DRUG & ALCOHOL FINDINGS *Matrix cell*

DOWNLOAD PDF for saving to your computer

Alcohol Treatment Matrix cell E4

Treatment systems; Psychosocial therapies

Key studies on local, regional and national systems for effectively and cost-effectively providing psychosocial therapies, and the roles of those therapies within the overall systems. Focus is on the potential of mutual aid to bridge the gap between diminished resources and heightened recovery ambitions.

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 Systematic facilitation transforms zero mutual aid group attendance into 100% (1981). Randomised trial with just 20 participants pioneered linking alcohol patients to mutual aid groups. After typical information and encouragement none went in the following week, but all did whose attendance had also been systematically facilitated by procedures which included a phone call during a counselling session to a group member, who accompanied the client to their first meeting. Similar contemporary trials from the UK and USA below. For related discussion click and scroll down to highlighted heading.

K In UK active referral significantly promotes NA/AA attendance but not abstinence (2012). Tested how to extend the recovery process 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. Seminal study above and similar US study below. For discussion click and scroll down to highlighted heading.

K In USA post-treatment substance use reduced by actively linking patients to mutual aid groups (2007). Among patients treated by the US medical service for ex-military personnel, persistent and practical efforts strengthened 12-step group involvement after treatment and modestly improved substance use outcomes. Seminal study and similar UK study above. For discussion click and scroll down to highlighted heading.

K Promoting SMART mutual aid (2010). Analyses the facilitators and obstacles to establishing a cognitive-behavioural alternative (SMART Recovery) to 12-step mutual aid at six sites in England. Prominent theme was the tension between being mutual aid being supported by treatment services versus being co-opted. For related discussions click here and here and scroll down to highlighted headings.

K Forging inter-service links to promote patient transition and aftercare (2012). Implementing psychosocial approaches to promoting patient transition between US services involved analysing how organisations relate to each other and how they deliver their services, in order to forge stronger service networks and identify gaps in the continuum of care. Discussed in cell E3, siting case managers at detoxification services has been (2006) one successful transition tactic.

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 about 1 in 5 of the patients alcohol was their primary substance.

K Text chat therapy (2011). Dutch trial of internet-based therapy for problem drinking via text-chat conversations with a real therapist found this improved on an automated self-help option. Impacts were included in a simulation study (2011) which suggested health would improve and/or costs reduce if across a country on-line interventions supplemented or replaced conventional care. See also hot topic on computerised therapy and advice.

R What promotes longer term care and aftercare (2011). Includes the implementation of psychosocial strategies to help ensure patients who need it receive long-term care or aftercare; discussion in cell D2.

R Peer-based support for recovery from problem substance use (2009). Compendious review from leading authority on recovery systems based on mutual aid. Remit is any form of recovery-oriented mutual assistance involving people whose credentials rest on personal experience, whether offered informally or as part of a service. For discussion click and scroll down to highlighted heading. Will inform planners and commissioners of services aiming to improve linkage to peer-based recovery support; for related discussion click and scroll down to highlighted heading. Also reviews literature on peer-based support itself; for related discussion click and scroll down to highlighted heading.

R Attending AA meetings after treatment helps sustain drinking reductions (2014). That was the implication of what the authors believed was "the most rigorous assessment yet of a 70-year old mutual help organization". Our

commentary discusses whether these results mean treatment services will further prevent heavy drinking or its consequences by promoting participation in 12-step fellowships. For related discussions click here and here and scroll down to highlighted headings.

R Varieties and impacts of case management (2019). An expert Euro-US collaboration examines the most common mechanism for transforming isolated treatment episodes into coherently staged and holistic recovery programmes – the appointment of a 'case manager' who remains a stable hub orchestrating service delivery. From some of the same team see earlier review (2006) published by Findings. Related guidance below. For related discussion click and scroll down to highlighted heading.

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, 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 and mainly concerned with use of illicit drugs.

