Routes to recovery Part 1

ITEP: challenging and changing the ways we think
What is ITEP?

Over the past two years, the NTA has sponsored a programme of psychosocial interventions known as ITEP (the International Treatment Effectiveness Project). 1

As its name suggests, ITEP has one simple aim – to improve treatment effectiveness. It does this by making the delivery of psychosocial interventions both easier and clearer, and by promoting organisational improvements. In particular, ITEP improves the quality of care planning through the use of a simple manual.

A lack of structure to the psychosocial elements of treatment can mean that care planning is sometimes not as clearly articulated as it could be. A most structured, systematised approach is needed if we are to make the most of ‘talking therapies’ and engage service users more effectively in care plan delivery – and ITEP provides this.

The approach which ITEP is founded on places psychosocial interventions at the heart of drug treatment by recasting the way we look at care planning and keyworking. In turn, this can help workers to maximise their ambitions for clients.

Evidence also tells us that the way a drug treatment service is organised and managed can have as much – if not more – impact on client outcomes as the interventions on offer and the characteristics of an agency’s clients.

The success of ITEP is therefore built on findings that the adoption of a relatively simple psychosocial intervention, coupled with a focus on organisational functioning, can have positive and measurable effects, helping to make a treatment service and a local treatment system stronger and more efficient.

The basics of ITEP

At its core, ITEP is built around a step-by-step, easy-to-use manual that takes the worker through the processes needed to make the intervention work. The manual forms the basis of part 2 in the ‘Routes to Recovery’ suite.

It is based on a cognitive approach known as ‘node-link mapping’. This is a technique for discussing issues with clients and visualising them in a series of ‘maps’. It’s important to stress that node-link mapping isn’t a new theoretical approach – it uses the same cognitive behavioural principles as motivational interviewing and relapse prevention.

However, mapping does reduce the often complex and tangled results of keyworking sessions to a simple and orderly record of decisions and progress. It can therefore help clients and keyworkers to clarify and focus on an issue, with minimal distraction, and without going off on tangents.

The regular use of mapping during keyworking sessions also provides a model for systematic ‘cause-and-effect’ thinking and problem-solving, which clients can begin to adopt. The ITEP manual shows workers how to do this clearly and simply.

As well as mapping, ITEP also involves a brief intervention aimed at changing thinking patterns. These sessions can help a client and keyworker address thought-processes that

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1 The ITEP and BTEI programmes have been national collaborations between the NTA, researchers at the University of Birmingham and a range of service providers in London, Manchester, Birmingham and the West Midlands. The work could not have been carried out without our international collaborators – under the leadership of Professor Dwayne Simpson – from the Texas Christian University, or with funding from NIDA and the NTA. This partnership has allowed us to transfer technologies to England which have been shown to be effective in the USA and Italy.
can hamper behavioural change. This intervention also uses maps as a way of creating a visual ‘hook’ for the discussion, and employs other psycho-educational materials and handouts. Again, the manual explains how to do this.

The benefits of maps

- Provide a workspace for exploring problems
- Improve therapeutic alliance
- Focus attention on the topic at hand
- Clearer and more systematic thinking
- Provide easy reference to earlier discussions
- Create memory aids for client and worker
- Provide a method for getting ‘unstuck’
- Useful structure for clinical supervision

Mapping works

As part of the ITEP programme, both the mapping and the brief intervention were evaluated by a number of questionnaires measuring organisational climate and client appraisals of self and treatment, as well as training and implementation of the manual. The results can be found in part 8 of the ‘Routes to recovery’ suite.

At this stage it is worth noting the evaluation found that just by implementing ITEP, treatment agencies underwent significant and lasting organisational improvements – with positive impacts on the effectiveness of treatment delivery. This bears out other research, which found that organisational structure and climate influences the use, effectiveness and efficiency of such interventions, and is predictive of treatment satisfaction and client-practitioner rapport.²

There is a strong evidence base for mapping’s role in increasing the effectiveness of drug treatment. American-led research on non-residential offenders on probation orders found that treatment mapping was a successful way of communicating important information on drug use.³ The effectiveness of mapping has also been borne out by a number of randomised clinical trials that compared clients receiving mapping and enhanced counselling with those only receiving counselling:

The former were less likely to test positive for opiates or cocaine both during treatment and 12 months after treatment.

Mapping clients also missed fewer counselling sessions, and had higher ratings of their own progress.

Self reports of using needles and criminal activities were also lower a year after treatment.

Mapping has been shown to have a significant and positive influence compared with standard counselling on client evaluations of group meetings, their keyworkers and their self-efficacy and treatment effort.

