DRUG & ALCOHOL FINDINGS *Matrix cell*

DOWNLOAD PDF for saving to your computer

Alcohol Treatment Matrix cell A2

Interventions; Generic and cross-cutting issues

Seminal and key studies on aspects of the treatment of problem drinking relevant both to psychosocial and medical approaches. Focuses on 'common factors' often sidelined as components of the 'placebo effect', but which are actually active ingredients now recognised as at least as important as the particular therapy. See the remaining four cells in row 2 of the matrix for more on generic features of medical and psychosocial therapies.

S Seminal studies **K** Key studies **R** Reviews **G** Guidance **MORE** Search for more studies

Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text

S Shock to the system: handing patients responsibility matches extended treatment (1999). On first page under heading, "The alcohol clinic," describes the study in London (1977) which questioned the orthodoxy that "alcoholism" requires extensive treatment. After thorough assessment, the extended treatment of the time worked no better than one brief session handing responsibility to a married couple to tackle the husband's drinking. See also commentary (2015) around four decades later from a study researcher. Trial was broadly replicated (1988; free source at time of writing) at a Scottish alcohol clinic, where extended treatment led to some (but generally not statistically significant) further improvements. For related discussions click here, here and here, and scroll down to highlighted headings.

S Empathy and organisation transform alcohol clinic (1970). Analyses the book which documented a remarkable series of US studies from the late 1950s, showing that an alcohol clinic's intake and attendance can be transformed by treating even the most unpromising of patients with warmth and respect. It can be thought of as having systematically deployed the 'common factors' explained below. For discussion click and scroll down to highlighted heading.

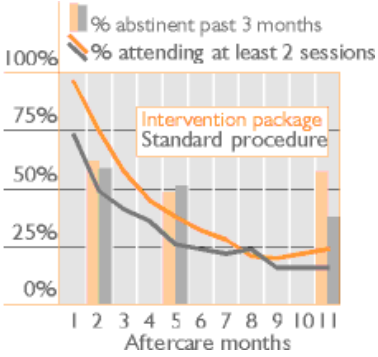
Jerome D. Frank

S Pioneering insight into the 'common factors' underlying effective therapies (1991). First published in 1961 and culminating in a third edition in 1991, Jerome D. Frank's book *Persuasion and Healing* has afforded an enduring insight into the shared features underlying effective therapies in mental health, including the addictions – features now widely acknowledged as more influential than the distinctive theories and methods of different approaches. For discussions click here and here and scroll down to highlighted headings.

K Treatment entry often the key event (2005). Reanalysis of data from the multi-million dollar US Project MATCH alcohol therapies trial showed treatment entry was associated with major drinking reductions even before treatment had been delivered. For the analysts their findings suggested that "current treatments are not effective". See also rejoinder (2005) from a MATCH researcher and an informal commentary (2008) for the Effectiveness Bank on this and similar findings. For discussion click and scroll down to highlighted heading.

K Non-residential rehabilitation usually matches residential ... but not always (2007). Confirmed that unless there are pressing contraindications, intensive day options deliver outcomes equivalent to residential care. Often of course, there *are* pressing contraindications. See also this informal Effectiveness Bank review. For related discussion click and scroll down to highlighted heading.

K Motivating aftercare (2007). Inspiring story of how a US inpatient treatment centre systematically tackled what is widely seen as the greatest weakness of current treatments – the lack of continuing care or aftercare. By applying simple prompts and motivators, the centre substantially improved aftercare attendance and helped sustained abstinence ▸ chart. See also later report from same study focusing on substance use patients with mental health problems.



K Remission is the norm among dependent US drinkers; multiple problems mean some take longer to get there (2011). US national survey found that just a third of dependent drinkers remained dependent three years later and three-quarters remitted without treatment. Compared to other dependent drinkers, despite accessing more treatment twice as many of the heaviest drinkers with multiple psychological problems remained dependent. Reanalysis (2013) of same surveys challenges assumptions that progressive neural, lifestyle or psychological changes increasingly lock-in dependence. For discussion click and scroll down to highlighted heading.

R Internationally, remission is the norm (2010). In the general population and in treatment samples, on average studies have found half (or more in recent studies) of all problem substance users were later in remission. Among

general population samples, six out of ten who remitted continued to use, but among those whose problems led them to engage in professional treatment, six out of ten remitted by becoming abstinent. For related discussion click and scroll down to highlighted heading.

