ALCOHOL RESEARCH UK

Development of the Brief Addiction Therapist Scale (BATS)

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Key findings

- A literature review and three-round Delphi survey facilitated the development of a Brief Addiction Therapist Scale (BATS), designed to evaluate the delivery of substance use treatment in routine practice.
- Practitioner feedback, and validation in four clinical samples including two multi-site studies, suggests the scale has good psychometric properties and high inter-rater reliability.
- In initial feedback practitioners and experts have been positive, supporting its utility, ease of use and importance.

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Background

Research has identified a number of effective components of treatment for alcohol and drug misuse and addiction. However, in order to ensure best practice and the maintenance of universal standards, continued monitoring and supervision of delivery is needed. This monitoring needs to be able to assess the extent to which effective methods are being used by therapists in routine practice. A number of instruments have previously been developed for treatment process evaluation (Madson & Campbell 2006). However, these tend either to focus on specific treatment types (e.g. Tober et al. 2008; Madson et al. 2005) or be too lengthy for use in routine practice (e.g. Carroll et al. 2000).

The aim of this study was to develop and validate a trans-theoretical scale that could allow for effective monitoring across a range of treatment types, and in a range of routine settings.

Methods

A literature review of existing scales designed to measure active components of effective treatments found 26 instruments with a total of 793 items. After thematic coding, eighteen 'exemplar items' were identified.

These 'exemplar items' were considered by 12 experts in the field of service provision and practice evaluation, using a Delphi survey (Powell 2003). After three rounds, consensus was reached on 12 items, which formed the first version of the scale. Item definitions providing guidance were also produced. Practitioners from four treatment sites were then consulted and minor amendments were made. Validity testing was conducted by the primary investigator by

using the scale to evaluate four video-recorded sessions. Reliability testing was conducted by two researchers by independently rating a sample of video from these clinical samples.

The final scale was tested for validity with 80 pre-existing recordings of therapy sessions in routine practice. These had been created as part of three previous randomised controlled trials, and ranged from brief opportunistic intervention in hospital and primary care to hour-long sessions in specialist treatment settings. Providers included both NHS and third sector, and practitioners included psychiatrists, medical staff, general and psychiatric nurses, counsellors, and addiction therapists. Concurrent validity was based on the finding of significant correlations with ratings from two other instruments in previous research reports (Watson et al 2013a; Watson et al. 2013b). Pearson's r = 0.678, p=0.01; r=0.805, p=0.01 respectively. Twenty recordings were randomly selected for double rating by two members of the research team to test for inter-rater reliability: individual item agreement ranged from 74% to 89%. Overall agreement per tape rated ranged from 83% to 100%.

Implications

In the absence of regular supervision and monitoring of practice, practitioners can lapse into ineffective interactions with service users (Martino et al. 2008). The Brief Addiction Therapist Scale was designed to promote the maintenance of effective practice by supporting both training and routine supervision. It can be applied with no additional costs to services, and can be used to evaluate standards at both individual and agency level. In each case, it can help assess the quality of the treatment being delivered.

The scale sets key standards for competence in treatment delivery, using Likert scale ratings to enable the tracking of improvements (or deterioration) in delivery. The quality of practice can, therefore, be better quantified and the effects on treatment outcome more consistently measured (Schoenwald & Garland 2013).

The BATS scale has acceptable psychometric properties and has been shown to be well understood and accessible to a range of practitioners. The scale has been adopted for peer supervision at a multi-site NHS addiction service in the UK, demonstrating its potential to impact on service delivery. It has been requested for use in specialist services in Estonia and Wales and implementation is being followed up. Feedback continues to be sought.

Further Information

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B A T S

Brief Addiction Therapist Scale

A tool for evaluating therapists' delivery of psychological therapies for alcohol and drug use problems.

Designed to facilitate training and supervision, and enhance therapist skill.

Instructions for use: For each item, circle a number on the 5-point scale reflecting the extent to which the therapist carried out the behaviour. For items that are not applicable to the session, score 0 'not at all'. Use the space provided on page 2 to give context, comments, and additional information e.g. the client's first session. Item definitions are provided on page 2. To be used with audio or video recordings of therapy sessions.

During the session…	Not at all	A little	Somewhat	A good	Extensivel
1. The therapist kept the session focused on the aims for that session.	0	1	2	3	4
2. The therapist attempted to work together with the client.	0	1	2	3	4
3. The therapist conveyed empathy.	0	1	2	3	4
4. The therapist focused on the client's strengths.	0	1	2	3	4
5. The therapist used "complex reflections" – offering a perspective which added meaning and enabled the client to make connections.	0	1	2	3	4
6. The therapist and the client planned tasks for the client to do between sessions.	0	1	2	3	4
7. The therapist and the client reviewed tasks planned in the previous session.	0	1	2	3	4
8. The therapist enabled the client's goals for treatment to be discussed.	0	1	2	3	4
If in this session the focus was on building motivation for change:					
9. The therapist encouraged the client to consider inconsistencies between their substance use, and personal goals or values.	0	1	2	3	4
10. The therapist encouraged the client to talk about the positive aspects of changing substance use.	0	1	2	3	4
If in this session the focus was on planning or maintaining change:					
11. The therapist enabled a plan for changing the client's substance use, or maintaining change, to be discussed.	0	1	2	3	4
12. The therapist discussed how the client's social network might support changing substance use or maintaining change.	0	1	2	3	4

Total score:	

Item definitions

1. **Session aims:** The therapist kept the session focused on clinically relevant aims during the session, e.g. target behaviour. This may or may not include explicit discussion of the purpose of the session, *e.g. to describe a relapse prevention plan*. Aims may change during the course of the session following disclosure of risk.
2. **Working together**: Developing a collaborative relationship between the client and the therapist. It is about discussing, actively seeking the client's input; not telling, and not arguing.
3. **Convey empathy**: Making efforts to convey warmth and understanding of the client's thoughts and feelings. The therapist avoids any blaming or labelling.
4. **The client's strengths**: Helping the client to identify and focus on what they can do, not what they cannot do: achievements rather than failings.
5. **Complex reflections**: Helping the client to gain insight by making and/or strengthening connections between things they have said. Going beyond repeating or slightly rephrasing what the client has said.
6. **Planning tasks**: Any task that is planned (the therapist and the client agreed what to do and how to do it) for the client to do between sessions, *e.g. specific homework tasks, trying new behaviours*.
7. **Reviewing tasks**: Explicit discussion in which tasks set in the previous session are reviewed. This item is not applicable if it is the client's first session, tick the box as appropriate.
8. **Treatment goals**: Goals refer to the overall treatment goals, *e.g. abstinence, harm reduction, moderation*. The goals could be discussed by the therapist and/or the client.
9. **Considering inconsistencies**: Exploring how the client's behaviour conflicts with his/her personal goals and values, *e.g. I need to drink a bottle of gin but I want to be a good parent*.
10. **Talking about change**: The therapist encourages the client to talk about the positive aspects of changing.
11. **Change planning**: Discussion of an overall plan to achieve the agreed treatment goals. Tasks represent the steps in the plan to achieve the overall treatment goals.
12. **The social network**: The therapist facilitates a discussion about the client's actual and/or potential social network to identify how this may support the overall plan.

Context, comments, and additional information:

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Figure 1: Brief Addiction Therapist Scale