DRUG & ALCOHOL FINDINGS *Matrix cell*

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Alcohol Treatment Matrix cell C2

Management/supervision; Generic and cross-cutting issues

Key studies on management and supervision across psychosocial and medical treatments of problem drinking. Highlights that "Manners Matter", focuses on staff recruitment, queries the ubiquitous stages of change model, and details the fascinating history of the most controversial issue in alcohol treatment: whether to insist dependent drinkers try for abstinence. See the rest of row 2 of the matrix for more on features common to psychosocial and medical treatments.

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 The abstinent alcoholic (1962). Classic description of the patient who has sustained abstinence after treatment but is still unhappy, unfulfilled and/or nervously hanging on – in other words, not really 'recovered'. They formed the majority of now-abstinent patients who had been seen at US alcohol clinics in the 1950s. Related study and review below. For related discussion click and scroll down to highlighted heading.

S Alcoholics *can* learn to moderate their drinking (1973). Not the first, but the most incendiary paper to challenge the orthodoxy that abstinence must be the only treatment goal for dependent drinkers. See also second- (1976) and third-year (1978) follow-up results. This refutation (1982) based on a 10-year follow-up was itself refuted (1984) by the original authors. Related study above and review below. For discussion click and scroll down to highlighted heading.

S Organised caring transforms alcohol clinic (1970). Remarkable series of US studies from the late 1950s proved that fresh management can transform an alcohol clinic's intake and attendance – in this case by listening to previously dismissed 'skid-row alcoholics', being responsive to their needs, and systematically yet caringly keeping in touch. See also a slide presentation which ends by focusing on the studies.

Clinic manager transformed response of patients dismissed as intractably treatment-resistant.

S Relapse-preventing social skills of counsellors can be identified in advance (1981). US study at an inpatient alcohol unit found strong links between the interpersonal qualities and skills exhibited by counsellors in response to typical patient/family scenarios and how many of their patients later relapsed. Later Finnish study using same methods below. For discussion click and scroll down to highlighted heading.

K Identifying rapport-generating counsellors (2002). Responses to written counselling scenarios identified which counsellors would best generate retention-enhancing rapport at a Finnish outpatient alcohol clinic. Partial replication of US study above. For discussion click and scroll down to highlighted heading.

K First get the staffing right (2004). US study suggests that recruiting the 'right' clinicians who have *not* been trained in appropriate ways to relate to patients is preferable to choosing the 'wrong' ones who have been trained. The 'naturals' also gain most from training. For discussion click and scroll down to highlighted heading.

K Try walking in their shoes (2008). When senior staff role-played becoming a new client (a 'walk-through') at their own US substance use service, the resulting enlightenment helped halve waiting times and extend retention. See also this extension (2012) to the programme and an account (2007; free source at time of writing) of the walk-through procedure. Walk-throughs are a key element in the NIATx quality improvement model; see document and web site listed below. For discussion click and scroll down to highlighted heading.

K "You cannot treat an empty chair" (2013; free source at the time of writing). Title is from a report of how 67 US substance use outpatient clinics used the NIATx quality improvement model (see web site below) to reduce 'no-shows' through sensitively-handled reminder calls, cutting waiting times, increasing capacity (eg, extra hours), and psychosocial interventions such as motivational interviewing to bolster engagement. Related document above.

K Systematically link assessments to services (2005). In Philadelphia researchers tried automatically linking problems identified at treatment intake to relevant local services. It transformed assessments from clinically redundant paperwork into a practical route to the 'wrap-around' care advocated to deepen and extend recovery. For discussion click and scroll down to highlighted heading.

R How to generate evidence-informed practice ([Australian] National Centre for Education and Training on Addiction,

2008). Though they found few studies on substance use treatment, reviewers from Australia's national centre for workforce development in substance use extracted valuable lessons from health services on how to implement research-based innovations to improve treatment practice. Part of a package of three reviews and a presentation.

R Care enough to be personal but also to be systematic and persistent (2004). In seemingly mundane tasks like appointment-reminders and checking how former patients are doing, individualised and welcoming communications characterise retention-enhancing services. Systematising such procedures embeds 'caring' in routine pracctice. For related discussion click and scroll down to highlighted heading.

R 'Cycle of change' model poor guide to intervention (2001). Its simplicity is beguiling, but can services trust Prochaska and DiClemente's ubiquitous model to guide them in matching interventions to a client's 'stage of change'? Since this thorough but easy-reading review was written not much has changed. For discussion click and scroll down to highlighted heading.

