

# How good are psychosocial interventions in the UK?

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WATCH WHAT I  
CAN MAKE PAVLOV DO.  
AS SOON AS I DROOL,  
HE'LL SMILE AND WRITE  
IN HIS LITTLE BOOK.

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**Why does it matter?**

The process of behaviour change is...

“...multi-dimensional, and it is not likely that any one factor operating as part of this process will account for a large amount of the variance.”

Source: Bourgeois, Sabourin and Wright 1990

# What accounts for treatment outcome?

- Pre treatment, during treatment and post treatment **client** factors – social stability and support, and motivation
- The specific **treatment**
- **Practitioner** variables
- **Site / organisational** factors

# Common Components of Treatments that Work

- Cognitive behavioural
- Social support
- Goal direction
- Structure
- Coping skills and self efficacy
- Address motivation, rewards and models
- Extended

Source: Moos 2007

**What the US studies  
tell us**

# US studies

	treatment	practitioners	training	outcome
<b>Alcohol</b> <b>MATCH</b> n=952; 774	<b>CBCST; MET; 12 Step</b>  10 sites	N=80 selected Age F 62%  Masters 58%, PhD 23% BA 20%	Manual & protocol Intensive startup Supervision	Significant reductions in drinking at 1yr
<b>Drugs</b> Ball et al. 2007 n=461	3sessions <b>MET</b> or CAU  5 sites	N=35 Usual staff Age 39 F 60% Masters 43% Randomised	Manual & protocol Intensive startup Supervision of MET	Reductions in drug use; MET did better for alcohol, treatment retention and at 3mo
<b>Cocaine</b> <b>NIDA CCTS</b> n=487	<b>CT; IDC; SE; GDC</b>  5 sites	N=12 Selected Age F 66% Masters max	Manual & protocol Intensive startup Supervision of IDC	Significant reductions in cocaine use
<b>Marijuana</b> <b>MTP</b> n=450	<b>9 vs 2 vs delayed MET, CBT, CM</b>  3 sites	N=11 Usual staff Age 44 F 55% Masters 91%	Manual & protocol Intensive startup Supervision	Significant reductions 9sessions>2sessions>delayed

# Selection, Training and Delivery

- Therapist selection, training and supervision can rule out variability
- Expert led intensive training followed by program based continuing supervision produced discriminable levels of adherence and competence
- Can deliver treatments in community settings with good fidelity

# Adherence, Competence and Alliance

- The therapist alliance can moderate the influence of adherence: where alliance strong, adherence matters less
- Where alliance is low, therapist flexible adherence is associated with best outcome
- Patients improved more with moderate adherence than with low and high adherence

# Therapeutic alliance

- Importance of alliance in brief treatment
- Improves with more sessions
- Interacts with therapist adherence and competence
- To influence outcome
- Alliance independently related to outcome

Sources: Gibbons et al. forthcoming; Barber et al. 2006; Martino et al. 2008

# What the UK studies tell us

UK Alcohol Treatment Trial (UKATT 2005)

Treatment as Usual (Raistrick et al. 2009)

Training drug treatment practitioners (Mitcheson et al. 2009)

# UK studies

	treatment	practitioners	training	outcome
<b>Alcohol</b> <b>UKATT</b>	MET(3)vSBNT(8) 7 sites	N=52 usual Age 37 F 65% 67% degree+ Field exp 57mo; docs, nurses, counsellors Randomised	Manual, protocol, 3 day workshop; continuing supervision, compulsory for practice	Sig reductions dependence, psych health, symptoms, increase social satisfaction
<b>Drugs</b> <b>CCETAU</b>	TAU Various 7 sites	TAU	None	Sig but small reductions dependence, psych health, symptoms, increase social satisfaction
<b>Drugs</b> <b>Training</b>	Role played motivational interviewing	N=30 usual Practitioners SpRs, nurses and drug workers, mainly < masters, stat and non stat sector	“Materials” and mot int protocol 2 day workshops/offer four supervision sessions	No change in skills

# UKATT Therapist training

	MET n=22	SBNT n=29
Number of clients <sup>1</sup>	19 (2-41)	11 (2-41)
Training Cases <sup>2</sup>	4.4 (2-8)	3.0 (1-6)
Supervision sessions <sup>2</sup>	9.5 (5-19)	14.3 (7-24)
Duration of training	8.1 mths (2.1-13.5)	6.6 mths (2.7-18.6)

