DRUG & ALCOHOL FINDINGS Matrix cell

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Alcohol Matrix cell C2: Management/supervision; Generic and cross-cutting issues

S Organised caring transforms alcohol clinic (1970). Remarkable series of US studies from the late 1950s proved that an alcohol clinic's intake and attendance can be transformed by being responsive to need and systematically and caringly keeping in touch with patients. See also slide presentation and video, which end by focusing on the featured studies.

S Alcoholics *can* learn to moderate their drinking (1973). Not the first, but the most incendiary paper to challenge the orthodoxy that abstinence must be the only treatment goal for dependent drinkers. See also second- (1976) and third-year (1978) follow-up results. This refutation (1982) based on a 10-year follow-up was itself refuted (1984) by the original authors. Discussion in bite's *Issues* section.

S The abstinent alcoholic (1962). Classic description of the patient who has sustained abstinence but is nevertheless unhappy, unfulfilled and/or nervously hanging on – in this study from Connecticut alcohol clinics in the 1950s, they were the majority among the non-drinkers. Discussion in bite's *Issues* section.

S Relapse-preventing social skills of counsellors can be identified in advance (1981). US study at an inpatient alcohol unit found strong links between the interpersonal qualities and skills exhibited by counsellors in response to written cameos of typical patient/family comments and how many of their patients later relapsed. Related study below. Discussion in bite's *Issues* section.

K Identifying rapport-generating counsellors (2002). Responses to written counselling scenarios identified which counsellors would best generate retention-enhancing rapport at a Finnish outpatient alcohol clinic. Partial replication of US study above. Discussion in bite's *Issues* section.

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. Discussion in bite's *Issues* section.

K Try walking in their shoes (2008). Getting staff to simulate being a new client helped halve waiting times and extend retention in US substance use services. See also this extension (2012) to the programme and this account (2007) of the 'walk-through' procedure. Walk-throughs are a key element in the NIATx quality improvement model. Discussion in drug matrix cell C2.

K "You cannot treat an empty chair" (2013). Title is from a report of how 67 US substance use outpatient clinics used the NIATx model to reduce 'no-shows' through reminder calls, cutting waiting times, increasing capacity (eg, extra hours), and psychosocial approaches to bolster engagement such as motivational interviewing.

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. Discussion in bite's *Issues* section.

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

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. Discussion in bite's *Where should I start?* section.

R Cycle of change model poor guide to intervention (2001). Its simplicity is beguiling, but can services trust Prochaska and DiClemente's ubiquitous model to guide them in matching interventions to a client's 'stage of change'? This thorough but easy-reading review found little evidence to support this popular strategy, and that remains the case. Discussion in bite's *Issues* section.

R Offer moderation as well as abstinence as a treatment goal (2013). Concludes that dependent drinkers can cut down, that psychosocial treatments based on this goal are probably just as effective as abstinence-oriented approaches, and that allowing patients a choice improves outcomes. Discussion in bite's *Issues* section.

G Inpectors' criteria for quality substance use services ([English] Care Quality Commission, 2015). Official inspectors of health and social care services ask 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 UK staff development toolkit ([English] National Treatment Agency for Substance Misuse, 2003). Recruitment, training and staff development, appraisals and supervision, exit interviews and more. Discussion in bite's *Issues* section.

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 Managing peer supporters (2015) Guidance from the UK Substance Misuse Skills Consortium on how to manage current and former problem substance users who support and mentor other users through and out of treatment.

G Improving efficiency and capacity means more patients can be helped ([US] NIATx, accessed 2014). Web-based service 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' (see this example) and increasing admissions and retention (see this example).

G Managing non-residential programmes ([US] Substance Abuse and Mental Health Services Administration, 2006). US consensus guidance 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, how these can ensure culturally competence,

ethical and legal issues, and performance monitoring. Includes an implementation guide for administrators.

G US guide to matching type of treatment to the patient (2013). From the American Society of Addiction Medicine, what the 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 change or cease offering it.

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 alcohol treatments to the patient, and individualising treatment. See also this reading list from a leading US analyst intended to help treatment services develop recovery-oriented programmes and this resource list from the UK Substance Misuse Skills Consortium to help managers (among other topics) recruit and supervise staff, manage organisational change, and foster effective team working/

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

What is this cell about? This row of which this one of the five cells 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 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. 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 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 was the transformation brought about at Massachusetts General Hospital's alcohol clinic, documented in studies listed above and explored further in cell A2.

Highlighted study 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 we know that in therapy, the practitioner's ability to think themselves into the shoes of the client is fundamental. Perhaps this is true too of the managers of those services, and perhaps it is even better to actually try on the patient's shoes and *feel* them pinch rather than leaving the self-serving possibility of imagining all is well with a service for which you are responsible.

Trying one those shoes is exactly what staff did (they also role-played being a relative of the client) as part of our highlighted study of 327 US services. 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 12 US areas, walk-throughs by senior staff became the key tactic for the strand of the project intended to identify service delivery problems and improve clinical procedures. All three original articles in the entry 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 US 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 – why the tactic features so strongly in a US quality improvement resource. We might ask though whether it would be better to systematically gather feedback on how *real* patients experience treatment procedures, or to engage 'mystery shoppers' to act the part of a client and to feed back the results – in walk-throughs, staff know what is happening and usually too will know the staff playing the role of a patient

or a patient's relative.

