DRUG & ALCOHOL FINDINGS *Matrix cell*

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Alcohol Treatment Matrix cell C4

Management/supervision; Psychosocial therapies

Seminal and key studies on management and supervision in psychosocial therapies. Focus is on evidence of the need for post-training 'coaching' and for letting therapists know how their clients are doing – especially when they are doing badly.

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

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

S No need to insist on abstinence; patients can choose their (non-)drinking goals (1973). Not the first but the most incendiary paper to challenge the then orthodoxy that abstinence must be the only treatment goal for dependent drinkers. See also second- (1976) and third-year (1978) follow-up results. A refutation (1982) based on a 10-year follow-up was itself refuted (1984) by the original authors. Related contemporary UK study, review and guidance below. Discussion in cell C2.

S Key management task: recruiting the right people (1981). US study showed that responses to written counselling scenarios could be used to assess the interpersonal skills of alcohol counsellors, which were strongly linked to their patients' post-treatment relapse. Study was later replicated/extended in Finland (2002). Related study and review below. For discussion see cell C2.

S Target-setting and feedback to counsellors improves client engagement (1991; alternative source; article starts on page 204 as printed). Client engagement in non-residential counselling and therapy was improved by setting engagement targets plus feedback to counsellors against those targets, while retention was promoted by seeing the same key worker in residential and follow-on non-residential phases of treatment. Related study and guidance below. For discussion click and scroll down to highlighted heading.

K No clear advantage in UK from choosing abstinent versus non-abstinent treatment goals (2010). Britain's largest alcohol treatment trial (known as UKATT) primarily aimed to compare social network and motivational therapies, but also shed light on whether services should offer moderation as well as abstinence goals to dependent patients. With no clear lasting advantage for either on drink-related measures, 'Let the patient choose' seems the implication of the findings. More from UKATT below and in cell A4. Related seminal study above and review and guidance below. Discussion in cell C2.

K Screening applicant therapists for empathy saves on training (2005; free source at time of writing). The research team behind the large US COMBINE alcohol treatment trial (of which more on its medical treatments in cell A3 and psychosocial in cell A4) saved on training by using responses to simulated clients to screen candidate therapists for "accurate empathy". Same method could help services spot people with the hard-to-teach (2006) ability to form good relationships with clients. Related study above and review below. Discussion of empathy in cell B2 and of staff recruitment in cell C2.

K Gaining competence in cognitive-behavioural therapy requires more than just studying the manual (2005; free source at time of writing). After being told to 'read the manual' and practice its guidance on cognitive-behavioural therapy (and doing so for on average nine hours), just 15% of substance use counsellors and clinicians who volunteered for this US study were acceptably competent. Adding web-based training comparing performance in role-plays to the ideal helped, but greater and more consistent gains were made by adding a training seminar subsequently reinforced by expert coaching based on taped sessions with real clients. Counsellors with personal experience of problem substance use (presumed likely to be 12-step adherents and least familiar with formal therapies) benefited most from the addition of coaching. Related motivational interviewing study and reviews (1 2) below. For discussion click and scroll down to highlighted heading.

K Coaching helps counsellors learn to motivate (2004; free source at time of writing). How clients responded to trainees during counselling sessions improved only when motivational interviewing workshops had been reinforced by expert coaching and feedback on performance. See also report from the same study suggesting that the important quality of seeming genuine can suffer if training mandates withholding natural responses. Related cognitive-behavioural study above and reviews (1 2 3) below. For discussion click and scroll down to highlighted heading.

K Seven coaching sessions needed before UK therapists competent (2005). The UKATT trial compared social network and motivational therapies for alcohol-dependent patients, in the process developing comprehensive models for recruitment, training and supervision. One lesson was that "supervision after initial training was critical in the acquisition of competence". Despite often being conducted by phone, it added substantially to training costs. More

from UKATT above and in cell A4. Related review below. For discussion click and scroll down to highlighted heading.

K Assess how well clients are doing and tell their counsellors (2012). To maximally improve outcomes feedback to counsellors needs to identify which of their clients are doing poorly and recommend remedial actions. The same feedback system has been found beneficial across psychotherapy (1; 2; 3, free source at time of writing). Related study above and guidance below. For discussion click and scroll down to highlighted heading.

