

# Pluralistic counselling versus counselling as usual for young people presenting with addiction issues: A pilot randomised controlled trial

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## Abstract

**Aim:** The purpose of this study was to pilot a randomised controlled trial that aimed to test the hypothesis that counselling utilising a pluralistic framework was more effective than counselling as usual for young people experiencing issues as a result of their addiction.

**Method:** Sixty-four clients presenting with issues of addiction were allocated to either a counselling-as-usual ( $n = 33$ ) or a pluralistic ( $n = 31$ ) intervention. Psychometric measures (YP-CORE and SDQ) were taken at baseline, endpoint and 3-month follow-up to compare changes in levels of psychological distress.

**Results:** The use of a randomised controlled trial in practice-based research was found to be feasible to both clients and the organisation in which the study took place. Recruitment and retention rates were acceptable. No statistically significant differences between groups were found on the primary and secondary measures.

**Discussion:** The findings highlight the feasibility and acceptability of conducting such research within this unique context. The findings give preliminary evidence of the effectiveness of both counselling interventions. The absence of significant differences on our primary outcome between the two arms in this trial is not unexpected given its lack of power. Further research should continue to develop protocols to further maximise client retention and counsellor adherence.

## KEYWORDS

addiction, counselling, outcomes, pilot RCT, young people

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## 1 | INTRODUCTION

Therapeutic work with children and young people has received greater attention and research focus in the UK through increased recognition of children and young people's specific needs (McLaughlin et al., 2013). However, this increase has not yet extended to young people presenting with issues relating to addiction.

Prevalence rates in relation to addictions within youth populations are difficult to estimate because of the often illegal or shameful nature of the addiction. However, adolescence is often thought of as the peak risk period for the initiation and escalation of addictions such as substance use: around 90% of substance-abusing adults reported misuse starting in this period (Taylor & Gunn, 2013). Although drug misuse in young people, as reported by those in treatment services, remains low (UK Government, 2019), almost a quarter (24%) of young people in England reported drug-taking at least once (NHS Digital, 2018), a figure comparable with young people in Scotland, with 16% reporting having used drugs in the month previous to the study (Scottish Government, 2018). With respect to other addictions such as Internet addiction, rates have been reported to be between 1.5% and 11.6% (Kuss et al., 2013).

As with prevalence rates, the existing literature of effective interventions in relation to addiction in young people is sparse and limited by a range of factors, such as the lack of trials with treatment control groups (Fonagy et al., 2015, 2017; Waldron & Turner, 2008). However, research suggests that any therapeutic intervention tends to be more effective than none (Suls et al., 2012; Tanner-Smith et al., 2013). In addition, clinical outcomes of interventions appear to be similar. The largest multi-site trial of interventions for young people presenting with cannabis use found little difference in outcome between motivational enhancement therapy, cognitive behavioural therapy, adolescent community reinforcement therapy and multidimensional family therapy (Dennis et al., 2004). This 'dodo bird' finding was duplicated in more recent literature reviews of the evidence of the effectiveness of psychological interventions for substance misuse more broadly (Tanner-Smith et al., 2013; Waldron & Turner, 2008).

Pluralistic therapy is an evolving approach to therapy, first articulated by Cooper and McLeod (2007, 2011). The philosophical basis for pluralism is the belief that 'any substantial question admits a variety of plausible but mutually conflicting responses' (Rescher, 1993, p. 79). Pluralistic therapists therefore try to move away from the assumption that there is one 'best' therapy for all clients. Rather, pluralistic therapists try to consider, in collaboration with individual clients, what would best allow that particular client to meet their identified goals. In this respect, 'metatherapeutic dialogue'—or 'shared decision-making'—between therapist and counsellor is at the heart of the therapeutic work. By adopting this ethos of care (Cooper, 2020, Smith & de la Prida, 2021), the pluralistic counsellor sees the client as the primary agent for change and encourages them to draw on their own individual and cultural resources. An initial study of pluralistic therapy for adults with depression found high rates of completion and outcomes at a level similar to interventions

### Implications for Practice

- This pilot study shows that recruitment and retention is possible for a trial of PC against CaU. However, strategies will need to be put in place to ensure a clear differentiation between the two conditions.
- In addition, methods will be needed to ensure retention for follow-up testing.

recommended by the National Institute of Health and Clinical Excellence (NICE) (Cooper et al., 2015).

