Title:

An Evaluation of the Psychosocial Group Programme at an Inpatient Detoxification and Stabilization Unit: A Service Improvement Project

Word Count: 6,309

Abstract

Purpose: The benefits of including a psychosocial group programme alongside a medical inpatient detoxification and stabilisation regime has been recognized within addiction research, however a 'gold standard' psychosocial intervention has not been established. This small-scale project evaluated the psychosocial group ('Straight Ahead') currently running at a substance use inpatient unit based in the United Kingdom (UK).

Design: A mixed-methods questionnaire design aimed to capture service user perspectives of the group programme via a questionnaire, and assess whether an individual's recovery capital and emotion regulation scores improved during their stay.

Findings: Thirty-four service users participated in the evaluation. Results indicate the group significantly increased individuals' recovery capital scores, however did not significantly improve emotion regulation. The three themes from the qualitative results focused on the importance of shared experiences, learning of new skills, and the group as a positive experience. Service users provided suggestions for improvements, and these informed the provision of service-specific recommendations for the team and project commissioner.

Originality: The evaluation provides tentative support for the use of the Straight Ahead programme, and provides an insight into what service users find helpful when attending a psychosocial group during an inpatient detoxification admission.

Keywords: Inpatient detoxification, substance use, psychosocial group, recovery.

Detoxification is a medical treatment aiming to help individuals overcome substance dependency, and is often an initial step towards recovery (Hayashida, 1998). Detoxes are mainly conducted within the community, however when individuals have complex physical or mental health needs they may be offered an inpatient detoxification (NCCMH, 2008). These units provide 24-hour medical intervention and psychosocial support from a multidisciplinary team (Public Health England, 2017). Inpatient units also often provide stabilization support, where individuals cease illicit use and are stabilized onto a medical dose of their substance (Public Health England, 2017).

Psychological support is an important part of the inpatient process. Relapse rates following detox are around 61% (Aguiar *et al.*, 2012), and a lack of coping skills (e.g. emotion regulation) and low self-efficacy are factors associated with relapse (Marlatt and Donovan, 2005). Psychosocial interventions delivered to individuals or groups aim to elicit lasting behaviour change and improve psychological health (Jhanjee, 2014), and UK clinical guidelines have highlighted their importance throughout treatment (Department of Health, 2017). Supporting this, a Cochrane meta-analysis reported better outcomes for opioid detoxification when both psychosocial and pharmacological treatments were combined, in comparison to pharmacology alone (Amato *et al.*, 2011).

The processes underlying substance-related behaviour change have been described by Moos (2007) using four key theories, alongside the group processes theorized to be effective in promoting this change (Moos, 2008; see Table I). In summary, change is associated with developing positive relationships with others, having recovery role models and norms, developing emotion regulation and coping skills and experiencing alternative rewards to using substances.

Despite evidence supporting these group-related processes (Moos, 2008; Rettie *et al.*, 2021), due to the diverse nature of the substance using population, there is currently no gold standard for psychosocial interventions (Amato *et al.*, 2011; National Institute for Health and Care Excellence, 2012). As a result, units may choose interventions based on staff skills and service user needs.

[INSERT TABLE I]

The Current Evaluation

Given the importance of psychosocial interventions and the lack of consensus on what makes an effective group programme, it is therefore important that services ensure their psychosocial groups are evidence-based, and audit their effectiveness

regularly. The current evaluation was completed at a specialist substance inpatient unit in the UK, which utilized an adapted version of the 'Straight Ahead' programme. The original 10-session programme aims to reinforce recovery through building support networks and enhancing skills, and was developed from the evidence base for early recovery (Bartholomew *et al.*, 1993). There is no published research assessing its effectiveness.

Due to the lack of evidence it seemed pertinent to explore the effectiveness of this group within the unit, and consider how it may help individuals maintain their abstinence post-treatment. To do this, two key concepts identified in both theory (e.g. Moos, 2008) and UK policy (e.g. Department of Health, 2017) were used to evaluate the group (emotion regulation and recovery capital), alongside qualitatively gaining the service user perspective.

