Innovation in Alcohol Treatment

A Thematic Review of Recent Developments in Treatments for Alcohol Problems

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Executive Summary

- Alcohol problems exists on continuum of severity. Population studies show that 70 per cent of people with alcohol use disorders have a late onset problem and are liable to remit within 3-4 years. Early onset problems tend to be chronic and recurrent with at least five episodes across the life course.
- There is an emergent research base that suggests that moderately structured interventions delivered within the context of a supportive therapeutic alliance that help clients shaped their social environments demonstrate superior outcomes.
- There remains a significant number of unanswered questions regarding treatment effectiveness.
- There is a limit to how clinical modalities developed within the context of Randomised Control Trials can be applied to everyday practice.
- There is limited support for the use of a stepped care approach in alcohol service design. Evidence is weakened by the fact that few stepped care systems operate in everyday practice as they are liable to drift towards sequenced treatment. So whilst the stepped care structure should remain, greater attention is needed to ensure it is delivered in accordance with the specification.
- AUDIT and SAD-Q remain the gold standard for screening and assessing severity of presenting alcohol problems.
- Assessment must be proportionate to level of interventions. Consideration should be given to the adoption of the ASAM Placement Criteria as a triage assessment tool.
- Case management is reserved for the highest presentation of need only. Lower order problem presentations should be addressed through initial care plans and augmented with contracting and prompt arrangements.
- NICE (2011) recommendation for the use of AUDIT as an outcome measure is simply not supported by the clinical evidence. It is recommended to continue the use of the Partners in Progress Outcomes tool (ORS / SRS) in combination with standardised drinking measures. These should be linked to AUDIT scores for evaluation purposes.
- Alliance factors and outcomes are misrepresented within NICE (2011). These common factors should be promoted within the treatment system.
- Real-time feedback measures have become the most pressing research concern since the award of the last contract. Clients utilising real-time feedback are 3.5 times more likely to achieve significant outcomes as well 50 per cent less likely to drop out of treatment. The Partners in Progress system needs to be expanded in the new specification with greater attention focussed on the clinical outcome spread that is achieved by the Service Provider supervisors and commissioners.

- Evaluation of different psychotherapies shows that they mostly produce a similar range of treatment outcomes. General counselling, psychodynamic therapies, TSF and MET are not supported by research and should not be considered within the next Specification.
- E Self Help is an emergent area that shows good outcomes but the expense of licences must be considered against the low rate of treatment completion that these models demonstrate.
- Medications show a similar range of outcomes, with research slightly favouring Naltrexone in aftercare.
- Compliance to the medication is a central issues in the effectiveness of prescribing options. The new specification should require a clear compliance counselling protocol to maximise the effect of prescribed medications.
- The development of the CPR shows significant outcomes in maximising aftercare attendance and promoting long term treatment gains, especially in the area of abstinence. This model should be incorporated into the new specification to augment aftercare gains and promote long term recovery.
- 50 clinical recommendations are made to enhance the delivery of a stepped care alcohol system across Gwent.

Introduction

In 2008, the five counties of Gwent re-commissioned new alcohol services. This newly commissioned approach was in accordance with both national policy and informed by clinical research. Clinical research recognised that alcohol problems occurred on a broad spectrum from short term non-chronic to long term chronic ends of a spectrum. This high variance in severity required greater calibration of treatment intensity to ensure that levels of support were appropriate to need. This was based on a 'stepped care model' as described by MoCAM (Dept of Health 2006). In this system, clients are offered the least intrusive therapeutic approach first which could then be stepped up to more intensive options if necessary. Multiple Service Providers delivered this approach across Gwent and were free to select specific interventions across this hierarchy of support. Most agencies adopted a similar range of modalities, including Motivational Enhancement Therapy, Social Behavioural Network Therapy and Community Reinforcement Approach. Relapse prevention models were also included that adopted a broadly Cognitive-Behavioural Approach. Whilst novel in 2007, these interventions have since become mainstream in the alcohol treatment landscape of Gwent.

A Gwent-wide alcohol treatment system will be re-commissioned in 2014. In order to advance alcohol treatment services this paper will review developments in clinical research in the intervening period. This will review focus on the clinical application of treatment interventions for adult problem drinkers. It is based on the extremely comprehensive NICE Guideline (2011) but with some caveats. This paper will explore the recommendations of NICE as well address some of the apparent limitations within the guidance both in terms of its evidence, recommendations and gaps in service provision. NICE have also published an update, NICE (2013), but none of these recommendations have any significant revision of the original review. Therefore, this paper will place NICE (2011) in a wider context of research, an existing knowledge of the previous treatment systems in Gwent as well as focus on the pragmatic delivery of effective services. This will provide a range of recommendations to inform the next commissioning cycle.

Diagnosis and Treatment Cohorts

Drinking problems exist on two axis. This includes the development of physiological dependency on alcohol, as characterized by tolerance and withdrawal which require medical interventions. Secondly, alcohol problems occur a wide range of social and psychological complications that require psychosocial support. Modern diagnostic criteria for alcohol problems are based on the Alcohol Dependence Syndrome. World Health Organisation approached two researchers to develop specific diagnostic criteria that could identify physically dependent drinkers *who required medical attention*. These researchers, Edwards & Gross (1976), suggested that alcoholism could be understood as occurring on a spectrum of severity rather than

as an absolute condition. Examination of physically dependent drinkers revealed a cluster of seven common symptoms described in table 1.

Key Symptoms	Descriptors
Narrowing of repertoire	The problem individual begins to drink the same regardless of social context. With advanced drinking, consumption follows a strict daily timetable.
Salience of drinking	Priority is given to maintaining alcohol intake over time, relationships and finances.
Increased tolerance	The drinker can tolerate and still operate under the influence of large doses of alcohol that would incapacitate an ordinary drinker. Will also develop cross-tolerance to other depressant drugs.
Withdrawal symptoms	The client will experience severe and multiple symptoms, usually on waking that include tremor, nausea sweating and mood disturbance.
Relief or avoidance of withdrawal symptoms by further drinking	Drinking occurs earlier in the day as dependence progresses to alleviate the onset of withdrawal. Usually the periods of abstinence are limited to 3-4 hours. Drinking is triggered by mild withdrawal in anticipation of worsening symptoms. Often early drinking becomes ritualised with the client knowing the exact amount to consume to avoid rather than alleviate withdrawal.
Subjective awareness of compulsion to drink	May be ruminating on alcohol during a period of withdrawal as well as loss of control over drinking once initiated.
Reinstatement after abstinence.	A rapid return to pre-treatment drinking levels after relapse.

Table 1: The Alcohol Dependence Syndrome (Edwards & Gross, 1976)

Tolerance is the adjustment the body makes to compensate for the action of a drug. At its simplest, in light of the depressant action of alcohol, regions of the brain are required to work harder to compensate for this action. When the substance subsequently wears off, the tolerant individual will be left over-compensating state for a period of time which is experienced as withdrawal. The Alcohol Dependence Syndrome assumes a proportionality in these symptoms. The higher the tolerance then the greater the withdrawal, leading to higher levels of subjective compulsion and a greater need to organise one's life around alcohol consumption etc. Whilst this research has been supported by a dearth of follow up studies, not all symptoms are as strong predictors as others. *Narrowing of repertoire*, *subjective compulsion* and *reinstatement* have proved difficult to validate. This led Cottler et al (1995) to suggest that physical withdrawal should be the key symptom of physical dependence for diagnostic purposes. As Edwards et al (2003) state "…but for clinical purposes it is probably best to restrict the diagnosis of alcohol dependence to patients who have experienced withdrawal symptoms to at least some degree." (Edwards et al, 2003 p.59). Whilst all modern diagnosis are based on the Alcohol Dependence Syndrome,

currently, the diagnostic criteria for an Alcohol Use Disorders are based on the American Psychiatric Association's (APA 2013.) The criteria has undergone recent revision. Previously the DSM IV offered separate diagnostic criteria for a low severity Abuse diagnosis and more profound Dependence diagnosis. However, the spectrum of use meant that these were not neat categorical disorders but overlapped so have now been reduced to one Alcohol Use Disorder.

As these symptoms can occur on a spectrum, population studies suggest that within this diagnostic framework there are three distinct groups of drinkers. This includes people whose drinking never exceeds the recommended guidelines; at-risk drinkers who exceed the guidelines but have no alcohol dependence or current complication; and people with symptoms or consequences related to their drinking who thus can be diagnosed with an Alcohol Use Disorder. Most people who develop an Alcohol Use Disorder have only three or four symptoms and do not develop severe life disruption as a result of their drinking. They sustain wider social responsibilities and problem use is only known in their closest friends and family. It is estimated that 72 percent of people who develop alcohol dependence have a single episode of 3 - 4 years on average without reoccurrence (Hasin et al 2007). Whilst the 28 percent who have recurrences have an average of five episodes (Hasin et al 2007). So there may two forms of the disorder, with a mild self-limited form and a more severe recurrent form. This suggests that there are four types of drinking patterns:

- Abstainers
- At Risk Drinkers
- High risk functional drinkers
- Severe and Recurrent problem drinkers

Functional Alcohol Use Disorders seldom seek treatment (Hasin et al 2007) but overcome their compulsive drinking either through abstaining or cutting back to low-risk drinking (Moss et al 2007). It tends to occur with a later onset from late teens to older age. Functional Alcohol Use Disorders resemble others who experience sub-clinical depression or anxiety who are able to function but with a significant level of distress. Severe recurrent Alcohol Use Disorders are more likely to have family history of Alcohol Use Disorders, experience behavioral problems as children and antisocial behavior as adults, to come from chaotic families and tend to have an early onset Alcohol Use Disorders from the early to mid-teens (Moss et al. 2007). Many become dependent on wider substances such as cannabis, cocaine, or methamphetamine (Grant 2004). They also may have other serious psychiatric disorders, such as depression, anxiety disorders, bipolar disorder, or psychosis (Grant et al 2004; Hasin et al 2007). This group tends to seek professional treatment especially in mid-life (Moss et al. 2007). As such they resemble the clinical profiles identified in the Torfaen and Monsmouthshire Youth Service design (see Harris 2011).

Treatment Evidence Overview

Early alcohol treatment was characterized by core assumptions:

> (1) Change occurred because of therapeutic interaction between a client and professional

(2) Differences between different psychotherapeutic approaches would generate divergent outcomes,
(3) All people with alcohol dependence had severe, recurrent dependence
(4) Change processes were reliant on the development of insight and the conscious application of techniques or methods taught by an expert
(5) Alcoholism and heavy drinking were considered to be quite different categorical entities.

None of these core assumption has been supported by recent research but remain prevalent. Approximately 75 per cent of people with alcohol disorders curtail or stop drinking without treatment (Dawson et al. 2005). Psychotherapies have not produced differential outcomes. The majority of people who develop alcohol problems (70 per cent) have mild-to-moderate forms that are self-limiting (Hasin et al 2007; Moss et al 2007). Finally, there is no clear separation between heavy drinking and "addiction." Heavy drinking can move into mild then moderate dependence and, in some, severe and recurrent dependence. This is not progressive but can have periods of stability or oscillate between heavy, light drinking and abstinence (Dawson and Grant 2006; Dawson et al. 2005; Vaillant 2003). Furthermore, treatment engagement tends to occur after the individual has recognized that successful change is not possible by their own efforts. So, even in clinical trials pre-treatment assessment demonstrates that many research subjects implemented forms of change sometimes weeks prior to treatment entry (Penberthy 2007; Orford et al 2005). As such, seeking professional help may be a symptom of change rather than its driver.

This is not to suggest that treatment does not work. Despite the complexity of enduring and recurrent problems, research shows that treatment interventions achieve significant outcomes. Research suggests that that one third of patients treated in randomized control trials are in full remission 1 year post treatment, whilst two-thirds shows substantial reductions in drinking, from 70 to 10 drinks per week (Miller 2001). It is rather that little is understand about the mechanism of how treatment works. This is vital in the commissioning of services to ensure the most effective practices are implement and that existing provision is optimized. Therefore, before exploring the specific NICE recommendations, it is important to understand the principles and puzzles that have emerged in the research base. These contradictions have been summarised by Moos (2009). This has highlighted 7 core themes of effective treatment and also highlighted unresolved issues (see table 2).

Principle	**Descriptor**
Treated or untreated, addiction is not an island unto itself	• Alcohol problems exists within a social context. • Treatment interventions can be powerful but short lived compared to long standing relationships. • This requires a deeper focus on the wider social environmental influences that support recovery in the client's life.
Common Dynamics Underlie the Process of Problem Resolution the occurs in formal treatment, informal Care, and "natural" recovery	• Individuals attempting to resolve alcohol problems rely upon identified individual's within their life for help. • When these attempts fail do they seek professional help. • Treatment seekers tend to have more chronic problems and poorer social functioning. • The cognitive and social processes that underpin these recoveries is identical to untreated remission and can be replicated.
The Duration and	• In a large sample of 20,000 in national treatment programme

Continuity of Care are more closely related to Outcomes than Amount of intensity of Care	in the US, found patients with a longer mental health care had greater risk-adjusted substance use, family and legal outcomes, even when adjusted for intensity. • In other studies patient who had received 1 year care did better than those in shorter programmes and were more likely to experience remission at two year follow–up. • This occurred regardless of treatment setting and was not related to the amount of treatment time people received.
Patients treated by substance abuse or mental health specialist experience better outcomes than do patients treated by primary care or non-speciality providers.	• Research supports non-specialist involvement in the delivery of brief interventions for non-chronic problems. • In a sample of 20,000 clients with substance use disorders, those who had received treatment from substance misuse specialists or mental health professionals had better risk adjusted outcomes than those in non-speciality services. • This included higher rates of abstinence, mental health symptoms and higher employment rates.
Treatment settings and counsellors who establish a therapeutic alliance, are orientated towards personal growth goal and are moderately structured tend to promote positive outcomes.	• Common aspects of treatment such as the therapeutic alliances is a stronger predictor of treatment outcome than specific modality. • Treatment that identifies specific goals and provides structure maximises outcomes. • Treatment is more effective when it focuses on real-life social contexts. As clients exhibit a variance in treatment, the concept of 'moderately structured' becomes integral in outcomes • Therapeutic adjustment is required within structured treatment according to the responsiveness of the client.
The common component of effective psychosocial intervention is the focus on helping clients shape and adapt to their life circumstances.	• Treatment with an effective evidence bases such as CBT, social skills training, CRA, and relapse prevention share a common theme. • They enhance the client's ability to cope with the pressures of daily life, enhance social relationships and improve the match between the client's resources and the demands of their environment. • They help the client to understand, adapt and alter their life circumstances.
Among individual who recognise a problem and are motivated to receive help, formal intervention or treatment leads to better outcomes than those remaining untreated.	• Research suggest that treatment intervention can improve outcomes at both the low and high chronic end of the spectrum. • Treatment seekers show better outcomes than control groups who do not seek help.

Table 1: Principles of Treatment (Moos 2009)

Despite these consistent findings in over 30 years of research, there remain unresolved issues as well.