Pluralistic therapy has not yet been tested with young people or those with addiction issues. However, several of the main tenets of the approach show promise to these populations. A collaborative, shared decision-making approach has been shown to improve psychosocial difficulties, increase treatment satisfaction and decrease decisional conflict with young people (Edbrooke-Childs et al., 2016; Simmons et al., 2017; Wolpert et al., 2014). In addition, supporting adults to make decisions has been found to increase engagement in a substance misuse population (Bergman et al., 2016). Goal setting has been evidenced as important in both generic (Feltham et al., 2018), and addiction-specific, youth settings (Schroder et al., 2009; Tanner-Smith & Lipsey, 2015). A lack of goals in therapy was associated with little or no improvement, and early dropout, for young people (Schroder et al., 2009; Werbart et al., 2015).

The aim of this study was to pilot a randomised controlled trial (RCT) of pluralistic counselling (PC) against counselling as usual (CaU) for young people with addiction issues. Our objectives were to assess the feasibility of such a trial and to establish initial indicators of effect.

## 2 | METHOD

### 2.1 | Design

The pilot study adopted an individual, within-counsellor randomised controlled design. The sample size for this pilot study was based on recommendations by Torgerson and Torgerson (2008) of a minimum of 32 clients across conditions. This is based on the numbers needed to observe a difference of one standard deviation between two randomised groups with 80% power. Given trends towards the pooling of data from RCTs in meta-analyses, we chose to continue recruiting past this minimum mark, and took into the study all young people referred, and assessed as eligible, during our recruitment period.

For the purposes of this study, we used the broad-based model of addiction suggested by Orford (2001), a model also utilised in the project being studied. The key factors recognised within the model are that addiction is a largely psychological process, rather than a physical disease, and that addiction can occur in response to a wide range of different behaviours (Orford, 2001). Hence, we

included addictions discussed by Orford as part of his *excessive appetite* model of drinking, gambling, drug-taking, eating and exercise, as well as Internet addiction. Through the reading of recent research and following discussions with the Child and Adolescent Mental Health Services (CAMHS) team where the study took place, it was also decided to include self-harm as an addiction (Blasco-Fontecilla et al., 2016; Nixon et al., 2002). Additionally, following feedback from users, and based on discussions in the field (Shoshanna, 2008), anger was also included as an addictive behaviour. This inclusion was in response to clients who described anger in terms of it being a repeated failure to resist an impulse, drive or urge to perform an act that is rewarding to the person (at least in the short term), despite longer term harm either to the individual or to others (Grant et al., 2014; WHO, 2021). This ritualistic use is consistent with Orford's excessive appetite model (2002).

Risk to self and others was considered when assessing for suitability to the service. This risk was continually monitored through the use of YP-CORE at the beginning of every session.

## 2.2 | Participants

The service was open to all young people who were affected by addiction (either their own or that of another) between the ages of 12 and 25 who lived in Moray, Scotland. Recruitment took place between September 2013 and January 2015 in a service in the Moray area. Clients came from secondary schools throughout Moray: six state-funded day schools and one privately funded boarding school. All were of mixed sex. Young people who were no longer at school were also referred from various services: supported housing projects, social work criminal justice services, Careers Scotland and the local college. Eligibility criteria for inclusion in the study were as follows: aged at least 13 years at baseline, primary presentation of addiction (as per the definition above), an expressed desire to reduce their addictive behaviour, an expressed desire to see a counsellor and sufficient maturity to be able to consent to participate in research.

Referees who declined to be part of the study, but met the organisation's criteria for acceptance, were offered a counselling-as-usual intervention.

