


DRUG & ALCOHOL FINDINGS *Matrix cell*



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Drug Treatment Matrix cell E4: Treatment systems; Psychosocial therapies

One of 25 cells in the [Drug Treatment Matrix](#)

K [Forging inter-service links in US states](#) (2012). Implementing psychosocial approaches to promoting patient transition between services involved inter-organisational and operational analyses that forged stronger service networks and identified gaps in the continuum of care. Siting case managers at detoxification services [has been](#) (2006) one successful linkage tactic, discussed in [cell E3's bite](#).

K [De-individualisation forced by cost-containment associated with worse treatment outcomes](#) (2008). Advanced US analysis of comprehensive data from a national treatment study found substance use outcomes were relatively poor after treatment at centres constrained by funders in the services they could offer and in their ability to individualise treatment, but relatively good in services subject to quality accreditation.

K [Active referral significantly promotes NA/AA attendance in UK but not abstinence](#) (2012). Tests the ambition to extend recovery beyond formal treatment by systematically linking patients to mutual aid groups. Being encouraged by a doctor or peer (especially the latter) substantially improved attendance at 12-step groups, but impacts on abstinence were much smaller and not statistically significant. Corresponding [US study](#) below. For discussion [click](#) and scroll down to highlighted heading.

K [In USA active and persistent attempts to link patients to mutual aid groups helps reduce substance use](#) (2007). Among patients treated by the US medical service for ex-military personnel (the Veterans Affairs Health Care System), persistent and practical efforts strengthened 12-step group involvement after treatment and modestly improved substance use outcomes. Corresponding [British study](#) above. For discussion [click](#) and scroll down to highlighted heading.

K [Determining who needs residential care](#) (2001). US study's criteria and the methods used to develop them offer a way to reserve residential rehabilitation for those who need it, improving treatment completion rates for both residential and non-residential options. For discussion [click](#) and scroll down to highlighted heading.

R [Ways to continue to care for patients](#) (2011). Psychosocial strategies to help ensure patients who need it receive long-term care or aftercare. Discussion in [cell D2's bite](#).

R [Peer-based recovery support services](#) (2009). Compendious review of interest (among others) to service planners and commissioners interested in improving linkage to mutual aid groups and other peer-based recovery-support resources. Also reviews literature on peer-based support itself. For discussion [click](#) and scroll down to highlighted heading.

R [Varieties and impacts of case management](#) (2006). An expert Euro-US collaboration examines the most common mechanism for transforming isolated treatment episodes into coherently staged and comprehensive recovery programmes – the appointment of a 'case manager' who remains a stable hub orchestrating service delivery. See related [US guidance](#) below.

R [Severe cases differentially benefit from residential care](#) (2003). Notes from Drug and Alcohol Findings on studies comparing residential with non-residential treatment. Concludes that for patients who accept and can safely be sent to either, on average there is little to choose between them. Severe cases may however differentially benefit from residential care. See also a [review](#) (2006) limited to randomised trials of therapeutic communities. For discussion [click](#) and scroll down to highlighted heading.

G [Guidance for England on commissioning for recovery](#) ([UK] National Treatment Agency for Substance Misuse, 2010). Includes recommended psychosocial services and linkages to mutual aid networks. For discussion [click](#) and scroll down to highlighted heading.

 [NICE-recommended psychosocial interventions](#) ([UK] National Institute for Health and Care Excellence [NICE], 2007). UK's official health advisory body recommends contingency management, couples therapy and facilitating contact with mutual aid groups, and says residential treatment should be reserved for severe and complex cases not

helped by non-residential care. Implementation guidance [below](#). For discussions click [here](#) and [here](#) and scroll down to highlighted headings.

G [Implementing NICE-recommended psychosocial interventions](#) ([UK] National Treatment Agency for Substance Misuse, 2010). Commissioned by England's National Treatment Agency from the British Psychological Society. Building on the psychosocial interventions recommended (see [above](#)) by the UK's health service improvement authority, offers a framework for planning these interventions, commissioning them, developing required skills, and auditing provision.

G [Coordinating services to meet individual needs](#) ([UK] National Treatment Agency for Substance Misuse, 2006). Guidance on care planning and care coordination ("the processes that need to be in place to ensure that drug treatment [and other services] work together effectively to meet service users' individual needs") based on the good practice identified in a national review of the performance of treatment commissioning bodies in England. See also [slightly earlier guidance](#) ([UK] National Treatment Agency for Substance Misuse, 2006) on care planning from the same body.

