

**Pathways to Recovery**  
**Psycho-Social Groupwork**  
**Programme: An Initial**  
**Evaluation Report**

**April 2011**

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## Executive Summary and Recommendations

This report provides an initial evaluation of the Pathways to Recovery Group Psycho-Social Intervention programme for people with substance misuse problems and co-occurring mild to moderate mental health problems. It outlines the referral process, the delivery of the programme, the quantitative outcomes and the views of the group facilitators, referring organisations, and service users. Along with strong statistical evidence of change, the programme outlines the clinical significance of the outcomes. Importantly, the participant views of the programme and its impact on their lives were sought:

***“Since coming on the programme I haven’t touched gear for months. [My] whole attitude has changed.”***

***“I feel the person who came three months ago is a different person to me.”***

***“I’ve never been clean since I was 12 years old. In 19 months of methadone and not one clean test until now. This is the first Christmas in 22 years I’ve been straight; I used but not a full relapse. It does [the programme] work in practice.”***

A range ( $n = 83$ ) of professionals from 28 organisations were trained in the 3-day Brief Psychosocial Intervention (PSI) approach. Brief PSI is a stand-alone 3-session intervention or a precursor assessment for the Group PSI programme. Of the professionals trained in Brief PSI  $n = 44$  went on to train on the 7-day Group PSI approach; of these  $n = 18$  practitioners went on to facilitate 10 group programmes in the counties of Carmarthen, Ceredigion, Pembrokeshire, and Powys.

It was established that the PSI training had a positive impact on development of the knowledge and skills of practitioners. Treatment integrity was rated and established through the independent observation of six of the ten group programmes.

Up to December 2010,  $n = 164$  referrals were made to the Pathways to Recovery Programme, with  $n = 102$  service users allocated to a group programme. Of these,  $n = 17$  did not start,  $n = 40$  dropped out, and  $n = 45$  completed, giving a retention rate of 53%. Although this completion rate was lower than the anticipated rate, 25% of those who did

not complete gave a valid reason for dropping out (e.g., they found work, were hospitalised or they had died). Although there were no differences in age, gender, or substance of concern between those who did not complete the programme (non-completers) and those who did (completers), non-completers had higher levels of substance dependency, greater impairment in their social functioning, and greater psychological distress.

Measures of post-group outcomes showed that the Pathways to Recovery Group Programme had a significant impact on service user outcomes. There were clear statistically significant and clinically significant improvements for the majority of service users. who reduced their levels of substance dependency, low mood, anxiety and increased their levels of personal well-being, social functioning and quality of life. Clinically significant outcomes showed two- and three-fold increases in those no longer meeting clinical criteria for substance dependency, social functioning impairment, anxiety, and depression. The 100% consistency across a range of measures gives additional confidence in the interpretation of these results. Service user and facilitator feedback provided additional support for the approach. Ten recommendations are provided (more detailed recommendations are provided at the end of this report):

**Recommendation 1:** Provide a greater number of groups to the more densely populated counties of Carmarthenshire and Pembrokeshire.

**Recommendation 2:** Take steps to improve the appropriateness of referrals.

**Recommendation 3:** Increase the number of groups delivered in partnership with referring organisations.

**Recommendation 4:** Where possible, ensure that the Brief PSI assessment practitioners are the group facilitators of the intended group programme.

**Recommendation 5:** Where possible, take steps to ease the access to the group programme and provide reinforcers for attendance.

**Recommendation 6:** Provide a (pre-) group session before the more formal delivery of the group programme.

**Recommendation 7:** Identify and support those with greatest levels of need.

**Recommendation 8:** Provide a service user-led social support group following the group programme.

**Recommendation 9:** Provide group facilitators with adequate time to prepare materials, deliver the programme and key-working sessions, and access supervision.

**Recommendation 10:** Enhance information sharing with community services.

## **Acknowledgements**

I would like to thank the Helping Groups to Grow (HG2G) staff of Kevin Fisher, Kim Johnson, Hector Walker and Sian Jenkins for all their diligence and help in this evaluation process. I appreciate the helpful feedback from all of the HG2G board members on an earlier interim report. I would like to thank all of the group facilitators (and their organisations) for their time and commitment to the evaluation, which exceeded all my expectations. Finally, I am extremely grateful to all of the service users who gave me their time, thoughtful feedback, and help with this evaluation.

## Background

The Pathways to Recovery Group Psychosocial Programme is an innovative 12-week programme developed to meet the needs of people with substance misuse problems that co-occur with mild to moderate mental health difficulties (i.e., anxiety, depression, low self-esteem, and panic disorders). The programme is available to those in the rural Welsh counties of Carmarthenshire, Ceredigion, Pembrokeshire, and Powys. The aim of the programme is to help people to overcome their problems and achieve a more healthy and balanced lifestyle.

The programme, which was developed by Clinical Psychological Associates, is underpinned the Lifestyle Balance Model (LBM), which is heavily influenced by a cognitive behavioural framework. The LBM allows the programme to draw from a variety of evidence-based psychosocial interventions (i.e., cognitive behavioural therapy, relapse prevention, mindfulness, and acceptance and commitment therapy) to provide service users with a range of coping strategies to help them manage difficult situations and psychological distress.

The treatment programme starts with three individual Brief psychosocial intervention (PSI) sessions. These sessions are designed to provide initial intervention and assessment of service users prior to their progression on to the groupwork programme. Service users receive a graphical representation of the assessment measures (e.g., social functioning, levels of substance dependency, substance use, anxiety, and depression) in the form of a Lifestyle Profile booklet. After their Brief PSI assessment, service users are allocated to a group programme. Each of the 12 weekly Group PSI sessions is supported by an individual key-working session with one of the group facilitators. After completion of the group programme, each service user is re-assessed with the same assessment measures used in the Brief PSI sessions and he or she receives an updated Lifestyle Profile.

The group programme and key-working sessions explore a range of topics related to managing substance misuse and its negative consequences (see Table 1.). First, service users are introduced to the basic underlying Lifestyle Balance Model before moving on to understand the function of their own substance use. The programme helps service users to consider any potential risks to their current behaviours and it helps them to plan for how they might minimise these. Service users learn to understand and manage cravings and urges associated with substance use before being introduced to the possibility of

sampling a period of sobriety. Significant changes to lifestyle are introduced next through the re-building of relationships and new social networks, with the introduction of self-rewards for successes. The programme has four related sessions that cover mental health: from understanding thoughts, feelings, and behaviours to the underlying beliefs that underpin many mental health problems before ending on planning for the future.

*Table 1. Content of the Group PSI and Key-working Sessions.*

<b>Session Number</b>	<b>Session Content</b>
1	Introduction to the Group PSI programme
2	Understanding substance dependence
3	Staying safe and managing risk
4	Managing cravings and urges
5	Planning for sobriety sampling
6	Building relationships and social networks
7	Planning to reward successes
8	Understanding mental health
9	Overcoming negative thoughts
10	Replacing destructive behaviours
11	Exploring negative beliefs
12	Creating a roadmap for success

## Evaluation Aims

The key requirements for this evaluation, which were set out by Helping Groups to Grow, were as follows:

- (a) Evaluate whether Helping Groups to Grow is achieving its remit of developing and sustaining a rolling programme of group based psychosocial interventions.
- (b) Comment on the differing service delivery modalities (i.e., the effectiveness and sustainability of different delivery approaches).
- (c) Comment on the training programme and its effectiveness in developing knowledge and skills to workers' clinical practice.
- (d) Report on the programme effectiveness, whether service user change is sustained over time, and whether the programme is more or less effective with some service users than others.
- (e) Comment on the clinical governance and on the programme integrity issues.
- (f) Comment on the views of service users, group facilitators and partner/referring organisations.
- (g) Comment on the uptake of peer mentoring.

## Research Methods

A series of activities and means of data collection were undertaken for this evaluation. The Helping Groups to Grow referral database was examined. Analyses were undertaken using assessment data of  $n = 85$  service users, using independent  $t$  tests. Further, more detailed, analyses took place on the assessment and follow-up data of  $n = 41$  service users, using within groups  $t$  tests. Further post group questionnaire data, examining the use of strategies, was examined on a further  $n = 27$  service users. Seven focus groups were undertaken with  $n = 33$  service users. Practitioner views of the pathways to Recovery Programme were assessed in two ways: with an anonymous questionnaire with  $n = 18$  practitioners and with individual semi-structured interviews with  $n = 15$  practitioners. Six independent groups were observed and assessed for treatment fidelity. Organisational views were also sought.

## Pathways to Recovery Group Programmes

**SECTION AIM:** This section aims to establish whether, *“Helping Groups to Grow is achieving its remit of developing and sustaining a rolling programme of group-based psychosocial interventions.”*

**METHODS:** The current provision of the Pathways to Recovery Group Programme is reviewed in terms of the delivery of groups in the counties of Pembrokeshire, Carmarthenshire, Ceredigion, and Powys. An assessment is undertaken of how best these groups serve these local populations.

Helping Groups to Grow (HG2G) delivered 10 groups from September 2009 to December 2010. These programmes were located at nine sites in the counties of Pembrokeshire, Carmarthenshire, Ceredigion, and Powys (see Figure 2.), in line with the HG2G’s aims. Five of these sites were in Powys (i.e., Brecon, Newtown, Welshpool, and two groups held in Llandrindod Wells), two in Pembrokeshire (i.e., Haverfordwest and Pembroke Dock), two in Carmarthenshire (i.e., Carmarthen and Llanelli) and one in Ceredigion (i.e., Aberystwyth).

