

WHAT WORKS IN THE TREATMENT OF ADULT SUBSTANCE DEPENDENCY?

This document gives the reader an overview of treatment approaches for alcohol and other drug use disorders that have evidence of effectiveness and are supported by research. Treatment professionals are advised to develop skills in a variety of these techniques in order to improve the quality of treatment.

Introduction

By our choice to work in the challenging field of addictions, we all face stigma in one form or another. This plays out, in part, by some societal reluctance to support the services we provide.

As such, it is important to remember that recovery from substance use disorders is comparable to illnesses such as diabetes, hypertension, asthma, and smoking cessation. About 30-40 percent recover after the first episode of treatment. Also, since the first-ever cost-benefit study was conducted back in 1974 and many more that have followed, treatment for substance use disorders has been shown to be a good societal investment with short and long-term economic savings and social benefits that far outweigh the costs of services.

There have been, however, some legitimate questions raised about the treatment provided to persons with substance use disorders. Is it "research-based" treatment? Is treatment merely a reflection of counselors' own recovery experiences? How well is the field keeping up with new and more effective treatment approaches? Wouldn't persons with substance use disorders, if left to their own resources, achieve recovery at the same rate as those receiving professional treatment? These are important concerns that should not be ignored.

This paper is a brief summary of the scientific literature, going back to the 1970's and up through the 1990's, about what works in the treatment of persons with substance use disorders. While there are many approaches to treatment, the ones that have not been studied rigorously will not be addressed here. This paper will also not be critical about what doesn't work or what has not been studied but will rather present those treatment components that have evidence of effectiveness. With the stigma and the many questions we face working in this field, it is important to be aware of the approaches that have been studied and which of them are effective.

Before presenting this summary of findings, it is valuable to know that the studies, in general, show that treatment is effective for those who receive it and treatment is significantly better than no treatment. In addition, no single treatment

modality or approach stands head and shoulders above the rest and there is no single treatment that is most effective for everyone. The treatment methods and approaches introduced here have been extensively evaluated, many in rigorous clinical trials, and have solid empirical support to function as effective components within an overall treatment regimen.

Regardless of what the scientific literature says, let's not forget that probably one of the single most important factors in effective treatment is the quality of the relationship between the counselor or therapist and the client. A positive, caring, empathic, and sensitive counselor with good listening skills who seeks to replace the client's intimate relationship with substances, with satisfying positive relationships with people and satisfying daily activities, and who instills a sense of hope for a full and lasting recovery will do much to ensure treatment effectiveness.

Some general principles for effective treatment

To start with, treatment must be readily available. Clients entering treatment from waiting lists generally have poorer outcomes. Treatment should be individualized, culture- and gender-specific, attend to the multiple needs of clients, include case management services, and afford informed client choice. Staff need to be competent in practicing a variety of research-based approaches. Treatments that address aspects of the client's post-treatment environment and offer a continuum of care will be successful. Clients with co-existing disorders should receive services that are integrated. Client progress in treatment should be closely monitored, particularly substance use, and treatment plans modified as needed. Research has shown that treatment duration (at least 3 months) is related to better outcomes. In addition, agencies with flexible policies and a quality improvement focus will further bolster successful outcomes.

What are some of the client characteristics that signal poorer recovery possibilities?

Considering all types of treatment for substance use disorders, studies have identified key client characteristics that are associated with poorer treatment outcomes. The clinician who assesses clients for these characteristics, can know, in advance, that adjustments need to be made in the customary treatment regimen in order to increase the client's chances for recovery. These characteristics are listed in the table below.

Client Characteristics Associated with Poorer Outcomes

Unemployed
Never married, separated, or divorced
Abuses more than 1 substance
Age of onset of regular use of substances prior to age 15
Younger age (18-25)
Current or history of withdrawal symptoms
Prior treatment
Needle use (injection)
Two or more arrests in the past year
Perpetrator of physical abuse as an adult
Victim of physical or sexual abuse as an adult
Lack of positive support system
Co-occurring psychiatric disorder
Major medical condition associated with substance use
Low motivation/treatment resistance

Cognitive-Behavioral Techniques Supported by Substance Abuse Research

Coping skills training
Relapse prevention
Stress management training
Relaxation training
Social skills training
Communication skills training
Life skills training
Aerobic exercise
Biofeedback
Assertiveness training
Anger management training

What works?

