DRUG & ALCOHOL FINDINGS *Matrix cell*

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Alcohol Treatment Matrix cell C3

Management/supervision; Medical treatment

Seminal and key studies on the impact of management on medical interventions and treatment for problem drinking in medical settings. Asks how we can identify effective clinicians and effective medications, and highlights the remarkable transformation brought about in the 1950s at a US clinic which few referred patients attended and fewer still engaged with.

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

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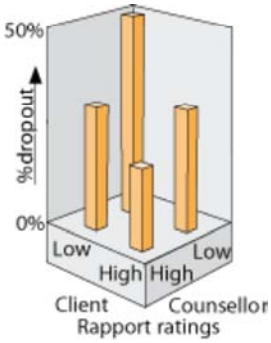
S Impact of training depends on workplace support and experience (1980). English study found that if post-training experience in working with problem drinkers and support from experienced colleagues were lacking, six months later the trainees (mainly from specialist alcohol services) were barely more committed to and confident about working with drinkers than before being trained.

S Listening management transforms alcohol clinic (1970). Remarkable series of US studies from the late 1950s proved that an alcohol clinic's intake and attendance can be transformed by a management which listens to the patients and systematically ensures they are treated with warmth and respect. More in presentation which ends by focusing on the studies. For discussion click and scroll down to highlighted heading.

S Some counsellors inspire retention, others rapid drop-out (1976). Turning the spotlight on recruitment, at a US alcohol treatment clinic trainee counsellors differed greatly in patient retention. Neither experience of alcoholism treatment nor further on-the-job training greatly affected performance. Related study below. For related discussion click and scroll down to highlighted heading.

S Written test for therapy-related social skills helps identify effective counsellors (1981). US study in a hospital alcohol clinic used a simple written method to score the therapy-related social skills of counsellors, which were strongly related to how many of their patients relapsed after treatment. Replication study below. For discussion click and scroll down to highlighted heading.

K How to identify rapport- and retention- generating counsellors (2002). Replication at a Finnish outpatient alcohol clinic of US study above, which used the same system to identify counsellors who would generate the mutual client–counsellor rapport associated with retention in treatment ▸chart. For discussion click and scroll down to highlighted heading.



K Trainees already best at client-centred counselling gain most from training (2004). Highlighting the importance of staff recruitment, US study at a medical centre's addictions programme suggests that recruiting the 'right' clinicians who have not been trained in motivational interviewing would be better than choosing the 'wrong' ones who have been, and the former gain most from training. Simple indices of experience and qualifications did not identify proficient clinicians. Related study above. For related discussion click and scroll down to highlighted heading.

K Practice (and coaching) makes perfect; motivational counselling in primary care (2015). Focused on smoking cessation, a half-day workshop was not enough to develop the motivational interviewing skills of primary care doctors, nurses and pharmacists. Skills were sustained and improved only when the workshop was bolstered by expert coaching based on practice with simulated patients. These findings from a randomised trial are in line with those for therapists and counsellors discussed in cell C4. Related study above.

K Stepping up intensity of care spends more without improving outcomes (1999). From Canada the first evaluation of 'stepped care' for heavy drinkers found no added benefit from offering further treatment to patients who did not respond to initial therapy, but the study was not a definitive refutation of this potentially cost-saving strategy. Related guidelines below. For discussion click and scroll down to highlighted heading.

K Group-based medication management gives more patients the chance to benefit (2013; free source at time of writing). Common in psychosocial therapy, a US treatment centre extended the group format to medication-based treatment for alcohol dependence, considering, reviewing and adjusting medication and discussing treatment issues with other patients also taking or considering pharmacotherapy. Results included slashed waiting times and a threefold increase in patients on medication due to more starting treatment.

R Strategies for incorporating evidence into practice ([Australian] National Centre for Education and Training on

Addiction, 2008). Lessons from health promotion and medical care on how to improve addiction treatment practice by introducing research-based innovations, including common medical education and training strategies.

R Worth training clinicians in motivational interviewing (2013; free source at time of writing). Across medical care, clinicians who adopt a motivational interviewing style achieve significantly better outcomes than those who offer usual care, and training clinicians in motivational interviewing improves (2013) their skills, especially when reinforced by supervision or coaching based on feedback on trainees' actual performance. For related discussion click and scroll down to highlighted heading.