G Commissioning an alcohol intervention and treatment system ([UK] National Institute for Health and Care Excellence, 2011). Authoritative guidance from England's gatekeeper to the public provision of health services on how commissioners should organise and procure treatment services across an area which implement national guidance and satisfy policy requirements. On psychosocial interventions, NICE took its lead from associated clinical guidelines ([UK] National Institute for Health and Care Excellence, 2011). For discussion click here and for related discussions here, here and here, and scroll down to highlighted headings.

G Setting up a local treatment system ([UK] Department of Health and National Treatment Agency for Substance Misuse, 2006). Guidance for local health organisations in England and their partners on delivering a planned and integrated treatment system for adults with drinking problems.

G Organising integrated and holistic care (Report Produced for the Scottish Advisory Committee on Drug Misuse, 2008). Treatment system guidance for Scotland on an "an approach that aims to combine and co-ordinate all the services required to meet the assessed needs of the individual," requiring "collaborative working between agencies and service providers" to address the multiple difficulties often found among people who have drug or alcohol use problems.

G Case management ([US] Substance Abuse and Mental Health Services Administration, 1998). Based on research and experience indicating that "substance abusers have better treatment outcomes if their other problems are addressed concurrently," US consensus guidance on case management to orchestrate the range of services often needed to promote lasting and multi-faceted recovery. Related review above. For related discussion click and scroll down to highlighted heading.

MORE Retrieve all relevant Effectiveness Bank analyses or search more specifically at the subject search page. See also hot topics on computerised therapy and advice, residential rehabilitation, 12-step mutual aid groups, and commissioning treatment systems.

Last revised 20 November 2020. First uploaded 01 June 2013

▶ Comment/query
▶ Suggest a new document to add to this cell
▶ Return to/go to Alcohol Matrix
▶ Open Effectiveness Bank home page
▶ Add your name to the mailing list to be alerted to new studies and other site updates

Close Matrix Bite

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

What is this cell about? The roles of the 'psychosocial' therapies introduced in cell A4 in building a cost-effective mix of services across an administrative area which offers people with alcohol use problems attractive access points, appropriate options for moving between services or using them in parallel, and which promotes the integration of services to achieved holistic and lasting recovery.

In this endeavour, psychosocial therapies are critical. Though medication use has been increasing, treatment usually still consists entirely of advice and support. Medications are almost universally used to ease withdrawal in inpatient units, but in itself this is not a treatment for the dependency which gave rise to the need for managed withdrawal. Treatment for alcohol dependence mainly occurs in non-residential community settings or primary care. In those settings in 2018/19 in England, of the 73,556 drinkers not also being treated for drug dependence, just 19% were prescribed a medication to treat their dependency; specifically in primary care, the only identifiably medical setting, it was 47%, still under half.

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 into one sort versus another based on the equivalent of a toss of a coin, leaving us largely reliant on studies of how things work out in the 'messier' world of everyday practice. These studies 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 of relevance also to this cell.

Where should I start? Anyone in England (and perhaps too in other UK nations) responsible for alcohol treatment systems is likely to start with the guidance listed above from the National Institute for Health and Care Excellence (NICE), England's gatekeeper to the public provision of health care and an authoritative source of UK-wide advice. Based on associated clinical guidelines also listed above, NICE says commissioners "should consider commissioning psychological interventions … as a key component of their specialist alcohol service," and should go so far as to "specify [their] structure and duration … including the length, number and frequency of sessions". Though overall we saw the guidance as an "impressive" achievement, this bit of their advice can serve to illustrate a general point about being *too* doggedly 'evidence-based' to the point of being 'evidence-bound'.