R Offer moderation as well as abstinence as a treatment goal (2013). Concludes that dependent drinkers can cut down, that treatments based on this goal are probably just as effective as abstinence-oriented approaches, and that allowing patients a choice improves outcomes. Related studies (1 2) above and review below. For related discussion click and scroll down to highlighted heading.

R Tentative support for matching treatment to patient preferences (2016). The first review to evaluate shared decision-making between substance use patients and their clinicians and matching treatment to patient preferences found evidence that greater patient involvement can improve outcomes without unwelcome 'side effects'. Related review above. For related discussion click and scroll down to highlighted heading.

R Involving former problem substance users in promoting recovery (2014). For such a widely implemented and recommended adjunct to formal treatment, the revelation from this review is how little evidence there is for involving former substance users in promoting recovery – a lack which may simply reflect the paucity of adequate research. However, on balance the evidence we do have is positive. Related UK and US supervision guidelines below.

R G Train for skills, not for programmes (2010; free source at time of writing). "Shift the focus of dissemination efforts from manualized psychosocial interventions to specific skill sets … broadly applicable and easily learned by clinicians" – the core recommendation in this thoughtful US essay on integrating evidence-based practices into real-world clinical settings. Also makes a stab at what those skills should be in order to target key therapeutic goals.

G English inspectorate's criteria for quality in substance use services ([English] Care Quality Commission (CQC), accessed 2020). Official inspector of health and social care services in England asks five key questions of specialist NHS and independent substance use services. One ("Is it well-led?") assesses management through questions such as, "Is the culture centred on the needs and experience of people who use services?" More on what "well-led" means in appendices to prior consultation. Standards based on the CQC's requirements listed below.

G English drug services define their own quality standards (2016). From the English addictions treatment sector, standards developed after consultation and piloting to help services assess how they support clients into and through recovery and the quality of vital aspects of their organisations. Can act as a checklist for managers as well as services and commissioners. Consists of: standards for non-residential services (2016); implementation guide (2016) for these standards; and standards for residential rehabilitation (2016). Based partly on the CQC requirements listed above.

G Criteria for quality in substance use treatment in Scotland (Convention of Scottish Local Authorities and Scottish Government, 2014). Developed to ensure anyone looking to address their problem drug and/or alcohol use receives high-quality treatment and support that assists long-term, sustained recovery and keeps them safe from harm. Can act as a quality-assurance checklist for service managers.

G UK staff development toolkit ([English] National Treatment Agency for Substance Misuse, 2006). From the former central authority for substance use treatment in England, guidance including recruitment, training, staff development, appraisals, supervision, and exit interviews. For related discussion click and scroll down to highlighted heading.

G Managing peer supporters ([UK] Substance Misuse Skills Consortium, 2015). Guidance from what was the government-supported skills body for the substance use sector on how to manage (ex-)problem substance users who support other users through and out of treatment. Related review above and US guidelines below.

G Supervising peer supporters (2017). US checklist and training curriculum for developing and evaluating a service's competence to supervise (ex-)substance users whose role is to promote recovery among the service's patients. Related review and UK guidelines above.

G Assessing whether the workforce has the required knowledge, skills and ability (NHS Health Scotland, 2009). Desired competencies for Scotland's substance use workforce and assessing their training needs. Covers all levels from addictions specialists to generic workers who may deal with substance use only peripherally.

G Improving efficiency and capacity means more patients can be helped ([US] NIATx, accessed 2020). Web-based service provided by the University of Wisconsin offers practical strategies to improve management of substance use treatment services. Objectives include reducing waiting times and the number of 'no-shows' (example above) and increasing admissions and retention (example above). For related discussion clickand scroll down to highlighted heading.

G Managing non-residential programmes ([US] Substance Abuse and Mental Health Services Administration, 2006). US expert consensus on managing outpatient, counselling and day-care substance use services, including strategies to meet "the challenges facing executives".

G Clinical supervision and professional development of substance use counsellors ([US] Substance Abuse and Mental Health Services Administration, 2009). US expert consensus on monitoring staff performance and supervision methods and models, including how these can address cultural, ethical and legal issues. Provides an implementation guide for administrators.

G Workforce development aid for managers ([Australian] National Centre for Education and Training on Addiction, 2005). From Australia's national centre for workforce development in substance use, evidence-based strategies to address priority issues such as supervision, team building and performance appraisal, plus resources to help managers implement the strategies. Endorsed by the Australian government.

G Implementing change ([US] Substance Abuse and Mental Health Services Administration, 2009). Guide for managers on how to assess an organisation's capacity to identify priorities, implement changes, evaluate progress, and sustain effective programmes, and how to implement these programmes. Substantially draws on a broader review (2005).