K Leaders set the context for training to be implemented (2012). Whether substance use counsellors initiate and spread training-based practice improvements is strongly influenced by the ethos and support stemming from an organisation's leadership, especially the degree to which it fosters professional development. Similar findings in review below. For discussion click and scroll down to highlighted heading.

K Take a walk in the client's shoes (2008). When senior staff role-played the process of becoming a new client it helped halve waiting times and extend retention at substance use counselling and residential services. See also report on an extension (2012) to the programme and an account (2007; free source at time of writing) of the 'walk-through' procedure. Discussion in cell C2.

K No lasting benefit from therapist input supplementing computerised programme (2019; free source at time of writing). In Sweden whether therapists supplemented an internet-based treatment programme with personal support via messaging two to three times a week did not significantly alter drinking outcomes six months after the trial started, though there were signs that the support did help while it lasted. Both treatments were superior to merely being placed on the waiting list for the programme.

R Offer moderation as well as abstinence as a treatment goal (2013). Concludes that dependent drinkers can drink more moderately, that psychosocial treatments based on this goal are probably just as effective as abstinence-oriented approaches, and that allowing patients a choice improves outcomes. Related seminal study and UK study above and guidance below. Discussion in cell C2.

R One-off workshop training is not enough (2005). Review spanning basic counselling and more complex psychosocial therapies in the treatment of problem substance use found that retaining skills after workshop training requires follow-up consultation, supervision or feedback. Also, " Studies which compared trainees' perceptions with observers' ratings of their interactions with clients uniformly found trainees overestimated their skills." Related studies (1 2 3) above and reviews (1 2 3) below. For discussion click and scroll down to highlighted heading.

R Motivational interviewing training works best with post-workshop coaching (2013). Synthesis of findings on training clinicians (broadly defined and not limited to those working with problem substance use) in motivational interviewing finds it does develop competence, especially when supplemented by coaching/supervision based on feeding back trainees' actual performance. Given motivated trainees, initial training can be via books or videos rather than face-to-face workshops. Related review and studies (1 2) above and reviews (1 2) below. For discussion click and scroll down to highlighted heading.

R Sustaining motivational interviewing skills after training (2014; free source at time of writing). Studies mainly but not only of substance use treatment show that retaining competence in motivational interviewing after training requires follow-up feedback and/or coaching – at least three to four sessions over a six-month period. Just offering these is not enough; trainees have to attend. Related studies (1 2) and reviews (1 2) above and review below. For discussion click and scroll down to highlighted heading.

R The importance of supervision (2011). Systematic and expert continuing supervision emerged as a key to newly introduced psychosocial treatments actually improving practice and outcomes in specialist substance use treatment settings. Implementation was more likely if supported or mandated by agency leaders or supervisors. Despite best efforts, "what was striking was that trainees whose attitudes to treatment were not conducive to adopting a motivational approach benefited relatively little even from the extended training and supervision". In respect of motivational interviewing, studies were available which showed that the accounts of treatment providers and therapists themselves bore little relation to how well therapists actually conducted new interventions. Related studies (1 2 3 4 5) and reviews (1 2 3) above. For discussions click here and here scroll down to highlighted headings.

R Let motivational counsellors adapt to the client (2005). Effectiveness Bank review and a synthesis of the research (2005) find inflexible manualisation of motivational approaches associated with worse outcomes. For related discussion click and scroll down to highlighted heading.

R Implementation lessons from trials of psychosocial therapies (2007; free source at time of writing). This single review covers many of the issues management faces in trying to implement evidence-based practice. Concludes that research has demonstrated the importance of therapist selection and post-training supervision, and the pitfalls of assuming researched interventions will translate into routine practice and of relying on a therapist's own assessment of their competence. Ten years later and focusing on cognitive-behavioural approaches, the same lead author effectively updated (2017; free source at time of writing) aspects of the earlier essay. For discussion of this review click here and for a related discussion here, then scroll down to highlighted headings.

G UK guidance on choosing treatment goal ([UK] Department of Health and National Treatment Agency for Substance Misuse, 2006). Guidance on models of care for problem drinkers stressed that whatever their goals it should not exclude them from support or treatment, but saw abstinence as the preferred objective for many moderately or severely dependent drinkers. Related seminal study, contemporary UK study, and review above. Related discussion in cell C2

G Clinical supervision and professional development of substance use counsellors ([US] Substance Abuse and Mental Health Services Administration, 2009). Intended be the focus of a series of six or so meetings in which the contents would be reviewed, discussed, and in other ways used as an educational and training vehicle for the improvement of clinical supervision skills. Related guidance below. For related discussion click and scroll down to highlighted heading.