Puzzle	Descriptor
How can we best conceptualise and examine service episode and treatment careers?	• Treatment studies examined the outcome of 'one' episode of treatment from one provider during episode in a client's life. • In everyday life, most clients will have multiple treatment episodes with a wide variety of providers. These merge in time to create treatment careers rather than a standalone intervention. • It is very difficult to dismantle the effects of multiple sources of support and numerous treatment episodes.
What is the role of health care work	• The environments in which care is delivered has an important impact on outcome but is much neglected.

environment in treatment process and outcome and in enhancing clinical morale and openness to innovation in treatment Delivery?	• A cohesive work environment that emphasises a task orientation and clarity is strongly associate with service user's satisfaction and performance in health care • Little is known about the connection between the quality of the work place, staff member's beliefs about addictive disorders and the quality of treatment. • Many organisation experience problem which legislate against the adoption of innovative and evidenced based practices such as high work pressure, ambiguity in ethos, conflicts with other providers and demoralisation in staff teams • How to address this is a new area of research
How can we better understand the Theory, Process and Outcome of Treatment?	• Randomised control trials pay scant attention to how, for whom or how treatment can work better • There is a rift between treatment models which had largely remained static in comparison to research findings that have advanced significantly • Whilst treatments work, research shows they rarely do so in accordance with their theoretical rationale
How can we identify effective treatment matching strategies?	• Treatment matching to client personality has shown poor results • Treatment matching to social functioning of the client has been more effective rather than stable personality factors • The best results have been found when treatment interventions are matched to the *specific presenting problems* of the client • Therefore practical interventions offer better outcomes than abstract theoretical interventions. • Clients who stay in focussed treatment longer, show better outcome at 6 months than those in treatment as usual conditions which do not targeted specific issues
How should we best organise and sequence treatment for dual diagnosis clients?	• Between 30-60 per cent of clients with substance use disorders have concurrent mental illness. • These clients show poor outcomes and have more complex treatment needs • Research identified that dual diagnosis patients did best in services with high support, housing support, legal and family interventions and greater emphasis on medication compliance had superior outcomes at one year follow up • Problems remain with gaps in the evidence. For example, how best to apply structured treatment to poor impulse control in these clients?
How can we best integrate formal substance misuse treatment and patient involvement in and participation in self-Help Groups?	• Patients engaged in self-help groups such as AA show superior outcomes whether they are also in formal treatment or not. • It is not known whether this is a booster effect or an amplification of treatment effects. • As self-help does not include coping skills, is mere attendance in itself effective and so does the benefit of attendance decline more steeply than coping skills programmes?
How can we develop more unified models of role of life context factors and formal and informal care in the recovery process?	• To grasp the essence of recovery, life factors, self-help and formal treatment need to be integrated into a more cohesive model of understanding. • This appears reliant on maximising three elements of treatment: a) Quality of interpersonal relationships b) Personal growth of goals c) Level of structure • There is a consistent link between these three elements and positive treatment outcome. • When treatment interventions, self-help and families are cohesive, clients appear more motivated and bonded to these settings • When these three elements emphasis independence and task orientation, they increase assertiveness and self-direction in the

	client. • Little is understood between these relationships through. For example, the CRA model may be more helpful to single clients as it supports the reconstruction of new relationships and thus increase their social resources. The Twelve Step programme may be more effective for those in high drinking social networks as it provides a new non-drinking social network. In other words, there needs to be greater understanding on how treatment affects the existing life situation of the client, whether it is a substitute, amplifies or diminishes these wider life factors.

Table 3: Puzzles in Treatment Research (Moos 2009)

Despite an emergent and consistent research base, attempts to shape everyday practice in accordance to this evidence base has often failed to materialise in everyday practice. Attempts to resolve these problem has relied upon the application of random control trials or the findings of meta-analytic studies. These approaches demand treatment is delivered to a high fidelity to a clinical manual or protocol. However, there are limits to this approach. Randomised control trials are conducted on singular diagnosis clients that are somewhat unrepresentative of those presenting in everyday treatment settings. As Moos (2009) hazard, there is no evidence based in terms of trying to apply a narrow set of treatment approaches to a much broader client cohort that exist in everyday treatment settings- "more broadly, we should recognise that efficacy trials provide only one specific context for observation and are not necessarily the royal road to a divine blue print for revealed truth" (p.551, Moos 2009). Furthermore, the failure for clinical evidence to alter everyday practice has occurred for a number of reasons:

1) Limited evidence base of what works.
2) Colleague debate about the validity of current research in respect to their own underlying assumptions about treatment
3) The inability to generalise treatment practices from Random Control Trials to everyday clinical settings
4) Less well trained and supervised staff teams working in everyday practice compared to clinical trials.
5) Self-correction of inappropriate therapy is more probable in everyday practice where it does not occur in manualised therapies in Randomised Control Trials

A central question arises whether the overt focus purely on evidence based practice as developed from clinical trials can determine everyday practice, where high treatment fidelity comes at an additional cost of inflexibility for clients. Especially as the working relationship with the client is diminished to adherence to set of clinical techniques that can interfere with the alliance that is central to treatment outcome. For example, the manualisation of motivational interviewing in itself has led to poorer outcomes. It can be difficult to square any wider goal focus in the client with the restriction of the therapeutic model. Therefore in order for treatment to be effective in everyday practice there must be an acceptable margin of deviation within the application of any standardised treatment approach to account for the wider needs.

Hence Moos (2009) phrase that 'moderately structured' treatment is the most effective. These issues can inform the broad development of an effective alcohol specification. This includes:-

- Treatment models should be selected which focus on the acquisition of life skills that facilitated the creation of social environment that is conducive to long term recovery.
- Matching clients to treatment by social functioning produced better outcomes than other personality measures. Although this is inherent within a stepped care model, it requires organisations have a clear calibration process to assess the clients function.
- Matching treatment to real problems in the client's life shows superior outcomes. Abstract or theoretically based treatment approaches should be avoided. Greater attention must be paid to the assessment and selection of specific interventions relevant to a client's life.
- Specific attention should be given to how clients will be supported into self-help movements such as AA or Smart recovery to enhance and sustain long term treatment gains.
- Family cohesion is important in increasing motivation and self-direction. Models of concerned other support should be considered an integral treatment on recovery orientated treatment services.
- Treatment outcomes are influenced by organisational cohesion. The award of new commission contract will require changes in cultures of practice within the staff teams in order to maximise the outcomes. Specific attention should be given to how organisations will manage this technology transfer.
- Duration of care is more important than intensity. Specific measures should be introduced in order to maximise attendance for the optimal treatment period in order maximise client outcomes.
- The treatment system cannot rely purely on the adoption of evidence based models of practice based on randomised control trials that have limited applicability to treatment in practice. Acceptable margins of tolerance need to be incorporated into these treatment models to account for a more diverse and complex treatment group than is included in randomised control trials.

These core themes can provide an important benchmark of contrast point to the development of the evidence base in the UK. The major policy development in alcohol treatment in the UK since the implementation of the stepped care model in Gwent was the issue of NICE Guidance in 2011. Three guidance documents were released to inform, develop and standardised treatment approaches in England and Wales. This review will focus on core elements of the Alcohol Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking (NICE 2011), in terms of how it relates to the practical delivery of alcohol services to adults in a community

settings. This is a comprehensive review and so this paper will examine core themes within the Guideline against the wider research base. The development of the alcohol system across Gwent should also consider the more detailed recommendations made by NICE as well.

Integrated Treatment Pathways: Stepped Care

NICE (2011) examined the clinical evidence of alcohol treatment pathways. Treatment pathways refer to the anticipated journey the clients makes through treatment services. The Review of Effectiveness of Treatment of Alcohol Problems (Raistrick et al 2006) advocated an integrated stepped care model as the recommended treatment framework for alcohol problems. The stepped care framework organises a range of increasingly intensive range of treatment options that are matched to the severity of the presenting clinical problems. This assumes that clients will be offered the least intensive (and cost effective) intervention first. These interventions may then be 'stepped up' should they fail to address the presenting alcohol issue into more intensive forms of treatment. The interventions of increased intensity need to be distinct in their own right rather than represent 'more of the same.' Treatment entry can occur at any level. This framework does require effective monitoring systems of the client's progress in response to their current level of treatment. Without such monitoring it is impossible to ascertain when to 'step up' interventions that are ineffective for the client.

This treatment structure offers four tiers of intervention that can be delivered by multiple or singular providers. However, this four tier alcohol model is often confused with the similar four tier structure for drug services as described by the Models of Care (NTA). Treatment in the drug misuse field tends to be sequential, with client's moving through harm reduction and motivational interventions at tier two, into a panoply of case management and treatment options at tier 3. Conversely, alcohol stepped care systems can be entered at any level. Furthermore, the distinction between tiers is more finely graded as alcohol modalities are arranged by intensity of intervention compared to drug treatment. Alcohol services are also more fluid model in offering the clients greater capacity to move through levels of treatment intensity (See table 4).

Tier	Intervention
1 Non-specialists in universal services	Bibliotherapy, computerised self-help, Information on sensible drinking, simple brief interventions, referral to more intensive care
2 General specialist and low thresh substance misuse services.	Brief interventions, triage assessments, specialist alcohol information, referral to more intensive care
3 Specialist services	Care planned specialist community

	interventions, comprehensives assessed, structured interventions, assisted community detoxification
4 Specialist intensive services	Residential treatment, inpatient detoxification, acute hospitals, mental health services

Table 4: Tiers of Services

The stepped care model has been widely used in a range of clinical settings for a diverse range of health and mental health options. However, there has been limited research conducted on the effectiveness of this organisational approach. Validation of the approach would have to examine whether the stepped care model did produce differential outcomes at low and high intensity, as this has not been demonstrated in Randomised Control Trials. Furthermore it would have to assess whether treatment preference of the client and the practitioner was a more significant arbitrator of treatment intensity entered. These issues have not yet been addressed through research.

Those studies that have been conducted, whilst insufficient to warrant a gold standard rating in terms of quality, have shown mixed results. Breslin et al (1997) found that without the objective clinical measures of appropriate treatment intensity practitioners were fairly good at identifying appropriate levels of treatment for clients. Although a later study of sequenced treatment system by Breslin et al (1999) found that more intensive treatment interventions had no added outcome for those that had responded poorly to the an initial motivational interviewing based intervention. Other studies that have been conducted tend to compare two different lower range interventions as opposed to compare a wider range of intensity. In a more limited stepped care comparison, Bishcoff et al (2000) found little difference in outcome between computer self-help and motivational interviewing telephone counselling. Non- responders in this study received continued care in the same modality though rather than being stepped up. Conversely, in a more suitable study, Drummond et al (2009) compared minimal intervention outcomes with stepped care. This stepped care model did offer a wider range of distinct higher intensity options from 5 minutes brief advice, an hour MET and then referral to intensive community treatment. This study, most closely replicating the idealised model, did find advantages in this stepped care approach though they were moderate.

The paucity of the research on the use of stepped care is situated in a wide range of factors. In practice, it appears that the term ‘stepped care’ has been misapplied to service models that were actually sequenced care. This has also occurred at a commissioning level with some areas interpreting it as the *organisation of agencies* rather than interventions. Finally, stepped care systems delivered within an agency need very clear distinction between different interventions being delivered by the same practitioners. There is a risk of therapeutic cross over, with models merging into a more integrative package of care. This can certainly be the case where there is a strong personal or organisational loyalty to specific interventions rather than the

framework itself. The paucity of the evidence on stepped care meant that the NICE Guidance (2011) was unable to make any clinical recommendations based on evidenced and so offers opinion on its use. As no negative outcomes were associated with this model, and some moderately positive outcomes, the stepped care arrangement should remain. Therefore it is recommended that the Gwent wide alcohol service retain the stepped care model but with some important caveats. Most developments of the current provision should be to ensure the integrity of the treatment system and include adaptations that improve the clinical outcomes.

Although NICE does not draw conclusions from the limited evidence base, this is revealing in itself. Whilst many agencies purport to the use of a stepped care model, they actually deliver sequenced treatment. A range of agencies currently operate alcohol services across Gwent at present based on the same commissioning contract. However, this research base suggest that they are liable to experience significant drift towards sequenced care as opposed to stepped care. This may be because sequenced care tends to be the modus operandi of drug treatment services, and therefore is inherent in many agencies work culture. Integration of drug and alcohol services may mean that the central differences between alcohol and drug systems is also lost. Greater scrutiny is therefore required to create clearly defined stepped model of alcohol.

Furthermore, whilst drug services were well established in Gwent, there may also be compromises in the implementation of a very different treatment system. Implementing and embedding new cultures of practice is difficult. This has led to greater research interest into what is termed *technology transfer.* This is the examination of how changes in policy can be effectively translated into changes in work practices (See Peters et al 2006). NICE (2011) do not refer to this evidence base, even though the central agenda of the report is to change work practice. Without the capacity to change internal cultures of practice the new specification will not be implemented with the award of a new contract. Whilst the specifications often ask how new practices will be marketed to external agencies, scant attention is often paid to the exact processes by which an agency will change its own work practices. Technology transfer research has identified a number of strategies to enhance this process. For example by the identification and targeting of opinion leaders within an agency to promote the new model of practice. Interestingly, these individuals are rarely managers or supervisors but appear to have profound influence on shaping everyday practice in their organisations. Wider strategies have included:

- Engagement of the Service Provider
- Involvement of CEOs in all Stages of Implementation
- Identification of Evidence Based Protocol
- Developing and Refine Protocols
- Mobilising Organisational Opinion Leaders
- Monitoring Fidelity of Training and Implementation

- Data Evaluation of Implemented Outcomes

Therefore, this research suggests that that the following recommendations be applied to the next specification:

- The Provider should detail the systematic monitoring of treatment response rates in order to identify where the current treatment intensity is effective.
- The Provider should stipulate referral processes for those who will step up into a higher level of interventions.
- The Provider should detail a clear system of post-treatment contact in order to ensure re-referral occurs for those who complete brief interventions
- Tiers of interventions in the stepped care model must be equitable in terms of access, rather than the dependant on the organisational preference within an agency
- Data reporting must routinely include the numbers of clients who complete lower intensity interventions and those who transit into higher intensity options
- The provider should detail its strategies to promote adherence to the stepped care framework internally and externally through technology transfer processes

Clinical Tools: General

The NTA (2011) examined 39 potential clinical assessment tools only of which five were listed as appropriate for use in NHS settings. The current evidence base remains largely unchanged as these tools are well-established. The Alcohol Use Disorders Identification Test (AUDIT) remains the gold standard for screening and assessment, whilst Severity Alcohol Dependence Questionnaire (SAD-Q) is used most widely in England to assess severity for those identified with physical dependency. The Leeds Dependence Questionnaire (LDQ) has a similar function but is less common in daily practice. The Alcohol Problems Questionnaire (APQ) has a wider role in assessing more alcohol related social problems besides dependence and may have utility in triage. Finally the Readiness to Change Questionnaire-Treatment Version (RCQ-TV) is a very brief tool for assessing the client's motivation in terms of stages of change. However, the stepped care approach is not a trans-theoretical model so probably has far less significance to everyday practice.

In the last specification, issues did arise in terms of the external agencies use of AUDIT. The take up of the tool is low in some areas and unknown in other counties. Some research found a wide variety of take up of the tool when implemented across services but could identify no mechanism that accounted for this variance. It is recommended that AUDIT remain and should be conducted at triage in order to objectively assess the severity of presentation and inform treatment placement. This might also serve as a benchmark in future analysis of the treatment system, if linked to treatment outcomes. At its simplest it might also identify functional from

dependant drinkers and their differential treatment and outcomes. Creating a field PalPase will make reporting these scores more routine and easier to extract.

In terms of comprehensive assessment, little has changed in term of the NICE guidance. However, greater attention is paid to the roles and depth of assessment at different tiers of the stepped care system. The stepped care model does require a wider range of intensity of assessment and care planning. In general, lower order assessments are not common in everyday practice, with comprehensive assessments being used regardless of the presenting need of the alcohol using client (see table 5).