Clients in treatment for less than six months who received mapping interventions were also found to have better urinalysis outcomes (for opiates) than their counterparts.

Studies also show that node-link mapping is particularly beneficial for clients from different racial and ethnic backgrounds, and those with low educational levels or behavioural difficulties.

Case study: Tracey Hogan, Director of Clinical Standards and Practice, Alcohol and Drug Services (ADS)

It is well known that organisational functioning and climate are intrinsically linked to the effectiveness of interventions delivered to clients. As an organisation committed and known for quality, we were excited to contribute to this body of work as it provided us with additional validated materials and methodology to link organisational factors and treatment interventions together, and to evaluate and improve upon both.

ADS selected and trained staff within six sites representing seven treatment units:

1. Structured day programmes (drug)
2. Structured day programmes (integrated)
3. Structured day programmes (drug abstinence)
4. Stimulant services
5. Primary care – brief interventions pre/early dependant drinkers
6. Prison in-reach (drug)
7. Benzodiazepine withdrawal service.

It was also essential for us to assure competence and confidence in the delivery of the mapping interventions after workers had been trained. So we provided line managers and trained staff with group and individual clinical supervision. Staff were encouraged to bring along anonymised

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copies of completed maps to these sessions. As clients are encouraged to rate the usefulness of each individual map using a 10-point scale, this process provided a rich source of information about the effectiveness of ITEP. Most maps were rated 8 or more, while those scoring under 5 still resulted in positive interactions between client and worker, as they sought greater clarity.

Key themes reported through this process were the ease of transfer from training into practice, with immediate gains and successes. In particular, there was an improvement in the quality of client interactions in both individual and group work, while sessions were reported to have a better ‘flow’ with less opportunity for them to get side-tracked. There was also an increased level of confidence among staff, especially those who were new to the field.

As with any project implementation, the lessons learnt can provide key support for future development. We have summarised ours:

1. **Multi-agency partnerships work:** ADS has enjoyed working with its partners on this project. In particular, multi-agency training has been highly effective and senior managers and clinicians have continued to share best practice and support each other across organisations

2. **Engage key people:** ADS engaged all line managers in the ‘train-the-trainer’ model. This ensured clarity of purpose, full support, and a high level of implementation effectiveness

3. **Ensure clients are involved:** Service user groups were informed throughout the project and helped to advertise groups and promote the completion of CEST questionnaires. These groups also provided valuable feedback during the testing of the materials and group work packages

4. **Make the materials easily available:** All staff who received the training also received a complete ITEP manual. We also ensured that every participating site had laminated master copies and every session room contained an easy to access, clearly labelled file system with all the materials and a replenishment process. As a key factor is ensuring clients receive a copy of every map, we are reviewing the production of two-part carbon copies

5. **Supervision is as important as the training:** The support and supervision for staff has been essential. It assured competence and confidence and highlighted any areas of difficulty early on, thus enabling a clear action/improvement plan.

In summary, we have valued our involvement with ITEP. The project has delivered immediate and tangible benefits for clients through mapping interventions that are clear, straightforward and meaningful. We have found the ORC and CEST questionnaires to be extremely useful tools for organisational assessment and have now embedded their use into our existing quality management system.

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**A focus on organisational functioning**

Although ITEP takes an individual or group psychosocial structured intervention as its basis, it is as much about enhancing organisational functioning and improvements within drug services as encouraging behavioural change among clients. In fact, this is central to the success of the approach.

Alongside the mapping intervention, organisational assessment is built into the ITEP programme via the Organisational Readiness to Change (ORC) and the Client Evaluation of Self in Treatment (CES) evaluative tools. In particular, this helps services and their managers to target training skills towards specific members of staff who have a responsibility for clients at different stages of the treatment journey.

These tools are in appendices at the back of the ITEP manual.
Explaining the manual

The ITEP manual can be used in both group and individual keyworker sessions. It has proved particularly helpful to new clients, those who are hard to engage or reluctant, and those who get ‘stuck’.

The manual has two main sections – the first on mapping techniques (with ‘how to’ guidance and sample maps), and the second on the ‘changing thinking patterns’ brief intervention (with step-by-step session guides, handouts and worksheets).

The maps

The manual covers areas where maps can be used, each exploring a number of different themes.

