DRUG & ALCOHOL FINDINGS *Matrix cell*

S Seminal studies **K** Key studies **R** Reviews **G** Guidance **MORE** Search for more studies
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Drug Treatment Matrix cell B3: Practitioners; Medical treatment

S Quasi-randomisation reveals methadone counsellor is an 'active ingredient' (1988). Effectively random allocation of patients to different methadone counsellors at the same service revealed that effective counsellors were more diligent and active, helping patients anticipate problems and solutions. Related study below. For discussion click here and scroll down to highlighted heading.

S What makes a methadone counsellor effective? (1985). In US study differences in effectiveness could partly be explained by the personalities of the therapists, particularly their abilities to quickly form warm, supportive relationships with patients.

K Treatment staff matter as much as the drug (1999). Trio of US studies finds methadone patients do better with active counsellors who respond constructively to their problems. One of the three was the study below.

K Quasi-random allocation exposes impact of methadone counsellors (1999). When methadone doses had been tailored to the individual and stable for at least three months – effectively taking them out of the equation – US study found which counsellor the patient had effectively at random been assigned to substantially affected retention and illegal substance use. One of three studies featured in entry above. Related study above. For discussions click here and here and scroll down to highlighted heading.

K Patients more likely to avoid illegal opioid use when relationship good with methadone-prescriber (2014). Of all the assessed variables, whether six months in to treatment patients in France felt they had a good relationship with their doctors was most closely related to the elimination of non-prescribed opioid use six months later, possibly because it meant they were more likely to discuss their dose with their physician and therefore to be prescribed appropriately. For discussion click here and scroll down to highlighted heading.

K Patients do best with GPs who they feel know them as a whole person (2007). Free source at time of writing. US patients referred to primary care after detoxification reduced drug use/problems most when they saw GPs who they felt knew them as a whole person and who consistently saw them rather than referring to a colleague or assistant. Related studies below (1 2). For discussion click here and scroll down to highlighted heading.

K Not just a methadone patient (2013). When some Australian methadone clinics started offering treatment for hepatitis C the unexpected effect was to improve relationships with patients who felt they were no longer there just to be dosed with methadone but to be cared for as a (whole) person. Related studies above and below. For discussion click here and scroll down to highlighted heading.

K Not just an addict/patient (2007). Free source at the time of writing. Interviews with long-term buprenorphine maintenance patients in France revealed that "the physician's behaviour may convey to the user that s/he is … a life-long junkie or a repentant junkie, or on the other hand may allow him to see himself as a whole person," promoting "a positive worthwhile image free of the stigma of the junkie". Related studies above (1 2). For discussion click here and scroll down to highlighted heading.

R Clinicians' impact on treatment quality (2000). Free source at the time of writing. Found great variations in retention and substance use outcomes between clinicians and that "past assumptions that levels of training, experience, or other simple therapist variables could account for such differences does not hold". For discussion click here 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. For more on the importance of *not* doing the wrong things see cell B2.

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.

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 specialising in treating addiction on what they are expected to do and the standards they should meet throughout addiction treatment from assessment to aftercare.

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What is this cell about? About the treatment of dependence on illegal drugs in a medical context and/or involving medical care, typically by GPs or hospital drug treatment units. Clinical staff are responsible for medications, so the centrality of these to an intervention distinguishes it most clearly as medical. Medications may be intended to help patients withdraw from drugs, sustain longer term abstinence, or to replace the drug the patient is dependent on with a prescribed drug of the kind, but one which can be taken more safely and is more conducive to social stabilisation.

Medications are, however, never all there is to medical care. Even when they seem to be all there is, that in itself sends a message to the patient about how they are seen and valued by the service. Founded on a good relationship with the prescriber, effective prescribing requires the collaboration of the patient to stay in or complete treatment and help choose the medication and set an appropriate dose by disclosing their use or non-use of the medication, how they have reacted to it, and their non-prescribed drug use, while appropriate provision of ancillary support depends on a frank admission of needs. In particular, how long patients stay in treatment is related to the quality of their relationship with clinical staff, and retention is the main factor in the effectiveness of long-term, open-ended treatments such as methadone maintenance.

