DRUG & ALCOHOL FINDINGS Matrix cell

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Drug Treatment Matrix cell B2: Practitioners: Generic and cross-cutting issues

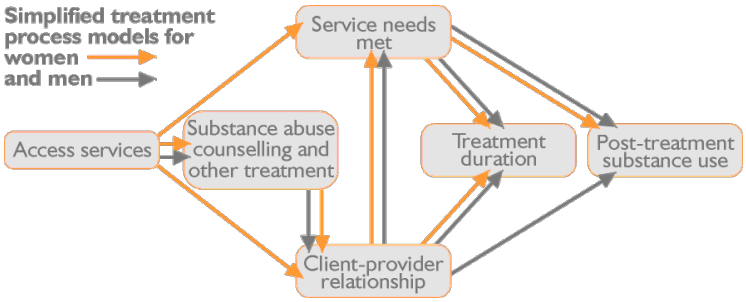
S What makes some therapists more successful? (1985). A by-product of a randomised trial of different therapies, instead this study ended up highlighting the "dramatic" difference made by the therapist, some on average achieving little (or on some measures, negative) change among methadone patients, while others generated consistent and substantial improvements across substance use, psychological and social outcomes. Based on ratings made by their peers and other assessments, the impression was that skilled therapists most interested in helping patients and who formed warm, supportive relationships generated greater improvements.

K Best drug workers are non-conformist hedonists – like their clients? (2008). Findings of a small study in an English drug service for marginalised clients suggests that workers whose values and preferences deviate from the norm in the same direction as their clients are most able to help them. Findings are tentative, but similar to those from a US study (1974) of ex-addict methadone counsellors. For discussion click here and scroll down to highlighted heading.

K Client-receptive treatment more important than treatment-receptive clients (1999). Engagement and substance use outcomes at US drug counselling services were more strongly associated with how well counsellors related to their mainly stimulant-using clients than to the clients' pre-treatment motivation.

K Clients who feel positive about their counsellors stay longer and feel better (2002). US study which benefited from a large and varied sample of counsellors working in residential and counselling/day centres found that favourable perceptions of one's counsellor were significantly related to how long patients stayed in treatment. A year after the initial research assessments there were also significant relationships with psychiatric health, but not with the severity of drug problems and only modestly with alcohol problems. For discussion click here and scroll down to highlighted heading.

K Strong therapeutic relationships mean patients get more of the services they need (2010). How does a close working relationship with your keyworker improve drug use outcomes after treatment? According to this analysis based on over 3000 US clients, mainly by meaning they got more of the 'wrap-around' services they needed. Good relationships also extended retention, but once the sexes were analysed separately, retention was unrelated to post-treatment drug use ▶diagram. For discussion click here and scroll down to highlighted heading.



R Directiveness is a key dimension of therapeutic style (2006). We all know people who bristle when someone else takes the lead, others who gladly take a back seat. In substance use treatment too, the interaction of therapist 'directiveness' with client preferences seems the most consistently influential dimension of interpersonal style. For discussion click here and scroll down to highlighted heading.

R Some therapists are just better than others (2012). Free source at time of writing. Ingenious analysis finds that across behavioural and mental health problems, the contribution of the therapist to the creation of a strong alliance and resultant improvement in outcomes is greater than that of the patients: "These results suggest that some therapists develop stronger alliances with their patients (irrespective of diagnosis) and that these therapists' patients do better at the conclusion of therapy."

R Good therapeutic relationships mean patients stay longer (2005). Free source at time of writing. The therapeutic relationship between patient and worker early in treatment was more consistently related to engagement and retention than to substance use outcomes, especially when those outcomes were assessed at times distant from the assessment of the alliance. For discussion click here and scroll down to highlighted heading.

R Select and evaluate clinicians based on 'track records' (2000). Free source at time of writing. After exploring the evidence for just about every way you could think of to identify the most effective substance use clinicians, concludes that "past assumptions that levels of training, experience, or other simple therapist variables" would work are mistaken, and that there is no substitute for monitoring actual performance. For discussion click here and scroll down to highlighted heading.