Over the period of the study, 137 clients were referred to the service and 101 were assessed for eligibility to participate (Figure 1). Of these, 10 declined to participate and four withdrew consent after the baseline test. In addition, 23 clients attended the baseline testing appointment but, through discussion at this appointment, decided that they did not require counselling. The remaining 64 clients were deemed eligible to participate in the trial, gave written informed consent and were randomised to PC ( $n = 31$ ) or CaU ( $n = 33$ ).

Across both conditions, 36 clients were female (56.3%) and 28 were male (43.8%; Table 1). The majority of clients were in the 13–15 age range ( $n = 35$ , 54.7%) and described their ethnic origin as

Scottish ( $n = 45$ , 70.3%). In most cases, clients lived with their parents/carers ( $n = 47$ , 73.4%). Self-harm was the most common presenting issue ( $n = 27$ , 40.3%), followed by smoking ( $n = 10$ , 15.6%) and gaming ( $n = 6$ , 9.4%). There were no noticeable differences in demographic characteristics by condition.

## 2.3 | Measures

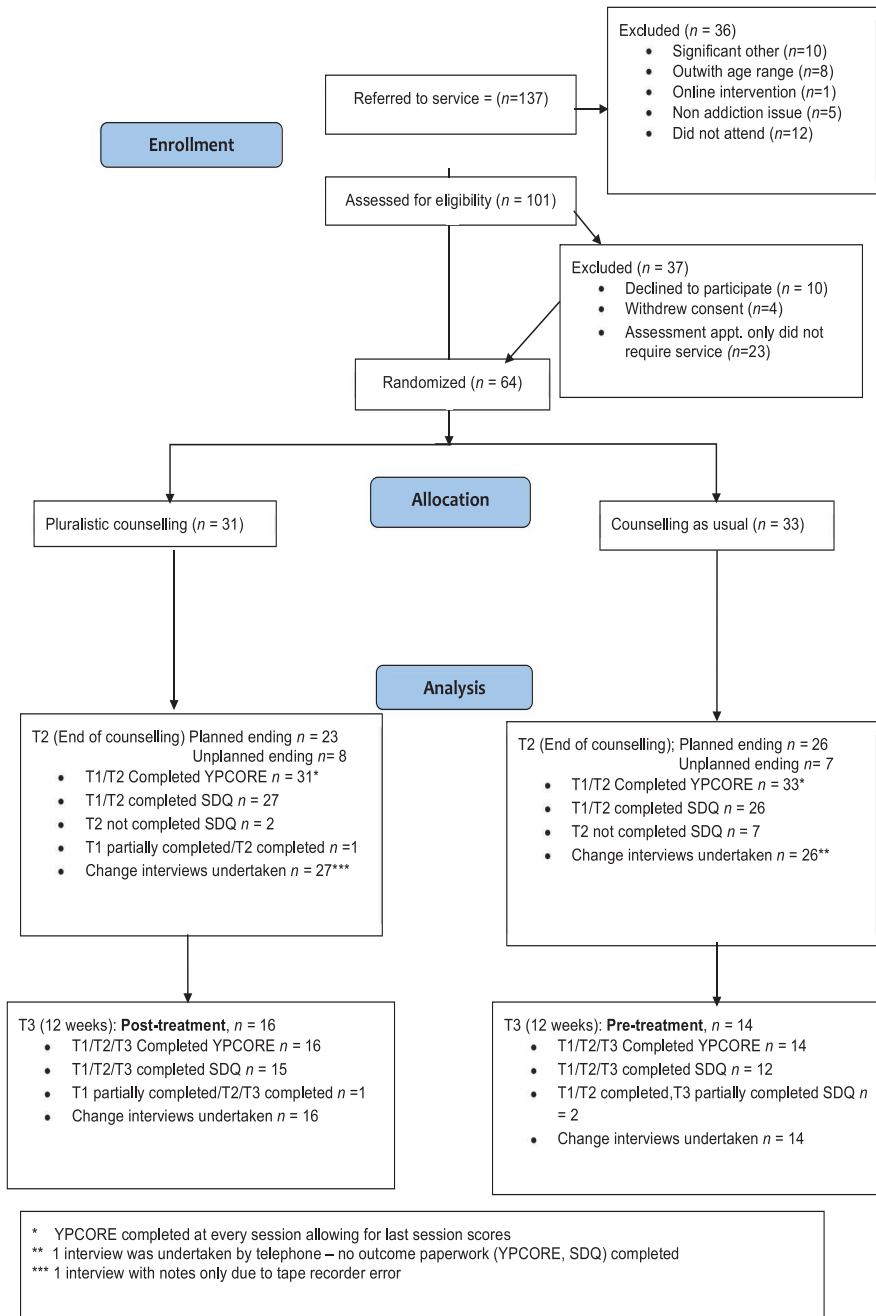
The primary outcome was psychological distress, as measured by the Young Person's CORE (YP-CORE; Twigg et al., 2009, 2016). Responses are rated using a 5-point Likert scale ranging from 0 (not at all), 1 (only occasionally), 2 (sometimes), 3 (often) to 4 (most or all the time). The internal and test-retest reliability of the YP-CORE has been established. In the present data, the measure showed good internal consistency:  $\alpha = 0.86$  at baseline.