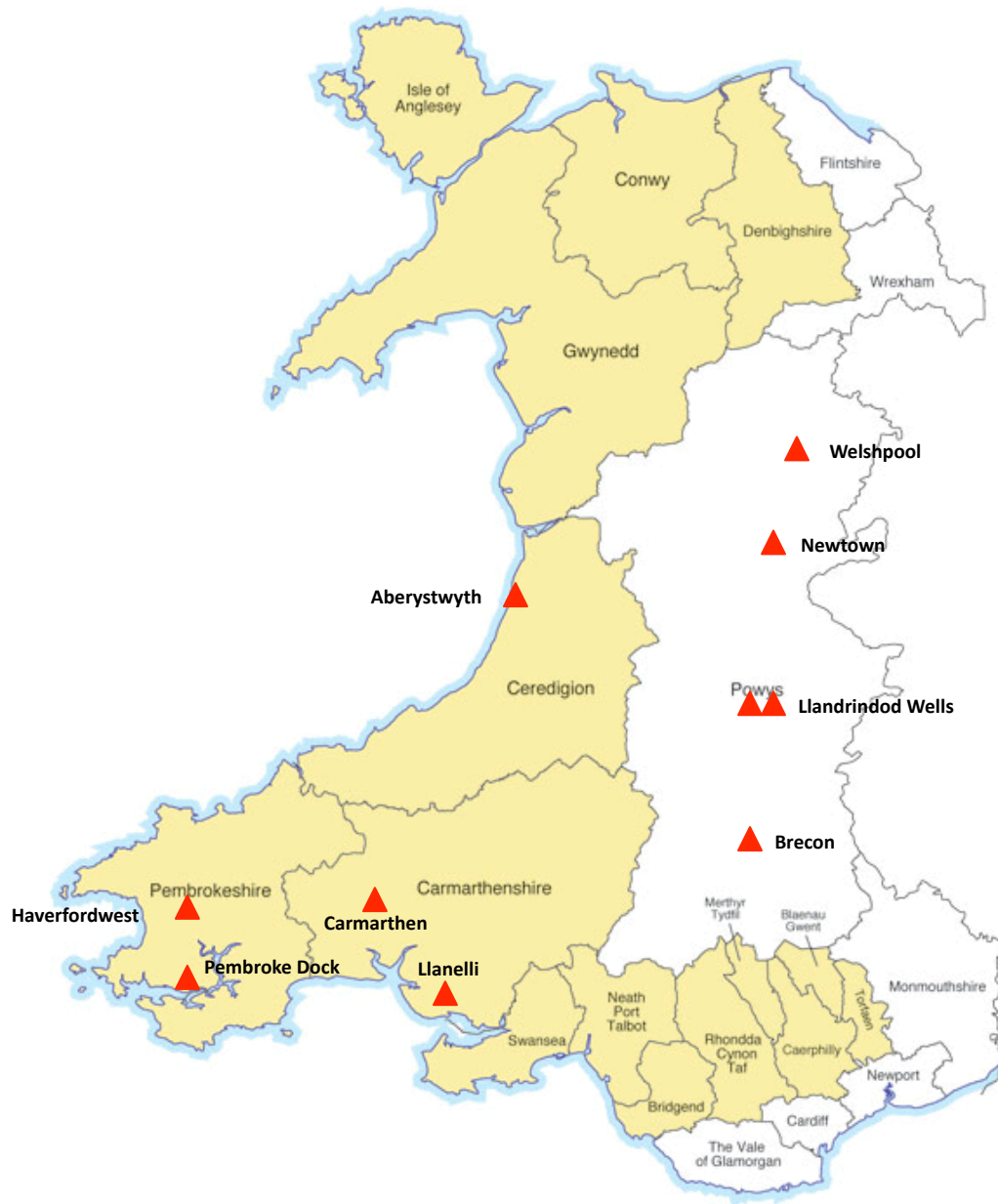


Figure 2. Group Locations Indicated by the ▲ Symbol

To understand how the delivery of these groups best serves the local county populations it is necessary to evaluate the population densities of all four counties and the level of referrals for drug or alcohol problems. All four counties are in the bottom five of the 22 counties of Wales in terms of population density, with Powys the least densely populated of all with just 25 people per km<sup>2</sup>. Ceredigion has almost double the population density of Powys (44 people per km<sup>2</sup>), and Pembrokeshire and Carmarthenshire each has almost three times that of Powys (with 74 people per km<sup>2</sup>). Population rates indicate, however, that Carmarthen has the greatest number of people

(180,500), then Powys (132,500), followed by Pembrokeshire (118,200), and then Ceredigion (78,000) (ONS, 2008). In 2008 – 2009 the Welsh Assembly Government published the rates of referrals for people seeking treatment for alcohol and drug use problems for each county in Wales. Carmarthenshire had the greatest number of referrals for drug and alcohol problems combined ( $n = 1386$ ), followed by Pembrokeshire ( $n = 903$ ), Powys ( $n = 701$ ), and then Ceredigion ( $n = 596$ ). Given the differences in population density and referral rates for drug and alcohol use problems the distribution of ten groups might be better served with Carmarthenshire being allocated four groups, Pembrokeshire three groups, Powys two groups and Ceredigion one.

**CONCLUSIONS:** Geographically it does appear that Helping Groups to Grow has achieved its aim of delivering group programmes across the four target counties; however, the population rates and referral demands for services suggest that greater provision should be targeted at Pembrokeshire and Carmarthenshire. To understand how the current provision was delivered with a greater intensity in Powys compared to other counties it is necessary to evaluate the contribution of partner organisations (see the following section). The delivery of service provision is outlined in Recommendation 1.

### Training Provision and Partner Organisations

**SECTION AIM:** This section aims to establish whether, *“The differing service delivery modalities impact on the effectiveness and sustainability of different delivery approaches.”* By December 2010, HG2G set out to achieve the delivery of 10 – 12 groups, with 80 starts and 50 completers (62.5%): this aim will also be evaluated.

**METHODS:** The training provision and referral pathways to the Pathways to Recovery Group Programme are reviewed. Group completion rates are assessed.

A total of  $n = 83$  professionals (e.g., including substance misuse specific key-workers, counsellors, youth workers and nurses and non-substance misuse specific key-workers, nurses, social workers, counsellors, and occupational therapists) were trained on

the 3-day Brief PSI training. These workers came from a total of 28 statutory and non-statutory substance misuse and mental health services (see Table 2.).

*Table 2. The 28 Organisations Represented in the Training of Brief PSI.*

1 BTCV	15 Mind – Carmarthen
2 Catalyst	16 Mind – Haverford West
3 Ceredigion Social Services	17 Powys Drug and Alcohol Centre – Brecon
4 Community Mental Health Team – Carmarthen	18 Powys Drug and Alcohol Centre – Llandrindod Wells
5 Community Mental Health Team – Newcastle Emlyn	19 Powys Drug and Alcohol Centre – Newtown
6 CMP	20 Powys Drug and Alcohol Centre – Welshpool
7 Crisis Resolution Team	21 Powys Drug and Alcohol Centre – Ystradgynlais
8 Cyswllt Contact	22 Prism
9 DIP – Carmarthen	23 Sure Start
10 DIP – Pembrokeshire	24 The Wallich
11 DIP – Prism	25 TSS
12 Hafan Cymru	26 Turning Point
13 Help Groups to Grow	27 Women’s Aid – Carmarthen
14 Home Start	28 West Wales Substance Misuse Services

Of the  $\underline{n} = 83$  professionals trained in Brief PSI,  $\underline{n} = 44$  went on to complete the 7-day training for the Group PSI programme, which were represented by 10 organisations and 14 services (see Table 3.). Of those who were trained, just the Helping Groups to Grow Practitioners ( $\underline{n} = 5$ ), Helping Groups to Grow staff ( $\underline{n} = 2$ ), PDAC staff ( $\underline{n} = 8$ ), Cyswllt Contact ( $\underline{n} = 1$ ), DIP Pembrokeshire ( $\underline{n} = 1$ ), and Turning Point ( $\underline{n} = 1$ ) went on to deliver the Group Programme.

Table 3. A List of Organisations and the Number of Individuals Trained in Group PSI.

Organisation	<u>n</u>	Organisation	<u>n</u>
HG2G - Practitioner*	8	Catalyst	2
HG2G - staff*	5	Turning Point*	2
PDAC – Newtown*	6	DIP Pembs*	2
PDAC - Brecon*	5	Cyswllt Contact*	1
PDAC - Llandrindod W.*	4	WWSMS	1
PDAC - Welshpool*	2	DIP Prism	1
The Wallich	4	BTCV	1

\* Staff from the organisations who have delivered the Group PSI Programme

From September 2009 to August 2010 a total of n = 164 participants were referred to the Pathways to Recovery Group PSI programme. The referrals to the group programme came from a variety of sources (see Table 4.). Powys Drug and Alcohol services (PDAC) referred the greatest number of service users, although they did have the greatest number of Brief PSI practitioners (n = 24) and Group PSI practitioners (n = 17). West Wales Substance Misuse Services referred the second greatest number of service users to the Pathways to Recovery Programme (n = 31 or 19%), and this service had just one practitioner trained in Brief PSI and Group PSI, but who did not facilitate a group.

Table 4. Referral Sources to the Group Programme

Organisation	Number of Referrals
Powys Drug and Alcohol Services*	62
West Wales Substance Misuse Service	31
Drug Intervention Programme*	15
Pembroke Substance Misuse Service	13
Prism*	13
Crisis Home Resolution Team	9
Carmarthen Substance Misuse Service	6
Cyswllt Contact*	5
Community Mental Health Team	2
Probation	2
Kaleidoscope	2
Not Indicated	2
Turning Point*	1
Self Referral	1

\* Indicates Services that Facilitated or Co-facilitated the Group Programme

Figure 2. displays the referrals to the Pathways to Recovery Programme. At the first stage in this referral process  $n = 10$  service users were adjudged to be inappropriate for the service (e.g., they did not have a co-occurring mental health problems). The remaining service users were allocated for the three-session Brief PSI assessment. Of these individuals  $n = 52$  were discharged from the service: a variety of reasons were cited (e.g., missed appointments, requests for alternative services such as counselling, or simply opting out of further treatment). Of the  $n = 102$  who were allocated to a group,  $n = 17$  did not start,  $n = 40$  dropped out part way through and  $n = 45$  completed. Giving an overall completion rate of 53%.

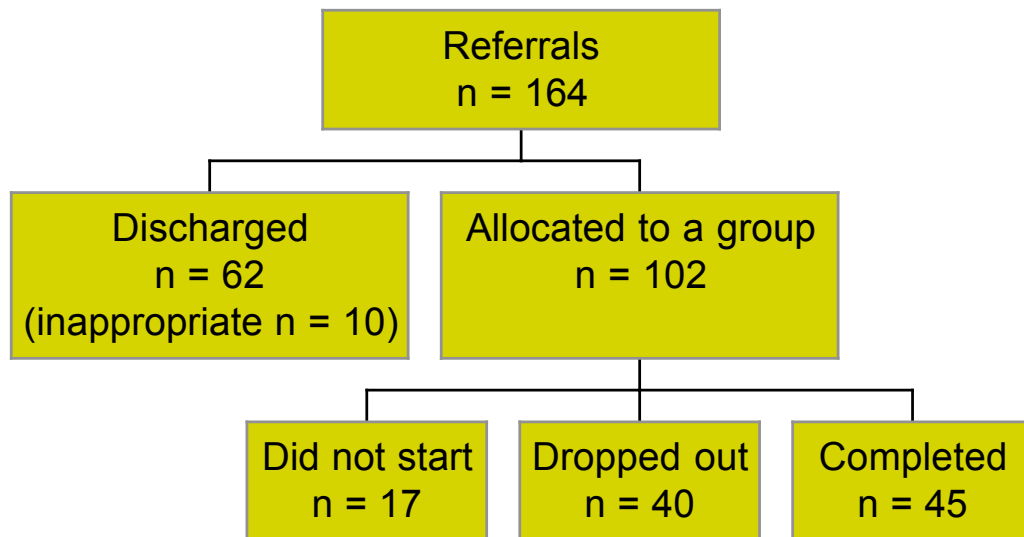


Figure 2. Referral Rates to the Pathways to Recovery Programme

The appropriateness of referrals was considered by the referral source. Displayed in Table 5. are the number (and percentage) of referrals to the Pathways to Recovery Programme for each referring organisation, which are separated by the outcome of the referral. In some instances, service users were discharged from the service because they were inappropriate or required a different service; in others, service users were allocated to a group programme but they did not start it; in some cases service users dropped out part way through the programme; and finally, some service users completed the whole programme. Those services that had few or no practitioners trained in Brief or Group PSI appeared to have the greatest number of service users discharged from the Pathways to Recovery Programme (e.g., Carmarthen SMS, DIP, CRHT, Kaleidoscope, WWSMS). Those services that appeared to have the best completion rates were those that had practitioners who had been trained in Group PSI and who co-facilitated the group programme (see Recommendation 3 for further discussion).

