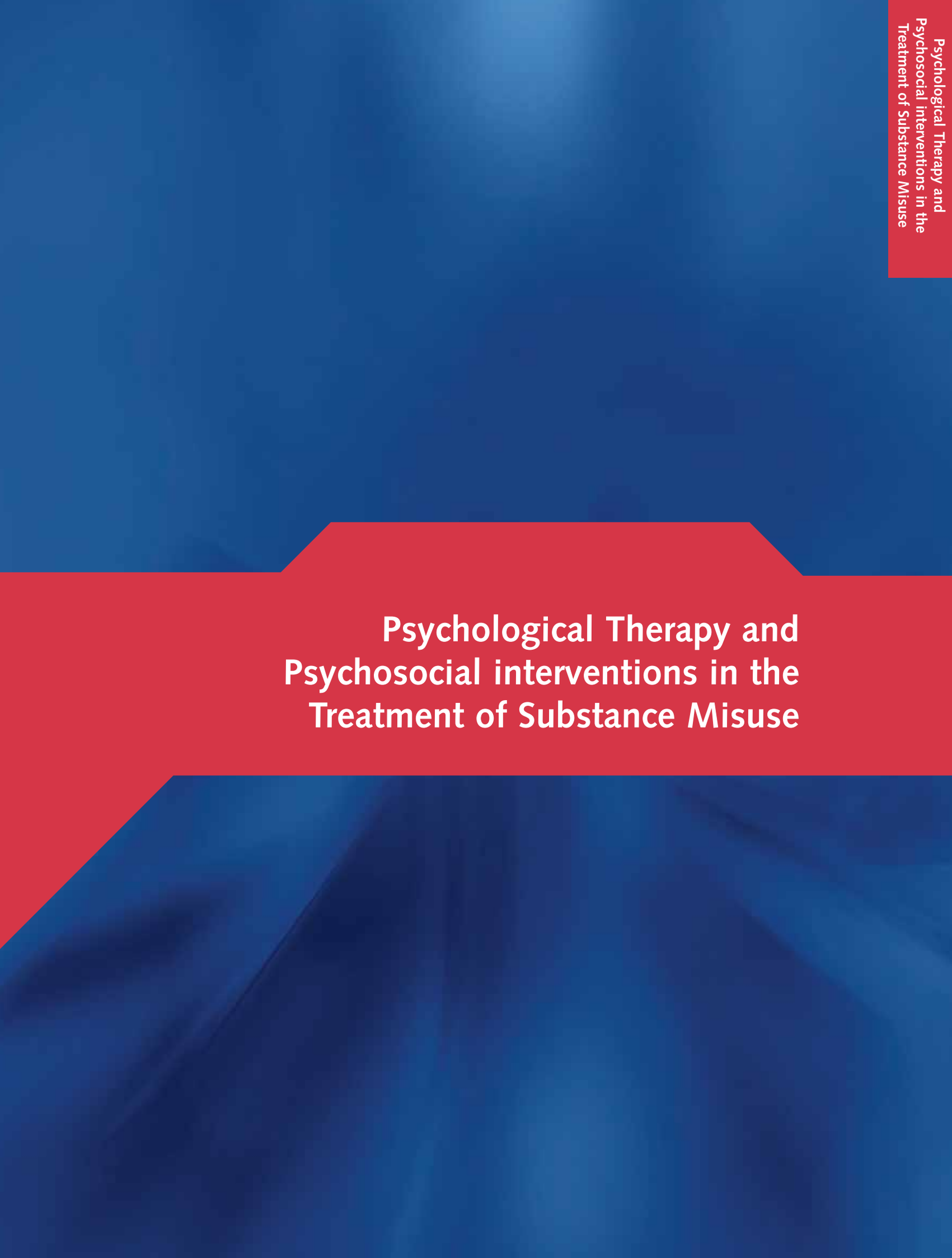
Psychological Therapy and Psychosocial interventions in the Treatment of Substance Misuse



Psychological Therapy and Psychosocial interventions in the Treatment of Substance Misuse

1. Overview

Psychosocial interventions play a significant role in the treatment and rehabilitation of substance misusers. There is a developing, though limited, evidence base for their effectiveness from clinical trials and routine services. The evidence does suggest that "counsellor characteristics" are important criteria for success.