G Skills and abilities for clinical supervision ([US] Substance Abuse and Mental Health Services Administration, 2012). Competencies needed for effective clinical supervision in substance use disorder treatment. Includes a step-by-step guide to implementing comprehensive supervisory training and workforce development. See also US checklist of competencies (2017; described here) for people with personal experience of substance use problems engaged in supervising people with similar experience who are supporting patients or clients. Related guidance above. For related discussions click here and here and scroll down to highlighted headings.

G How to use client progress measures in counsellor supervision (2014; free source at time of writing). Thoughtful suggestions on how clinical supervision of therapists and counsellors can promote staff development by incorporating discussion of measures of how well their clients are progressing. Not specific to substance use but applicable across therapy and counselling. Related seminal and key studies above.

G Staff selection, training and supervision for group substance use therapy ([US] Substance Abuse and Mental Health Services Administration, 2005). Consensus guidance on the different types of groups, how to organise and lead them, desirable staff attributes, and staff training and supervision. Related guidance below.

G Training and supervising addiction counsellors to deliver group cognitive-behavioural therapy (2013; free source at time of writing). Based on experience in US addiction treatment settings in developing and evaluating group cognitive-behavioural therapy programmes for depression and substance use. Related guidance above.

MORE Search for all relevant Effectiveness Bank analyses or search more specifically at the subject search page. See also hot topics on individualising treatment, staffing treatment services, holistic service delivery, matching treatment to the patient, and whether dependent drinkers should always be encouraged or required to try for abstinence.

Last revised 05 November 2020. First uploaded 22 March 2014

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What is this cell about? Every treatment involves direct or indirect human interaction, but this cell is about the management of interventions in which that interaction is *intended* to be the main active ingredient – 'psychosocial' or 'talking' therapies.

Based on varied understandings of how dependence arises and how it can be overcome, these interventions attempt to change the patient's behaviour directly by 'shaping' it through rewards and sanctions, or indirectly via changes in their beliefs and attitudes, how they relate to others, and how others relate to them. Programmes range in form from brief advice and counselling to extended outpatient therapies and all-embracing residential communities where clients stay for months.

Differences between psychosocial therapies have been tested and contested and occupied the lion's share of research time, but as long as it is a well structured intervention which 'makes sense' to patient and therapist, the 'common factors' shared by supposedly distinct therapies (on which see cell A4) seem more critical to their success.

Explored in the preceding cells of this row of the matrix, the content and approach of these therapies and the qualities of the staff delivering them matter of course, but so too do the management functions of selecting, training and managing staff, and managing the service's interventions, including setting treatment goals and deciding which types of patients are offered which types of therapies. 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 staff are able to develop, maintain and improve competence, depend on management and supervision – functions at the heart of the current cell.

Where should I start? With an essay listed above which touched many of the bases found scattered among other listed reviews and studies. It was led by Kathleen Carroll, a clinical psychologist and researcher and professor of psychiatry at the USA's Yale university, who has done much to advance understanding of psychosocial treatments in the addictions. She had teamed up with Bruce Rounsaville, another eminent researcher, to stand back to take a broad view over what is known about whether and how interventions supported by research (termed "empirically supported therapies") find their way into practice. Think of it as two researchers who have spent working lives generating empirically supported therapies bravely questioning what it's all been for. Based on a lecture delivered in 2005, the article is relatively easy reading, and there is a free source. Here we pick out some main themes relating to this cell's agenda.

> *Think of it as two researchers bravely questioning what it's all been for*

The essay squarely addressed the "implementation gap" between research and practice: "Now that we have all these [empirically supported therapies], what should we do with them? … What do we need to know about [their] efficacy, value, and transferability … into clinical practice?" Despite there being many evidenced therapies, "the majority of treatment programs in the United States remain grounded in traditional counseling models that have largely not been evaluated rigorously [and] many … persist in their use of interventions and strategies that have been demonstrated to be ineffective … and even some that may be harmful to some populations". Training and monitoring of the performance of clinicians was also lacking or rudimentary – all features identifiable in the UK.

