This extra burden on staff needs to be carefully weighed against the benefits.

The third is about engaging clients or former clients as volunteers, potentially complicated if they are still involved in street networks. They require a great deal of training, supervision and support to establish clear boundaries around confidentiality and roles. The Booth Centre trains clients to help with activity programmes but not with drop-in sessions; they are involved in practical tasks, but not in giving confidential advice or decision-making with clients. They benefit from playing a constructive role in a safe and familiar setting while gaining confidence and skills, ideally an interim step to voluntary work or training outside the centre.[i]

DON'T LOSE CONTROL

While working supportively with people who have challenging behaviour, wet centres must also provide a safe environment. It is essential that the centre is well managed, that staff maintain control, and that clear boundaries are set. If this does not happen, the likely results are bullying, intimidation and attempts by the clients to control who comes in to the centre.

These problems occurred at Tollington Way and the Anchor Centre, creating a volatile and intimidatory atmosphere which some vulnerable clients preferred to stay away from. Since introducing stricter regimes and barring policies, arguments and violence have decreased. Moreover, barred clients have returned and their behaviour has improved. Staff believe barring gives clients a reason to control their behaviour and sends a message to other clients about what is unacceptable.

Control in the current centres is maintained by:

- restricting the number of clients admitted at any one time, particularly if the centre is small, and having staff at the entrance to admit clients;
- stipulating rules about behaviour in and around the centre;
- adopting a policy of barring, generally in response to violent or threatening behaviour which risks the safety of clients or staff, or infringements of the rules which have serious implications for the service, such as dealing illegal drugs on the premises; and
- challenging clients who are abusive or threatening (not that day but later if they are intoxicated) and working with them to control their behaviour, rather than impos-

THE RESEARCH BEHIND THE REPORT

This article was based on research which included an in-depth study of four wet day centres:

- Tollington Way, north London;
- Booth Centre, Manchester;
- Handel Street Centre, Nottingham;
- Anchor Centre, Leicester.

These were selected to represent different ways of working with street drinkers. Tollington Way allows drinking on the premises, while the Booth Centre permits drinking in the garden and provides a service to drinkers alongside an activities-based day centre. The Anchor Centre works with street drinkers together with drug misusers, while the Handel Street Centre (managed by Framework Housing Association) also provides a tenancy support service.

Download Wet Day Centres in the United Kingdom: a Research Report and Manual from www.kingsfund. org.uk or purchase hard copy from Kate Smith, Sheffield Institute for Studies on Ageing, Community Sciences Centre, Northern General Hospital, Herries Road, Sheffield S5 7AU, price £12.50, cheques payable to University of Sheffield.

ing long-term bans.

People who are intoxicated and behave in a threatening manner are barred for that day, while bans of a week or more are imposed for more serious incidents. The Anchor Centre has a 'behaviour contract' which barred clients have to sign before they are readmitted.

NURTURE LINKS WITH OTHER AGENCIES

In part one of this series we stressed the need to establish links with external specialist agencies at the planning stage. Once the centre is operating, these contacts should continue and develop, not least to explore the most appropriate and cost-effective ways of working together. For example, when the Anchor Centre first opened, a social worker came one day a week, but the workload was insufficient. Hours were reduced to a half a day, but staff can contact them any time to arrange for clients to be seen.

Regular meetings should be held with all relevant agencies, including street outreach workers, to discuss the centre's impacts on the locality, its effectiveness in targeting street drinkers and other street people, its contributions to local homelessness strategies, the services it provides, and gaps in service provision.

KEEP THE NEIGHBOURS ON SIDE

Clear procedures are essential for managing the area adjacent to the centre and minimising impact on the neighbourhood. Ways of initially gaining local support and reducing opposition were discussed in part one. Regular meetings with the community should continue once the centre has opened, providing opportunities to air views and raise concerns. After opening, Tollington Way allowed these to lapse, now seen as a mistake. Even centres open for years still hear intermittent concerns and complaints from the local community.

It is important that centre managers and staff respond when concerns are expressed. After complaints about client behaviour outside the centre, staff from Tollington Way met with the clients and agreed a code of conduct. At the Anchor Centre, council and centre staff worked with the theatre next door to overcome problems. At the Specialist Dependency Service in Camden, one of the manager's roles is to liaise with local residents and businesses. They have the centre's phone number and can ring, for example, if someone is sitting in their doorway; staff respond by coming to talk to the person. The centre's neighbourhood policy stipulates that:

- staff will ensure that there is no disruptive behaviour in the vicinity during the half-hour before opening and after closing;
- one team member will carry out health and safety checks every 30 minutes while the service is open, including the area immediately outside the entrance, and collect litter discarded by clients;
- the service will not accept people who are disorderly or aggressive and ensure that they leave the vicinity, calling police if necessary.

KNOW AND SHOW WHAT YOU ACHIEVE

Many voluntary homeless people's services devote little time and effort to setting standards and targets and monitoring performance. Doing so is hard for day centres, particularly those which attract many attenders and have a high client turnover. Consequently, they have great difficulties in demonstrating achievement and securing competitive funding.

Progress has recently been made in developing standards relevant to the homeless sector, though implementation in this sector is still in its infancy. *Quality in Alcohol and Drug Services* (QuADS), commissioned by the Department of Health, offers measurable minimum and good practice standards for the provision of drug and alcohol services and has been widely adopted by drug treatment services in England. The Leicester wet centre is participating because of its work with drug users. Commissioners of alcohol services increasingly expect alcohol agencies to meet the QuADS standards.

Funded by the Association of London Government, the Service Audit Partnership aims to improve the quality and safety of projects for homeless people through peer audits. For day centres, a sub-group is adapting the auditing methods and tools of the *National Housing Federation Framework for Housing with Support*.[ii] Their work can be downloaded at www.serviceaudit.org.

OUTCOMES AS WELL AS ACTIVITY

For wet day centres, measuring prevention and rehabilitation outcomes is unusually difficult, partly because there is no way of counting *non*-events (*not* becoming homeless, *not* causing a disturbance), and partly because clients who break free of problem substance use may also break contact with the centre. Some centres record what they do, such as the number of clients helped by staff and linked in to other services. The Anchor Centre also uses an assessment form to track individual changes in substance misuse and monitors housing outcomes. Both kinds of indicators can in fact readily be recorded and compiled ◤ *Performance indicators*, above.

IT'S NOT EASY, BUT IT IS WORTH IT

The challenges facing wet day centres are truly daunting. Relatively intensive and continuous supervision and staff support are required, yet a centre's management (or its parent organisation) must also work hard at developing and sustaining the collaboration and support of external agencies. Maintaining the effectiveness of these links is a continuing and demanding task.

But if the 'internal focus' and 'external network' are well maintained, wet day centres directly provide and establish access to a remarkable range and volume of treatment, support and services, making an impressive contribution to reducing unmet need among the most vulnerable people in our society – in very real ways, changing people's lives.

LINKS Nugget 3.5

PERFORMANCE INDICATORS

Activity indicators

- ☐ Referrals to temporary accommodation.
- ☐ Clients rehoused in permanent accommodation.
- ☐ Rough sleepers referred to outreach teams.
- ☐ Helped by substance misuse workers.
- ☐ Helped to register with a GP.
- ☐ Helped to claim (additional) social security benefits.
- ☐ Assessed by mental health services.
- ☐ Birth certificates and other identity papers obtained.
- ☐ Helped to make arrangements to pay rent arrears or utility debts.
- ☐ Participated in a tenancy support programme.
- ☐ Helped to budget weekly income.
- ☐ Participated in activities.
- ☐ Started education, training, employment or voluntary work.

Outcome indicators

- ☐ Tenancy outcomes after six and 12 months for clients who are rehoused.
- ☐ Improved eating habits, eg, more cooked meals.
- ☐ Changes in alcohol use (amount or type consumed).
- ☐ Reduction in street drinking.
- ☐ Changes in morale and motivation.
- ☐ Learned or rebuilt life-skills such as budgeting or cooking at the centre.

NOTES

i Managers can turn to national bodies for guidance and research on using volunteers. The National Centre for Volunteering, established in 1973, offers a range of services to support managers and organisations that work with volunteers, including practitioner networks, publications, and information services ◤ www.volunteering.org.uk. This body in association with the Centre for Institutional Studies at the University of East London has established an Institute for Volunteering Research ◤ www.ivr.org.uk.

ii Topics covered include the extent to which day centres have: clear aims and objectives; strategies that encourage targeted groups to attend; procedures for collecting participation data; written information for service users and referral agencies; procedures for the formal assessment of clients' needs and for planning care; procedures to manage and reduce risk; referral arrangements with other services; respectful and supportive relationships between staff and clients; staffing levels that reflect an appropriate workload to provide a safe service that meets users' needs; clear staff appraisal and supervision procedures; appropriately trained staff and volunteers; and buildings fit for their purpose with the facilities required by clients.

REFERENCES

1 Beard J. *et al*. "The Fountain House model of psychiatric rehabilitation." *Psychosocial Rehabilitation Journal*: 1982, 5(1), p. 47-53.

2 Cameron H. *et al*. *Crossing the threshold: successful learning provision for homeless people*. London: Learning and Skills Development Agency, 2003.