R Engaging the 'treatment-resistant' (2010; free summary). Shock-tactic confrontation and tough-love sanctions by the family and others found less likely to persuade dependent substance users to enter treatment than a 'community reinforcement' approach aimed at engaging them in fulfilling activities incompatible with continued use.

R Tailor induction into treatment (2005). When starting treatment or considering this move, some substance users need their motivation bolstered and to explore the options; for others this is not just unnecessary, but counterproductive. For related discussion click and scroll down to highlighted heading.

R Effective ways to relate to clients and patients (American Psychological Association, 2011). Effective ways to relate to psychotherapy clients in general (and by extension, other clients and patients), like forming a therapeutic alliance, being empathic, and appropriately adjusting to the individual – and perhaps even more important, what to avoid. For related discussion click and scroll down to highlighted heading.

R Chronic dependence benefits from long-term, continuing care (2014; free source at time of writing). Synthesis of research built on a previous review (2009) by adding 13 studies to the 20 identified earlier and aggregating all substance use outcomes. Nearly 9 in 10 of the trials were wholly or partly about alcohol use treatment. Found that patients allocated to aftercare/continuing care engaged in slightly but significantly less substance use at follow-up. Related guidelines below. Similar review narrowing in on problem drinkers and the most rigorous studies below. For discussions click here and here and scroll down to highlighted headings.

R Continuing care specifically benefits problem drinkers (2014; free source at time of writing). Focusing on solely alcohol-dependent patients and high quality randomised trials yielded just six trials, across which continuing care generally modestly improved on usual care. Similar review above based on many more studies because it included drug and/or alcohol use patients and less rigorous studies. For discussions click here and here and scroll down to highlighted headings.

R Case management function coordinates and extends care but patient welfare relatively unaffected (2019). In substance use treatment, case management has the intended effects of extending retention and linking patients to services which address their multiple needs, but overall had only minor and non-significant effects on substance use and other indicators of recovery. Related guidance below.

G Official British guidance on how to assess and treat problem drinking (National Institute for Health and Care Excellence, 2011). Recommendations from Britain's health technology advisers on overall principles and particular interventions. Among the former are that therapeutic staff should aim to build trusting relationships with clients and work in a supportive, empathic and non-judgmental manner.

G Evidence-informed principles of effective substance use treatment (2006; free source at time of writing). Based on reviews commissioned by the American Psychological Association, aims to promote evidence-informed practice integrating factors to do with the therapy, the patient, and their relationship with the clinician, whilst acknowledging that "There is no empirically complete formula to allow clinicians to plan and deliver with complete confidence the right treatment for any incoming client."

G US guidance on matching patients to an appropriate intensity and type of care (American Society of Addiction Medicine, 2013). From the professional body for US addiction clinicians, the world's most widely used criteria for deciding what kind of treatment to start with or move on to for different kinds of substance use patients. For related discussion click and scroll down to highlighted heading.

G US evidence-based treatment principles ([US] National Institute on Drug Abuse, 2012). Presents 13 research-based principles of addiction treatment. Seven have been tested against the North American evidence; principles relating to individualising treatment were consistently supported.

G Strategies to promote continuing care (2009; free source at time of writing). Expert US consensus on practical strategies to promote aftercare/continuing care for substance use patients; informed by review listed above.

G Implementing case management (Association of Alcohol and Other Drugs Agencies Northern Territory, 2015). Australian state's 'peak' body for non-governmental drug and alcohol services offers guidance on the widely implemented (but inadequately researched) role of the case manager in coordinating and integrating service delivery. Related review above.

MORE Search for all relevant Effectiveness Bank analyses or for subtopics go to the subject search or hot topics on promoting recovery through employment, mutual aid and user-involvement, the need for residential care, individualising treatment, and matching alcohol treatments to the patient. See also the collection of analyses relating to the common factors underlying different treatments.

Last revised 15 April 2020. First uploaded 01 June 2013

▶ Comment/query
▶ Suggest a new document to add to this cell
▶ Return to/go to Alcohol Matrix
▶ Open Effectiveness Bank home page

▶ Add your name to the mailing list to be alerted to new studies and other site updates

Close Matrix Bite

Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text

What is this cell about? Interventions which are identifiably either medical or psychosocial are respectively covered in cells A3 and A4. This cell is about the 'common factors' shared by both. Regardless of the treatment modality, patients have to decide to get help and find their way to treatment or get sent there. At a practical level, decisions must be made about treatment objectives and the form, intensity and duration of care, relationships forged, and attention paid to psychological problems and social circumstances which affect the probability of sustained remission. At a deeper level, influences include the very fact that someone or some institution has identified the patient as in need of and deserving help, believes they will benefit, is an acknowledged authority in the problem and its solutions, and offers a credible remedy via which they instil confidence and optimism – components often sidelined as the 'placebo effect', but which are actually active ingredients widely recognised as at least as important as the particular therapy. Other cells home in on common factors to do specifically with how the practitioner relates to the patient and the qualities of the treatment service.