Table 5. Referring Organisations and the Course of Service User Outcomes

Service	Discharged	Did Not Start	Dropped Out	Completed
	n (%)	n (%)	n (%)	n (%)
PDAC* ^	3 (4%)	9 (13%)	25 (36%)	32 (46%)
WWSMS*	13 (45%)	6 (21%)	6 (21%)	4 (14%)
Cyswllt Contact*^	-	1 (20%)	2 (40%)	2 (40%)
Pembroke SMS	5 (42%)	4 (33%)	1 (8%)	2 (17%)
Prism*	4 (31%)	7 (54%)	1 (8%)	1 (8%)
DIP* ^	7 (58%)	3 (25%)	1 (8%)	1 (8%)
Carmarthen SMS	4 (57%)	1 (14%)	2 (29%)	-
CRHT	3 (50%)	1 (17%)	1 (17%)	1 (17%)
CMP	-	-	-	1 (100%)
Kaleidoscope	1 (50%)	1 (50%)	-	-
Turning Point* ^	-	-	-	1 (100%)
Probation Trust	3 (100%)	-	-	-

\*Organisations with practitioners trained in Group PSI

^Organisations with practitioners who delivered the group programme

Table 6. displays the completion rate for each of the ten completed programmes. From the total of ten groups delivered, PDAC staff delivered five of them at their own service sites and just one of these with co-facilitation from Helping Groups to Grow<sup>1</sup> facilitators. Of the remaining five groups, Helping Groups to Grow delivered four of these groups jointly with other organisations and Helping Groups to Grow delivered one group, independently.

<sup>1</sup> Helping Groups to Grow facilitators are employed directly by the Pathways to Recovery Programme

Table 6. Group Modalities and Completion Rates.

HG2G Staff	Partner Staff	Venue	Starters n	Completers n	Completion Rate (%)
1	1	Aberystwyth	6	3	50
0	3	Brecon*	18	9	50
3	0	Carmarthen	4	1	25
1	1	Haverfordwest	7	4	57
1	1	Llandrindod Wells*	11	6	55
0	2	Llandrindod Wells (2)*	9	5	55
1	1	Llanelli	9	4	44
1	1	Newtown*	8	4	50
1	1	Pembroke Dock	5	4	80
0	2	Welshpool*	8	5	63

\* Groups delivered at the PDAC sites

The mean completion rate for all the groups was 53% (Range 25 – 80). There does not appear to be any clear patterns to indicate better completion rates (i.e., groups sizes or facilitator factors). The worst completion rate was for the Carmarthen group (25%). A number of factors might account for this poor completion rate: there were relatively few starters and the Helping Groups to Grow practitioners delivered this group independently. It is plausible that service users without an established relationship with at least one practitioner were more prone to drop out of the group programme (see Recommendation 3 for further discussion).

**CONCLUSIONS:** Helping Groups to Grow succeeded in generating a high “buy-in” to the Pathways to Recovery Programme by rolling out the Brief PSI training to a large number, and wide variety, of organisations. Those services that had greater buy-in (i.e., PDAC) referred the greatest number of service users. This approach appears to demonstrate a sustainable programme. Unsurprisingly, the appropriateness of referrals was better for those organisations that had staff who had completed both the Brief and Group PSI training. Based on the limited number of delivery modalities, it appeared that those groups who had at least one facilitator familiar with the referred service users had better completion rates. Finally, it appears that HG2G did achieve its aim of rolling out 10 – 12 programmes with more than 80 starts. It did fall short in its completion rates, which was 53% compared to the target of 62.5%. This aspect is explored in more detail in the next section. The detailed recommendations section outlines potential improvements in service delivery and increasing completion rates in detail.

### **Results: Completers and Non-completers of Treatment**

**SECTION AIM:** This section aims to establish differential factors between those who complete the programme (i.e., completers) and those who do not (i.e., non-completers), in line with the evaluation aim (d) “...whether the programme is more or less effective with some service users than others.”

**METHODS:** Statistical analyses are conducted, using independent *t*-tests, on questionnaires administered at baseline between completers and non-completers of treatment.

A series of baseline assessments were administered to service users prior to the group programme. These assessment measures included a number of valid and reliable measures. Each participant was administered the following questionnaires:

- (a) The Treatment Outcomes Profile: used primarily to assess alcohol and drug use.
- (b) The LBM screening tool: this 4-item screening tool assesses service users’ perception of impairment to their thinking, physical well-being, difficult emotions, and destructive behaviour. It is not a validated tool.

- (c) The 12-item General Health Questionnaire (GHQ-12; Goldberg & Williams, 1988): to assess general social functioning. This measure also contains validated clinical norms.
- (d) The Leeds Dependency Questionnaire (Raistrick et al., 1994): to assess substance use dependency. This measure also contains clinical norms.
- (e) The Personal Wellbeing Index-Adult (PWI-A; Personal Wellbeing Group, 2006): to assess wellbeing and quality of life. This measure also contains validated clinical norms.
- (f) The Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001): to assess low mood and depression. This measure also contains validated clinical norms.
- (g) The General Anxiety Disorder questionnaire (GAD-7; Spitzer et al., 2006): to assess levels of anxiety. This measure also contains validated clinical norms.
- (h) The General Self Efficacy scale (GSE; Schwarzer & Jerusalem, 1995): to assess general self-belief in the ability to cope with difficult situations.

Of the  $n = 102$  participants allocated to a group programme  $n = 17$  did not start. Of the total ( $n = 85$ ) who did start the group programme  $n = 45$  (53%) completed and  $n = 40$  (47%) dropped out. The completers of the treatment programme attended on average 9.7 group sessions and 7.7 key-working sessions. In contrast, the non-completers of treatment attended just 2.4 group sessions and 2.8 key-working sessions before they dropped out of treatment. In some cases the participant's reasons for dropping out or not starting a group programme were stated (see Table 7.). Of those who did not start the programme the most frequently cited reason was to seek an alternative service (e.g., counselling or going into rehabilitation). Of those who started but did not complete the group programme, 25% ( $n = 10$ ) had legitimate reasons for dropping out (i.e., they found work, were hospitalised or imprisoned, or had died).

*Table 7. The Number of Participants and Their Stated Reason for Not Starting the Group Programme or for Dropping-out Before Completion.*

<b>Stated Reason</b>	<b>Non-starter (n)</b>	<b>Non-completer (n)</b>
Found Work	-	5
Accessed Counselling	2	1
Hospitalised	1	2
Deceased	1	2
Imprisoned	-	1
Went to Rehab	1	-
Relapsed	1	1
No Stated Reason	11	28

There was a valid data set available on  $n = 42$  completers and  $n = 39$  non-completers of treatment. There was no difference between the mean age of completers, which was 41.8 years old ( $sd = 9.9$ , *Range* 25 – 63), and non-completers, which was 42.2 years old ( $sd = 12.5$ , *Range* 21 – 81). There was no statistical difference ( $Z = 1.43$ ,  $p > .05$ ) between the gender balance of the completer and non-completer groups: completers comprised 17 males (41%) and 25 females (59%) compared to the non-completers who comprised 22 males (56%) and 17 females (44%). Table 8. displays the number of participants by their main drug of concern for the completers and non-completers, which was proportionally similar across the groups.

*Table 8. The Number of Participants by Their Main Drug of Concern.*

<b>Drug of Concern</b>	<b>Completer n (%)</b>	<b>Non-completer n (%)</b>
Alcohol	25 (60%)	29 (74%)
Opiates	8 (19%)	5 (13%)
Cannabis	4 (10%)	1 (3%)
Amphetamine	1 (2%)	0 (0%)
Crack	-	1 (3%)
Other	4 (10%)	3 (8%)

There were three differences between the baseline measures of the completers and non-completers of treatment (see Table 9.). First, the non-completers of treatment ( $M = 12.41, sd = 7.63$ ) had significantly greater levels of substance dependency (measured by the Leeds Dependency Questionnaire), than the completers of treatment ( $M = 8.60, sd = 7.82$ ),  $t(77) = 2.19, p < .05$ . Second, the non-completers of treatment ( $M = 17.16, sd = 8.65$ ) had significantly greater impairment in social functioning (measured by the General Health Questionnaire), than the completers of treatment ( $M = 13.17, sd = 8.55$ ),  $t(78) = 2.07, p < .05$ . Finally, the non-completers of treatment ( $M = 5.87, sd = 2.72$ ) had significantly higher scores of psychological distress at the initial screening assessment (measured by a Lifestyle Balance Screening Questionnaire), than did the completers of treatment ( $M = 4.33, sd = 3.00$ ),  $t(79) = 2.41, p < .05$ .

*Table 9. Baseline Mean Scores and Standard Deviations.*

<b>Questionnaire Measure</b>	<b>Completer M (sd)</b>	<b>Non-completer M (sd)</b>
Screening Questionnaire*	4.33 (3.00)	5.87 (2.72)
Dependency*	8.60 (7.82)	12.41 (7.63)
Social Functioning*	13.17 (8.55)	17.16 (8.65)
Alcohol Consumption	24.71 (42.74)	49.37 (74.18)
Personal Well-being	53.04 (18.50)	50.10 (18.23)
Depression	11.12 (7.38)	12.71 (5.71)
Anxiety	9.05 (6.56)	9.24 (4.97)
Self Efficacy	27.95 (6.01)	27.18 (5.27)
Psychological Well-being	10.74 (5.12)	10.33 (4.73)
Physical Well-being	11.05 (5.24)	12.36 (4.48)
Quality of Life	10.88 (5.27)	11.18 (4.70)

\* = Statistically significant differences at the .05 level

On several other measures of well-being, quality of life, depression and anxiety, there were no differences between the completers and non-completers of treatment. Of note, the mean alcohol consumption of completers was 24.71 units ( $sd = 42.7$ ) per week

compared to non-completers 49.37 ( $sd = 74.2$ ): despite the non-completers average weekly consumption being almost double that of the completers, the variance of consumption was so great this difference was rendered statistically non-significant—this comparison is further confounded by the fact that there was a greater number of males in the non-completer group and a greater number of those in this group whose main drug of concern was alcohol.

