DRUG & ALCOHOL FINDINGS *Research analysis*

This entry is our analysis of a study considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original study was not published by Findings; click Title to order a copy. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text
The Summary conveys the findings and views expressed in the study. Below is a commentary from Drug and Alcohol Findings.

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Navigating the alcohol treatment pathway: A qualitative study from the service users' perspective.

Gilburt H., Drummond C., Sinclair J.

Alcohol and Alcoholism: 2015, 50(4), p. 444–450.

Patient interviews provide insight into low levels of engagement and retention in alcohol treatment services, hindering the effective provision of treatment for dependent drinkers. Findings suggest that treatment pathways should better reflect the capacity and capabilities of people with alcohol dependence.

SUMMARY Alcohol misuse in England costs an estimated £21 billion a year – £3.5 billion spent on healthcare, and a further £18 billion sustained as a result of alcohol-related crime and lost productivity. To reduce these costs, the government has made *effective treatment* for dependent drinkers a priority.

In the UK, treatment is primarily delivered through community agencies providing detoxification and structured psychological interventions, and residential agencies providing inpatient detoxification and rehabilitation. A key element of effective service provision is engagement and retention in treatment – length of contact with services, for example, being the single best predictor of post-treatment recovery. Yet, evidence suggests that levels of both engagement and retention are low.

Previous research has shown that the characteristics of patients, therapeutic relationships, and organisations can all influence effectiveness [see the Effectiveness Bank alcohol treatment matrix for more on these factors]. The premise of the featured study was to gain insight into treatment from the perspective of the patient; to understand what a patient's journey *to* treatment, *through* treatment, and *towards* recovery looks like; and to learn about the barriers and facilitators to engagement and positive treatment outcomes.

Key points
From summary and commentary

Low levels of engagement and retention are hindering the effective provision of treatment for dependent drinkers in the England.

Interviews with 20 patients in community alcohol treatment services in London reveal that treatment pathways can be confusing and unpredictable, requiring patients to draw on significant levels of motivation and self-efficacy.

Treatment pathways should better reflect the capacity and capabilities of patients, themselves affected by alcohol dependence.

Interviews were conducted with patients one year after initially entering treatment. All had a diagnosis of alcohol dependence, and were attending community alcohol treatment services in one of three London boroughs. From participants in a randomised trial, they were selected from those randomly assigned to receive 'treatment as usual' rather than assertive community treatment.

['Treatment as usual' included being allocated to a keyworker (when one became available); access to medical detoxification, psychological interventions, and aftercare (outside the community addiction services); input from specialists in addictions psychiatry, clinical psychology and social work where available; and signposting to other relevant agencies. Failure to attend appointments resulted in discharge from the service. The majority of patients were discharged to primary care within 12 weeks of being allocated a keyworker.]

To identify and recruit patients with a range of perspectives, they were sorted into four categories based on information collected in the trial about their stage of treatment, drinking in the previous 90 days, and severity of alcohol dependence. The interviewer asked a series of open-ended questions to guide participants to describe their journey and experiences from the point of seeking help one year before, to the present time.

Main findings

A total of 20 patients were recruited (eleven men and nine women), ranging in age from 22 to 55 years, including: people who had engaged in treatment offered and significantly reduced their alcohol intake or achieved abstinence (four patients); people who had not engaged in treatment or disengaged at the early stages of treatment and had significantly reduced their alcohol intake or achieved abstinence (four patients); people who had engaged in treatment and were drinking at the same level (six patients); and people who had not engaged in treatment or disengaged at the early stages of treatment and were drinking at the same level (six patients).

Alcohol was described by patients as having a powerful and extensive impact on their families, lifestyle and health. The physical experience of alcohol dependence was raised by almost all participants, and included sickness, diarrhoea, tiredness, sweating, breathlessness and pain. The decision to seek help was often preceded by reaching a point of being or feeling 'out of control'. Family members were instrumental in recognising the need to seek help – directly, through confronting them about their drinking and giving ultimatums, but more often indirectly, showing them the impact of their behaviour and alcohol dependence on others.

Many patients saw their alcohol dependence as a consequence of broader challenges they faced. One-to-one talking therapies were highlighted by almost half as important in supporting recovery, though access was described as poor. These therapies were distinguished from interactions with keyworkers who were perceived to have a largely functional role, for example doing assessments, providing set advice, performing tests, and setting up interventions. Talking therapies were primarily about patients talking about their problems. This process, described by one patient as "raw and intense", involved getting to the 'heart of the matter' – sometimes this was about dealing with stressors patients were aware of prior to help-seeking, and other times stressors that came to the fore during treatment.

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Patients described needing determination and significant personal investment to access services and continue in treatment. This included attending multiple appointments across different services, in some cases in limited timeslots and at inconvenient times. It was not uncommon for patients to describe several people in different agencies as taking a lead role in their alcohol treatment at the same time. Some described receiving conflicting information, or having to complete duplicate assessments at different services.

Patient belief in being able to succeed (self-efficacy) was underpinned by a perceived balance of responsibility between themselves and the services from which they were seeking help. A number of patients felt that the balance of responsibility tended to lay with them, so what could be experienced as empowering was also associated with considerable pressure. Both the interviewer and an independent transcriber noted a pervasive sense of hopelessness when discussing this. Over half of all patients reported feelings of failure and self-blame.