3 Randall G. and Drugscope. *Drug services for homeless people: a good practice handbook*. London: Office of the Deputy Prime Minister, 2002.

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There will be a prize of £300 for the most promising new research presented by poster paper. Work will be judged by an independent panel of addiction scientists. Prize is sponsored by the Society for the Study of Addiction.

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THE Motivational hallo

MANNERS MATTER • PART 3

With its empathic style, motivational interviewing seems the ideal way to engage new clients in treatment, a psychological handshake which avoids gripping too tightly yet subtly steers the patient in the intended direction. And often it is, as long as we avoid deploying a mechanical arm.

by Mike Ashton of FINDINGS

Thanks to Bill Miller, Jim McCambridge, Dwayne Simpson, Don Dansereau, Gerard Connors, and John Witton for their comments. Thanks also to Bill Miller, Janice Brown, Terri Moyers, Paul Amrhein, John Baer and Damaris Rohsenow for help with obtaining and interpreting their work. Though they have enriched it, none bear any responsibility for the final text.

THE MANNERS MATTER SERIES is about how services can encourage clients to stay and do well by the manner in which they offer treatment. Parts one and two dealt with practical issues like reminders, transport and childcare. Even at this level, more is involved: respect; treating people as individuals; conveying concern and caring.

From here on, relationship issues take centre stage. Relegated by medicine to the 'bedside manners' which lubricate the interaction while technical treatments do the curing, in psychological therapies, bedside manners *are* the treatment, or a large part of it.[1 2 3] We start with how to 'say hello', and specifically with motivational interviewing's role in preparing clients for treatment ('induction'), the role for which Bill Miller created it.[4]

MOTIVATION CAN BE MOVED

Induction strategies aim to prime the client for treatment by telling them what to expect, addressing concerns, enlisting support, and strengthening psychological resources. But most of all, the focus has been on reinforcing 'motivation', an amalgam of acknowledging a problem, wanting help, and resolving that treatment is the help you need.[5]

Once thought of as something the patient either did or did not have, motivation is now seen as a fluid state of mind susceptible to influence. Of the ways to exert this influence, motivational interviewing is by far the best known.[6] It qualifies for this review because it is more about *how* to relate to the client than *what* to say or do.[8]

We can see where it fits in through a model which encapsulates research on the processes underlying effective treatment and the points where these could be promoted by interventions ◤ *A model of treatment*, p. 24.[9] Motivational interviewing is among the "Readiness interventions" in the top left hand corner. Its importance is that the more motivated the patient is, the deeper their initial participation. This is linked to staying longer which in turn is linked to better outcomes.[10 11 12] Via this chain, if motivational interviewing does boost motivation, it should increase the effectiveness of subsequent treatment.

MM3 Positive verdict from aggregated research

Before analysing individual studies (numbered from 1 to 19[i]), we'll take what we can from analyses which have amalgamated these studies. Conclusively, these tell us there is something here worth investigating. From diabetes to problem drinking, high blood pressure and poor diet, motivational approaches help patients adhere to treatment and change their lifestyles more effectively than usual clinical advice.[13] For drinking in particular, it has a better research record than practically any other treatment.[14 15 16]

But these omnibus verdicts conflate very different scenarios. For current purposes, the ideal analysis would focus on people seeking treatment rather than identified through screening, and then on induction studies rather than studies of motivational interviewing as a treatment in its own right. It would then assess whether treatment participation was productively deepened by motivational preparation. None precisely fit the bill, but some come close.

STRONGEST RECORD IN INDUCTION STUDIES

Two analyses take us part way there.[14 17] Among drinkers known or presumed to be seeking treatment, these ranked motivational approaches eleventh and tenth in their league tables of evidence of effectiveness, outranking many treatments which take longer and cost more. Other analyses have confirmed this conclusion, and added that the benefits were significantly greater when motivational approaches were an induction to substance misuse treatment rather than a standalone therapy.[15 16 18 19]

A later analysis added two further observations.[20] First, that the gains from motivational induction are greater because they persist over at least the next 12 months while those from standalone therapies decay. Second, and contrary to expectations, therapists had *less* impact when they followed a manual. This finding's far-reaching implications are explored later ◤ *Is it dangerous to follow the manual?*, p. 28.

The final analysis focused on turning up for and sticking with treatment or aftercare.[21] Most of the studies it pooled were of substance misuse. On the basis that 12 found significant advantages for motivational interviewing, five that it was as effective as other approaches, and just four found no benefits, the authors declared themselves "cautiously optimistic". Though the weight of the evidence was positive, in three of the substance misuse studies (3, 6 & 10)

and in another not in the review,[25] motivational induction had no impact on starting or sticking with treatment. The reviewers argued that retention was already so good that there was little room for improvement, but in two studies (6 & 10) this does not seem to have been the case.

LOOSE ENDS

Of the loose ends left by these analyses, loosest of all was whether some other induction approach would do as well or better, including feedback in another style. Then there were the negative studies and, for some, no convincing explanations why motivational interviewing failed in these but not in others. Finally, we have greater confidence that one thing causes another when we can see the levers connecting the two, yet the reviewers found little evidence that motivational interviewing actually did stimulate motivation more than alternative approaches,[19] or that it improved outcomes by enhancing engagement with treatment.

To get more of a grip on these loose ends, the individual studies in these analyses and several later studies were analysed in depth *Get the full story*, p. 26. What follows focuses on the patterns which emerged. Rather than definitive conclusions, the interpretations offered here are an attempt to make sense of these patterns and to reconcile seemingly inconsistent results

Albuquerque air: the first studies of drinkers

The earliest trials of motivational interviewing were conducted by Bill Miller's team at Albuquerque in New Mexico. While therapists had the benefit of expert tuition and oversight from the approach's originator, as yet there was no manual for them to follow.

PROMISING STANDALONE INTERVENTION

First it was tried as a standalone brief intervention combined with feedback from the Drinker's Check-up, a battery of tests of alcohol use and related physical and social problems. Though concerned enough to respond to ads for the check-up, participants were not the highly dependent 'alcoholics' normally seen at treatment services.

1 Comparing immediate against delayed motivational feedback suggested that this approach could motivate reduced drinking and treatment entry among this type of client.[27] The non-stigmatising offer of a check-up seemed to enable many to take a first (if often incomplete) step towards cutting down or seeking help, without violating their self-image as non-alcoholics.

2 The next study was similar, except that feedback was provided in one of two styles.[28] One was the empathic motivational style, the other the supposedly counter-productive style it aimed to improve on: explicitly directive, confrontational, and (when the cap fitted) dubbing patients 'alcoholics'. As expected, the empathic style did result in greater reductions in drinking, but the differences were small and fell short of statistical significance.

The reason may have been that in practice the therapists did not implement radically distinct approaches. Only when the focus was shifted to how they and their clients *actually* behaved did clear and significant relationships emerge. The more the therapist had confronted (arguing, showing disbelief, being negative about the client), the more the client drank a year later. The same was true of 'resistant' client behaviours like interrupting, arguing, or being negative about their need to or prospects for change.

These client and therapist behaviours were closely related. For motivational interviewing, the favoured interpretation is that when therapists departed from its non-confrontational style, clients were provoked in to hitting back or withdrawing. The pattern of results suggests this was at least part of what was happening. An alternative explanation is that resistant clients provoked *the therapists* into non-motivational responses related to poorer outcomes with this kind of client.[29] It certainly can happen,[30] but other studies with similar findings have been able to eliminate this possibility.[29 31 32 33]

Conceivably, both processes were in play. Whatever the truth, the study heightened the profile of the therapist's interpersonal style, seeming to confirm that the style mandated by motivational interviewing was preferable to confrontation. The stage was set for trials of the approach in its intended role – as a prelude to further treatment.

STARTLING IMPACT IN INDUCTION STUDIES

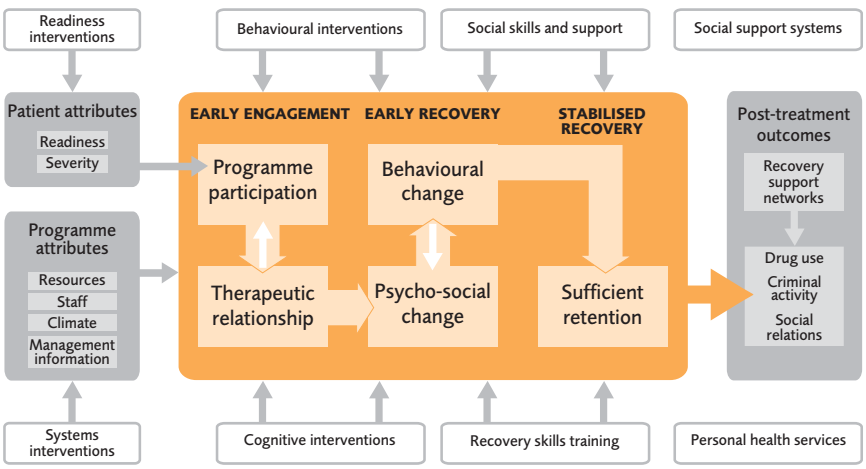
In 1993 results were published from the first trials of motivational interviewing as a prelude to respectively in- and out-patient treatment. In contrast to the check-up studies, patients had arrived for treatment via normal referral routes and were much heavier drinkers and more severely dependent.