Emotion Regulation

Emotion regulation is the ability to recognize, understand and appropriately respond to one's own emotions (Gratz and Roemer, 2004). Individuals with an alcohol dependency often have higher levels of emotional dysregulation compared to the general population (Fox *et al.*, 2008; Petit *et al.*, 2015); with Berking *et al.* (2011) concluding those with low emotion regulation skills were more likely to relapse after CBT treatment for alcohol dependence. UK government guidelines recommend trauma-informed delivery within substance use services, promoting the emotional stability and safety of service users (Department of Health, 2017). Thus, it seems important to assess whether interventions make a positive improvement to emotion regulation.

Recovery Capital

Recovery capital is the internal and external resources an individual has to move forwards in their recovery (Granfield and Cloud, 1999), such as having stable accommodation, supportive peers, coping skills, and good physical and mental health. Recovery capital is believed to be one of the best predictors for long-term recovery (Best *et al.*, 2010), with individuals in long-term recovery having increased levels of recovery capital (Rettie *et al.*, 2019a).

Research by Rettie *et al.* (2019a) highlighted the importance of group work within recovery, as resources developed within recovery groups (e.g. knowledge, self worth, social networks) were greater predictors of length of time in recovery than resources developed externally (e.g. physical health, accommodation, finances).

Assessing recovery capital is recommended within UK treatment guidelines during assessment processes (Department of Health, 2017), and measuring it within inpatient contexts could be a useful way to measure group effectiveness.

Service User Perspective

To gain a more in-depth insight into the efficacy of psychosocial groups it is also important to capture service user experiences. Gaining service user perspectives when evaluating and developing addiction services can provide new insights that may differ from those of service providers. For example, Neale *et al.*, (2015) found that service users highlighted issues with the use of language and choice of inappropriate outcomes in recovery measures which had been selected by service providers. They suggest that gaining service user perspectives can bring focus to under privileged narratives within recovery research.

Consultation Process

Project development was informed not just by the literature, but also by a number of consultation meetings held between the community service and ward managers, clinical psychologist and therapeutic programme facilitator. The Community Service Manager commissioned the evaluation.

The project rationale was the group programme not having been formally evaluated, and the service wanting to audit the programme to determine whether any improvements were required. During the consultation, the specific aims of this initial evaluation were developed, these being an understanding of service users' experiences of attending the group, and to assess whether scores improved on key recovery-related measures during their stay.

Evaluation Questions

1. Is the psychosocial group meeting the needs of the service users by contributing to an increase in their recovery capital and emotion regulation during admission?
2. What content do service users consider important in a psychosocial group, and what could be improved?

Method

Design

The evaluation used a mixed methods design, collecting both quantitative and qualitative data. This design was chosen because it provides an in-depth exploration of

the evaluation question, with the validated measures summarising outcomes, and the participants' voices providing insight into their experience of the outcomes (Halcomb and Hickman, 2015). Qualitative data collected from open-ended survey responses is often not as in-depth as responses gained from interviews and focus groups (LaDonna *et al.,* 2018), however the chosen design allowed the maximum amount of participants' voices to be heard.

To increase recruitment, a concurrent design was used, where qualitative and quantitative data were collected simultaneously (Creswell, 2013). The data was triangulated following analysis to inform recommendations and discussion.

The PDSA ('plan, do, study, act') cycle guided the service improvement process (Act Academy, 2018; Langley *et al.*, 1996). This NHS-recommended tool provides a model to follow when making improvements to a service, encouraging services to work cyclically. Once an evaluation question has been established, data should be collected, analysed, and then any changes suggested should be implemented and further evaluated via PDSA cycles.

Ethical approval for the project was obtained from the University of ANONYMISED ethics committee (PREC Ref: 19-222). Approval to complete the service evaluation was also obtained from the local NHS Trust.

