Evidence-based treatment:

Information for the service provider

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This document was prepared by Dr. John Weekes, Acting Director, Research and Policy, and Ms. Lianne Calvert, Director, Workforce Development, Canadian Centre on Substance Abuse (CCSA). It is intended to provide current, objective and empirical information to service providers interested in offering evidence-based treatment to clients.

Theory and evidence for the program model

People seeking treatment for substance abuse are entitled to receive high-quality services that are based on sound theory and evidence of effectiveness. Although such treatment models exist, some substance abuse programs currently available to Canadians lack a solid base in integrated theory and supporting evidence[1]; rather, they are based more on "belief about" or "experience of" addiction. As a result, it is difficult to measure the effectiveness of these programs or to hold them accountable to measurable standards of quality. It is interesting to note that this situation is relatively uncommon within other areas of health care and public health.

Contemporary theory and research indicate that problematic use of alcohol and other drugs evolves from a complex interplay of physiological (including genetic[2]), psychological, interpersonal and other social and situational factors. While recognizing the role of prolonged use of alcohol and other drugs on the body (e.g., neurochemical changes associated with physical dependence), "social learning" theory emphasizes the role of cognitive, emotional and environmental influences in shaping substance use behaviours. In turn, research-based intervention models respond by identifying the various factors that contribute to a person's problematic use, and then actively teaching new ways of thinking and behaving. Actively teaching clients new skills to successfully handle high-risk situations, for example, is often referred to as "cognitive-behavioural" because it is action-oriented and focuses on the person's present thoughts, feelings and actions—factors that are amenable to change.

[1] Recognizing that some culturally-specific approaches and practices may not be amenable to scientific testing.

[2] Isolating genetic markers predictive of substance abuse is proving difficult. Indeed, recent research has identified over 1,000 individual genes linked to alcohol.

Client motivation

Research indicates that client motivation is a potent predictor of behaviour change at all phases of the treatment process. Those with less serious problems may not see their behaviour as problematic—either to themselves or to those around them. Traditionally, this has been referred to as "denial" and has often been dealt with in treatment through overt confrontation—an approach with little evidence of effectiveness or appropriateness as a treatment strategy. Research also indicates that most people with serious substance abuse problems know they have a problem, but are relatively unmotivated to do anything about it. In recent years, the principles of "motivational interviewing" have been developed as a more effective way of helping individuals to recognize their problem and to do something about it.

Standardized and validated assessment leading to individualized treatment plans

Clearly, everyone is different and no single treatment plan is appropriate for all. The severity of alcohol and other drug problems varies from client to client. Therefore, it is important for service providers to use standardized and validated assessment tools and techniques to determine the severity of each client's problem (e.g., Alcohol Dependence Scale, Drug Abuse Screening Test, Addiction Severity Index, etc.). As in any other form of treatment, assessment results should be used to provide critical information for the development of a unique treatment plan for the individual. Assessment tools must be validated and appropriate for use according to the individual's gender, age, ethnicity, and language and intellectual abilities, etc.

Designing a treatment plan according to client needs

As in other health and mental health service contexts, a relatively individualized plan is constructed for each person, focusing on his or her needs and building on personal strengths and available resources. The plan is based on the individual's goals and choices (see discussion of abstinence versus moderated/reduced use below). Evidence indicates that a range of treatment services and options is needed to respond fully to each client's needs. These services will vary in intensity, duration and cost. People with low-severity problems generally need low-intensity, briefer services, while those with more serious problems may require higher-intensity and lengthier treatment. Brief "outpatient" care may be appropriate for some clients, while others may need detoxification and a residential setting in order to be stabilized and to receive the support they need to change their behaviour. Lengthy, intensive and expensive treatment services should be reserved for those individuals who clearly need this level of service.

Ongoing assessment/changes to treatment plans

A client's needs may change and evolve over the course of treatment. It is therefore important that the service provider monitor, assess (using standardized tools and methods), and modify both the detailed components and overall plan for each participant.