In these ways, relationships with staff may affect outcomes indirectly because they enable more or less appropriate prescribing and broader help. Interactions with staff are also in themselves potentially therapeutic, and medical care may consist entirely of advice and psychosocial support. These are among the reasons why of medical care in general, it has been said that " '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."

The relationship-forming qualities of treatment staff are much less easily manipulated by researchers and less commonly researched than the intervention. Studies usually have to rely on an association between relationship quality or staff attributes on the one hand, and retention or substance use on the other, rather than deliberately allocating patients to workers known to differ along these dimensions. This makes it difficult to be confident that relationship quality or staff attributes actually *caused* any differences in outcomes, rather than the reverse, or both ends of this supposed causal chain not being cause and effect at all, but related to other, more active ingredients.

Relevant specifically medical studies are few, but for further studies possibly as relevant to medical as to psychosocial care turn to the cell dealing generically with practitioner influences.

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".

If clinicians are important, the next question is, 'Why?' – one the rest of this 'bite' addresses more fully. The review itself examined research relating retention and substance use outcomes to the professional status of the clinician, whether they are an ex-addict, their adherence to protocols, emotional reactions to patients, personalities, beliefs about treatment, interpersonal functioning, and other factors. What did *not* account for differences in their impacts were professional characteristics, including qualifications and whether the clinicians were themselves ex-addicts. According to the reviewers, instead the most consistent influence has been the clinician's ability to build a positive relationship 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 Philadelphia in the USA was the site one of those invaluable accidents which permit previously obscured influences to come to light. We'll describe it fairly fully because it seems the article (listed above) is not freely available. The study was prompted by the sudden resignation of two counsellors at a methadone service. Their caseloads were reassigned effectively at random to remaining counsellors, offering the opportunity to see whether the four allocated at least a dozen of the 61 clients altered the trajectory of their progress from the six months before to the six months after. Not only did this permit the counsellors to be compared with each other, it also meant pre-transfer measures could be used to assess how patients *changed*, not just where they ended up. Clinic records were the data source in this study, which was led by an adviser on addiction treatment to Public Health England.

Before the transfer each of the sets of patients later allocated to the four counsellors was spread across the two counsellors who left, and each set was doing about equally well. After the transfer, each set was in the hands of a single counsellor, and the impacts were huge. Despite higher methadone doses and more of their patients being prescribed other medications, those transferred to the least effective counsellor worsened in their drug use, arrests and employment. In contrast, over a six-month period the most effective counsellor was able to bring patients to the point where their non-prescribed drug use was virtually zero and employment significantly improved, while at the same time substantially reducing their doses of methadone and the proportion prescribed ancillary medications.

Differences between patients and the qualifications of the counsellors did not account for the findings, which were also reflected in their prior caseloads; before and after the transfer, they consistently differed from each other in how well their patients did. Case notes indicated that all the good counsellors took a well-organised and diligent approach to care planning, documentation and clinic rules, suggesting that good organisation is a fundamental platform for everything else to work, including relationship-building. The stand-out counsellor built on this platform, anticipating patient problems and discussing strategies to deal with them in advance, focusing counselling on the development of new behaviours and new ways of thinking. He or she was not only administratively diligent, but actively problem-solving and therapeutic. The authors speculated that this enabled them not just to have better outcomes, but to achieve these with less medication and less use of street drugs by their patients.

This was one small – if virtually unique – study, but the proposition that methadone counsellors (the same seems true of the prescribing physician) alter the prospects of their patients is confirmed by another larger US study involving 265 patients and 13 counsellors, which was took advantage of what was said to be the random allocation by the clinic of patients to counsellors. Importantly perhaps, the clinic in this study comprehensively assessed each patient to determine and adjust the dose of methadone, which had been stable for at least three months, effectively taking dose out of the equation and enabling other influences to more strongly emerge. And one which "clearly stood out" was that "some counselors obtained better results than others" in terms of the illegal heroin and cocaine use of their patients.

Issues to consider and discuss

▸ **What do rules do to relationships?** Consider this quote from an article listed above and described in the previous section: "Methadone dose … has been given too much emphasis … the interpersonal processes involved in a working alliance with the substance-abusing patient and the assigned therapist has been given too little" – a conclusion based on the finding that counsellors significantly differed in their effectiveness, yet not because they authorised higher doses for their patients. Another study found (summary above) that the best counsellor in the study actually reduced doses relative to counsellors who did less well. Higher dosing is the most solidly established success factor in methadone maintenance. *If* relationships are as important, then they are *very* important.