Across medicine there are calls not just to recognise the power of the 'placebo effect', but to deliberately manipulate it in the in the interests of the patient. The flip side is avoiding negative manifestations of common factors, such as pessimistic expectations of the effectiveness of the treatment or its side effects, or interactions with the patient which obstruct engagement with or the effectiveness of treatment. In the treatment of problem drinking and in medicine generally, these negatives seem more powerful than the positives. Compounding the complications is that in certain contexts what are normally thought of as beneficial elements may be counterproductive. For example, optimism is important, but encouraging unrealistic expectations of a treatment's benefits or the probability of success risks increased distress, pessimism, and a sense of having failed in a treatment which should have worked, on top of having 'failed' in life by becoming in need of treatment. Even explicitly expressing empathy – often lauded as the essence of effective therapy – is not always positive; it all depends on the situation and the client.

Also this cell touches on the nature of dependence and the caseload seen in treatment services, helping place those services in the context of the spectrum of dependent substance use in society and the 'natural' processes of recovery which treatment seeks to harness and accelerate.

Where should I start? The corresponding cell of the Drug Treatment Matrix started at the end – where treatment should be trying to get to and in particular the concept of 'recovery', so central to UK policy in the 2000s. This cell starts where the patient journey usually starts – the decision to seek or accept treatment. It was investigated in a groundbreaking and frankly inspiring series of studies from the 1950s listed above led by Morris Chafetz, later to become the founding director of the US National Institute on Alcohol Abuse and Alcoholism.

Analysed for the Effectiveness Bank, Chafetz's innovations exposed why the supposedly intractable "alcoholics" seen in his hospital's emergency department were so hard to engage in treatment at the same hospital's alcohol clinic; it was not primarily due to the *patient's* rejection of the help they clearly needed, but to the *staff's* rejection of and hostility towards the patient, generated by what Chafetz came to see as moralising and punitive attitudes.

'Skid-row' alcoholics seen at a US emergency department were dismissed as intractably treatment-resistant, but the cause was hostility and rejection from staff.

Dr Chafetz also showed that such attitudes were not themselves intractable, creating instead a seamless treatment-entry procedure during which patients were listened to and treated with care and respect. It transformed what was almost universally an isolated episode of emergency care leading nowhere, into the start of a rehabilitation process which involved not just working with the patient, but networking to gain the cooperation of other hospital staff and external welfare and housing services. A later sub-study of the emergency doctors who made referrals to the alcohol treatment clinic found that tone of voice can betray cold 'professionalism' or convey personal concern, and revealed the positive difference the latter can make to whether referrals are followed through.

For more on this remarkable story whose lessons seem to need to be continually relearned, read the

Effectiveness Bank analysis and see this slide presentation which ends by focusing on the Chafetz studies.

Highlighted study There is no more fertile alcohol treatment study than the multi-million dollar US Project MATCH. Trialled in the early 1990s, its treatments were state-of-the-art and its methodology of unprecedented rigour, but what made it so fruitful was the need to explain why the expected findings nevertheless failed to materialise.

The study emerged from a conviction that alcohol treatments were relatively ineffective overall because the results were averaged across different types of patients, many of whom would be a poor match for any particular therapy. Instead of universally applied scatter-gun therapies, be more discerning, get the match between patient and therapy right, and the result could be a dramatic improvement in outcomes. That was not how it turned out. Conceived as a definitive test of matching different types of patients to three different psychosocial therapies, instead MATCH ended by prioritising not how therapies *differ*, but what they *share* – most of all, what the *patient* brings to treatment.