G Roles and benefits of employing nurses in specialist substance use treatment services (Public Health England and [UK] Royal College of Nursing, 2017). Describes the potential roles of nurses in alcohol and drug treatment in England. Aims to to help commissioners and providers of specialist services recruit the right workforce and maintain and develop their competence.

G What managers should expect of doctors caring for substance users ([UK] Royal College of Psychiatrists and Royal College of General Practitioners, 2012). Guidance from UK professional associations for GPs and for psychiatrists on the competencies, training and qualifications expected of doctors involved in caring for substance users, from generalists to addiction specialists. Other UK (Public Health England, [UK] Royal College of Psychiatrists, Royal College of General Practitioners, 2014) and US ([US] American Society of Addiction Medicine, 2014) guides focus on specialists.

G Staff development toolkit ([UK] National Treatment Agency for Substance Misuse, 2003). Workforce development guidance for managers in drug and alcohol services from what was the special health authority responsible for promoting addiction treatment in England, now absorbed into Public Health England.

G NICE advises stepped care ([UK] National Institute for Health and Clinical Excellence, 2011). Britain's official health intervention assessor endorses trying the least intensive potentially appropriate treatment and only 'stepping up' to more intensive and costly approaches if the initial attempt fails. Related evaluation above. For discussion click and scroll down to highlighted heading.

G K Failings of detoxification procedures in the independent sector ([UK] Care Quality Commission, 2017). Official regulator of health and adult social care in England sums up results of inspections of services offering residential care to people undergoing detoxification from drugs and alcohol, often preparatory to residential rehabilitation. Poor management was a major underlying cause of the failings which risked safety and effectiveness at almost two-thirds of services. Flip side of the failings constitute good practice recommendations.

G How to assess the performance of specialist doctors ([US] American Society of Addiction Medicine, 2014). Indices designed to evaluate an individual doctor's performance against US ([US] American Society of Addiction Medicine, 2014) for specialist addiction physicians.

G Models of care for alcohol misusers ([UK] Department of Health and National Treatment Agency for Substance Misuse, 2006). From the special health authority responsible for promoting addiction treatment in England, now absorbed into Public Health England. Guidance for health organisations and their partners on delivering an integrated local treatment system for problem drinkers. Includes (from page 74) quality criteria for managing alcohol services. For discussion click and scroll down to highlighted heading.

G Competencies for working with co-occurring substance use and mental health problems (2019). "Developed through" Public Health England by Clinks, a charity supporting voluntary organisations in the criminal justice system in England and Wales. Based on PHE's related guidance. Describes the values, knowledge and skills required for effective care of people with substance use plus mental health problems. Designed as an individual development tool, but "can also be used and modified by any service provider for workforce development. For example, when describing the specific capabilities required in job descriptions, for training curricula and for performance, development and appraisal systems."

G Treating substance use service clients with mental health problems ([Australian] National Drug and Alcohol Research Centre, 2016). Funded by the Australian government. Recommends services screen all patients for the full range of mental health problems and that mental illness should not be a barrier to treating substance use problems. Says research shows these patients can benefit as much as others from routine substance use treatments. UK guidelines ([UK] National Institute for Health and Care Excellence, 2016) on managing substance use plus *severe* mental illness says mental health services should take the lead.

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What is this cell about? About the treatment of alcohol dependence in a medical context and/or involving medical care, typically by GPs or at alcohol treatment or psychiatric units in hospitals. Clinical staff are responsible for medications, so the centrality of these to an intervention distinguishes it most clearly as medical. However, medications are never all there is to medical care and most treatments do not feature them. Though almost universally used to ease withdrawal in inpatient units, in 2018/19 in England just 19% of the 73,556 'alcohol-only' patients being treated in the community were prescribed an anti-alcohol medication. Narrowing in on primary care – the only identifiably medical setting – it was 47%, still just under half. Guidelines typically see psychosocial support as an essential component of treatment, and 'medical' treatment may consist entirely of advice and psychosocial support from clinicians. Apparent also in the studies listed in cell B2, how clinicians relate to patients affects whether they enter (study listed above) and engage in treatment. The clinician-patient relationship may also be a therapeutic influence in its own right.

