DRUG & ALCOHOL FINDINGS *Matrix cell*

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Alcohol Treatment Matrix cell B3

Practitioners; Medical treatment

The most important seminal and key studies and reviews shedding light on the impact of the practitioner in medical interventions and treatment for alcohol problems in medical settings.

S Seminal studies **K** Key studies **R** Reviews **G** Guidance **MORE** Search for more studies

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S Patients engage better with treatment when clinicians are committed to working with them (1996). See also related paper from same study (1996). Assessment staff at an English alcohol treatment clinic differed greatly in how many of their patients went on to engage with treatment; how committed the staff were to working with a client ('therapeutic commitment') was related to both therapeutic relationships and engagement, probably because clients experienced uncommitted workers as 'cold' and the committed as 'warm'. Later studies (1980) from the same team found commitment depended on workplace support for dealing with drink problems. Related study below. For discussions click here and here and scroll down to highlighted headings.

S It's the way you say it (1970). Final step of a remarkable series of studies from the late 1950s found that the warmth and concern a doctor expressed towards alcoholics in general was strongly related to whether at a US emergency department a year before their patients had followed through on the same doctor's referral to the hospital's alcohol treatment clinic. Related study above. For discussions click here and here and scroll down to highlighted headings.

K Patients progress better with optimistic doctors who flexibly respond to their needs (2008). Analysis confined to the arms of the US COMBINE alcohol treatment trial providing medical care which included medications but not psychosocial therapy. What made the difference to patients' drinking and clinical progress seemed to be how far the clinician maintained confident optimism and responded to the patient rather than strictly adhering to a treatment manual. For discussions click here and here and scroll down to highlighted headings.

K Patients do best when they feel GPs know them and communicate well (2007; free source at time of writing). US patients referred to primary care after detoxification reduced alcohol problems most when they saw doctors they trusted, they felt knew them as a whole person, and who probed/communicated thoroughly and well. For discussion click and scroll down to highlighted heading.

R Ability to forge positive relationships with patients accounts for clinicians' impact on treatment quality (2000; free source at the time of writing). Assessed whether retention and substance use were related to the clinician's professional status, personal experience of addiction, adherence to protocols, relationships with patients, personality, beliefs about treatment, and professional practice issues. Found clinicians vary greatly in their performance but that "past assumptions that levels of training, experience, or other simple therapist variables could account for such differences does not hold". More important were ability to build positive relationships with patients. For discussion click and scroll down to highlighted heading.

R Above all, don't do the *wrong* thing (2015; free source at the time of writing). Across health care in general, doctor-patient interactions that are invalidating (do not successfully communicate acceptance and understanding) damage relationships more powerfully than positive communications cement them. More on the importance of *not* doing the wrong things in cell B2. For discussion click here and scroll down to highlighted heading.

G What UK doctors should do and be able to do ([UK] Royal College of Psychiatrists and Royal College of General Practitioners, 2012). Guidance from UK professional associations for GPs and for psychiatrists on the competencies, training and qualifications expected of doctors involved in caring for substance users, from generalists such as doctors in emergency departments and general practitioners to addiction specialists. For related discussion click and scroll down to highlighted heading.

G What UK specialist addiction doctors should do and be able to do ([UK] Public Health England, Royal College of Psychiatrists and Royal College of General Practitioners, 2014). Guidance from body overseeing addiction treatment in England and from professional associations for GPs and for psychiatrists on the "essential functions which can usually only be carried out by addiction specialist doctors" and the importance of retaining their expertise in the sector.

G What US specialist addiction doctors should do and be able to do ([US] American Society of Addiction Medicine, 2014). Consensus guidelines from the US professional association for doctors who specialise in treating addiction on what they are expected to do and the standards they should meet throughout treatment from assessment to aftercare. For related discussion click and scroll down to highlighted heading.

G Competencies for working with co-occurring substance use and mental health problems (2019). From Clinks, a

national charity supporting voluntary organisations in the criminal justice system in England and Wales, and developed through Public Health England based on their related guidance. Advice on the values, knowledge and skills required for effective care of people whose substance use problems are complicated by poor mental health. Informed by patients who emphasised the "importance of workers' personal qualities and behaviour and how vital the workers' characteristics were to an individual's recovery journey".