**SECTION CONCLUSIONS:** A number of service users—some 25% of those who did so—had legitimate reasons for dropping out of the group programme. The group of treatment completers and treatment non-completers did not differ on age, gender, or substance of concern. There were some differences with non-completers scoring significantly higher on measures of difficulty with social functioning and on levels of substance dependency. In addition, service users who did not complete treatment scored significantly higher on the LBM screening tool, which was administered in the first Brief PSI assessment session. It is unsurprising that those who were most likely to drop out of treatment were those identified with the greatest level of impairments. Recommendation 7. discusses how best to identify and support those with the greatest levels of needs.

### Training Effectiveness

**SECTION AIM:** This section aims to establish whether, *“The training programme is effective in developing the knowledge and skills of workers’ clinical practice.”*

**METHODS:** An evaluation is made from an anonymous questionnaire administered to practitioners. Mean response scores and facilitator comments are also reported.

An anonymous questionnaire was sent to Group PSI practitioners to canvass their views about the effects of the PSI training on their clinical practice. A total of  $n = 18$  practitioners completed the questionnaire, which is an overall response rate of 41%. The questionnaire asked practitioners to rate on a five-point scale (from 1 = *not at all* to 5 = *very much*) the impact of the Brief PSI and Group PSI training on their practice. Additionally, practitioners were asked to comment on the ratings they made.

Practitioners rated that the Brief PSI training had changed their practice,  $M = 3.7$  ( $sd = 1.2$ ). They commented that it fitted well with their own ways of working (e.g., motivational interviewing, cognitive behavioural therapy), that it was structured, and that it gave them a range of techniques and exercises. Practitioners also rated that Group PSI training had changed their practice,  $M = 3.9$  ( $sd = 0.9$ ). Many commented that it gave them a new approach with a structure, greater scope and insight into addictions, and a number of tools and exercises that they have used successfully with substance use and other mental health problems.

Practitioners reported that the Brief and Group PSI training had given them a good understanding of the Lifestyle Balance Model,  $M = 4.3$  ( $sd = 0.6$ ). They commented that initially it was a difficult concept to understand (but those with a background in CBT found it easier), and that it clearly illustrated the issues (in particular the lifestyle factors) that drive substance misuse and other unhelpful behaviours. Practitioners also rated that overall Brief and Group PSI training had improved their practice,  $M = 4.1$  ( $sd = 0.9$ ). Many commented that it was the focus and structure of the approach and having evidence-based tools that gave them greater confidence in their work, that it enabled them to manage complex situations, and some integrated it into their own everyday practice. Finally, practitioners were asked if their training in Brief and Group PSI had negatively impacted on their practice. The average rating was  $M = 1.4$  ( $sd = 0.8$ ), with 78% rating that it had *not at all* negatively impacted on their practice, with four individuals rating the item that it *partly* negatively impacted on their practice. Those practitioners who commented on their ratings felt that any new model can have a negative impact on practice and that the effort required to deliver the group programme could have a negative impact on the other service users on their caseload.

**CONCLUSIONS:** An anonymous questionnaire with responses from a limited number of practitioners would suggest that Group PSI (and Brief PSI) had a positive impact on developing the knowledge and skills of workers' clinical practice.

## Treatment Effectiveness: Follow-up Analysis

**SECTION AIM:** This section aims to establish whether, “*The group programme is effective.*”

**METHODS:** Statistical analyses are conducted, using repeated measures *t*-tests, on baseline and post-group questionnaires. For each service user, scores are assessed for statistically significant and clinically significant changes. It is important to note that longer-term follow-up analyses (i.e., 3-month, 6-month, 12-month) are unavailable at the time of writing this report.

A full data set was available for follow-up analysis on  $n = 41$  of the  $n = 45$  service users who completed treatment. The follow-up assessments were conducted in the week following the last group session<sup>2</sup>. A series of repeated measures (within-subjects) *t* tests were completed on all the baseline measures that were repeatedly administered at the end of the group programme. On all measures there were statistically significant improvements in functioning at the follow-up time-point (see Table 10.). That is, levels of substance dependency decreased, as did levels of depression and anxiety. Social functioning improved, as did personal well-being, self-efficacy, psychological well-being, physical well-being, and quality of life. It is striking that there such a high level of consistency in improvements across a range of validated tools.

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<sup>2</sup> Only  $n = 6$  service users had 3-month follow-up data available for analysis at the time of writing this report: too few for statistical analysis.

Table 10. Baseline and Follow-up Mean Scores and Standard Deviations.

Questionnaire Measure	Baseline M (sd)	Follow-up M (sd)
Screening Questionnaire***	4.33 (3.00)	1.70 (2.39)
Dependency***	8.49 (7.88)	2.88 (5.15)
Social Functioning***	12.90 (8.48)	6.98 (5.67)
Alcohol Consumption*	24.71 (42.74)	11.24 (29.92)
Personal Wellbeing***	53.08 (18.73)	66.86 (19.76)
Depression***	10.78 (7.13)	6.17 (6.43)
Anxiety***	8.76 (6.36)	4.39 (5.14)
Self Efficacy***	28.17 (5.92)	32.51 (6.16)
Psychological Wellbeing***	10.73 (5.18)	14.46 (4.40)
Physical Wellbeing***	11.29 (5.05)	14.10 (4.08)
Quality of Life***	11.07 (5.18)	14.85 (4.59)

\* = Statistically significant differences at the .05 level

\*\*\* = Statistically significant differences at the .001 level

There were also clinically significant improvements across the measures from the baseline to the follow-up assessment. For example, the number of service users who were above the threshold for clinical levels of substance dependence on the Leeds Dependency Questionnaire prior to entering the programme (baseline) was  $n = 36$  (85.7%) with 38% of these in the moderate to high range (see Figure 3.). At the follow-up time-point (in the week following the last group session)  $n = 24$  (66%) remained above the threshold for clinical levels of substance dependence with less than 10% of these in the moderate to high range. The number of service users who did not meet the criteria for substance dependence increased from  $n = 6$  at baseline to  $n = 18$  at the follow-up.

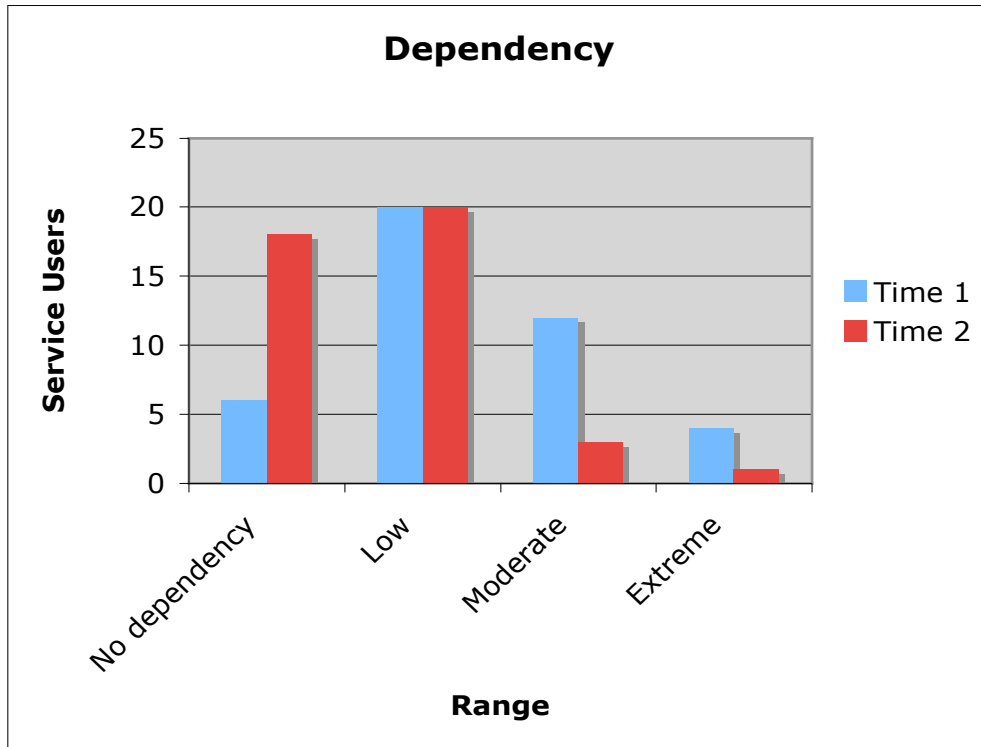


Figure 3. Number of Service Users by Level of Substance Use Dependency at Baseline (Time 1) and Follow-up (Time 2).

There were similar clinical improvements in social functioning from the baseline to the follow-up, based on the 12-item General Health Questionnaire. At baseline there was  $n = 29$  (71%) with impairments in social functioning, with 33% of these in the moderate to severe range (see Figure 4.). At the follow-up time-point  $n = 9$  (22%) remained above the threshold for clinical impairment with 10% of these in the moderate to severe range. The number of service users who did not meet the criteria for clinical impairment in social functioning increased from  $n = 12$  (29%) at baseline to  $n = 32$  (78%) at the follow-up.

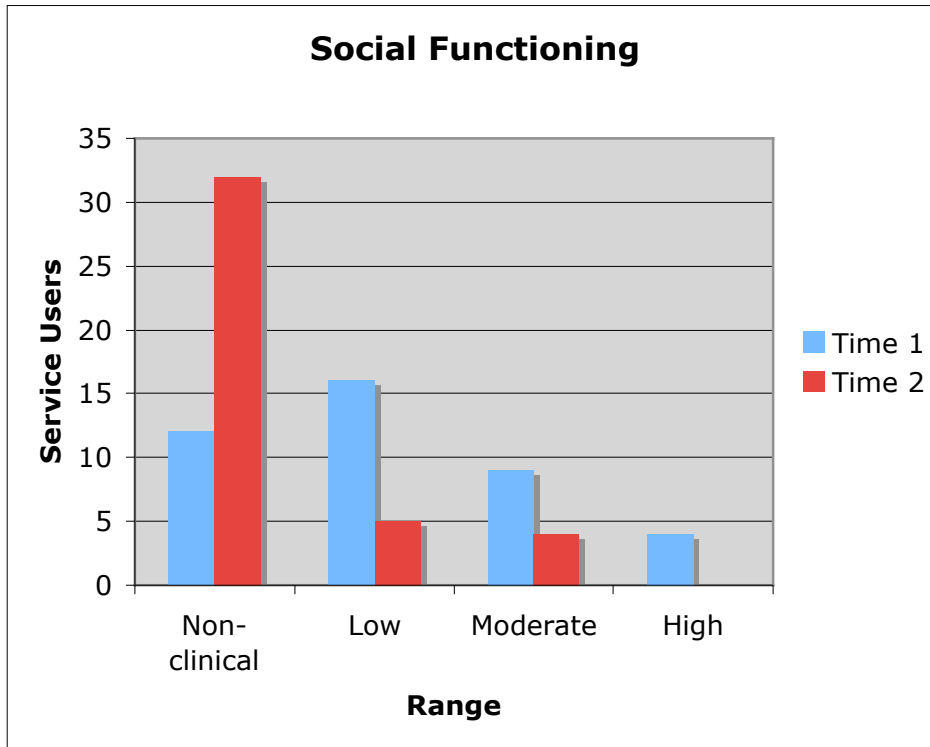


Figure 4. Number of Service Users by Level of Social Functioning at Baseline (Time 1) and Follow-up (Time 2).