In both trials, a non-directive, one-on-one motivational session preceded considerably more directive 12-step based group therapy.[21] There was a real chance one would undermine the other, but the opposite happened. Given that it was a brief prelude to more extended treatment, motivational feedback caused startlingly large reductions in post-treatment drinking.

3 The outpatient trial compared it with a typical 'You are an alcoholic and must return for treatment' induction.[22] During the succeeding months, the interview led to virtual 100% remission, perhaps partly because it avoided solidifying patients' identities as 'hopeless alcoholics'. Without it, a substantial minority of patients continued to drink at alcoholic levels, fulfilling the identity they had been given during induction and later treatment.

4 The inpatient trial was run on similar lines, except that the comparison group simply progressed through normal procedures.[26] From before treatment consuming about 20 UK units[ii] a day, the motivational patients cut down to on average four units; controls were still drinking 13 units a day. A new finding was that these benefits seemed to be due to motivational induction deepening engagement with the programme, an effect revealed by staff ratings of compliance with therapy. Here were some of the expected levers in action: motivational preparation leads to deepened engagement leads to less post-treatment drinking.

A MODEL OF TREATMENT



What goes on inside treatment (orange box) and how it might be influenced by interventions (white boxes).[9]

MM3 Leaving home: attempts to replicate early findings with drinkers

Attempts elsewhere to replicate the early induction findings had mixed results, perhaps partly for technical reasons (eg, which results were measured) and partly because the therapy, by now often hardened into manual form, failed to adapt to the patients.

MORE IMPACT THAN ROLE INDUCTION

5 One uniquely important study not only tested whether motivational interviewing led to less drinking than normal procedures, but whether it led to less than 'role induction' – the most popular alternative induction method – and if it did, whether this was because it truly did deepen engagement with treatment.[34] On all counts, the answers seemed 'Yes', though effects were neither large nor could they be securely attributed to motivational induction.

Compared to other induction samples, the 126 alcohol abusers (no diagnosis of dependence was required) who joined the study at an outpatient unit in Buffalo drank less heavily and more had retained employment and intimate relationships. Those randomly assigned to the motivational interview went on to attend 12 out of 24 therapy sessions compared to eight for the controls. This partly accounted for the fact that during treatment and the 12-month follow-up, motivational patients drank heavily on fewer days and used other drugs less often – again, the elusive 'levers' in action. Retention itself may have been aided by the fact motivational induction helped patients quickly curb their drinking.

Important ingredients may have been an emphasis on motivational principles rather than a pre-set agenda, skilled and perhaps motivated exponents, and a caseload which embraced those with relatively moderate problems who could have needed some priming to commit to treatment. Together with earlier work, the study provides strong (but not incontrovertible) evidence that in these circumstances, assessment plus motivational feedback can aid treatment.

SET AGENDA MANDATES WRONG FOCUS?

6 In contrast, a British study failed to confirm the promise of the early US work, possibly because for these patients its version of motivational interviewing mandated an inappropriate focus.[23]

Subjects were 60 dependent drinkers randomly allocated to one of two extra interventions when starting a day programme in Bournemouth. One was a pre-structured motivational intervention focused on eliciting from the patient the pros and cons of drinking and amplifying the salience of the cons. It was compared to education on the effects of drinking, using feedback of the client's answers to a "quiz".

Motivational induction had no impact on retention. This could have been because the patients already recognised their alcohol problems and said they were working hard to resolve them – and understandably so. Nearly all had lost whatever jobs they'd had, most had lost husbands or wives through divorce, each averaged over a decade of dependent drinking, and they had gone so far as to commit to and begin an intensive six-week programme.

For those who left early, the problem was unlikely to have been a failure to recognise the debit side of drinking. Given the stage they had reached, leading them to reflect on the *positives* of their drinking may also have seemed a disconcerting backward step.

DIFFERENT DRINKERS, DIFFERENT FORMAT

Remaining studies either involved special types of clients or departed from a mainstream motivational intervention.

DUAL DIAGNOSIS PATIENTS

8 One involved substance (mainly alcohol) abusing psychiatric patients with quite severe life problems starting a 12-week US day hospital programme.[35] Compared to a standard psychiatric induction, an initial motivational interview extended average retention from 22 to 31 days. Despite retaining people who would otherwise have left, it also improved their punctuality and halved the number of days of substance use while in treatment.

The interview incorporated feedback from prior assessments and a decisional balance exercise, but seemingly followed no set programme or manual.

HOW BRIEF CAN YOU CAN GET?

Among the loose ends left by the early US work was whether some other non-confrontational feedback approach might work as well. One possibility is simply providing new patients written materials – not as unlikely as it may seem.[36 37]

9 For induction purposes, the most relevant study was conducted at a

ROOTED IN RESISTANCE: THE ORIGINS OF MOTIVATIONAL INTERVIEWING

It doesn't have to be this way – push, push back, get nowhere

RESISTANCE TO TREATMENT is the central reality addressed by motivational induction.[56] In his first account of motivational interviewing,[57] Bill Miller noted that many clients resist because they reject stigmatisation through a process which entails being pigeon-holed as an 'addict' or 'alcoholic' no longer in control their lives.[58] Others may accept this yet be unconvinced that treatment will help.[59 60] Coerced patients may not think they have a problem at all and resent being forced to get 'it' treated. Others doubt the relevance of drug-focused treatment to what they see as their most urgent priorities.[61 62]

They encountered treatment services which demanded immediate abstinence, treated their patients as the embodiment of an addiction, and rarely offered effective help with the family, housing, employment, financial or other issues heading their list of concerns.[63 64] This mismatch can still be seen in British drug services.[65]

US researchers and clinicians observed the results: most dependent substance users avoided treatment or quickly left.[57] One interpretation of the genesis of motivational interviewing is that rather than realigning treatment, a way was found to get the patient to realign themselves via a roundabout route which gave them less to react against.[66] But the spirit of the approach demands that treatment too must adjust to the patient.

Swimming against the strong US disease-model tide, Dr Miller argued that the 'addict' should be treated (in both senses of the word) as someone who behaves just as 'we' might in a similar situation – someone whose self-perceptions and desires are to be respected as the valid expressions of a "responsible adult" capable of making their own decisions.[57 67] From this perspective, resistance is neither the manifestation of a character flaw nor a symptom of disease, but a product of interactions with therapists who impose their views of who/what the patient is and what they need, telling the client what they 'must' do, implying they are powerless, arguing, and confronting.

Dr Miller developed an approach which sidestepped these and other deterrent interactions.The result was motivational interviewing. One way to think of it is as a crystallisation of interpersonal styles which create a trusting, open and egalitarian relationship, and then use this as a communication medium across which influence can flow without disrupting the connection.[21 42] The 'crystallisation' consists of principles common to many therapies like 'expressing empathy', and specific tools like 'reflective listening'. Its main engine for change is the amplification of conflicts between the client's goals and values and their substance use.[67 68]

Directive in intention if not in words

Even if the client envisaged by motivational interviewing is at least to some degree ambivalent about their goals, the therapist typically knows where they want to get to and systematically seeks to get there.[67] In this sense, like more up-front tactics, motivational interviewing *is* 'directive'; the difference is that it seeks to generate momentum by *not* being explicitly directive with the client.[15]

Ethical issues raised by this more covert approach have been addressed by Bill Miller,[69] who accepted that it could be used to pursue goals which were not those of the client,[57] departing from its client-centred ethos.[67] He argued for the client's goals to be respected – but from a position where the therapist had their own ideas of what their problem was and what would constitute "unwise" and what "healthful" paths forward. The aim was get the patient *themselves* to come to a matching conclusion.

SECOND SIGHT

A message from Albuquerque

by Bill Miller
Motivatonal interviewing's founder, University of New Mexico

I got interested in this field on an internship in Milwaukee. The psychologist-director, Bob Hall, enticed me to work on the alcoholism unit, even though (and because) I had learned nothing about alcoholism. Knowing nothing, I did what came naturally to me – Carl Rogers – and in essence asked patients to teach me about alcoholism and tell me about themselves: how they got to where they were, what they planned to do, etc. I mostly listened with accurate empathy.

There was an immediate chemistry – I loved talking to them, and they seemed to enjoy talking to me. Then I began reading about the alleged nature of alcoholics as lying, conniving, defensive, denying, slippery, and incapable of seeing reality. "Gee, these aren't the same patients I've been talking to," I thought. The experience of listening empathically to alcoholics stayed with me, and became the basis for motivational interviewing.

Crash – and I wrote the manual!

To me our drug abuse study was a clear example of manuals failing to adapt to the patients ◤ study 13. I am now working on a paper which collapses the two 'poor outcome' groups (strugglers and discrepants) and the two 'good outcome' groups (changers and maintainers).[44] Their speech patterns are strikingly different.

Relative to good outcome patients, those who will have poor outcomes showed two substantial deviations. They backpedalled around the third decile [tenth of the session]. Commitment strength stopped climbing, and instead flattened out or fell. Then around the sixth decile it started picking up again, and actually reached the same point at decile 9 as the good outcome group. In decile 10, however, it fell abruptly back to zero.