MORE Search for all relevant Effectiveness Bank analyses or for sub-topics go to the subject search page or hot topics on why some treatment services are more effective than others, controlled drinking as a treatment goal, matching alcohol treatments to the patient, matching interventions to the client's 'stage of change', and individualising treatment. See also a reading list (2013) from a US recovery advocate and authority intended to help treatment services develop recovery-oriented programmes.

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What is this cell about? The five-cell matrix row in which this cell is located focuses on generic processes common to treatment, whatever the setting or modality. Patients have to decide to seek or accept help, find their way to treatment, decisions must be made about the objectives, form, intensity and duration of care, relationships forged, and attention paid to psychological problems and social circumstances which affect the chances of a sustained end to dependent substance use.

The current cell narrows in on how these processes are affected by the management functions of selecting, training and managing staff, and managing the intervention programme. In highly controlled studies, it may be possible to divorce the impact of interventions from the management of the service delivering them, but in everyday practice, whether interventions get adopted and adequately implemented, and whether practitioners can maintain recovery-generating attitudes and knowledge, depend on management and supervision. Compared to interventions, research on these issues is scarce, but can also be exciting and inspirational; at this level, whole organisations can be transformed from merely going through the motions into enthusiastic client-engagers.

Where should I start? With the truism that 'Manners matter' – the title of a series of reviews by Drug and Alcohol Findings not on *what* services do, but *how* they do it. Part one listed above dealt with seemingly mundane management tasks like managing waiting lists, setting up reminder systems for appointments, and checking on patients after they leave. In each case, research showed that individualised and welcoming communications characterise effective and retention-enhancing services. The overall conclusion was simple: "the human qualities which cement relationships outside treatment also do so within it".

Managements and services which care enough about these qualities also care enough to be organised and persistent about embedding them in routine practice. They centre initial contacts on the patient's priorities, provide (if need be, interim) help quickly, take responsibility for reminding patients they are looking forward to seeing them at their next appointment, if required help them get there, prepare the ground for keeping in touch after they leave, and then persistently and actively check how they are doing and if they need more help, at each stage showing that some*one* rather than an impersonal system is concerned about and wants to see them. One of the best examples was the transformation brought about at Massachusetts General Hospital's alcohol clinic, documented in studies listed above and explored further in cell A2.

Highlighted study The review discussed and listed above ended with, "Perhaps the main lesson of the research is that there is nothing special about … how substance misuse patients react. Reflection on how we might react if we were in their shoes can predict much of what researchers have painstakingly set out to prove." From cell B2 and general psychotherapy research we know that empathy – the therapist's ability to think themselves into the shoes of the client – is fundamental. This seems also true of the *managers* of those therapists. With perhaps no direct client contact, an alternative route to the client's world is metaphorically to 'try on the client's shoes' and *feel* if they pinch, rather than risking the self-serving illusion that all is well in a service for which you are responsible.

'Trying on the patient' shoes' was exactly what staff did (study listed above) at 327 US services by 'walking through' their service's admissions and induction procedures as if they were a client. The process was required in order to apply for a quality improvement programme, and the results were fed back to service managers. Listed above, an analysis of the walk-throughs – which started with the first phone or other contact and extended to the early stages of treatment – found that the role-players experienced: poor staff engagement and impersonal interactions; shortcomings in equipment, administrative procedures and premises; poorly communicated information; burdensome and repetitive processes and paperwork, including lengthy intake interviews focused not on the client's needs, but those of the agency; and failure to provide for clients with complex lives and problems. Extended (document listed above) to another twelve US areas, walk-throughs by senior staff became the key tactic for the strand of the quality improvement programme (see web site listed above) intended to identify service delivery problems and improve clinical procedures.

All three original articles in the entry listed above are freely available, the first two via the "alternative source" link in the Effectiveness Bank analyses, part of the article reference towards the top. Also freely available is practical guidance (1 2) on how to do a walk-through.

These reports offer abundant evidence that as part of a broader improvement programme, leaving the office and 'becoming' a patient opens eyes to shortcomings previously invisible to management and paves the way for improved procedures, streamlining admissions and retaining patients for longer – why the tactic features so strongly in the US quality improvement resource listed above. But can you think of any circumstances in which it might be counterproductive? And wouldn't it be better to systematically gather feedback on how *real* patients experience treatment procedures? What about true 'mystery shopping' – engaging an outsider to act the part of a client and to feed back the results? After all, in walk-throughs staff know what is happening and usually also know the staff doing the role plays and that they are not really patients. Look at the US guidance (1 2) on how to do a walk-through. Is this how you would do it at your service?