Participants

Service users attending the unit over a three and a half month period (22/07/19 – 31/10/19) were asked to complete the evaluation questionnaires. Over this period, 48 service users attended the unit. Thirty-four (69%) questionnaires were returned, and 21 of these were fully completed both pre and post-stay. Demographic information is provided in Table II for all thirty-four participants. Demographics were found to be unrelated to the questionnaire scores and importance ratings ($p > .05$), therefore were not controlled for in the main analyses.

[INSERT TABLE II]

Procedure

Staff members approached service users on admission to provide an information sheet about the evaluation. Those who provided written consent to participating then completed the questionnaires. At the end of their final group session, participants completed the emotion regulation and recovery capital questionnaires again, along with the evaluation form. Debriefing sheets were provided after evaluation completion.

Measures

Demographics Questionnaire

A demographics questionnaire collected information such as number of previous detoxifications and substance detoxing/stabilizing from.

Recovery Strengths Questionnaire (RSQ)

The RSQ is a 15-item measure assessing recovery capital, and has high internal consistency (α = .93) and good concurrent validity. Items are rated on a scale of 0-10 (0 = not at all satisfied, 10 = highly satisfied), and high scores indicate greater recovery capital. There are two subscales in the RSQ (externally generated and internally generated strengths), and it has been found that the internally generated subscale (i.e. resources developed within groups) predicts length of time in recovery (Rettie *et al.*, 2019a).

Difficulties in Emotion Regulation Scale (DERS)

The DERS is a 36-item measure of emotion regulation that has good reliability (α = .82) and validity (Gratz and Roemer, 2004), and has been used previously within addiction populations (e.g. Fox *et al.*, 2008). Items are rated on a scale of 1-5 (1 = almost never, 5 = almost always), and higher scores indicate greater difficulties in emotion regulation.

Evaluation Questionnaire

The evaluation questionnaire completed post-group was created jointly with staff at the unit, and asked questions about the individuals' experiences of engaging in the psychosocial groups. This included questions about their overall experience, what they found most and least helpful, and whether they had any suggestions for improvements. Participants were also asked to rate on a scale of 0-10 how important they felt the group and medication were for their stay both pre and post group.

Data Analysis

Quantitative Data Analysis

Paired t-tests were used to compare scores on the RSQ and DERS pre and post group. Inspection of the data using boxplots indicated no outliers, and the data was normally distributed as assessed by Shapiro-Wilk's test ($p > .05$). The exception to this was the RSQ external strengths subscale at time two, which was negatively skewed ($p = .025$). However, as paired samples t-tests are expected to be robust against violations to normality (Rasch and Guiard, 2004), no transformations were applied. Non-parametric

Wilcoxon signed-rank tests were used to compare the ratings of how important service users thought medication and groups were at the two time points.

Qualitative Data Analysis

The qualitative information from 28 completed evaluation forms was analysed using Braun and Clarke's (2006) thematic analysis (see Table III). Thematic analysis was chosen because it is a flexible method that can be used to analyse free-text responses (Braun and Clarke, 2006). The responses were reasonably short (*M*=15 words, range: 1-41), however the decision to analyse the text qualitatively was made as it was thought that analyzing the data quantitatively (i.e. by counting numbers of similar responses) would not capture the unique experiences of individuals attending these groups (O'Cathain and Thomas, 2004). Given the data available, the analysis was conducted primarily at the semantic rather than latent level (Braun and Clarke, 2006). In addition, a limited number of suggestions for improvement were provided, so these were summarized separately from the main themes.

Braun and Clarke's (2006) six steps of thematic analysis were followed when analyzing the participant's experiences of the psychosocial group. It is recommended that researchers use Braun and Clarke's steps flexibly and return to earlier steps if appropriate to develop the themes.