There were clinical improvements from the baseline to the follow-up in the number of service users who reached criteria for depressive symptoms, based on the validated depression screen PHQ-9. At baseline there was  $n = 33$  (81%) meeting clinical impairment, with 32% of these in the moderate to severe (score > 14) range (see Figure 5.). At the follow-up time-point  $n = 19$  (46%) remained above the threshold for clinical impairment with 17% of these in the moderate to severe range. The number of service users who did not meet the criteria for depressive symptoms increased from  $n = 8$  (19%) at baseline to  $n = 22$  (54%) at the follow-up.

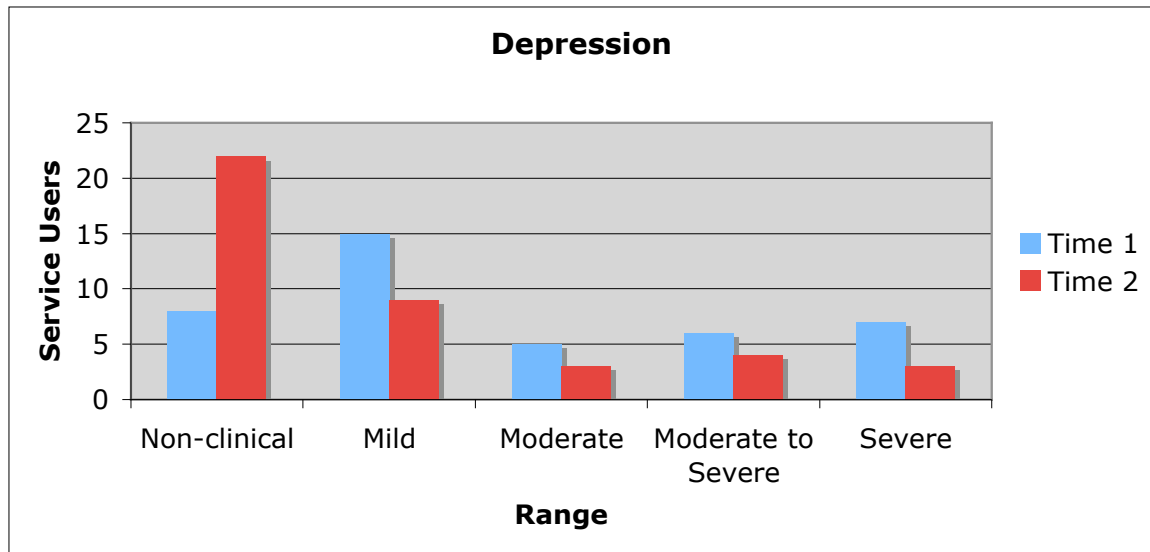


Figure 5. Number of Service Users by Level of Depressive Symptoms at Baseline (Time 1) and Follow-up (Time 2).

There were clinical improvements from the baseline to the follow-up in the number of service users who reached the criteria for anxiety symptoms, based on the validated anxiety screen GAD-7. At baseline there was  $n = 35$  (85%) meeting clinical impairment, with 41% of these in the moderate to severe (score > 11) range (see Figure 6.). At the follow-up time-point  $n = 26$  (63%) remained above the threshold for clinical impairment with 12.5% of these in the moderate to severe range. The number of service users who did not meet the criteria for anxiety symptoms increased from  $n = 6$  (15%) at baseline to  $n = 15$  (37%) at the follow-up.

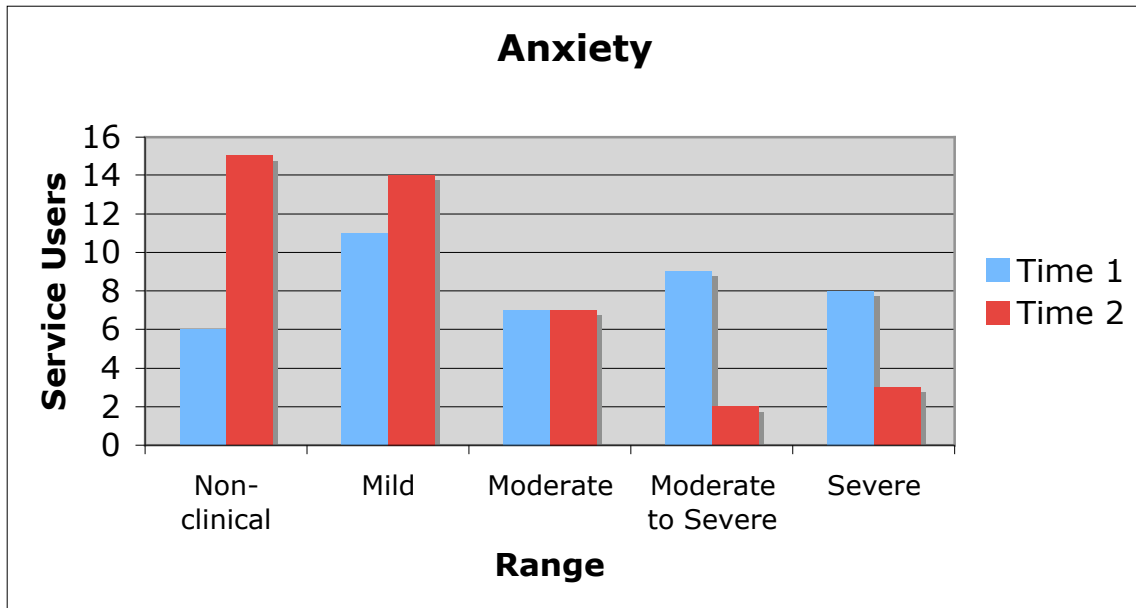


Figure 6. Number of Service Users by Level of Anxiety Symptoms at Baseline (Time 1) and Follow-up (Time 2).

**CONCLUSIONS:** It is clear that the Pathways to Recovery Group Programme had a significant impact on service user outcomes. There were clear improvements for the majority of service users in reducing their levels of substance dependency, low mood, anxiety and increasing their personal well-being, social functioning and quality of life. The 100% consistency across a range of measures gives additional confidence in the interpretation of these results.

## Treatment Integrity and Clinical Governance

**SECTION AIM:** This section aims to establish whether, “*The programme has adequate clinical governance and treatment integrity.*”

**METHODS:** The author<sup>3</sup> of this report observed and rated—using a 26-item checklist—one session for six separate groups. A total of  $n = 15$  group facilitators (83%) were interviewed, separately. A review of procedures and protocols is made.

Clinical governance is a fundamental aspect in the delivery of psychosocial interventions. In 2010 the NTA in collaboration with the British Psychological Society (BPS) published guidelines for ensuring adequate clinical governance of psychosocial interventions (Pilling et al., 2010). They suggested that service should ensure that (a) adequate training is given, (b) supervision is available, (c) protocols are in place, and (d) quality assurance is assessed.

All group facilitators have undergone sufficient training (i.e., a minimum of 10 days), by a competent trainer, in the delivery of Brief and Group PSI. For the delivery of each group programme facilitators were offered three sessions of group supervision from Helping Groups to Grow. Feedback from practitioners indicated that the supervision was of a high quality and was necessary given the complexity of the work carried out. Not all practitioners accessed supervision, however: some of the external services (i.e., those who delivered groups without HG2G co-facilitation) and the first programmes to be delivered, did not access supervision. In many cases these practitioners stated that they did access their own supervision, but in hindsight, they would have benefited from the HG2G supervision provision. The Pathways to Recovery Programme has clear protocols in place: practitioners felt very supported by the HG2G administration staff. The Group PSI Programme also has clear treatment manuals and is structured through power-point administration.

Using a 26-item checklist the delivery of the programme was further assessed for treatment integrity. The checklist was devised to assess practitioners’ delivery of the group sessions. Practitioners were rated on a 7-point scale (1 = *not at all* to 7 =

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<sup>3</sup> Dr. Hogan is a chartered clinical psychologist who co-developed and trained staff to deliver Brief PSI and Group PSI. For a more detailed account of his qualifications please see the **About the Author and Expressions of Interest** section at the end of this report.

*extensively*) on 13 core tasks. These task were to: (1) assess general functioning in major life areas of the service users; (2) ensure that task assignments between sessions were set; (3) review previous assignments and any difficulties with these and to reinforce practice between sessions; (4) evaluate and feedback to service users their cognitions in relation to managing difficult thoughts about substance use, major life areas, or mental health; (5) apply problem-solving techniques to issues raised in sessions; (6) prioritise non-substance use factors for intervention; (7) consistently remain on session tasks; (8) describe and an maintain agenda for the session; (9) build on the material discussed in past sessions; (10) reflectively listen to service users; (11) demonstrate empathy to service users; (12) discuss availability for support for service users; and (13) discuss the termination of therapy. Practitioners were rated on (a) the level they attended to the task and (b) how skilfully they did so (see Table 11.).

*Table 11. Mean Scores, Standard Deviations, and Range of Observer Ratings of Six Groups Using an Observation Checklist of Core Therapeutic Aims.*

Dimension	Attended to Task			Skill Level		
	Mean	sd	Range	Mean	sd	Range
General Functioning	5.83	.41	5 – 6	5.67	.52	5 – 6
Task Assignment	6.33	.52	6 – 7	6.00	.63	5 – 7
Review of Previous Assignments	6.50	.55	6 – 7	6.00	.63	5 – 7
Cognitive Factors	6.00	.63	5 – 7	5.83	.41	5 – 6
Problem Solving	6.50	.55	6 – 7	6.50	.55	6 – 7
Non-substance Use Factors	6.17	.75	5 – 7	6.00	.63	5 – 7
Maintaining Session Focus	5.67	.82	5 – 7	5.83	.75	5 – 7
Agenda Setting	6.83	.41	6 – 7	6.50	.55	6 – 7
Continuity from Past Sessions	6.00	.63	5 – 7	6.00	.63	5 – 7
Reflective Listening	6.67	.52	6 – 7	6.50	.55	6 – 7
Empathy	6.50	.55	6 – 7	6.33	.52	6 – 7
Supporting for Treatment Efforts	6.33	.82	5 – 7	6.33	.52	6 – 7
Termination of Therapy	6.00	.89	5 – 7	5.83	.75	5 – 7

The mean ratings of how much they attended to each task across all dimensions were high: with the lowest scores for maintaining the session focus (5.67) and for assessing general functioning (5.83); the highest scores were for agenda setting (6.83) and for reflective listening (6.67). The mean ratings of how skilfully they attended to each of these tasks across all dimensions were also high: with the lowest score for assessing general functioning (5.67); the highest scores were for agenda setting, reflective listening, and problem solving (each at 6.83). The structure of the sessions helped to maintain a focus on some core tasks (e.g., agenda setting, task assignment, reviewing homework etc) but not others (e.g., reflective listening, empathy, opportunities for support etc). Despite these differences, group facilitators maintained consistently high treatment integrity.