<table>
<thead>
<tr>
<th>Map area</th>
<th>Number and themes of maps</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Exploring the self’</td>
<td>1. Strengths</td>
<td>A useful starting point</td>
</tr>
<tr>
<td></td>
<td>2. Problems</td>
<td>• Starts clients thinking positively about themselves</td>
</tr>
<tr>
<td></td>
<td>3. Failure</td>
<td>• Identifies problems they may have in a number of important areas of life</td>
</tr>
<tr>
<td></td>
<td>4. Success</td>
<td>• Provides an overview of issues for client</td>
</tr>
<tr>
<td></td>
<td>1. Important people</td>
<td>Helps client to better understand and relate to others</td>
</tr>
<tr>
<td></td>
<td>2. Relationship problem</td>
<td>• Identify those people important to the client</td>
</tr>
<tr>
<td></td>
<td>3. Crucial conversation</td>
<td>• Explore difficulties in each relationship</td>
</tr>
<tr>
<td></td>
<td>1. Examining choices</td>
<td>Helps client to think through an important decision</td>
</tr>
<tr>
<td></td>
<td>2. Acting on the decision</td>
<td>• Focusing on the choices available, the consequences of each choice, planning what actions will arise once reaching a decision and evaluation of actions and progress</td>
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<tr>
<td></td>
<td>3. Decision process</td>
<td></td>
</tr>
<tr>
<td>‘Taking control’</td>
<td>1. Understanding</td>
<td>Helps client better understand LEEPS (life, events, emotions, problems, successes)</td>
</tr>
<tr>
<td></td>
<td>2. Actions</td>
<td>• Explore ways to avoid getting or giving a serious disease</td>
</tr>
<tr>
<td></td>
<td>3. Progress</td>
<td></td>
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</table>
These five subject areas make use of three types of map, which can be used in one-to-one or group sessions with clients:

1. **Guided maps** are topic-specific and similar to pre-structured mini interviews. They are already laid out, and the worker and client simply fill them in using a specific framework. Here’s an example:

   ![Guided Map Example](image)

   - **Physical, Health, Appearance**
   - **Learning, Problem Solving, Decision Making**
   - **Ethics, Morals, Beliefs**

   **Social Relationships**

   **Motivation and Emotions**

   **Job/Career?**

   **What are your strengths?**

   How can you use your strengths to improve your life?

2. **Free maps** are ‘draw-as-you-go’, where the worker and client work together to create maps on the problem or issue under discussion. The client and worker can move on to these once they are confident with guided maps, as in this example:

   ![Free Map Example](image)

   - **Stage 1**: George
   - **Stage 2**: George (Not bad looking, Good human being, Has family)
   - **Stage 3**: George (Previous ideas are shaded - new ones are not)

3. **Hybrid maps** are a combination of guided and free maps. The worker and client begin with a structured map and then develop it over time.
‘Changing thinking patterns’

The difference between the ‘changing thinking patterns’ brief intervention and the mapping elements of ITEP are that while mapping can be undertaken with clients right from their first contact with a keyworker, ‘changing thinking patterns’ is best delivered once a client has settled into regular contact and is more engaged in treatment. In other words, it is not suited to clients who are deeply chaotic, but rather to those who seem to be making progress in recovery and want the opportunity to address more deep-rooted problems that may be holding them back.

‘Changing thinking patterns’ is made up of three sessions, which address different aspects of the thought process.

1. Feelings, thoughts and mind traps

This involves a discussion about the characteristics of feelings and emotional states, how clients respond to emotions both physically and non-verbally and how they can match words to feelings. This session introduces the link between thoughts and feelings and explores ways of challenging unrealistic thinking patterns and avoiding ‘mind traps’. An example of a mind trap and the associated worksheet is given below:

**The blame trap**: We get caught in the blame trap when we refuse to take responsibility for our decisions and actions. Instead we try to make others responsible. The thoughts sound like: “he’s making me mad”; “she made me do it”; “it’s not my fault I slipped up, he’s the one who brought the dope home”; “it’s your fault things are not working out”.

**Challenge with**: I am responsible for my feelings and my actions. Blaming others keeps me from having to look at my part. I may have an emotional reaction to someone’s behaviour, but I am responsible for how I respond. Others may ask me to do things, or offer me opportunities, but no one is responsible for my decisions except me.

2. Roadblocks to healthy thinking

This session focuses on Ways Of Thinking (WOT) and how these can interfere with change and contribute to relapse. Clients are asked to identify negative ways of thinking and how these can be rationalised. The aim is to make clients aware of their own thinking habits and question how and why they fall into these patterns, their impact on relationships and recovery, and how they can learn to change unproductive ways of thinking. Some examples of negative thinking – and the responses to them – are:

“I don’t need this stupid group, I already know this stuff.” Grandiosity is the belief that we are superior to others, that we should never be questioned, and that we are right about everything (which means everyone else is wrong). No one can teach us anything because we believe we are smarter, better, more capable, or more ‘in the know’ than others, even if the facts don’t support it. We think our lives, experiences, knowledge, needs, problems, concerns, and opinions are the only ones that matter.
“It was just one lousy beer.” Minimising can be summarised as “trying to make a molehill out of a mountain”. When we minimise, we attempt to make others believe that what was, in fact, a big screw-up was really no big deal. Usually, the words “just” and “only” will be part of our attempts to minimise our actions. When we minimise, we are usually avoiding or reducing the consequences of our behaviour. The payoff is that if we believe our own minimising, we don’t have to feel remorse or make amends.