The self-reported Strengths and Difficulties Questionnaire (SDQ) was adopted as a secondary outcome measurement. The SDQ assesses psychological difficulties and is a widely used brief behavioural screening instrument for children and young people aged 11–16 (Goodman, 2001). It consists of 25 questions divided into five domains, four of which are difficulties-oriented: emotional symptoms (SDQ-ES), conduct problems (SDQ-CP), hyperactivity (SDQ-H) and peer relationship problems (SDQ-PP); and one of which is strengths-oriented: prosocial behaviour (SDQ-PS). The total difficulties score of the SDQ (SDQ-TD) is generated by summing the scores on the four distress-related scales. In contrast to the YP-CORE, instead of weekly, the clients were asked to reflect and report on their feelings over the last six months at baseline and then over the past month at follow-up.

The SDQ-TD score has been found to demonstrate adequate levels of internal consistency (Goodman, 2001; Goodman et al., 1998) and convergent validity with other child psychological distress measures such as the Child Behaviour Checklist (CBCL) (Muris et al., 2003), the Boxall Profile (Couture et al., 2011) and the Treatment Outcome Package (TOP) (Baxter et al., 2016). However, it has been found to have poor internal consistency on some subscales, such as peer problems and prosocial (Liang et al., 2019); and conduct problems, hyperactivity and peer problems (Mellor et al., 2016; Roy et al., 2008). In the present data, the internal consistency of the SDQ-TD scores was found to be satisfactory:  $\alpha = 0.72$  at baseline. Across the three time points, internal consistency was also satisfactory for the emotional symptoms (SDQ-ES;  $\alpha = 0.72$ – $0.80$ ) and hyperactivity subscales (SDQ-HA;  $\alpha = 0.69$ – $0.79$ ). However, for the three other subscales it was not at acceptable levels: SDQ peer problems:  $\alpha = 0.45$ – $0.64$ ; SDQ conduct problems:  $\alpha = 0.36$ – $0.51$ ; and SDQ prosocial:  $\alpha = 0.27$ – $0.57$ .

## 2.4 | Interventions

Clients were seen in both informal (youth clubs) and formal (school) settings. Each organisation that housed the project on a consistent



basis was given a time slot. This was negotiated based on the need for each organisation but was typically a half day per week. Young people were made aware of when the counsellor would be in the school and could either self-refer or be referred by another person (e.g. youth worker, teacher) via email or telephone. Potential clients could also simply drop in to see the counsellor. The interventions were not time-limited; the client and counsellor worked collaboratively to decide the length of the intervention.