Issues to consider and discuss

▸ **Recruitment: the critical missing link** Studies use existing staff or recruit their own before evaluation starts. Either way, recruitment lies outside the evaluation process – the missing link. Think of the clinical staff you have known. Did some seem good from the start, while others couldn't hit the right note with patients, no matter how much they were trained and supervised? Research backs you up. We know from cell B2 that clinicians vary greatly in effectiveness. A seminal British study spotlighted interpersonal warmth and commitment to working with alcoholics. Qualities such as empathy, genuineness, respect, and an ability to communicate have also been associated with retention and drinking outcomes.

If such qualities are lacking, training can't always fix the problem. Fixing them may take organisational commitment expressed through management, procedures and incentives, but it may also be a case of having employed the wrong people. Motivational interviewing is an empathic counselling style, the most influential in addiction treatment. This US study showed some clinicians 'get it' from the start and improve with training; others don't, and still don't get it as well *after* training as adept practitioners did before. Then look at this study borrowed from cell C4. It showed that applicants for alcohol counsellor positions can be screened for empathy and those who pass take less training. That study used audiotapes of sessions with simulated clients; others have used written client-therapist scenarios. Look at chapter 4 (Recruitment and selection) of guidance for England. Does it recommend these sorts of assessments? What is the balance to be struck between assessing applicants for appropriate interpersonal skills, assessing for technical competence, and training in either or both?

▸ **What use is assessment? ... without some way to act on the results** With admirable simplicity, this US study 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.

▸ **Should dependent drinkers always be advised to try for abstinence?** Hardly a 'bite'-sized issue, its centrality to alcohol dependence and its treatment makes it difficult to ignore but also demands extended coverage, so we offer a two-tier introduction. For a more bite-size chunk read just the paragraphs already showing below. For more, unfold 👁 the supplementary text.

Not so long ago the issue was not just about whether patients should be advised to aim for abstinence, but whether they should be denied treatment until deterioration forced them to accept the need to stop drinking altogether and forever. The debates go back decades, but abstinence has recently returned to prominence as an essential component of influential visions of 'recovery'. This is how we have summed up the evidence: "Treatment programmes for dependent drinkers should not be predicated on either abstinence or controlled drinking goals but offer both. Nor does the literature offer much support for requiring or imposing goals in the face of the patient's wishes. In general it seems that (perhaps especially after a little time in treatment) patients themselves gravitate towards what for them are feasible and suitable goals, without services having to risk alienating them by insisting on a currently unfavoured goal."

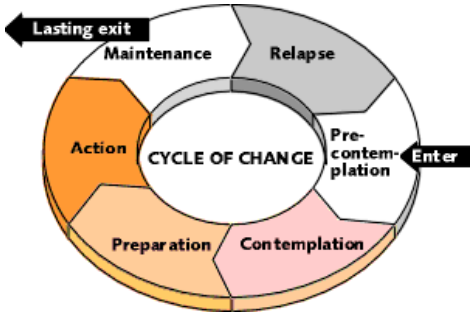
Another reason for not insisting on abstinence is that non-drinking does not always equate with 'recovery' as often defined. The recovery agenda directs us to value outcomes other than (non-)drinking, outcomes which reflect the quality of life of the individual and their integration in society. A classic paper from the 1960s reminds us that this can mean classifying some abstinent ex-patients as not really recovered. Without their favourite sedative and the friends and social activities that went with it, most in this study were living an empty and/or unhappy life.

For more on the controlled drinking controversy see this US account and if you can this British perspective (turn to chapter four of the book). See also the seminal US study listed in this cell and this British study of choice of treatment goal in psychosocial treatment (the background notes are particularly informative).

Armed with these, reflect on questions such as: Should very heavily dependent drinkers *always* be advised to try for abstinence? Is this because of their dependence, or lack of supports in their lives like a marriage, a job and a home worth keeping? Are there exceptions? Should it (albeit after advice) be the patient's choice – in practice, *must* it be the patient's choice? Is shared decision-making the best way to engage patients, or have they a right to expect direction from a professional expert? Should the goal-setting process model what we want patients to become – *in*dependent and in control of their lives? Or accept that for the moment they are neither? How strongly should the clinician advocate for *their* choice? What of less dependent drinkers and/or those with more supports in their lives? Would recommending abstinence drive them away from interventions? Or is at least a period without drink the best way to break any heavy-drinking habit? Are your answers based on an explicit or implicit understanding of the nature of alcohol dependence? Before you answer, consider

unfolding the supplementary text to learn more about the controlled drinking controversy.

▸ 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 and make 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?



Analysed in this Findings review, 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 in to something important and technical and scientifically valid, yet which accords with common sense understandings. For example, 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.

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 could only say matching interventions to stage of change was "probably effective" – and even "probably" seems optimistic. Another problem for the model is posed by precipitous, unplanned transitions to abstinence which defy the requirement to pass through the stages. Unfold text for more.

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 Findings 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?

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