As there is limited evidence exploring the experience of individuals attending a psychosocial group during an inpatient stay, an inductive approach was used during analysis. Yardley's (2000) quality criteria for qualitative research were adhered to throughout, and no second rater was used due to the non-positivist stance often taken within qualitative research (Cook, 2012). The researcher's position as a white, female trainee clinical psychologist, with a background in addiction recovery research should be held in mind when reading the qualitative analysis.

[INSERT TABLE III]

Results

Quantitative Results

Recovery capital scores on the RSQ were higher at the end of participants' stays (M = 92.04 , SD = 26.66) in comparison to scores at the start (M = 74.31 , SD = 23.75), and this was a significant, large effect ($t(25) = 4.10$, $p < .001$, d = 0.80; Cohen, 1988). There were also similar findings for the two subscales. Individuals' internal strengths (i.e. resources developed within recovery groups) increased from a mean of 47.22 (SD =

17.19) at the start of treatment to a mean of 59.26 (*SD* = 16.19) at the end ($t(26) = 3.98$, $p < .001$, $d = 0.77$), and external strengths (i.e. resources developed outside recovery groups) increased from a mean of 28.15 (*SD* = 10.44) at the start of their stay to a mean of 32.65 (*SD* = 13.01) at the end ($t(25) = 2.29$, $p = .031$, $d = 0.45$).

The findings from the DERS were less promising. The results show that there was no significant difference between participants' abilities to regulate their emotions at the start (*M* = 112.67, *SD* = 25.35) and end (*M* = 106.71, *SD* = 27.06) of treatment ($t(20) = -1.71$, $p = .103$, $d = 0.37$).

Finally, results from the importance ratings indicated that participants rated both medication (pre-stay *Mdn* = 10; post-stay *Mdn* = 10) and group-work (pre-stay *Mdn* = 9; post-stay *Mdn* = 10) as highly important to their inpatient experience. This small increase in importance ratings for group-work was significant ($z = 2.02$, $p = .044$).

Qualitative Results

From the analysis three key themes were identified from the participants' free-text responses: 1) shared experiences within the group, 2) opportunities to learn new information, and 3) the group as a positive experience. Each participant is given a number to highlight the responses across the dataset, and suggestions for group improvements are outlined separately.

Shared Experiences Within the Group

Many responses outlined how the group provided an opportunity to hear and share experiences with other service users. "Listening to others' stories" (12, 20, 26) was identified by some participants as the most helpful element of the group.

The reasons why shared experiences were helpful differed amongst participants. For some, shared experience helped them feel they were not alone: "I learnt more about other people's experiences of the effect of drugs and alcohol had on them. I am not the only one who struggles" (16).

The stories shared by others during the group gave participants new insights into the effects and impacts of substance use. For some participants, seeing others change inspired them to continue along their own journey: "Seeing other people change, it was encouraging for me as well, and helped with motivation" (7).

Individuals attend the unit to detox or reduce illicit use from a wide range of substances. However, it seemed that the type of substance individuals used was irrelevant when part of the group, with no participants mentioning differences between

group members. As one participant said, part of their experience involved "recognising the similarities between myself and other users on the programme regardless of drug use" (19). It appears that the majority of the time there was a sense of unity within the group, and that this positively benefitted the individuals involved.

Opportunities to Learn New Information

Individuals often spoke about how the group was helpful in developing their knowledge and skills. Some individuals outlined particular sessions they found helpful, and how they could "revisit the worksheets when in recovery" (22). For example, one participant said that "the groups helped me with behaviours and communication, and I will continue hopefully to use them as a reference" (6). There was a sense of longevity in responses such as this, with the groups as a starting point to a shift into recovery.

Alongside the group providing opportunities to develop skills, some individuals described their experiences as a life-changing journey of self-discovery. One participant noted: "I learnt more about myself in the time spent here, than in my whole life. I realize I'm vulnerable and need more help." (18). Learning to understand themselves and their reactions to situations was a transformative process, with individuals "learning how to take responsibility for my own feelings, and also how much I need to deal with my emotions" (15).

