DRUG & ALCOHOL FINDINGS *Matrix cell*

S Seminal studies **K** Key studies **R** Reviews **G** Guidance **MORE** Search for more studies
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Drug Treatment Matrix cell C2: Management/supervision; Generic and cross-cutting issues

S Qualifications do not a counsellor make (1984). Whether counselled by ex-addicts, paraprofessionals or degreed professionals, patients at methadone maintenance and drug-free outpatient services did just as well, findings in line with later work indicating that for these kinds of roles formal qualifications and experience are not indicative of quality. More on recruitment below and in cell C2 of the Alcohol Treatment Matrix.

K First get the staffing right (2004). US study suggests that recruiting the 'right' clinicians who have *not* been trained in appropriate ways to relate to patients would be better than choosing the 'wrong' ones who have been, and the former gain most from training. More on recruitment above and in cell C2 of the Alcohol Treatment Matrix.

K Motivating aftercare (2007). US residential centre systematically applied simple prompts and motivators to substantially improve aftercare attendance and sustain recovery. See also later report (2008) from same study. For discussion click here and scroll down to highlighted heading.

K Try walking in their shoes (2008). When senior staff role-played the process of becoming a new client (a 'walk-through' theirown service in the client's shoes) the resulting enlightenment helped halve waiting times and extend retention in US substance use services. See also this extension (2012) to the programme and this account (2007; free source at time of writing) of the 'walk-through' procedure. More on the NIATx quality improvement model and on the model's application below. For discussion click here and scroll down to highlighted heading.

K Systematically link assessments to services (2005). In Philadelphia automatically linking problems identified at treatment intake to relevant local services transformed assessments from clinically redundant paperwork into a practical route to the 'wrap-around' care advocated to deepen and extend recovery. For discussion click here and scroll down to highlighted heading.

K Responsiveness to patients' needs means better outcomes (2010). Analysis based on over 3000 US clients found they stayed longer and did better at services which showed responsiveness to need by offering help to get them to treatment and organising needed 'wrap-around' services.

K You cannot treat an empty chair (2013). Free source at the time of writing. Title is the opening quote in this study of how 67 US substance use outpatient clinics used the NIATx quality improvement model to reduce 'no-shows' through reminder calls (had to be sensitively handled), cutting waiting times, increasing capacity (eg, extra hours), and psychosocial approaches to bolster engagement such as motivational interviewing. More on the NIATx model below and on its application above.

R How to generate evidence-informed practice ([Australian] National Centre for Education and Training on Addiction, 2008). Though they found few studies on substance use treatment, reviewers extracted valuable lessons from health promotion and medical care services on how to implement research-based innovations to improve treatment practice.

R Cycle of change model poor guide to intervention (2001). Its simplicity is beguiling, but can services trust Prochaska and DiClemente's ubiquitous cycle of change model to guide the initial approach to their clients? This thorough but easy-reading review found little evidence to support this popular strategy. Since it was written (see Effectiveness Bank hot topic), not much has changed. For discussion click here and scroll down to highlighted heading.

R Care enough to be personal but also to be systematic and persistent (2004). In seemingly mundane tasks like reminding patients of appointments and checking how they are doing after they leave, individualised and welcoming communications characterise retention-enhancing services. Systematising these procedures is not the antithesis of being caring, but a sign that the service cares enough to make the most of every contact. For discussion click here and scroll down to highlighted heading.

R Tentative support for matching treatment to patient preferences (2016). The first review to evaluate shared decision-making and matching substance use treatment to patient preferences found some evidence that greater patient involvement in decisions has no negative impacts and can improve outcomes. For discussion click here and

scroll down to highlighted heading.

R Involving former problem substance users in promoting recovery (2014). For such a widely implemented and widely supported adjunct to formal treatment, the revelation from this review is how little evidence there is for involving former substance users in promoting recovery from problems similar to those they experienced – a lack which may simply reflect the paucity of adequate research. However, on balance the evidence we have is positive. Related UK and US supervision guidelines below.