Level 1: Case identification / diagnosis in universal services	• Identify individuals who need an intervention for armful or alcohol dependence • Identify those for referral to comprehensive assessment • Referral on those unresponsive to brief intervention • Identify those with significant alcohol related health problems
Level 2: Withdrawal assessment	• Assess severity of dependence • Level of alcohol consumption • Presence of co-morbid factors • Availability of personal support • Identify where withdrawal may be safely managed • Determine the urgency of the case • Provide sufficient information to integrate assisted withdrawal into a wider care plan
Level 3: Triage assessment	• Triage assessment conducted at presentation to develop and initial care plan • The need for emergency or acute interventions, health or mental health • Presence and degree of risk to self and others • Appropriate alcohol treatment intervention • Appropriate communication with those in the case management • The need for further comprehensive assessment • The need for follow-up plans
Level 4: Comprehensive Assessment	• To determine the exact nature of problems experienced by the individual across all domains • Specify needs to inform care plan • To identify planned outcomes to be achieved and methods to assess these outcomes • Alcohol consumption • Alcohol dependence • Alcohol related problems • Motivation • Self-efficacy • Co-occurring problems • Risk assessment • Treatment goals

• Assessment of the service users capacity to consent to treatment • Formulation of a care plan and risk management plan

Table 5: Levels of Assessment

The NICE (20011) list of functions of assessment at different levels is extremely comprehensive. However, they are not based on clinical evidence but rather from suggested good practice. It is also needs to be recognised that it would be impossible to implement these procedures and retain the NICE (2011) maxim that assessment should be proportional to the level of service. Based on these recommendations, each tier would be extremely assessment heavy and repetitive, as many of the domains cross over at each level. To simplify the system it would be more apt to either conduct a comprehensive assessment at the initiation of treatment to protect the client from the repeat experiences of similar assessment or offer a well-established alternatives at the triage level. Good assessment is not about rnge but relevance. The American Society of Addiction Medicine (ASAM 2001) have developed a validated brief assessment that might be deployed with non-dependant drinkers. The ASAM Patient Placement Criteria is a six domain assessment tool. Whilst it is used in the US as part of a wider treatment pathway, it may provide an effective alternative for those drinkers who are not requiring detoxification or full case management. This tool is very different from the comprehensive assessment and would offer a lower intensity, non-repetitive assessment alternative.

Recommendations:

- AUDIT is to remain the screening tool of choice
- AUDIT scores should be reported by modality
- SAD-Q or LDQ to be used by practitioners as the preferred assessment tool of dependence
- Ensure results of agreed clinical scores are embedded in PalBase for extraction.
- Consideration should be given to the ASAM or equivalent as a triage assessment tool.
- Linking AUDIT to outcome scores my offer deeper insight into treatment response rates and treatment placement in future analysis.

<u>Comprehensive Assessment</u>

The role of comprehensive assessment is to identify two specific domains of clinical problems; physiological dependence and wider complications. In terms of dependency, the comprehensive assessment must be based on established diagnostic frameworks as developed in the ICD 10 or DSM V. In general, the DSM V tends to be the diagnostic framework most used in everyday practice, but there are limitations. The DSM is designed for an American health care system where a formal diagnosis needs to be made in order for private health insurance to make a

payment for treatment. This means that the DSM V diagnosis tend to be far broader in its diagnostic range. This makes it less effective in discriminating heavy drinkers and dependant drinkers (Hasin et al 2007). In the UK, the identification of physical withdrawal is more salient, and therefore the ICD 10 may be a better diagnostic framework. Selection of consumption patterns of alcohol use may also contribute to outcome monitoring (q.v. Outcomes). Whilst some Service Providers in Gwent have incorporated diagnostic criteria into their comprehensive assessment, it is not known whether all alcohol services are using this criteria as a routine component of their assessment. The secondary function of the assessment should also be to identify the complications of alcohol consumption. This refers to the impact of alcohol on the social functioning, health and mental health.

NICE (2011) make a comprehensive list of the wider social and health domains that should be comprehensively assessed. Again, these are based on accepted practice rather than evidence. However, an emerging evidence has begun to identify pre-treatment indicators that have a predictive value on treatment outcomes. These indicators could be incorporated in to the comprehensive assessment of problem drinking to offer greater insight into the specific treatment course of the individual, specifically what needs to be addressed through case management. For example, Adams et al (2009) conducted a systematic three level analysis on predictive factors for treatment outcomes on alcohol users as well as predictive variance in outcome. The most consistent univariate predictor's were baseline alcohol consumption, dependence severity, employment, gender, psychopathology, treatment history, neuropsychological functioning, alcohol-related self-efficacy, motivation, socio-economic status / income, treatment goal and religion. When these factors were combined in a multivariate analysis, gender and baseline alcohol consumption become less predictive whilst the other factors remained stable. The most predictive factors overall were:

- Dependence severity
- Psychopathology
- Alcohol related efficacy
- Motivation
- Treatment Goal

The use of these predictive factors within the comprehensive assessment process may offer greater insight into the clinical interventions indicated and who best to address them. As such, they might serve as an important bench mark to develop

- The Provider must identify what diagnostic criteria will be included in comprehensive assessments
- Comprehensive assessment might be better informed by the inclusion of social domains that have predictive value of treatment
- Consumption patterns can contribute to baseline outcomes measures

Care Co-ordination

Case-management or care coordination are important features of all substance misuse treatment systems within the UK. However, these terms can be used interchangeably. Case-coordination refers to a role of brokering packages of care for an individual with little clinical input from the case manager. Whereas case management involves a more direct involvement in the actually care delivery of the individual, which may occur alongside other interventions. Although there are limited studies on the effectiveness of case management, research does suggests it improves outcome. Patterson (1997) found a significant difference between case managed and non-case managed clients who had lower relapse rates at 3, 4, and 5 year follow-up. Stout et al (1999) found significant difference case management and non-case managed clients, and longer periods before lapse / relapse occurred in clients. This study was interesting as a large percentage of clients also had significant dual diagnosis issues. Cox (1998) found that case management reduced the number of drinking days a client experienced post treatment, but only to a moderate degree.

This limited evidence base led NICE (2011) to categorise the outcome of case management as of moderate benefit. Whilst research has established benefits from case management in increasing motivation, engagement and take up of aftercare, it also constitutes an intensive treatment option. NICE (2011) recognised that there are more time efficient means of achieving the same outcomes, notably through the use of incentives and prompts to attend treatment. However, they do not recommend any alternative models of practice in how this would be delivered.

This does have implications for stepped care models. As we have seen, there tends to be significant drift in the delivery of stepped care approaches. Case management is a common feature throughout drug treatment systems and Providers may assume a similar delivery model in alcohol systems. Incorporating case management to all clients removes the concept of a stepped approach, reduces the economic advantages of the model and may not result in greater treatment gains at this level of service. For lower tier 2 problems, comprehensive assessment and case management is not be indicated. Instead they might benefit equally from a triage assessment and an initial care plan. These issue might them be addressed through one clinical intervention such as motivational interviewing, SBNT etc. This also requires that other systematic approaches need to be implemented by the Provider to support clients in lower intensity modalities without case management.

Based on this, the following recommendations should be followed:

- Case management is required for the highest levels of severity only
- The Provider should offer wider treatment support strategies for lower order problems that utilise routine contracting and prompt procedures such as C.P.R.

Outcomes

As social policy moves substance misuse services increasing towards outcome measures as opposed to output measures, the role of monitoring and evaluating clinical outcomes will become imperative. This requires effective and validated clinical tools that can measure treatment gains (or loses) with high degree of statistical confidence. Furthermore, treatment outcomes figures presented in isolation are meaningless. These measures need to be contextualised through benchmarking against national standards or amendable to reporting clinical significances of change. NICE (2011) reviewed a wide range of clinical outcome tools but most were rejected. This was because they were either too lengthy (ASI) or had not be sufficiently validated for alcohol services (CISS, CDP, MAP & RESULT). Alternatively, TOP is a primary drug outcome measurement tool. The protocol guidance for TOP explicitly states "the reporting of the TOP for adult primary alcohol users is not required" (National Treatment Agency for Substance Misuse, 2010.)

As a result, the NICE Guidance (2011) recommends that AUDIT is used as an outcome tool. This is a highly speculative suggestion. Whilst AUDIT is considered a gold standard for screening, it is not an outcome tool and has not been validated as such. Furthermore, the time frames involved in the AUDIT are simply too large for it to offer any hope of sensitivity to measure outcome. AUDIT asks clients to rate their drinking over the 'last 12 months.' This would mean any client completing treatment within twelve months would not register any changes whatsoever in their AUDIT score. Even if it did register change, there is no process to evaluate the significance of what this change means. Other tools commonly used in England for alcohol outcomes are the Outcome Star and Alcohol Star (www.outcomestar.org.uk). Despite their broad use in services in England they have not been subjected to full validation and validation that has been done has produced moderate results. As such, these tools still require significant research investment.

A simple and more effective alternative to outcome monitoring would be the continuation of the *Partners in Progress* already in operation at present which utilizes the ORS and SRS tools (q.v. Real Time Feedback). The ORS scales currently in use examine subjective improvement in social and psychological functioning. These measures have a very high statistical validity and can be benchmarked against global norms. However, they do not include measures of actual alcohol consumption which may be required by commissioners. This could be addressed in a very simple way. Research studies have utilised a plethora of alcohol consumption measures such as:

- Amount
- Frequency
- Amount per Episode
- Number of Days Non-Drinking
- Time Until First Drink Post Treatment

These measures could be included in the triage and assessment process creating baseline measures. As these measures are well established in multiple research studies they would not require a validation process. Selecting the consumption measures that are common in the wider clinical research could also have an advantage of offering comparison between changes in consumption patterns compared to those identified in clinical research. This would offer a bench mark of changes in consumption with these wider studies. If possible, linkage between AUDIT scores, ORS and consumption patterns might offer the opportunity for a deeper analysis of treatment service performance at different levels of interventions.

Therefore the following recommendations should be considered:

- NICE guidance does not adequately present the compelling use of any viable outcome measures, especially in the form of AUDIT
- ORS and SRS which is validated and offers wider benefits should remain the principle outcome tool.
- Additional alcohol consumption measures, harmonious with the wider clinical research may offer more accurate and clinically useful measures to assess impact on the actual consumption of use.

Alliance Factors

The weakest area of the NICE guidance (2011) is it investigation into the role of the therapeutic alliance factors on treatment outcomes. The therapeutic alliance describes the facets of treatment that are common to all therapies. This includes the establishment of:

- A warm and empathetic bond
- The establishment of goals relevant to the client
- The goodness to fit between technique and the client's treatment preference

Whilst the NICE (2011) guidance accepts that there is considerable debate regarding the impact of common factors in treatment, it does not represent this debate well. NICE (2011) suggests that the evidence of the common factors being the most important element of treatment delivery lies almost solely in the fact that randomised control trials tend to produce similar outcomes regardless of modality-known as the 'Do-Do bird effect.' Similarly, it likens alliance factors to the humanistic counselling tradition of the therapeutic relationship, but alliance research is far broader than this.

However, the evidence to support the common factors is far broader than this. Firstly, no single element of any therapeutic model has been shown to represent an active ingredient. For example, whilst CBT assumes it increases the self-efficacy of the client, clients can improve but their self-efficacy does not. Secondly, treatment outcomes in Randomised Control Trials may be similar because they do not measure the effectiveness of a treatment but the rate in which human beings can change. This may ultimately determine the rate of outcome rather than the therapy. This rate of change is effectively capped, as human beings can implement change at a top rate. Research suggests that whilst some therapeutic models cannot achieve this top rate and are sub-optimal, likewise effective therapies are unable to achieve outcomes faster than this top rate of change.

Whilst the weight of evidence supports the importance of the alliance factors, NICE (2011) does not subject these studies to a meta-analysis, but provides selective research that contradicts this evidence with one treatment study that did not find a strong relationship with outcomes and alliance factors (Ojehadon, et al 1997). However, this study was based on a third party rating of the alliance, and not the client's receiving treatment. NICE (2011) also cites Feeley et al (1999) who found that strong alliance factors tend to predict early improvement in the client. NICE (2011) cites this as evidence that variance in long term outcomes cannot be explained by alliance factors. This fails to extend this finding to the fact that early improvement *does* predict long term outcome in both psychosocial (Brown et al 1999) and pharmacological interventions (q.v. Pharmacology). This is known as the rush-trickle effect and has been identified in nearly all research studies (See Wampold 2001). The better a client does in the first three session of treatment, then the better they will be performing at two year follow-up. The lower the early response rate to treatment during the first three sessions then the poorer the client will be progressing at two year follow (see figure 1).

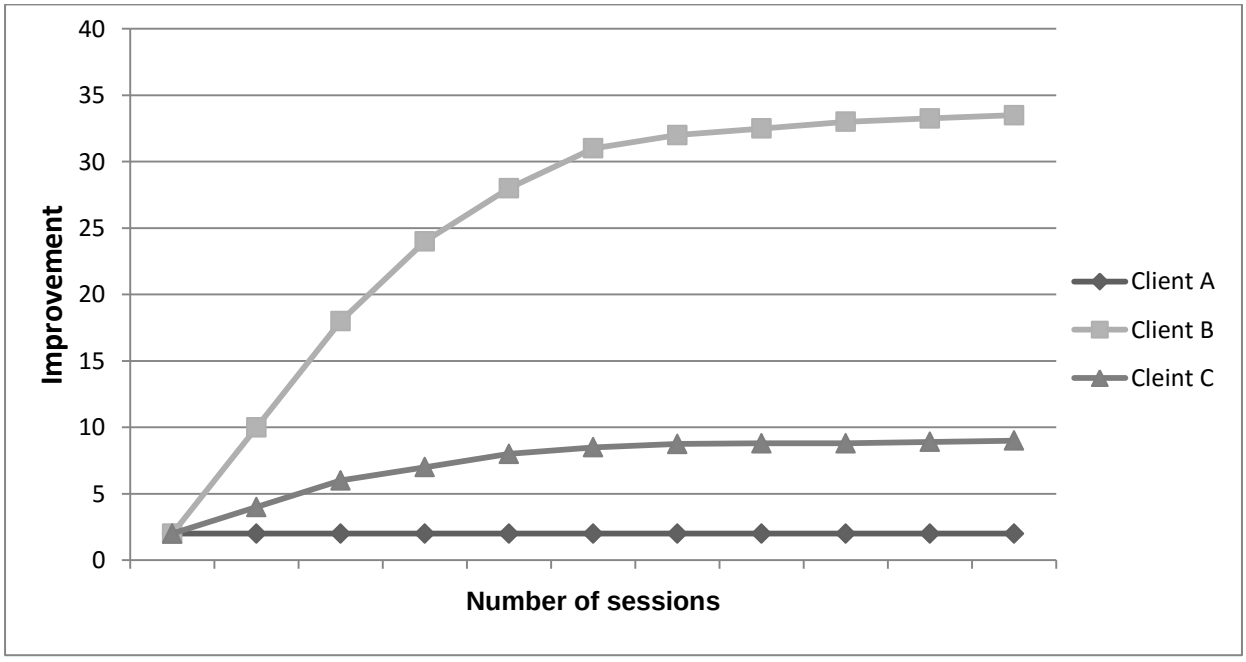


Figure 1: Representation of the rush-trickle effect.

Client A experiences no early subjective improvement
Client B experiences a low rate of early improvement
Client C experiences a high rate of early improvement

NICE (2011) suggests that alliance factors may account for 6 per cent variance in outcome. Again, this figure is misleading as it not contextualised. For example, Wamplod (2001) meta-analysis of psychotherapy outcomes found that type of therapy only accounted for 1 per cent of outcome. But the more the practitioner believed and invested in the approach accounted for 0.7 per cent of this. So alliance factors were still a bigger driver of outcome than type of therapy. Finally, there is some confusion in the NICE (2011) guidance which suggests alliance factors are an alternative to technique driven modalities. They are not. It is not that technique driven are unnecessary as unstructured treatment tends to produce worse outcomes than structured approaches. Effective structured therapies are wholly dependent rely upon the practitioner transmit them to the client in way that is meaningful to them and encourages their participation. The relevance, understanding and goodness fit between the technique and the client's preference is what is predictive of the outcome, not a relationship in itself.

For example Swift et al (2011) meta-analytic review of 35 studies which examined the relationship between client preferences and outcomes found that clients matched to their preferred therapy conditions were less likely to drop out of therapy prematurely and showed greater improvements in treatment outcomes. Improvement in outcomes occurred in all eight studies of concerning substance abuse. These outcome did not differ whether preference was chosen by preferred role, therapist characteristics or treatment approach. Clients hope and fears of treatment are not universal or necessarily harmonious with the treatment priorities of their practitioner. The clients preferences should be assessed before the start of treatment, re-assessed throughout the therapy process, and accommodated to whenever possible.