Issues to consider and discuss

Recruitment: the critical missing link "Missing" because treatment evaluation studies use existing staff or recruit their own before the trial starts. Either way, recruitment is completed *before* the evaluation, meaning its impact is unmeasured – the missing link. How significant an omission might this be? Think of the clinical staff you have known. Did some seem good from the start, while others couldn't hit the right note with patients, no matter how much they were trained and supervised? Appreciating its importance, do managers you know of focus effort on the recruitment process?

If they did, research would back them up. We know from cell B2 that clinicians vary greatly in effectiveness. Ideas about why came notably from a seminal British study, which spotlighted interpersonal warmth and commitment to working with problem-drinking patients. Qualities such as empathy, genuineness, respect and an ability to communicate have also been associated with retention and drinking outcomes.

If such qualities are lacking, training alone can't always fix the problem. Fixing it may require an overall organisational commitment expressed through training but also management attitudes, continued intensive supervision, and staff development procedures and incentives – but in the end, the problem may still boil down to having not having employed the right people. A US study listed above offers an example. It concerned motivational interviewing, an empathic counselling style highly influential in addiction treatment. The study showed that some clinicians 'get it' from the start and improve still further with training, while others don't get it initially, and still don't get it as well *after* training as adept practitioners did from the start.

Then look at a report (free source at time of writing) from the 'COMBINE' alcohol treatment trial listed in cell C4. Resource limitations led the study to save on training by screening applicant alcohol therapists for the "accurate empathy" fundamental to its motivational/cognitive-behavioural therapy. Despite applicants bring required to be qualified and experienced counsellors, about a third initially failed the screen; allowed to try again, 11 of 68 did not qualify for the study. "We were quite pleased with the result," said the researchers. "Compared with our experience in training unscreened counselors … therapists showed relatively few problems in manifesting the clinical style of motivational interviewing." Led by William Miller, the originator of motivational interviewing, their experience in the study and in routine practice led them to recommend such screening "as a prerequisite for employment of clinicians in community treatment programs".

The COMBINE study screened for empathy by rating audiotapes of a 10-minute non-clinical conversation conducted by the applicant with a member of the research staff and an equally brief clinical session with an actor simulating a client starting treatment. Other studies (1 2; listed above 1 2) have rated counsellors' written responses to written client-therapist scenarios.

After their experience in COMBINE, William Miller and colleague Theresa Moyers reviewed (free source at time of writing) the evidence for a link between clinician empathy and substance use outcomes. Their purview included the studies discussed above, plus others from their own research stable (1; 2, free source at time of writing) which showed that ratings made on the basis of session tapes before training in motivational interviewing were strongly related to how empathic the counsellors remained four months later. Given that "We know of no therapeutic approach where low empathy has been linked to better outcomes in any area of health care," they argued that "It is both possible and ethically sensible to screen potential providers of addiction treatment services for skilfulness in accurate empathy as an important general factor impacting client outcomes."

Look at chapter 4 ("Recruitment and selection") of the guidance for English substance use services on staff

development listed above. Does it recommend these sorts of assessments? What is the balance to be struck between assessing applicants for appropriate interpersonal skills, assessing for technical competence, and training in either or both?

▸What use is assessment … without some way to act on the results? With admirable simplicity, a US study listed above developed a computerised index of local resources and matched these to the broad range of needs revealed by a substance use service's assessments of its patients. It transformed the assessments from redundant but required paperwork into a practical route to the services seen today as important to holistic and sustainable recovery – and twice as many patients completed treatment. If you work in treatment, do you have such a system, is it easy to use, is it hard for counsellors to ignore, and is it used? If you have no such system, would it work in your service?

This is a rare study of the neglected assessment process – an unfortunate neglect, because research has backed up the common view that assessment is not a just a preparation for treatment, but its start, and the start of building a therapeutic alliance.

▸Should dependent drinkers always be advised to try for abstinence? Hardly a 'bite'-sized issue, its centrality to alcohol dependence and its treatment makes it difficult to ignore and demands comprehensive analysis, so we offer a two-tier introduction. For a more bite-size chunk, read just the paragraphs already showing below. For more, unfold the supplementary text.

Not so long ago the issue was not just whether patients should be *advised* to aim for abstinence, but whether they should be denied treatment until deterioration forced them to accept the need to stop drinking altogether and forever. The debates go back decades, but abstinence has recently returned to prominence as an essential component of influential visions of 'recovery'. Opinions differ, and are strongly held. As for the evidence, we have summed up its implications this way: "Treatment programmes for dependent drinkers should not be predicated on either abstinence or controlled drinking goals but offer both. Nor does the literature offer much support for requiring or imposing goals in the face of the patient's wishes. In general it seems that (perhaps especially after a little time in treatment) patients themselves gravitate towards what for them are feasible and suitable goals, without services having to risk alienating them by insisting on a currently unfavoured goal."