R Therapist effects more important than specific treatments (2014). Free source at time of writing. In substance use treatment, "one of the best indicators of clients' retention and outcome is the particular counselor to whom they happen to be assigned," was this essay's assessment of the evidence. Among the reasons were therapist expectancy of good outcomes, allegiance to the treatment approach they are providing, interpersonal skills including (▶below) empathy, and how competently they provide the therapy. For discussion click here and scroll down to highlighted heading.

R Authoritative, evidence-based assessment of how best to relate to therapy clients (American Psychological Association, 2011). Effective ways to relate to therapy clients (including those with substance use problems) common to different therapeutic traditions, like forming a therapeutic alliance, demonstrating empathy (▶below), and adjusting to the individual. Also what to avoid, like confrontation, negativity about the client, and inflexible adherence to one method. For discussions click here and here and scroll down to highlighted headings.

R Is low therapist empathy toxic? (2012). Free source at the time of writing. "Is low therapist empathy toxic?" was the title and the question answered in the affirmative by a review which synthesised findings on the relationship between ratings of a therapist's empathy and substance use outcomes. It found that "empathy may exert a larger effect in addiction treatment than has been generally true in psychotherapy, accounting in some studies for a majority of variance in client outcomes." For discussion click here and scroll down to highlighted heading.

R Complexity demands socially skilled and flexible therapists (2016). From Drug and Alcohol Findings, an issue-focused essay on the role of staff in brief interventions and addiction treatment, emphasising that the complexity of the interacting variables which

therapists have to respond to means there are no reliably standard ways of responding to a particular characteristic or need. For discussion click here and scroll down to highlighted heading.

G Principles of substance use treatment (2006). Free source at time of writing. Integrates reviews and guidance commissioned by the American Psychological Association (APA), in particular on relationship factors in relevant chapter of an APA book (2006). For clinicians, says "Development of an effective therapeutic alliance is crucial" and *inter alia* recommends accurate empathy, respect for client's experience, avoiding confrontational struggles, titrating confrontation to client's "reactance", and providing goal direction and a moderate level of structure for the therapy.

MORE This search retrieves all relevant analyses.
For subtopics go to the subject search page and hot topic on treatment staff.

Close Matrix Bite

Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text

What is this cell about? Whether medical or psychosocial, chosen positively or under pressure, among the 'common factors' affecting treatment's success is the nature of the patient's relationships with referral and treatment staff. Relationships affect whether people want to enter treatment after initial contact, whether they stay, and the services they receive. In these ways among others (▸ Key studies above for examples), ultimately relationships can (but not always) affect the degree to which treatment helps patients overcome their drug problems and improve their lives.

Relationships emerge partly from the patient, but of most interest is the therapist's contribution, because this is what can be changed by recruitment, training and experience. The interpersonal style and other features of treatment staff are much less commonly researched than the nature of the intervention, and many studies try to eliminate these influences in order to focus on the specific content of the intervention. In doing so they risk eliminating what matters in order to focus on what generally matters little or not at all.

Relative neglect means that associations between therapist factors and retention or outcomes often emerge from studies intended to investigate interventions, not interventionists. Without the reassurance of randomising patients to different therapists or therapist styles, it is usually impossible to be sure that these associations represent causal effects.

Here the focus is on therapist-related factors; common factors more generally are dealt with in cell A2.

Where should I start? This review comprehensively mapped the ways treatment practitioners of all kinds – medical, counsellors and therapists – might affect the quality and impact of treatment. Later studies may fine-tune the conclusions, but generally they remain robust, including the fact that while practitioners vary greatly in their effectiveness, what accounts for this is hard to pin down.

One thing we do know from this review and from later work is that formal quality indicators – like years of experience and professional training and qualifications – usually bear no relation to performance; in therapy for substance use and behavioural and mental health problems more generally, it is the relationship-building qualities that matter. Published in 2000, the reviewers' conclusions remain broadly supported: "The easiest clinician variables to measure are, unfortunately, some of the least relevant to quality of service delivery (eg, gender, race, age, training, years experience). Variables with much more relevance to quality care include empathy, ability to establish an alliance, emotional reactions to patients, professional demeanour and recordkeeping, ability to enforce clinic rules and make appropriate referrals to further care, beliefs about substance use disorder topics, etc."