It may, however, be false to oppose dose and relationships, because almost certainly they interact. Relationships may act partly *through* dose, permitting patients to feel they can be honest and open and enabling prescribers to flexibly adjust dose in response to those messages, at least as important as the average dose level across a caseload (1 2). The interaction might work the other too: patients who get the doses they feel they need are likely to be easier to form relationships with and more positive about the clinic and the staff responsible for their care.

However it happens, if relationships *are* important, that means influences on relationships are important too.

In methadone programmes, the most obvious are the sometimes unpalatable requirements imposed through keyworkers and doctors, including patients having to come to the clinic or pharmacy nearly every day to swallow their methadone in front of staff, and regular urine tests to spot unauthorised drug use. Both (see for example an evaluation of supervision) have their justifications, but both too are easily seen as signs of a lack of trust in the patient: in the case of supervision, that they will take their medication as directed rather than selling or otherwise 'diverting' it; and in the case of testing, that their reports of their (non-)substance use can be believed. Supervision forces the patient into what they may feel to be a stigmatising position, exposed as a drug user in the pharmacy, and when it happens in the clinic, can make this a dehumanising experience. The humiliation is obvious if it is felt that the submission of urine specimens has to be observed to prevent 'cheating'.

Current clinical guidelines acknowledge several valuable roles for urine testing but try to reduce it to a minimum and to make the undignified process of watching patients provide the specimen very much the exception, and then only with informed consent. "Many patients will," say the guidelines, "admit to continued drug use without the need for repeat testing, especially if they are clear that this information is welcomed positively with concern rather than with any disappointment or frustration." Effectively the guidelines construct a virtuous circle: trust in how the clinician will react maximises voluntary disclosure and minimises the need for trust-eroding drug tests.

The guidelines are also relatively (eg, in comparison with the USA and Australia) relaxed about supervising consumption, largely leaving it to clinical discretion. Without stipulating this, they recommend that in most cases it will be appropriate for new patients to be required to take their daily doses under the direct supervision of a professional for a period of time to allow monitoring of progress and ongoing risk assessment. How long supervision lasts should, say the guidelines, depend on assessed clinical need, not be arbitrarily determined. This step back from the three months' supervision previously recommended – a stipulation for which there is no evidence (1 2) – opens up the space for clinicians to give reasons the patient may accept for why in their individual case supervision is felt desirable.

How do the patients see this unusual requirement to take their medication under the eyes of clinic or pharmacy staff? They may accept the rationale for supervision at the start of treatment, but more extended supervision is generally unpopular (1 2 3 4). Doctors know patients find supervision aversive, so exploit its relaxation or imposition to manipulate how patients behave; in Scotland, 20 out of 32 clinicians said they did this, and 13 felt supervision led some patients to drop out prematurely. Supervision also entails near-daily attendance at the prescribing clinic or pharmacy, in itself an unpopular requirement.

How do you think imposition of these requirements might affect relationships with keyworkers and doctors? Can they be implemented in a sensitively skilled way which does not undermine the vital communication channel with the patient? From the *Highlighted study* described above, it would seem so; remember all the most effective counsellors were diligent in this respect as in others. How might they have defused this potential source of friction?

▸ **Not just an addiction** In this section we examine something which ought to be important, but for which in the context of the medical care of drug dependence, the evidence is slim. It is the adoption by the clinician of a 'whole person' approach to working with patients, in health and mental health (1 2) generally, a principal component of patient-centred care and a recovery orientation, especially for people with multiple and complex needs. Among the things service users want changed in mental health staff is their "failure to take account of all domains of a person's life; focus on symptoms and illness; … failure to see the 'whole person' ". Responding to patients as whole person means responding to their complaint in the context of its relationship to them as multi-faceted human being with other problems, strengths, interests and identities, even if in the case of drug dependence these may have been subjugated to their need to finance, find, and take illegal drugs. Effective treatment relieves these needs, opening the way for suppressed and new identities to flourish. As we'll see, whether they do flourish seems to depend partly on relationships with clinical staff.