The Group as a Positive Experience

The majority of participants did not identify anything that was unhelpful about the group, or suggest any improvements; with some individuals suggesting they would like "more groups" (1).

There was a sense for nearly all responses that the group experience was a positive process. For example, the group was described as a "positive, road map to successfully obtaining some abstinence" (7). This was still the case for some individuals who were apprehensive about attending the group at first, with someone saying, "initially I was very reluctant to attend the groups but they quickly proved to be helpful. Our group leader went above and beyond. I have only the highest praise" (9). Also, the two individuals who did not report an overall positive experience did still suggest that some group elements ("socialising" and "listening to others") were helpful (25, 26).

The importance of the staff was highlighted. The staff played a vital part of many individuals' recovery journeys, as seen when one participant said "I couldn't have achieved this piece of work without the members of staff" (14). The group leader was

described as "very good at explaining gets right to the point and listens, and helped me a lot" (11).

Suggestions for Improvements

Thirty percent of participants identified unhelpful aspects of the group, and 46% provided suggestions for improvements. These were mainly focused on group dynamics and group structure.

Group Dynamics. Non-engagement from some individuals could negatively impact on the group, with "distractions and group dynamics" making it "hard to concentrate sometimes" (2). A few participants wondered whether there was "a way that each, especially quieter and shy members, are encouraged to speak and join in and not be over-powered" (21), and the idea of "putting our hands up when we have something to say" was suggested to prevent "people interrupting others" (5).

Structure of the Group. Some participants felt that they would like more or longer groups, as at times some of the content felt "rushed" (26). The structure the groups gave was valued by individuals, and on days when there was no group a few participants found "not having the structure of the group" (2) unhelpful. It was also wondered whether there could be additional content for individuals who had longer stays or had attended the detox previously (9, 15).

Recommendations

Feedback to the Staff Team

Results and preliminary recommendations were initially discussed with the evaluation supervisors, and from this conversation a feedback session was developed for all staff at the unit. This session was completed on a staff away day, and involved a summary of the findings, followed by a discussion with staff about ways to implement the recommendations. Staff who attended the away day included the ward manager, psychosocial group facilitator, nurses, medical staff and senior managers from within the Trust. Feedback was received both verbally on the day and by email afterwards. Table IV summarizes the recommendations that were shared. The reasoning behind these recommendations and the content of the feedback discussion is outlined below.

[INSERT TABLE IV]

Recommendation 1: Recovery Capital

The quantitative results indicated that most individuals' recovery capitals significantly increased during the programme. As outlined earlier, recovery capital is

believed to be one of the best predictors for long-term recovery (Best *et al*., 2010), therefore it could be helpful to track and assess an individual's recovery capital as part of their psychosocial programme. This could also be beneficial from a therapeutic stance, helping identify areas that could be useful to focus on.

Research indicates that RSQ scores of 106.5 and over are predictive of individuals in later recovery (i.e. over six months; Rettie *et al.*, 2019a), and the average recovery capital score post-group in this evaluation was slightly below this at 92.04. This highlights the ongoing journey individuals will experience in building their recovery capital post-admission, and as a result it may be helpful for community workers to also use the RSQ in their ongoing care planning.

The staff team thought that measuring recovery capital and sharing this with the client could help individuals shape their focus in the unit and ongoing recovery journey, and that it could be a powerful therapeutic experience for individuals to see their own recovery capital scores. This led the team onto a useful discussion about how to improve the link between the unit and outside recovery community.

Recommendation 2: Emotion Regulation

Previous research highlighted the importance of developing emotion regulation skills during addiction treatment (Berking *et al*., 2011). The current evaluation indicated that clients' emotion regulation did not change over the course of the group. This is not entirely surprising, as the 'Straight Ahead' programme does not focus on these skills, however it does call into question whether an alternative programme would be better suited.