Likewise, NICE (2011) state that outcomes are located in practitioner competence. However, the studies they cite compare therapist outcomes *within* studies rather than across their careers. In a meta-analytic study that compared years of practice with clinical outcomes found no correlation between these two domains (Beutler et al 1994). Practitioners in Randomised Control Trials are closely monitored in order to ensure treatment fidelity to the model being studied. Research suggest that this high fidelity is not maintained once the cameras cease. Studies reviewing practitioners across their careers has identified little differences between novice and experienced practitioners. For example, the most effective therapist achieve 50 per cent greater outcomes and 50 per cent less drop out than the least effective therapists even in deploying the same therapy (Wampold & Brown 2005). Furthermore, 97 per cent of this variation is attributable to alliance factors (Baldwin et al 2007). So, it is not that the averaged treatment outcomes of different therapies that supports alliance research, but the variance that occurs within these studies that is most revealing.

The area of the therapeutic alliance and therapist factors that influence outcomes are not systematically explored within the NICE (2011) guidance perhaps because of project bias. The central function of the NICE guidance (2011) is to promote the most effective models of interventions delivered to the right client by appropriately skilled practitioners. This methodology works very well in general medicine. However, the extant research base in talking cures disputes the possibility of this project. This is because treatment outcomes reside in a wider range of defuse factors, some of which are even beyond the reach of treatment.

Research has focussed more deeply on therapist factors that led to improved outcomes. This research has challenges the accepted wisdom that experience, training and supervision leads to increased effectiveness. Instead, an emerging evidence base has found wider variable that influence the effectiveness of the practitioner. For example, a study of the impact of a two day motivational interviewing training course demonstrated that the skills tended to decay in most practitioners. However, in the most proficient pre-training practitioners, it excelled their practice (Baer et al 2004). Research has increasing illuminated the drivers of effective practice has excelled in the last decade (see Orlinsky & Ronnestad 2009). However these findings are yet to percolate workforce development strategies that still tend to operate on the misguided assumption that experience, qualifications and supervision improve practice when they have little impact (Nyman et al 2010). Workforce development should be embracing this emergent research base, less it fall foul of the very problems it hopes to address.

- NICE (2011) displays a misunderstanding of the common factors of treatment outcomes that need to be promoted within any treatment system
- NICE (2011) suggestions of practitioner competence do not tally with the wider clinical research
- Workforce development strategies can be significantly enhanced through the adoption of research that has identified factors that do improve a practitioners outcomes

Real-Time Feedback

The most significant area of interest and rapidly expanding research base in treatment outcome is the use of real time feedback processes to enhance treatment outcomes. This entails session by session monitoring of client progress and offers the opportunity to rapidly intercept clients who are not responding to their current treatment intervention as expected. Within the context of the last contract awards, the utilisation of client feedback was included as an integral element of data reporting and treatment activity. Research into this area has increased since this

time and continued to support the central importance of routine clinical feedback. This research has substantiated the fact that feedback not only increases client outcomes but also reduces negative cases. For example, Crits-Chirstophe et al (2012) offered counsellors at non-methadone substance use counselling services regular feedback on their overall caseloads progress. This broad figure had little impact on treatment gains. Instead, feedback was provided on each individual client in terms of:

- assessment of the therapeutic alliance
- satisfaction with treatment
- psychiatric wellbeing
- social functioning
- drug and alcohol use

These assessments were made just before each counselling session and therapists could automatically see the client's treatment responses. This feedback also categorised patients as:

- doing so well that treatment might be ended
- progressing as expected
- doing worse than expected ('off-track' clients)

When clients failed to make the anticipated progress, counsellors were instructed to consider changing treatment based on a second questionnaire that was automatically triggered if the client's outcomes were off track. When these did not seem to account for poor progress, counsellors were trained to consider a different kind of treatment, such medications rather than just counselling. About 40% were calculated to be doing less well than expected – off-track – at some stage in their treatment and (in the feedback phase) were asked to complete the second questionnaire. On all three measures (drug use, drinking, total problem scores) off-track patients whose counsellors were offered feedback on their progress and given suggestions about how to respond progressed better than similar patients without feedback. However, only in respect of days drinking in the past week did the trends differ to a statistically significant degree, resulting in the poorly progressing clients drinking no more than 'on-track' patients.

A second analysis followed the off-track clients but only from the time counsellors were alerted to their poor progress. Responding to feedback in these clients triggered positive change. Up to the point when counsellors were alerted there was little difference between feedback and non-feedback patients, but from then on feedback patients progressed much better on all three measures (drug use, drinking, total problem scores), though now it was the results for drug use and total problems which diverged to a statistically significant degree, while days of drinking did not.

In terms of negative outcomes, research reveals that between 5-10 per cent of clients deteriorate with in treatment despite the best efforts of their therapist

(Lambert & Ogles 2004). Lambert (2010) has developed an IT feedback system whereby a client reports their progress on a lap top prior to treatment sessions. This progress is then benchmarked against similar client's progress. When the client is not achieving this rate of change, a further questionnaire is flagged up that asks the client specifically about their reason for treatment progress. This has reduced negative cases from 20 per cent of cases to 5 per cent of case load.

A meta-analytic review commissioned by the American Psychological Association (Lambert & Shmokawa 2011) also found that feedback improved outcomes. Furthermore clients doing poorly in treatment could be 'rescued' when therapists get real-time feedback on patient progress and the client-therapist relationship. This review drew on this existing meta-analysis with randomisation, and conducted a new one amalgamating results from the three Partners for Change system studies. (The Partners for Change system is the operational name of the Outcome and Session Rating Scales currently endorsed in Gwent.) Across the three studies of the Partners for Change system, clients in the feedback group was better off than about 68% of those whose treatment did not utilise systematic feedback. For both feedback and non-feedback groups, the odds of being an improver versus a non-improver were 3.5 times higher in the feedback condition. Whilst deterioration versus non-deterioration was more than halved in feedback-informed therapy.

The Outcomes Questionaire (OQ System) (Hawkins et al 2004) feedback is another real time feedback model designed to reduce negative outcomes. Across the six studies on this approach, fewer clients did poorly in feedback-informed therapy than without systematic feedback. As measured by the system's own scale, feedback significantly improved post-treatment psychological wellbeing and social functioning to a small to medium effect size of 0.25 when feedback on these dimensions was provided only to the therapist. This effect was no stronger when feedback was also provided to the client. However, it was strengthened when instead of feeding back to the client, the therapist was given feedback from the therapeutic relationship scale plus guidance on corrective action. The average clients in the feedback condition ended better off than 70% to 76% of those without systematic feedback.

These studies point to the importance of dealing with poor response in clients. A meta-analytic review (Safron & Muran 2011) reported on two research synthesis describing response to alliance breakdowns between client and therapist – known as 'alliance ruptures' – and the impact of repairing this relationship. The first analysis examined the relationship between outcomes and alliance ruptures and their repair during treatment. These three studies identified that rupture-repair episodes existed in nearly all treatment cases, as indicated by substantial downs then ups in therapeutic alliance measures taken in adjacent sessions. These tensions therefore seem inherent in therapeutic relationships. The second analysis examined eight studies which provided data on the impact of efforts to help therapists avoid and repair ruptures through training or supervision with a specific focus on improving therapists' abilities to manage alliance ruptures. Seven of these studies included a control group of clients where practitioners had not received any training in rupture resolution.

This study found that the number of rupture-resolution events identified by alliance fluctuations was predictive of the progress made by clients. This link equates to an effect size of 0.24, a statistically significant, moderate-strength relationship. These results also indicated that depressed or personality disordered clients, who figure heavily in alcohol using populations, achieved greater symptom relief and improvement in wellbeing when difficulties with their practitioner were overcome by the next session. There was significant client improvement associated with rupture repair training or supervision. In the seven studies which used control groups, rupture repair skills gained by training or supervision equated to an effect size of 0.11, about 1% of the variance in outcomes. The greatest extra gains occurred within brief cognitive-behavioural treatments of anxious or depressed clients. In contrast, clients in longer, dynamic and relational treatments for personality disorder experienced no extra benefit from practitioners who had received rupture repair training. These studies did not report increased rates of drop-out for those with rupture repair though. In this domain, the intervention may have produced more significant outcomes.

From these studies it seems that individualisation of feedback, including actual substance use and not just the therapy was important. Plus, the counsellor access to guidance on how to respond to blocked clients. A further consideration was also offered regarding how likely counsellors were to respond to non-responsiveness. If there is no risk of any reputational damage to either the practitioner or the organization, then poor performance is generally disregarded. Only when the feedback is made public, such as with managers or through commissioning reviews does it exert pressure on practitioners to respond and address treatment non-responsiveness. The NICE guidance (2011) recognises the importance of real-time feedback processes “Routine outcome monitoring (including feedback to staff and patients) has been shown to be effective in improving outcomes (Lambert et al 2002). Routine session-to-session measurement provides a more accurate assessment of overall patient outcomes (Clarke et al 2009)” (NICE 2011 p. 163)

This is an important finding considering that real time feedback was included in the last specifications in Gwent. Utilisation of the approach has been polarised with some agencies making extensive use of the system whilst others have not. Data compiled from organisation that have used real-time feedback demonstrate very low rates of poor treatment response but this cannot be assessed in those agencies that have not implemented the system. This needs to be address, particularly in light of the increased international recognition of real-time feedback in enhancing outcomes. Since the implementation of the previous contracts, the ORS / SRS outcome monitoring (Bringhurst et al 2006; Campbell & Hemsley 2009) has been recognised by the US National Registry of Evidence Based Programmes and Practices, who rated the approach as excellent and without weaknesses. The NICE guidance also recognises the value of the real time feedback but does not name any model or approach. Therefore, it is recommended that the now named ‘Partners for Change’ approach is continued in the treatment contracts. Furthermore, the outcomes produced through Reliability Change Indication should play a more prominent role in Quarterly Reports and in practitioner supervision in order exert optimal leverage on its unilateral adoption. This will also become increasingly important within a policy climate determined by outcomes rather than KPI output measures.

The Reliability Change Indication should occur by intervention and detail what clients are experiencing:

- Deterioration
- Null Change
- Reliable Change
- Clinically Significant Change

As 5-10 per cent of client deteriorate in treatment, this should be used as a benchmark to these outcomes. Higher rates of deterioration or non-change should be examined more closely to establish the Providers response to these lower than expected outcomes. As treatment drop out is closely associated with poor treatment response, non-completion of the clinical tools should regarded as a negative outcome. Furthermore, within a stepped care system, which operates on the principle of 'stepping up' non-responsive cases to a higher level of intervention, this close monitoring of clients progress should be intrinsic element of treatment delivery.

Therefore the debate regarding treatment efficacy is not an issue of whether the most effective models should be deployed, or whether common factors should prevail. Rather the most effective models should be delivered within an outcome informed structure and adapted according the responsive and preference of the client. The most powerful outcomes will therefore be achieved through the application of NICE guidance and the client's participation in these processes.

- Real-time client feedback improves psychotherapy outcomes overall and reduces the risk of deterioration or drop-out.
- The role of outcome reporting must play a more central role in the reporting of client outcomes and supervision. Whilst some agencies in Gwent have made considerable progress in the use of this system, coverage must occur across all modalities.
- Scrutiny of the outcomes from real-time feedback must become a central activity for commissioners in order to exert greater pressure on the systematic implementation of feedback approaches to minimise negative cases
- Consideration should be given to using electronic versions of feedback systems and accompanying manuals should be included within the specification
- Training programmes should include skills in repairing ruptured alliance and poor treatment responses in clients in order to increase practitioner confidence in successful addressing poor response rates in clients, especially for supervisors
- Non completion of the tools with a client should be considered as a negative case

Psychotherapy Models

NICE Guidance (2011) concerns the evaluation of various established talking therapies within the field of alcohol using a strict review and selection process. Modalities were included if they were:

- Planned
- Relevant to the treatment population
- Manaulised or well structured
- Ethical

Significant mental illness is treated separately. In accordance with wider research NICE (2011) suggest that individuals with co-occurring anxiety or depression should be treated for alcohol problems first. This is because alcohol has such a high causal role in the development of these disorders that people are liable to remit from these disorders should they stop drinking. However, NICE (2011) suggest a trial 4 weeks treatment before referral onwards to primary mental health care. Whereas clinical research suggests that treatment gains do not occur in significant mental health until 6 weeks. The main evaluation findings are described in table 6:

Therapy	Outcomes
Brief-MI / MET (Includes Motivational Interviewing, MET)	• Performed better than control groups but same outcomes in comparison to other models, especially when combined with relapse prevention • Combination therapies are important as some studies have shown MI's effectiveness is not enduring
Twelve Step Facilitation (A manualised version of Twelve Step Treatment)	• No difference between TSF and other comparative treatment • TSF slightly better at reducing drinking days in the first 6 months but no difference after this point
Cognitive Behavioural Therapy (Social Skills, Coping Skills, Structure Relapse Prevention, Relapse Prevention, , General CBT)	• CBT out-performed control groups in reducing heavy drinking episodes but not number of days drinking or relapse rates at 6 months • CBT reduced relapse rates at 6 month follow up compared to treatment as usual • No significant differences in outcome have been found between CBT and other structured interventions • Comparison of different types of CBT found little differences in outcome, though the results did favour Relapse Prevention to other forms of CBT • Intensive Coping Skills CBT did better than standard Coping Skills, but differences disappeared at 18 month follow up
Behaviour approaches (Cue	• One study found behavioural therapies were far more

exposure, Control Drinking –Behavioural Skills Control Training)	effective than control groups in reducing drinking or controlling use but between relapse rates • No differences emerged between behavioural approaches and other structured interventions • Dropout rates were slightly higher in behavioural groups • No significant difference emerged between types of behavioural therapy
Contingencies management (Use of rewards in combination with behavioural contracts)	• Based on study, considerable difference emerged between contingency and control groups until 15 months when outcomes equalised • In comparison to standard treatment, no differences emerged except contingency's reduced relapse into heavy drinking • The addition of contingencies increase attendance rates • Contingency did not add to the outcomes of support network therapies • Network therapy with contingencies did show better abstinence rates at 12-24 months follow up • Contingency have shown much better result for drug users than alcohol users
Social Environment Therapies (SBNT CRA)	• SBNT increased changes to pro-social drinking groups and attending AA compared to case management only • Both SBNT and CRA were significantly better than control groups at sustaining abstinence than control groups until 24 month follow-up point • SBNT & CRA were no better at reducing drinking at follow-up compared to control but did reduce quantities drunk on these occasions • CRA & SBNT saw no advantage over other active therapies in clinical trials.
Couple Therapy (including Behavioural couple therapy)	• No active differences between couple therapies and other active interventions at two month follow up but it was more effective in sustaining abstinence over 12 month follow-up but not longer • One study found CBT was slightly more effective in reducing relapse than BCT • BCT showed no significant differences with other comparative couple interventions at 24 month follow up • Intensive brief couples therapy was more effective than couples therapy in achieving abstinence at 1 month follow up but outcomes equalised at 18 month follow up • Combing parental skills with BCT did not significantly improve abstinence rates at 12 month follow up
Counselling	• Difficult to define this more generalised approach • Counselling did not show any significant over control groups in reducing heavy drinking or in maintaining abstinence • No differences between counselling and other interventions when assessed at 6 month follow up

	• Couple therapies and CBT coping skills training showed significant benefits over counselling in maintaining abstinence at longer term follow up periods of up to 18 months.
Short term Psychodynamic	• Single study showed moderate improvement over CBT in maintaining abstinence at 15 month follow up • No differences in quantity of alcohol consumed, heavy drinking rate or attrition
Multi-modal: Components of a number of interventions such as MET/ TSF/ AA/ Self-Help.	• A small effect in better outcomes were achieved in psycho-education over multi-modal therapy in maintain abstinence post treatment • Counselling more effective the multi-modal therapy in reducing relapse rates but not after 12 month follow up
Self-Help (bibliotherapy, computer assisted programmes, web pages or self-help manuals.)	• One study found that guided self-help appeared more effective than non-guided self-help in terms of quantity of drinks consumed at 9 month follow-up but no difference at 23 months follow up • Most studies were excluded as they target hazardous drinkers as opposed to heavier/dependent drinkers
Psycho-educational Interventions (Videos, lectures, advice, usually used in an adjunct to other treatment.)	• Mixed results in terms of some studies found active interventions better or no different in outcome to psycho-education • Some studies found active interventions more effective in increasing the length of period of abstinence post-treatment at 6 and 12 month follow ups
Mindfullness	• One study found superior outcomes for mindfulness over chemical dependency programme & psycho-education • However, these modalities were blurred in delivery and severity of alcohol problems pre-treatment was not reported • Another pilot study examined mindfullness for those leaving an outpatient programme found that mindfulness cohort reported significantly fewer drinking days at 4-, 8 and 12 week follow up but not 16.
Acupuncture	• One non-randomised study found reduced drinking episodes in 3 and 6 month follow up compared to control group • One study compared acupuncture to transdermal stimulation and a control group and found no differences in outcome • Other studies found no difference in craving reduction, one of the central aims of acupuncture
Carers	• No differences between CRAFT and 12 Step self-help groups in reducing drinking rates in loved one • Significant improvement in the carers occurred in both groups. In terms of the Five Step approach, no differences were found between active and self-help versions of the intervention

Table 6: Evaluation of Modalities

Based on the findings *and the quality* of these studies, NICE recommended that BCT showed superior outcomes to treatment as usual, active controls and other active interventions. Furthermore the evidence supported CBT, SBNT and behavioural therapies as better than treatment as usual or control groups. Twelve Step Facilitation and Motivational Techniques appeared no better than standard interventions, and a lack of evidence to suggest that they were better than treatment as usual or control groups. Instead they were seen by NICE (2011) as important components of the alcohol treatment system rather than main stay interventions in tier own right. There was very limited evidence to support the use of counselling, short term psychodynamic therapies, multi-modal treatment, self-help based treatment, psycho-education or mindfulnesses. Again, some of these interventions move into the category because of the paucity of research rather than anything else.