Frequent contact with practitioners was seen as an important way of maintaining motivation. Some community programmes were thought to offer too few and infrequent sessions. Patients valued an assertive manner in their practitioners – not in the sense of dictating treatment, but addressing issues of motivation and being honest and open about the process and requirements of treatment. Feeling judged, staff not listening to or believing, being dismissed as unmotivated for missing an appointment, and rudeness all had a negative impact on patient engagement, feeding into an internalised negative identity as an alcoholic, and contributing to low self-esteem and lack of confidence that they could succeed.

Patients identified a number of things that would help them to prepare for treatment and a life after treatment, including having a clear understanding of what to expect after detoxification, learning about alcohol dependence, and support on a practical level to deal with real-world situations where they would encounter alcohol. Some patients said that rehabilitation groups talked a lot about drinking, but not much about how to succeed at being abstinent within the contexts of their lives.

Definitions of alcohol dependence varied widely. For some it depended on volume or strength of alcohol consumed, and for others it represented a need (as opposed to a want) to keep drinking. These different views of dependence influenced views of *what* and *who* treatment was for. A number of patients said treatment was for when 'you're really, really ill' or when you've run out of other options. There was some indication that this came from treatment staff, with some patients reportedly being told by treatment staff that they didn't qualify for treatment because of the amount they were drinking or their pattern of drinking. This led some patients to delay treatment, and others who had sought treatment being turned away.

"…what have I got to do, go out and drink every day and make myself worse in order to get some kind of help"

Treatment was often described by patients as 'getting a detox', however, there was a degree of confusion around what detoxification meant and what it involved.

Cutting down was seen by many as an important step in being able to regain control of drinking or achieving abstinence. Though reducing consumption was often supported in principle by services, when staff felt it had become an outcome rather than a process, patients were reportedly told it was not an option. Some patients described being advised by staff to 'keep drinking' to prevent fits, withdrawal and ensure access to treatment, which conflicted with their perception that cutting down would be a logical pathway to tackling excessive drinking.

More than half of patients had experienced a 12-step programme such as Alcoholics Anonymous (AA). Many rehabilitation programmes applied the 12-step model in some way, either integrating group sessions into treatment or encouraging attendance at AA groups. Some described being 'pushed' into AA. Pros of 12-step groups included being able to draw on support and understanding from peers, and learning from others. Yet overall there was an impression that AA was 'second class' to treatment or not part of the legitimate treatment services available.

The authors' conclusions

Current alcohol treatment pathways can be confusing and unpredictable, requiring patients to draw on significant levels of motivation and self-efficacy in order to navigate them. This can be immensely challenging due to the nature and impact of alcohol dependence. To successfully support recovery, these findings suggest that pathways should better reflect the capacity and capabilities of patients. Health care professionals have an important role to play in supporting and building self-efficacy. They can do so by developing positive therapeutic relationships with patients, using assertive engagement techniques, having honest and overt discussions about treatment, and providing advice and encouragement.

FINDINGS COMMENTARY The featured study was designed to provide a deeper level of understanding of low levels of engagement and retention in alcohol treatment services. Though focused on a small non-representative sample, it covered a breadth of experiences of engagement with alcohol treatment services, levels of drinking in the previous 90 days, and severity of alcohol dependence. Despite these differences, there were some common themes across participants, including: desperate circumstances before seeking treatment; a need for supportive but challenging therapeutic relationships; a need for support to build self-efficacy, and prevent patients feeling over-burdened by responsibility; clear and consistent messages about alcohol dependence and treatment; access to group therapies; and access to psychological therapies to support treatment and deal with stressors underpinning dependence. Barriers to engagement with treatment included rudeness, feeling judged, staff not listening to or believing, and being dismissed as unmotivated for missing an appointment. Interestingly, and this is where the value of qualitative research is demonstrated, these factors contributed to a negative self-identity, compromising self-efficacy and the ability to continue through treatment.

Another theme that emerged was a discrepancy between patients and practitioners over the value or purpose of cutting down alcohol consumption. While for many patients, cutting down was seen as a step towards being able to regain control of drinking *or* achieve abstinence, staff were apparently supportive to the extent that cutting down was a step towards abstinence, not the goal in itself. According to the study protocol for this trial, the 'treatment as usual' arm was focused on "promoting abstinence and relapse prevention". The question of whether dependent drinkers should always try for abstinence is discussed in this Effectiveness Bank hot topic. Guidance published in 2006 by the Department of Health and National Treatment Agency for Substance Misuse stressed that goal choice should not exclude drinkers from support or treatment, though did see abstinence as "the preferred goal for many problem drinkers with moderate to severe levels of alcohol dependence, particularly … whose organs have already been severely damaged through alcohol use, and perhaps for those who have previously attempted to moderate … without success". We know from research that moderation is feasible for some people (especially where they have sufficient support), and may lead to abstinence. But as severity of dependence increases, so does the likelihood that abstinence is the most suitable strategy. The above guidance sees patient choice about the goal of treatment not just as an entitlement, but

suitable strategy. The above guidance sees patient choice about the goal of treatment not just as an entitlement, but a strategy which improves the chances that the treatment approach will succeed because "it has been selected and committed to by the individual".

This draft entry is currently subject to consultation and correction by the study authors and other experts.

Last revised 31 October 2016. First uploaded 23 October 2016

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