"What were you doing to these people?" Paul Amrhein [language analyst] asked. The answer is that in deciles 1 and 2 we

I BEGAN READING ABOUT ALCOHOLICS AS LYING AND DEFENSIVE. "GEE, THESE AREN'T THE SAME PATIENTS I'VE BEEN TALKING TO."

were doing pure motivational interviewing. Around decile 3, we started assessment feedback. About 70% of patients went with it and showed the expected effect of increasing commitment to change, but the poor outcome group did not. They seemed to balk at or resist the feedback. I gave the therapists no choice in the manual but to continue with the feedback. Then around decile 6, the therapists went back to pure motivational interviewing.

Then the manual says to develop a change plan by the end of the interview. Again, the manual (which I wrote!) left no flexibility. The essential message was, develop a change plan whether or not the patient is ready. Crash. Any decent practitioner would know not to persist when patients start balking.

Best for the ambivalent?

Your collection of studies suggesting an adverse effect with motivational interviewing for 'more-ready' clients is an important observation. The same direction is there in the anger match in Project MATCH. Low-anger clients showed somewhat worse outcomes with motivational therapy relative to the other two treatments. I can understand motivational interviewing having no effect with clients who are already ready for change, but the seeming adverse effect, now observed in several studies, seems surprising.

The clinical sense I can make of it is that when clients are ready to go, it is not time to be reflecting on whether they want to do so. Motivational interviewing was originally envisaged for working with people who are ambivalent or unclear about change, and perhaps that is the group for whom it will be most helpful.

Carl Rogers ◤ What happened when he let a troubled mother tell her own story convinced him that the therapist's task is to rely on the client for direction – the person-centred approach which inspired motivational interviewing.

GET THE FULL STORY

This analysis is distilled from an extended review available free on request from editor@drugandalcoholfindings.org.uk. Note that the aim is to investigate motivational interviewing as a preparation for patients seeking treatment without being legally coerced to do so, rather than as a treatment in its own right or a way of encouraging take-up of aftercare.

Toronto addiction treatment centre.[38] On alternate months each new alcohol patient was handed the *Alcohol and You* booklet at the end of their intake assessment. Written by Bill Miller,[4] this combined motivational elements and individualised assessment feedback comparing the drinker to national norms. It invited readers to reconsider their drinking but did *not* advocate return for treatment, an attempt to avoid its rejection by people who had decided not to come back.

Despite this, patients given the booklet were slightly *more* likely to return, but the biggest effect was to substantially reduce drinking over the next six months, especially among the minority who did not come back. These findings underline the twin arguments for motivational induction: not only may it promote engagement with treatment, but it also constitutes a potentially effective brief intervention for those who drop out.

MM3 Beyond drinkers: pluses and minuses

For users of drugs including heroin, cocaine and cannabis, motivational interviewing has now been tried during the waiting period for treatment and the initial stages. Results have been mixed, perhaps because the patients themselves were mixed in the degree to which they needed a motivational boost or were at the stage where they could benefit from one.

BRIEF RESPITE VERSUS INTENSIVE MARATHON

Two studies have trialed motivational interviewing to tide people over while waiting for treatment to start. Though really *pre*-induction, the results are relevant. In one there was no impact, in the other, long-lasting benefits. The difference may have been down to the degree to which motivation was the issue.

10 In Washington, the unsuccessful trial inserted measures including a manual-guided motivational interview between the time drug (mainly cocaine) abusing patients had been referred for treatment and their first appointment.[24] A relatively full-featured attempt to bridge this gap, it made no difference to how many patients started or completed treatment (a commendable 71% in both cases) or how well they did.

The 654 who joined the study typically suffered severe and multiple problems (including poor housing), and were overwhelmingly committed to the treatment on offer. For 85%, this was a short stay in hospital – conceivably an attractive respite from the streets, especially since most did not face opiate withdrawal. Those who nevertheless failed to turn up were probably less in need of a motivational boost than of intensive support.

11 A Spanish trial provides an instructive contrast. The marathon *Proyecto Hombre* rehabilitation programme attracted mainly heroin users living with their parents or in their own family home.[39 40] It started with roughly a year-long day programme during which the families came with the clients. Before this phase was half way through, four out of five had dropped out.

Seeking ways to stem the outflow, detoxified patients awaiting entry were randomly allocated to normal procedures or to a three-session motivational intervention, structured according to a broad outline rather than a detailed manual. Three months into treatment, the motivational group showed improved retention. The gap grew until by six months half were left compared to

just 1 in 5 after normal procedures.

These Spanish addicts had the home support lacking in Washington, potentially leaving their commitment to the programme as the main influence on whether they stayed. No respite from the streets, this was an extraordinarily extensive and intensive programme which would dominate their lives for nearly two years. Wavering commitment would have provided fertile ground for motivational interviewing.

MIXED RECORD AS INDUCTION METHOD

The few direct tests of motivational induction for heroin or cocaine users confirm that it is most beneficial for those ambivalent about treatment and go further, showing that it can actually be counter-productive for more committed patients.

12 The first such study took place at an Australian methadone clinic.[41 42] There researchers had structured the motivational style into a one-hour 'bolt-on' module (plus a brief review session a week later) consisting of a seven-point agenda.

As adapted for heroin users, a brief examination of what they see as the good side of heroin use is intended to establish this as a chosen rather than an out-of-control behaviour. Then the focus is on eliciting and amplifying the client's account of the debit side of heroin use, featuring a balance sheet of the pros and cons completed at home for review at the follow-up session.

Compared with educational sessions on opiate use, on average motivational induction extended retention from about 18 to 22 weeks and delayed relapse to heroin use, consistent with an impact on outcomes via retention. However, improved retention may itself (as in study 5) have been due to the interviews helping patients rapidly curtail substance use.[iii]

How can we account for these findings, when adaptations of the same model for drinkers and cocaine users failed to improve on normal procedures ◤ studies 6 & 10? First, in contrast to these studies, many of the Australian patients were ambivalent about ending substance use. After all, patients starting *methadone* treatment clearly are not yet ready to see use of opiate-type drugs as an unambiguously bad thing.

Another key may have been the holding power of the intervention over the week between the sessions. Patients appreciated the chance to explore their experiences with a "highly skilled" therapist who rapidly established rapport. To return for 'closure' of this valued intervention, they had to stay on methadone for at least the first week after being stabilised, a vulnerable period. More did so than after the alternative induction, accounting for better long-term retention.

Underneath it all may have been the 'developer effect': the intervention was being trialed its creators, presumably enthusiastic exponents. Perhaps also, as its 'owners', the Australian team had the licence to adapt it. Where they stressed skilful flexibility, the other two papers suggest a more prescriptive implementation. The initial focus on the positives of substance use may need particular care unless, as with methadone patients, it simply acknowledges an undeniable and current reality for the client.

"PUZZLING" FAILURE WITH DRUG USERS

13 A 'developer effect' was notably lacking when Bill Miller's team extended their work to drug users. The study took place in Albuquerque at his university's outpatient centre and at an inpatient detoxification unit.[43] For most of the 208 patients, cocaine (especially crack) was their primary problem, and for nearly one in three, heroin.

Half were randomly allocated to continue as normal and half to a motivational interview conducted by therapists trained and supervised to follow a manual. On practically every measure taken and no matter how the sample was divided up, the interview made no difference to motivation for change, retention, or drug and alcohol use outcomes over the next 12 months.

Among the possible explanations are that, according to paper-and-pen tests, nearly all the patients were in no need of a motivational boost, but an analysis of what they actually said in counselling sessions seems to belie this interpretation.[44] Several other explanations are feasible. For one, the same analysis provided empirical confirmation: the study's inflexible, manualised approach to motivational induction had left insufficient room for therapists to adjust and provoked counterproductive reactions when its instructions clashed with the client's state of mind ◤ *Care too with the unconvinced*, p. 38.

DEPENDS ON INITIAL COMMITMENT

The next two studies found that motivational induction had no *overall* impact on retention, but also that this masked positive impacts among patients who saw themselves as still thinking about curbing drug use rather than having started the process. Less expected was a *negative* effect among the latter. These findings are explored later ◤ *More committed react badly*, p. 28.

AMONG INDIGENT POOR

14 In Houston, 105 cocaine users started a ten-day outpatient 'detoxification'.[45] Most were black and unemployed and smoking crack. Patients who achieved abstinence could transfer to relapse prevention aftercare. The issue was whether starting detoxification with a motivational interview would improve transfer rates.

Patients were randomly allocated to normal procedures or additionally to a two-session motivational interview on days one and four, conducted by therapists trained and supervised to follow a detailed manual. There was no overall effect on transfer rates, but the interviews did help less motivated patients complete detoxification and transfer to aftercare. By doing so, they might have been expected to lead to a higher relapse rate during aftercare. The opposite occurred. More motivational patients started aftercare cocaine-free and over the next 12 weeks they continued in the same vein.

Drug use reductions seen in this study and the extra impact on less motivated patients were both absent in Albuquerque ◤ study 13. A possible reason is the way the patients entered treatment, in Albuquerque via normal routes, in Houston, via ads for the study. Judging from their motivational profiles, many in Houston would not have sought treatment unless prompted by the ads; motivational interviewing had something to bite on.