**CONCLUSIONS:** The Group PSI programme had good treatment integrity and clinical governance. Participants who delivered the programme all undertook sufficient training in psychosocial interventions. The power point slides and the treatment manual structured the clinical delivery of the programme. Treatment integrity was assessed through group observation and the adherence to a set checklist. The treatment concordance was high. Supervision was available to almost all facilitators and was accessed by the majority of practitioners. Supervision was highly valued with many practitioners recognising it as “very good”.

### Service User, Facilitator, and Organisation Feedback

**SECTION AIM:** This section aims to, “*Outline the views of service users, group facilitators and partner/referring organisations.*” It also examines whether the, “*Service users took up peer mentoring.*”

**METHODS:** A post group questionnaire, completed by  $n = 27$  service users, and seven separate focus groups, conducted with  $n = 33$  service users, are analysed quantitatively and qualitatively. Interview data from a semi-structured interview with group facilitators ( $n = 15$ ) is reported. Referring organisations comments are also reported.

## Service User Feedback

Two methods were undertaken to gather service user feedback. First, seven separate focus groups were conducted with  $n = 33$  service users. Second, a post group questionnaire was completed by  $n = 27$  service users. The post group questionnaire asked service users to rate five aspects of how the programme might have affected them. First, service users were asked to rate their mental health on an 11-point scale (0 = *poor mental health* to 10 = *excellent mental health*); the average rating was  $M = 7.78$  ( $sd = 2.08$ ): indicating, overall good mental health. Service users were next asked to rate the strategies they used to manage their mental health on an 11-point scale (-5 = *previously learned strategies*, 0 = *Equal*, 5 = *PSI strategies*). Figure 7. displays the frequency of respondents ratings of the strategies they used: none of the respondents limited themselves to previously learned strategies with 41% using a combination of previously learned strategies and PSI strategies and the remaining 59% showing a preference for PSI strategies.

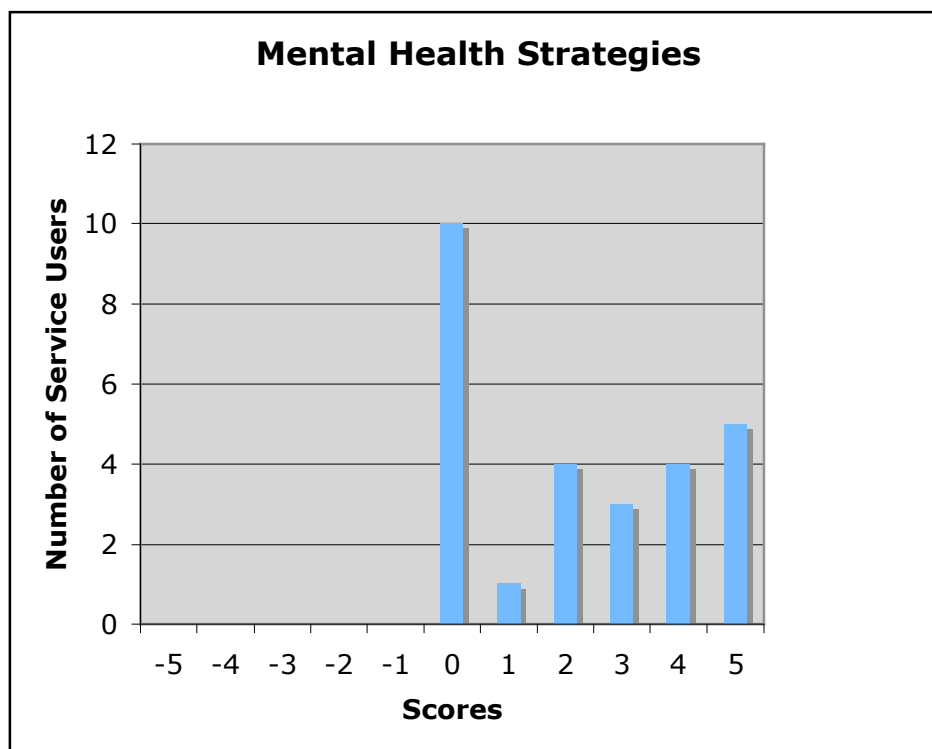


Figure 7. Ratings of Service Users Mental Health Strategies (-5 = *previously learned strategies*; 0 = *combination of previously learned and PSI strategies*; 5 = *completely PSI strategies*).

Service users were asked to rate how they were managing their substance use on an 11-point scale (0 = *completely dissatisfied* to 10 = *completely satisfied*); the average rating was  $\bar{M} = 9.07$  ( $\underline{sd} = 1.77$ ): indicating service users were managing their substance use extremely well. Service users were next asked to rate the strategies they used to manage their substance use on an 11-point scale (-5 = *previously learned strategies*, 0 = *Equal*, to 5 = *PSI strategies*). Figure 8. displays the frequency of respondents ratings of strategies used: none of the respondents limited themselves to previously learned strategies with 33% using a combination of previously learned strategies and PSI strategies and the remaining 67% showing a preference for PSI strategies.

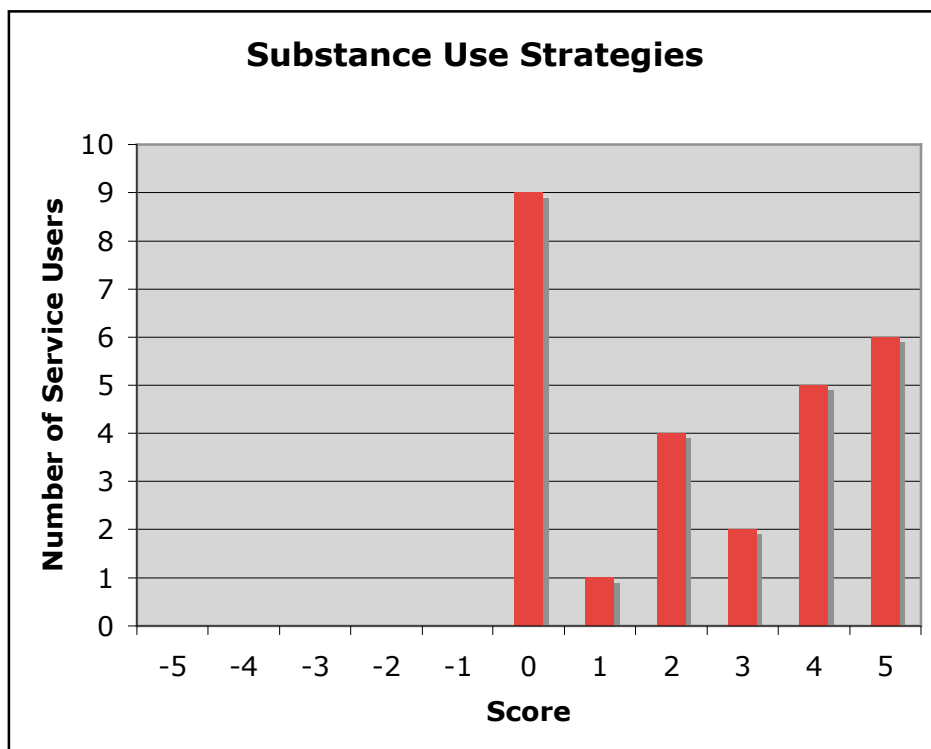


Figure 8. Ratings of Service Users Substance Use Strategies (-5 = *previously learned strategies*; 0 = *combination of previously learned and PSI strategies*; 5 = *completely PSI strategies*).

Finally, service users were asked to rate how satisfied they were with the Group programme on an 11-point scale (0 = *completely dissatisfied* to 10 = *completely satisfied*); the average rating was  $\bar{M} = 9.04$  ( $\underline{sd} = 1.34$ ): indicating that overall respondents were highly satisfied with the programme. Figure 9. displays the frequency of respondents ratings: 48% gave the programme a score of 10; 26% a score of 9, 19% a score of 8; and just 4% gave a score of 7 and a score of 4.

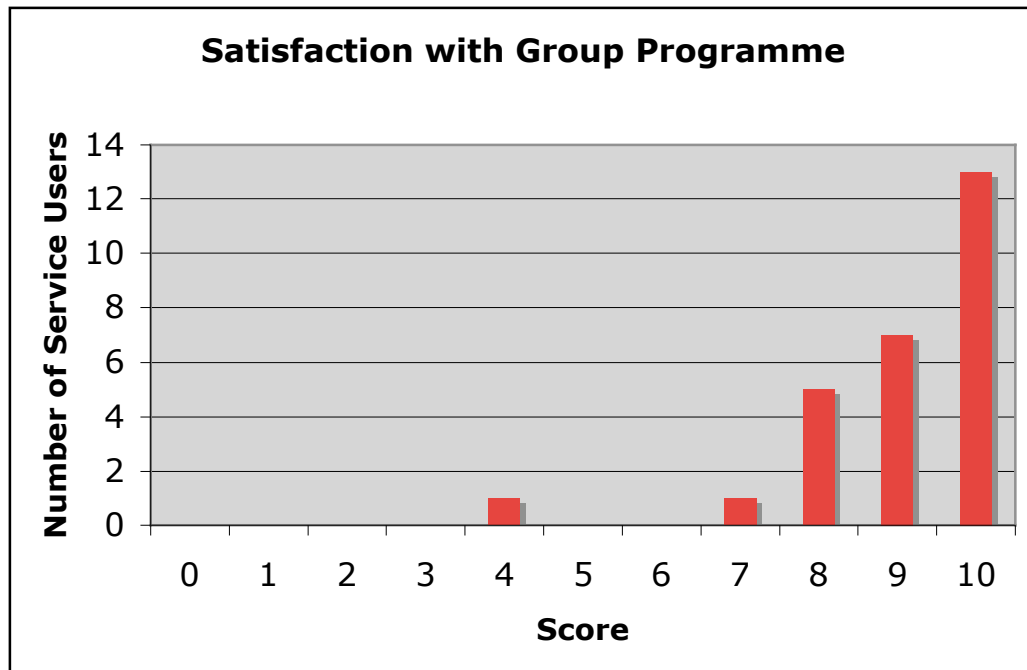


Figure 9. Ratings of Service User Feedback of the Group Programme (0 = completely dissatisfied; 10 = completely satisfied).