G UK staff development toolkit ([English] National Treatment Agency for Substance Misuse, 2006). Recruitment, training and staff development, appraisals and supervision, exit interviews and more.

G Criteria for quality in substance use treatment in Scotland (Convention of Scottish Local Authorities and Scottish Government, 2014). Developed to ensure anyone looking to address their problem drug and/or alcohol use receives high-quality treatment and support that assists long-term, sustained recovery and keeps them safe from harm. Can act as a quality-assurance checklist for service managers.

G English inpectorate's criteria for quality in substance use services ([English] Care Quality Commission, 2015). Official inspector of health and social care services in England asks five key questions of specialist substance use services, including, "Are they well-led?" – by which they mean that "leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture." More on what this means in appendices.

G Assessing whether the workforce has the required knowledge, skills and ability (NHS Health Scotland, 2009). Desired competencies and assessing the training needs of Scotland's substance use workforce at all levels, from specialists to generic workers who may deal with substance use only peripherally.

G Managing peer supporters ([UK] Substance Misuse Skills Consortium, 2015). Guidance from (now no longer operational) government-supported skills body for the substance use sector on how to manage current and former problem substance users who support and mentor other users through and out of treatment. Related review above and US guidelines below.

G Supervising peer supporters (2017). US checklist and training curriculum for evaluating and developing competence to supervise (ex-)substance using peers to promote recovery among a service's patients. Related review and UK guidelines above.

G Managing non-residential programmes ([US] Substance Abuse and Mental Health Services Administration, 2006). US expert consensus on running outpatient, counselling and day-care substance use programmes, including strategies to meet "the challenges facing executives and the opportunities for employing available resources and skills to meet program goals".

G Clinical supervision and professional development of counsellors ([US] Substance Abuse and Mental Health Services Administration, 2009). US expert consensus on supervision methods and models, including how these can address cultural, ethical and legal issues, and monitoring performance. Includes an implementation guide for administrators.

G Workforce development aid for managers ([Australian] National Centre for Education and Training on Addiction, 2005). Evidence-based strategies to address priority workforce development issues such as supervision, team building and performance appraisal, plus resources to help managers implement the strategies. Endorsed by the Australian government.

G Improving efficiency and capacity means more patients can be helped ([US] NIATx, accessed 2017). Web-based service based at University of Wisconsin and supported by US government. Offers practical strategies to improve the management of substance use treatment services. Objectives include reducing waiting times and the number of 'no-shows' and increasing admissions and retention; examples above (1 2). NIATx also co-provides the Network of Practice, a web resource on learning how to implement evidence-based practices.

G Implementing change ([US] Substance Abuse and Mental Health Services Administration, 2009). Guide for managers on how to assess an organisation's capacity to identify priorities, implement changes, evaluate progress, and sustain effective programmes, and how to implement these programmes. Substantially draws on a broader review, one of the resources available through the Network of Practice resource listed above.

G US guide to matching type of treatment to the patient (American Society of Addiction Medicine, 2013). What the US professional body for addiction medicine society says are the world's "most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions". Helps decide what intensity and setting of care to offer and when to stop or change.

MORE This search retrieves all relevant analyses.
For subtopics go to the subject search page and hot topics on why some treatment services more effective than others, matching interventions to the patient's 'stage of change', and individualising treatment. See also a reading list from a leading US analyst intended to help treatment services develop recovery-oriented programmes, and a resource list from the UK Substance Misuse Skills Consortium to (among other topics) help managers recruit and supervise staff, manage organisational change, and foster effective team working.