Like a whisper in the ear, a motivational interview can have a dramatic impact, but just what that is depends on the relationship, the situation, what's said, and how it fits into what went before and what is yet to come.

AND EMPLOYED PRIVATE PATIENTS

15 A similar study which used a similar measure of motivation also found that this determined how patients would react.[46] The programme was a day-hospital regime in Rhode Island with an abstinence and 12-step orientation. Over 7 in 10 of the cocaine-dependent patients who joined the study smoked crack, but at this private facility they were not the poor minority caseload seen in Houston ◤ study 14.

Half were randomly allocated to a motivational interview planned for day two and half to meditation and relaxation. Therapists were trained and supervised and motivational sessions recorded to ensure they competently followed a manual. Though the emphasis could vary,[47] this prescribed an exploration of the pros and cons of cocaine use, how use or non-use fitted with the patient's goals, feedback of a prior assessment of their drug use and its consequences, and the formulation of a change plan.

At issue was whether this would improve on the inactive and it was thought ineffective relaxation approach. The answer was a surprising 'No'. Patients as a whole did well, but on none of the measures of retention or outcomes up to 12 months did the motivational interview further improve things. As in Houston, this was not because the interview itself was inactive, but because it had opposing impacts on different patients.

MM3 Is it dangerous to follow the manual?

Manual-guided programmes have become seen as essential for any treatment which claims to be evidence-based.[48] The research rationale is to standardise 'inputs' so these can be related to outcomes, the clinical justification, that they enable clinicians to "replicate" proven treatments.[49]

An alternative view is that such detailed programming cramps client participation and clinical judgement[3] and focuses attention on techniques rather than ways of relating which cut across therapies.[2] If these are what matters, then the baby could be exiting with the bath water. Such prescriptiveness seems particularly risky for motivational interviewing, whose essence is to respond to clues from across the table, and whose mantra is that the "responsibility and capability for change lie within the client".[50]

Support for this view comes from a recent meta-analysis.[20] The studies it analysed differed in how they implemented motivational approaches. Of all the variations 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 therapist followed a manual: manualised therapy had *less* impact.

MORE COMMITTED REACT BADLY

This result could have been due to differences between the studies other than whether they used a manual. But signs of the same effect can be seen *within* studies. In three, motivational induction helped 'low motivation' patients but retarded those more committed to action ◤ *charts*. Each time, therapists were supervised to ensure they adhered to a detailed manual which prescribed 'decisional balance' exercises, leading the patient to review the pros and cons of changing substance use or engaging in treatment or aftercare.

Two of the studies have already featured in this article. Both involved mainly cocaine users attending a short-term day detoxification programme, and divided patients into those typified more by 'taking action' to tackle their substance use as opposed to 'still thinking' about it.

In Houston (14), motivational induction improved completion rates among 'still thinking' patients, counterbalanced by the *opposite* effect in those who saw themselves as having already started this process – they did worse after the interviews. These effects were substantial and statistically significant.

In Rhode Island (15), consistently the interviews worsened cocaine use outcomes among 'taking action' patients while (to a lesser and non-significant extent) improving outcomes among those 'still thinking'. Seemingly no fluke, there was a similar pattern with drinking.

ALSO IN AFTERCARE STUDY

19 The third study concerned alcohol patients admitted for on average five days of inpatient detoxification in Rhode Island.[51] It has not featured so far because the aim was to motivate take-up of aftercare.

After settling in for at least a day, randomly selected patient intakes were allocated to one of two types of induction. The first was five minutes of advice which comprehensively contravened motivational interviewing's code. Patients were told they had a significant drink problem, that abstinence was very important, and to get as involved as possible in AA aftercare groups.

The second type of session was a one-hour motivational interview. It also advised abstinence and AA, but not in the unambiguous manner of the more abrupt intervention. Instead, patients were led through exercises weighing the pros and cons of abstinence and AA and exploring how drinking conflicted with longer-term goals. Finally, they were asked to choose their own goals for attending AA groups or were informed of alternative sources of support.

> "THE PARADOX OF MANUALIZATION IS THAT THE PATIENT'S ACTIVE INVOLVEMENT IS LIKELY TO BE ESSENTIAL TO GOOD OUTCOME BUT DESTRUCTIVE OF EXPERIMENTAL CONTROL"[3]

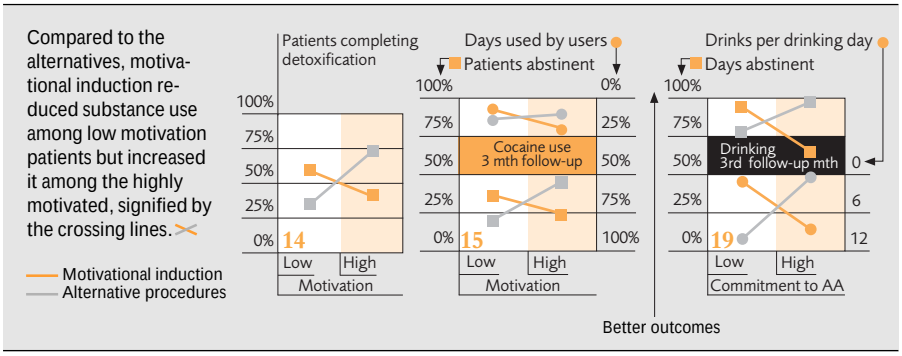
Among patients whose current plans and past records of attending AA/NA indicated less commitment to AA, the interviews had the expected effects. They abstained more often, and when they drank, drank less than patients given brief advice. But this was counterbalanced by an even greater *negative* effect on more committed patients.

Over a six-month follow-up, as long as patients *most* committed to AA had been directed to abstain and attend the groups, and those *least* committed had been through the motivational exercises, on average each sustained near 100% abstinence and drank little when they did. When this matching was reversed, outcomes were far worse.

TWO STEPS BACK?

In all three studies, the puzzle is not why the least committed benefited (this is expected), but why the most committed reacted badly. It seems that motivational interviewing of this kind is as capable of knocking back more motivated patients as it is of helping those in need of convincing.

The explanation might be what to the patient could have seemed an undermining backward step to re-examine the pros and cons of whether they really did want to stop using drugs or commit to treatment and aftercare, when they had already decided to do so and started the process. Other unsuccessful induction trials might also be explained by the relatively high commitment of the clients allied with an insufficiently flexible approach ◤ studies 6, 10 & 13.



CARE TOO WITH THE UNCONVINCED

One of these trials (13) uncovered another hazard of prescriptive therapy – failing to back off in the face of continuing ambivalence. Though the hazard is different, the study provides insights into how both sorts of mistakes can occur.

Despite considerable experience supplemented by 16 hours' training and feedback on their videoed performances from Bill Miller, who personally certified their competence, the study's motivational therapists failed to improve retention or outcomes.

In this study, so tightly was the interview programmed through a detailed manual, and so diligent, well trained and closely supervised were the therapists, that they introduced the same topics at roughly the same point with all their clients. It enabled what clients and therapists said to be matched to the topics addressed in each succeeding tenth of each session.[44 52]

Analysis of the videotapes suggested that it was not (as previously believed[20 53]) the frequency of 'change talk' which related to outcomes, but the strength of the client's determination to change versus to stay as they are. The difference between 'I hope to' and 'I *will*' (or similar) was more important than how many times either was said.

WRONG MOVES AND PREMATURE CALLS

During the first five to ten minutes of each session clients were asked what had led them to seek treatment. Here the strength of their commitment to reduce drug use

simply reflected how far they had already done so. From then on, commitment strength started to respond to what the therapist was doing, and instead of reflecting where the client had come from, became a potent predictor of where they would end up in a year's time.

The first clue came around the middle of each session when clients had received feedback from an assessment of their drug use and related problems. As intended, about 70% expressed sustained or increased commitment to tackle these problems. Over the following year, they largely remained abstinent from their primary drug.

But faced with this almost unremittingly negative feedback, a minority retrenched towards a commitment to continued drug use, especially the ones who from the start had been less convinced that their drug use really had been all bad. Over the next year, they struggled to control their drug use.

The same patients tended to be among[iv] the ones who at the end of the interview backpedalled in their commitment to change. At this stage therapists tried to get their clients to tie up all the ends – no matter how loose – into a plan for tackling drug use, one concrete enough to have explicit criteria of success, and sufficiently well grounded to withstand the anticipated pressures of life beyond treatment.

Despite being tested in these ways, most sustained the strength of their commitment and went on to express this in reduced drug use. But a minority sharply backed down; 'I wills' or equivalent rapidly became 'I'm not sure'. The strength of this final, concrete, public and verifiable commitment was the single most reliable harbinger of whether clients would later control their drug use.[v]

Another significant juncture came about two-thirds through each session when therapists asked if the client was yet ready to change. Again, those who backtracked tended to do badly over the following year.

It seemed that some clients reacted badly to these attempts to push them forward. Instead of firming up their expressed commitment to curtailing drug use, they reversed, a setback followed by the predictable outcomes in terms of actual drug use. As far as could be determined, this was not just a case of people who had a poor prognosis anyhow reacting poorly to counselling.