Look at the relevant recommendations (section 6.24) in the full version of the guidelines. Should commissioners really stipulate that cognitive-behavioural and behavioural therapies "usually" occupy an hourly session a week, and social network and environment-based therapies eight 50-minute sessions, all spanning 12 weeks? Our analysis of the guidelines warned that "the expert group was vulnerable to seeing what researchers have chosen to study for research purposes as the way practitioners should do things". Now the mystery of why 12 weeks becomes clear: that span is typically chosen by researchers. Yet as cautioned in cell A4, there is no reason to believe this is also how patients should be treated – in fact, no reason to believe there is *any* "usual" span, frequency or session length for what should be a highly individualised endeavour.

What we have is a cascade from how researchers standardise for research purposes, to clinical guidelines, to commissioners, who on this basis are advised to embed these practices in services. Among others, a US study which found substance use outcomes were relatively poor at centres constrained by funders in the services they could offer and in their ability to individualise treatment, suggests we should question any advice or service-delivery system which is likely to have the effect of de-individualising treatment. A related issue – how much commissioners should leave to the discretion of services – is discussed below.

Highlighted study Listed above, William White's monograph ranges over the various forms of support provided by people with lived experience of substance use problems to those currently trying to extricate themselves from these problems. Comprehensively researched and cogently argued, the monograph is arguably more important now then when it was written: in the era of austerity, these low-cost or free resources (of which the most prominent are mutual aid groups) 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 social and health risks. 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 as a route to recovery in its own right, asking whether its clear potential to advance and sustain recovery can profitably be drawn on by treatment services and commissioners and integrated into a local treatment/recovery system.

Issues to consider and discuss

▸ **So fundamental it needs no evidence?** Here's another recommendation from the same NICE guidance (listed above) for commissioners we used as our starting point: "Care coordination should be part of the routine care of all service users in specialist alcohol services." Again the source for this recommendation is the associated clinical guidelines listed above. What the clinical guidelines mean by 'care coordination' is that someone should "assure all agreed elements of the care package are linked together and communicated in a clear and effective manner". According to the guidelines, another manifestation of this 'anchor' function is the ubiquitous keyworker role. However, for this core function, the guidelines offer no evidence at all. At the heart of the way addiction treatment is practised in the UK lines lies an evidence black hole.

Is it that the need for care coordination/keyworking is so obvious that it no more requires a randomised trial than does strapping on a parachute before leaping from a plane? Before accepting this, remember that trials have overturned other seemingly self-evident truths – such as that fully-fledged treatment *must* be better than brief advice which then leaves 'alcoholic' patients to sink or swim on their own.

In contrast to the core care coordination role, the similar but more active and specialised case management role (recommended only for harder-to-hold and more complex cases) is supported by at least some research evidence in NICE's clinical guidelines and from documents listed above (1 2 3). Should the variously termed care management, care coordination or keyworking role also be subject to validation through research trials, and how would such a study be done? Without these trials, can we *really* say care coordination should be mandatory for everyone in specialist treatment?

▸ **How much should be left to services?** What this bite's "Where should I start?" section hinted is here tackled head on: What interventions and competencies should commissioners specify in their invitations for bids and their agreements with providers, and what should they leave to the discretion of services' managers and clinical staff? That is an issue for treatment of any kind, but it is most pertinent in psychosocial therapies. Of course, prescribing is not a mechanical process: medications have to be adjusted to the individual and the situation. Nevertheless, 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 and professional bodies which set quality and ethical standards, and guidelines which call for approaches to be well-structured, monitored, and supervised. It is by no means a case of 'anything goes'; some ways of treating clients are unacceptable or acknowledged to be less effective than others. 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 A2 (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 use unqualified counsellors and therapists and deliver programmes which might be idiosyncratic or simply those which appeal to the manager or the therapist rather than those which suit the individual or the caseload. Though hard to predict from the more obvious indicators of the quality of psychosocial therapies, the consequence could be that patients do less well than they might, and interventions may even be counterproductive, an issue explored in cell A4. Regardless of impacts on the patients, commissioners are on safer ground if they specify that the services they commission must employ personnel with relevant 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, leaving most of how they get to those outcomes to the service – but this strategy is itself largely unevidenced, and what evidence we have from the UK substance use sector is not encouraging.