3. Thinking and behaviour cycles

This final session aims to address how behaviour and ways of doing things become a habit, a ritual or a cycle. The client describes their behavioural cycles, and can discuss tips that can be used to break them. An example of a behaviour cycle worksheet is set out below:
The keys to ITEP success

The aim in developing the manual was that it should be easy to use by all keyworkers (not just those with extensive training). Repeated use of the techniques and materials contained in the manual can help improve keyworker competence, and because the maps are not prescriptive, they allow for substantial key worker and client freedom to develop their own unique ways of using ITEP.

There are two main measures of ITEP success which should become immediately apparent to clients, keyworkers and their supervisors:

• Firstly, maps and worksheets can help with ‘problem definition’ – they can systematically highlight issues for the client in terms of causes, consequences and solutions (it is a good idea to give copies of completed maps and worksheets to clients as a record of their sessions, which they can take home and share with friends/family)

• Secondly, maps and worksheets provide easy-to-read summaries of a keyworking session that are not only useful for quick recall of session issues but also for reviewing a case in clinical supervision.

Equally important is the role of clinical supervision. It’s all very well to show people how to use the manual, but it’s the repeated use of it that embeds ITEP into effective and efficient treatment delivery. It is therefore vital that keyworkers have the opportunity to discuss their experiences of using the manual during regular clinical supervisions (at least one hour a month). For this reason, it is also important that processes are established that document the intervention on a session-by-session basis.

Finally, although ITEP takes an individual or group psychosocial structured intervention as its basis, it is as much about organisational change as encouraging behavioural change among clients. By creating an easy-to-use systematised intervention, it can help organisations to re-prioritise the place of psychosocial interventions in treatment delivery – and as such, it can promote strong leadership, a learning culture and clarity of purpose, the three key elements of organisational health.
The NTA view of ITEP

The NTA has watched the drug treatment system in Manchester develop, and supported the implementation of the psychosocial interventions in ITEP (especially the mapping) and the focus on organisational functioning this approach has brought.

We are impressed by the testimonies from the commissioners, managers, clinicians and service users who have participated in this initiative and found it valuable.

We have seen evidence of improvement in services, in therapeutic relationships and in client outcomes from the data that has been collected. We are also impressed by the spirit of joint working that has been generated and is evident across the services that have engaged in ITEP. We are particularly impressed by local systems sharing training and supervision resources – particularly across statutory and voluntary sector services – and the improvement in relationships and system functioning this has brought.

The 2007 Clinical Guidelines ('Drug Misuse and Dependence: UK Guidelines on Clinical Management') endorsed mapping techniques and said they “have been found to enhance both the therapeutic relationship and treatment engagement, and to improve the patient’s memory and understanding of the therapeutic session”.

It is for these reasons that the NTA has given the ITEP project and its manual the NTA seal of approval. Not only does the NTA endorse the implementation of the psychosocial mapping interventions, we also endorse the focus on organisational functioning and service management that this approach advocates.

We would ask that service providers and commissioners consider:

- Implementing the ITEP manual – especially where keyworking requires improvement
- Utilising the tools to aid organisational review and development – especially in services where management and competence may require improvement
- Investing in training and supervision in using the ITEP manual across local systems – this can improve working relationships and core competence in keyworking across a range of statutory and voluntary sector funded treatment services.

For further details on ITEP, you can contact:
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The Routes to Recovery suite

The NTA is rolling a series of reports and manuals that the treatment sector can use to help improve treatment effectiveness:

- Part 2, ‘The ITEP Training Manual’, is a simple tool for implementing the ITEP psychosocial intervention
- Part 3, ‘The BTEI Approach’, explains the BTEI intervention and how it modifies ITEP
- Parts 4, 5, 6 and 7, ‘The BTEI Manuals’, are tools for implementing the full BTEI intervention – covering care planning, building motivation (for individuals and groups) and treatment exiting
- Part 8, ‘The ITEP Research’, sets out the ITEP pilot work in Manchester
- Part 9, ‘The BTEI Research’, sets out the ITEP pilot work in Birmingham and the West Midlands.