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What is this cell about? About the treatment of alcohol dependence in a medical context and/or involving medical care, typically by GPs or at alcohol treatment or psychiatric units in hospitals. Clinical staff are responsible for medications, so the centrality of these to an intervention distinguishes it most clearly as medical. However, medications are never all there is to medical care and most treatments do not feature them. Though almost universally used to ease withdrawal in inpatient units, in 2018/19 in England just 19% of the 73,556 'alcohol-only' patients being treated in the community were prescribed an anti-alcohol medication. Narrowing in on primary care – the only identifiably medical setting – it was 47%, still just under half. Typically guidelines see psychosocial support as an essential component of treatment, and 'medical' treatment may consist entirely of advice and psychosocial support from clinicians.

Apparent also in the studies set in hospital treatment units listed in cell B2, how clinicians relate to patients affects whether they enter (study listed above) and engage (study listed above) in treatment. The clinician-patient relationship may also be a therapeutic – or possibly anti-therapeutic – influence in its own right.

Even when medications are prescribed, the clinician-patient relationship remains critical. Effective prescribing requires the collaboration of the patient to stay in and complete treatment, to help select the appropriate medication and dose, and to help monitor the need for changes by disclosing their use or non-use of the medication, how they have reacted to it, and their drinking or drug use. Good relationships also promote the provision of broader psychological, social and practical support, which can improve substance outcomes.

Through these mechanisms, relationships ultimately affect the degree to which treatment helps patients overcome (study listed above) their drinking problems, and feature among the reasons why in medical care in general, " 'talk is the main ingredient … and it is the fundamental instrument by which the doctor-patient relationship is crafted and by which therapeutic goals are achieved'. From this viewpoint, a good interpersonal relationship can be regarded as a prerequisite for optimal medical care."

Pinning down the impact of these influences is much harder than for medications or other specific interventions. To set the scene for randomised trials, researchers can ensure some patients get treatment x, and others treatment y or no treatment at all. The relationship-forming qualities of treatment staff are not so easily controlled. Rather than deliberately allocating patients to workers known to differ along these dimensions, studies often have to rely on associations observed in everyday practice between outcomes and relationship quality or staff attributes, or links which emerge as a by-product of a trial organised for another purpose. Typically the most that can be said is that the findings are *consistent* with these qualities affecting outcomes, not that they actually *did*. Such research designs cannot eliminate the possibilities that clinicians are reacting to the patient's progress rather than causing it, that patients differed from the start, or that the clinician's behaviour and the patient's progress are both related to other factors. However, difficulty in demonstrating to scientific standards that something is true, does not mean it is *un*true. Observations and patient feedback testifying to the role of the clinician-patient relationship are persuasive, if not definitive, evidence.

Where should I start? With this freely available review listed above, still a valuable introduction to the issues. It systematically runs through evidence on the possible reasons why patients do better with one clinician than another. The reviewers comment that such effects often emerge from studies not designed to find them, sometimes being strong enough to surface through the study's attempt to eliminate 'extraneous' influences. Relative neglect by research is contrasted with the everyday experience of front-line clinicians, managers and patients, for whom it is "obvious … that some practitioners are highly regarded whereas others are avoided". The reviewed research reveals that "clinicians typically account for more [of the difference] in patient outcomes than do differences between active treatments or patients' baseline characteristics".

> *It is obvious that some practitioners are highly regarded whereas others are avoided*

If clinicians are important, the next question is, 'Why?' – one the rest of this 'bite' addresses more fully. The review examined research relating retention and substance use outcomes to (among other potential influences) the professional status of the clinician, their personal experience of addiction, their adherence to protocols, emotional reactions to patients,

personalities, beliefs about treatment, and interpersonal functioning. What did *not* account for differences in clinicians' impacts were professional characteristics, including qualifications and whether they were former problem substance users. According to the reviewers, instead the most consistent influence has been clinician's ability to build positive relationships with patients, one best identified in practice: "Select and evaluate clinicians based on their 'track record' … assumptions that levels of training, experience, or other simple therapist variables could account for such differences does not hold. Selecting and evaluating clinicians based on how they actually perform, using standardised measures, is rarely done but is an effort that could greatly improve the quality of care."