This cell focuses 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 (cell A3) get adopted and adequately implemented, and whether practitioners (cell B3) are able to develop and maintain recovery-generating attitudes and knowledge, depend on management and supervision.

Highlighted study In the *Manners Matter* series we argued that the human qualities which cement everyday relationships also make client-clinician relationships work, and that managements and services which care about fostering these qualities will also care enough to be organised and persistent about embedding them in routine practice. Organised and rigorously implemented reminder systems, routinised and well-planned patient follow-up procedures, holistic, structured assessments, robust staff supervision and organisation – all these are not antithetical to caring and responsive service provision, but its expressions in practice. Though the word 'systems' has connotations of a dehumanised rigidity, to work well these must be imbued with a welcoming and personalised ethos.

One of the best examples (listed above) dates from the 1950s when Massachusetts General Hospital established an alcohol treatment clinic. The same study featured in cell A2's bite, but here the focus is on the remarkable transformation brought about by the clinic's manager, Morris Chafetz, later to become the founding director of the US National Institute on Alcohol Abuse and Alcoholism. Click here to unfold a story which ought to have been truly seminal in spawning a new era in the treatment of dependent drinkers, but which seems largely to have been forgotten. Dust it off, and ask yourself: Is this post-prohibition era episode from 1950s' Massachusetts of historical interest only, or resonant with current relevance?

Dr Morris Chafetz; transformed patient engagement at a Boston alcohol clinic.

Close supplementary text

Dr Chafetz took on the job reluctantly, at first sharing the general distaste for 'alcoholics'. "At that time ... people with alcohol problems were reviled," said Chafetz's colleague Howard Blane. "Criminalised ... put in hospitals ... left to lie in the streets ... very little in the way of humane treatment." Chafetz was not immune: "I did not think much of alcoholic people. I did not like them."

Within months of taking on a job no one else wanted, his personal transformation had prefigured that of the clinic and its main potential source of patients, the emergency unit: "Having experienced the extent of my own prejudices and my own ignorance of the issue, I was bound and determined to turn the country around and to treat alcoholics as ill human beings who needed treatment, not as bad people who should be ignored and neglected."

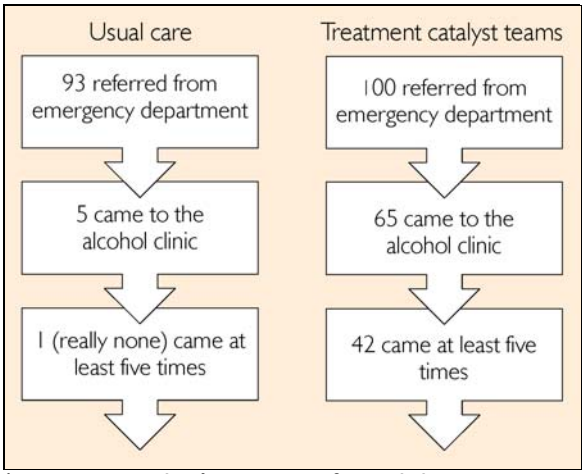
An alcohol-field outsider, it seems his greatest asset was an open mind – despite his prejudices, open enough to listen to the patients: "It only took me a few months of listening to these patients to recognize my prejudices and the prejudices of others." His overarching strategy at the clinic was to ensure others also listened. More controversially perhaps, at a time when the remnants of the prohibition era had yet to be dismantled, it may have helped that Chafetz liked a drink himself; he was

not on a totally different teetotal planet. “My feelings about alcohol are similar to those of Winston Churchill, who once said, ‘I have taken more good from alcohol than alcohol has taken from me.’ ” Whatever the roots of his new approach, the effect was to change the clinic from a service virtually no one wanted to go after emergency care, to one many engaged with to overcome their drinking problems.

Step one was a refusal to accept the status quo that less than one per cent of alcoholics seen in the hospital’s emergency department subsequently sought treatment at the alcoholic clinic, despite the nominal policy of referring all such patients. Given the ethos of the time, it was natural to attribute this to the patients’ intractable refusal to acknowledge they needed help; they were ‘no-hopers’. Instead Chafetz checked whether the hospital was itself causing the problem. A micro-analysis of the referral process revealed that it entailed seeing perhaps a dozen individuals and numerous delays and opportunities to be baulked by the system. Staff attitudes did not help. Typically these ‘skid row’ alcoholics were in crisis (the reason for emergency admission), dirty, disturbed and disturbing, often dragged in by the police. In the staff supposed to care for them they evoked outright hostility and rejection on top of underlying moralising and punitive attitudes. Effectively, nearly every one of the patients rejected back. Chafetz recognised that if the patients were to change, their carers had to change first.

