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Counselling provision in specialist drug treatment services

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Counselling provision in specialist drug treatment services

ABSTRACT

Background: Counselling is one of the most common treatment options in drug services, and recent research has convincingly demonstrated its effectiveness if certain quality parameters regarding intensity and qualifications of those providing it are observed. However, there is a remarkable paucity of literature on the nature of counselling provision in UK drug treatment.

Aims: To describe the extent and nature of counselling provision in UK drug treatment services

Method: A national survey of specialist drug services in England and Wales was carried out and information was obtained from 326 services.

Results: Levels of counselling provision were very similar in non-statutory community based, residential, day care and statutory community based services (around 90%), with slightly lower levels in inpatient services (78%, difference not significant). In the majority of services (74%), individual sessions were provided by drug workers without counselling accreditation. In 32% of agencies, counselling was provided only by drug workers, whereas 36% of agencies employed both drug workers and accredited counsellors. In 17% of agencies, sessions were run by accredited counsellors only. Volunteers without formal training provided one-to-one sessions in 27% of agencies, mostly in agencies also employing counsellors and drug workers. Most agencies (66%) operated a schedule of weekly sessions; 12% of agencies offered fortnightly or less frequent sessions, whereas 15% of agencies offered several sessions a week. More than three-quarters of all sessions were scheduled to last between 50 and 60 minutes.

Conclusion: Typically, counselling is provided on a weekly to fortnightly basis by drug workers without formal counselling qualification. In-depth research is needed to examine whether and how sessions provided by drug workers differ from sessions provided by counsellors, as past research has only demonstrated the effectiveness of counselling in studies using highly trained counselling staff.

Key words: Drug treatment, counselling, service provision

Counselling provision in specialist drug treatment services

INTRODUCTION

The provision of counselling has a positive impact on drug treatment outcomes (McLellan et al. 1993). The intensity of interventions seems to have a significant effect on the likelihood of a client being retained in treatment and the extent of positive outcome (eg. Fiorentine & Anglin 1996; 1997).

Several studies have addressed the efficacy of counselling in drug treatment, and contrasted different intensities and modalities of treatment. A small randomised control trial compared two intensity levels of counselling and psychosocial services with a minimal counselling control group (McLellan et al. 1993). Clients, all of whom were receiving prescribed methadone, were assigned either to minimal support (one individual counselling session per month), intermediate support (three individual counselling sessions per week) or to high support (seven counselling sessions per week plus employment, medical, and psychiatric services). Although there was a reduction in illicit opiate use across all groups, two thirds of those in the minimal support group had to be transferred to more intensive treatment due to medical, psychiatric, or drug use emergencies. Clients remaining in the minimal support group showed few improvements after six months. The group with the most intensive treatment showed the best treatment outcomes, but very closely followed by the intermediate group. Another paper analysed the same dataset and concluded that at the end of treatment and a year after treatment, the most cost-effective methadone treatment modality was the intermediate group (Kraft et al. 1997).

In two studies, Fiorentine and Anglin investigated whether more frequent participation in counselling was associated with better outcomes in outpatient drug-free programmes (Fiorentine & Anglin 1996; 1997). Monthly counselling frequency varied substantially but on average, clients attended individual sessions five times a month, group sessions ten times a month and 12-step meetings eight times a month. Despite the fact that treatment intensity was fairly high for all clients, more frequent counselling was associated with lower levels of relapse to drug use, even for individuals who successfully completed the treatment programme. Increasing the opportunity for counselling by increasing the number of sessions offered to clients enhanced the actual uptake. The association between counselling frequency and relapse probability applied to group and, to a lesser degree, individual counselling (Fiorentine & Anglin, 1996). Fiorentine later replicated the 1996 study with a different sample, and found that in this sample, the crucial counselling element was frequent participation in group counselling, the effect for individual counselling could not be replicated (Fiorentine 2001).