Another reason for not insisting on abstinence is that non-drinking does not always equate to 'recovery', a concept which directs us to value outcomes other than (non-)drinking which reflect the quality of life of the individual and their social integration. Analysed for this cell, a classic paper from the 1960s listed above reminds us that this can mean classifying some abstinent ex-patients as not really recovered; without their favourite sedative and coping mechanism, and the friends and social activities that went with it, most in this study were living an empty and/or unhappy life. However, nothing here is intended to deny that especially among the severely affected drinkers seen at treatment services, abstinence is a common, valued (free source at time of writing) and attainable goal.

As well as by unfolding the supplementary text (or reading essentially the same text in the form of an Effectiveness Bank hot topic), you can explore the controlled drinking controversy through a US account, through a British perspective (turn to chapter four of the book), and through a seminal US study and its sequelae listed above. Of greatest contemporary UK relevance are the findings of a major British study, which as a side issue investigated choice of treatment goal in psychosocial treatment. Bottom line (▸chart) was that patients who did not choose abstinence as their initial treatment goal did about as well as those who did, and both sets of patients more often resolved their dependence while continuing to drink than by stopping altogether. The background notes to our analysis are, we think, particularly informative.

Armed with these sources, reflect on questions such as: Should very heavily dependent drinkers *always* be advised to try for abstinence? Should the goal-setting process model what we want patients to become – *in*dependent and in control of their lives, and by extension of their treatment objectives? Or should we accept that at this stage they are in no position to exercise control over so crucial an issue? Might their decision be an *expression* of their dependence rather than the best way to overcome it? How strongly should the clinician advocate for his or her preference? Would this in any event prove futile, because the patient has the final word? What of less dependent drinkers and/or those with more supports in their

lives? Would recommending abstinence drive them away from treatment? Or is at least a period without drink the best way to break any heavy-drinking habit? Are your answers based on an explicit or implicit understanding of the nature of alcohol dependence? Before you answer, consider unfolding the supplementary text to learn more about the controlled drinking controversy; it's a fascinating story.

Supplementary text Click to close

Why such heat over a seemingly innocuous decision between patient and clinician on what degree of change in drinking to go for? In part it was generated by two opposing concerns. First was the fear that allowing controlled drinking would let alcoholics (assumed constitutionally unable to stop drinking once they start) off the necessary hook of non-drinking and set them up to fail – risking their lives and damaging those of people around them. Opposing this was the concern that while insisting on abstinence did nothing to improve outcomes, it did limit treatment to the minority of problem drinkers prepared to countenance a life without drink. This concern derived partly from the ambition to extend the benefits of intervention to less dependent and non-dependent heavy drinkers. Behind the opposing positions were alternative visions of dependence as a distinct disorder characterised by inevitable loss of control, versus one end of a continuum of learnt behaviour, which even at its most extreme can be replaced by learning to drink in moderation.

Origins of the controversy

Controversy dates back at least to a 1962 report by British psychiatrist D. L. Davies on seven 'alcoholic' patients said to have sustained controlled drinking. Contradicting the findings, a re-appraisal of the study published in 1994 said the patients had deceived a research-naive clinician. Its main source was a 1985 paper documenting interviews with the patients and others and a (re)examination of records, to which the original author (he had died three years before) was unable to respond. Both of the critical papers were by the prestigious figure of Professor Griffith Edwards. Later he was to embrace 'normal' drinking as a goal for many patients, but still maintained that (emphasis added) "abstinence is the *only* feasible objective" for those with a fully developed history of dependence. Among his criteria for identifying which drinkers should attempt which objective were those (see below) trialled by the Sobells in the USA.

The D. L. Davies episode was relatively gentlemanly and limited to professional circles, but the following decade bitter disputes originating with US research literally hit the headlines and spread across TV networks, in one case spawning legal proceedings. Subject of one of the disputes was a report published in 1976 by the Rand Corporation on the US government's new alcohol treatment centres. Findings were that fairly complete remission was the norm, that most patients achieved this without altogether stopping drinking, and that as many resumed normal drinking as sustained abstinence. Aware of the storm their findings might provoke, the authors disavowed any intention to recommend alcoholics resume drinking. Nevertheless the storm broke, as holding out the prospect of controlled drinking was likened to "playing Russian roulette with the lives of human beings". The authors themselves felt the most important implication of their findings was that "the key ingredient in remission may be a client's decision to seek and remain in treatment rather than the specific nature of the treatment received" – an insight revisited decades later on the basis of the findings of another major US study, the Project MATCH trial highlighted in cell A2.