Evidence-based treatment techniques

Many program providers use treatment techniques that they *think* are helpful and useful to clients, but are not based on research (or theory). In fact, relatively few approaches have been evaluated by researchers. The following list contains some of the more prominent evidence-based treatment techniques with demonstrated effectiveness. Most can be delivered in either individual or small group (four to six participants) treatment settings.

- Skill development exercises, including role-plays, active rehearsal and repetitive practice;
- Cognitive-behavioural relapse prevention training;
- "High risk" identification training;
- Social skills training;
- Problem-solving skills training;
- Coping skills training (e.g., dealing with "cravings" and "urges");
- Goal-setting;
- "Motivational Interviewing"/motivational enhancement techniques;
- Employment skills training;
- Behavioural marital counselling;
- Stress management training;
- Maintenance, "booster" sessions, monitoring and aftercare; and
- Community reinforcement and support services.

Even a quick examination of these approaches indicates that effective programs actively teach participants skills and techniques, and train them to anticipate and cope with a wide range of common situations that are "high risk" for substance use. Clients learn to minimize the damaging effects of potential "slips", lapses and relapses by recognizing these as normal events in the post-treatment phase. In fact, if handled well, a slip can be turned into a positive experience that leaves the client stronger and better prepared to successfully handle future situations when they arise.

Maintenance, aftercare and post-treatment support

The process of change does not end on the final day of treatment. In fact, some experts have argued that the real work of maintaining behaviour change begins when treatment ends. It is then that clients are likely to experience urges and cravings, and to encounter various kinds of situations and circumstances that challenge their resolve and coping skills and abilities. As a result, a key ingredient in a client's long-term success is involvement in post-treatment maintenance sessions, aftercare and support. In addition, participation in "self-help" support services (e.g., AA/NA meetings, SMART Recovery, Moderation Management, Women for Sobriety, etc.) can play an important role in providing support and assistance to individuals who are attempting to maintain behaviour

change.[3] Indeed, studies reveal that clients are more likely to continue to moderate their substance use or to work successfully towards abstinence if they participate in various types of post-program maintenance or "booster" sessions, as well as various self-help activities and services.

Unique treatment for specific populations

Clients seeking treatment for substance abuse vary widely in their demographic characteristics and relationship to their social environment. Treatment programs have historically been designed to meet the needs of a culturally-homogeneous Caucasian adult male population and this may be true of many existing programs. However, other populations, including women, the young and the elderly, require treatment approaches that are designed specifically to meet their unique needs (e.g., address the strong relationship between women's substance abuse, and trauma and violence in their lives). Further, treatment providers need to respond appropriately to a culturally-diverse client population (e.g., Aboriginal peoples and their experience of oppression, including residential schools, etc.) and to provide treatment options to accommodate persons with accessibility issues, including learning disabilities, "cognitive" orientation, co-occurring conditions and other mental health challenges (e.g., clients with Fetal Alcohol Spectrum Disorder), or physical disabilities.

Full range of services

Comprehensive, well-designed programs recognize the wide-ranging impact of substance use on a person's physical and mental health, family, friends and employment, and they offer services to address various health, social, vocational, employment and legal challenges the person may be experiencing. Where appropriate, programs need to provide or be linked to services that provide pharmacological interventions for the purpose of minimizing or eliminating withdrawal symptoms, or managing co-occurring mental health issues, such as schizophrenia, bi-polar disorder, anxiety or depression. To ensure that there are adequate services to meet the many treatment needs of this diverse client population, service providers need to coordinate with each other across agencies, jurisdictions and professions to identify and address gaps in services, and to avoid duplication. This must be done as seamlessly as possible while maximizing client safety, privacy, dignity and self-respect.