The analysts cautioned that "a prescribed and less flexible approach to MI (as can occur with manual-guided interventions) could paradoxically yield worse outcomes among initially less motivated clients." Leading the client to review the good side of their drug use is, they thought, particularly risky; by fostering an 'It wasn't all bad' perception it might pave the way for resistant reactions to assessment feedback.

What caused these reversals was, for motivational interviewing, an atypical degree of directiveness by the therapist. If this can be seen in motivational therapy, it should also be apparent elsewhere.

This is territory to be covered later in the *Manners Matter* series. Here it's relevant to note the key finding: patients who like to feel in control of their lives, who react against being directed, and resist therapy, do best when therapists are less directive (as in true-to-type motivational interviewing), while those willing to accept direction do better when this is what they get.[29 31 32 33]

ACCEPTANCE ELICITS HONESTY

Among these salutary lessons was a silver lining: the strength of the client's commitment to change at key junctures was so closely related to later drug use, that from this alone one could predict with remarkable precision (in 85% of cases) who would do well and who would struggle.

As required by motivational interviewing, the therapists had created a non-judgemental social space within which what the client said was a valid reflection of their state of mind and determination to change, rather than acting as a way to placate, save face, or terminate the encounter. The problem was that therapists were so constrained that they could not respond to these clues.

Interchange; time to reflect

Still to come are the implications of these findings for training, research with legally coerced populations, and studies of linkage to aftercare. But in true motivational interviewing style, now is a good time to summarise and reflect.

First, clearly there is something here which works most of the time and more consistently and at less cost than the usual alternatives. What that 'something' is remains to be clearly defined. In every induction study in which motivational interviewing has apparently had a positive overall impact, this can be explained by 'non-specific' factors common to other therapies rather than the specific approach.

Most common, and potentially most powerful, is the enthusiasm and faith of the therapists, often newly trained and/or associated with the approach's developers ◤ studies 3, 4, 5, 8 & 12. Then there is extra assessment and/or feedback of assessment results (studies 3, 4, 5 & 8) and in some cases perhaps, simply spending time with a sympathetic listener ◤ studies 3, 4, 8 & 11. Finally, in two studies patients may have perceived the interviews as an earlier start to treatment ◤ studies 5 & 11.

Ironically, studies in which some patients did *worse* after a motivational interview show there is more to the approach than these non-specific influences; if these were all there was to it, we would expect every patient to benefit.

SKILL AND SENSITIVITY NOT TRICKERY

Rather than some psychological trickery,[20] motivational interviewing's strength may be that it provides a platform for these generic, relationship-building behaviours: empathy, respect, optimism, enthusiasm, confidence. At a minimum, it seeks to avoid behaviours which erode these qualities; at best, discovering motivational interviewing helps to generate them. One of the approach's virtues is that it instills optimism and demands sustained respect even in the face what would otherwise be demoralising clients.[70]

Though trickery is not required, social skills and judgement are, because a 'one size fits all' programme risks negative interactions. The truer therapists stay to motivational interviewing's 'It's up to you' stance, the less they will provoke clients unwilling to accept direction. The problem with maintaining this stance regardless, is that it may also short-change clients ready and willing to follow the therapist's lead or who feel unable to self-initiate change.

Other hazards await therapists who forego sensitivity in favour of programmes which mandate a review of the good things about drug use, even if clients have moved beyond needing this as a way of establishing empathy, which land damningly negative assessments of drug use on people who may not be ready to see it that way, or seek commitment regardless of whether the ground has been firmed up sufficiently to support it. Done in this way, motivational interviewing is not always the safe, 'at least it can't hurt' option it once seemed.[6]

Managers also need to exercise judgement. Since these are what is researched, manualised programmes gather an evidence base around them and become seen as a therapeutic gold standard, while principle-based approaches reliant on the right spirit and social and clinical skills remain unsupported. Staff and commissioners under pressure[54] to base practice on evidence may then transfer over-prescriptive research programmes in to practice, valuing adherence to protocol above interpersonal skills.[3]

BACK TO BASICS

No matter how well it is done, there is no universal answer to whether motivational interviewing is an effective induction approach and preferable to the alternatives.

In the first instance, it depends on the nature of the blockages to turning up and staying in treatment. Where these are primarily being unconvinced that you have a problem that needs treating or that treatment can help, motivational approaches

should have a role. Where they are to do with access-blocking administrative procedures, changing these is the first line of attack. Where they are to with the client's over-stretched life and inadequate resources, no feasible amount of motivational enhancement will provide all the answers.

When motivational interviewing does fit the bill, the research argues for a return to the modus operandi of the successful early studies, when absorbing principles took precedence over a set agenda, and to the client originally envisaged – not one already convinced they must change or determined on a way to get there, but unsure whether they want to. These are the conditions in which motivational interviewing has been most successful at improving retention and substance use outcomes. The effect is often to even out response to treatment by preventing initial low commitment becoming expressed in extremely poor outcomes ◤ studies 3, 4, 9, 14 & 15.

But even in the most conducive of circumstances, the approach requires sensitivity and social skills.[55] That perhaps understates it. True-to-type motivational interviewing *is* the application of sensitivity and social skills. The bad news is that this is not a packageable 'programme' to be lifted off the shelf – or is that the good news?

NOTES

i To preserve compatibility with the extended review some studies have been omitted without renumbering the rest.

ii Each unit is about 8gm or 10ml of pure alcohol.

iii Compared to control patients, over the first week motivational patients significantly hardened their intention to abstain from heroin or cut down.

iv The relationship was significant but not one-to-one: patients who had not reacted badly to feedback may still have backpedalled.

v Whether this would also be the case in normal practice may depend on the context. In this study, the motivational therapists were independent from the treatment programme – they had no power over the client. Second, from the client's point of view, it may well have seemed that their commitments were indeed subject to verification through research follow-ups and perhaps also through continuing contacts with the main treatment service.

REFERENCES

1 Hubble M.A. *et al. The heart and soul of change: what works in therapy*. American Psychological Association, 1999.

2 Wampold B.E. *The great psychotherapy debate: models, methods, and findings*. Lawrence Erlbaum Associates, 2001.

3 Westen D. *et al*. "Empirical status of empirically supported psychotherapies: assumptions, findings, and reporting in controlled clinical trials." *Psych. Bull.*: 2004, 130, p. 631–663.

4 Personal communication from William Miller, May 2005.

5 Knight K. *et al*. *TCU psychosocial functioning and motivation scales: manual on psychometric properties*. 1994.

6 Heather N. "Motivational interviewing: is it all our clients need?" *Addiction Research and Theory*: 2005, 13(1), p. 1–18.

7 Squires. D.D. *et al*. *Motivational interviewing. A guideline developed for the Behavioral Health Recovery Management project. Undated*.

8 Rollnick S. "Enthusiasm, quick fixes and premature controlled trials." *Addiction*: 2001, 96(12), p. 1769–1770.

9 Simpson D.D. "A conceptual framework for drug treatment process and outcomes." *J. Substance Abuse Treatment*: 2004, 27(2), p. 99–121.

10 Simpson D.D. *et al*. "A longitudinal evaluation of treatment engagement and recovery stages." *J. Substance Abuse Treatment*: 2004, 27(2), p. 89–97.

11 Gossop M. *et al*. "Treatment process components and heroin use outcome among methadone patients." *Drug and Alcohol Dependence*: 2003, 71(1), p. 93–102.

12 Joe G.W. *et al*. "Retention and patient engagement models for different treatment modalities in DATOS." *Drug and Alcohol Dependence*: 1999, 57, p. 113—125.

13 Rubak S. *et al*. "Motivational interviewing: a systematic review and meta-analysis." *British Journal of General Practice*: 2005, 55, p. 305–312.

14 Miller W.R. *et al*. "Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders." *Addiction*: 2002, 97, p. 265–277.

15 Burke B.L. *et al*. "The efficacy of motivational interviewing: a meta-analysis of controlled clinical trials." *J. Consulting and Clinical Psychology*: 2003, 71(5), p. 843–861.

16 Burke B.L. *et al*. "The emerging evidence base for motivational interviewing: a meta-analytic and qualitative inquiry." *J. Cognitive Psychotherapy*: 2004, 18(4).

17 Finney J.W. *et al*. "The cost effectiveness of treatment for alcoholism: a second approximation." *J. Studies in Alcohol*: 1996, 57, p. 229–243.

18 Burke B.L. *et al*. "The efficacy of motivational interviewing and its adaptation." In: Miller W.R. *et al, eds. Motivational interviewing: preparing people for change*. Guilford Press, 2002, p. 217-250.

19 Dunn C. *et al*. "The use of brief interventions adapted from motivational interviewing across behavioral domains: a systematic review." *Addiction*: 2001, 96(12), p. 1725–1742.

20 Hettema J. *et al*. "Motivational interviewing." *Annual Review of Clinical Psychology*: 2005, 1, p. 91–111.

21 Zweben A. *et al*. "Motivational interviewing and treatment adherence." In: Miller W.R. *et al, eds. Motivational interviewing: preparing people for change*. Guilford Press, 2002, p. 299-319.

22 Bien T. *et al*. "Motivational interviewing with alcohol outpatients." *Behav. & Cognitive Psychotherapy*: 1993, 21, p. 347–356.