Research is beginning to explore whether Dialectical Behaviour Therapy (DBT) could be used to help individuals with substance use difficulties regulate their emotions and achieve abstinence. DBT focuses on the dialectic of change and acceptance, and was originally developed for patients who were chronically suicidal (Dimeff and Linehan, 2008). Standard DBT involves multiple treatments (e.g. skills groups, individual therapy and phone coaching), and has been shown to be effective for individuals with co-morbid borderline personality disorder and drug dependence (Linehan *et al.*, 1999). However due to service restraints, the skills groups are often used as a standalone treatment across a range of clinical presentations (Valentine *et al.*, 2014). Initial evidence supports the use of these groups within substance use treatment, with a 3-month DBT skills group improving emotion regulation skills and rates of relapse in a

joint inpatient and outpatient alcohol treatment center (Maffei *et al.*, 2018). Whilst this finding is promising, further research using control groups and a longitudinal approach is needed to better understand the effectiveness of DBT skills groups within addiction treatment.

The staff team was keen to make changes to the current programme to increase individuals' emotion regulation skills during their time on the unit. Suggestions from the team included DBT skills group and compassion focused approaches, with the team encouraged to explore the evidence-base when making any amendments.

Recommendation 3: Group Dynamics

It was clear from the findings that, whilst cohesiveness was a strength of the psychosocial group, difficult group dynamics could have a negative impact on this. Research suggests that in peer-led addiction groups, group cohesion is considered a key ingredient (Moos, 2008), and it is likely to be the same in professional-led groups.

One well-known way to increase cohesion and manage group dynamics is using group rules (Burlingame *et al.*, 2002). Discussions with the staff team indicated that whilst group rules are already being used, as individuals join the group at different times these are not always co-created and reviewed.

Alternative creative ways to manage group dynamics were discussed. For example, staff suggested putting cartoons on the wall that represent common patterns of behaviour within groups. These could then be referred to if the group leader or participants noticed these particular group dynamics (e.g. "You're rescuing this person").

Recommendation 4: Positive Experiences

The results indicated that most people found the groups a positive experience, and this was captured by many of the comments shared in the evaluation questionnaires. Sharing stories with others is often an important part of addiction recovery groups (Rettie *et al.,* 2019b), and this recommendation asked the team to consider how this could be utilized within the unit.

The team felt that it was important to capture these positive experiences, and discussed ways of doing so. For example, it was suggested that a video could be created sharing peoples' experiences, or a handout with quotes that could be given out during admission.

Recommendation 5: Reviewing Group Structure

The suggestions for improvements indicated that some clients wanted more or longer groups. The staff fed back that there was a general sense that clients enjoyed the groups, and discussed plans for further audits to determine whether it would be beneficial to have more groups. Furthermore, the staff discussed whether it was possible to develop the role of deputy group facilitator, to make the potential expansion of the group programme more feasible.

Recommendation 6: Adapting Programme for Longer Stays

Individuals who had longer admissions would attend some sessions twice, and some service users had wondered whether there was any additional content they could have in these circumstances. Staff suggested those who stayed longer could perhaps take a more active role within the group, for example, being part of the welcoming committee when new service users come in. The idea of giving back to the group mirrors what often happens in community recovery groups, for example being a sponsor in a 12-step group (Humphreys, 2004) or helping organize events in a social-based group (Rettie *et al*., 2019b).

Discussion

This project aimed to evaluate the psychosocial group at an inpatient detoxification and stabilization unit by measuring improvements in emotion regulation and recovery capital, and gaining a qualitative overview of service users' experiences of the group. The results indicate that the group is typically a positive experience for individuals, and is effective in increasing service user's recovery capital. However, the group did not significantly increase emotion regulation skills, and recommendations relating to group structure and dynamics were highlighted. Both the quantitative and qualitative findings were combined to provide recommendations to the service, with the service planning to utilise these to inform the redevelopment of the psychosocial group.