#### 2.4.1 | Counselling as usual

The CaU intervention began with a dialogue between the client and counsellor on the client's stage of the transtheoretical model

of change (Prochaska & DiClemente, 1983). Based on this collaborative assessment and ongoing dialogue, the counsellor then utilised a variety of different interventions within a humanistic framework. These interventions most commonly included motivational interviewing (Miller & Rollnick, 2013) to resolve ambivalence and CBT to promote introspective thinking and to increase awareness of behaviours and motivations to avoid or minimise the addiction or to avoid high-risk situations (Velleman, 2011). Relapse prevention and management therapy were also used adjunctively (Witkiewitz & Marlatt, 2004). As it is recognised that there is no dominant paradigm when working with addiction, the tailored integration of these evidence-based principles and practices was thought to be effective for individuals seeking behavioural change (Velleman, 2011).

TABLE 1 Client demographics

	PC	CaU	All clients
	N (%within cond.)	N (% within cond.)	
<b>Gender</b>			
Male	14 (45.2)	14 (42.4)	28
Female	17 (54.8)	19 (57.6)	36
<b>Ethnic origin</b>			
Scottish	24(77.4)	21(63.6)	45
British other	2(6.5)	3(9.1)	5
White other	2(6.5)	–	2
British	3(9.6)	8(24.2)	11
Other	–	1(3.2)	1
<b>Age range</b>			
13–15	20(64.5)	15 (45.5)	35
16–18	7(22.6)	11(33.3)	18
19+	4(3.2)	7 (21.2)	11
<b>Presenting issue</b>			
Self-harm	14 (45.2)	13 (39.4)	27
Gaming	6 (19.3)	2 (6.1)	8
Alcohol	4 (12.9)	4 (12.1)	8
Smoking	4 (12.9)	6 (18.2)	10
Drugs	2 (6.5)	5 (15.2)	7
Anger	1 (3.2)	1 (3.0)	2
Eating	–	1 (3.0)	1
Gambling	–	1 (3.0)	1
<b>Living circumstances</b>			
With parent(s)	24 (77.5)	23 (69.7)	47
Supported acc.	4 (12.9)	4 (12.1)	8
On own	1 (3.2)	2 (6.1)	3
With guardians	1 (3.2)	1 (3.0)	2
Res. school	1 (3.2)	–	1
With partner	–	3 (9.1)	3

## 2.4.2 | Pluralistic therapy

The PC therapy intervention drew on methods described by Cooper and McLeod (2011). A collaborative assessment was firstly undertaken that included the construction of a 'goals, tasks and methods' sheet to gain a shared understanding of the client's therapy goals, and the tasks and methods that they believed could help them reach these goals. The sheet was then reviewed at the beginning of each session, allowing for a continued dialogue and facilitating understanding of the continued needs of the client. A young person-specific Therapy Personalisation Form (YP-TPF) was also developed and used within the collaborative assessment. This aimed to identify the style of therapy that might be suited to the needs of the individual client. A Session Rating Scale form (SRS; Duncan et al., 2004) was also completed at the end of each therapy session. This was to continue further dialogue on the client's needs and preferences for in-session activities.

There was no formal checking of adherence to PC. However, data were available on whether the clients had completed the three PC measures.

## 2.4.3 | Supervision

To ensure there was a demarcation between the two interventions, counsellors attended separate supervision for CaU and PC. Those who clinically supervised CaU were trained to a professionally recognised training level, having achieved COSCA (Counselling & Psychotherapy in Scotland) supervisor accreditation. All clinical supervisors had a minimum of 5 years' clinical supervisory experience. The first author undertook the clinical supervision of PC. They are a COSCA-trained and COSCA-accredited clinical supervisor with more than 10 years of experience, who has undertaken further supplementary pluralistic supervisory training at the Abertay University.

## 2.5 | Procedures

Ethics approval was obtained from the relevant university ethics committee. To ensure there was consistency across schools, the Director of Education for Moray was contacted to explain the study and explore mechanisms for informing the schools and the primary carers of potential participation. From this discussion, a letter was composed and sent to all secondary school headteachers in the Moray area. This information provided instruction on the need to inform parents of all secondary school young people of their right to withhold consent to be part of the research (parental assent). The vulnerability of the potential participants (young people with addiction) was considered, and a decision was made that no communication to individual parents of participants would be forthcoming to ensure the right of the young person to a confidential service was upheld. Those in other settings were informed by the co-ordinator of the service of the study's aims and objectives in a manner appropriate to each setting.