G [Integrated care for drug and alcohol users](#) (Report Produced for the Scottish Advisory Committee on Drug Misuse, 2008). Treatment system guidance for Scotland.

G [Organising holistic and continuing care](#) ([US] Substance Abuse and Mental Health Services Administration, 1998). US consensus guidance on case management to orchestrate the range of services often needed to promote lasting and multi-faceted recovery. Related [review](#) above.

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What is this cell about? The roles of the ‘psychosocial’ therapies introduced in [cell A4](#) in building a cost-effective mix of services across an administrative area which offers problem drug users attractive access points and appropriate options for moving between services or using them in parallel.

Creating a local treatment system involves commissioning, contracting and purchasing decisions to meet local needs in the context of resource constraints and national policy. At this level, research is rarely of the ‘gold standard’ randomised-controlled-trial format. Unlike intervention programmes, whole treatment systems are not easily manipulated by researchers based on the equivalent of a toss of a coin, leaving us largely reliant on studies of how things work out naturally. These have to try to adjust for the multiple influences and differences between areas which obscure the impacts of the features researchers are attempting to assess. Such studies will often include but not focus on psychosocial services, making the [corresponding cell](#) on treatment systems as a whole also of relevance.

Where should I start? [Listed above](#), William White’s [monograph](#) on peer-based recovery support through mutual aid groups and other resources is comprehensively researched and cogently argued. Its importance is that these low-cost or free resources [seem the only feasible way](#) to square the circle of doing more with less – reconciling [dramatically reduced funding](#) with [the ambition](#) to bring more patients to the point where they can achieve wide-ranging, whole-life recovery and leave treatment, yet avoid relapse with its associated risks to lives and health and of a return to crime. Apart from cost, peer support’s virtues include potentially life-long support available 24 hours a day, and possibly too self-empowerment not naturally promoted by the roles of ‘patient’ or ‘client’.

The monograph comes from (see his [collected writings](#)) someone who more than any other has promoted the recovery movement and provided its scholarly underpinnings, helping contextualise treatment as often merely the first step to the prolonged “recovery maintenance” [advocated](#) by a US expert who advised Public Health England on addiction treatment. In this vision, the focus shifts to systems around the clinic within which the patient must eventually reshape their life in community with others who have done or are trying to do the same, secured by ties to family, community, and work. Peer-based support is an essential element within these (to use William White’s terminology) “[recovery-oriented systems of care](#)”.

In a more modest and selective way, [below](#) we look at the evidence on mutual aid as an aftercare resource, and in a [hot topic](#) essay also as a route to recovery in its own right.

Highlighted study As outlined [above](#), mutual aid has the potential to help bridge the gap between diminished treatment resources and enlarged recovery expectations. In evidencing whether this potential can be realised, much has been built on a [US study listed above](#) which showed that if they intensify and structure this attempt, services can improve outcomes by steering patients towards continuing support from mutual aid groups. Later there was a corresponding [UK study](#) (also [listed above](#)), but its limitations leave the US study as still the major source of evidence – the reason for choosing it as our *Highlighted study*.

Based on six-month outcomes, it was the only study cited by the UK’s health service intervention assessors which could [directly](#) support NICE’s [recommendation](#) that for patients who have expressed an interest, “staff should consider facilitating ... initial contact with the [12-step] group, for example by making the appointment, arranging transport, accompanying him or her to the first session and dealing with any concerns”. Similarly, national [commissioning guidance listed above](#) advised that treatment should be coupled with “ongoing mutual aid support”. Check whether the evidence for these recommendations stacks up by [unfolding](#) and working through the supplementary text.



Taken as a whole, studies support provision of a range of aftercare options, permitting a more

individualised offer to patients than a focus on mutual aid only or service-based aftercare only. If the default option is mutual aid, though some patients will benefit, even extensive attempts to encourage attendance will generate at best modest impacts across a caseload. When groups are abstinence-based, such efforts may lead more patients to recover via abstinence, but sometimes only instead of non-abstinent routes.