Last revised 26 December 2017. First uploaded 01 June 2013

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Close Matrix Bite

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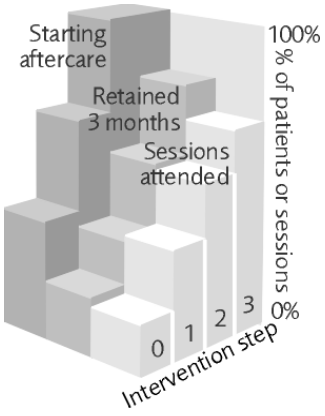
What is this cell about? The five-cell matrix row in which this cell is located focuses on generic processes common to treatment, whatever the setting or modality. Patients have to decide to get or accept help, find their way to treatment, decisions must be made about the objectives, form, intensity and duration of care, relationships forged, and attention paid to psychological problems and social circumstances which affect the chances of a sustained end to dependent substance use.

The current cell narrows in on how these processes are affected by the management functions of selecting, training and managing staff, and managing the intervention programme. In highly controlled studies, it may be possible to divorce the impact of interventions from the management of the service delivering them, but in everyday practice, whether interventions get adopted and adequately implemented, and whether practitioners can maintain recovery-generating attitudes and knowledge, depend on management and supervision. Compared to research on interventions, research on these issues is scarce, but also exciting and inspirational, for it is at this level that whole organisations can be transformed from merely going through the motions, to enthusiastic client-engagers.

Where should I start? With the truism that 'Manners matter' – the title of a series of reviews by Drug and Alcohol Findings not on *what* services do, but *how* they do it. Part one (listed above) dealt with seemingly mundane management tasks like managing waiting lists, setting up reminder systems for appointments, and checking on patients after they leave. In each case, research showed that individualised and welcoming communications characterise effective and retention-enhancing services. The overall conclusion was simple: "the human qualities which cement relationships outside treatment also do so within it".

Managements and services which care enough about these qualities also care enough to be organised and persistent about embedding them in routine practice. They centre initial contacts on the patient's priorities, provide (if need be, interim) help quickly, take the responsibility for reminding patients they want to see them and help them get to appointments, prepare the ground for keeping in touch after they leave, and then persistently and actively check how they are doing and if they need more help, at each stage showing that some*one* rather than some machine at the clinic is concerned about them and wants to see them. One of the best examples is our *Highlighted study* below.

Highlighted study It is unusual for a series of studies to coherently explore a single theme over many years, each study building on the other, and the results have been among the most valuable in addiction treatment research. A perfect example is a series of studies (listed above) at a US residential centre, which systematically applied one tactic on top of another to cumulatively improve aftercare attendance and sustain recovery.



We first introduced this work as a 'Transformation story' in the *Manners Matter* series (turn to the sixth page of this PDF file), where we tracked the improvements from a dispiritingly poor record to 100% initiation of aftercare and 80% of patients attending for at least three months ▸ chart. Those studies and later reports (1 2) showed the procedures also substantially improved long-term abstinence rates – and they cost little or nothing.

If your service is finding it hard to sustain treatment gains through aftercare, these studies prove that performance can be transformed by a welcoming attitude, personalised reminders, recognition of patients' achievements, and, more generally, the systematic application of process analysis, sensitivity to patients, and evaluation of how things turn out.

Issues to consider and discuss

▸ **Is there anything more instructive than *being* the patient?** Our starting-point review ended with, "Perhaps the main lesson of the research is that there is nothing special about … how substance misuse patients react. Reflection on how we might react if we were in their shoes can predict much of what

researchers have painstakingly set out to prove." From cell B2 and general psychotherapy research we know that the therapist's ability to think themselves into the shoes of the client ('empathy') is fundamental. Perhaps this is also true of the managers of those therapists, and that for them it is better actually to try on the client's shoes and *feel* them pinch rather than risking the self-serving illusion that all is well in a service for which you are responsible.