In terms of economic benefits. The research suggests that adding psychological therapies to home detoxification would have cost saving benefits. One study identified that Coping Skills Training, BCST (controlled drinking programme), MET & Martial family therapy offered significant health care cost savings compared to standard care. MET was found to produce cost savings in moderate problem drinkers. Whilst another study found MET generated higher cost savings compared to Twelve Step Facilitation or CBT, largely due to its brief nature. Likewise, Brief Relationship Therapy was found more economically effective than Behavioural Couples Therapy or IBT. However, paucity in the research make this impossible to be truly definitive. NICE do offer a breakdown of the unit cost of each therapy based on costs derived from clinical studies or current rates of professionals time. However, these figures are somewhat meaningless in a competitively tendered market place.

There are issues in the organisation of this table. For example, BCT is included as a couple therapy and CRA is an environmental therapy when they in fact both behaviour approaches that make extensive use of contingencies. Likewise Relapse Prevention often makes extensive use of Cue Exposure. The outcomes used in the evaluation of these studies are largely based on drinking rates. However, there is a pattern of jagged drinking over two years post treatment, even in successful changers. Scant attention is paid to the improvement is psychosocial functioning, even though this tends to be more predictive of long terms gains. Finally, improvements in therapy tend to occur early and even out over time, particularly at the two year mark. At this point, treatment and non-treatment groups tend to achieve a similar rate of gain.

NICE (2011) set a high bar in term of quality control for the assessment of suitable research studies that could be included. This excluded a number of studies leading to some modalities being evaluated based on one single study. There is a conflict between quality assurance versus the actual treatment sample sizes that get

included into the final summary. The strictness of their criteria excluded so many studies that ultimately the NICE Guidance at times only offers an opinion of the panel rather than clinical evidence.

Motional Interviewing and Motivational Enhancement Therapy

Specific issues were raised in regarding motivational interviewing based approaches. This is a widely adopted modality within the counties of Gwent, along with the spin-off intervention Motivational Enhancement Therapy (Miller et al 1992). Recent progress in research has made significant revision to the former and identified significant problems with the latter. Motivational interviewing was a brief intervention developed in the 1980's as a new model to address alcohol problems, but has since been applied to a wide variety of fields. In its original inception, motivational interviewing was a personal-centred / directive approach that looked to increase motivation to change in problem drinkers who were contemplating change but yet to commit change. The 1st Edition of Motivational Interviewing was based on an emergent research base that indicated that a warm collaborative relationship was necessary to facilitate change. Within this, there was considerable emphasis on resolving ambivalent feelings towards change which were assumed to paralyse the change processes. For example, whilst clients recognised that there drinking was problematic they also perceived many psychological and social benefits in continued use. Where these pros and cons remained in balance, the drinker would continue to drink until the balance was tipped. This might be through life events or could be achieved cognitively through a review of the cost-benefits of use. This was a combined with a reflective listening style that sought to identify the deeper values and beliefs of the client. As they values emerged, there would be a greater discrepancy between their current behaviour and their values, prompting lifestyle change. This was revised in the 2nd Edition of motivational interviewing, which placed greater emphasis upon the development of internal discrepancy in the client and even more importance to the use of the deep reflective listening style. Resistance to change was not seen as a the result of a deep psychological denial in the client, but the product of a confrontative interviewing style that was liable to generate reactance in the client, forcing them to formulate an opinion in the opposite direction.

In March 2013, the 3rd Edition of Motivational Interviewing (Miller & Rollnick 2013) was published. In light of extensive research, substantial revision has occurred with the context of this approach. Working in partnership with linguistic analysis, it was discovered that the resolution of ambivalence was not necessary for change to occur. Instead, the reflective listening component of the intervention appeared to be the most important element of the intervention. These studies reveal that the commitment inherent in the clients statements regarding change were highly predictive of subsequent commitment to change. During the course of treatment, the client's language commitment would deepen from 'I might' or 'I could' statements towards greater commitment. This included 'I will..' 'When I do..' 'I must…' within

this reflective listening did not merely reach beneath the meaning of the clients statement but had to exhibit linguistic parity. The strength of the reflection has to mirror the clients own language commitment. This is not just driven by the client's own process as improving this skill in Motivational Interviewing training leads to improved outcomes (Amrhien et al 2004). Where the practitioner out paces the client, i.e. they reply with a statement that is greater than the clients actual language commitment, there could be a collapse in outcome. Change occurs when clients shift up into this deeper language commitment in harmony with the practitioner's reflection.

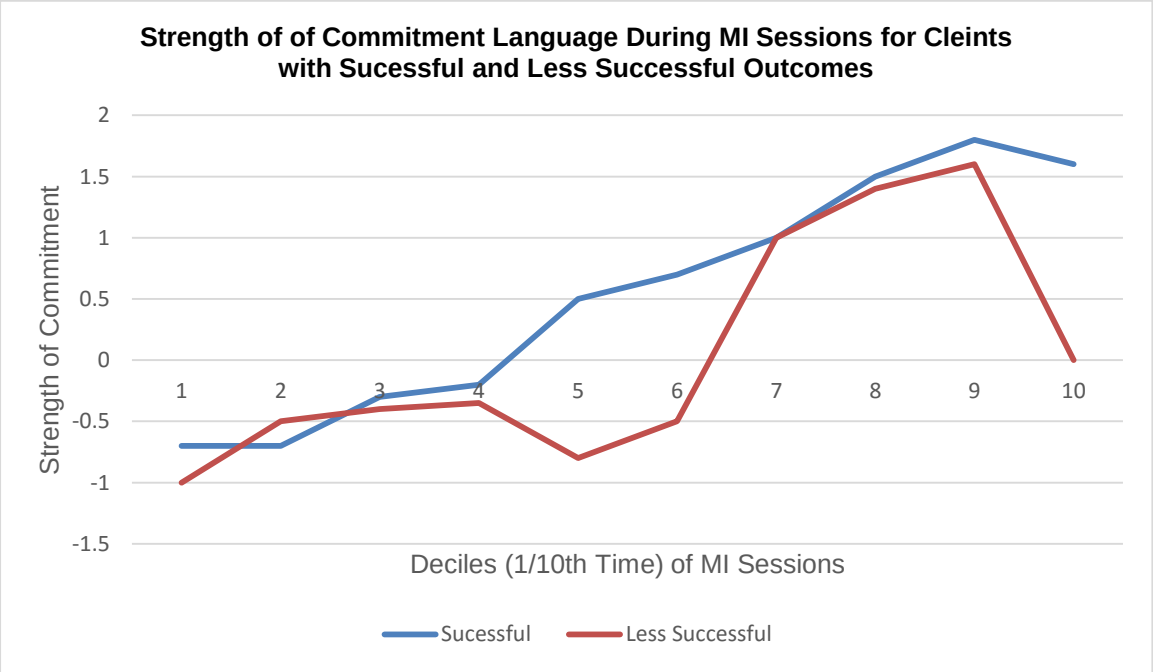


Figure 2: Commit Levels in Motivational Interviewing Verses MET (Amrhein et al 2003)

These developments raises serious questions regarding the efficacy of Motivational Enhancement Therapy. As a manualised approach it pays far less attention to the pace of the client's language commitment. In clinical trials that compared practitioners using Motivational Interviewing to Motivational Enhancement, clients appeared to progress at very similar rates until the moment of committing to change was reached. In the Motivational Interviewing cohort only, this commitment phase elicited behaviour change. However, in the clients that experienced element of Motivational Enhancement Therapy it marked a collapse in commitment. The threshold of language commitment had not been achieved and resulted in the client reversing motivation (Amrhien, et al 2003). This effect has also been identified within some of the treatment data in the counties of Gwent. It suggests that the Motivational Enhancement Therapy could be sub-optimal compared to Motivational interviewing in its latest incarnation. As the same research team was responsible for the development of both models, this may not simply be a partisan opinion or an allegiance bias effect. Therefore, based on the data, Motivational Enhancement

Therapy is not indicated and should not be considered with the framework of the new contract.

Furthermore, if Providers within the new bidding process deploy Motivational Interviewing as a treatment modality, it will be vital that this is based on the 3rd Edition as opposed to the older variants. The Provider will need to demonstrate how this specific edition will be developed within the teams and ensure that workers operate under this new context. Supervision codes exists to monitor the application of this new approach.

This also has some implications by default for social behaviour network therapy. Again, this is a popular model within the current milieu of treatment interventions in the Gwent region. Randomised control trials by the UKATT teams compared the efficacy of social behaviour network therapy with motivational enhancement therapy. Both produced a similar range of outcomes. AS these outcomes were similar, and motivational enhancement appears sub-optimal, it does raise issues with the viability of social behavioural network therapy as well. However, this is an inference rather than an established fact.

- Anxious or depressed patients should be offered 6 weeks treatment, not four weeks.
- Most structured model produced a similar range of outcomes with environmental models being the most consistent (SBNT, CRA, CBT, BCT)
- General counselling models are not to be included in the next specification
- MET is not indicated and should not be considered in the next specification
- MI should be based on the third edition and used in combination of relapse prevention

Internet Based Self-Help

A considerable area of development in recent years has been internet based self-help programmes. Computer-delivered self-help interventions offer a low-cost way to extend intervention to risky and problem drinkers. Such treatment by-passes stigmatisation of treatment entry and retains anonymity. Automation also assures treatment is delivered as intended. NICE (2011) does not examine these models in depth but research has found positive outcomes from their use. Riper et al (2011) synthesised nine studies into a meta-analysis which found positive results. Typically these interventions tend to two take one of two forms. One is based on screening, along with a single session of normative feedback and guidance on controlled drinking. Other interventions are longer, comprises of a virtual treatment programme. These can be up-to six weeks and are based on protocol-driven therapeutic programmes usually influenced by behavioural self-control, cognitive-behavioural therapy, motivational interviewing, or a combination of these models.

The nine trials examined involved 1,553 risky drinkers. Five trials tested single-session personalised normative feedback interventions, as well as four more extended programmes. Substantial differences in the results of the studies meant there was no single 'true' impact of e-self-help. However, across the studies the impact on drinking amounted to a statistically significant moderate effect size of 0.44 adjusted for sample size. One study showed a very high rate and another a very low rate of impact through. Excluding these studies still produced an effect size to 0.39. The findings were equivalent to needing to intervene with five excessive drinkers in order for one to achieve the desired reduction in drinking sustained over the next six to nine months. The extended self-help programmes demonstrated the largest effect size (0.61) than the four of (0.27) brief interventions, though both were statistically significant impacts. However, no significant differences in impact were related to whether the intervention was delivered at home or elsewhere, how the control group was constructed, the size of the sample, or whether only people who actually participated in the intervention were included in the analysis.

E-self-help interventions might be effective as first-line choice in a 'stepped-care' approach to problem drinking, followed only if needed by more extensive or expensive interventions. Requiring no face-to-face contact, in economic terms they have considerable promise compared to other approaches with relatively high implementation costs. A particular role for alcohol self-help web sites is that they offer a quick and accessible way for drinkers to address their desire to tackle their problems. Some suggest it is this rapid access to treatment that may be more important than treatment itself, in a society with the expectancy that treatment interventions are required to address these problems.

Certainly E-self-help tends to attract functioning problem drinkers. The most researched British alcohol self-help web site is the Down Your Drink site. An analysis of data provided by the first 10,000 people who registered at the site revealed that most were between 30 - 40s years old, half were women, almost two-thirds were married or living with a partner, only 4% were unemployed and most were in occupations from higher socioeconomic positions. Similar result have been found in other studies. However, the low commitment demanded by these programmes appears to cut both ways. In one study of Down Your Drink (Linke et al 2004), there were 7,581 visits to the site in six months. A total of 1,319 registrations occurred of which 61.8 per cent completed week 1 treatment, but only 6.0 per cent stayed on programme to the end. Such low completion rates undermine the cost benefits of the approach. These software programmes can be expensive to purchase through annual licences, with one commercial programme costing £32,000. In a small area of Gwent, this might not represent good value, largely because of these poor completion rates. Closer examination of cost verses likely completion rates would need to be examined before they were adopted.

- E-Self help offers a novel low tier interventions.
- Cost effectiveness can only be achieved if suitable numbers of clients engage and complete. This would require a review on a cost per programme basis.

Modalities: Pharmacotherapy

Recommendations regarding prescribing options are beyond the remit of the author. So this following section is included for information purposes only with some wider psycho-social considerations included. NICE (2011) reviewed five assisted withdrawal studies, one being randomised, three were retrospectively matched and one was a case study based on patient characteristics. A further 5 open studies were also included, one including an element of psychotherapy within the process. These studies compared both the outcomes and the safety of inpatient versus home detox. Most studies found home detox was safe, but many of these studies had excluded clients with the sever withdrawal and psychiatric symptoms. On the whole, inpatient, day hospital and community based detoxes have tended to produce similar outcomes regardless of medications used. Inpatient detox may be indicator for clients with more complex needs such as:

- Those experience severe withdrawal and delirium tremors
- A history of repeat detoxification episodes
- Pregnancy
- Co-morbid medical, psychiatric or surgical disorders
- Patient is unable to take medication by mouth
- Some evidence suggests repeat detoxification increase risk of fitting or seizures
- Concurrent drug problems
- Failure to complete home / community based detoxification

A summary of the main findings are described in table 7.