Despite advances, research too has its gaps, leaving questions of intense interest to clinicians unanswered: Are these therapies really any better than my routine practice? Which should I use for which type of client? What do I do when they fail? Some important questions can however be answered. For this expert duo, the research we do have supports the contention that motivational interviewing and/or cognitive-behavioural therapy are broadly applicable and feasible starting points for treatment in non-residential settings, to be followed by more intensive and costly interventions if "objective benchmarking outcomes (retention, urine toxicology screen results)" indicate more is needed.

Identified as the main bottleneck in disseminating therapies was that "Unlike … approved medications that can be manufactured in bulk and delivered in pure form anywhere in the world, new behavioral treatments can be disseminated only through training therapist after therapist, with the hope that they will remain in practice and stay motivated to deliver the treatment."

> *Unlike medications, new behavioural treatments can be disseminated only through training*

This effort is hampered by there being "no system or standards for ensuring that empirically supported behavioral therapies are delivered with even minimal levels of adherence or competence". The standard training approach of brief workshops "has been shown to be of limited effectiveness in imparting key skills and competence to experienced clinicians". Training plus performance-based supervision and feedback does better, but is expensive, time-consuming, and removes clinical staff from their day-jobs for several days. More feasible perhaps are 'train the trainer' models, in which a key clinical leader is thoroughly trained not only in the therapy, but also in how to train other clinicians and to monitor and supervise their implementation of the approach. Speaking in 2005, already they could hazard a guess that the "surprisingly positive" performance of computer-based training suggests this too may be a more feasible option.

If blanket training of clinicians in multiple therapies is unrealistic, they suggested that a starting point might be first to teach the basic principles and strategies shared by effective therapies, then for therapists to be required to master an implementation of these in the form of at least one well-evidenced therapy needed for their work or which appeals to the practitioner. After building this foundation, therapists could then be exposed to newly emerging therapies as needed and as dictated by their caseloads.

Again, experience suggested to the two experts that even this more modest strategy may not work. Anywhere near 'mastery' in the form of consistently competent delivery of a therapy is rarely achieved in normal practice. Even with adequate training, we cannot assume that everyone will be able to achieve competence in every approach. Techniques and tactics can be taught, but if basic skills are lacking, "it is not clear how [these] should be taught, or even whether they can be taught". In turn this raises the issue of whether findings from research for which therapists are highly selected, trained and monitored would transfer to normal practice. On the other hand, what observers may see as faithful and skilled implementation of a therapy does not necessarily generate the best outcomes: "while therapist skill and adherence to manual guidelines have been linked to outcomes for several treatments, in other areas the findings have been more mixed or even negative".

Once acquired, maintaining competence was judged likely to require ongoing monitoring of a clinician's implementation of a given therapy allied with ongoing supervision and support from clinicians trained and experienced in the approach. Here another yawning gap emerges in the implementation infrastructure: "clinical supervision based on objective standards or systems is virtually nonexistent in the United States," and given the "high rate of turnover of clinicians in substance abuse treatment programs, extensive training, certification and supervision procedures may not be seen as cost-effective".

An alternative strategy would be to dispense with the face-to-face therapist altogether and deliver treatments directly to patients via computer, standardising quality, enhancing convenience and lowering costs. In 2005 the two essayists were optimistic: "Computer-assisted therapies potentially also offer more consistent delivery of interventions to patients, particularly for comparatively complex approaches such as [cognitive-behavioural therapy] where clinician fidelity and skill in implementing the treatment tends to be variable." Ten years later and focusing on cognitive-behavioural approaches, the same lead author effectively updated aspects of the earlier review in a freely available essay listed above. This time technology was the major theme, and the earlier optimism was yet more apparent: "The studies reviewed above suggest that technology-based [cognitive-behavioural therapy] interventions, provided that they are carefully constructed, developed to be as engaging as possible, and rigorously evaluated in methodologically sound clinical trials, have tremendous potential as a dissemination strategy to reach the majority of individuals with substance use problems who do not receive care due to issues of access, stigma, costs, concerns about confidentiality, and many more." However, "promising" results were somewhat undermined by the "variable" methodological quality of studies in what remained a "young field". Whether technology really is the way forward is still to be seen – an issue we investigated in a hot topic devoted to computerised therapies.