Why a whole-person approach ought to be important was explained in cell A2, where it was pointed that for behaviours as socially unacceptable as heroin or cocaine dependence, "by the time you have narrowed down to the minority who try these drugs, the very few who become regular users, the fewer still who become clinically dependent, and finally the subset who want to stop but feel they can't without treatment, then you have sifted down to a highly atypical and usually multiply disadvantaged and/or troubled population … whose drug use is entangled with social, economic and psychological features which unless addressed repeatedly

precipitate them back into dependent substance use." That constellation seems to demand holistic support, and that demands assessing and understanding the person as a whole.

There is another reason too. Creating a new identity both in terms of one's self-conception and one's social network is an important task in avoiding a return to addiction (1 2). In cell E2 we argued that "Making substance use central to a person's identity is not necessarily the best way to help them de-centralise from substance use". Instead of being something they do among others, users of illegal drugs are reinforced in seeing their drugtaking as central to their identity because this is how they are treated by people and institutions with power over their lives, among whom are treatment staff who control access to medications and broader support. If the patient is led to see themselves as nothing but a 'junkie', the route to recovery is likely to be that much harder.

These concerns may be particularly applicable to medical care. With just a few minutes to spare in a typical consultation, and the tendency of medical training to generate a focus on "techniques and procedures", issues like adjusting the medication regimen may be all that are seriously addressed.

So much for the theory, what of the evidence? From France we have evidence that for patients the distinction between whole-person and more limiting relationships with doctors is a reality, emerging (study listed above) in interviews with long-term buprenorphine maintenance patients. Four relationship patterns were identified, focused on: dose; compliance with treatment; drug prescription; or on the person – a whole-person approach. The first three were characterised as consigning the user to a "lifetime identity as a junkie", to being a compliant ex-addict patient, or a acting the role of a compliant patient to obtain drugs. Only the whole-person relationship promoted "The redefinition of self in an identity released from the stigma of drug dependence," making it possible for the user to "express himself/herself in the relationship as a person in his/her own right". Unfold the supplementary text for more on how these kinds of relationships were seen by the patients and their advantages and limitations.

> Close supplementary text
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> "These users did not perceive going to the doctor as a constraint; the doctor's office was instead a special space where they could renew their strength, rest, be themselves, and find some kind of comfort. The physician appears to be the user's preferred contact, viewed as a bridge between the world of drugs and mainstream society. At this point in their progress, these drug users felt they occupied a difficult position between these worlds. They no longer fully shared the values, references, interests and lifestyles that previously linked them to the drug culture, but could not yet lay claim to those prevailing in mainstream society. In this context, the physician may be the only touchstone that gives meaning and continuity to their history (depository for the past, witness to the present, participant in a future). The doctor is one of the rare persons in their environment with whom they can 'fully exist' and remain coherent with themselves."
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> That sounds distinctly preferable to the other patterns built more on distrust than trust, but especially after it had been cemented, fear of jeopardising this valued relationship could lead patients to conceal misuse of illegal drugs – an attempt to preserve trust and avoid the guilt of disappointing the doctor. "The relationship is sometimes trapped by the image reflected by the physician, and may be depleted by the accumulation of lies or even of things left unsaid. It can lead to situations of great vulnerability that become dead ends." There were similar and seemingly more intrinsic and damaging downsides to the other relationship patterns, which lacked the redeeming features of the person-focused relationship.
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> Close supplementary text

If the distinction between whole-person and more circumscribed doctor-patient relationships is a real one, what are the consequences? Here we run up against the difficulty of disentangling cause and effect. It may, for example, be that rather than promoting recovery, such relationships form because the patient is already doing well, and there is less need to focus on compliance, stabilisation and control. With that caveat, the search for consequences takes us to at least three studies. Unfold the supplementary text to read about what they found.

> Close supplementary text
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> **1** First is another French study listed above, but of methadone patients starting maintenance treatment or transferring to it from buprenorphine because that was not working well for them. As perceived by the patient, the closest it came to identifying whole-person or person-focused relationships involved patients who at six months into treatment felt they had a very good relationship with their doctor. The raw figures

were that among the 'very good' relationship patients, 18% went on to use non-prescribed opioids five to six months later, twice the average of 37% across the entire sample.