With – in the counsellor role – no formal badges predictive of effectiveness, the reviewers emphasised that there is no substitute for evaluating clinicians based on how they perform with clients. However, this need not entirely be a 'suck it and see' experience, with clients as the guinea pigs. Using realistic therapy cameos, staff recruitment and evaluation procedures can get close enough to eliciting how the clinician *would* react to real clients to make this a worthwhile predictor of their actual performance; more in cell C2 of the Alcohol Treatment Matrix.

Highlighted study We select a small British study to highlight not because its findings were definitive, but because they help focus the mind on what kind of person excels at face-to-face work with clients who regularly use illegal drugs – conventional personalities who value conformity and security, or those who (like we can guess, many of their clients) prioritise stimulation and hedonism and are prepared to contravene social norms – people more open to experience and change. In this study, it was the latter who were associated with the greatest improvements in their clients.

How much can we take from this finding? Take a look at our analysis and the original, freely available study linked to in the analysis. In assessing articles for the Effectiveness Bank, we ask two main questions: 'Do the findings have important implications?' and 'Can they be relied on as a guide to practice?' To the first the answer seems to be, 'Yes; the implications are important,' to the second, 'No; the methodology is not strong enough for this study on its own to influence practice.' However, it is *not* on its own. Look at our commentary and you will see that its findings chime with other research within and beyond substance use treatment. Also, the findings 'make sense'; intuitively we can see how they might have arisen from mechanisms familiar in our everyday lives.

None of this is a substitute for stronger, more rigorous methodologies – the findings from which can sometimes contradict both weaker research and intuition. But it does mean the findings should not be

dismissed. Think about them, discuss the implications with colleagues, and see if they make sense and resonate with your experiences. It could make the difference between staffing the front line of your service with pleasant, buttoned-down professionals, or more open and receptive but also more edgy thrill-seekers – or maybe both/somewhere in between! Maybe too, the findings were contingent on the types of clients seen in the studied service and would not be universally replicated – a possibility explored in the next section.

Issues to consider and discuss

▸ **Is it best to busk it?** Or perhaps more plausibly, best to follow a detailed manual drafted by international experts on the basis of research findings? Surprisingly, the evidence leans towards the 'busk it' end of the spectrum. Let's explore why this might be.

Readers who turned to the original report of the *Highlighted study* will know its findings derived from a distinct client group even more socially excluded than the general run of dependent users of illegal drugs in Britain. Critical readers may reflect that perhaps unconventional workers best relate to these clients, but that doesn't make it a universal rule; others may react better to different approaches. That takes us to arguably *the* fundamental principle about how to relate to patients and clients: beyond the unacceptability boundaries of ethics, law and culture, there are, it seems, no universal rules. Experts convened by the American Psychological Association say that is the case across therapy, whether or not focused on substance use. Based on an exhaustive series of reviews, they recommended therapists tailor the relationship to the client and warned against rigidity and uniformity.

Especially (but not only) in the psychosocial treatment of psychological and behavioural conditions, it is "the meaning that the client gives to the experience of therapy that is important," and that meaning is constructed from the context within which an intervention is delivered, including the practitioner. Rather than seeing the intervention as the treatment, it is more realistic to see treatment as a package of interacting elements including (among other factors) the intervention, the way the therapist relates to the patient, the patient's predispositions, responses and how they manage their condition, and the credibility of the context as a healing environment.

Defining the treatment package in this way means that each of these factors affects not just how the patient *feels* about their treatment, but the impact it has on the condition being treated. Because these influences interact, it would be simplistic (one of the main points made in our hot topic listed above) to expect better outcomes always to be associated with a high level of a given factor; whether this happens or not will depend on the other factors. That would explain why across psychotherapy and counselling, the relationship between outcomes and therapist competence and the fidelity of their delivery of an intervention is in both cases practically zero, but only because the very different relationships in different study contexts even out across the studies.