Highlighted study An organisation's leader does literally set the lead, and we can expect that to extend to innovation in general, and in particular implementation of evidence-based and effective clinical practices. Expecting is one thing, demonstrating to scientific standards is another. Fortunately, the leader's influence was explored in unusual detail by the research stable (the Institute of Behavioral Research at the Texas Christian University) behind the investigation of the organisational health of British treatment services discussed in cell D2. The same fertile source also conducted this cell's highlighted study. Listed above, its findings were consistent with the picture that the ethos and support stemming from managers strongly influences the degree to which counsellors are willing to initiate new ways of working and encourage their colleagues also to develop their

> *In these kinds of environments front-line clinical staff improve*

practice. The implication is that even when leaders do not themselves initiate improvements, their influence cascades down to affect staff-initiated innovation. Qualities investigated among managers included setting an example, encouraging new ways of looking at the work, and providing well defined performance goals and objectives. These seemed to exert their effects by helping construct what counsellors saw as a conducive organisational environment, characterised by strength of mission, staff cohesion, good communications, professional autonomy, not being stressful, and receptiveness to change. In these kinds of environments front-line clinical staff pick up the baton themselves and improve practice without it having to be mandated by managers.

> *practice without it having to be mandated*

Extracts from our summary encapsulate the implications of the findings: "leaders … have a cascading impact on their staff in ways other than through mandate, findings which highlight the importance of training leaders to be supportive of innovation and to construct an environment which bolsters open thinking among staff … Most of all, it seems essential that leaders use their influence (including support of new interventions and establishing a clear and forward-thinking mission) to promote a commitment to professional development among their staff, without which even the best leaders will find staff less amenable to initiating change." Adding another link to the chain, from the same research stable the organisational health study discussed in cell D2 suggested that services with leaders like these are the kinds of services which best engage patients; one mechanism might be the enthusiasm and optimism generated by appropriate and effective clinical innovation. Completing the chain, to the degree that innovation and enhanced engagement enables treatment to generate behaviour change with the patients, the leader's influence will have affected the bottom line: patient welfare.

Issues to consider and discuss

▸ **Is coaching the right model for producing good counsellors and therapists?** Employing the right people in the first place is critical was a message from cell C2, and more evidence can be found among this cell's seminal and key studies and reviews. Had it been looked for, it's a fair bet that other studies on the impact of training would also have registered the importance of where clinicians *start* from in determining where they end up after training.

But managers often have to make the most of the staff they have or can find. What then? The evidence forces us to accept a difficult conclusion: *really* developing your workforce demands considerable and extended investment. Shortcuts tick boxes, but typically fail to sustainably or appreciably improve practice or outcomes, leading to the "implementation gap" between research-tested interventions and real life identified by the starting point essay discussed above. Let's explore the evidence.

Even if they diligently followed its instructions, handing staff a manual – including those drafted by world experts – and telling them to follow it would probably be ineffective (study listed above) and possibly counterproductive (review listed above). Moving up a step, one of the best established findings in the development of (among others) the substance use workforce is that sending counsellors away on a course is often a waste without post-workshop feedback on their performance with clients, ideally allied with expert coaching (1, listed above; 2, listed above; 3, listed above; 4, listed above; 5, listed above); more on feedback below.

Of the different therapies, acquiring proficiency in motivational interviewing has been most thoroughly examined. Among primary care clinicians being trained to address substance use, and beyond substance use among clinicians in general (review listed above), *really* getting to grips with motivational interviewing has been shown to require post-training coaching. Without this, even after (free source at time of writing) two days of training, proficiency rapidly reverts towards pre-training levels.

Let's pin down what these generalities might mean in practice through two studies, one from the USA, the other the UK. From the USA, William Miller's research on the motivational interviewing approach he originated includes an influential demonstration (listed above) that performance feedback and expert coaching are both needed for workshop training to impact on patients. The participants were an unusually diverse (in terms of initial proficiency) set of addiction counsellors and clinicians who applied for training in motivational interviewing.