Service users were also asked to comment on their ratings of the programme. A full list of comments is shown in Appendix A. The majority of feedback (i.e., 14 out of the 23 comments) gave high praise for the programme.

**“The whole programme made me stop and think about life in general and turn my negative thinking to positive thinking. Would recommend anyone to go on programme and see how your thoughts can change and there is light at the end of the tunnel.”**

**“I can’t give the programme enough praise it has helped me so much”**

**“I feel that PSI has helped me in a positive way and certainly makes me think about things. The best thing was my motivation cards. Meeting people which made me think I am not on my own. Group work.”**

**“Very useful. Gave insight into things not thought about before, realise reasons for addiction.”**

**“Brilliant programme reinforced what I had learned in rehab and I learnt more ways of coping. Relapse prevention, core beliefs, coping strategies.”**

Some service users (i.e., 6 out of the 23 comments) simply stated the strategies they had found useful from the programme:

**“Relaxation and learning about situations and taking control.”**

**“Learning to cope with my cravings and destructive behaviours.”**

**“Groupwork”**

There were just three comments that contained neutral or negative feedback:

**“I felt that the programme was geared toward people in very early recovery or still in active addiction. I would like to see more things for people in longer term abstinence...”**

**“Enjoyed groupwork, all thing helped me but thing didn’t like were grapefruit stuff.”**

**“All sessions were helpful but some could be laid out better. Found myself too busy with other commitments to apply myself to the key working sessions.”**

Seven separate focus groups were conducted with  $n = 33$  service users, which is 73% response rate. The focus groups schedule guided service users to recount aspects of the Groupwork, the Key-working sessions, Assignments and Handouts. It also explored the impact of the programme on the service users’ substance use, mental health, and life in general. Finally service users were guided to consider their future plans and any improvements to enhance the programme. In general, service users appeared to be very committed and involved in giving their views about the Pathways to Recovery Programme.

All groups were consistent in their views that the focus on mental health was important. They reported that the sessions (and coping strategies) for managing negative thoughts were very helpful. Urge surfing and flashcards were the most frequently praised

techniques. Attending to lifestyle factors, using the LBM, and focusing on relationships were also deemed important, although one individual found the focus on relationships particularly challenging. The majority of individuals reported that the key-working sessions were a vital component of the programme, where they could clear up any difficulties and discuss any problems; a small number of service users did not see these key-working sessions as important. The majority of people found the assignments very useful and manageable, although some commented that they could be better worded. The handout material was deemed very helpful with some stating that, "Everything just fitted into place"; many people reported that they kept the materials in a folder to review again in the future. Criticisms of the programme focused on being unaware of the level of commitment at the start, being unaware of the benefits of the course, or simply not knowing what was ahead.

All of the groups interviewed reported that the programme had a significant impact on their substance use, mental health and lifestyle. In terms of substance use service users frequently cited that the programme boosted their motivation and gave them the coping strategies to manage their substance use: several reported that they had stopped using while on the programme. The focus on mental health appeared to give service users a greater understanding, more confidence, a more positive attitude and coping strategies to manage it. There was a consensus that the focus on lifestyle and life factors was an important element to the programme, with many reporting a more positive outlook on life.

Service users were unanimous in their opinions that a follow-on group should be available. One group had continued to meet up on a weekly basis after the groups had finished and three others were planning to do so. Some service users reported a sense of loss at the termination of the group programme. The continuation of an assisted group was suggested. Recommendation 8. explores this issue in more detail. Service users indicated that a pre-group session might help prepare people for the programme, allow them to meet up informally, and this could be enhanced further with the inclusion of service users who had been on the programme previously. Many expressed the view that they were apprehensive before the first group session, "*...terrifying but having a familiar face [key-worker] was helpful*". Recommendation 6. explores this in more detail.

A selection of comments from service users gives some indication to the life-changing experience that some experienced from the programme. For example, one service user (a 38 year-old lady) stated:

***“I’ve never been clean since I was 12 years old. In 19 months of methadone and not one clean test until now. This is the first Christmas in 22 years I’ve been straight; I used but not a full relapse. It does [the programme] work in practice.”***

Other service users commented on the impact of the programme:

***“I feel the person who came three months ago is a different person to me.”***

***“Since coming on the programme I haven’t touched gear for months. [My] whole attitude has changed.”***

***“I stopped drinking during the programme”***

Many service users attributed their successful outcomes to the various strategies taught on the programme. The coping strategies that received the most positive feedback were the Flashcards, Urge Surfing, and Positive Thinking:

***“I used coping strategies – [I] got [flash]cards out after a slip, which was alcohol not drugs.”***

***“It made me feel stronger having the coping strategies.”***

Service users reported that having the key-working sessions was essential. In addition, the focus on mental health was highly valued and many service users felt this was a unique aspect of the programme. Almost all service users reported that they would recommend the programme to others and the majority wanted to do the course again.

Some participants described aspects of the programme as challenging. For example, some topics like sobriety sampling, core beliefs, and exploring relationships were cited as more challenging than others. The group programme also required a level of concentration and a focus on reading and writing. Despite this, many reported that they frequently reviewed their course material and they continued to employ the coping strategies.

A third of those interviewed (e.g., 11 out of 33) stated that they were undertaking peer-mentoring training following their participation on the group programme and four participants had enrolled on counselling courses. Three service users had got back into employment. Many of the service users expressed an interest in delivering the programme themselves in the future. As a consequence of the group programme many groups had set up their own service user groups to continue their self-support.

### **Facilitator Feedback**

All group facilitators ( $n = 15$ ) were interviewed with a semi-structured interview schedule. The interview schedule focused on three aspects: (a) their views on the content of the group and key-working sessions, (b) the impact the sessions might have had on service users, and (c) the practicalities of delivering the groups. Each of the facilitators had positive feedback about the programme.

A general theme emerged that practitioners valued the structure and the flexibility of the approach. Positive comments described the programme as, “Fantastic”, “It covers everything a service users needs”, “An excellent programme”, “I enjoyed the delivery”. Negative comments focused on, “It takes a lot of your time”, “It adds to the workload”, “What happens next? [for service users]”

Facilitators reported that they felt the programme was effective, citing that some service users were still abstinent and others continued to use coping strategies from the programme. One practitioner commented that, “The programme is more effective than anything else we do”. Aspects of the programme that appeared most challenging were the sessions on *core beliefs* and *sobriety sampling*. Some reported that service users found the commitment to the programme challenging. The ending of the programme was also difficult for facilitators, especially given the lack of continuation for the strongly bonded groups. There was a general consensus that the delivery of the programme was hard work (physically and emotionally), but also a very rewarding experience. For example, it was described as a going on a shared journey with the service users and members of the group made some major life changes, very rarely experienced in other aspects of their work.

The majority of facilitators felt very supported by HG2G, their co-facilitators, or their own organisations, although for some their experience was varied. For example, some organisations expected practitioners to carry their usual caseload in addition to

delivering the group programme (see Recommendation 9. for further discussion). Supervision was considered beneficial although it was not accessed by all facilitators, for sessional workers the supervision was not remunerated.

Practitioners consistently reported that the handouts were a very useful addition to the programme. Assessments were considered a burden by some practitioners, although being able to feedback assessments in a Lifestyle Profile was seen as beneficial.

### ***Organisational Feedback***

A number of organisations were contacted to enquire about their experience of the Pathways to Recovery Programme. Contributions were received from West Wales Substance Misuse Service, Pembroke Substance Misuse Service, and Cyswllt Contact. The statutory West Wales Substance Misuse Service Manager reported that the feedback from their service users was very positive: “On speaking with workers in the other two counties - Ceredigion and Pembrokeshire the experience had been very positive in terms of improvement/benefit to the service users.” The manager went on to expand on her views:

**“The only wider comments were about the frequency of the programmes ( Pembs) and availability in some areas (Ceredigion) , and also about linking in more with the wider treatment system, in terms of an developing an improved skill base across all services re PSI, so can support service users going in and out of the programme, and knits in with overall treatment approach across all services.”**

One worker highlighted the benefits for two of her service users:

**“I had 2 clients complete the last group and both took a lot from the experience and also stated that they learned a lot. They both attended the group and the 1-1 sessions. Both are currently not using any illicit opiates and 1 has gone on to start the SDP with us also. They stated that the group has helped them with their ways of thinking and coping and were glad to have the chance to complete it.”**

A second worker highlighted the lack of provision in some areas:

**“I have had one client that completed the HG2G group who really enjoyed the experience and felt he benefited from this, He is still doing extremely well and is now**

**attending our SDP programme. He informed me that the HG2G group changed his way of thinking and he also enjoyed having a one to one session with the counsellor separate to the group. I have a few clients that would have liked to attend the women's group but live in Llanelli and it is taking place in Carmarthen."**

A social worker for Pembrokeshire County Council, Substance Misuse Team gave the following feedback:

**"The group has been an excellent addition to treatment services in Pembrokeshire. We are aware that those referred really need a significant level of motivation to attend and this causes us some difficulty as we work with customers/clients who have considerable difficulty engaging with services. Despite this we have experienced very positive joint working with HG2G and this has enabled some customers/clients to engage positively with the group. Feedback from those who have engaged has been excellent and they feel they have benefited in relation to their substance misuse and social isolation."**

Cyswllt Contact reported that the groups were "Well structured over 12 weeks", that it was "good at developing group dynamic" and "Good at linking thoughts, feelings and behaviours-CBT model". They highlighted that it, "Promotes abstinence, goal based thinking and motivates clients towards planning and achieving goals." It was highlighted that, "The participants appeared to gain confidence in the group, a sense of bonding and motivation." Cyswllt Contact also felt that there was, "Good admin back up from HG2G".

Cyswllt Contact reported on some negative elements of the groups. For example, the, "Lack of focus on mutual support outside the group and no mention of community based self help groups." They highlighted that, "Clients need to be quite literate-lots of reading powerpoint and written homework assignments. Some sessions highly emotive, in particular exploring core beliefs. Group facilitators need to be experienced enough to handle this in sessions. Lack of follow on-exploring next steps. Running the programme requires significant time input: 2 hour weekly session, hourly weekly 1-1 key working session, 1 hour minimum preparation time for preparing material for the week."

Despite these drawbacks, Cyswllt Contact commented that, "In terms of referrals into the PSI group this proved to be seamless in terms of transition from our generic services both into and out of the group."