Bell and colleagues report effects of both individual and group counselling intensity on outcomes (Bell et al. 1996). The treatment programme provided a maximum of nine sessions of treatment per week in the first three months followed by weekly sessions for six months. The number of counselling sessions attended predicted drug use outcomes, improvements in emotional well-being, cognitive functioning and quality of relationships. Moreover, the number of sessions attended outperformed retention in treatment as a predictor of treatment outcome.

In contrast, a large US cocaine user study did not find a relationship between amount of individual counselling received and treatment outcomes (Etheridge et al. 1999). However, the study included only clients retained in treatment for at least three months. This means that those who felt they were not receiving the treatment they needed and dropped out may not have made it into the study. A large randomised control trial also failed to find significant differences in outcomes during or after treatment between three different levels of service provision: weekly individual counselling, weekly individual and group counselling, and group counselling three times a week (Gottheil et al. 1998). All three options led to significant improvements in drug use and depressive symptoms.

A point to note is that most of the reviewed studies were randomised control trials, in which clients were allocated to treatments at random, not according to preference or needs assessment. Results might well have been different if clients had been matched to treatment intensity according to preference or problem severity. Crucially, the effectiveness of counselling interventions on their own or as an adjunct to methadone treatment has been demonstrated only under conditions in which counsellors are well-trained, follow a manual and provide at least weekly sessions. From the evidence in the literature, it appears that a methadone prescription with only monthly counselling is not sufficient for the majority of clients (McLellan et al. 1993). It seems that there are critical thresholds for counselling frequency, below which counselling ceases to be effective and above which no further gains are made and cost-effectiveness is compromised, but more research would be needed to draw firm conclusions as to where these thresholds are.

To understand better the extent and nature of counselling provision in specialist drug treatment services in the UK, a national survey of all specialist drug treatment services in England and Wales was carried out, covering five treatment modalities: statutory community based drug services, non-statutory drug services, residential rehabilitation services, day care services and inpatient treatment services. The aim was to provide information about a) the proportion of services offering structured counselling by treatment modality, b) staff providing counselling, c) the frequency and intensity of counselling offered and d) the level of training amongst counselling staff in specialist drug treatment services.

METHOD

Instrument

The survey questionnaire consisted of a double-sided A4 page, the reverse of the page was to be completed only by those agencies providing individual counselling to their clients. The first section asked for agency name, address, job title of the respondent and service type (statutory community based, non-statutory community based, in-patient, day care, young persons, outreach/drop-in, or residential rehabilitation and whether they work with criminal justice referred clients exclusively). The second section consisted of a comprehensive list of treatment options and respondents were asked to tick all options provided. If structured individual counselling was one of the treatments provided, managers were asked to continue with the second page. The definition of structured counselling used was that of the England and Wales national monitoring system NDTMS, ie "structured, ongoing and careplanned counselling". They were then asked about the frequency and duration of counselling sessions and number of staff providing counselling, how many of them were accredited counsellors (with or without extra training in drug treatment), drug workers without counselling qualification but at least some training in the addiction field, or volunteers without training in either counselling or drug treatment.

Procedure

The survey questionnaire was sent to all services providing structured treatment for adult drug users in February 2002. These were identified by combining two data sources: the SCODA directory of drug treatment services (Standing Conference on Drug Abuse 1998) and a list of all services contributing data to the UK National Drug Treatment Monitoring System (NDTMS) in 2001/02 obtained from each regional NDTMS centre.

As the main purpose of the survey was to describe structured counselling provision to adult drug users in non-criminal justice settings, services were excluded if they were known to be young persons services, criminal justice services, or alcohol only services. Also excluded were low-threshold services such as needle exchanges and telephone helplines, unless they formed part of a larger treatment organisation.

Where the two sources of information on services were not clear about the treatment provided by the service, services were sent the survey, but their responses were disregarded if it became clear that they met the exclusion criteria (see below).