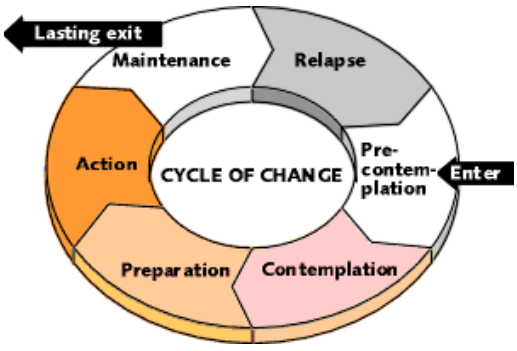
Trying on those shoes is exactly what staff did (see listing above) at 327 US services, 'walking through' their service's admissions and induction procedures as if they were a client. The process was required in the application procedure for a quality improvement programme, and the results were fed back to programme managers. An analysis of the 'walk-throughs' – which started with the first phone or other contact and extended to the early stages of treatment – showed that the role-players experienced: poor staff engagement and impersonal interactions; shortcomings in equipment, administrative procedures and premises; poorly communicated information; burdensome and repetitive processes and paperwork, including lengthy intake interviews focused not on the client's needs, but those of the agency; and failure to provide for clients with complex lives and problems. Extended to another twelve US areas, walk-throughs by senior staff became the key tactic for the strand of the quality improvement programme intended to identify service delivery problems and improve clinical procedures.

All three original articles in the entry listed above are freely available, in the case of the first two via the 'alternative source' link in the Effectiveness Bank analyses, part of the article reference towards the top. Also freely available is practical guidance (1 2) on how to do a walk-through.

These reports offer abundant evidence that as part of a broader improvement programme, leaving the office and 'becoming' a patient opens eyes to shortcomings previously invisible to management and fosters improved procedures, streamlining admissions and retaining patients for longer. That is why it features so strongly in the US quality improvement resource listed above.

It seems a valuable exercise, but can you think of any circumstances in which it might be counterproductive? Wouldn't it be better to systematically gather feedback on how *real* patients experience treatment procedures? What about true 'mystery shopping' – engaging an outsider to act the part of a client and to feed back the results. After all, in walk-throughs staff know what is happening and usually too will know the staff doing the role plays. Look at the US guidance (1 2) on how to do a walk-through. Is this how you would do it at your service?

▸ **Match interventions to the client's 'stage of change'?** Prochaska and DiClemente's ubiquitous 'stage of change' model seems to offer managers a scientific system staff can follow to decide how to work with patients, avoiding wasteful change attempts with those not yet ready to change, a rationale for instead nudging them to the next more receptive stage, and a way to recognise when someone is ready to commit to the changes needed to overcome their substance use problems. Implicitly or explicitly, in services across the UK this system is used to categorise patients and clarify how to efficiently promote progression to sustained recovery. Its simplicity is beguiling, but can it really be used to *generate* change by matching patients to interventions, or does it simply *describe* one type of change process? Should managers promote or discourage its use?



Analysed in an Effectiveness Bank review and hot topic listed above, the model portrays motivational transition as a fixed, segmented sequence leading from 'No acknowledged problem' through to 'No problem now.' In between are stages where change is pondered, prepared for, implemented and stabilised. Among its attractions is the feeling that one has gained insight into something important, technical and scientifically valid, yet which accords with common sense understandings. It seems self-evident that it is no use trying to close the deal on a change plan if the client has yet to see the need for change, and that overcoming dependent substance use is no quick fix, but sequentially requires awareness, thought, preparation, implementation and stabilisation, each stage of which must be completed to provide a foundation on which the next stage can build with a chance of success, and it feels more scientific and precise to talk of someone being in 'precontemplation' with its objective criteria, than to say, 'S/he just doesn't seem ready to stop'.

The model amounts to a broad guide to what (not) to do with patients at different stages of change. If it truly gets to the heart of the change process, then interventions built on the model ought to improve on those which are not. It is at this crunch point, when it actively engages with change through treatment, that research support is almost entirely lacking. That is true not just of drug and alcohol problems and of smoking, but of therapy for psychological problems in general. Read our review and you will understand why the American Psychological Association (APA) could only say matching interventions to stage of change was "probably effective" – and even "probably" seems optimistic. In contrast, the APA could be much more definite about matching to other patient characteristics: patient preferences (discussed below); the patient's resistance to change or being directed; culture; and religion/spirituality. The stages of change model has, however, been very widely applied, and in other fields (promoting exercise seems an example) it may be better supported.