In practice what he did was to establish “treatment catalyst” teams to reach out from the alcohol clinic: a psychiatrist on 24-hour call to immediately see patients in the emergency room, and a social worker who worked with the patient, their family and outside services. By being welcoming, respectful and concerned, and by continuing to care for the patient throughout, they sought to convey that they were the patient’s own personal doctor and social worker. “The psychiatrist and social worker show the patient that he is always welcome, and demonstrate that he will be met with interest and respect whatever … Direct contact with the patient is increased, and every attempt is made to avoid impersonality, rejection or hostility.” Rather than the insight-oriented psychotherapy then in vogue, they stressed practical actions responsive to the patient’s expressed needs, such as help with housing, money, or getting a meal or a shave. Chafetz’s team also systematically and persistently instilled the resultant attitudes and understandings across the hospital’s contact points with the patients and removed barriers to engagement with treatment. Then they went outside the hospital to gain the cooperation of welfare and housing services.

The result (figure) was to engage a far higher proportion of alcoholics identified at the hospital’s emergency department. Nearly two-thirds of treatment-catalyst patients turned up at the clinic compared to just 5% of normal procedure patients. Forty-two of the 100 patients seen by the teams made five or more visits compared to just one of 93 normal-procedure patients – and he was a former clinic patient. From seeming to be treatment-resistant cases who did not want help, alcohol-dependent emergency patients become as ‘engageable’ as the typical psychiatric patient. The supposedly insoluble problem of engaging these patients was exposed as due not to *their* intractability, but to that of an inappropriate clinical response.



‘Treatment catalyst’ teams transformed clinic attendance.

For Chafetz this was still not enough. He took a further step towards the clinic’s transformation and with it, that of the patients. Now coming to the clinic, still many did not return, particularly those (the most inebriated and debilitated) who after assessment had first to be sent to an inpatient unit to ‘dry out’. The clinic’s first attempt to retrieve them was a handwritten letter sent the day after their assessment. It expressed personalised concern (‘I am concerned about you’) and equally personalised desire that the individual would return, when the service would be ‘glad to work with you’. It was sent to 50 randomly selected patients; another 50 were handled as usual. The impact was striking: 25 returned, all but five sober, and 19 the day they were discharged from the unit; without the letter, 16 returned, just two without delay and most after having resumed drinking. Replacing the letter with a phone call to the inpatient unit had a similar impact.

Close supplementary text

Chafetz himself saw his innovations as turning the tables on the existing order: "The technique we used is not new. Its uniqueness lies in … placing the responsibility for achieving a therapeutic alliance on the caretaker rather than the patient." That fundamental message – don't blame the patient, look to yourself – was revolutionary then, and is not altogether redundant today. Take a look inside this 2014 report on alcohol services in Scotland: "Many service users described missed opportunities for referral to treatment, typically relating these to the attitudes of medical staff. Staff … and service users … described instances of poor treatment at A&E, linking this to negative judgements and attitudes of doctors and nurses towards people attending because of alcohol misuse. For example, a service manager said: 'You tend to find that because they [service users] are chronic and almost have a revolving door admission they are not well liked by medical and nursing staff.' "

> *That fundamental message – don't blame the patient, look to yourself – was revolutionary*

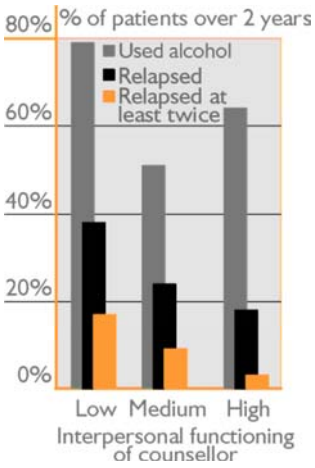
Issues to consider and discuss

▸ **How *do* you identify effective clinicians?** Here we return to what we have described as the "critical missing link" in improving the effectiveness of treatment: recruitment. First some context before tackling the key practical issue – how to identify who to recruit.