Highlighted study Mount Zeehan alcohol treatment unit in Kent was the site for a seminal British study listed above of patients starting treatment in 1990/91 and the nurses who assessed them. Though all six nurses were experienced and well trained and supported, at one extreme fewer than a fifth of the patients they assessed went on to engage with treatment, at the other, over three-quarters. Whether a patient engaged with treatment was strongly related to how the nurse felt about them. Their 'therapeutic commitment' to the patient was comprehensively measured after each assessment, but in practice responses to just two of the 24 questions they were asked were sufficient to predict the engagement of over two-thirds of the clients. If workers agreed with, "I like this client," but disagreed with, "The best I can offer to this client is referral to somebody else," patients were highly likely to engage. In turn the worker's commitment to them and to participating in their recovery seemed to affect the patient's experience of the assessment and the assessor. When answers to the two key questions indicated therapeutic commitment, "the client was more likely to report that they felt respected and at ease with an interviewer who liked them, who was friendly and honest … There is a strong sense that clients experience committed interviewers as interpersonally warm and less committed ones as interpersonally cold."

> *Alan Cartwright argued that the patient was actually assessing the assessor*

Interpreting this data in the light of patients' comments, Alan Cartwright and colleagues argued that the patient was actually assessing the worker, and that their main concern was, "How does the worker see me? Does the worker like me? Do they accept me? Are they critical of me?" Arriving at the clinic in a fragile state with low self-esteem, their sensors were tuned to recognise signs of rejection. When rejection was sensed, they tended to reject back by not engaging with treatment. Though these specialist workers could be expected to be committed to working with alcoholics in general, still about a third of their clients did not feel sufficiently accepted or understood. What seemed to be happening was that some workers were more able than others to maintain a sense of commitment when clients were resistant or 'difficult'. Even in the face of a client seemingly rejecting their efforts, they could continue to convey warmth, acceptance and understanding, and convince the client that they still genuinely wanted to work with them.

There is a striking parallel with the implications explored below of the US COMBINE study listed above. Its findings were interpreted as showing that a clinician's ability to credibly convey optimism in the face of discouraging news from the patient was instrumental in reducing drinking. The themes of patients "sensitized to rejection" and the disarming interpersonal warmth of clincians were also central to a seminal US study listed above. It found emergency doctors' responses to the question, "What has been your experience with alcoholics?" were closely related to how many of their alcohol-dependent patients had a year before followed through on a referral to the treatment clinic. The more a doctor had evidenced personal (rather than coldly professional) concern in tone as well as words, the more likely their former patients had been to treat the emergency unit encounter as the start of a treatment relationship they wished to continue.

Issues to consider and discuss

▸ **How much is down to workplace leadership and context?** The studies highlighted in the section above revealed the influence of the relationship style of the doctors and nurses – how they 'treated' patients in the colloquial sense of the word and their "therapeutic commitment" to the individual. Later Alan Cartwright and colleagues responsible for the British studies found that as a general predisposition, commitment itself was not (or not just) an inherent trait of the practitioner or generated by their interactions with individual patients, but was influenced by management and workplace culture.

Listed above, their earlier study had been set in a specialist alcohol treatment unit, so all the clinicians had a workplace supportive of working with drinkers. With no variation in workplace environment, each clinician's therapeutic commitment to each individual patient emerged as the overriding influence on

patients' engagement with treatment. In contrast, the later studies (also listed above) involved practitioners working in a range of specialist and non-specialist settings. Now it became clear that therapeutic commitment itself depended on whether the workplace engendered the feeling that dealing with drink problems was a legitimate and supported activity.

The influence of workplace culture and management also became visible in a seminal US study listed above, this time by determining whether differences between clinicians could emerge as an influence on engagement with treatment. Cell A2's 'bite' commentary described how a new management transformed attendance at Massachusetts General Hospital's alcohol treatment unit by deploying specialist 'treatment catalyst' staff trained to show unwavering respect and warmth to alcoholic patients seen in the hospital's emergency department. In the follow-up study described in the preceding section, only among patients *not* allocated to this new regimen were the attitudes to 'alcoholics' expressed by emergency doctors related to whether their patients had accepted a referral to the alcohol treatment unit. Among the other patients, it seemed that the innovations introduced by a new-broom management had overshadowed the influence of each individual clinician.

▸ **What are the attributes of effective clinicians?** First thing to say is that to a degree effectiveness can be generated and sustained by management and workplace culture (see section above), not just found as a natural quality. But we know too that no matter how rigorous the training or how supportive the workplace, clinicians may still substantially differ in how well they promote substance use reductions and other desired outcomes.

What accounts for these differences was the subject of a review listed above, selected for the "Where should I start?" section. It highlighted the clinician's ability to build a positive relationship with patients as the factor most consistently found to relate to differences in outcomes, and advised that this be identified via the clinician's record with actual patients.

How clinicians relate to patients is central to the 'placebo effect' and the 'common factors' found to account for the greatest part of the impacts of addiction treatments. In cell A3's bite it was argued that even when medications are prescribed, "The placebo effect is the main active ingredient," and that this effect is driven partly by the how the clinician relates to the patient.