The findings came as a "surprise" to the study's eminent researchers. They expected that the most highly technical of the therapies – 12 sessions of face-to-face cognitive-behavioural therapy – would prove superior for most of the categories of patients defined for the trial. Yet on the primary measures, "all three treatments yielded virtually identical outcomes". Worse still, "few of the matching hypotheses were confirmed"; the raison d'etre of the study proved largely a chimera. Even the saving grace that all three manualised and advanced therapies were an improvement on usual approaches was contradicted by a report from one of MATCH's clinics. There the centre's usual treatments reduced drinking among patients recruited into another study just as much as among the similar patients in the MATCH trial – though perhaps 'usual' treatment at this centre, which hosted motivational interviewing's originator William Miller, was of unusually high quality and well informed by research.

Our concern here, however, is not so much with the results MATCH intended to generate (for which see the Effectiveness Bank analysis), as with those which emerged from a re-analysis by MATCH outsiders Robert Cutler and colleague, whose startling findings sparked a rebuttal from William Miller, one of MATCH's principal investigators. The controversy has been informally explored for the Effectiveness Bank, an essay to be found among the relevant documents listed above.

Miller's rebuttal made valid criticisms, but the fundamental question remained: how could it be that on average patients who did not return for therapy at all or attended only once did almost as well as those who attended all 12 sessions of the longer therapies (cognitive-behavioural and 12-step based) tested in the trial? If treatment is an important active ingredient, shouldn't there have been a substantial gap? Instead there was on average rapid remission in the first week of the intended treatment period which was largely sustained after it ended, *even if no treatment* had been received. Contrast this with the MATCH finding that how much patients wanted to change and were ready to do so beforehand was strongly and lastingly linked to how well they did.

To make sense of their findings, Cutler's team argued that in the circumstances of the trial, treatment content and techniques were simply ineffective – an account which would also explain why in MATCH and across alcohol treatment, different psychosocial therapies result in similar outcomes, as largely they do for common mental health problems in general (1, free source at time of writing; 2; 3, free source at time of writing). For Cutler and colleague, what mattered was not the supposed specific mechanisms of the therapies, but the patient's motivation and the process of entering treatment and being assessed and monitored: "Enrolling in the trial suggests that the alcoholic has crystallized a decision to reduce or abstain from drinking."

By the time they came to integrate their many findings in a book, MATCH researchers were also de-emphasising the vision on which the study was predicated in favour of these "common mechanisms" – not treatment techniques at all, but influences such as empathy, an effective working alliance between therapist and client, the latter's desire to get better and inner resources to overcome alcohol dependence, a supportive social network, and the "provision of a culturally appropriate solution to a socially defined problem".

In these formulations, treatment was envisaged not as a 'technological fix' keyed to a matching malfunction, but as an appropriate-looking door through which patients could pass to actualise their impetus to get better. At a conference in London, a senior MATCH investigator speculated that in other cultures, faith healers and witch doctors offer such doors in a way essentially no different from that offered by 'treatment' or 'therapy' in

> *Faith healers and witch doctors act in the same way as 'treatment' in Western societies*

Western societies. “What may be required even more than the specific components of a therapeutic intervention is the belief on the part of both the patient and the therapist that this particular treatment is likely to be effective,” was how MATCH researchers less picturesquely phrased it in their book.

The ‘crystallisation’ phenomenon invoked by Cutler and colleague to explain their findings is marked by rapid and lasting remission after taking steps to start treatment, but before any or much has been delivered. This pattern has a considerable history which keeps getting repeated in the few studies able to spot it. A notable example was able to segment reductions in drinking over time and pinpoint when these happened (1 2). It revealed that what looked like reductions caused by the study’s brief treatments had in fact happened before these were received in the mail by the participants, and even before they had completed a detailed assessment. The critical period was after responding to an advert asking if they wanted to change their drinking and being briefly assessed over the phone by a researcher to see if they were eligible. It was then that their (on average quite heavy and probably dependent) drinking dipped and more or less stayed dipped for at least the next year, with little or no further remission consequent upon assessment or treatment. Examples can be even be found in trials of drug-based treatment for drinking problems, such as the one which found that substantial minorities of dependent drinkers lastingly remitted to low-risk drinking before taking a single pill.

Then look back at this very different study (listed above; see “The alcohol clinic” on the first page of the linked document) from 1970s England, which found alcohol-dependent men did as well after a single advice session with their wives as after fully fledged treatment. Forty years later a researcher from the study argued these findings meant “that ‘treatment’ was less important than those aspects of the process which treatment and advice couples shared: all the negotiations and arguments that must have gone on between husband and wife prior to and after the visit to the general practitioner; the referral to a psychiatric hospital and the wait for the appointment letter; the whole morning spent going over one’s drinking and one’s marriage with a group of expert strangers; the unequivocal advice, delivered in the presence of one’s spouse ... knowing that the hospital was keeping a watching brief and that questions were being asked about your behaviour every month and that you would be asked to account for yourself at the year’s end”.