Survey questionnaires with a letter explaining the purpose of the survey were sent to 551 service managers. Pre-paid addressed envelopes were included with the survey. Services

were asked to reply within three weeks, and a reminder letter including a copy of the survey questionnaire was sent a week after the deadline. Validation checks were carried out after all data had been received and entered: Cross-tabulations were used to highlight inconsistencies between data items, for example if agencies had not ticked that they provided counselling, but gave information about counselling approaches. Wherever possible, inconsistencies were resolved by contacting the agency.

RESULTS

Response rate

Of the 551 agencies that were sent a questionnaire, 361 services responded (66%). Of these, 35 were agencies that met the exclusion criteria or information was obtained that they were no longer operational (corrected response rate 63%): Three agencies had closed down. Nine agencies were part of the same organisation as another responder. The remaining 23 services provided treatment exclusively to young persons, offenders, alcoholics only, or were telephone helplines or outreach services. Data from the remaining 326 agencies, which represented all regions of England and Wales, were used for this study.

Sample

Of the 326 responders, 130 (40%) were statutory community based services, 106 non-statutory community based services (32%), 58 residential rehabilitation units (18%), 23 inpatient units (7%) and 9 day care agencies (3%).

Non-responders

Agency type information was available for the 190 agencies that did not respond to the survey. Of these, 59 (31%) were non-statutory community based services, 63 (33%) statutory community based services, 22 (24%) were residential rehabilitation units, 5 (3%) day care services and 17 (9%) inpatient units. The remaining 13% were found to be services that had been sent questionnaires in error as they met the exclusion criteria (housing services, helplines, needle exchanges, young persons services). There was no significant difference in the agency type distribution between responders and non-responders ($\chi^2 < 1$; $df=4$, $p > .10$)

There are also indications that the respondents are broadly representative of drug services in the UK as a whole. The distribution of agency types is in line with recent data published by Stewart, Gossop, Marsden and Strang (2000) about variations between and within drug treatment modalities in the UK.

Provision of structured counselling

Table 1 shows that the vast majority of services (87%) provided structured individual counselling. There were no significant differences between different types of agencies.

(Insert Table 1 about here)

Counsellors

Drug workers without counselling certification provided individual sessions in the majority of drug services (74%). In 32% of agencies, only drug workers provided individual sessions, whereas 36% of agencies employed both drug workers and certified counsellors. Seventeen percent of agencies employed qualified counsellors only (as mentioned before these may or may not be drug workers). Volunteers without formal training in drug work or counselling provided individual sessions in 27% of agencies, mostly alongside with counsellors and/or drug workers. Only seven agencies reported relying entirely on volunteer input. The composition of counselling practitioners is summarised in Table 2. There were differences in staff composition depending on agency type. Residential, non-statutory community-based and day care services were the most likely to employ accredited counsellors (62%, 63% and 75% respectively). In contrast, only just over half of statutory community-based and inpatient services employed accredited counsellors. Non-statutory community-based services were the most likely to use volunteer counsellors (45%), whereas only 17% of statutory community-based and residential services used volunteer counsellors.

(Insert Table 2 about here)

Sessions

Table 3 shows the frequency and length of sessions typically offered to clients at the service. Although this may vary depending on the client's needs, most agencies (66%) appeared to operate a schedule of weekly counselling sessions. 12% of agencies offered fortnightly or less frequent counselling, whereas 15% of agencies offered more than one session a week. More than three-quarters of all sessions were scheduled to last between 50 and 60 minutes.

(insert Table 3 about here)

DISCUSSION

This short piece of research aimed to address some of the shortfalls in the knowledge about the current extent and nature of counselling provision in UK drug services.