When a large number of variables including patient characteristics, drug use, and relationships with their doctors, were put into the mix together to identify active ingredients, most strongly related to opioid use was having versus not having a very good relationship with the doctor. It was estimated that if all the patients had such a relationship, over a quarter who later used opioids would not have done so – an estimate which assumes a causal relationship the study was not designed to establish, but which at least had the advantage of presumed cause coming well before presumed effect. If there was cause and effect, the link between them, thought the researchers, was probably that a very good relationship meant patients were more likely to discuss their dose with their physician and therefore to be prescribed doses appropriate to their specific needs.

2 Like the French study above, data relevant to the doctor-patient relationship emerged from a US study primarily intended to test an intervention through a randomised trial. In both cases the reassurance of the level playing field created by randomisation applied only to the interventions, not to the presumed impact of the doctor-patient relationship. Instead results were adjusted for a long list of factors which might have influenced outcomes, an attempt to isolate the effect in this case of the quality of primary care services.

For the main analysis patients leaving a residential detoxification unit had been at random more or less intensively referred to primary care services. Intensity of referral improved service uptake but made no significant difference to substance use. The analysis (listed above) which used the same study to investigate doctor-patient relationships drew this data from a standard questionnaire to assess the quality of their care administered to patients in the study who initiated primary care. Most of these patients primarily used heroin or cocaine, but many alcohol. At issue was whether questionnaire responses were related to change in the severity of alcohol or drug use at least six months later.

Once other variables had been taken into account, the only dimension of the doctor-patient interaction significantly related to greater severity reductions for both types of substances was "Whole-person knowledge". For drug use severity, this was the only dimension significantly related to severity reductions. When the outcome was any cocaine or heroin use or any heavy drinking, to whole-person knowledge was added trust in the doctor. The authors concluded that "whole-person knowledge emerged as the most consistent predictor of better addiction outcomes. Individualizing clinical decisions based upon the 'contextual knowledge' of a patient's beliefs and values as well as responsibilities at work, home, or school may have particular importance for individuals with addiction problems."

3 Lastly and most peripherally are findings from an Australian study listed above which found that extending care at methadone clinics to include treatment for hepatitis C infection had the unexpected effect of improving relationships with patients, who felt they were no longer there just to be dosed with methadone but to be cared for as a (whole) person. Service extension challenged "the discredited identity of the 'drug user' ' evident in the accounts of patients who "felt trapped –fixed – in an undesirable, stigmatizing identity by their place of treatment" – an identity pressed on patients by the perceived attitudes of clinic staff and by the "depressing" environment, in which they lined up "like you're a cow going into slaughter" to be dosed with methadone and little else.

Extension of the service made patients feel more like people being cared for and less like merely addicts there to be dosed: "the experience of being recognized beyond the immediate and instrumental needs of their daily 'dose' opened up other, more expansive narratives about the self, creating new and enabling possibilities for identity formation". The transformation for staff was perhaps even greater, as they began to see themselves as relating to service users "as a whole" and as people worthy of the same kind of medical care afforded the general population.

Among other things, what we can take from this study is that whole-person care can only flourish (or flourish best) when the organisational environment in which that relationship is formed is conducive to making a reality of treating the 'drug user' as more than that.

Close supplementary text

These three studies are suggestive but cannot be definitive about the consequences of a whole-person relationship. If these consequences are real, almost certainly they are overshadowed by the effects (for example) of being offered versus denied effective pharmacotherapy, though they may help that

pharmacotherapy *be* effective by keeping patients in treatment, taking the medication, and feeling able to be frank with their doctors about the dose they need and how it is best dispensed. Whether on its own a whole-person relationship with a doctor can be therapeutic is untested, and testing it may be unrealistic because it would require either the blanket standardisation of other aspects of care, in itself antithetical to a whole-person relationship. It is one example of how what may be quite important cannot easily be proved.

Given the evidence we have, your own experiences as a patient (not necessarily in addiction treatment) and perhaps as a doctor, and your experiences of addiction treatment services, how would you rate the importance of what we have short-handed as a 'whole-person' relationship? Nice, but not an active ingredient in medication-based recovery, a diversion from the technical care and prescribing which are active ingredients, or a way of optimising the care of complex cases?

Thanks for their comments on the original entry in draft to James Bell of the National Addiction Centre in London, England. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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