That was one of the understandings which led to the *My way or yours?* part of our *Manners Matter* series of reviews. Read especially the conclusion beginning on the sixth page of the PDF file. It reminds you that while researchers can tease out one or two relationship dimensions to analyse, therapists and clinicians have to deal with the multidimensionality of human encounters; one client characteristic or reaction might suggest a certain approach, another the opposite. Such complexity, we concluded in an essay listed above, makes relating a matter of judgement, of the kind socially skilled and flexible therapists make every day.

From outside substance use treatment, take a look at a fascinating mini-sample of this complexity. It shows that *even in the treatment of a physical condition*, conveying positive expectations about treatment generally helps, but this effect is negated if the clinician acts in an emotionally cold manner and seems less than fully competent. In other words, it is not enough to reassure patients, 'It will work'; the relational and cultural context within which this message is received determines its impact.

The perhaps difficult message for practitioners across mental and behavioural health is that there is no simple, 'Do this and your patients will maximally improve' formula – it all depends. Even an authoritative manual drafted by the originator of the most influential therapeutic approach in addiction counselling, who themselves intensively trained and certified the counsellors, becomes a counterproductive millstone when practitioners are made to adhere to it almost regardless of the clients' reactions. Paradoxically, motivational interviewing, the approach concerned, was intended to ensure counsellors remain *non*-directive in their interactions with clients. In motivational interviewing and probably too more broadly, sometimes it really is best to 'break the rules' by adhering to the 'meta-rule' that no specific tactic is always the best way to help every client in every situation – individualisation is the essence of treatment.

> *There is no 'Do this and your patients will maximally improve' formula*

Does all this read like a counsel of despair? Or a manifesto for liberating therapists to do what to them seems best? Remember that the therapists in studies tend to be experienced and well trained and supervised. Perhaps constraining less competent practitioners to a pre-ordained style and programme *generally* applicable to a service's clients is better than leaving them to intuit what may be the wrong approach for each individual – much as burger-bar uniformity may be safer than leaving untrained and perhaps unhygienic 'chefs' to do their own thing. Perhaps cordon-bleu individuality in therapeutic relationships is an unrealistic aspiration in the pressured, low-pay environments of some addiction treatment services.

Turning to practicalities, what kind of people do we need to handle these complexities, and how can we

identify or foster them? That is an issue for management addressed in cell C2 of the Alcohol Treatment Matrix under the heading, "Recruitment: the critical missing link." Suffice it to say here that it is possible to identify in advance applicants who will turn out to be retention- and outcome-promoting substance use counsellors, and that this is at least as important as trying to generate them through training.

▸ **Do relationship-forging staff just mean clients stay longer?** Imagine yourself looking round the shops for a new dress, suit or pair of jeans you have decided you must get because your clothes are in a bad state and getting worse, and you can't mend them yourself. Only one local shop offers what you might want. It and the staff may be rather cold and not on your fashion wavelength, but you make the purchase because you need to and (unless it is pouring outside) quickly move on. If the assistant is friendly and understanding, the shop warm and congenial (especially in contrast to outside), you may stay longer. The extra time and greater attention might make no or only a slight difference to your purchases – perhaps a better look or a fit – but make you feel better in other ways. Of course, if the assistant ignores you, is blatantly hostile, or brings goods that to you don't look like clothes at all, you may simply walk out. Short of those extremes, you make do and get what you need.

That analogy makes sense of at least some of the addiction treatment literature. The decision that you need to change and need help to do so is the main driver of overcoming dependence through treatment. Within reason, however the service and staff behave, the patient will use them to get where they want. But whether they stick around (retention) depends largely on other things, like how welcoming and understanding it is inside the service compared to what they are used to/expect outside. Perhaps a retention-enhancing service means they get more of what they need to sustainably control their substance use, but often not enough to register in research. However, they may benefit in ways they did not anticipate or go there to achieve.