The majority of treatment services responding to the survey provided individual counselling, and there were few differences according to treatment modality. In as few as 16% of services was counselling provided exclusively by qualified counsellors, although clients in 51% of services had access to at least one qualified counsellor. This is of importance, as the effectiveness of counselling as a treatment for drug use has, as yet, been demonstrated only for qualified and highly experienced counsellors (Crits-Christoph et al. 1999; Simpson et al. 1997). For example, the study by Crits-Christoph et al. (1999) found that drug counselling was as effective a treatment for drug use as psychotherapy, but counsellors in that study were all educated at least to degree level and had an average of 10 years experience of working in the drugs field, averaging 330 previous clients. Most other studies also required a high level of training and experience among participating counsellors. Clearly, this is not the level of training and experience that staff in UK drug services usually has. Therefore, an urgent question that needs to be addressed by future research regards the effectiveness of counselling as provided by staff in “real” drug services.

In terms of the frequency of counselling sessions, the literature does not allow a firm conclusion where the lower and higher thresholds for effective counselling are. It appears that monthly counselling is not sufficient to achieve behaviour change, however one, two and three individual counselling sessions per week have been shown to be as effective as higher treatment intensities (Bell et al. 1996; Gottheil et al. 1998; McLellan et al. 1993). Over 80% of services in the present study offered clients at least weekly sessions. It is not clear from the data in this study how many of these sessions clients actually attended and previous research has pointed to considerable discrepancies between the number of sessions scheduled and the number attended (Fiorentine & Anglin 1997). However, if clients were indeed receiving one session of individual counselling per week, possibly in combination with group work, this would be at the level found to be effective in the literature.

One point which has been largely ignored by drug counselling research is that different client groups may have very different requirements in terms of the level of counsellor training and counselling intensity. It might be speculated that clients who have special problems or issues that need to be addressed (such as child sexual abuse, domestic violence, living with HIV infection, dual diagnosis) require more intensive attention than clients who are known not have such issues. On the other hand, at least in the early phases of treatment, intensive counselling by an experienced counsellor may be needed to bring to light such issues which

would otherwise remain hidden and which might then negatively affect the clients' chances to benefit from treatment.

Another question that has yet to be addressed by researchers is how long a particular frequency of counselling sessions should be maintained. Studies investigating the effectiveness of counselling have compared different intensities at the start of treatment for the duration of up to six months, but nothing is known about whether intensive counselling (or, indeed, any counselling) is still beneficial towards the middle and later stages of treatment, particularly in longer-term treatments such as methadone maintenance. This is an important issue to address, as providing counselling when it is not needed any more or needed on a less intensive basis is an issue of cost-effectiveness. However, the right level of ongoing contact with a client might enable a service to identify problems which might occur at any time in the treatment process such as non-compliance (eg with a methadone prescription) or emergence of relapse hazards. This in turn might enable a service to respond to a client's problems more promptly and relevantly. As such, the failure to provide counselling where it is needed might well have negative effects on client engagement and retention in the programme.

CONCLUSIONS

In the UK, counselling is typically provided on a weekly to fortnightly basis by drug workers without formal counselling qualification. In-depth research is needed to examine whether and how sessions provided by drug workers differ from sessions provided by counsellors, as past research has only demonstrated the effectiveness of counselling in studies using highly trained counselling staff and high intensity treatment.

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Table 1. Number of agencies providing structured individual counselling by agency type

Agency type	Individual counselling	
	n	%
Statutory community	112	86.3
Non-statutory community	96	90.6
Inpatient	18	78.3
Day care	8	88.9
Residential rehabilitation	51	87.9
Total	285	87.4

Table 2. Professional background of staff providing counselling in drug services

	n	% of services providing counselling
Counsellors only	46	15.8
Counsellors and non-counsellor drug workers	73	25.0
Counsellors and volunteers	23	7.9
Counsellors, drug workers and volunteers	32	11.0
Non-counsellor drug workers only	93	31.8
Non-counsellor drug workers and volunteers	18	6.2
Volunteers only	7	2.4

Table 3. Number counselling sessions provided per month and length of typical session

Number of sessions per month	n	%
1	2	0.8
2	28	11.6
3	16	6.6
4	158	65.6
5+	37	15.4
Total	241	100
Length of sessions in minutes		
<45	28	10.4
45	30	11.1
50-55	71	26.3
60	135	50.0
70+	6	2.2
Total	270	100