DRUG ALCOHOL FINDINGS Funded by and in association with ALCOHOL RESEARCH UK Society for the Study of Addiction Substance Misuse Skills Consortium

Drug Matrix cell C4: Management/supervision; Psychosocial therapies

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

S Target-setting and feedback to counsellors can improve client engagement (1991). Client participation was improved by setting 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. See p. 211 (numbered 204) of linked PDF.

K Coaching helps counsellors learn to motivate (2004). Client responses to trainees improved only when motivational interviewing workshops had been reinforced by continued expert coaching and feedback on performance. See also this Findings analysis of a later report from the same study.

K Leaders set context for training to be implemented (2012). Whether counsellors initiate training-based practice improvements is strongly influenced by the ethos and support emanating from an organisation's leadership, especially how far it fosters professional development.

K Put your best people up front (2000). Interactive exercises and games and induction by senior staff helped new residential rehabilitation residents engage with the programme.

K Tell clinic counsellors how their clients are doing (2012). To maximally improve outcomes feedback needs to identify which individuals are doing poorly and recommend remedial actions. The same system has been found beneficial (2011) in psychotherapy generally.

K Walk in their shoes (2008). Getting staff to simulate being a new client helped halve waiting times and extend retention in non-medical services. See also this extension (2012) to the programme and this account (2007) of the 'walk-through' procedure.

K Don't make counsellors stick to the manual no matter what (2006). Findings from a US study of cocaine dependence treatment suggest that especially when the therapeutic relationship is not going well, counsellors should feel free to depart from the counselling 'script' without altogether abandoning it. Data came from a national study (1999) which found drug counselling at least as effective as psychological therapies.

R Let motivational counsellors adapt to the client (2005). Findings analysis and a synthesis of the research (2005) find inflexible manualisation of motivational approaches associated with worse outcomes.

R Implementation lessons from clinical trials (2007). Research shows importance of therapist selection and post-training supervision and the pitfalls of assuming researched interventions will translate to routine practice.

R The importance of supervision (2011). Systematic and expert continuing supervision emerged as a key to newly introduced psychosocial treatments improving practice and outcomes.

R Workshop training not enough (2005). Retaining psychosocial therapy skills after this popular training format requires follow-up consultation, supervision or feedback. Same picture specifically with respect to motivational interviewing – see below.

R Motivational interviewing training works best with post-workshop coaching (2013). Synthesis of findings on training clinicians in motivational interviewing finds it does develop competence, especially when supplemented by supervision or coaching feeding back trainees' actual performance; same picture with respect to workshop training in general – see above. For initial training, motivated trainees can do as well using books and videos as in face-to-face workshops.

G Implementing NICE-recommended psychosocial interventions ([UK] National Treatment Agency for Substance Misuse, 2010). Commissioned from British Psychological Society; includes competencies and training/supervision for main therapies recommended by the UK's health intervention assessor.

G Clinical supervision and professional development of counsellors ([US] Substance Abuse and Mental Health Services Administration, 2009).

G Skills and abilities of clinical supervisors ([US] Substance Abuse and Mental Health Services Administration, 2007).

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

MORE This search retrieves all relevant analyses.
For subtopics go to the subject search page. See also this hot topic on individualising treatment.

Matrix Bite a commentary on this cell from the cell-by-cell Matrix Bites course funded by the Society for the Study of Addiction

Click underlined text to highlight text/link in cell

What is this cell about? About managing services which deliver psychosocial therapies. Every treatment involves direct or indirect human interaction, but this cell is about 'psychosocial' therapies in which interaction is *intended* to be the main ingredient. These range in form from brief advice and counselling to extended therapies based on psychological theories, and all-embracing residential communities where clients stay for months. The content and approach of therapy and the qualities of the staff matter of course, but these exert their influence within a context set by the management functions of selecting, training and managing staff, and managing the intervention programme, including deciding treatment goals and which patients are offered which 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 and maintain appropriate attitudes and knowledge, depend on management and supervision.

Where should I start? Where so much starts – at the top, with the organisation's leader. In our starting point study, 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 of the organisational health of British treatment services highlighted in cell D2. Their leadership study seemed to confirm that improvements initiated 'bottom-up' by counsellors are strongly influenced by the ethos and support (especially for open thinking) emanating from managers, implying that even when they do not themselves initiate improvements, leadership influences cascade down to staff. Qualities they investigated among leaders included setting an example, encouraging new ways of looking at the work, and providing well defined performance goals and objectives.

Completing the circle, the organisational health study from cell D2 suggested that services with leaders like these are the kind of services that best engage patients. It found clear relationships between the micro level of the degree to which patients engaged with treatment, and macro organisational features such as team working and mutual trust, whether the service fostered open communication between staff and was receptive to staff ideas and concerns, and had a clear mission and programme.

Highlighted study Human beings build brains and lives based on feedback loops through which we can know and adapt to the results of our actions. Without these we neither know how we are doing, nor how to improve or correct it.

In substance use treatment, systematising feedback was tried in a simple but effective way in the late '80s. More sophisticated systems benefit general psychotherapy patients 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 therapist-client relationship. Gains are greater still if feedback is supplemented by

guidance on how to get patients back on track. The underlying assumption that the relationship of the therapist or counsellor to drug using clients affects the client's progress has (see cell B4) has some research support.

That sets the background for our highlighted study, an adaptation of the same system at three US substance use services. It gave counsellors feedback on why individuals might be lagging due to poor therapeutic relationships, flagging motivation, weak or the wrong kind of social support, or stressful events. Read the analysis, and you will see that these patients ended up using drugs as little as initially more promising patients (the same was true of drinking). How feedback helped 'rescue' them 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?') offers several ideas. Most favourable to the new system is that by identifying individuals doing poorly, giving concrete feedback on their substance use to their counsellors, and offering guidance on how to respond, it made it easy for them to do the job to which they were committed – helping problem substance users get better. But read the 'small print' of the analysis and you will see there are alternative explanations. You might wish to discuss with colleagues which explanations make most sense. If you decide the most likely explanation is that the system had the desired impacts, consider/discuss whether some such system might be incorporated in the services you work at or know of.

Issues to think about

▶ **Is 'coaching' the right model for producing good counsellors and therapists?** Getting the right people is critical was a message of cell B2. But as a manager, you have to make the most of the staff you have or can find. What then? Even if it worked, handing staff an expert manual and telling them to follow it would be undesirable. Sending your counsellors away on a course is often a waste without post-workshop feedback (for more on feedback *Highlighted study*) to the trainee on their performance with clients ideally allied with expert coaching. More generally, systematic and expert supervision is needed before newly introduced psychosocial approaches improve practice and outcomes. William Miller's research on the motivational interviewing approach he originated includes this demonstration that performance feedback and expert coaching are both needed for workshop training to impact on patients.

Have a look at the original article (link is to a freely available copy). Note that in passing it confirmed the importance of having the right trainees to begin with. Then it showed that even with the right trainees, post-workshop competence boosts did not last without follow-up feedback and/or coaching. Finally, the crunch finding: the responses of the patients themselves – what the whole process was about – improved *only* when trainees were offered continuing expert coaching *and* when this included an opportunity to discuss feedback on how their work with clients matched up to that expected of an expert.

Look at the detail of what 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 it better, and checking later with another video that the lessons had been absorbed. 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?

Close Matrix Bite

Last revised 03 October 2014. First uploaded 01 June 2013

▶ Comment on this entry
▶ Suggest a new document to add to this cell
▶ Return to/go to Drugs matrix
▶ Open Effectiveness Bank home page and enter e-mail address to be alerted to new studies