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▶ Relating counselor attributes to client engagement in England.

Simpson D., Rowan-Szal G.A., Joe G.W. et al. Request reprint

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The most wide-ranging investigation of the organisational health of British treatment services found clients engaged best when services fostered communication, participation and trust among staff, had a clear mission, but were open to new ideas and practices.

Abstract In collaboration with England's National Treatment Agency for Substance Misuse, this study aimed to profile the organisational 'health' and resources of addiction services in England and the motivation and psychosocial functioning of their clients. Further analysis related both these influences to how far clients reported actively engaging in their treatments and experienced a positive relationship with their counsellors or key workers − variables found in other studies to in turn be related to better treatment outcomes.

Data was collected through questionnaires sent to 44 voluntary and statutory agencies which volunteered to participate in the study. Recipients offered services for alcohol and other drug clients and included day care programmes, outreach services, community drug teams, and Drug Interventions Programme teams in and around Manchester, Birmingham, or Wolverhampton. Each took a 'snapshot' of their clients and service profiles during the same fortnight in 2006. During this fortnight, CEST (Client Evaluation of Self and Treatment) forms were to be handed to each client as they presented to the service; 1539 completed the forms, of whom just over two thirds had been in treatment for at least three months. The forms asked them to rate themselves on statements representing their motivation and readiness for treatment, psychological and social functioning, and engagement with treatment. At the same time, 439 counsellors at the services completed ORC (Organizational Readiness for Change) forms assessing their perceptions of the service they worked for and of their own professional functioning and needs.

The analysis centred on two dimensions from the CEST form reflecting the client's engagement with treatment. A measure of **participation** in treatment combined

compliance with treatment requirements, active engagement, and making therapeutic progress. Greater participation was significantly and often quite strongly related to other items on the forms reflecting the client's motivation to overcome their substance use problems through treatment, and their psychosocial functioning. Similar relationships were found with the degree to which clients felt **rapport** with their counsellors, an amalgam of feeling understood, respected, supported and helped.

Averaged across all the clients at an agency, these same two dimensions were also related to that agency's functioning averaged counsellors from that agency. Effectively this analysis sought to relate the organisation's health as perceived by its staff, to how deeply its clients engaged with its services. Some significant relationships emerged, notably between client treatment participation and rapport with their counsellor, and how far the agency's staff felt it provided opportunities for professional development and to what degree they took up those opportunities. The participation dimension was also related to staff's feelings that they had the skills to do their jobs, but were also willing to try new things and adapt, and to their perceptions that the agency had a clear mission and programme and that staff were not unduly pressured.

Relationships between these variables differed substantially from those recorded in the USA, where feelings of rapport with one's counsellor were strongly related to many more aspects of the organisation's functioning. The analysts suspected this might be due to the diversity of agencies in the English sample, some of which would not have been expected to develop therapeutic relationships with their clients.

To narrow in on a more homogenous set of treatment services, another analysis confined itself to 22 agencies in the Birmingham region, embracing 142 counsellors and 858 clients. Importantly, these clients could be individually linked to their counsellors, meaning the client's engagement with treatment could be related to their *own* counsellor's perceptions of themselves and the service they worked for. At this more fine grained level, client participation was greater in services whose premises were more suited to counselling and which had gone further in computerising their work, including client assessments and records. Apart from these concrete features, participation was also greater in services characterised by team working and mutual trust among staff, and which encouraged discussion and implementation of new ideas and procedures – attributes also related to greater client rapport with their counsellor. In addition, rapport was greater when staff felt services had adequate guidance on providing an effective service, were better resourced in terms of staff, training, and equipment, had a clear mission and programme, fostered open communication, and were receptive to staff suggestions, ideas and concerns.

Given the Birmingham findings, the analysts concluded that relationships between organisational functioning and quality of services were rooted in the personal interactions between clients and counsellors. The implications were that engagement might be improved by starting treatment with interventions (if needed) to rectify clients' low motivation, poor mental health, and anger-related problems, and by developing well resourced organisations which foster communication, participation and trust among staff, have a clear mission, but are open to new ideas and working practices.

FINDINGS This study is the most wide-ranging and systematic investigation of the organisational health of British treatment services, and of its potential impacts on the

degree to which clients are enabled to benefit from treatment by deepening their engagement and strengthening their relationships with their key workers.

Despite their complexity, there is a coherence to the findings. Most striking is role of openness to change − to new ideas, new ways of working, to developing skills and knowledge among staff − and openness to change agents in the form of staff who suggest changes (facilitated by an environment which encourages open communication) and training and educational inputs. Staff working in an atmosphere of support and respect for their views, and concern for their development, tended to have clients who also felt understood, respected, supported and helped. Openness to change and respect for other people may also have been expressed in the more concrete features which characterised engaging services − premises which afforded privacy and an environment conducive to counselling, and the embracing of new technology. Importantly, also influential was the degree to which a service was clear about what it was trying to do and how it was trying to do it, and communicated this to its staff. The study provides no mandate for undiscriminating innovation or undirected change, rather for change in the context of a securely anchored foundation of mission and methods.

The analysis could only discover associations between organisational health and treatment engagement measured at the same time, not whether one actually led to the other. However, there is a growing weight of similar evidence of which only a few examples can be cited here. Clearly relevant is a UK study featured in Findings which found that openness to change among drug workers was strongly related to the degree of improvement in their clients' substance use and social and psychological functioning from intake to treatment exit.

Organisational openness may also be reflected in willingness to submit the agency to scrutiny from external accreditation bodies (presumably entailing readiness to change in response to that assessment) and in actively networking with other agencies, both of which render the organisation more porous to different ways of working. Studies of drug treatment services (1 2 3) have found both these variables can be quite strongly related to the adoption of evidence-based practices.

One mechanism via which organisational openness might have an impact is readiness to change in order to adopt evidence-based practices (which in turn should improve outcomes). Just such a relationship has been noted across behavioural health services. Agencies which defensively prioritised convention and conformity were least likely to be open to new practices, more dynamic agencies which prioritised achievement, individualism and self-actualisation rather than security were most likely. It also seems that staff in agencies of the kind found most engaging in the featured study are personally most able to implement new learning gained in training, and also see their agencies as more likely to adopt innovations and techniques from training.

Studies are lacking on whether it is possible to *deliberately* engineer organisational change along the dimensions investigated in the study in ways which actually improve treatment engagement or outcomes. Such studies are rare probably because change along dimensions like mutual trust among staff, or willingness to listen to their suggestions, cannot simply be introduced by researchers and then studied. However, at least one study has shown that feedback of scores from the organisational health scale used in the featured study can motivate less well functioning agencies to engage in an

improvement programme. Agencies which scored as less open to change and staff suggestions – the ones which would normally be least likely to engage in a change process – were the ones most likely to commit to change when faced with the evidence of their shortcomings.

The implications of the study and of allied work stretch down from the organisation to its staff and up to the national, regional and professional regulatory and other structures which influence organisations and staffing. These are capable of confusing services and staff about their mission and forcing contradictory objectives on services, or of giving a clear mission which services and staff can embrace. They may also promote responsiveness to people and ideas within a clear framework, or in effect if not intention, encourage services and staff to play safe and conform to current accepted practice, risking de-individualisation of treatment and stifling innovation and staff commitment.

Thanks for their comments on this entry to Dwayne Simpson of the Institute of Behavioral Research at the Texas Christian University, USA. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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