> *Leave it to the service and risk idiosyncratic interventions, 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, discouraging innovation and risking the de-individualisation of treatment? In the intriguingly titled article, "What do hamburgers and drug care have in common," the latter has been likened (free source at the time of writing) to the "McDonaldization" of the restaurant sector – standardised and safe but not the most satisfying or nutritious, yet preferable perhaps to the 'individualisation' of a careless cook in a bug-ridden kitchen.

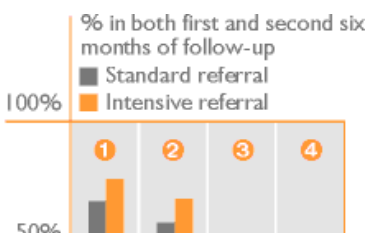
▸**Build your aftercare system on mutual aid?** Since austerity bit in 2010 the biggest challenge in the commissioning of substance use services in the UK has been dramatically reduced funding allied with the recovery-era aim of holistic recovery extending deeper and wider than the remission of dependent substance use – effectively, an expectation to do more with less. Usually freely available, mutual aid groups could offer a way to square this circle. Nearly all the research has focused on groups based on the 12 steps of Alcoholics Anonymous and in particular on their impacts in the US context. Though reflecting this, we do not intend to dismiss the contributions of other mutual aid approaches such as SMART Recovery, piloted (report listed above) with, according to the views of members, some success among drinkers in England – a particularly important alternative in the UK where 12-step approaches are not as dominant as in the USA.

In evidencing whether the potential of 12-step mutual aid 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. Conducted by the US medical service for ex-military personnel (the Veterans Affairs health care system), it was the only study cited in NICE's clinical guidelines (listed above) to directly test whether investing in relatively intensive encouragement and direct help to attend 12-step groups gained better outcomes. The intervention entailed counsellors linking patients to volunteers from 12-step groups who would accompany them to meeting, using the groups' journals to check on meeting attendance, and on this basis re-encouraging attendance if needed.

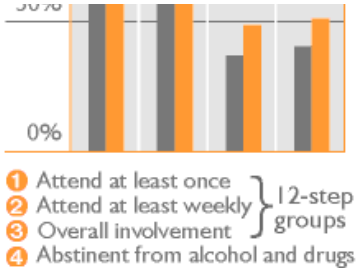
Largely relying these findings, NICE's alcohol services commissioning guidance (listed above) recommended similar efforts "for all people seeking help for alcohol misuse". Specifically, help-seekers were to be given "information on the value and availability of community support networks and self-help groups (for example, Alcoholics Anonymous or SMART recovery)," and helped to participate in these networks "by encouraging them to go to meetings and arranging support so that they can attend" – broadly the approach tested in the Veterans Affairs study. Check whether the evidence relied on by NICE stacks up by unfolding and working through the supplementary text, then continue reading the main text for further evidence not available to NICE at the time it made its recommendations.

Supplementary text. Click to close

Read the Effectiveness Bank analysis of the US Veterans Affairs study and you will see that though worthwhile, impacts of intensive referral to 12-step groups versus merely being encouraged to go were modest: another 10% of former patients abstinent from alcohol and drugs (51% v. 41%; ▸chart right) and small extra reductions in drink- and drug-related problems. Whether these gains



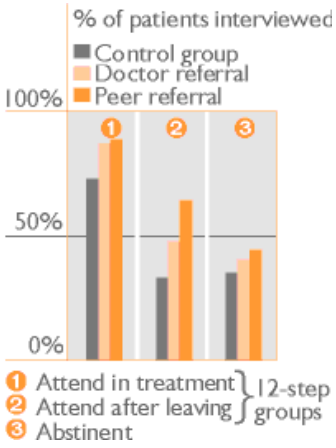
are more or less than might be expected in routine practice in the UK is unclear. On the one hand they emerged from an intervention and a comparator which should have maximised the advantages of intensive referral. On the other hand, they also emerged in the US context, where virtually all the patients were already familiar with 12-step groups, and the core treatment programme was in any event infused with a 12-step orientation. For these patients, three sessions of intensive referral were perhaps merely the icing on the cake, most having already made up their minds whether to get involved in the groups based on their previous experiences and current treatment.