<sup>1</sup> p<.005    <sup>2</sup> p<.001

**Ukatt** – United Kingdom Alcohol Treatment Trial

Source: Tober *et al.* 2005

## UKATT summary of findings

- For MET, relationship between therapist adherence (PRS) and working alliance, and between MI global scores and client adherence (MITI) (Lakin *et al.* 2009)
- Relationship between client adherence and outcome and working alliance and outcome both treatments (Morton *et al.* in press)
- Client qualitative data (Orford *et al.* 2006)
- Can train staff normally employed (Tober *et al.* 2005)

## UKATT client treatment adherence

**n=742; fu: 3/12 = 94.9%; 12/12 = 83.2%**

- 20.5% did not attend any treatment sessions (17.5% in MET; 24.4% in SBNT  $p<0.05$ )
- 31.9% attended all planned sessions (42% in MET (3 sessions); 19.1% in SBNT (8 sessions))

Source: Morton *et al.* forthcoming

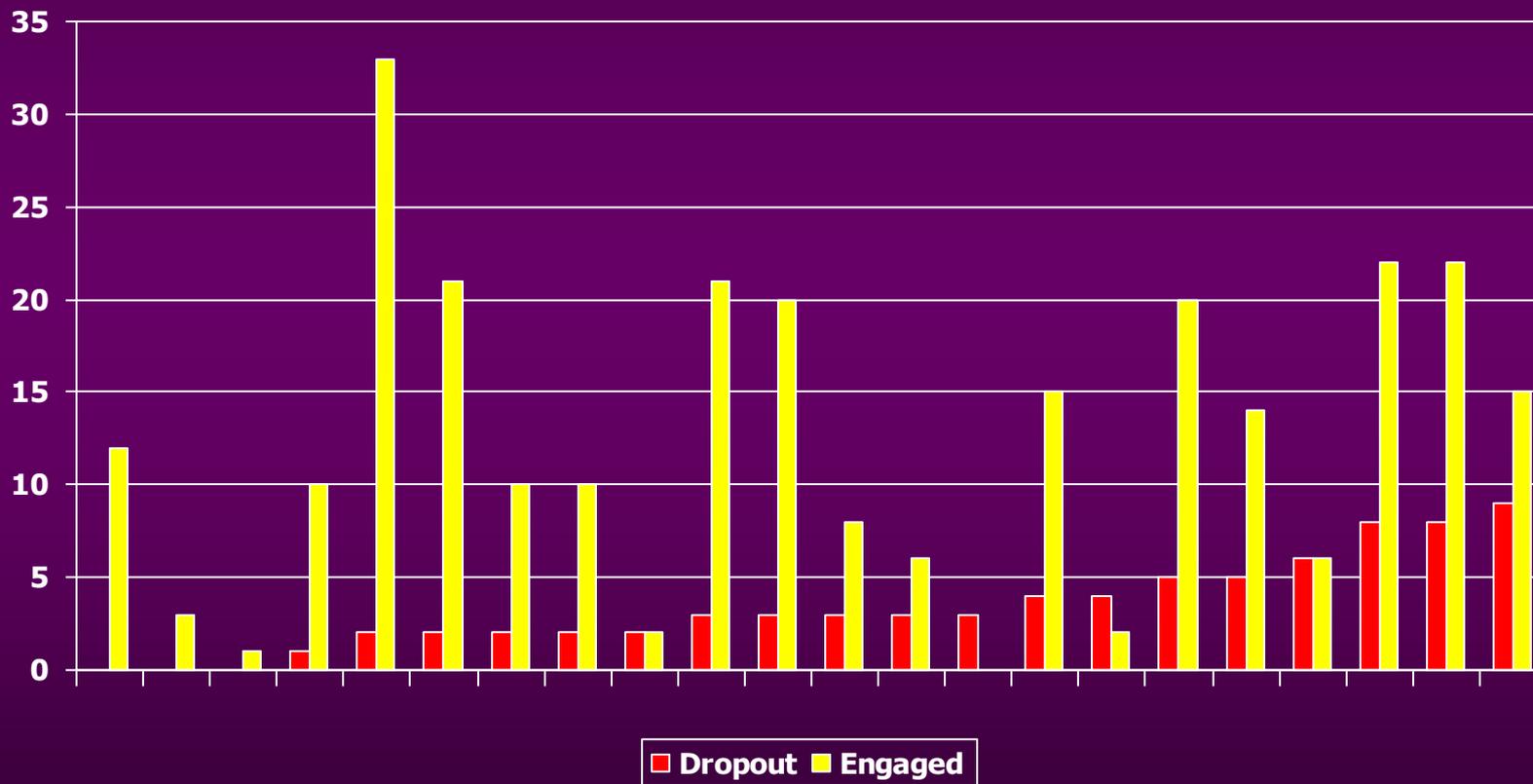
# UK Alcohol Treatment Trial

A strong relationship was found between attendance and treatment adherence and outcome at 3 and 12 months:

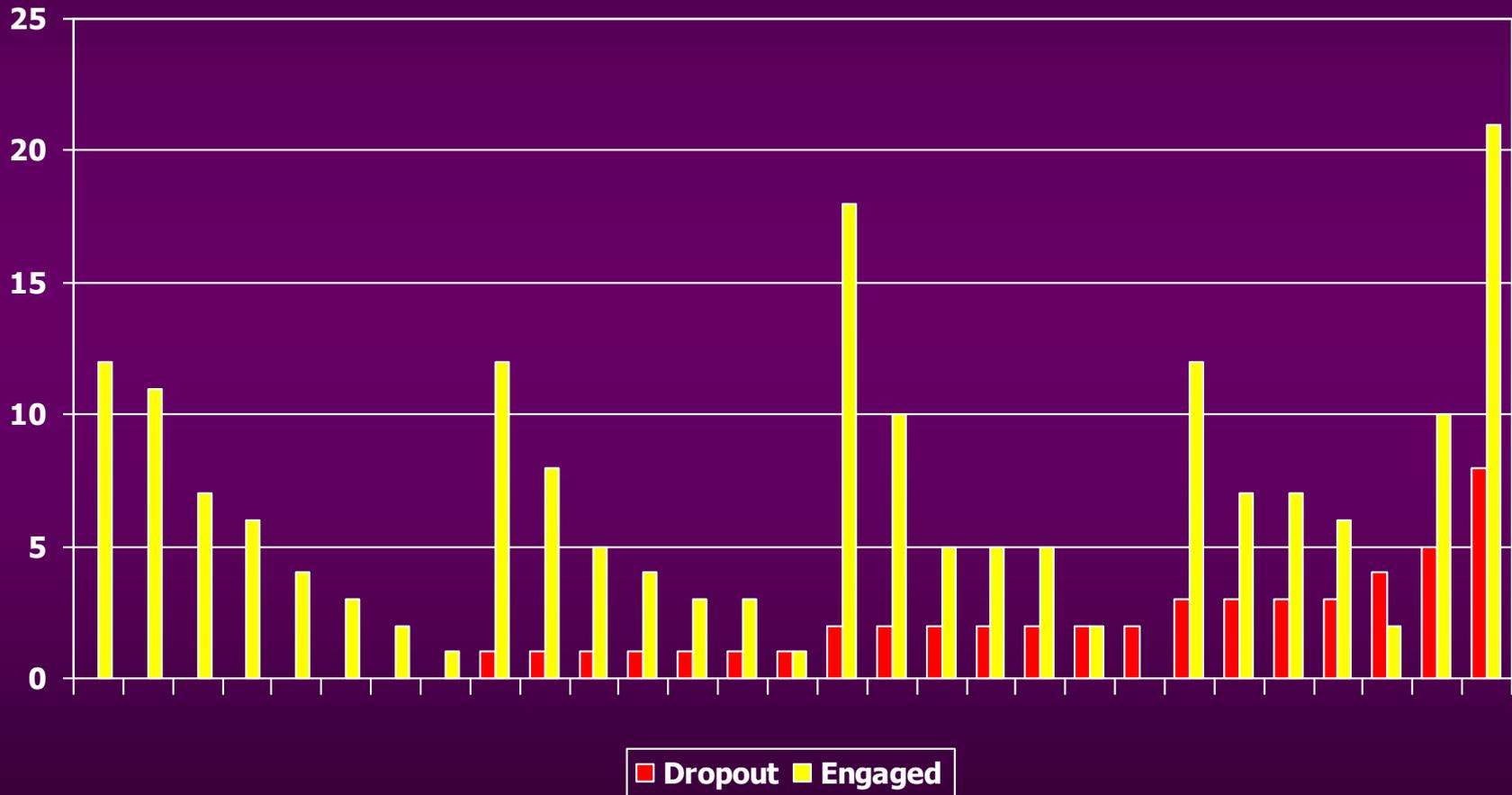
- At 3mth the more sessions attended, the fewer drinking days, the more abstinent days, the lower dependence and fewer alcohol related problems
- At 12mth latter two outcomes remained improved

Source: Morton et al.