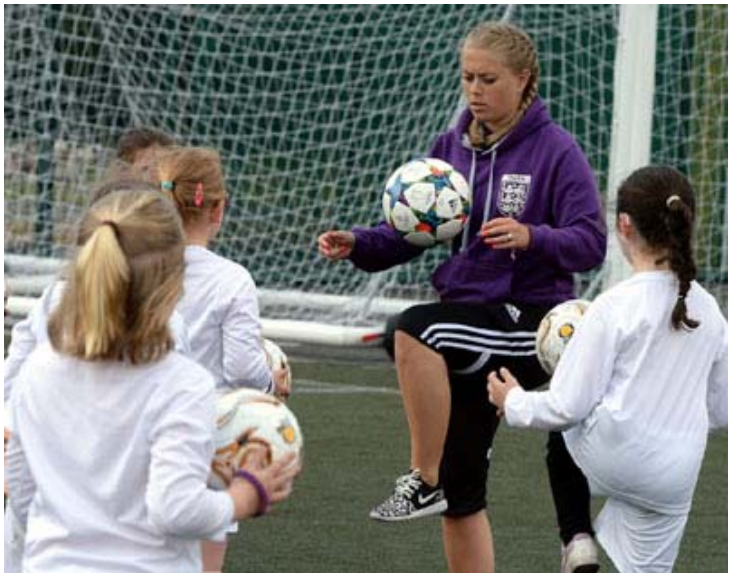
> *Finally, the crunch finding: patients responded only when trainees had expert coaching*

Take a look at the original article (see listing above for how to get a free copy) and at the Effectiveness Bank analysis of a later report from the same study. Note in passing that the study

and feedback

confirmed the importance of having the right trainees to begin with. Then it showed that even with the right trainees, post-workshop boosts in proficiency did not persist without follow-up feedback and/or coaching. Finally, the crunch finding: assessed before and four months after training, the responses of the patients themselves had significantly improved *only* when trainees had been offered continuing expert coaching *and* when this included an opportunity to discuss feedback on how their work with clients compared to the performance expected of an expert – highly suggestive, yet not definitive findings. The responses assessed were 'change talk' – indicative of a commitment to reducing substance use – and resistance, indicative of the opposite, close to what ultimately the study and the intervention were about, but not actually measures of substance use or problems. And though the improvements were highly statistically significant after (and only after) feedback and coaching, whether these gains were significantly *greater* than after less extensive post-training reinforcement is unclear. Also, the sessions the trainees chose to submit for rating may not have been representative of their usual practice. However, ratings of the trainees' practice support the implication that extensive post-training reinforcement had helped sustain their workshop learning, resulting in the desired responses from clients.

Then look at the detail of what in this study 'coaching' entailed. It can be likened to a sports coach reviewing with the players a video of the last game, reinforcing the good points, pointing out where they fell short of expectations, getting them to practice how they could have done better, and checking later with another video that the lessons had been absorbed. For motivational interviewing in particular, the study suggests that at least three to four sessions over a six-month period are required, though much may depend on the *quality* of those sessions and probably too on the openness to learning and experience (see cell B4) of the trainees. Appreciable resources will also need to be devoted to assessing therapist competence; generally (study listed above) and specifically in respect of motivational interviewing (1; 2, listed above), substance use therapists' own assessments of their competence have been shown to be near useless when compared to ratings made by observers.



Demonstrate, practice, review, feedback, practice again; becoming proficient in therapy is more like sports coaching than book learning

In Britain the need for training programmes to include coaching based on work with clients became apparent (report listed above) as a by-product of the UKATT alcohol treatment trial. Despite initial extensive training, on average it took about seven supervision sessions before therapists achieved the study's standards in its motivational and social network therapies. During supervision, videos of the therapist conducting a session with a client were viewed simultaneously by the trainee and by an expert in the therapy, who communicated by phone or face-to-face. The experience led to this conclusion: "supervision after initial training was critical in the acquisition of competence. Not only did we believe that supervision ensured that therapists adhered to treatment protocols over time, but also that it underpinned understanding of the treatment and its purpose. Provision of both technical support and time was essential. Manuals do not provide these. Indeed they were less likely to be followed without these elements."

Though motivational interviewing has been most studied, similar messages emerged from a study listed above of training substance use counsellors and clinicians in cognitive-behavioural therapy – which incidentally also indicated that counsellors who were former substance users (presumed likely to be 12-step adherents and least familiar with formal therapies) benefited most from being coached rather than just being told to study the manual and practice following its guidance.

Here too we should sound a note of caution. Though there is some positive evidence, 'better marks' on one's implementation of a therapy are not consistently associated with better patient substance use

outcomes (see discussion above and our analysis of a review listed above). To more validly assess the effectiveness of a clinician, we need directly to assess how well their patients progress. That is also the case across psychosocial therapy for diverse mental health and other problems: amalgamated findings from 36 studies led to the "striking result … that variability in neither adherence nor competence [of the therapist in respect of the intended therapy] was found to be related to patient outcome and indeed that the aggregate estimates of their effects were very close to zero".