In cell B3's bite we discovered that though effectiveness can be generated and sustained (study listed above) through training and a conducive work environment (1 2), there can remain (study listed above) substantial differences in how well individual clinicians and counsellors promote desired outcomes – differences which may even be magnified (study listed above) by training.

In cell C2 we suggested that these findings make recruitment a critical missing link in research on managing services. But how at the recruitment stage can you identify effective clinicians? A comprehensive review highlighted the ability to build a positive relationship with patients as the factor most consistently found to relate to effectiveness, but offered what may be seen as a counsel of despair when it came to identifying these skilled relaters: "Select and evaluate clinicians based on their 'track record' … assumptions that levels of training, experience, or other simple therapist variables could account for such differences does not hold. Selecting and evaluating clinicians based on how they actually perform, using standardised measures, is rarely done but is an effort that could greatly improve the quality of care."

In other words, one tells whether a clinician is likely to be effective in the future by finding out if they have been or are currently effective – scientifically sound perhaps, but usually not a feasible recruitment strategy. Fortunately, things are not quite this bad. While observing sessions and/or getting patient feedback and improvement records may be ideal, much can also be gained from assessing an applicant's reactions to simulated clients (study listed above) or to written counselling scenarios.



Of the available options, most convenient is to assess the applicant's responses to written counselling scenarios. Whether the results can be an adequate indicator was tested (study listed above) by a seminal US study conducted at an alcohol treatment clinic. The written scenarios were intended to approximate real interactions between counsellors and patients or their relatives. Counsellors responded also in writing, responses rated for empathy, genuineness, respect for the client, and the ability to be specific and direct in expressing feelings and experiences. The key finding was that the higher the counsellor's combined score, the less likely their patients were to relapse over the following two years ▸ chart. The same method was found to transfer (study listed above) to another country and to a non-residential treatment setting, where higher ratings were linked to better rapport between client and counsellor and longer stays in treatment.

Imagine you are responsible for an alcohol treatment clinic's staff selection strategy. How would you weight the results of assessments like these compared to conventional recruitment criteria like extent and relevance of qualifications and experience? Relationships may be important, but as observed in the cell B3, patients are not fatally affected by poor client-clinician relationships, but could be by careless or inexpert prescribing. Then again, a poor relationship may ultimately cause serious illness and death if it deters patients from continuing in treatment, means they do not take medication, or otherwise obstructs their recovery. Of course, you may say, 'I'll look for both

these kinds of attributes.' But sometimes they will not co-occur, or not to the same degree. You may face the choice between a highly qualified and seemingly expert medical 'technician', and a less expert applicant patients can relate to and get inspired by. Difficult choice? One actually faced in practice?

Start small (and less costly) and build up if needed? That was the advice offered by NICE in guidance listed above, an authoritative steer from Britain's gatekeepers to the public provision of health interventions. In this they were echoing recommendations listed above from the National Treatment Agency for Substance Misuse (then responsible for promoting substance use treatment in England) that new patients "should be assessed, and initially receive the least intensive or least prolonged intervention considered suitable for the level of need and complexity identified. If response … is inadequate, a more intensive or prolonged package of care may be needed." Intuitively, this so-called 'stepped care' strategy makes sense – but will intensifying treatment really help when less intensive interventions have failed?

> *Will intensifying treatment really help when less intensive interventions have failed?*

Listed above, the only direct test we know of came from Canada, where about half the problem drinkers still drinking heavily after initial treatment were randomly assigned to stepped care in the form of a further session and aftercare. Stepped-care patients attended more treatment sessions, but in terms of their drinking did no better than those left in the basic treatment.

For stepped care, the worst explanation is that clients resistant to initial treatment largely continue to be so even when intensity is stepped up, making this merely a further waste of resources. Given the limitations of the study, this would be a premature verdict. In particular, the supplemental 'step' was effectively just a little more of the same rather than the large step up and/or change of tack which may have been needed to generate progress among patients resistant to the initial attempt. But from the highlighted US study in cell A2's bite and the seminal UK study described in cell A3, we know that patients assumed to need extended care can on average do just as well in brief treatment. Does stepped care lack evidence-based credentials simply because it has never been adequately evaluated, or is this another case of what seems 'obvious' failing in practice?