Finally, step back even further to 1961 and Jerome Frank’s prescient exposition (listed above and discussed below) of a common factors theory, and marvel at how his ideas predicted the findings described in this section and continue to be offered as explanations for treatment study findings.

What might all this mean? Perhaps this – that by the time many drinkers have decided they have a problem they must do something about, most of the therapeutic work has already been done. And that though for the rest, treatment ‘works’, it is not the therapeutic theories and techniques over which we agonise that matter, but the patient’s resolution to get better and the actions, rituals and relationships involved in doing that through treatment.

> *By the time a problem drinker has decided to enter treatment, most of the therapeutic work has already been done*

Issues to consider and discuss

▸ **What is treatment’s primary role?** One answer emerged in the “Highlighted study” section above – that for people ready and willing to get better, treatment offers a culturally endorsed door for them to pass through – one which also looks ‘right’ to the patient, or which they become convinced leads to a better life. It follows that treatment’s primary role is to make those doors look right, to provide a variety attractive to different beliefs and tastes, and to make them easy to find and easy to pass through – as MATCH researchers put it, “access to treatment may be as important as the type of treatment”. Once would-be patients approach, knock on and seek to pass through those doors, it would seem important to *avoid* obstructing the process started by the patient by, for example, confrontationally provoking resistance or being judgemental. At their best, treatment services are havens where the more despised and stigmatised in our society find acceptance and understanding.

> *Simply being available and not doing the wrong thing may be fundamental*

Simply being available and *not* doing the wrong thing (of which there is a distinct echo in brief interventions) may be fundamental, but that is not all there is to treatment. Perhaps treatment also has to build motivation (document listed above), show a structured route to recovery once the door is passed

through, and by ongoing contact, reassure the patient that someone still cares about them and is checking on how they are doing? (1 listed above; 2 listed above; 3 listed above)

It is in the nature of research trials that participants are not just checked up on, but know they will be, as researchers try to follow them up to assess their progress. Sometimes too, that is a strong feature of the overall intervention package, as in the study from 1970s England (listed above; see "The alcohol clinic" on first page of linked document) which found alcohol-dependent husbands did as well after a single session as after extended treatment. The single-session patients were not entirely left to their own devices: they faced what it is easy to imagine was the bracing prospect of home visits from a social worker who "would call each month to see the wife and collect news of progress". Just knowing – or thinking – that you are being observed and evaluated changes behaviour. And all well structured psychosocial therapies may be roughly equivalent, but they are all *structured*; they offer a coherent schema which for patient and therapist makes sense of how the patient developed a problem with substance use and shows them a navigable way out – something *to do* to get better, a focus for the motivation.

What else does treatment offer and how does it offer it? If you work in a treatment service, think about what you do in the round, not just the therapies you offer: your manner when you answer the phone and greet newcomers, the look of the service and the appearance of the staff, how you generate hope, offer coherent accounts of ways in and out of addiction, inspire confidence, signify acceptance, and monitor how the patient is doing. These are the sorts of things that seem to matter at least as much as the specific techniques which characterise different approaches – the reason why Drug and Alcohol Findings created the five-part Manners Matter series.

▸ **Role different for different people?** Perhaps the question posed by the section above was based on a false premise – that in fact there *is* no primary role for treatment, but different roles in different situations for different people.

A national US survey listed above suggested that most dependent drinkers have the resources to extricate themselves from a phase not too deeply embedded in their lives, but some are too severely and multiply disturbed to 'bootstrap' themselves out of their troubles. Read this Effectiveness Bank analysis and you will see that the study highlighted above tended to exclude these less promising drinkers. Similarly, the English seminal study listed above was limited to men who despite their heavy drinking had sustained a relationship supportive enough for their wives to join them in treatment and spend many hours helping them recover. In general, the typical exclusion criteria employed by alcohol treatment researchers can eliminate the great majority of treatment-seeking drinkers from trials, leaving a relatively stable and committed set with an unusually good prognosis.

Is this why in some trials treatment seemed 'merely' to provide a way to actualise the patient's decision to get better? Other drinkers need much more, such as the 24-hour protection of a residential setting (document listed above); who they might be is formalised in US guidelines listed above. It's true that some patients (document listed above) have already decided how to overcome their dependence and further cogitation risks obstructing them, but others do need help to decide and benefit from discussing this with treatment staff.