# MET participants engaged/dropped out by therapist



# SBNT participants engaged/dropped out by therapist



*Ukatt* – United Kingdom Alcohol Treatment Trial

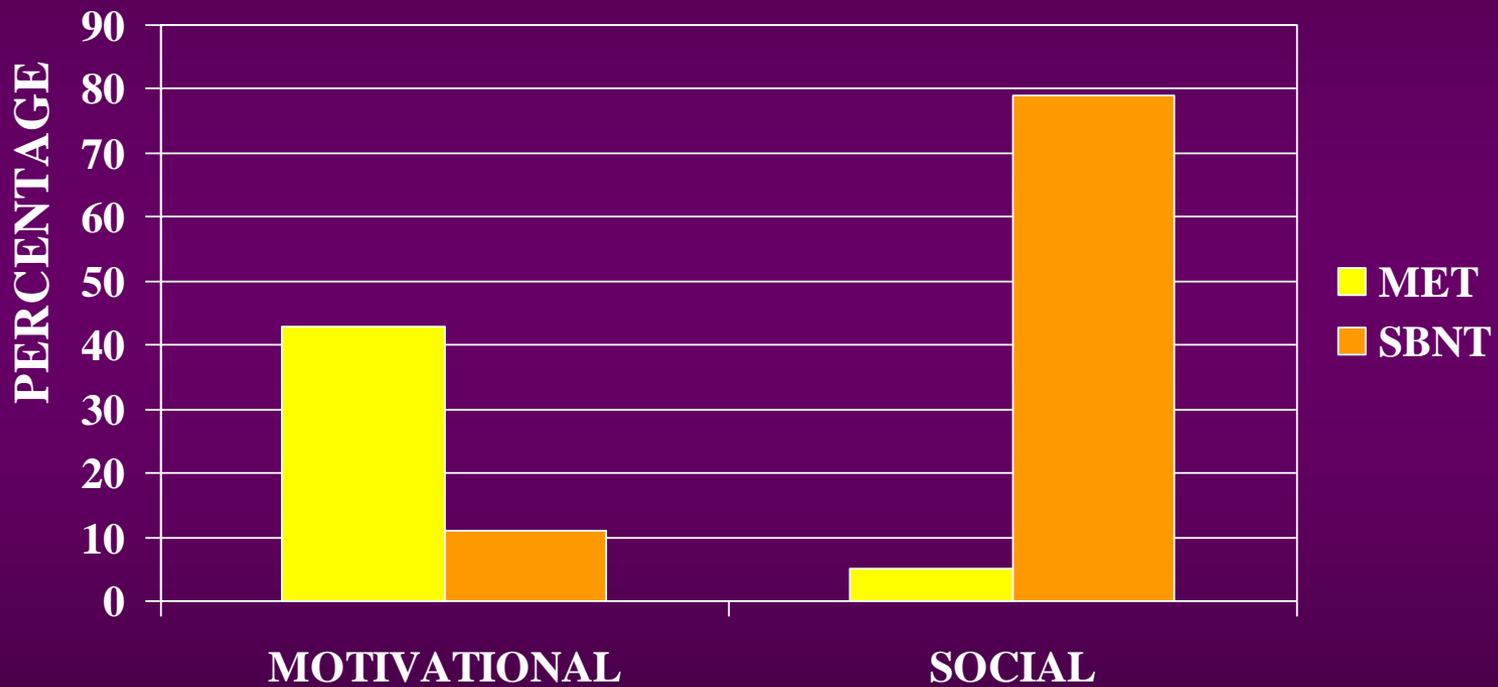
# What did service users value?

- **Structure**: specific components of both treatment protocols eg feedback
- **Alliance**: feeling understood, reporting back
- **Goal setting and decision making**

Source: Orford et al. 2009

Also found in Jones 2009, Moos 1997, 2007, Lovejoy 1995,

# Most Useful Aspects of Session



# What happens in treatment as usual?

## Session content

Agency	A	B	C	D	E	F	G
Homeworkf	0.2	0.2	0	0	0.2	0	0
Homeworkq	0.4	0.2	0	0	0.2	0	0
Alterf	1.2	0.6	0	0	0.2	0	0.17
Alterq	1.2	0.8	0	0	0	0	0
Idsupportf	2.4	0.2	0	0	0.2	0.2	0.17
Idsupportq	2.0	0.2	0	0	0.2	0	0.17
Skillstrainf	1.2	0	0	0	0	0.2	0
Skillstrainq	1.4	0	0	0	0	0	0
Assusef	1.6	1.0	1.6	1.2	0.6	0	1.0
Assuseq	2.0	0	0.6	0.6	0.6	0	0.5