Though that seems as far as the evidence can take us, absence of strong evidence for 'x' does not mean, 'Do not offer x,' – it just means it has yet to be *proved* that it should be offered. Even without strong positive evidence, if 'x' makes sense, costs little, may help some, and is unlikely to harm others, that may be considered enough to place it on the intervention menu. Referral to 12-step groups seems to fit these criteria, *as long as* it is not pursued to the exclusion of other options which suit some patients better, and as long as unsuitable patients and groups are not pressured into contact. Given what we know from everyday life and from studies of coerced AA attendance [reviewed](#) in the Alcohol Treatment Matrix, it would be extraordinary if 12-step social support failed to help some people, and extraordinary too if foisting the same resource on unsuitable people was not counterproductive.

Issues to consider and discuss

► **How much should be left to services?** What should commissioners specify in their tenders and agreements with services, and what should they leave to clinical staff in the services? That is an issue for treatment of any kind, but is most pertinent for psychosocial therapies. Medications have to be adjusted to the individual and the situation, but regulatory authorities and pharmaceutical companies set clear expectations about what conditions and types of patients the drugs are for, there are protocols for induction, dosing and treatment termination, and documented effects and side effects. Qualified and professionally regulated experts in the form of doctors and pharmacists interpret these guidelines, and unqualified personnel are not allowed to supply prescription-only medications.

Counselling and psychosocial therapies also have regulators, professional bodies which set quality and ethical standards, some ways of treating clients are considered unacceptable, and guidelines call for approaches to be well-structured, monitored, and supervised. But in practice, unsystematic and obscurely founded variations in practice [may be the rule](#). When it comes to the rights and wrongs of working with a particular individual, beyond the generalities of the 'common factors' introduced in [cell A4's bite](#) (and qualities like empathy are hard to contractually require) there seem few rules which should not [sometimes be broken](#). It is [not even the case](#) ([free source](#) at time of writing) that qualified 'experts' do better on average than 'counsellors by experience'.

In this environment, commissioners who leave it all to the service risk the quality of the interventions for which they are responsible. Services could legally use unqualified counsellors and therapists and deliver programmes which might be recognised therapies, but also might be idiosyncratic or simply those which appeal to the manager or the therapist. The consequence could be that patients are short-changed and do less well than they might, though that is hard to predict; under-dosing a medication or [substituting a placebo](#) may predictably worsen outcomes, but corresponding statements [cannot be upheld](#) for psychosocial therapies. Nevertheless, commissioners are on safer ground if they specify that the services they commission must employ personnel with stipulated qualifications to deliver certain specified, accepted and research-validated interventions.

That strategy does, however, raise an alternative risk – that if commissioners specify too tightly or on inappropriate dimensions, they may counterproductively limit the service's responsiveness to the needs and preferences of individual patients. One way out is to specify (and pay for) only the required outcomes and leave most of how they get to those outcomes to the service – but this strategy is itself [largely unevicenced](#), and what evidence we have from the UK substance misuse sector is not encouraging.

Leave it to the service and risk quality, or tie the service down to the tried and tested?



Where do you stand on this dilemma? Leave it to the service and risk idiosyncratic interventions from unsuitable personnel, or tie the service down to the tried and tested and risk de-individualisation and discouraging innovation?

► **Who needs residential care?** That may seem a straightforward question tailor-made for a scientifically objective answer; you will have guessed that is not the case. Nevertheless, there is some science to inform those answers, notably a [US study listed above](#) which developed a ‘decision-tree’ indicating who is likely to benefit most from a therapeutic community programme offered on a residential versus a non-residential basis. It was one of the few studies not just to record who benefits most, but to have tested how this information might be used to guide placements.

Check [our analysis](#) and you will see that first the protocol excluded patients who must be allocated to one of the settings on practical or safety grounds, then chose residential care for patients least likely to be able to sustain their recovery due to their past record and their lack of critical elements of what today we call ‘recovery capital’. The upshot was that patients were 60% more likely to have been retained in or completed treatment if they were matched to settings according to these criteria than if they were not. This matching effect was seen in those allocated to non-residential as well as residential care; in other words, residential care was not *universally* preferable. Note that in this study the protocol would have allocated 8 in 10 patients to residential care, perhaps unrealistic on resource grounds.

For more research turn to an informal [Findings review](#) comparing outcomes from residential and non-residential care, and a [highly formal review](#) which did the same (and more), but specifically in relation to residential therapeutic communities. Both are listed above ([1](#) [2](#)). The former gained in breadth what it lacked in rigour. The latter suffered from a dearth of data due to selecting only the methodologically strongest form of studies – randomised trials.