▸ **What are these 'common factors'?** The non-specific, common factors shared by different treatments are mainly what this cell is about, but validating them is difficult. You cannot, for example, randomly send someone in desperate need of help either to a bona fide treatment service or to a seedy non-clinic staffed by unwelcoming therapists, just to see what happens and to confirm that the treatment context really is influential. Nevertheless, from the broader psychotherapy literature we can get a good idea of what these factors.

The usual starting point is the work of Jerome Frank (listed above) published first in 1961 and finally in 1991 in an edition co-authored with his daughter. His insistence that "much, if not all, of the effectiveness of different forms of psychotherapy may be due to those features that all have in common rather than to those that distinguish them from each other" amounted to a revolutionary undermining of the competition for primacy between different schools of therapy.

Bruce Wampold's meta-analytic demonstration of the validity of a common factors understanding of therapy included this summary of Frank's views on what treatment – the attempt "to enhance a person's feeling of well-being" – consists of. "The first component is that psychotherapy involves an emotionally charged, confiding relationship with a helping person (ie, the therapist). The second component is that the context of the relationship is a healing setting, in which the client presents to a professional who the client believes can provide help and who is entrusted to work on his or her behalf. The third component is that

there exists a rationale, conceptual scheme, or myth that provides a plausible explanation for the patient's symptoms and prescribes a ritual or procedure for resolving them. According to Frank and Frank, the particular rationale needs to be accepted by the client and by the therapist, but need not be 'true' … However, it is critical that the rationale for the treatment be consistent with the world view, assumptive base, and attitudes and values of the client or, alternatively, that the therapist assists the client to become in accord with the rationale. Simply stated, the client must believe in the treatment or be lead to believe in it. The final component is a ritual or procedure that requires the active participation of both client and therapist and is based on the rationale (ie, the ritual or procedure is believed to be a viable means of helping the client)."

Jerome David Frank

Wampold was one of the authors who brought (document listed above) elements of this formulation up to date based on research syntheses commissioned by the American Psychological Association, and who co-edited a book also from the American Psychological Association on common factors theory and evidence.

Does this theory break down when it comes to drug-based therapies? Surely these work regardless, as long as the pills are taken? Maybe, but the pills have to be taken, and none are so attractive and so effective that therapeutic relationships are irrelevant – as this analysis found. In the treatment of alcohol dependence, active medications generally add little to the improvements seen among patients prescribed a placebo. Something else accounts for the bulk of the improvements, and the prime candidates are the common factors involved in engaging in treatment, even if the treatment's 'medication' is a dummy pill and the psychosocial content is basic clinical care.

For more on 'common factors' in addiction treatment, see this Effectiveness Bank collection of studies.

Does long-term care/aftercare make a difference? If addiction at least *behaves* like a chronic relapsing condition, and even if that is only broadly valid for treatment populations, long-term monitoring and care would seem an appropriate and effective treatment strategy. Embedding this perspective into UK health service quality standards, the National Institute for Health and Care Excellence stipulated that even after having achieved abstinence, problem drug using patients should be offered continued treatment or support for at least six months. In support, a review which amalgamated the results of relevant research (listed above) found that patients allocated effectively at random to systematic aftercare/continuing care versus usual care engaged in slightly but significantly less substance use at follow-up.

That analysis included drug and alcohol use studies. Arguing that dependent drinkers who also use other drugs materially differ from those who do not, another review (listed above; free source at time of writing) focused on solely alcohol-dependent patients. It found just six high quality randomised trials, across which experimental continuing care approaches generally modestly improved on usual approaches. The experimental interventions tended to more proactively and regularly re-contact the patient and to be more active in their interventions, whereas usual care consisted mainly of supportive counselling and promoting attendance at Alcoholics Anonymous groups. Effective interventions also targeted the patient's family network and sought to improve coordination between different healthcare sectors. Even follow-up research assessments not meant to be therapeutic can nevertheless have a therapeutic effect. Compared to infrequent and brief assessments, more intense and frequent follow-ups have been found to reduce drinking and ameliorate its consequences in the year after starting outpatient treatment. The effect was not due to the follow-ups promoting further treatment; it was the follow-ups themselves which seemed therapeutic.

Based partly on the reviews cited above, cell D2 offers more thoughts on how to implement longer term care.

Close Matrix Bite