Another problem for the model is it cannot account for precipitous, unplanned transitions to abstinence which defy the requirement to pass through the stages. Though of great importance in the overcoming of problem substance use, these are beyond the model's remit, which is confined to *intentional* change. Unfold text for more.

Supplementary text Click to close

Precipitous, unplanned change (typically from excess to abstinence) seems common and the changes are often enduring, yet these events defy the requirement to pass through the stages hypothesised by the cycle of change model. There can also seem no sign of the model's change mechanisms – the expected process of the user re-evaluating the pros and cons of continuing as they are, until so decisively do the cons outweigh the pros, that with sufficient confidence in their ability to change ('self-efficacy') along with other burgeoning 'processes of change', the decision is made, plans laid, carried out and sustained. When this process *is* intentional, the model offers a detailed and possibly valid description. But what of when a smoker suddenly becomes disgusted with their smoking, spits out the cigarette half way through, dumps the remnants of the packet in a bin, and never turns back, as if something had *overtaken* them, rather than them intentionally deciding to change? Intentional change is not the only or it seems the most robust way people initiate change. For smoking in particular, it may be a minority route, and one half as likely to 'stick' as planned attempts. Similarly in California, a survey of problem drinkers found that weighing the pros and cons of drinking as a reason for cutting down was much less likely to lead to lasting remission than 'conversion' experiences like hitting rock bottom, a traumatic event, or experiencing a religious or spiritual awakening.

Unplanned and famously successful drinking cessation events have been documented (free source at time of writing) by recovery analyst and advocate William White. They include that of Bill Wilson, who went on to co-found Alcoholics Anonymous. Hospitalised for the fourth time for alcohol detoxification, "he cried, 'If there is a God, let Him show Himself!', the room became ablaze with light and Wilson was overwhelmed by a Presence and a vision of being at the summit of a mountain where a spirit wind blew through him, leaving the thought, 'You are a free man.' Wilson never took another drink." In less florid manifestations, that also seems a common kind of experience among dependent drinker in treatment in Britain. In the UK Alcohol Treatment Trial (UKATT), asked what they thought had helped them overcome their dependence on drink, patients commonly described revelatory moments which precipitated wholesale transitions in how they saw drinking and drink and in their determination to change. As with smoking, in these situations half-finished bottles can simply be poured down the sink or thrown away in disgust.

That doesn't mean to say unplanned abandonment of substance use is also un-caused; at the time, the desperate Wilson was ripe for such an experience. A UK survey which confirmed that unplanned stop-smoking attempts were twice as likely to succeed as planned, also discovered these attempts were commonly triggered by health advice/concerns, expense, and pressure from family/friends, though 1 in 6 respondents could cite no particular reason. But whatever leads to this brink, at the moment of change immediate causes take the form of triggers which precipitate abstinence rather than a weighing-up of the pros and cons and a transition through stages.

Close supplementary text

Despite its limitations, there may still be reasons why the cycle of change model remains valuable, though perhaps not in its intended role of helping match interventions to stage of change. Look at the last paragraph of the Effectiveness Bank review. The author, a cogent critic, nevertheless finds many ways in which the model might be a positive influence – a kind of benevolent fiction which gives hope to and motivates both worker

and client. Is this enough? Or in the end, should we let science consign this popular prop to the 'unproven' shelf of history?

Is patient choice supreme? We return to an issue addressed in cell A2 – the role of patient choice and preferences in treatment planning. There it was in the context of advocates for certain treatment goals claiming the ethical 'high ground' of being on the side of the patients. Here instead the context is the steer service managers might give staff on eliciting and responding to patient preferences, drawing on a review listed above for evidence of whether acceding to those preferences might improve outcomes. There are no easy answers, partly because whether a treatment is safe and effective itself partly depends on the patient's preferences; a nominally safe and effective treatment may no longer be either if the patient does not comply or engage with it.

