DRUG & ALCOHOL FINDINGS Hot topic

Below is one of our selection of Hot Topics, important issues which sometimes generate heated debate over the facts or their interpretation. Click the **GO** button or the Blue title to trigger a customised search for relevant FINDINGS documents. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text.

GO The therapeutic potential of patients and clients

Focus here is on gathering together examples of the many ways problem drug users and drinkers contribute to their own treatment and recovery and that of others, and among injectors in particular, help reduce substance-related harm. But before turning to specifics, we should acknowledge the argument that even if no specific steps are taken to involve them, still treatment and harm reduction are in essence something the client or patient *does* rather than something done to them – that treatment, medications and needles and syringes, are not things they just receive, but things they *make use of*.

Patients do it for themselves

Across psychotherapy the client's contribution to their own improvement was the theme of the book, *How Clients Make Therapy Work: The Process of Active Self-healing*, published by the American Psychological Association. For therapists there was a clear, overriding message: "The single most important thing ... is clients' involvement and investment in the process. Involved clients will frequently be able to use whatever approach to therapy is being offered them. It follows that the most important thing for the therapist to do is to facilitate, support, and help develop client involvement." The radical implication is that it is not your skills in cognitive-behavioural therapy, motivational interviewing or some other therapy which count, but how well you promote the client's engagement in their process of getting better.

That argument was explored in our Alcohol Treatment Matrix, where we told the story of how researchers responsible for Project MATCH, the most sophisticated attempt to differentiate the impacts of distinct therapies ever seen in the alcohol treatment field, ended up prioritising not how therapies differed, but what they had in common – most of all, what the patients brought to treatment. Turning the thesis of the study on its head, they came to see treatment's role as primarily to offer a "culturally appropriate solution to a socially defined problem" – not a 'technical fix' which works regardless of the patient, but a door through which they can pass to actualise their impetus to get better.

Such a perspective helps explain why in this study patients who did not return for therapy did almost as well as those who attended all 12 sessions of the longer therapies, and that how much patients wanted to change and were ready to do so beforehand was strongly and lastingly linked to how well they did.

It also helps explain why in other studies (1 2 3) patients achieved most of the improvements they would make after deciding to enter treatment, but before it had started. So-called 'Dodo Bird' findings that different treatments usually have more or less equivalent effects also make sense if we believe the patient rather than the treatment is the main active ingredient. An early exemplar was the surprising outcome of a seminal British study from the 1970s. It discovered that its sample of male alcoholics did as well after a single session which put the onus for improvement on them as after fully fledged treatment spanning many weeks. It seems that for some and perhaps for many (but not all) patients, by the time they have decided they have a problem and have started to do something about it, most of the therapeutic work has already been done.

Resource constraints turn spotlight on mutual aid

Such thoughts are not, however, why from the late 2000s the (ex)problem substance user's contribution started to be forefronted in the UK, but the more prosaic issue of the prospect or actuality of dwindling resources. Hard times turned thoughts to ways to make what resources were left go further by getting people out the other end of treatment rather than keeping them in, an imperative which found a more attractive expression in the recovery agenda with its emphasis on the social and occupational reintegration needed to avoid life-threatening relapse. Whether it works this way or not, mutual aid seems to offer a way to safely free up treatment slots by promoting stable recovery and providing 24/7 aftercare support to discharged patients, services unaffordable on a professional basis.

From this perspective, it is no surprise that in 2010 mutual aid groups featured in commissioning guidance from England's National Treatment Agency for Substance Misuse, nor that the agency's final annual plans (2009–10; 2010–11; 2011–12; 2012–13) before its absorption into Public Health England saw promoting mutual aid networks as a key way to achieve its objectives. In the Public Health England era the emphasis remained in the form of a suite of documents (1 2 3 4 5 6) encouraging and offering guidance for commissioners and treatment services on helping patients make the most of mutual aid. The message got through to commissioners and was reflected in local treatment strategies.

> *Resource limitations and the need to free treatment slots escalated interest in peer-based initiatives*

Resource limitations and the need to free treatment slots may have escalated support for peer-based initiatives, but these have been around for much longer and for different reasons, appealing for their empowering philosophical foundations and their promise to create a more recovery-friendly environment outside as well as inside treatment. Plans for England formulated by the National Treatment Agency for Substance Misuse saw former problem drug users becoming visible symbols of the reality of recovery, and active in making it more of a reality by becoming 'recovery champions', participating in local recovery networks and mutual aid organisations, and offering current problem users support to overcome their problems, reintegrate into mainstream society, and sustain recovery.

In Scotland the Scottish Drugs Recovery Consortium has declared that "Mutual-aid fellowships and other recovery self-help organisations ... are spreading across Scotland. Addiction treatment providers are steadily building more recovery pathways that connect people in treatment with local self-help and mutual-aid groups ... People in recovery are increasingly involved in 'giving something back' to the communities and families that have suffered from the effects of addiction." This independent charity funded by the Scottish Government was seen by a watchdog monitoring the national drugs strategy as a sign of the government's commitment to its recovery-oriented agenda, though evidence

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that it was really making a difference was as yet insufficient, including evidence of the promotion of peer support and mutual aid.