	Licenced Treatment
Acamprosate (Anti-craving medication for relapse prevention.	Significant but small effect in promoting abstinence compared to placebo Most pronounced outcomes at 6 month follow up but remained significant at 12 month follow up One trial found outcomes continued for a further 12 months post-treatment. Tended to show high retention rates.
Naltrexone: Opiate blocker that reduces the euphoric effects of alcohol. Used as a relapse prevention drug.	Oral naltrexone showed small but significant effect on reducing relapsing rates to heavy drinking compared to placebo Adverse side effects of naltrexone attributed for higher dropout rate A comparative trail found no differences between Naltrexone and Acamprosate but the Naltrexone group were less likely to return to drinking. No significant difference occurred between Naltrexone and Topiramate, or Naltrexone versus Naltrexone plus Sertraline.
Acamprosate and Naltrexone combined	No difference between combined or individual prescribed medications

	Though a moderate effect was seen in slightly lower relapse rates in the combined group at 6 month follow up but no difference at 3 or 12 months
Oral Disulfiram (blocks enzymes that metabolism enzymes causing adverse reaction if used in combination with alcohol.	No significant differences in outcomes between Disulfiram and placebo-but Disulfiram delayed the onset of first drink post treatment compared to Acamprosate, decreased alcohol consumed and number of drinking days It also had the same delay effect in comparison to Naltrexone, but the naltrexone group were more likely to return to drinking or relapse into heavy drinking compared to the Disulfiram in open label trials Similar results were also found in comparison to Topiramate. Disulfiram as an adjunct to counselling produced no difference in outcomes to counselling alone.
Non-Licenced Medications	
Extended release injectable Naltrexone	Did not reduce drinking, though generated a longer period before first drinking and higher abstinence rates in favour of the naltrexone A second study of high dose Naltrexone compared to standard dose found reduced heavy drinking in both groups, but favouring the high dose cohort.
Nalmefene (Akin to a long acting Naltrexone)	One study reported significantly fewer relapse with Nalmefene but a second study found no efficacy of the drug compared to placebo even across a range of doses.
SSRI (Antidepressants that operate on the sertongenic systems.)	Mixed results with some studies finding a positive effect for type A and Type I alcoholism but worsening outcomes for type B or type II compared to placebo. In combination with naltrexone it also had little effect.
Baclofen (GABA-B Agonists)	Currently under investigation but existing research has not supported its use.
Topiramate (Anti-convulsant)	It has been shown to reduce heavy drinking and promote abstinence Can be initiated whilst people are drinking but working towards abstinence Some studies found it had an early effect that diminished at the 12 week follow up point No difference in outcomes compared to Naltrexone More severe side effects reduce compliance rates
Gabapentin & Pregabalin (Anti-convulsants and anxiolytics)	Reducing calcium currents in the brain, leading to easing of withdrawal Gabapentin has been shown in some studies to reduce alcohol craving and increase time to heavy drinking One study found that Pregabalin showed

better outcomes than Naltrexone.

Table 7: Pharmacology Evaluation

In summary, NICE (2011) suggest that SSRIS are not considered a first line of prescribing for alcohol problems. Injectable Naltrexone has shown potential but needs further study before routine use is recommended. There is limited and inconclusive evidence for Nalmefene, and limited evidence for baclofen and anti-convulsants.

In the opiate blocker naltrexone has been licensed in the UK for the treatment of alcohol dependence. The delay in licensing was due to no applications being made rather than any clinical evidence against its use. This now means naltrexone may have a far more prominent role in the UK treatment field compared to the main alternative, Acamprosate. Statistics for England in 2012 (HSCIC 2012) demonstrate that doctors (largely GPS) have favoured Acamprosate, prescribed 117,405 times compared to 60,842 for Disulfiram. However, in hospitals with severely dependant patient group, tend to favour Disulfiram. Initial abstinence is a preferred objective in this group and there is immediate support for patients and staff to manage the risks of prescribing Disulfiram.

Medication Compliance

Adherence to medication prescribing regimes is a central challenge for the treatment all a wide range of disorders, but is particularly salient in the alcohol field. The prescribing of medications is costly and their effectiveness relies purely on the patient's willingness to take the drug, be it Naltrexone, Acamprosate or Disulfiram. This may also be important with the context of home detoxification from alcohol, which can also show very poor treatment completion rates. Therefore, measures that improve compliance and completions rates for clients on medications can improve outcomes and cost effectiveness of the service. Heffner et al (2010) combined motivational interviewing with compliance enhancement therapy (MI-CET) in a randomised clinical trial comparing alcohol-dependent patients' responses to citalopram versus a placebo. As compliance can run as low as 56%, MI-CET attempted to improve this. Session one consisted of motivational interview feedback to the patient on the severity of their drinking. It concluded with instructions for taking the medication and problem-solving. Remaining sessions included reviewing side effects and perceived effectiveness of the medication, patient's record of taking the medication and reviewing the links between taking medication and their progress in reducing their drinking. Impact on retention and compliance were assessed by comparing records of the first 121 patients who entered the trial with those of patients in other similar trials. These included alcohol-dependent patients and the same type of antidepressant (though sertraline rather than citalopram) but which sought to increase compliance through AA's 12 steps, cognitive-behavioural therapy, or compliance enhancement therapy.

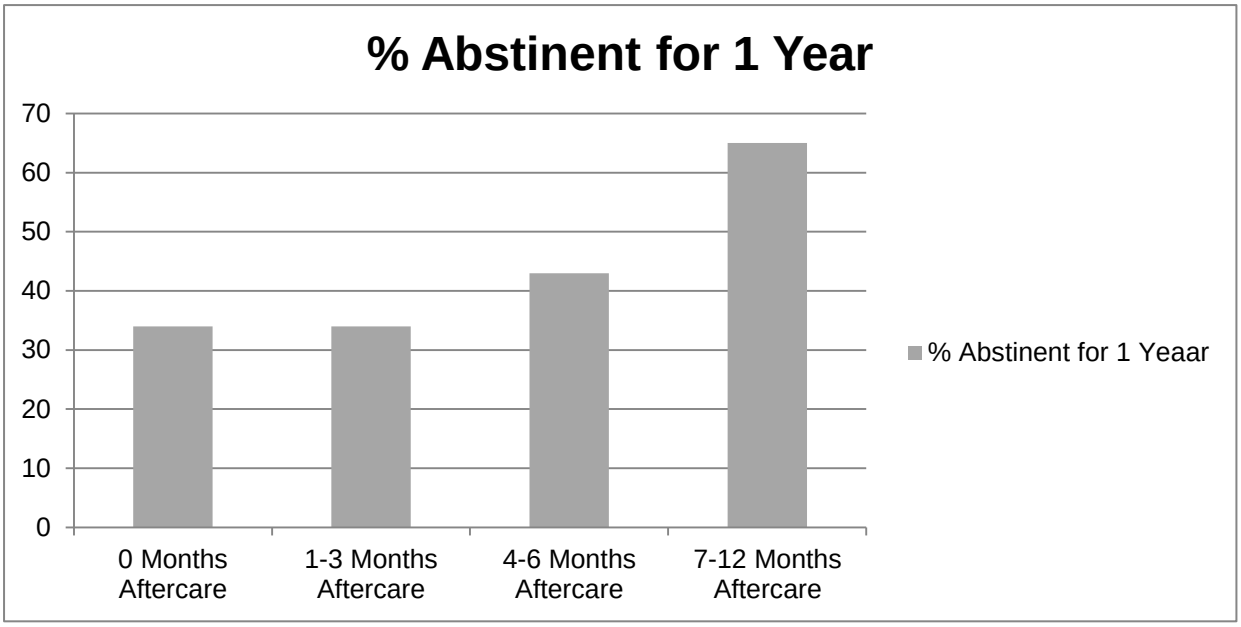
In the MI-CET group 83% of the 121 patients completed the 12-week treatment phase of the study, including 81% of patients prescribed the active medication. Among patients being prescribed placebos, 88% completed. Whereas only 48% to 78% in the comparable trials completed. Comparison with the trial which offered compliance enhancement therapy (56%–78% completion over 10 weeks) suggests adding brief motivational interviewing did enhance retention. The MI-CET patients on active mediation also attended 90% of their sessions and 93% in the placebo group. This compared to 54%–61% attendance in the other trials.

A number of strategies have been developed and been shown to enhance compliance rates, these include medical and professional based intervention, pharmacy based interventions, family based interventions (Disulfiram assurance) and technology based interventions. Therefore they should be included within the next specification with a stated model of intervention.

- The Specification should clearly state the exact medication adherence procedures that will be used routinely with all clients undertaking medications for alcohol related disorders.

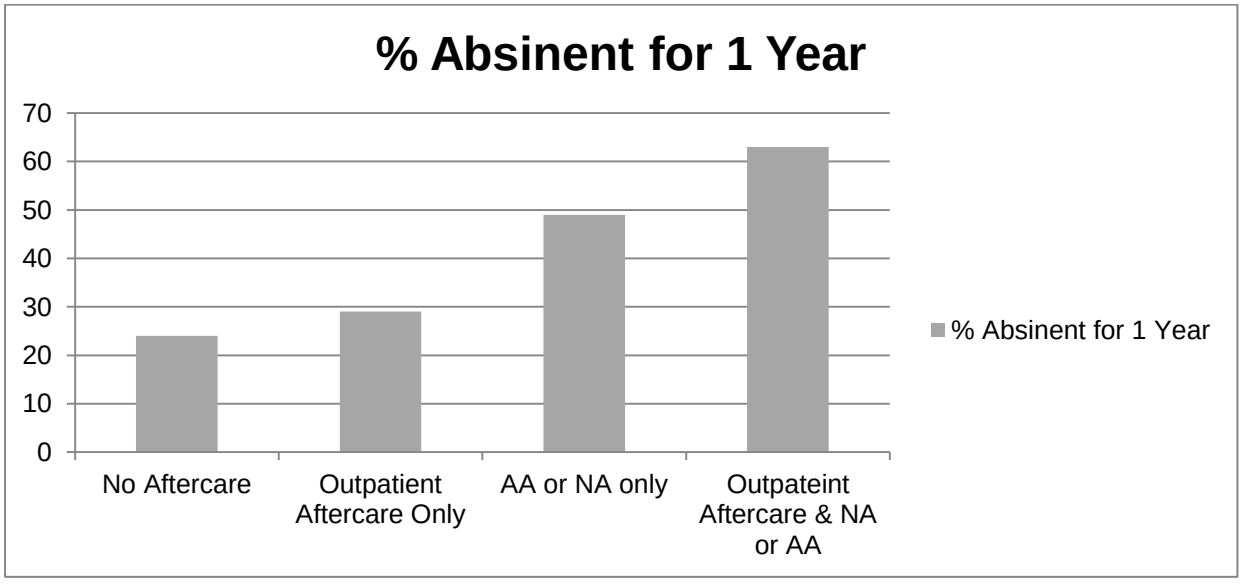
Relapse Prevention: Maximising Outcomes

The NICE Guideline (2011) suggest that contracting and prompts should replace case management for lower order problems but do not stipulate a structure for this. This section examines the evidence base of these approaches and offers an integrated model to maximise aftercare outcomes. There have been long standing debates regarding the relationship between treatment attendance and clinical outcome. Whilst it has been recognised that those clients who remain in treatment services for the longest periods of time obtain the best outcomes, the direction of causality was debated. It had been assumed that long term engagement and outcome were driven by the same common factor. This was that highly motivated clients engaged in treatment for longer and were more likely to sustain effortful attempts at change. Research has disputed this assumption. Vannicelli (1978) research demonstrated that attendance in treatment programmes promoted sobriety in a way that sobriety did not correlate with treatment attendance. Walker et al (1983) found similar findings, in this study problematic alcohol users who attended a 9 month aftercare programme were three times more likely to sustain abstinence compared to non-completers in the same programme. Furthermore, aftercare attendance was a better predictor of outcome than previous inpatient treatment and 10 other variables associated with treatment outcomes. Ito & Donavan (1990) also found that attendance in aftercare predicted treatment outcomes amongst problem drinkers more significantly than the client's social profiles, age of onset of drinking and coping repertoire.



Graph 1: The relationship between treatment duration and outcome (Moos et al 1999)

Timko et al (1995) identified that additional attendance in AA and NA during aftercare also increased treatment outcomes at 3 year follow up compared to aftercare alone. Again, although treatment orientation and length of inpatient care was related to outcome, they found that the duration of care appeared to be a stronger association to overall treatment gains. Moos et al (1999) extensive study identified that 34 per cent of clients who did not enter into aftercare remained abstinent at 12 month follow up compared to 65 per cent of clients who attended at least two aftercare sessions a month for 7 months (see graph 1 & 2). Gains were highest for those in formal treatment and attending AA or NA as opposed to treatment attendance alone. These findings were sustained at two year and eight year follow-up (Moos & Moos 2003).



Graph 2: Outcomes in aftercare based on modalities (Ouimette, Moos & Finney 1998)

Research consistently shows strong concordance in identifying the length of treatment engagement and outcome are strongly related and these outcomes are reflected in long term follow up studies. Whilst treatment attendance and outcomes have a strong relationship, treatment engagement rates remain low. A review of treatment compliance demonstrates high drop-out and non-completion rates. This creates a tension in treatment services. On the one hand the duration of treatment is important in outcome whilst at the same time clients appear more likely to drop out of a protracted treatment regime (see table 8). Given these low rates of completion, treatment outcomes could be significantly enhanced by retaining client in aftercare services for extended periods.

Study	Setting	Drop-out Rates
Moos et al 1999	Outpatient	• Only 28 per cent of clients continued treatment beyond 3 months • Only 36 Per cent attend 10 or more NA \ AA groups
Fortney et al 1995	Outpatient	• Only 54 per cent attended first aftercare appointment • Only 20 per cent attended 2 or more sessions in the first month

Table 8: Drop-out rates in aftercare services

Increasing Treatment Participation

It is difficult to establish a clear causal link between treatment attendance and clinical outcome as a number of other key variables may influence outcome. This might include client motivation, quality of care, greater social support etc. However, a number of studies have found that attendance rates and subsequent treatment outcomes can be improved by the application of behavioural reinforcement. This has been pioneered by a range of behavioural-based modalities that have operated under the banner of the Community Reinforcement Approach. For example, Ossip et al (1984) compared outpatient's attendance rates between those who signed a behavioural contract to attend with those with no contract. Behaviour contracts are an agreement between the client and the service provider that the client will adhere to the expectations of the treatment programme. In this study, behavioural contracts were co-signed by a concerned other who would prompt attendance and reward engagement with a favourite meal. Those on the behavioural contract demonstrated an 88 per cent increase in attendance over the first 16 weeks of aftercare and had a 3.5 times higher abstinence rate at 12 month follow-up.

The use of 'contingency management' (where a client is rewarded contingent on meeting the requirements of behavioural contract) has also demonstrated a substantial impact on treatment attendance for a wide range of substance related issues. The behaviour contract sets out the expectations on the client and describes rewards they will receive should they meet the requirements of this contract. The awarding of vouchers for negative urine-screens and treatment attendance has

demonstrated significant improvements in problematic cocaine users in numerous clinical trial (see Higgins et al 1993; Higgins at al 1994; Higgins et al 1995). Whilst these studies did not demonstrate differences in outcomes in all measures between voucher and non-voucher groups, those in receipt of vouchers had higher treatment engagement rates; higher 1 year abstinence rates; and lower drug related problems at follow-up.

Similar contingency management approaches have been adopted in opiate using patients on methadone prescriptions. Contingent prescribing reinforces change by the application of treatment rewards for the achievement of set treatment goals. This demonstrated a dramatic improvement on reducing the adjunct use of illicit opiates on top of prescriptions. For example Iguchi et al (1998) were able to increase the number of drug free urine samples from 18 per cent at the start of the contingency programme to between 35-65 per cent by including take home dosage privileges. Contingency management has also been used effectively to increase rates of attendance into additional support services. For example, Kidorf et al (1994) were able to improve attendance at additional therapy through increasing take home privileges based on the number of sessions attended. Similar findings were replicated in the Iguchi et al (1996) where take home privileges were used in to increase attendance on problem solving groups. These programmes make the assumption that those on methadone prescriptions could reframe from using opiates in addition to their prescribed drugs but simply lack the motivation to do so. Therefore making rewards and privileges contingent on abstinence can increase abstention by increasing motivation.