First there is a fundamental question to be settled: does addiction limit the patient's ability to make rational choices related to their drug use and its treatment to the degree that those choices must be made for them? In the end we go along with guidance offered the World Health Organization, that other than in extreme circumstances, this is an unwarranted diminution of the patient's autonomy and human rights. However, this is not a trivial or easily settled issue because definitions of dependence entail impaired self-control and decision-making. For more on this fundamental issue, unfold the supplementary text.

Close supplementary text

Some claim addiction does limit the patient's ability to make rational choices because it is a disease of the brain which undermines the ability to choose not to use the drugs which 'caused' that disease: "… repeated drug use can lead to brain changes that challenge an addicted person's self-control and interfere with their ability to resist intense urges to take drugs." A corollary is that treatment choices which affect access to drugs are also constrained, and may be relegated to the status of manifestations of the 'disease' rather than valid choices which the clinician must take fully into account.

Though it solidifies the rationale into a physical cause, you don't have to believe in the brain-disease model of addiction to believe dependence/addiction compromises choice. When it required doctors to notify patients dependent on cocaine or opioids to the Home Office, the UK's Misuse of Drugs Act defined those patients as people who "as a result of repeated administration [have] become so dependent upon the drug that he has an overwhelming desire for the administration of it to be continued". Impaired control is also a key criterion for substance use disorders in the US psychiatric classification system DSM-5, and for dependence in the European ICD-10 and its forthcoming revision, which it is planned will include substance use addictions among the "impulse control disorders".

A review of the ethics of opioid addiction treatment conducted for the World Health Organization saw the nature of addiction as "central to … what ethical treatment of opioid dependence involves", affecting views of the extent to which (prospective) patients are "able to make decisions about their drug use, consent to enter treatment, choose not to use drugs, be involved in decisions regarding their treatment, and take responsibility for their actions". The authors' view was that "drug dependent people are able to give free and informed consent so long as they are not intoxicated or suffering acute withdrawal symptoms", and have "the capacity to choose a specific treatment from the types available."

Though they stressed that patients must be involved in planning their treatment and their preferences and autonomy respected, for these experts the patient's decision in the end amounts to "consent" – a choice of whether or not to accept an offer of treatment based not necessarily on what the patient wants, but on the clinician's judgment of its likely safety and effectiveness for this particular patient.

Close supplementary text

On the basis that the patient's choices cannot be dismissed as merely manifestations of their addiction, we can turn to how those choices should be responded to. Guidance for substance use services from Public Health England says service users should be involved in their own treatment, and illustrates how this can be done. UK clinical guidelines on the treatment substance use problems seem to go further – and constitute an important yardstick for courts and tribunals in determining what constitutes lawful and acceptable medical practice.

In the guidelines 'informed consent' is the bedrock, but more active involvement is demanded: "the main role of clinicians is to assist patients in making their own, informed, choices about their treatment goals and

priorities, and to agree the actions to try to best achieve them". Treatment organisations should, say the guidelines, "ensure there is a visible positive service ethos … supporting patient choice and access to the variety of recovery paths and options". Referring to trauma-informed care, one principle was said to be that it should "support patients to make choices and take control of treatment decisions". The control these and other patients might exercise includes deciding to withdraw from opioid maintenance programmes, to opt for non-drug based treatment, determine their recovery pathway, and whether to participate in group therapy, but on other issues the patient's preferences are simply to be taken into account. Among these are which medication to use to aid withdrawal, the duration of maintenance, and how to address mental health problems alongside dependence. More generally, "Prescribing is the responsibility of the person signing the prescription" – not one they can abdicate to the patient.