Source: Raistrick et al. 2009

# What happens in treatment as usual?

## Practitioner style

Agency	A	B	C	D	E	F	G
Taskorf	<b>2.2</b>	0.2	0	0	0	0.2	0.17
Taskorq	1.8	0.4	0	0	0	0.2	0.17
Reflectf	<b>2.6</b>	0.4	0	0	1.0	0.2	0.5
Reflectq	<b>2.0</b>	0.4	0	0	0.6	0.2	0.5
Empathyf	<b>2.8</b>	0.6	0	0	0.4	0.2	0.5
Empathyq	<b>2.2</b>	0.4	0	0	0.2	0.2	0.5
Openqf	<b>3.0</b>	1.6	0.6	0.8	<b>2.0</b>	1.2	1.0
Openqq	<b>2.0</b>	1.2	0.2	0.6	0.8	0.6	0.67
Motintstyf	<b>3.0</b>	0.4	0	0	0	0	0.5
Motintstyq	<b>2.0</b>	0.2	0	0	0	0	0.33
Frustration	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	1.4	<b>0</b>	<b>0</b>

Source: Raistrick et al. 2009

# What happens in treatment as usual?

## Session management

Agency	A	B	C	D	E	F	G
Agendaf	1.6	0	0	0.4	0	0	0.17
Agendaq	1.8	0	0	0.2	0	0	0.17
Philsof	1.0	0	0	0	0	0.2	0
Philsoq	1.6	0	0	0	0	0	0
Reviewf	1.6	0.2	0	0	0.4	0.8	0.67
Reviewq	2.0	0	0	0	0.4	0	0.5
Goalf	1.8	1.0	0.4	0.8	0.2	0.6	0.67
Goalq	1.8	1.0	0.4	0.4	0	0.2	0.33
Planf	1.6	0	0	0	0	0.2	0.5
Planq	2.0	0	0	0	0	0.2	0
Socfuncf	2.0	0.6	0.6	0.2	0.4	0	0.67
Socfuncq	2.0	0.2	0.2	0	0.6	0	0.67

Source: Raistrick et al. 2009

## Recommendations TAU

- Agencies could rationalise the number and variety of interventions they offer. Interventions should be specified in protocols and supported by training and routine supervision of recorded practice.
- It is possible to conduct good quality research in practice settings. Further research into methods for improving treatment delivery is needed – with particular reference to organisational support, training and staff development.

Source: Raistrick et al. 2009

# Randomised trial of training and supervision in motivational interviewing

- Practitioners trained using standard two day format and offer of post training supervision, not a requirement and low take up, lack of motivation cited.
- “Training and supervision were found to have no impact on skill level as measured by MITI, had small but significant impact on motivational interviewing “spirit”.

Source: Mitcheson et al. 2009

## Organisational support is critical for...

- recording practice and uptake of supervision
- employment of staff with basic counselling skills on which to build

Source: Mitcheson et al. 2009

**Effective training** is intensive expert led training...

...followed by continued clinical **supervision** based on recorded delivery of treatment as in UKATT and US studies...

...**make a difference** to whether practitioners do anything at all.

Sources; Miller and Mount 2001; Miller et al. 2004, Mitcheson et al. 2009.

**What we have known  
for a long time..**

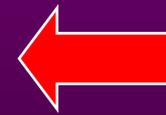
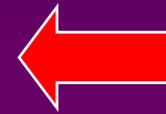
Training and self-esteem  
only make a difference in the presence of...



Role support and experience  
which are necessary but not sufficient for...



Overall therapeutic attitude



Situational constraints

Source: Cartwright 1980; Lightfoot and Orford 1986

# Doing good and doing harm

- **Practitioners** have the capacity to do good and to do harm (Moos 2007; Amrhein et al. 2003)

About 10% of patients who participate in psychosocial treatments of substance use disorders may be worse off after treatment

- Lack of bonding and monitoring
- Stigma, confrontation and criticism
- Lack of goal direction inc inappropriate or low expectations
- Modelling of deviant behaviour

Source: Rudolf Moos (2007)

**What to do..**



leeds addiction unit