In the alcohol field, Petry et al (2000) used the opportunity to win prizes if clients produced negative urine samples and breathalyser tests as well as achievement of treatment goals such as AA attendance. In this study, 84 per cent of those on this reinforcement schedule completed the outpatient treatment compared to 22 per cent of the non-reinforced group. Furthermore, 69 per cent of the reinforcement group were abstinent at 1 month follow-up compared to 39 per cent of the non-reinforced group. Project MATCH (1993) is one of the only randomised control trials that has attempted to increase aftercare treatment participation amongst problem drinkers. This $36 million study compared treatment outcomes between Cognitive Behavioural Therapy, Motivational Enhancement and Twelve Step Facilitation. The Twelve Step Facilitation approach successfully increased attendance in AA meetings both during and post-treatment. Whilst outcomes did not differ significantly in the three treatment modalities, the Twelve Step Facilitation treatment group showed a higher level of continuous abstinence and this appeared to be mediated by mutual aid group attendance.

It is important to note that not all studies have shown such strong relationship between attendance and outcome. McLatchie & Lomp (1980) study did not show a strong relationship between duration of care and outcome but did find a tendency towards significant differences in a small research sample. Gilbert (1988) found no

relationship between treatment attendance and improved treatment outcome. Connors et al (1992) found little benefit in reinforcing attendance in 8 aftercare groups with mild to moderate drinking populations compared to a no aftercare control group. However, this shorter duration of treatment and milder alcohol related problems may have influenced these findings. In general, the vast majority of experimental studies have supported the idea that treatment duration and outcome are strongly linked and this can be enhanced through the adoption of clinical procedures.

Whilst the use of contingencies can increase treatment attendance and clinical gains it also poses challenges at the same time. Firstly, the use of contingencies such as offering vouchers for clean urine samples is expensive and can incur high funding costs. In addition, there is some evidence to suggest that high value contingencies tend to decrease treatment gains as the client may attribute treatment efforts solely to the achievement of the reward rather than their own motivation for behavioural change. Secondly, the use of contingencies can raise ethical concerns. Rewarding those that have engaged in anti-social behaviours can be regarded as inappropriate by the wider community whilst the use of prizes and lottery tickets may be perceived as an endorsement of gambling. This is even in light of a consistent clinical finding that randomised rewards exert the most powerful influence over behavioural change. Lottery tickets are cheap but the possible rewards are high-and failure to win a prize in one draw does not preclude the possibility of a big win in the next. Thirdly, some contingency programme rely upon a supportive non-using other. Not all clients in treatment have concerned others to support their recovery process. This may narrow the options for social reinforcement to occur. Thirdly, rewards need to be applied only where the client has met clear goals that can be monitored and confirmed in everyday clinical settings. There also have been broader issues in the research base. For example, whilst co-attendance at a mutual aid support groups appears to enhance outcomes, very few studies have included this requisite in their contracting procedures. Finally, different types of behavioural procedures have been adopted in these studies-contracting, prompts and reinforcement-but these have not been studied independently or in an accumulative manner. The influence of different element on treatment gains has not been established. Therefore it is unclear which elements are important in overall outcomes.

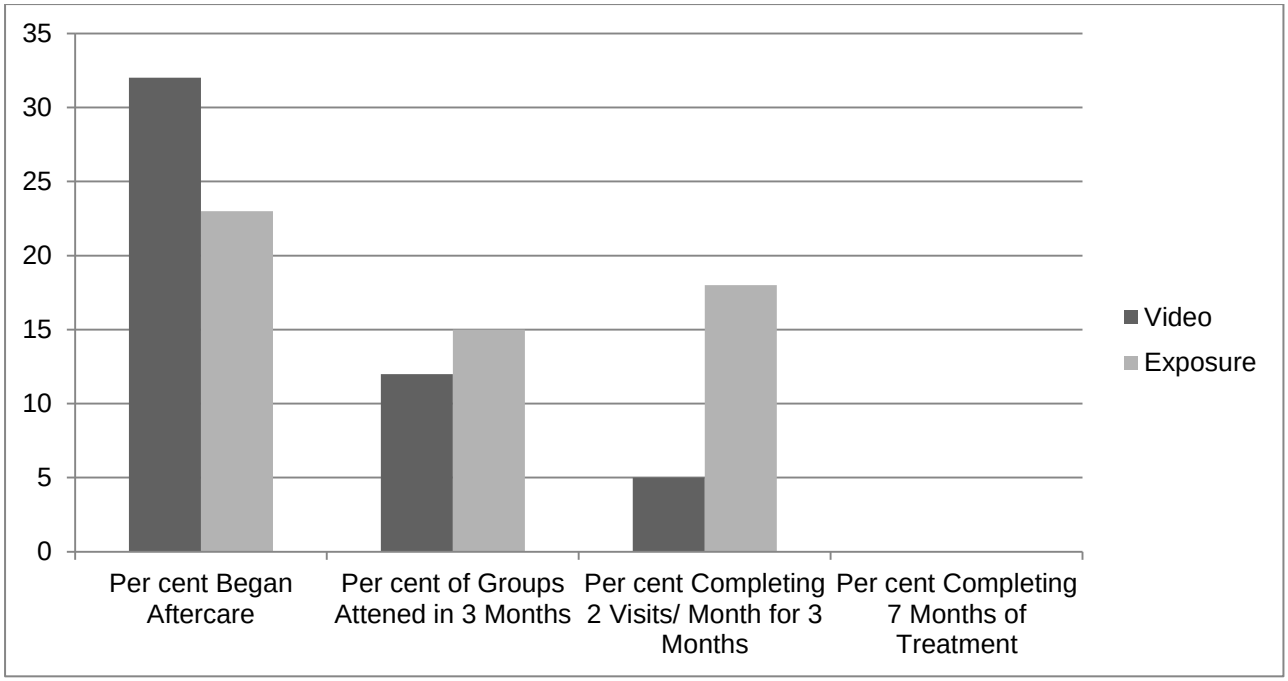
The CPR Approach

Lash et al (1996; 2001; 2004; 2005; 2006) developed a systematic analysis of the use of contracting, prompts and reinforcement methods for aftercare clients across four randomised quasi-experimental studies. The aim of these studies was to assess whether retention rates could be increased to ensure clients completed a minimum of three months aftercare treatment. Treatment subjects were primarily male (95-100 per cent), Caucasian (42-62 per cent) and residential patients (86-100 per cent) though a smaller outpatient cohort was also included (0-14 per cent). This client cohort attended a cognitive behavioural relapse prevention programme in

addition to AA \ NA mutual aid support groups. The Contract, Prompt and Reinforce procedures were developed as an adjunct to this treatment. So whilst these behavioural principles were applied to this specific modality in the clinical trials, the CPR to the procedure may be used to increase any group attendance regardless of modality.

The four trials were designed to build incrementally by adding contracting, prompts and reinforcement procedures one component at a time. So the first procedure tested simple exposure to aftercare without any additional techniques. The second phase then tested whether clients who signed a behavioural contract demonstrated better retention rates than those who did not. If the behavioural contract group did better-this would become the standard condition for the next trial. The next trial would then compare a behavioural contract group with those who also signed a contract and were also 'prompted' to attend their sessions. If the prompt group performed better this would be the next standard approach. In the subsequent study, both groups would contract, receive prompts but only one cohort would also be reinforced in their attendance. If this improved retention and outcomes it would become the new standard. If any additional procedure did not improve gains the team would continue with the least intrusive approach.

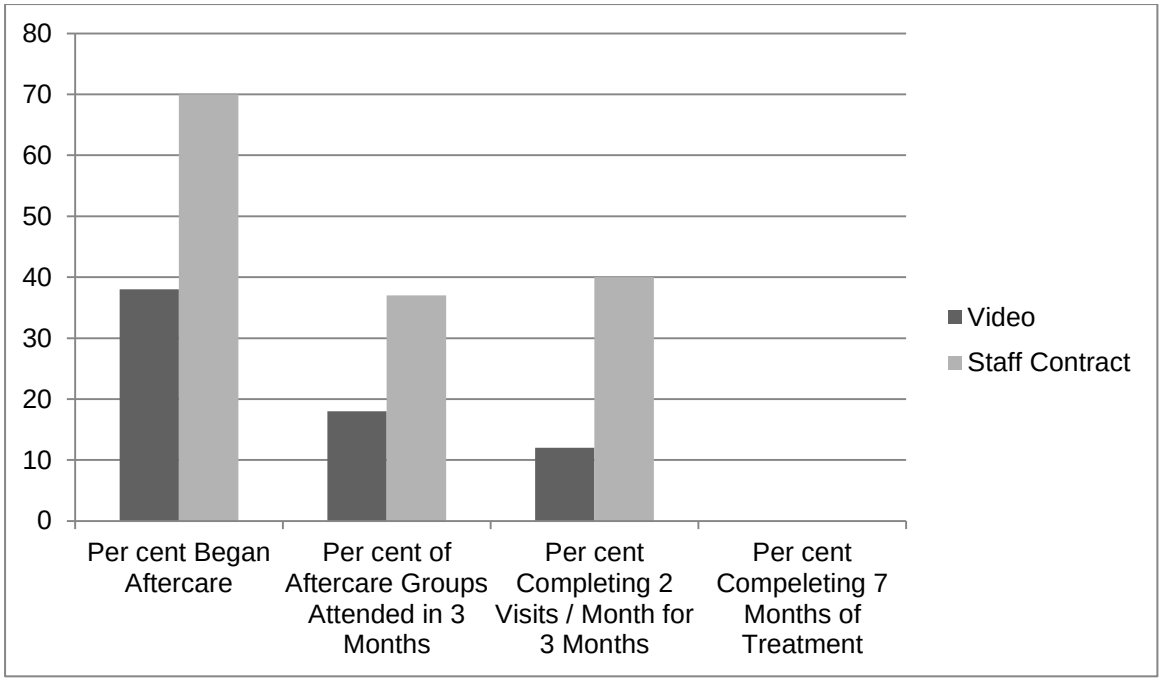
In the first phase of the experiment clients in inpatient treatment would be offered an orientation session regarding the nature of aftercare groups or be exposed to aftercare by actually attending an introductory after group. For those in the orientation arm, clients were shown a video of a motivational speaker who emphasised the importance of self-belief in sustaining effort to achieve personal goals. In the exposure group, clients were introduced and existing group members informed the potential group-member of how aftercare support had assisted them to sustain their recovery. Twenty-two clients were randomly assigned to the exposure session whilst nineteen were assigned to the video. No clear differences emerged between the video or the exposure conditions (see graph 3)



Graph 3: Comparison of orientation and exposure attendance and outcome (Lash et al 2006)

This comparative study did not show that simple exposure to group aftercare increased treatment attendance to any greater degree than a more directive orientation approach. Little difference emerged in the frequency of attendance of the two groups. As treatment outcomes in aftercare tend to be related to duration of treatment as opposed to intensity-the number of individuals competing 3 months of treatment was still very low at 18 per cent.

The next phase of the study reviewed contracting arrangements. A behavioural contract is a written agreement whereby a client commits to certain behaviours in the form of an agreed and signed contract. This is supported with feedback and information from a worker regarding the rationale and the clinical benefits of adhering to the contract. Contracts can include time keeping, attendance or drinking rates and have been used heavily in behavioural treatment programmes. An initial trial compared whether peer contracting, where a volunteer in recovery conducted the behavioural contract, would be a cost effective means of promoting attendance in comparison to the video approach. However, no differences were found on any measure. In a re-run, contracting was conducted by a staff member in comparison to an exposure group-and in this condition significant differences emerged (see graph 4).



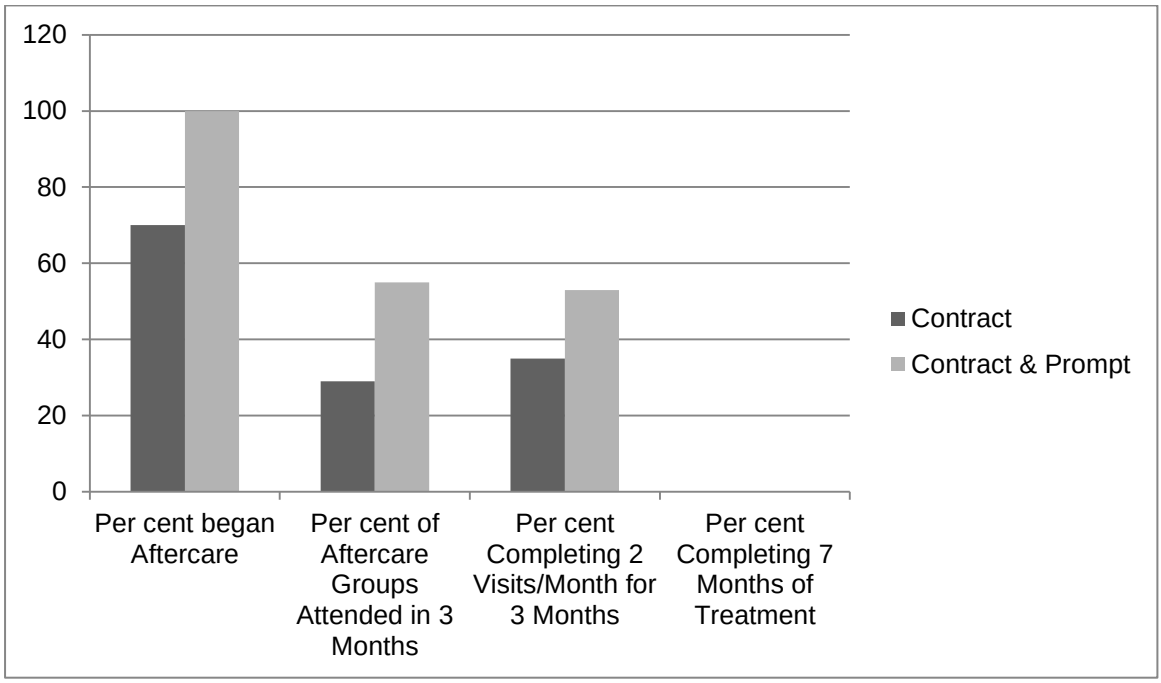
Graph 4: Comparison of staff contracting verses orientation attendance and outcome (Lash 2006).

In comparison to the video condition, clients were more likely to begin aftercare (70 per cent verses 40 per cent) and twice as likely to attend weekly group meetings (37 per cent verses 17 per cent.) This cost effective approach of behavioural contracting did increase engagement to higher levels than typically found but the overall three month completion rate remained low.

Behavioural contracting appears to increase initial engagement but does not sustain attendance. Missed sessions can occur with a few weeks of treatment entry, and once a couple of sessions are missed clients are less likely to return. Many clients report that they no longer require treatment anymore, however, relapse tends to occur shortly after premature treatment exits. Embarrassment and guilt may then compound client's reluctance to re-enter treatment as identified in Marlatt & Gordon (1985) *goal violation effect*. Research has demonstrated that encouragement from a non-judgmental worker can assist clients in overcoming these psychological blocks.

Behavioural prompts have been used in a wide range of services to remind clients to engage in behaviours to increases follow through. This is most effective when combined with behavioural feedback that provides additional information on how much progress been made in either completing treatment goals or on other measures such as outcomes. This awareness may enhance client's outcomes by increasing their self-efficacy in achieving their goals. In Lash et al treatment study, hand written letters and phone calls prompted clients to attend their sessions. This also includes feedback on the progress on achieving their treatment goals of attending the agreed number of session as stipulated in the behavioural contract. Again, a behavioural contract only group was used in comparison to the behavioural

contract and prompting procedure. The sample size was 41 clients who were randomly assigned to either condition (see graph 5).



Graph 5: Comparison of staff contracting and prompts verses staff contracting attendance and outcome (Lash 2006).