All potential referrers—for example pastoral staff in schools, social workers, young people support staff—were given training prior to study commencement about the participant selection criteria and to inform them of the aims and objectives of the study.

### 2.5.1 | Randomisation

Randomisation was within counsellors, with study counsellors delivering both the experimental (PC) and control (CaU) intervention. Client allocation to the counsellor was dependent on their geographical location.

Randomisation was carried out using a randomisation sequence generated by an online computer programme (<https://www.sealedenvelope.com>). Randomisation was blocked using random permuted blocks of four. Once the initial baseline test was undertaken, the organisation administrator (on receipt of baseline paperwork that included signed consent) would then assign a unique client ID to the client and randomise. At the weekly allocation meeting, the study counsellors were informed of their new clients for the week and the condition to which they were allocated.

Clients were not explicitly informed of the condition they were allocated to. However, clients in the PC condition were given an information leaflet at their first appointment explaining the pluralistic approach. This information was also further discussed by their counsellor. Those allocated to CaU received information on the counselling-as-usual approach orally.

### 2.5.2 | Testers

Testers met with the client to collect data at baseline, the end of counselling and three months after the end of counselling. Baseline and end of counselling tests were undertaken by the

manager of the service and other volunteer counsellors at the organisation. All testers were informed of the purpose and principles of the study and trained in the use of the documentation and tools that would be utilised. Testers were not blinded to the clients' allocations.

### 2.5.3 | Counsellors

Three counsellors delivered both the PC and CaU therapy in the study. They were two women and one man, one aged between 45 and 54 and two between 55 and 64. The counsellors had originally trained to diploma level in a humanistic modality and had subsequently undertaken specific training for work in addictions with young people. All three had been qualified as counsellors for between 5 and 10 years.

Prior to the study, each counsellor was given training on implementing a pluralistic approach in their work. This was via weekly meetings over a period of approximately six weeks, and an additional half-day input from a trained pluralistic therapist. Additionally, throughout the study, an opportunity was given to continue to explore this way of working within team meetings.

## 2.6 | Data analysis

All quantitative analyses were conducted using SPSS version 24. As YP-CORE scores were collected at each session, last session scores were available if clients dropped out before the end of therapy. SDQ data were only available if clients undertook an end of therapy testing meeting. Three-month follow-up data for both measures (YP-CORE and SDQ) were only available if the client attended the 3-month follow-up testing point.

Data were inspected for outliers, defined as any score falling more than 1.5 times the interquartile range above the third quartile or below the first quartile.

One-way between-groups analysis of covariance (ANCOVA) was conducted to compare the YP-CORE and SDQ scores of those in PC and CaU at the end of therapy and at 3-month follow-up. Baseline YP-CORE and SDQ scores were used as the covariate.

The cut-off for statistical significance was set at  $\alpha < 0.05$  (two-tailed). Because of the pilot nature of the study, Bonferroni's corrections were not applied. Effect sizes and 95% confidence intervals were calculated using the effect size calculator from the Centre for Evaluation and Monitoring, Durham University (<http://www.cemcentre.org/>). Effect sizes are given as Hedges'  $g$  (Hedges & Olkin, 1985), which multiplies Cohen's  $d$  by a small correction factor to compensate for bias in small sample sizes. To describe the magnitude of effect sizes, standardised criteria from Cohen (1988) have been used whereby an effect size (Cohen's  $d$ ) of 0.2 can be considered small, 0.5 medium and 0.8 large. Hedges'  $g$  can be converted to Cohen's  $d$  for this purpose.