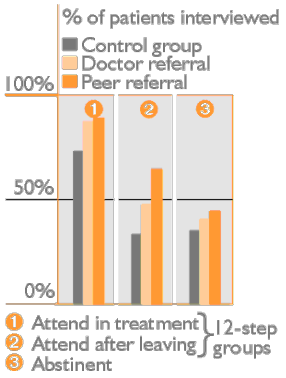
User involvement in services

Mutual aid is not the only guise in which current or former problem substance users contribute to other people's recovery. In various roles, they also help as peer supporters paid by services or working as volunteers. An expert group from England has explained that mutual aid entails "people coming together as equals to share stories and offer support. Peer support is typically about relationships between individuals who are not 'equal' – inherent in the concept is the notion of a role model whose progress in recovery is inspirational and provides a platform from which to help others less advanced in their recovery journeys." There is a difference too in the origins and ownership of these resources: "mutual aid tends to emerge from user-led structures outside formal treatment, whereas peer support may be encouraged and commissioned by those treatment agencies".

User involvement is not limited to treatment services. For as long as there have been needle exchanges, so too have current and former drug users been at the forefront of providing a harm reduction safety net. Now they have a new role in being equipped and trained to administer naloxone to prevent opiate overdoses becoming fatal, though in some areas progress has been slow in recruiting people who may feel they have left drug use and users behind.

One of the key peer support roles for those who have been there and done it and emerged with a better life is to advocate on behalf of patients and clients still grappling with treatment systems. But this role is not universally accepted as a 'good thing', and in practice in both England and Scotland provision is limited and patchy, as commissioners muddle through with a variety of informal and ad hoc arrangements.

To progress practice, in 2015 the treatment services which form the Substance Misuse Skills Consortium produced a *Peer Support Toolkit* offering practice examples, guidance and resources to peer supporters and their managers, a sign of the importance the UK drug misuse treatment field attaches to this source of support. At a strategic level Public Health England has also contributed in the form of guide for commissioners, providers and service users on service user involvement.



Though almost universally advocated, evidence of the contribution of (ex)substance using 'peers' to the treatment and recovery of others is surprisingly thin because so few high-quality studies have been done, but it is not entirely absent. One of the few studies to equalise other factors by randomly allocating patients was a British trial which found that being systematically encouraged to attend 12-step groups after detoxification substantially improved attendance, especially when encouragement came from an active member of these groups rather than a doctor ▸ chart.

Indirectly relevant is a small British study of eight drug workers and 58 clients recruited at a charity working with problem drug users who were also socially excluded. The workers completed a questionnaire to elicit their personal values and this was related to an assessment of client outcomes. Workers who (like we can guess, many of their clients) prioritised stimulation and hedonism and were prepared to contravene social norms – people more open to experience and change – recorded the greatest improvements in their clients. The study's findings were reminiscent of a US study of ex-addict methadone counsellors published in 1974, which found that rather than the 'perfect' profile of a stable, psychologically healthy therapist, "deviant" personalities who shared the insecurities and edginess of their patients and had a suspicious outlook on life had patients who engaged better and used drugs less. Our commentary on the British study cites other findings which seem to suggest that workers whose values and preferences deviate from the norm in the same direction as those of their drugtaking clients are most able to help them, but also cautions that this speculation is tentative; the findings are subject to alternative explanations and reliance on them is weakened by methodological concerns.

Patients as collaborators in their own treatment

As well as peer support, Public Health England's guide describes how service users can, should and have been involved in their own treatment and in the strategic development and commissioning of treatment services.

User involvement in their own treatment is partly driven by broader developments in health and social care aimed at engaging the client or patient as co-producer of their own care plan. Although considered appealing for their empowering, non-patronising stance, within addiction treatment such initiatives have a small evidence base to back them. Among the studies is a British trial which found that when opiate-dependent patients *chose* lofexidine as their detoxification medication, they did as well as patients who chose buprenorphine, but when allocated to lofexidine by the researchers, they did considerably worse. When buprenorphine/naloxone is being prescribed on a maintenance basis, even the rather tricky start of treatment can for many patients be left for them to complete at home, rather than all doses for all patients having to be supervised and adjusted at the clinic. Another simple way to give patients control is to let them set their own dose of substitute drugs like methadone, a tactic successfully tried several times in the treatment of heroin addiction.

Choice of drinking goal – abstinence or moderation – has for decades been a controversial issue. The fascinating history is outlined in another hot topic. Findings from a major UK study and from most others support arguments that treatment programmes for dependent drinkers should not be predicated on *either* abstinence or controlled drinking goals, but offer both and facilitate an informed choice. In general it seems that (perhaps especially after a little time in treatment) patients gravitate towards what for them are feasible and suitable goals, without services having to risk alienating them by insisting on a currently unfavoured goal.

Involvement is, however, just that, not solo decision-making by the patient, who may have come to treatment precisely because they are looking for expert guidance. Across psychotherapy, the evidence is strongly in favour of patients and therapists collaboratively agreeing goals and how they will go about reaching them, and underscores the centrality of incorporating patient preferences when making treatment decisions.

The ferment around peer-based initiatives and mutual aid is palpable, but scientific evidence for its impact hard to come by. Running this customised hot topic search delivers at one click all our analyses of research on peer support, mutual aid and user involvement.

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