A possible explanation is that sticking *very* closely to a therapy programme somehow leads to worse outcomes – a finding reminiscent of those of a study which found substance use reductions were most sustained among clients not of the 'best' counsellors, but of those rated about average in terms of their clients' experiences of working with them. The implications are discussed in "Isn't it just a matter of being nice?" in cell B2.

Such findings mean management is critical to staff development and ultimately to client progress. Without this being mandated/expected and supported by the service's management, practitioners tend not to engage with ongoing coaching and clinical supervision – and unless they do (review listed above), competence gained through training will be lost. Management also needs to set up systems to assess therapist competence which go beyond their self-assessments, and ideally to assess effectiveness by tracking how well their clients progress in terms of the intended outcomes, not just how well counselling sessions go. All that transforms training into an extended workforce development programme, and the 'done that' boxes cannot be ticked until the trainee has demonstrated proficiency, preferably through objective ratings of session recordings and measures of client substance use and/or related problems.

> *Do you have to take a deep breath, and accept this is the intensity and extensity of input needed to really make a difference?*

As a manager, do you have to take a deep breath, and accept this is the intensity and extensity of input needed to really make a difference to clients? If we believe (as suggested in cell B4) that relationship quality is the essence of psychosocial treatment, perhaps we also have to accept this cannot be acquired quickly and easily through didactic teaching or from a manual. Teleconferencing and phone-based supervision (report listed above) reduce costs and may be adequate coaching vehicles, but this work remains labour-intensive. Is expecting this investment realistic, and is there a better use for limited resources?

▸ **Where would we be without feedback?** The short answer is, we would not know! To build brains and lives, human beings rely on feedback loops (an entertaining account makes this point in the context of generating good and bad habits). Without these, we know neither where we have got to in our attempts to progress nor how to improve or correct these. In substance use treatment, clinical supervision based on session recordings are a tried and tested way to provide feedback and correctives (see section above), but perhaps some of this can also be built into routine systems.

In substance use treatment, systematising feedback to therapists was tried (seminal study listed above) in a simple but effective way in the late 1980s. More sophisticated systems have benefited psychotherapy clients (see articles listed above) by giving therapists feedback on who is doing less well than expected, and clues to why this might be the case based on an assessment of the client–therapist relationship. Gains are greater still if feedback is supplemented by guidance on how to get clients back on track. The underlying assumption that the client–therapist relationship affects client progress has (see cells B4 of both the drug and alcohol matrices) some research support in the treatment of problem substance use. Before moving on to the application of these sophisticated feedback systems in substance use, unfold the supplementary text to appreciate why supplying objective feedback is important.

That sets the background for examining the results of an important study listed above. Published in 2012, it adapted the same feedback system tried (seminal study listed above) in the late 1980s. At three US substance use services, counsellors were given feedback on why individual clients might be lagging due to poor therapeutic relationships, flagging motivation, weak or the wrong kind of social support, or stressful events. The feedback derived from patients' answers to a computerised questionnaire on their substance use and psychiatric wellbeing and functioning, assessments made just before each counselling session and immediately fed back to the therapist.

Read our analysis of the study and you will see that clients at first doing less well than expected ended up using substances no more than those initially more promising. How feedback to the therapist helped 'rescue' these "off track" clients is unclear. Illuminated by the fact that a different feedback system had previously failed to make a difference, the analysis (see section headed "Why the difference?") offered

several ideas. Most favourable to the revised system was that identifying individuals doing poorly, giving concrete feedback on their substance use to their counsellors, and offering guidance on how to respond, made it easier for counsellors to do the job to which they were committed – helping problem substance users get better. But in the 'small print' of the analysis you will find alternative explanations. You might wish to discuss with colleagues which makes most sense to you. If you favour the explanation that the system did indeed have the desired impacts, it might be worth considering whether it, or something like it, could be incorporated in the services you know.

In passing, note that feedback is also important for managers. One way to get it is the 'walk-through' procedure trialled in the USA (study listed above and highlighted in cell C2), entailing senior staff taking on the roles of patients in their service and seeing how it feels – almost literally, 'Walking in their shoes'.

Close Matrix Bite