### 3 | RESULTS

#### 3.1 | Feasibility

As indicated in Figure 1, 37 of 101 clients (36.6%) assessed for eligibility declined to participate, withdrew consent or decided that they did not require counselling. Thirty-one young people completed the PC arm of the counselling, with 27 (90%) available for endpoint testing. Within the CaU cohort, 33 young people completed the counselling, and 26 (78.8%) were available for endpoint testing. As the Young Persons Clinical Outcome in Routine Evaluation (YP-CORE) data were collected at the beginning of each session, start and endpoint data were available for 100% of both PC ( $n = 31$ ) and CaU participants ( $n = 33$ ). Strengths and Difficulties Questionnaire (SDQ) data were available for 52 (81.2%) participants: 26 (83.9%) PC and 26 (78.8%) CaU.

The mean total sessions offered to those in the PC arm of the study were 13.4:  $M = 9.0$  sessions attended,  $M = 2.1$  sessions cancelled and  $M = 2.3$  sessions non-attended without reason (DNA). In the CaU arm, the reported sessions offered were  $M = 10.5$  sessions,  $M = 6.9$  sessions attended,  $M = 2.1$  sessions cancelled and  $M = 1.6$  sessions non-attended without reason (DNA).

#### 3.2 | Primary outcome: YP-CORE

At baseline, the mean scores on the YP-CORE in the PC and CaU groups were 19.7 ( $SD = 8.5$ ) and 19.0 ( $SD = 9.1$ ), respectively

(Table 2). At the end of therapy, there was no statistically significant difference in psychological distress between the PC and CaU arms,  $F(1,58) = 0.91$ ,  $p = .34$ ,  $g = 0.19$ . This was also the case at 3-month follow-up,  $F(1,25) = 0.85$ ,  $p = .37$ ,  $g = 0.25$  (Table 3).

#### 3.3 | Secondary outcome: SDQ

There was no statistically significant difference at the end of counselling in psychological difficulties on the SDQ-TD,  $F(1,49) = 0.27$ ,  $p = .61$ ,  $g = 0.02$ . Similarly, no statistical difference was found in relation to the SDQ-ES subscale,  $F(1,49) = 0.05$ ,  $p = .83$ ,  $g = -0.01$ ; or the SDQ-HA subscale,  $F(1,49) = 1.12$ ,  $p = .30$ ,  $g = 0.16$ .

At 3-month follow-up, there was a statistically significant difference on SDQ-TD,  $F(1,24) = 9.02$ ,  $p = .01$ ,  $g = 0.44$ , with clients in the CaU condition showing greater positive change than clients in the PC condition. There was also a statistically significant difference in favour of the CaU group on the SDQ-H subscale scores,  $F(1,24) = 5.32$ ,  $p = .03$ ,  $g = 0.67$ . No statistical difference was found on the SDQ-ES subscale,  $F(1,24) = 0.96$ ,  $p = .34$ ,  $g = 0.22$ .

#### 3.4 | Sensitivity analyses

Three clients were identified as outliers on the YP-CORE, two at endpoint and one at 3-month follow-up. A sensitivity analysis of

TABLE 2 Baseline and end of counselling scores

	PC					CaU				
	Baseline		End of counselling		N	Baseline		End of counselling		N
	M	SD	M	SD		M	SD	M	SD	
YP-CORE	19.68	8.54	10.26	9.33	31	19.00	9.15	9.58	7.68	33
SDQ-TD	16.77	4.11	13.58	5.22	26	17.65	6.18	13.50	5.99	26
SDQ-ES	5.00	3.11	3.81	2.71	26	5.69	2.51	4.12	2.30	26
SDQ-H	5.23	1.95	4.85	2.28	26	5.69	2.43	4.58	2.67	26

Abbreviations: CaU, counselling as usual; PC, pluralistic counselling; SDQ-ES, SDQ emotional symptoms; SDQ-H, SDQ hyperactivity; SDQ-TD, SDQ total difficulties; YP-CORE, young person's CORE.