**CONCLUSIONS:** Two independent methods of analysis were undertaken to canvass service user views of the programme: using post-group questionnaires and focus groups. Service users reported that overall their mental health was good with 59% of people showing a preference for PSI strategies. Service users also reported that overall their satisfaction with their substance use was very high with 67% of people showing a preference for PSI strategies. The vast majority of service users were very satisfied with the Pathways to Recovery Programme with almost half of respondents giving it a 10 out of 10, although one service user felt there was not enough in the programme for abstinent service users. Focus group responses reinforced the questionnaire outcomes: a high degree of confidence can be taken from this data, given the high response rate from the focus groups (i.e., 73%). Consistently groups valued the mental health component in the programme. The acquisition of coping strategies was valued as was the focus on lifestyle factors and relationships, in particular. Key-working was viewed as an essential element to the approach. Service users were unaware of the level of commitment prior to enrolling on the programme. Service users also highlighted their apprehension at terminating the programme and their desire for a continuation of the groups meeting (see Recommendation 8.).

Facilitator feedback reinforced the views given by the service users. They had consistently high praise for the group programme. In general, the programme was considered to be hard work but a rewarding activity that was able to bring about change often not seen in other areas of everyday practice. Organisational feedback also reinforced the views of service users. In addition, one service manager expressed an interest in linking the PSI strategies to the community services in order to further support service users (see Recommendation 10.). A need for a greater frequency and distribution of groups was also identified.

## Discussion and Detailed Recommendations

The Pathways to Recovery Programme is a structured but flexible approach for assisting service users to manage their substance use and mental health difficulties, as well as helping them improve their lifestyles. The focus on the lifestyle balance model allows the programme to draw on a range of evidence-based techniques. The 12 weekly group sessions combined with the 12 individual key-working sessions enables practitioners to collaboratively work with service users to develop a range of coping strategies. The Brief PSI assessment can be a stand-alone activity or a precursor to the group programme. Through the provision of Brief PSI training, Helping Groups to Grow (HG2G) have widened the knowledge and understanding of the group programme amongst potential referring organisations, whilst also providing practitioners with a structured psychosocial intervention.

A broad aim of HG2G was to deliver 10 group programmes to 80 service users in the counties of Carmarthenshire, Ceredigion, Pembrokeshire, and Powys by December 2010, which they successfully achieved. Partnering organisations significantly influenced the location of these groups within these counties. For example, PDAC contributed to the high density of groups ( $n = 5$ ) in Powys. Given the expanse of this county, the locations of the groups in Powys appears appropriate, however, the remaining and more densely populated counties of Pembrokeshire and Carmarthen, in particular, needed greater provision.

**Recommendation 1:** Provide a greater number of groups to the more densely populated counties of Carmarthenshire and Pembrokeshire. Proportionally, based on geographical factors and referral rates, for each group provided to Ceredigion, two groups might be provided in Powys, three in Pembrokeshire and four in Carmarthenshire. The wider implications of delivery of such groups will be influenced by the capacity of partner organisations to participate in the group delivery (see Recommendation 3.).

The inappropriate referral of a service user to any given service has significant implications for the referred service (i.e., time and effort expenditure), for the referring service (i.e., credibility from partner organisations and service users), and for the service user (i.e., unnecessary effort/cost, its impact on wider motivation and beliefs about self worth etc). Clear inclusion / exclusion criteria, programme aims, and processes should be

available to referring organisations and service users. For each inappropriate referral a “lessons-learned” procedure should be undertaken with that referring agency. Greater effort should be made to ensure service users are aware of the Pathways to Recovery Group Programme’s expectations.

**Recommendation 2:** Take steps to improve the appropriateness of referrals. This might be achieved by clearly informing potential referring organisations and their service users of the Pathways to Recovery Group Programme’s inclusion / exclusion criteria, programme aims, and processes: clear literature outlining these details might be helpful. The use of pre-group taster sessions and service user involvement might enhance the motivation of some service users (see Recommendation 3.).

A number of recommendations are suggested in order to retain a greater number of service users in the Pathways to Recovery Group Programme. This evaluation has shown that the current retention rate is 53%, which is below the target rate of 62.5% set out by Helping Groups to Grow. Given the heterogeneity, and complexity of problems, of the service users recruited into the Pathways to Recovery Programme, which is unlike many empirical trials, attrition rates of 40 -50% are likely to remain a feature of the programme. Importantly, retention in any given programme is associated with better outcomes for service users and maximising retention should be a priority (Carroll, 1995). Five recommendations are made to improve retention: (a) enhance partnership working, (b) ensure continuity between Brief PSI assessment staff and Group PSI facilitators, (c) ensure easier access and reinforcement for attendance, (d) provide shorter “taster” pre-group session(s) and (e) to support those with the greatest needs.

Partnership delivery of the programme (i.e., between HG2G and the main referring organisations) might have several benefits. A review of the completion rates of the 10 group programmes completed by the Pathways to Recovery Programme suggests that the least effective method of delivery was external delivery, although other factors might have contributed to this outcome (i.e., a small number of starters in the group). Given that only one group was delivered in this manner it might be unwise to draw substantial conclusions, however, greater partnership delivery might enhance completion rates in several ways: the selection of more appropriate and committed service users, given that staff from the referring agency are part of its delivery; a reduction in service

users' feelings of apprehension by having a familiar person involved in the delivery of the group programme; and a greater sense of security for service users knowing that after-care and continuity is assured by their referring agency. Partnership working, rather than internal delivery, might also change the perception of service users that the group programme is something more specialised and a "different" intervention to typical ways of working, which can enhance commitment and retention (Carroll, 1995).

**Recommendation 3:** Increase the number of groups delivered in partnership with referring organisations.

Improving the continuity, where possible, between the Brief PSI assessment practitioner and Group PSI practitioners will reduce the feelings of apprehension for some service users when attending the group programme. It will also assist the group practitioners in developing rapport with the group. Where this continuity is not possible, Brief PSI practitioners might attend a pre-group session (see Recommendation 6.).

**Recommendation 4:** Where possible, ensure that the Brief PSI assessment practitioners are the group facilitators of the intended group programme.

Improving the ease of access for service users and ensuring that there are methods of reinforcement for attendance will enhance retention. For example, providing means of transport, timing programmes to cater for childcare issues or evening times will assist retention. Some services, that had a morning group and provided lunch for their service users had high retention rates. Service users reported that folders to store their Group materials were helpful.

**Recommendation 5:** Where possible, take steps to ease the access to the group programme and provide reinforcers for attendance. Provide service users with neat folders for their group materials. Provide reinforcement through refreshments/food.

The provision of a pre-session group prior to the more formal delivery of the group programme might better ease participants into the programme. This pre-session session might outline the expectations and commitments to the group programme, allow

service users to informally meet other participants and to feel support at this most difficult time (see Recommendation 4.).

**Recommendation 6:** Provide a (pre-) group session before the more formal delivery of the group programme.

This evaluation has highlighted that those with higher levels of dependency and greater impairments in social functioning are those at the greatest risk of dropping out of the group programme. The screening assessment measure also found that the majority of those scoring 7 or 8 on this measure were more likely to drop out of the group programme. Identifying those with the greatest needs will enable staff to offer greater support to assist them to stay in the programme. In some instances greater preparation might be required. For example, the provision of a four-session briefer group programme might be more suitable.

**Recommendation 7:** Identify and support those with greatest levels of need.

A majority of the service users interviewed in this evaluation expressed a wish to have a continued support group. One group had maintained a continuation of their group, which was partly supported (through the provision of a venue and refreshments); other groups planned to do so. Facilitators and service user consistently highlighted that they had come to rely on the support and structure that their group provided and were apprehensive that this would be unavailable. Many felt that the gains that they had achieved would be lost. Service users reported that a group offering a combination of support, recreation, and a range of skills-based sessions would suit their needs best.

**Recommendation 8:** Provide a service user-led social support group following the group programme. These recovery-based groups might be best served if they are service user-led, offering a combination of recreational activities, skill-based sessions, refreshers on PSI strategies etc.

Based on the feedback from practitioners, it appears that not all partner organisations allowed their practitioners sufficient time to deliver the group programme. For example, many practitioners reported that they had to continue to carry their usual

caseloads as well as deliver the group and key-working sessions. They highlighted the emotional and practical challenges of delivering the group programme (e.g., preparing materials, gaining familiarity with materials prior to the session, conducting the key-working sessions, and accessing supervision).

**Recommendation 9:** Group facilitators should be given adequate time to prepare materials, deliver the programme and key-working sessions, and access supervision.

Efforts should be made to increase the sharing of information to the community workers following service users completion of the group programme. A general overview of the programme and its contents should be available to the referring agency. Partner organisations might benefit from familiarity of the Group PSI coping strategies, which can largely be achieved through Brief PSI training. Consolidation material, through the Lifestyle Profile booklet, could be passed on to the referring service, with the service user consent.

**Recommendation 10:** Enhance information sharing with community services.

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### **About the Author and Expression of Interests**

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## Appendix – Full List of Service User Feedback

**“The whole programme made me stop and think about life in general and turn my negative thinking to positive thinking. Would recommend anyone to go on programme and see how your thoughts can change and there is light at the end of the tunnel.”**

**“I can’t give the programme enough praise it has helped me so much”**

**“I feel that PSI has helped me in a positive way and certainly makes me think about things. The best thing was my motivation cards. Meeting people which made me think I am not on my own. Group work.”**

**“Very useful. Gave insight into things not thought about before, realise reasons for addiction.”**

**“Brilliant programme reinforced what I had learned in rehab and I learnt more ways of coping. Relapse prevention, core beliefs, coping strategies.”**

**“Great key-working and coping strategies.”**

**“Talking in a group helped most.”**

**“Risk management sessions and the flashcards”**

**“How to deal with difficult situations and urge surfing found helpful!!”**

**“1<sup>st</sup> getting out once a week, 2<sup>nd</sup> having something to look forward to and focus on and 3<sup>rd</sup> making new friends and giving and receiving support.”**

**“Coping strategies and the mental health week was a good one for me although hard at the time.”**

**“Group and Key-working very positive as was group support”**

**“Overall I found the programme constructive, beneficial and conducive to recovery. I took more positive than negatives from the key-working sessions and in that respect they were successful.”**

**“Good to have key-working to develop (sic) strategies to my lifestyle issues. Group was excellent.”**

**“Relaxation and learning about situations and taking control.”**

**“Enjoyed groupwork, all things helped me but things I didn't like were grapefruit stuff.”**

**“I felt that the programme was geared toward people in very early recovery or still in active addiction. I would like to see more things for people in longer term abstinence...”**

**“Coping with cravings and learning they will pass and building relationships and I had good key sessions and enjoyed.”**

**“Learning to cope with my cravings and destructive behaviours.”**

**“Groupwork”**

**“All sessions were helpful but some could be laid out better. Found myself too busy with other commitments to apply myself to the key working sessions.”**

**“The programme taught me a few new ways of coping and reinforced others I had already learnt.”**

**“The group was very useful—peer support – feeling you are not alone with your problems – lots of positive feedback from others towards myself: the key-working sessions were invaluable.”**

**“Some parts useful now and bites (sic) will be really helpful in future.”**