23 Dench S. *et al*. "The impact of brief motivational intervention at the start of an outpatient day programme for alcohol dependence." *Behavioural and Cognitive Psychotherapy*: 2000, 28, p. 121–130.

24 Donovan D.M. "Attrition prevention with individuals awaiting publicly funded drug treatment." *Addiction*: 2001, 96, p. 1149-1160.

25 Wertz J. "Effect of motivational interviewing on treatment participation, self-efficacy, and alcohol use at follow-up in inpatient alcohol dependent adults." *Dissertation Abstracts International*: 1994, 55(1), 219-B.

26 Brown J.M. *et al*. "Impact of motivational interviewing on participation and outcome in residential alcoholism treatment." *Psychology of Addictive Behaviors*: 1993, 7(4), p. 211–218.

27 Miller W.R. *et al*. "Motivational interviewing with problem drinkers: II. The Drinker's Check-up as a preventive intervention." *Behavioural Psychotherapy*: 1988, 16, p. 251–268.

28 Miller W.R. *et al*. "Enhancing motivation for change in problem drinking: a controlled comparison of two therapist styles." *J. Consulting and Clin. Psychol.*: 1993, 61, p. 455–461.

29 Karno M.P. *et al*. "Less directiveness by therapists improves drinking outcomes of reactant clients in alcoholism treatment." *J. Consulting and Clin. Psychol.*: 2005, 73(2), p. 262–267.

30 Francis N. *et al*. "An experimental manipulation of client resistance to determine its effects on practitioner behaviour." Draft submitted for publication.

31 Karno M.P. *et al*. "Interactions between psychotherapy procedures and patient attributes that predict alcohol treatment effectiveness: a preliminary report." *Addictive Behaviors*: 2002, 27, p. 779–797.

32 Gottheil E. *et al*. "Effectiveness of high versus low structure individual counseling for substance abuse." *American J. Addictions*: 2002, 11, p. 279–290.

33 Thornton C.C. *et al*. "High- and low-structure treatments for substance dependence: role of learned helplessness." *American J. Drug and Alcohol Abuse*: 2003, 29(3), p. 567–584.

34 Connors G.J. *et al*. "Preparing clients for alcoholism treatment: effects on treatment participation and outcomes." *J. Consulting and Clin. Psychol.*: 2002, 70(5), p. 1161–1169.

35 Martino S. *et al*. "Motivational interviewing with psychiatrically ill substance abusing patients." *American J. Addictions*: 2000, 9(1), p. 88–91.

36 Apodaca T.R. *et al*. "A meta-analysis of the effectiveness of bibliotherapy for alcohol problems." *J. Consulting and Clinical Psychology*: 2003, 59(3), p. 289–304.

37 Sanchez-Craig M. *et al*. "A self-help approach for high-risk drinking: effect of an initial assessment." *J. Consulting and Clinical Psychology*: 1996, 64(4), p. 694–700.

38 Cunningham J.A. *et al*. "Using self-help materials to motivate change at assessment for alcohol treatment." *J. Substance Abuse Treatment*: 2001, 20, p. 301–304.

39 Secades-Villa R. *et al*. "Motivational interviewing and treatment retention among drug user patients: a pilot study." *Substance Use and Misuse*: 2004, 39(9), p. 1369–1378.

40 Fernández-Hermida J-R. *et al*. "Effectiveness of a therapeutic community treatment in Spain: a long-term follow-up study." *European Addiction Research*: 2002, 8, p. 22–29.

41 Saunders B. *et al*. "The impact of a brief motivational intervention with opiate users attending a methadone programme." *Addiction*: 1995, 90, p. 415–424.

42 Saunders B. *et al*. "Motivational intervention with heroin users attending a methadone clinic" In: Miller W.R. *et al. Motivational interviewing: preparing people to change addictive behaviour*. Guilford Press, 1991, p. 279–292.

43 Miller W.R. *et al*. "Motivational interviewing in drug abuse services: a randomized trial." *J. Consulting and Clinical Psychology*: 2003, 71(4), p. 754–763. D

44 Amrhein P.C. *et al*. "Client commitment language during motivational interviewing predicts drug use outcomes." *J. Consulting and Clinical Psychology*: 2003, 71(5), p. 862–878.

45 Stotts A.L. *et al*. "Motivational interviewing with cocaine-dependent patients: a pilot study." *J. Consulting and Clinical Psychology*: 2001, 69(5), p. 858–862.

46 Rohsenow D.J. *et al*. "Motivational enhancement and coping skills training for cocaine abusers: effects on substance use outcomes." *Addiction*: 2004, 99, p. 862–874.

47 Personal communication from Damaris Rohsenow, 2005.

48 Chambless D.L. *et al*. "Update on empirically validated therapies, II." *The Clinical Psychologist*: 1998, 51(1), p. 3–16.

49 Woody S.R. *et al, eds*. "Manuals for empirically supported treatments: 1998 update." *The Clinical Psychologist*: 1998, 51(1), p. 17–21.

50 Miller W.R. *et al. Motivational enhancement therapy manual: a clinical research guide for therapists treating individuals with alcohol abuse and dependence*. US Department of Health and Human Services, 1995.

51 Kahler C.W. *et al*. "Motivational enhancement for 12-step involvement among patients undergoing alcohol detoxification." *Journal of Consulting and Clinical Psychology*: 2004, 72(4), p. 736–741.

52 Amrhein P.C. "How does motivational interviewing work? What client talk reveals." *J. Cognitive Psychotherapy*: 2004, 18(4).

53 Miller W.R. *et al. Manual for the Motivational Interviewing Skill Code (MISC). Version 2.0*. University of New Mexico, 2003.

54 Reimer B. *Strengthening evidence-based addictions programs: a policy discussion paper*. Alberta Alcohol and Drug Abuse Commission [etc], 2003.

55 Moyers T.B. *et al*. "What makes motivational interviewing work? Therapist interpersonal skill as a predictor of client involvement within motivational interviewing sessions." *J. Consulting and Clinical Psychology*: in press, 2005.

56 Miller W.R. "Integrating motivational approaches into treatment programs." In: *Enhancing motivation for change in substance abuse treatment*. US Dept. Health and Human Services etc, 1999.

57 Miller W.R. "Motivational interviewing with problem drinkers." *Behavioural Psychotherapy*: 1983, 11, p. 147–172.

58 Klingemann H. *et al*. *Promoting self change from problem substance use. Practical implications for policy, prevention and treatment*. Kluwer Academic Publishers, 2001.

59 Marlatt A. *et al*. "Help-seeking by substance abusers: the role of harm reduction and behavioral-economic approaches to facilitate treatment entry and retention" In: Onken L.S. *et al, eds*. *Beyond the therapeutic alliance: keeping the drug-dependent individual in treatment*. NIDA, 1997.

60 Marlatt G. *et al*. "Harm reduction approaches to alcohol use: health promotion, prevention, and treatment." *Addictive Behaviors*: 2002, 27, p. 867–886.

61 Tucker J.A. *et al*. "Resolving alcohol and drug problems: influences on addictive behavior change and help-seeking processes." In: Tucker J.A. *et al, eds*. *Changing addictive behavior*. Guilford Press, 1999, p. 97–126.

62 Tucker J.A. "Resolving problems associated with alcohol and drug misuse: understanding relations between addictive behavior change and the use of services." *Substance Use and Misuse*: 2001, 36(11), p. 1501–1518.

63 Hardwick L. *et al*. "The needs of crack-cocaine users: lessons to be learnt from a study into the needs of crack-cocaine users." *Drugs: Education, Prevention & Policy*: 2003, 10(2), p. 121–134.

64 *Drug misuse 2004. Reducing the local impact*. London: Audit Commission, 2004.

65 *Service user views of drug treatment: research conducted for the Audit Commission*. EATA, 2004.

66 Woody G.E. "Research findings on psychotherapy of addictive disorders." *American J. Addictions*: 2003 12 (Suppl), S19-S26.

67 Miller W.R. *et al. Motivational interviewing: preparing people to change addictive behaviour*. Guilford Press, 1991.

68 Miller W.R. *Motivational enhancement therapy with drug abusers*. 1995.

69 Miller W.R. "Motivational interviewing: III. On the ethics of motivational intervention." *Behavioral and Cognitive Psychotherapy*: 1994, 22, p. 111–123.

70 Motivational interviewing training web site motivationalinterviewtraining.com, 10/08/05.

New literature reviews, meta-analyses, and evidence-based resources

NATIONAL POLICY

ILLICIT DRUGS POLICY: USING EVIDENCE TO GET BETTER OUTCOMES. Royal Australasian College of Physicians and Royal Australian and NZ College of Psychiatrists, 2005.
Supply reduction measures cause 'collateral' harm yet are better funded than safe and effective treatment and harm reduction interventions.
Copies: www.racp.edu.au.

PREVENTING HARMFUL SUBSTANCE USE: THE EVIDENCE BASE FOR POLICY AND PRACTICE. Stockwell T. et al, eds. John Wiley, 2005 BS
Essays cumulatively supporting a reconfiguration of national policies on alcohol, tobacco and illicit drugs.