Of the other studies cited by NICE, the most relevant was a US trial which found that more extensive encouragement to attend AA groups did somewhat promote abstinence, but also that alcohol-related problems and heavy drinking were unaffected. In a third US trial cited by NICE, more extended encouragement to attend 12-step groups after inpatient detoxification made no overall difference to drinking. However, in this study not just the duration but also the style of the encouragement differed, and the overall 'no effect' finding concealed differential impacts on different kinds of patients. Those already set on attending AA groups drank less after five minutes of highly directive advice during which they were unambiguously advised to get as involved as possible in 12-step groups, while those less committed to this path did better with an extended one-hour session in the non-directive style of motivational interviewing. Both these studies were analysed in our commentary on the Veterans Affairs' study.

Close supplementary text

Not at the time available to NICE were the results of a British study (listed above) which might have tempered its enthusiasm for encouraging referral to 12-step groups. The general picture was that being encouraged by either a doctor or a peer (especially the latter) substantially improved attendance at the groups, but resulting impacts on abstinence were much smaller and not statistically significant ▸ chart right. Our commentary on the study explains why this contrast calls in to question whether attendance generated by special efforts during treatment has a substantial impact on later abstinence. Rather than attendance fostering abstinence, the results seem more consistent with attendance being a marker of a pre-existing ability and determination to sustain abstinence.



However, the study was never meant to be a definitive test of the potential impact of intensive referral in Britain, so neither are its results a definitive verdict on such interventions. It trialled a very modest single-session intervention, and assessed its impact with a single, limited measure of substance use among a small group of patients from one unit over a short time period. Though falling short of statistical significance, the small increase in the proportions abstinent might (if further studies suggest this was not a chance finding) be considered clinically worthwhile, especially if associated with broader welfare gains.

The final strand of evidence we offer derived from an innovative synthesis of US trials of encouraging patients to attend AA meetings after treatment. Listed above, the analysis was not intended to establish whether treatment services can preserve treatment gains by actively promoting attendance, but our commentary used the same trials to tackle this issue. Relative to alternative treatments, the general pattern was that despite often substantially increasing attendance, interventions based on facilitating involvement in 12-step groups have generated no or only modest statistically significant impacts on drinking. Some studies have found abstinence modestly boosted relative to alternative approaches, but generally without any extra impacts on heavy drinking or its adverse consequences. We have not conducted a similar assessment of the studies included in a later review of 12-step programmes for alcohol use disorder, but its findings suggest our conclusions would not be altered: compared to other treatments, no reliable advantage for these programmes in curbing post-treatment heavy drinking or reducing alcohol-related consequences, but patchy evidence that abstinence could be boosted, especially the length of continuous abstinence after manual-based 12-step treatment.

What then is the answer to the question we began with – whether to build your aftercare system on mutual aid? Taken as a whole, studies support provision of a range of aftercare options, permitting a more individualised offer to patients than an exclusive focus on mutual aid or service-based

What then is the answer to the question we began with?

aftercare. If the default option is mutual aid, though some patients will benefit, even extensive attempts to encourage attendance will generate at best modest impacts on drinking across a caseload relative to less extensive efforts or other forms of treatment. When the mutual aid approach is abstinence-based, such efforts may lead more patients to recover via abstinence, but sometimes only instead of non-abstinent routes and without evidence of extra impact on what for health services treatment is all about – reducing the adverse consequences of heavy drinking.