An example emerged in the US COMBINE trial of medical care allied with pharmacotherapy. Listed above, the substudy which found these effects was confined to the arms of the trial in which patients were not additionally offered psychotherapy, leaving the medical clinician as the main source of psychosocial support. An analysis of recorded consultations with patients highlighted the clinician's ability to instil confidence in the treatment, and especially their ability to credibly convey optimism about recovery even in the face of discouraging news from the patient. Allied (and only when allied) with a flexible approach to delivering the medical care programme, patients seen by these clinicians less often drank at all and less often drank heavily than other patients.

Already noted above in the "Highlighted study" section is the parallel between these findings and the implications of a seminal British study. It suggested that during patient assessments at an alcohol clinic, what made the difference to whether patients engaged with the treatment on offer was whether workers maintained acceptance, warmth, understanding and optimism even when clients were resistant to changing their drinking.

In the US COMBINE substudy the conclusion was that "some flexibility in delivering Medical Management, based on good clinical judgment and in conjunction with optimism and hope for recovery, supports better outcomes". In line with the findings of a comprehensive review listed above, the clinician's level of professional training bore no relationship to outcomes. Relationship factors also emerged in another US study (listed above), but this time based on the patient's perceptions rather than observations made by the researchers. For more on this study unfold the supplementary text.

> Close supplementary text
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> Conducted in Boston, the study trialled an intervention to link inpatients detoxified from alcohol or other drugs to follow-on primary care after discharge. Its main findings were that the intervention worked as a linkage mechanism, but did not as a result affect substance use outcomes. The researchers reasoned that the quality of that care might have been a factor. For this substudy, only patients who actually attended primary care practices after discharge were included. They were interviewed to assess their perspectives on the care they had received, and their responses were related to substance use at least six months later.
>
> Among patients for whom alcohol was their first or second substance of choice, reductions in severity

of drinking were associated with nearly all the variables constituting quality in primary care. Strongest links were with the thoroughness of assessment, ability to listen and communicate, patience, friendliness, caring, and respect, and knowledge of the patient both as a patient and as a person. On the face of it, it seemed that these severely dependent and economically deprived patients were responding well to doctors who evidenced their concern for the patients both in the thoroughness of their work and in their attitudes. However, the potential for such results to be due to other factors (warned about in the "What is this cell about?" section above) cannot be ignored. For example, in this study patients who were going to do well anyway and were most cooperative may also have seen their doctors through rather rose-tinted spectacles. In this scenario, their perceptions of the doctors would not be a causal factor in their recovery, but a by-product of what truly did advance their progress. Set against this is the fact that measures of how well patients did do were taken well after the consultations on the basis of which they had formed their impressions of the doctors.

Close supplementary text

While we have focused so far on the positive, it is perhaps even more clear that negative behaviour from clinicians has a destructive impact. In cell A2 we theorised that once would-be patients seek to pass through the doors to treatment, doing the right things help, but what is critical is to *avoid* obstructing the process started by the patient by, for example, confrontationally provoking resistance or being judgemental. Such impacts have been demonstrated most clearly among risky drinkers intercepted by screening programmes. The impact of brief interventions to moderate their drinking can it seems be scuppered by just one or two instances of practitioners expressing the non-collaborative stance of someone who knows best, and is therefore in a position to confront, warn, direct, or advise the drinker. Those findings may not be duplicated in treatment studies where the patient has implicitly given permission for the clinician to 'treat' them, but in medicine generally, comments patients see as 'invalidating', like being dismissed or not taken seriously, have a detrimental impact thought to be greater (review listed above) than the positive impact of validating comments.

By now you may be thinking, but surely for doctors and nurses, technical knowledge too is critical? A patient may not die (or not immediately – they might in the longer run if deterred from treatment) from being cold-shouldered, but they could die if mistakes are made in prescribing medications or co-occurring illnesses remain undiagnosed. Indeed, British and US guidelines listed above (1; 2) focus on these technical aspects, largely (but not entirely) ignoring relationship quality and the instilling of hope and confidence in patients. One possible explanation for why relationship factors emerge as the dominant influence in research is that trials cannot afford to endanger participants by allowing technically sub-standard doctors and nurses to treat them. Typically clinicians are highly selected and well-trained and supervised. What remains is variation in what is less easily controlled by researchers – how well the clinicians relate to their patients.

Close Matrix Bite