ALCOHOLISM MEDICATIONS

PHARMACOTHERAPIES FOR RELAPSE PREVENTION IN ALCOHOL DEPENDENCE. Gowing L.R. Drug and Alcohol Services South Australia, 2005.
Acamprosate best for abstinence, naltrexone for preventing heavy drinking, limited evidence for disulfiram.
Copies: www.dassa.sa.gov.au.

OPIOID ANTAGONISTS FOR ALCOHOL DEPENDENCE. Srisurapanont M. et al. The Cochrane Database of Systematic Reviews: 2005, 1.
Naltrexone should be accepted as a short-term treatment.
Copies: www.thecochranelibrary.com.

PATIENT-TREATMENT MATCHING WITH ANTI-CRAVING MEDICATIONS IN ALCOHOL-DEPENDENT PATIENTS: A REVIEW ON PHENOTYPIC, ENDOPHENOTYPIC AND GENETIC INDICATORS. Ooteman W. et al. J. Substance Use: 2005, 10(2–3), p. 75–96 AC
Which patients do best with drugs such as naltrexone and acamprosate.

DUAL DIAGNOSIS

SUBSTANCE ABUSE TREATMENT FOR PERSONS WITH CO-OCCURRING DISORDERS. Treatment Improvement Protocol (TIP) Series 42. [US] Substance Abuse and Mental Health Services Administration, 2005.
Expert consensus on good practice.
Copies: www.ncadi.samhsa.gov.

SCREENING, ASSESSMENT, AND TREATMENT PLANNING. [US] Substance Abuse and Mental Health Services Administration [etc], 2005.
Briefing encapsulating evidence and expert consensus on initiating and planning treatment.
Copies: www.coce.samhsa.gov.

INTEGRATED VERSUS NON-INTEGRATED MANAGEMENT AND CARE FOR CLIENTS WITH CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS: A QUALITATIVE SYSTEMATIC REVIEW OF RANDOMISED CONTROLLED TRIALS. Donald M. et al. Social Science and Medicine: 2005, 60(6), p. 1371–1383 DS
Deals with the key issue of whether integrating addiction and mental health treatment improves outcomes.

ANTIDEPRESSANT TREATMENT OF CO-OCCURRING DEPRESSION AND ALCOHOL DEPENDENCE. Pettinati H.M. Biological Psych.: 2004, 56, p. 785–792 AC
Antidepressants relieve depression but have little impact on drinking.

TREATMENT OF DEPRESSION IN PATIENTS WITH ALCOHOL OR OTHER DRUG DEPENDENCE: A META-ANALYSIS. Nunes E.V. et al. Journal of the American Medical Association: 2004, 291(15), p. 1887–1896 DS
Suggests delaying antidepressants until after a short period of abstinence or until addiction treatment has started to disentangle primary from drug-induced depression.

TREATMENT OF DEPRESSION IN PATIENTS WITH OPIATE DEPENDENCE. Nunes E.V. et al. Biological Psychiatry: 2004, 56(10), p. 793–802 DS
Implications as above.

MOTIVATIONAL INTERVIEWS

MOTIVATIONAL INTERVIEWING: A SYSTEMATIC REVIEW AND META-ANALYSIS. Rubak S. British J. General Practice: 2005, p. 305–312 AC
Synthesises studies comparing against usual clinical advice or counselling.

MOTIVATIONAL INTERVIEWING. Hettema J. et al. Ann. Rev. Clinical Psychology: 2005, 1, p. 91–111 AC
Meta-analysis finds best evidence relates to substance use especially when motivational interviewing is a prelude to main treatment and done without following a manual.

TREATMENT OTHER

BENEFITS OF DRUG TREATMENT: A CRITICAL REVIEW OF THE EVIDENCE FOR POLICY MAKERS. Belenko S. et al. Alcohol & Drug Problem Association of North America, 2005.
Which treatments for which patients result in the greatest net cost-savings.
Copies: www.adpana.com.

SUBSTANCE ABUSE TREATMENT: GROUP THERAPY. Treatment Improvement Protocol (TIP) Series 41. [US] Substance Abuse and Mental Health Services Administration, 2005.
Expert consensus on good practice.
Copies: www.ncadi.samhsa.gov.

THE ROLE OF THE THERAPEUTIC ALLIANCE IN THE TREATMENT OF SUBSTANCE MISUSE: A CRITICAL REVIEW OF THE LITERATURE. Meier P.S. et al. Addiction: 2005,100, p. 304–316 DS
Good early worker-client relationship consistently related to improved engagement in alcohol/drug treatment.

EFFICACY OF ACUPUNCTURE FOR COCAINE DEPENDENCE: A SYSTEMATIC REVIEW AND META-ANALYSIS. Mills E.J. et al. Harm Reduction Journal: 2005, 2(4).
Pooled results from seven studies show no evidence that acupuncture helps patients stop using cocaine.
Copies: www.harmreductionjournal.com.

THE EFFECTIVENESS OF VOCATIONAL SERVICES FOR SUBSTANCE USERS IN TREATMENT. Magura S. et al. Substance Use and Misuse: 2004, 39(13–14), p. 2165-2213 DS
Focuses on competitive employment as an outcome.

HARM REDUCTION

SUPERVISED INJECTION FACILITIES (SIFS). FAQS. Canadian Centre on Substance Abuse, 2004.
Useful concise briefing on working methods and impacts.
Copies: www.ccsa.ca.

PRISON NEEDLE EXCHANGE: LESSONS FROM A COMPREHENSIVE REVIEW OF INTERNATIONAL EVIDENCE AND EXPERIENCE. Lines R. et al. Canadian HIV/AIDS Legal Network, 2004.
Country by country review concludes that prison services should trial exchange schemes.
Copies: www.aidslaw.ca.

PREVENTION

SCHOOL-BASED PREVENTION FOR ILLICIT DRUGS USE. Faggiano F. et al. The Cochrane Database of Systematic Reviews: 2005, 2.
Social skills lessons delay drug use.
Copies: www.thecochranelibrary.com.

PREVENTION AND REDUCTION OF ALCOHOL MISUSE. EVIDENCE BRIEFING. Mulvihill C. et al. Health Development Agency, 2005.
UK review of reviews finds support for anti-drink driving regulations and enforcement and brief interventions.
Copies: www.publichealth.nice.org.uk.

DRUG PREVENTION WITH VULNERABLE YOUNG PEOPLE: A REVIEW. Roe S. et al. Drugs: Education, Prevention & Policy: 2005, 12(2), p. 85–99 DS
UK Home Office analysts review studies of intervening with children at high risk of drug problems.

RANDOM DRUG TESTING OF SCHOOL-CHILDREN. A SHOT IN THE ARM OR A SHOT IN THE FOOT FOR DRUG PREVENTION? McKeganey N. Joseph Rowntree Foundation, 2005.
Assesses UK policy and practice and international evidence. Finds substantial risks and little evidence of benefit.
Copies: www.jrf.org.uk.

DRINK DRIVING

EFFECTIVENESS OF SCHOOL-BASED PROGRAMS FOR REDUCING DRINKING AND DRIVING AND RIDING WITH DRINKING DRIVERS. Elder R.W. et al. American Journal of Preventive Medicine: 2005, 28(5 suppl.), p. 288–304 AC
Systematic review finds that interactive lessons can help children avoid travelling with a drink-driver.

EFFECTIVENESS OF DESIGNATED DRIVER PROGRAMS FOR REDUCING ALCOHOL-IMPAIRED DRIVING. Ditter S.M. et al. Am. J. Preventive Medicine: 2005, 28(5 suppl.), p. 280–287 AC
Casts doubt on the effectiveness of incentives and campaigns for drinkers to arrange for a sober driver.

BEST PRACTICES. TREATMENT AND REHABILITATION FOR DRIVING WHILE IMPAIRED OFFENDERS. Health Canada, 2004.
Supports treatment/education programmes for drink-drivers; reinstatement of license should be dependent on programme completion.
Copies: www.healthcanada.ca.

CRIMINAL JUSTICE

THE EFFECTIVENESS OF CRIMINAL JUSTICE AND TREATMENT PROGRAMMES IN REDUCING DRUG-RELATED CRIME: A SYSTEMATIC REVIEW. Holloway K. et al. Home Office, 2005.
Meta-analytic review finds that therapeutic communities and drug courts have the strongest record.
Copies: www.homeoffice.gov.uk.

ADULT DRUG COURTS. EVIDENCE INDICATES RECIDIVISM REDUCTIONS AND MIXED RESULTS FOR OTHER OUTCOMES. US Government Accountability Office, 2005.
Mandatory treatment and testing supervised by specialist drug courts reduces crime while offenders are in the programme.
Copies: www.gao.gov.

QUASI-COMPULSORY TREATMENT OF DRUG DEPENDENT OFFENDERS: AN INTERNATIONAL LITERATURE REVIEW. Stevens A. et al. Substance Use and Misuse: 2005, 40(3), p. 269–283 DS
Research on legally coerced treatment originally published in English or four other European languages.
Related report also at www.kent.ac.uk.

THE ROLE OF POLICE IN PREVENTING AND MINIMISING ILLICIT DRUG USE AND ITS HARMS. Spooner C. Commonwealth of Australia, 2004.
Report for the Australian government on how policing can mitigate or amplify drug-related harm.
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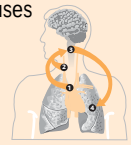

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