In support, look at this review. It found just one study in which a stronger client/therapist alliance was related to better long-term substance use outcomes, and many which found no such link. In contrast, stronger alliances were consistently associated with longer retention. And what of this careful analysis, which found only a very weak link between client-keyworker relationships and substance use after leaving treatment, and then only for men, but for both sexes stronger links between relationships and retention. And this one too, which found that favourable perceptions of one's counsellor were significantly related to how long patients stayed and improvements in psychological health, but much less so or not at all to remission of drug or alcohol problems.

> *Even if 'all' better relationships do is improve retention, that is not to be dismissed*

Even if 'all' better relationships do is improve retention, that is not something to be dismissed. In itself, a longer stay is in some circumstances a good thing – most strongly evidenced for substitute prescribing, because its lifesaving impact largely depends on *being in* the treatment, not having completed it. For criminal justice clients too, treatment completion can be one element of the compliance which means they successfully complete a court order and avoid a more severe penalty. But often retention and post-treatment substance use are unrelated, and when they are related, generally studies are unable to exclude the possibility that patients who are in any event going to do better also stay longer.

As ever, there are exceptions, and the client-worker relationship has sometimes been found or strongly suspected to have been an active ingredient, not only in improving retention and psychological health and reducing harm, but also in overcoming dependence. Some of the studies listed above in this cell testify to that proposition. So the questions become not either/or, but when and under what circumstances. Under what circumstances is the client-worker relationship an active ingredient in overcoming dependence? When does a good relationship simply reflect the fact that the patient is in any event doing well? When does it help improve lives after and more broadly than short-term recovery from dependence, and how can we make that happen? Reflect on your experience and discuss with colleagues and clients. It might help you make the most of this important and malleable part of the treatment context.

▸ **You're not taking me seriously!** … the spoken or unspoken complaint of many a patient faced by the wrong kind of bedside manner. In medicine generally, comments patients see as 'invalidating', like being dismissed or not taken seriously, have a detrimental impact thought to be greater than the positive impact of validating comments. It would be surprising if substance use patients sensitised to stigma, rejection and judgmentalism, did not react at least as strongly. For the clients, above all their experience of health service interactions is tarnished by "Negative attitudes [which leave them] feeling not valued and feeling like 'scum'."

In the context of the treatment of drinking problems, we theorised that once would-be patients approach, knock on and seek to pass through doors to treatment, doing the right things help, but what is critical is to avoid obstructing the process started by the patient by doing the *wrong* thing. One pretty reliable way to do that is authoritarian confrontation – the opposite of the 'accurate empathy' stressed in the seminal writings of Carl Rogers (▸ cell B4). Some of his successors – William Miller of motivational interviewing fame and his colleague Theresa Moyers – have described this as including "a commitment to understanding the client's personal frame of reference and the ability to convey this heard meaning back to the client via reflective listening". Their essay asked if lack of this quality was "toxic" to client progress in substance use therapy, adducing evidence that it was.

The American Psychological Association has provided us with a rogues' gallery of these and other ways of

undermining therapy. It starts with the *opposite* of what *to* do, like *not* expressing accurate empathy. It moves on to confrontation, hostile, pejorative, critical, rejecting, or blaming comments or behaviour, assuming (without checking) that thing are going well, and centring on your own perspective rather than that of the client. But it ends with "inflexibly and excessively structuring treatment" and "using an identical therapy relationship (or treatment method) for all clients". The implication is that all the previous 'rules' might sometimes (judiciously and exceptionally) need to be broken to tailor therapy appropriately – a proposition we have already come across in the first of our issues for discussion.

Directiveness is one example. Probably the most well-evidenced way to obstruct the progress of substance use patients is to 'direct' through advice and warnings when the client is of the kind likely to react against being 'told what to do' – the classic counterproductive reaction which leads patients to dig in their heels and which motivational interviewing was designed to circumvent.

Sometimes, however, being directive is good, and failing to direct the client is a mistake. Take a look at this Effectiveness Bank review listed above. Think about your own relationships. As the review says, in principle things are no different in therapy. Some people, sometimes, and in some situations, expect and need direction, other times it will be resisted – an example of why we should value socially skilled therapists who can react appropriately.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