Regardless of the setting of treatment (outpatient office, residential, home visit, individual, group, therapeutic community, etc.), this summary of studies points to approaches that are research-based and can be considered effective adjuncts in the treatment of substance dependency.

1. Cognitive-Behavior Therapy (CBT). Based upon learning theory, cognitive-behavioral styles of therapy attempt to help clients recognize and understand the causes of their problems and teach them the skills necessary to overcome them. The substance abuse research in this area emphasizes and supports the skills training aspects here. While the cognitive aspects are important, insight should not be the predominant focus if one wishes to practice researched-based techniques in this area. The table below lists CBT techniques that are supported:

2. Motivational Enhancement Therapy (MET). MET is based upon the principles of motivational psychology and is a client-centered counseling approach that attempts to deal with resistance or ambivalence about engaging in treatment. It seeks to reverse and/or strengthen and sustain motivation to change. The therapist instills internally motivated change and mobilizes the individual's own resources, usually involving a significant other. Fear of negative consequences (loss of job, health or family, legal actions) is replaced with a sense of hope for positive change and a "can do" attitude. MET is short-term in nature (as few as 4 sessions) and is an effective precursor to additional treatment.

3. Community Reinforcement Approach (CRA). CRA is considered to be more a form of behavior therapy since there are limited cognitive aspects. It generally utilizes social, recreational, familial, vocational, and other community reinforcers to aid clients in the recovery process. Typical components might include vocational counseling; job finding club; recreational counseling and activities; social skills training; social clubs; family/significant other/buddy/sponsor support; contingency management (see below); problem solving, time and money management training; and may include AA. The setting of treatment is varied and usually involves contact with clients in natural settings (at home; on the street; drop-in center; detox center; etc.).

4. Contingency Management. Sometimes referred to as behavioral contracting, this means the use of tangible positive and negative reinforcers (rewards and punishments) to aid the client in recovery. It covers token economies where points are given or taken away based upon the client's behavior. Points are redeemable for retail items agreed upon beforehand by the

counselor. Behavioral contracts may take the form of actual agreements that are signed by the client and counselor. Examples of rewards used include lower fees, unescorted passes, outings, free access to recreational activities (pool table; gymnasium; etc.), methadone take-home privileges, and the like.

5. Behavioral Marital, Family, and Relationship Therapy.

This treatment adjunct seeks to improve relationships through teaching interpersonal problem solving and conflict resolution skills, communication skills, parenting skills, shared decision-making, money management, and how to appropriately display affection. It involves reinforcing desirable and undesirable behaviors in appropriate ways.

6. Conditioning-Based Approaches. Sometimes called cue-exposure, these approaches focus on relapse triggers (like the sight and smell of alcohol/drugs, walking through a neighborhood where drugs are available or taverns plentiful, pay day, arguments, pressure, etc.). By repeated exposure to relapse triggers or preingestion cues, in the absence of alcohol or drug use, the client learns to stay alcohol/drug free in high-risk situations.

7. Medication Adjuncts. Aversive medications like Antabuse (Disulfiram), anti-craving medications like Naltrexone, and Methadone are included here. Antabuse can be effective when combined with counseling. Clients should have high motivation to stop drinking, a significant other that can monitor behavior, absence of liver or cardiovascular disease, and good cognitive functioning. Antabuse should be considered a short-term treatment adjunct. Joined with counseling (like relapse prevention), Naltrexone is effective for both alcohol and opiate addicted (not heroin) clients who exhibit extreme craving, an absence of liver disease, and an ability to pay for the costly medicine.

8. AA Twelve-Step Facilitation Therapy. This approach was studied as part of the Project Match experiment and it includes an orientation to AA, facilitation through the steps of AA, and attendance at AA meetings. Although found to be somewhat less effective with clients having a co-existing disorder, persons attending 12 weekly outpatient sessions had 6-month post-treatment abstinence rates of 46 percent.

Implications

With these eight approaches in mind, we must ask ourselves, "How many of these techniques is my agency incorporating into the treatment we provide?" As alluded to earlier, no single approach is effective for all clients and the more approaches we practice, the better will be the treatment outcomes. It was our intent here to give treatment professionals in Wisconsin a brief overview of what has been proven to work in the treatment of adult substance dependency. We encourage you to seek books

and manuals, professionals who have these skills, and training so that your agency's repertoire of approaches is such that it improves the quality of care provided to the persons we serve.

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