The clients' influence is relegated to the elements that to them matter least

Nowhere is this more evident than in the decision on whether to prescribe heroin itself to heroin-dependent patients. Gone are the days when with a relevant drug use profile and dogged insistence, a heroin-dependent patient could in some clinics be fairly confident of being prescribed heroin. Now that preference will generally be denied, or if accepted, be trammelled with other conditions the patient would *not* prefer, such as having to attend several times a day to be dispensed and inject their prescribed heroin under clinical supervision. They and other patients who would prefer not to have to take medication under supervision will often find their preferences subjugated to clinical guidelines and safety-first principles. When in 1999 and 2001 a London clinic surveyed its patients' satisfaction levels, the researcher admitted that:

> "how far the clinic could/would move to satisfy clients' desires was constrained by national guidelines and professional standards on issues such as supervised consumption, daily pick-up of prescriptions, and the prescribing of injectables. Agencies and doctors are not prepared to risk being pilloried for transgressing these 'guidelines' if something goes wrong. Though they can express an opinion on whatever they like, the clients' influence is effectively relegated to the elements of the service that for most probably matter least. For the rest, a central authority has already decided (perhaps rightly) what is best for them."

Decisions such as those on supervising consumption, on dose levels, and on leaving treatment, are potentially life and death decisions which no responsible practitioner could leave up to the patient. Even when studies have allowed methadone patients to select their own dose, this has been done within rules set by the clinic to ensure safety. But clinicians also have to consider that a treatment which in theory is safe and effective cannot be either if unacceptable to the patient. A patient who rejects opioid substitute prescribing treatment because in the interests of safety it requires supervised consumption and witnessed urine testing will probably be less safe with no treatment than with treatment shorn of these elements.

Ethical considerations are bound up not just with offering safe, but also effective treatment. If acceding to patients' wishes improves effectiveness, that in turn strengthens the ethical case to provide the treatment they want, since offering effective treatment is an ethical requirement. Across psychotherapy, evidence on effectiveness is strongly in favour of patients and therapists collaboratively agreeing goals and how they will go about reaching them, and underscores the centrality of incorporating patient preferences when making treatment decisions. In relation to substance use treatment in particular, a review listed above found the evidence on whether matching treatment to the patient's preferences improves outcomes was equivocal, opting instead to recommend that patients be involved in treatment decisions via shared decision-making.

For more read our hot topic on patient involvement, our commentary on the review listed above, and the ethical arguments rehearsed for the World Health Organization's opioid prescribing guidelines. You will then be well equipped to consider what weight your own and other services should give to patient choices and preferences, whether this weight changes in respect of different types of decisions, and whether if acceptably safe, feasible and likely to prove effective, the presumption should be in favour of providing treatment in line with the patient's informed choice. Another stance – one many patients may endorse – is that they have come to a specialist service to take advantage of its concentrated expertise, and it is expected that the service will rule in some options and rule out others, and sometimes strongly argue for treatments in the face of the patient's less well-informed, and perhaps more ambivalent, wishes.

Along the way you may also consider that by definition an addicted patient persists in doing something harmful which they wish to stop doing but can't, and that this failure to do what is best for them may also extend to their preferences for treatment. An alternative argument advanced by some is that the very fact that someone has come forward for treatment means they have transcended their loss of control and started to get

a grip on their own destiny which should be nurtured, not co-opted by the clinician. Moving up a level, are these kinds of issues susceptible to management policymaking, or should management step back and let the dialogue between practitioner and patient take its natural course?

What use is assessment … without some way to act on the results? With admirable simplicity, a US study listed above developed a computerised index of local services keyed in to the needs revealed by assessment. It transformed the assessment from redundant but required paperwork in to a practical route to the services seen today as important to holistic and sustainable recovery – and twice as many patients completed treatment. If you work in treatment, do you have such a system, is it easy to use, is it hard for counsellors to ignore, and is it used? If you have no such system, would it work in your service?

This is a rare study of the neglected assessment process – an unfortunate neglect because research has backed up the common view that assessment is not a just a preparation for but the start of treatment, and the start of building a therapeutic alliance.

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