Abstinence versus reduced and moderated use

Many service providers insist on complete abstinence from all drugs throughout the treatment process (some require a period of abstinence prior to participation in a program as proof of commitment). This approach is somewhat counter-intuitive and fails to recognize the cyclical pattern of abstinence and relapse that is likely to occur as a person attempts to disengage from an established habit pattern. It also fails to consider the client's treatment goals, which may range from modified use of substances to complete

[3] Although it should be noted that the services listed vary widely in their perspective and very few have been evaluated for effectiveness.

abstinence. The concept of "harm reduction" recognizes that many individuals are *unwilling* or simply *unable* to completely abstain, particularly within a short timeframe. Not surprisingly, programs that insist on complete abstinence often have very high drop-out rates because participants are unable to successfully fulfil program requirements.

Obstacles to treatment

As described above, the research literature has focused attention on the techniques and modalities of substance abuse treatment models. However, it is becoming increasingly clear that a broad range of factors have the potential to seriously interfere with an individual's ability to change his or her substance use behaviour. While some of these obstacles may not appear to be directly related to substance use, in the end, they may be critical in determining who remains in treatment, as well as who is successful. Some of these factors include housing, transportation to and from the treatment setting, scheduling conflicts with work or school, competing work and school priorities, lack of money, outstanding legal issues, lack of a support network, and a number of gender-specific issues for women such as the availability of child care, fear of loss of child custody, and anger/retaliation from spouse/partner. In order to maximize and preserve the gains made during treatment (and to minimize the negative impact of obstacles), treatment providers need to connect their clients with a range of care and supports, including primary health care, emergency services, mental health programs, court and criminal justice services, supportive housing options, employment services, and mutual aid and peer self-help initiatives (see above).

Characteristics of front-line program deliverers

A growing body of research highlights the impact of the characteristics of those who deliver front-line services on client outcomes (either positively or negatively). Some of the characteristics that have the potential to positively influence outcomes include compassion, caring, understanding, acceptance, being non-judgmental and empathetic, while at the same time maintaining professional distance and objectivity.

Training and qualifications of service providers

Currently in Canada there is no legal requirement for certification as an "addictions specialist" to work as an addictions treatment provider. However, many community colleges and universities offer certificate, diploma and degree programs in addictions and national certification based on education and work experience. Treatment service providers should ensure that the individuals they hire have the appropriate qualifications to perform their duties and should also provide staff with ongoing training and professional development opportunities in order to remain current with new developments and best practices in substance abuse service delivery.

Endnotes

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Suggested reference materials

Andrews, D. A., Bonta, J., & Hoge, R. (1990). Classification for effective rehabilitation: Rediscovering psychology, *Criminal Justice and Behavior, 17,* 19-52.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.

Irvin, J. E., Bowers, C. A., Dunn, M. E., & Wang, M. C. (1999). Efficacy of relapse prevention: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 67,* 563-570. http://homepage.psy.utexas.edu/homepage/class/Psy394Q/Behavior%20Therapy%20Class/Assigned%20Readings/Substance%20Abuse/Irvin99.pdf

Marlatt, G. A. (1998). *Harm reduction: Pragmatic strategies for managing high-risk behaviors*. New York: Guilford.

Marlatt, G. A., & Gordon, J. R. (Eds.). (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford.

Miller, W. R., & Heather, N. (1998). *Treating addictive behaviors (2nd Ed.)*. New York: Plenum.

Miller, W. R., & Hester, R. K. (1986). In-patient alcoholism treatment: Who benefits? *American Psychologist, 41,* 794-805.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford.

Miller, W. R., & Rollnick, S. (Eds.). (2002). *Motivational interviewing: Preparing people for change, 2nd edition*, New York: Guilford Press.

Poole, N., & Dell, C. A. (2005). *Girls, women and substance use*. Ottawa: Canadian Centre on Substance Abuse.

Prochaska, J. O., & DiClemente, C. C. (1986). Toward a comprehensive model of change. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Processes of change*. New York: Plenum.

Sobell, M. B., & Sobell, L. C. (1993). *Problem drinkers: Guided self-change treatment*. New York: Guilford.

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