Despite being seen as the best way to establish whether an intervention has an effect, randomised trials too have limitations. In this case, they had to restrict themselves to patients who could safely and practically be allocated at random to either residential or non-residential treatment. Nevertheless, across the reviewed studies over half the patients did not start their allotted treatments, being considered unsuitable by the service or failing to attend. As well as undermining the studies, when the settings are so different and require such different forms of commitment from the patients, this degree of attrition seems a sign that sometimes it is not feasible to decide who goes where by a virtual flip of a coin. It was one of the reasons why the formal review was unable to conclude anything much, leaving no convincing reason to deploy the more expensive residential setting as a frontline alternative to non-residential care.

Residential settings seem to help extricate residents from particularly damaging environments

Prepared to walk on shakier ground, the [Findings review](#) got further, but at the cost of not being able to be definite in its conclusions due to the methodological limitations of the research. These conclusions were that residential settings seem to help extricate residents from particularly damaging environments, but also that the added benefits can fade after

discharge back to those environments. In some studies people at risk of suicide and those with relatively severe psychiatric problems, perhaps combined with severe employment or family problems, particularly benefited from residential settings, supporting the common belief that these differentially benefit more severely dependent clients whose care is complicated by multiple problems and disadvantages.

So much for the uncertain science; what of other considerations like policy and cost? Faced with what they saw as cost-driven cutbacks, providers of residential care in the UK [joined forces](#) to oppose what was characterised as the drastic under-use of their services. In badging themselves providers of “full recovery”, they decisively entered the contested territory (explored in [cell A2’s bite](#)) of just what recovery is – let alone how the ‘full’ version differs from any other.



Their ambition for a more frontline status for residential care was flatly contradicted by heavyweight

and unambiguous [guidance](#) from NICE, the UK's authority on evidence-based ways to improve health and social care. [Listed above](#), NICE's experts advised that residential treatment be reserved for substance users with "significant comorbid physical, mental health or social (for example, housing) problems", who should also have "not benefited from previous community-based psychosocial treatment".

That in practice cost is as much a consideration as the prospective resident's potential to benefit was apparent in a [report](#) on drug misuse in the UK in 2016 submitted to the European Union by Public Health England on behalf of the governments of the United Kingdom. It noted that the average cost to local authorities of a spell in residential rehabilitation was £7,750: "As such, clients accessing rehabilitation will usually be required to meet certain admission criteria, including: being abstinent from drugs and alcohol following detoxification; a commitment to becoming substance free; a desire to leave treatment; and having been assessed as capable of achieving abstinence and being prepared to do so. Clients are usually also required to complete a period of community treatment prior to rehabilitation and may return to community services for further support" (emphasis added).

The implication is that even the highly vulnerable cases referred to residential services must first have tried and done poorly in non-residential options, perhaps risking life-threatening relapse and an extended addiction career which might have ended sooner. Critics of NICE's 'last resort' position argue that the reason why treatment patients are often in poor mental, physical and social condition, is that residential rehabilitation had been denied them earlier in their drug using careers, when they had a greater chance of succeeding before the deterioration went too far. An opposing argument is that at the level of an individual, predicting for whom non-residential care will fail is such an imprecise science that 'suck it and see' is the only realistic strategy. If non-residential care would have been suitable and effective, to instead try residential services first incurs unnecessary expenditure, draining the resources available for other patients.

Even highly vulnerable cases must first have tried and done poorly in non-residential options

In practice, according to [an analysis](#) for what was England's national addiction treatment authority, residential rehabilitation is very rarely used, and rather than 'full recovery', a spell in 'rehab' ends for 7 in 10 with drop-out from treatment or the need for further treatment. But perhaps that is due to last-resort policies reserving residential rehabilitation for the most needy clients – and perhaps too, if half these very severe cases have later been able to leave treatment and be signed off as no longer dependent, that is a good record. Set against this is that while referrers to residential rehabilitation might select for severity, they are also meant to select (perhaps because of the hurdles clients have to surmount to get funded) the most highly motivated drug users prepared to do what it takes to get placed away from home and out of reach of drugs.

Now perhaps you see more clearly why – as with the opposite treatment pole, [methadone maintenance](#) – science can only inform, not decide these issues. Think through the origins of your feelings about what the role of residential care should be; how much does your stance on its appropriate extent and targeting rely on research, how much on experience, how much on affection for one or other type of service, how much on values – and how much on cost?



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