> *Bitter disputes over US controlled drinking research literally hit the headlines and spread across TV networks*

One reason why Rand's authors knew their findings might be controversial was the reaction three years before to one of this cell's seminal studies; it and its sequelae are listed above. Husband and wife team Mark and Linda Sobell had conducted an audacious and, for the time, methodologically advanced experiment, allocating hospitalised physically dependent alcoholics with what generally seemed a poor prognosis either to try for abstinence or for controlled drinking. Patients were allocated to controlled drinking principally on the basis they had asked for this, shown in the past they could manage it, and had a supportive environment to return to on discharge. Within each group allocated to different objectives, half were offered normal abstinence-oriented treatment and half a radical procedure geared to the abstinence or controlled drinking goal to which the patient had been assigned. It entailed allowing patients to drink, showing them via videos how they looked when drunk, and training them how to manage or avoid what for them were situations conducive to drinking or over-consumption.

Over the second half of the follow-up year patients assigned to try for controlled drinking, and who had

been trained in how to manage this, spent nearly three-quarters of the time out of hospital and prison and not drinking heavily, though all but four of the 40 continued to drink, the best results of all the patients. Those given the same treatment but allocated to an abstinence goal did almost as well, but many more did so via not drinking at all.

It seemed a clear vindication of an intervention based on seeing addiction as learnt behaviour and of the judicious allocation of even physically dependent patients to try to learn moderation. Controlled-drinking patients had been selected partly because of their "sincere dissatisfaction with [Alcoholics Anonymous] and with traditional treatment modalities"; the study showed this rejection of US orthodoxy need not condemn them to the progressive deterioration predicted for untreated alcoholics.

But just as with the Davies' research in London, a later follow-up (listed above) of the same patients cast doubt on the validity of the findings; in the *New York Times*, one of its authors publicly alleged scientific fraud. In transparent detail, the Sobells dismantled (document listed above) the refutation, highlighting its fundamental weakness: it did document the fates of patients assigned to and trained in controlled drinking, but failed to benchmark their progress against the other groups. In respect of the most important outcome – supposedly alcohol-related mortality – this omission was clearly critical, because further investigation by the Sobells showed the death record was worse among patients assigned to traditional abstinence-based treatment. The Sobells' integrity was upheld by an investigation by their employers, by one commissioned by a committee of the US Congress, and by a more limited investigation on behalf the US government's drug and alcohol department, and their research was judged fairly presented.

Evidence accumulates and expert opinion converges

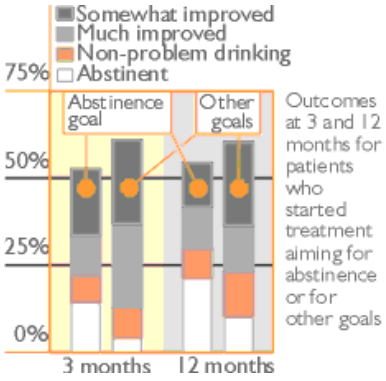
In 1995 in an editorial for the *Addiction* journal, the Sobells revisited the debate they had ignited over two decades earlier. Eight responses published in the same issue of the journal signified its continuing vitality. In their editorial the Sobells accepted that "Recoveries of individuals who have been severely dependent on alcohol predominantly involve abstinence" – possibly, they speculated, not because of the severity of their drinking, but because poor social support and employment prospects tend to accompany more severe dependence. Beyond this minority, they argued that reducing alcohol-related harm across an entire population demanded acceptance of the moderation goal, because many (especially less or non-dependent) drinkers simply will not accept interventions predicated on abstinence.

In 2011, once again the Sobells addressed the controlled drinking issue in an *Addiction* journal editorial. Since their last essay, they said, evidence had accumulated (see this example) that across the full spectrum of alcohol disorders and including people who have not been in treatment, "low-risk drinking outcomes occur and are common". However, due they said to a history of staffing by formerly dependent drinkers steeped in the philosophy of Alcoholics Anonymous, US treatment services had largely ignored the evidence, deterring patients who might have sought treatment if controlled drinking had been on the table.