Providers in a number of settings across Wales are currently using a wide range of psychological and psychosocial interventions.

Psychological therapy and psychosocial interventions (which includes structured counselling) are skilled activities requiring *specific training and supervision* to be practised safely. Increasingly therapists seek accreditation from voluntary psychological associations (in addition to core professional registration where appropriate) but these activities currently remain unregulated in the UK.

Workers with generic counselling skills (see **context** below) should not equate this with their ability to be qualified to provide structured counselling or other psychological therapies.

Psychological therapy and psychosocial interventions should only be offered after a thorough assessment of the potential to benefit. They require clearly defined treatment plans, measurable goals and a review process.

The application of these interventions has to be considered carefully as there are risks to client welfare of inappropriate use. There are also risks of resource wastage as a consequence of ineffective and/or inappropriate use.

Psychological therapies and psychosocial intervention have to be provided within the NHS clinical governance arrangements within Wales which were delegated to Local Health Boards and NHS trusts in April 2003.

2. Context

The therapeutic relationship that develops between worker and client is one of the most important elements of substance misuse treatment. Counselling skills, which include non-judgemental positive regard and empathy, the use of reflective practice and an awareness of the power of non-verbal communication etc, are core skills applied by substance misuse workers. These are essential for the effective delivery of practical help, crisis intervention, advice giving and support, and prescribing programmes etc.

However a distinction must be made between the use of these counselling skills and the provision of structured counselling and the other psychological and psychosocial interventions provided.

Structured counselling and other psychological interventions can be used in all of the main treatment contexts. They are usually offered as part of a care package that may also include prescribing, education and training, and the management of physical and psychological health, and social and forensic problems.

3. Philosophy and approach

A number of theoretical approaches may be applied to the provision of psychological therapy and psychosocial interventions. The most significant are:

- "Brief interventions"
- cognitive-behavioural therapy
- motivational approaches.

With specific regard to the use of structured counselling, and in addition to the cognitive behaviour therapy approach, the Effectiveness Review (Task Force to Review Services for Drug Misusers 1996) identified other approaches, i.e.:

- 12-step addiction counselling
- gestalt and
- family therapy.

Many people working in substance misuse also have specific training in offering modularised psychological or psychosocial interventions such as motivational enhancement therapy or social and behaviour network therapy. These have often been developed and described by expert practitioners within a particular orientation and staff have been trained in these approaches to widen access to treatment. *(It is essential that supervision is available from expert therapists trained within the parent psychological orientation of the modularised therapeutic approach for competent and safe practice.)*

4. Duration of intervention

The duration of the therapeutic intervention will depend upon the assessment of client need and the type of intervention/therapy employed. This can vary along a continuum, from brief interventions through motivational interviewing and cognitive-behavioural to longer-term psychotherapeutic interventions. The anticipated term should be indicated at the beginning of the treatment. A six-week duration in brief interventions would be typical for briefer or solution-focused interventions whilst motivational enhancement therapy has been manualised based on a three session contract. Slightly longer contracts may be more typical

for formulation-driven therapy. Duration of the programme may also depend on the context in which the intervention takes place (e.g. residential rehabilitation, inpatient and community prescribing, structured day programme).

5. Staffing and competence

Psychological and psychosocial therapy has to be based on written procedures and demonstrable staff competence. This includes therapists having access to regular supervision from a member of staff skilled in the intervention being used. The emerging consensus amongst professionals is that supervision ideally be carried out by someone other than the employees direct line manger. Group supervision is also an option.

Former service users can be effective therapists providing appropriate safeguards are in place, including an adequate period of recovery before engaging in this type of work as well as adequate training and supervision.