Can we tell who will be helped by which medication? The preceding sections have shown that identifying effective clinicians and allocating patients to the right intensity of treatment is partly a matter of trial and error. To a degree, so too is choosing the medication if prescribing seems worth trying. Their effectiveness was the subject of cell A3, so only a brief recap is offered here. Reviews have variously estimated that acamprosate and oral naltrexone respectively prevent one patient in 12 or one in 20 returning to drinking, and that eight patients would need to be treated with acamprosate to gain an additional case of abstinence, and nine with naltrexone to prevent an additional case of return to heavy drinking.

As these figures suggest, acamprosate and naltrexone do not prevent drinking but can reduce it. Disulfiram ('Antabuse') in contrast causes very unpleasant reactions to alcohol, deterring patients from drinking altogether while the medication is active. This more absolutist effect means it is generally considered to have more of a niche role than the other two medications, but when properly applied and assessed seems the most effective of the medications approved for treating drinking problems in the UK and the USA. The task for clinicians is to identify which (if any) of these or other medications an individual patient might benefit from, and in collaboration with their managers, to develop service guidelines or information to aid these individual decisions.

US guidelines have offered some clues to who might best be prescribed what. Disulfiram should, the US experts agreed, be reserved for patients committed to and who have a good chance of sustaining abstinence; otherwise, naltrexone or acamprosate are more feasible. A high degree of motivation was also a criterion for the experts behind guidance for England and Wales. As well as being highly motivated, they saw the evidence as most supportive of its role among patients who are relatively older, socially stable, enjoy strong home-based or clinical support, especially in the form of someone to supervise consumption, but who are also "impulsive", presumably because taken in the morning the medication deters such patients from acting on a later impulse to drink. Another perspective focuses instead on the consequences for the patient of a return to or continued drinking: "the clear superiority of [supervised administration of disulfiram] should make it the first treatment consideration for patients whose social, housing, legal, financial, marital or medical problems would rapidly become much worse (and thus make treatment even more difficult) if they had an early relapse". Unlike the other medications, disulfiram's efficacy is dependent not just on the patient's diligence and motivation, but those of their associate who has agreed

to make sure the patient takes the pills – 'supervised administration'. It means the treatment largely relies on there being someone in the patient's everyday life who can and will supervise disulfiram's administration and whom the patient will accept in this role. Typically this would be a spouse or other close associate or relative, but it might involve "people ranging from friends, neighbours and colleagues to probation officers and priests".

When it comes to choosing between naltrexone and acamprosate, the US guidelines could find no reliable indications of who would benefit most, except that acamprosate seems most effective for patients aiming for complete abstinence rather than decreased drinking. Beyond this are practical considerations such as needing to be able to remember to take acamprosate three times a day and naltrexone's interference with the effects of opiate-type drugs – a bonus perhaps for patients also dependent on these drugs, but not for those who are or may soon be in need of opioid-based pain relief.

Though they were published in 2009, not much has changed since the US guidelines offered this advice. Research to date assessed by the reviews in cell A3 finds only slight differences between naltrexone and acamprosate, but across randomised trials, naltrexone has indeed been best at reducing heavy drinking and acamprosate at promoting abstinence. On these grounds, it suggests that the choice for patients with different goals might be weighted towards the corresponding medication. However, this slight on-average indication found across thousands of patients is a minor consideration in respect of an individual. Beyond medical contraindications, there is no evidence-based way to tell which drug will work best for an individual, or if any will help. That and the fact that all three medications are acceptably safe when well monitored and can (in their oral forms) easily be terminated paves the way for a trial and error approach – not unusual in medical practice. For this to work, it is essential to have a structured and regular re-assessment of patients, the results of which are fed back to clinicians, a loop-back procedure for which there is some evidence across medical care generally.

Given that only a minority benefit and the impossibility of identifying them in advance, do you agree with reviewers for the British Association for Psychopharmacology that drug-based treatment should be seen as the norm for dependent drinkers, and even for non-dependent problem drinkers who have not responded to 'talking' therapies? Or since so few patients have been shown to have been helped, should we see medications as a minor fallback option? In practice, that seems more the case in England, where only about 1 in 5 of the 'alcohol-only' patients being treated in the community were prescribed an anti-alcohol medication.

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