TABLE 3 Baseline and 3-month follow-up scores

	PC					CaU				
	Baseline		3-month FU		N	Baseline		3-month FU		N
	M	SD	M	SD		M	SD	M	SD	
YP-CORE	19.50	10.47	12.13	7.16	16	18.36	8.33	8.79	4.84	14
SDQ-TD	16.73	4.32	17.80	5.38	15	19.00	4.22	14.92	5.52	12
SDQ-ES	5.20	5.51	5.27	2.79	15	5.33	2.10	4.67	2.43	12
SDQ-H	5.07	1.83	5.87	2.33	15	6.08	1.93	4.33	1.97	12

Abbreviations: CaU, counselling as usual; PC, pluralistic counselling; SDQ-ES, SDQ emotional symptoms; SDQ-H, SDQ hyperactivity; SDQ-TD, SDQ total difficulties; YP-CORE, young person's CORE.



outcomes was conducted with these clients removed. This did not affect results on the YP-CORE measure.

## 4 | DISCUSSION

The findings from this study suggest that the present design is feasible in terms of recruitment and retention of clients from baseline to end of counselling. However, the low retention of clients at 3-month follow-up was a significant problem identified.

Evidence suggests that the design was acceptable to participants: when asked their opinion of being part of the research at endpoint, none of the 53 clients reported negative responses. The majority of participants also indicated that the YP-CORE was an easy-to-complete outcome tool. However, they were less positive about the SDQ, with some clients describing it as confusing and age-inappropriate. The response structure for the SDQ items, with three tick boxes, was described by some participants as making it difficult to give appropriate responses to the questions. The study was also, in general, acceptable to the counsellors. They reported positive experiences of trialling the new intervention and described as helpful the tools used. The study was also acceptable to the organisation in which it took place. The use of an active (CaU) rather than passive (waiting list) control group, and follow-up procedures, gave reassurance to the organisation of the safety of the clients.

The absence of significant differences on our primary outcome between the two arms in this trial is not unexpected given its lack of power. However, the study design had important limitations. Although multi-sited, the work was undertaken in one local authority area that was predominately rural, with only one organisation and with a lack of ethnic diversity. In addition, although attrition in other young people studies has been observed at follow-up time points (Pearce et al., 2017; Pybis et al., 2015), this was not to the level observed in the present study. Most importantly perhaps, there may have been crossover effects between the PC and CaU conditions, reducing any differences in effects between groups. Each of the three counsellors delivered both interventions of the study, and the counsellors reported that the only differences in their practices were the structured use of the three tools in the PC arm. Clients in both arms also reported similar experiences.

Before a fully powered trial is conducted, therefore, it is recommended that further pilots are undertaken, with design adjustments made to address these issues and increase feasibility. Adherence checking to ensure counsellors deliver a PC counselling intervention is required, for instance through recordings that could identify moments of shared decision-making. Also, the use of different, appropriately trained, counsellors for each arm of the study is essential to ensure a clear differentiation between treatment arms. The low numbers at follow-up needs to be addressed through the establishment of more robust protocols for testing. Additionally, the definition of addiction in this study was

broad-based and included some behaviours not often thought of as addictive. Restricting inclusion to presenting behaviours most often thought of as addictive, that is, drugs, alcohol and nicotine—and, conversely, including a more diverse sample from other organisations and areas of the country—would give more definitive evidence of the effectiveness of a PC approach with this particular community.

In conclusion, this pilot study shows that recruitment and retention is possible for a trial of PC against CaU. However, strategies will need to be put in place to ensure a clear differentiation between the two conditions. In addition, methods will be needed to ensure retention for follow-up testing.

### ETHICS APPROVAL

Ethics approval for the original project was given by Strathclyde University Ref UEC13/19 on 21 May 2013 and for the additional aspects by the University of Roehampton Ref PSYC 15/ 170 on 8 July 2015.

### PATIENT CONSENT STATEMENT

All participants gave informed consent to participate in the study.

### CLINICAL TRIAL REGISTRATION

As an initial pilot study, we did not register this trial.

### DATA AVAILABILITY STATEMENT

Due to initial consent agreements with participants, the data for this study are not available for reuse.

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