The evaluation has provided the unit with information about the efficacy of the group programme that they previously did not have, and offered a service user perspective on the experience of attending the group, including both strengths and areas for improvement. The staff reported finding the evaluation and feedback session a helpful opportunity to discuss the current group programme and potential redevelopments. Hearing the positive feedback was described as a "moving experience" by the group facilitator.

The next step for staff is to determine how they wish to implement these changes, and this is something that will be led by the service commissioner and clinical psychologist. In line with the PDSA cycle there will need to be a re-evaluation of the group after these changes have been implemented to assess their effectiveness (ACT Academy, 2018). This could be achieved by repeating the current evaluation, combining changes in standardized measures with qualitative reports to determine whether the changes have been helpful.

The current evaluation also builds on theoretical knowledge about the importance of psychosocial group programmes within detoxification and stabilisation units. Previous literature indicates that the addition of a psychosocial group programme to an opioid detox is often more effective than a medical detox alone (Amato *et al*., 2011), and the current evaluation has expanded on potential reasons for this finding by capturing the service user experience across substances. The participants outlined elements of the psychosocial group they found most helpful (e.g. shared experiences, learning new skills), building evidence towards uncovering what makes an inpatient psychosocial group effective. Moos (2008) theorized that there are 'active ingredients' of 12-step mutual-aid recovery groups, and some of these ingredients (e.g. cohesion, developing self-efficacy, confidence and coping skills) mirrored the findings of the current evaluation. This supports that idea that even though a structured inpatient group does have clear differences to self-help groups (i.e. self-help being less structured and non-compulsory), there could be core components of addiction recovery groups that contribute towards their effectiveness (Humphreys, 2004). It is not clear whether other psychosocial group programmes using different approaches would have received similar feedback, and future research could explore this by evaluating a variety of groups on different units.

Limitations

As a small-scale evaluation of a specific programme used within one inpatient unit, it is unclear how generalizable the findings are to other units. However, considering the limited evidence base, this evaluation provides tentative support for the use of the Straight Ahead programme within inpatient units, and provides us with an insight into what service users find helpful when attending a psychosocial group during an inpatient admission.

The primary aim of the design used in this evaluation was to allow maximum recruitment of participants using processes already running within the unit (e.g. routine feedback from participants at the end of the group). However because of this, there are a number of limitations worth noting. Firstly, as all participants are required to attend the psychosocial group programme it was not possible to have a control group. This means that the increase in recovery capital may not specifically be as a result of the group programme, and could be a product of the overall admission. Future studies could address this limitation by evaluating the group programme on a larger scale, by using a quasi-experimental design that includes a control group who has only a pharmacological detox/stabilisation. Secondly, recovery capital and emotion regulation were only assessed at two time points, and a multiple baseline design could have controlled for time effects and strengthened conclusions that the change in recovery capital was a result of the intervention (Hawkins *et al.,* 2007).

Due to the small number of stabilisation patients in the current evaluation (9%), the needs of detox and stabilisation patients were not considered separately. However, the treatment goals of these groups are likely to differ, and future research could consider the differing experiences these groups may have of inpatient detox.

Finally, it would be useful to explore the long-term effects of the psychosocial group on someone's recovery capital, as inpatient admissions are only often the start of someone's recovery journey (Hayashida, 1998). Nonetheless, with previous literature reporting that the addition of psychosocial groups to a medical detox results in more abstinence (Amato *et al*., 2011), the findings could suggest these groups help individuals build the resources they need to keep them in recovery.

Conclusions

Overall, the current evaluation provided a summary of both service users' experiences of the unit's current psychosocial programme, and the impact the group has on their recovery capital and emotion regulation skills. This was used to develop service-specific recommendations when thinking about how to redevelop the group, prior to a planned re-design of the psychosocial group programme within the service.

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Acknowledgements

The authors would like to thank the service users who took part in this project, and the staff at the detoxification unit for their help with recruitment.