In support of its arguments, the first editorial had cited a Canadian trial (free source at the time of writing) published in 1984 which had randomly allocated problem drinkers to treatment aiming either for abstinence or for moderation. The main difference between the two was the expressed objective and training in controlled drinking offered later in treatment only to patients allocated to moderation. Most patients seemed to be drinking heavily enough to meet criteria for dependence but had yet to be severely affected by their drinking. Told their allocation during the first session of counselling, 23 of the 35 allocated to an abstinence goal either found it unacceptable or expressed reservations, but were not allowed by the study to switch to moderation. In contrast, just five of the 35 allocated to moderation rejected that endeavour; on ethical grounds, they were allowed to switch to an abstinence goal. During and at the end of treatment, allocation generally had not significantly affected drinking reductions. In the six months after treatment had ended, whatever goal had been impressed on them, most patients in the end had chosen to drink moderately, generally without reporting serious consequences; just 7% allocated to abstinence had actually achieved this goal.

Skipping other important studies in Britain and elsewhere (for which see these background notes) we come more up to date with the UKATT study of psychosocial therapy for 742 patients seeking treatment for alcohol problems at specialist treatment services in England and Wales. Implemented in the late '90s, it remains Britain's largest alcohol treatment trial. In cell A4 we described the main findings: that eight sessions of an extensive, intensive and comprehensive therapy based on enlisting the patient's social network were no more effective overall than three of a more basic motivational approach, and

that neither proved differentially effective for the types of patients expected to particularly suit one or other of the approaches.



Here our interest is in a secondary analysis from UKATT of how patients fared depending on whether they had opted for abstinence as an initial treatment goal. Read our analysis and you will see that regardless of their initial choice, patients did about equally well. Even among those who at first wanted to stop drinking altogether, more later substantially ameliorated their drink-related problems while continuing to drink than did so by abstaining ▸ chart.

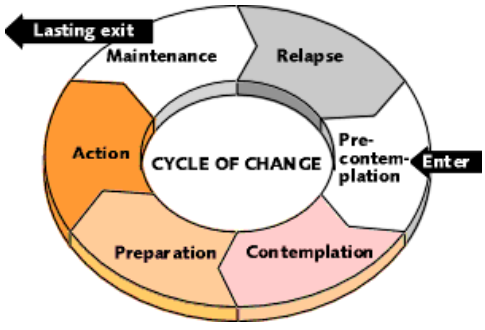
UKATT was among the studies assessed in a review listed above from academics at the University of Amsterdam. Published in 2013 their conclusions were broadly in line with earlier reviews from North America, though perhaps more enthusiastic about embracing moderation as a goal in order to make treatment more palatable for the (in various studies) 20–80% of dependent drinkers who prefer try for reduced-risk drinking. The Dutch review seemed to prefer shared decision-making when selecting a treatment goal, with moderation as well as abstinence on the table, so the patient makes a positive choice rather than being 'told what to do'. Also from the Netherlands, a study showed that shared decision-making can be systematised. In relation to life in general, one result was that patients felt more able to make their own decisions, more in control, and less submissive – possibly portending a more stable shift away from a dependent mind-set than could be achieved by less explicit shared decision-making. However, the lack of studies (document listed above) leaves it an open question whether systematic shared decision-making improves drinking outcomes.

That brings us to what seems mainstream contemporary opinion, enshrined in 2006 in alcohol treatment guidance from England's Department of Health and what was its National Treatment Agency for Substance Misuse. It stressed that goal choice should not exclude drinkers from support or treatment, but did see abstinence as "the preferred goal for many problem drinkers with moderate to severe levels of alcohol dependence, particularly … whose organs have already been severely damaged through alcohol use, and perhaps for those who have previously attempted to moderate … without success". Even for these drinkers, it continued, if abstinence is not acceptable, moderation is better than nothing, and may lead to abstinence. We know from research that no matter how physically dependent, moderation is for some feasible, especially when there are sufficient supports in the patient's life, but the more severe the dependence, the more likely abstinence is to be the suitable strategy. On how the decision should be made, in relation to care planning in general the guidance sees patient choice as not just as an entitlement, but as a strategy which improves the chances that the treatment approach will succeed because "it has been selected and committed to by the individual".

Close supplementary text

▸ **Match interventions to the client's 'stage of change'?** Prochaska and DiClemente's ubiquitous 'stage of change' model seems to offer managers a scientific system all staff can use regardless of therapeutic orientation to decide how to work with patients. It promised a way to avoid wastefully premature change attempts with those not yet ready to change, but without abandoning them. Instead it offered a rationale for nudging them to the next, more receptive stage in the change process, and a methodology for recognising when they become ready to commit to and make the changes needed to overcome their substance use problems. Implicitly or explicitly, in services across the UK this system is used to categorise patients and clarify how to efficiently promote progression to sustained recovery. Its simplicity and face validity are beguiling, but can it really be used to *augment* change by matching patients to interventions, or does it simply *describe* one type of change process?