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 attendance at 12-step groups (see below), 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.

Support mutual aid says NICE The section above addressed the issue of whether treatment services should intensively refer patients to mutual aid groups, but these groups also gain adherents outside the context of and instead of treatment, forming a standalone recovery resource. For NICE, this too should be encouraged. NICE's commissioning guidance (listed above) recommended that commissioners consider "supporting the establishment of new groups and networks [and] encourage local providers to make rooms available within treatment centres for meetings [and] ensure that case management is available to people with complex needs, so they receive additional support and/or transport to make it easier for them to attend meetings." If implemented, these recommendations should promote mutual aid as a standalone resort for problem drinkers who do not opt for treatment, as well as an extra resource for those who do. If even in the absence of treatment, mutual aid can attract and work well at least for an appreciable proportion of dependent drinkers, for a commissioning system the return on the modest investment involved in promoting these groups would be substantial.

Establishing whether attending Alcoholics Anonymous mutual aid groups really does help was the main purpose of the synthesis of US studies referred to in the section above. It concluded that their amalgamated results showed that attending AA meetings after treatment really does help sustain drinking reductions – it was not just a case of patients who are in any event going to do well also attending the groups.

But even this sophisticated analysis did not answer the question of whether *outside of a treatment context* attending mutual aid groups is beneficial. To get closer to that we can turn to an earlier analysis led by the same author and described in our commentary on his later review. In the paragraph starting, "A second study", you will see that among drinkers who contacted gateways to treatment yet remained untreated, attending AA groups was estimated to help reduce the severity of their drinking. Crucially, rather than these groups attracting problem drinkers most likely to do well anyway, the opposite was the case, suggesting these findings were not due to the sifting of more promising drinkers into the groups. It is, however, worth noting that while drinkers who attended AA were much more likely to be abstinent than those who chose to go it alone, there was no substantial or significant difference in their experience of drink-related problems. Neither did the analysis have available to it a measure of motivation to reduce drinking, possibly important to whether participants attended groups and whether they cut their drinking. If the more motivated were most likely to attend groups, these would look like an active ingredient in reducing drinking even if they were not. The analysis was intended to cater for this other such influences, but a direct assessment would have added credibility.

Another analysis derived from the same study found that those who initially opted for AA rather than outpatient treatment cost health services much less, but did no worse in respect of their drinking and related problems. Cost-savings were also apparent when the health-care costs of patients treated in US 12-step-based treatment programmes were compared with those treated in cognitive-behavioural programmes.

These rather convoluted attempts to disentangle the effects of attending mutual aid groups from self-selection bias are critical because the best way to achieve this separation – a randomised trial – has proved unsuitable. All three to date were deeply flawed as assessments of AA as usually accessed and attended, and in two of the trials methodological features meant they were poor indicators of relative impacts on drinking. But the results of these trials do act as a caution that people forced to attend AA do

worse than when coerced instead into professionally run treatments or simply left to their own devices. Focusing on the comparison with those left to their own devices, a synthesis of the findings found coercion into AA groups led to no statistically significant outcome advantages over no treatment at all, but the trend was for coerced participants to do worse.

Though for testing mutual aid randomised trials seem inappropriate, evidence gathered through other kinds of analyses is subject to too many caveats to be convincing. Despite the analyses referred to above, the evidence remains weak and apart from abstinence as an outcome, almost entirely lacking in analyses which have focused on adjusting for self-selection bias. Rather than these weaknesses being due to little or no impacts of mutual aid, they may be due to the difficulty of finding a way to convincingly demonstrate those impacts. Fostering mutual aid as recommended by NICE can be a low-resource strategy to widen access to recovery resources, so the evidence bar can be correspondingly lower than for a costly strategy. Worth prioritising, worth trying among other things, or too uncertain and best left to develop on its own – what would your assessment be?

 **Close Matrix Bite**