Behavioural contracting with prompts outperformed contracting alone. A 100 per cent of clients in the contracting and prompt group attended the first session compared to 70 per cent in the standard condition. Prompting also increased the frequency of attendance and treatment completions rates at the three month mark. In addition, follow-up research demonstrated significant reductions in hospitalisations rates in this group.

Contracting and prompting has an influence on increasing frequency of attendance and positive outcomes. However, it did not appear to increase the number of clients completing 3 months of treatment. Optimum treatment outcomes are achieved over 7-12 months. The final study by Lash et al (2006) attempted to increase aftercare by the use of social reinforcement. Social reinforcement has been used successfully in a number of clinical trials to aid retention rates and relies upon the treatment group recognising the individual client's achievements at specific landmarks in their treatment journey. For example Ahles et al (1983) found that clients reinforced by the group to attend aftercare attended twice as many sessions and exhibited 3..5 times higher abstinence rates at 1 year follow-up compared to a control group.

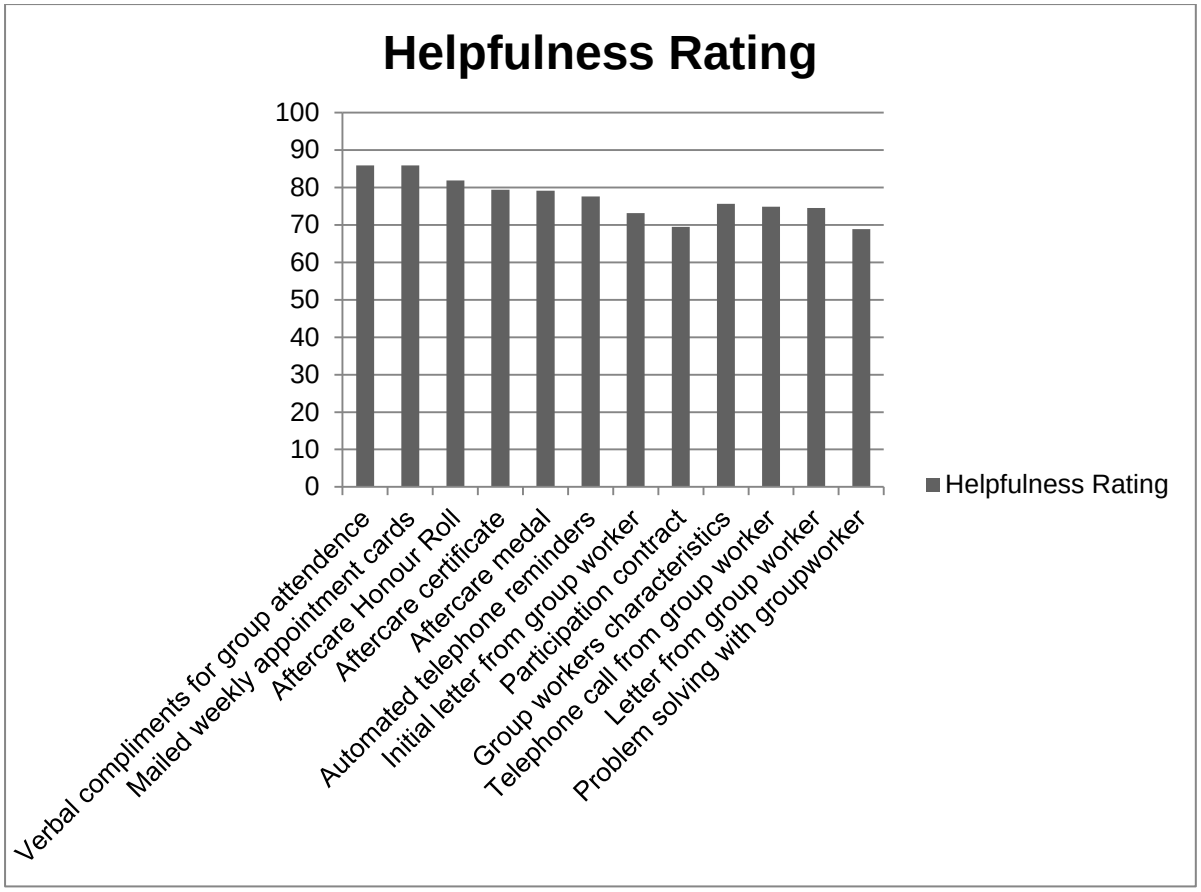
In the final experiment a range of reinforcement was deployed for those also on contracts & prompts in comparison to contracting & prompts alone. Reinforcement took several cost-effective forms. The primary source of reinforcement was social. Clients achieving landmarks in the group session would have this acknowledged by the facilitators and the group as a whole. The active participation of other group's

members appears to increase their own self-efficacy in achievement. Based on these findings, they developed a reinforcement schedule outlined in table 9. Details of the reinforcement schedules were included in the behavioural contract that clients signed prior to treatment entry.

Session	Reinforcement
Aftercare Session One	Group facilitator recognised and congratulated the participant for following through their commitment to attending aftercare
Third Aftercare Session	Group facilitator recognised and congratulated the participant for achieving half the six weeks contracted attendance in the first two months of treatment
Three months	The participant received a 3 month certificate of achievement completing inpatient care and for engaging in treatment for 12 weeks and attending at 8 groups
Three months	The client would have their name display on a Roll of Hour for completing three months of treatment.
Three months	The client how attended 8 sessions in the first three months of treatment received an engraved medallion with the message 'To thine own self to be true' inscribed upon in.

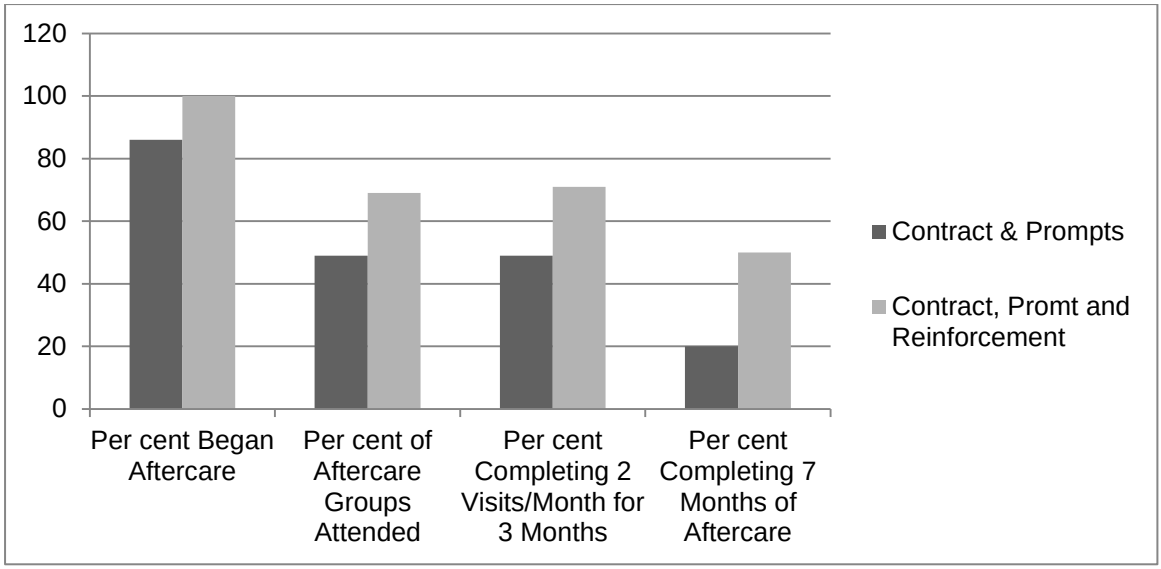
Table 9: Reinforcement schedule (Lash et al 2006)

At post-treatment clients were asked to rate which of the following reinforcement procedures that they had found most helpful. This also included identifying what had been helpful in addressing missed appointments. Clients often reported feeling of shame or guilt in missing appointments and this tended to increase non-attendance once it had occurred. Therefore they reviewed how helpful were the 'worker characteristics', 'telephone contact', 'a letter' and 'problem solving' in returning clients back into treatment once they had a setback (see graph 6).



Graph 6: Helpfulness of reinforcement schedules (Lash et al 2006)

The application of these reinforcements to only half the group in randomly assigned treatment was not possible. This is because if one half of the treatment population received reinforcement and the other half did not, it would generate demoralisation in the unreinforced group. Therefore, 38 clients received a contract, prompt & reinforcement group and their outcomes compared to 43 clients on a contract & prompt only group. Both groups were similar demographically and in terms of severity of substance use disorder though the reinforcement group had higher levels of psychiatric co-morbidity. The results are shown on graph 7.



Graph 7: Comparison of staff contracting, prompts and reinforcement verses staff contracting attendance and prompts only (Lash 2006).

The contract, prompt and reinforcement group all attended their first appointment and attended 70 per cent of their aftercare groups compared to 50 per cent of the contract and prompt group. The contract, prompt and reinforcement group showed higher rates of treatment completion. Most promisingly was the fact that this this rate was maintained at one year follow up even though the invention only last three months. The contract, prompt and reinforcement groups were twice as likely to be retained in treatment at the 7 months mark. This is important when considering the optimum time in aftercare treatment is 7-12 months. Not only was their attendance rate higher but at 6 months follow-up 76 per cent of the reinforced group were abstinent of all drug and alcohol compared to 40 per cent of the control group. Little difference emerged between reduced hospitalisation rates in both populations.

- CPR procedures can enhance treatment attendance and maximize long term recovery trajectories, specifically through the attainment and maintenance of abstinence.
- CPR procedures may offer a lower intensity clients as an alternative to case management
- The Service Provider should develop behavior contracts as an integral part of the aftercare process.
- The Service Provider should describe the prompting procedures they will use to maximize attendance for 7 months after care
- The Provider should detail the reward used to sustain engagement over the optimal period of time

Conclusion

Significant advances have occurred within the alcohol treatment systems of Gwent within the last few years. These systems can be augmented with the recommendations if NICE (2011) and enriched with the wider research base. The subsequent round of commissioning should focus on the entrenchment of the stepped care structure with close monitoring of its fidelity. Each additional component needs to be assimilated and can make accumulative differences to outcomes. However, this cannot be achieved merely through the application of Randomised Control Trials recommendations to everyday. It can be achieved by the optimisation of the fabric in which treatment is delivered, at a commissioning organisational, practitioner, family and client level.

Summary of Recommendations

Treatment Overview	Actions
1) Treatment models should be selected which focus on the acquisition of life skills that facilitated the creation of social environment that is conducive to long term recovery.	
2) Matching clients to treatment by social functioning produced better outcomes than other personality measures. Although this is inherent within a stepped care model, it requires organisations have a clear calibration process to assess the clients function.	
3) Matching treatment to real problems in the client's life shows superior outcomes. Abstract or theoretically based treatment approaches should be avoided. Greater attention must be paid to the assessment and selection of specific interventions relevant to a client's life.	
4) Specific attention should be given to how clients will be supported into self-help movements such as AA or Smart recovery to enhance and sustain long term treatment gains.	
5) Family cohesion is important in increasing motivation and self-direction. Models of concerned other support should be considered an integral treatment on recovery orientated treatment services.	
6) Treatment outcomes are influenced by	

organisational cohesion. The award of new commission contract will require changes in cultures of practice within the staff teams in order to maximise the outcomes. Specific attention should be given to how organisations will manage this technology transfer.	
7) Duration of care is more important than intensity. Specific measures should be introduced in order to maximise attendance for the optimal treatment period in order maximise client outcomes.	
8) The treatment system cannot rely purely on the adoption of evidence based models of practice based on randomised control trials that have limited applicability to treatment in practice. Acceptable margins of tolerance need to be incorporated into these treatment models to account for a more diverse and complex treatment group than is included in randomised control trials	
Integrated Pathways	
9) The Provider should detail the systematic monitoring of treatment response rates in order to identify where the current treatment intensity is effective.	
10) The Provider should stipulate referral processes for those who will step up into a higher level of interventions.	
11) The Provider should detail a clear system of post-treatment contact in order to ensure re-referral occurs for those who complete brief interventions	
12) Tiers of interventions in the stepped care model must be equitable in terms of access, rather than the dependant on the organisational preference within an agency	
13) Data reporting must routinely include the numbers of clients who complete lower intensity interventions and those who transit into higher intensity options	
14) The provider should detail its strategies to promote adherence to the stepped care framework internally and externally through technology transfer processes	
Clinical Tools	
15) AUDIT is to remain the screening tool of choice	

16) AUDIT scores should be reported by modality	
17) SAD-Q or LDQ to be used by practitioners as the preferred assessment tool of dependence	
18) Ensure results of agreed clinical scores are embedded in PalBase for extraction.	
19) Consideration should be given to the ASAM or equivalent as a triage assessment tool.	
20) Linking AUDIT to outcome scores my offer deeper insight into treatment response rates and treatment placement in future analysis.	
Assessment	
21) Provider must identify what diagnostic criteria will be included in comprehensive assessments	
22) Comprehensive assessment might be better informed by the inclusion of social domains that have predictive value of treatment	
23) Consumption patterns can contribute to baseline outcomes measures	
Care Planning	
24) Case management is required for the highest levels of severity only	
25) The Provider should offer wider treatment support strategies for lower order problems that utilise routine contracting and prompt procedures such as C.P.R	
Outcomes	
26) NICE guidance does not adequately present the compelling use of any viable outcome measures, especially in the form of AUDIT	
27) ORS and SRS which is validated and offers wider benefits should remain the principle outcome tool.	
28) Additional alcohol consumption measures, harmonious with the wider clinical research may offer more accurate and clinically useful measures to assess impact on the actual consumption of use.	
Alliance Factors	

29) NICE (2011) displays a misunderstanding of the common factors of treatment outcomes that need to be promoted within any treatment system	
30) NICE (2011) suggestions of practitioner competence do not tally with the wider clinical research	
31) Workforce development strategies can be significantly enhanced through the adoption of research that has identified factors that do improve a practitioners outcomes	
Realtime Feedback	
32) Real-time client feedback improves psychotherapy outcomes overall and reduces the risk of deterioration or drop-out.	
33) The role of outcome reporting must play a more central role in the reporting of client outcomes and supervision. Whilst some agencies in Gwent have made considerable progress in the use of this system, coverage must occur across all modalities.	
34) Scrutiny of the outcomes from real-time feedback must become a central activity for commissioners in order to exert greater pressure on the systematic implementation of feedback approaches to minimise negative cases	
35) Consideration should be given to using electronic versions of feedback systems and accompanying manuals should be included within the specification	
36) Training programmes should include skills in repairing ruptured alliance and poor treatment responses in clients in order to increase practitioner confidence in successful addressing poor response rates in clients, especially for supervisors	
37) Non completion of the tools with a client should be considered as a negative case	
Psychotherapies	
38) Anxious or depressed patients should be offered 6 weeks treatment, not four weeks.	
39) Most structured model produced a similar range of outcomes with environmental models being the most consistent (SBNT, CRA, CBT, BCT)	

40) General counselling models are not to be included in the next specification	
41) MET is not indicated and should not be considered in the next specification	
42) MI should be based on the third edition and used in combination of relapse prevention	
E Self Help	
43) E-Self help offers a novel low tier interventions.	
44) Cost effectiveness can only be achieved if suitable numbers of clients engage and complete. This would require a review on a cost per programme basis.	
Medication Compliance	
45) The Specification should clearly state the exact medication adherence procedures that will be used routinely with all clients undertaking medications for alcohol related disorders.	
Relapse Prevention and Aftercare	
46) CPR procedures can enhance treatment attendance and maximize long term recovery trajectories, specifically through the attainment and maintenance of abstinence.	
47) CPR procedures may offer a lower intensity clients as an alternative to case management	
48) The Service Provider should develop behavior contracts as an integral part of the aftercare process.	
49) The Service Provider should describe the prompting procedures they will use to maximize attendance for 7 months after care	
50) The Provider should detail the rewards used to sustain engagement over the optimal period of time	

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