Analysed in an Effectiveness Bank review (listed above) and one of our hot topics, the model portrays motivational transition as a fixed, segmented sequence leading from 'Problem not even acknowledged' through to 'Problem overcome.' In between are stages where change is pondered, prepared for, implemented and stabilised. Among its attractions is the feeling that one has gained insight in to something important and technical and scientifically valid, yet which accords with common sense understandings. For



example, it seems self-evident that it is futile to try to close the deal on a change plan if the client has yet to see the need for change, and that overcoming dependent substance use is no quick fix, but sequentially requires awareness, thought, preparation, implementation and stabilisation, each stage of which must be completed to provide a foundation on which the next can build with a chance of success.

The model amounts to a broad guide to what (not) to do with patients at different stages of change. If it truly gets to the heart of the change process, then interventions built on the model ought to improve on those which are not. It is at this crunch point, when it actively engages with change through treatment, that research support is almost entirely lacking. That is true not just of drug and alcohol problems and of smoking, but of therapy for psychological problems in general. Read our review and you will understand why the American Psychological Association could only say matching interventions to stage of change was "probably effective" – and even "probably" seems optimistic. The model has, however, been very widely applied, and in some other fields (promoting exercise seems an example) it is better supported.

Whether the model can actually promote change is the key practical issue, but at a theoretical level, it faces a more fundamental challenge from accounts of precipitous, unplanned transitions to abstinence which defy the requirement to pass through the stages; for more on this instructive phenomenon, unfold the supplementary text.

Supplementary text Click to close

Precipitous, unplanned change (typically from excess to abstinence) seems common, and the changes are often enduring, yet these events defy the requirement to pass through the stages presupposed by the cycle of change model. There can also seem no sign of the model's change mechanisms – the expected process of the user re-evaluating the pros and cons of continuing as they are, until so decisively do the cons outweigh the pros that with sufficient confidence in their ability to change ('self-efficacy') along with other burgeoning 'processes of change', the decision is made, and plans are laid and then carried out and sustained.

When this process *is* intentional, the model offers a detailed and possibly valid description. But what of when a smoker suddenly becomes disgusted with their smoking, spits out the cigarette half way through, dumps the remnants of the packet in a bin, and never turns back, as if something had *overtaken* them, rather than them intentionally deciding to change? Intentional change is not the only or it seems the most robust way people initiate change. For smoking in particular, it may be a minority route, one half as likely to 'stick' as planned attempts. Similarly, in California a survey of problem drinkers found that weighing up the pros and cons of drinking as a reason for cutting down was much less likely to lead to lasting remission than 'conversion' experiences like hitting rock bottom, a traumatic event, or experiencing a religious or spiritual awakening.

Unplanned and famously successful drinking cessation events have been documented (free source at time of writing) by recovery analyst and advocate William White. They include that of Bill Wilson, who went on to co-found Alcoholics Anonymous. Hospitalised for alcohol detoxification for the fourth time, "he cried, 'If there is a God, let Him show Himself!', the room became ablaze with light and Wilson was overwhelmed by a Presence and a vision of being at the summit of a mountain where a spirit wind blew through him, leaving the thought, 'You are a free man.' Wilson never took another drink." In less florid manifestations, that also seems a common kind of experience among dependent drinker in treatment in Britain. In the UK Alcohol Treatment Trial (UKATT), asked what they thought had helped them overcome their dependence on drink, patients commonly described revelatory moments which precipitated wholesale transitions in how they saw drinking and drink, in turn transforming their determination to change. As with smoking, in these situations half-finished bottles can simply be poured down the sink or thrown away in disgust.

That doesn't mean to say unplanned abandonment of substance use is without its causes and happens entirely out of the blue; for example, at the time the desperate Bill Wilson had become ripe a revelatory experience. But whatever led to this brink, at the moment of change immediate causes take the form of triggers which *precipitate* abstinence, rather than a more cold-blooded weighing up of the pros and cons. A UK survey which confirmed that unplanned stop-smoking attempts were twice as likely to succeed as planned, also discovered that unplanned attempts were commonly triggered by health advice/concerns, expense, and pressure from family/friends, though one in six respondents could cite no particular reason.

Close supplementary text

Despite its limitations, there may still be reasons why the cycle of change model remains valuable, though perhaps not in its intended role of helping match interventions to stage of change. Look at the last

paragraph of the Effectiveness Bank review. The author, a cogent critic, nevertheless finds many ways in which the model might be a positive influence – a kind of benevolent fiction which gives hope to and motivates both worker and client. Is this enough? Or in the end, should we let science consign this popular prop to the 'unproven' shelf of history?

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