Drug and Alcohol National Occupational Sstandards (DAN0S) have to be complied with. Services providing structured counselling should:

- employ staff who are seeking professionally accredited qualifications (e.g. BACP accredited, National Vocational Qualification (NVQ) qualified or some approved equivalent
- adhere to relevant Codes of Practice (e.g. British Association of Counselling and Psychotherapy (BACP) or UK Council of Psychotherapists (UKCP)
- have written supervision protocols, which identify the purpose, regularity and process of supervision. The four elements of this are, to seek appropriate supervision, make a supervision contract, bring work to supervision, and review supervision
- employ appropriately competent and accredited supervisors (BACP or other equivalent)
- have established, clear links with other specialist counselling services for referral and joint provision
- have clear outcome and output measures for therapeutic services
- monitor and report on outcome measures
- use outcome and other performance monitoring measures to inform strategic/business planning/service delivery and policies and practices of the service
- have established membership of Local Psychological Treatment Committees.

6. Aims and Objectives

The overall aim of psychological therapy and psychosocial interventions is to make a measurable improvement to the client's welfare and ability to function.

CAMPAG, the body charged with developing standards for advice, guidance, counselling and psychotherapy, describes the objective of counselling as *"the principled use of a relationship to provide someone with the opportunity to work towards living in a more satisfying and resourceful way".*

The intervention has to be offered to clients within a deliberately undertaken contract with clear professional boundaries. Therapists should offer a commitment to privacy and confidentiality within professional and legal limits.

7. Access

Client access to psychological therapy and psychosocial interventions is voluntary and its offer should follow on from a full assessment. Services offering these treatments should provide *written information on*:

- types of therapies offered and a statement of evidence for its relative merits for specific problems
- waiting times
- place of therapy for the treatment programme offered
- qualifications and gender of counsellors.

8. Referral pathway(s)

Referral pathway(s) mirror those for the context within which the intervention is provided (e.g. inpatient and community-based prescribing, residential rehabilitation, structured day programmes). Open-access, low-threshold services can also provide structured counselling. This can take place in conjunction with treatment provided by other organisations (e.g. prescribing services).

9. Contact and referral

Services offering psychological therapy and psychosocial interventions as part of their modality should have clear protocols for referral, whether self-referral in the case of low-threshold services, or referral from outside agencies. Within modalities, the interventions are planned as part of an overall package of care.

Services offering these therapies should have clear assessment procedures, which must be completed prior to the commencement of the intervention.

10. Management

The key management processes in the provision of psychological therapy and psychosocial interventions are:

- an assessment based upon clear procedures in line with the Unified Assessment Process in Wales (see appropriate document)

- the presenting problem identified and the preferred/indicated approach specified
- allocation to therapist in line with agreed criteria
- goals for achievement agreed and set with the service user
- therapy reviewed as part of the care plan review process (see 10.1 below)
- procedures for case/closure/transfer applied (see 10.2 below)
- service user satisfaction audited upon completion of treatment.

10.1 Care planning and review

As indicated above psychological therapy and psychosocial interventions should be planned as part of the overall package of care. The care plan should be devised in partnership with the service user. Service users should be clearly informed about all timescales relating to this component of the care plan (e.g. number of sessions, timing of sessions, timing of review of progress, etc). Goals for the therapy aspect of the care plan should be agreed and reviewed with the service user. These goals should relate to dimensions of behaviour change related to the user's substance misuse. The service user has the option to withdraw from the programme at any time.

10.2 Departure Planning

Service users may end the therapy/intervention by leaving, whether or not the aims of this treatment have been fulfilled. The after care plan must be agreed from the outset so that any other professionals/agencies involved with the client will be aware of the situation. In any case, care plans can continue with any other forms of treatment in which the client may be engaged. If the client leaves prematurely, every effort should be made to re-engage them as this can be a vulnerable time and may result in relapse or increased drug/alcohol use.

11. Aftercare/continued support

The need for further therapy may become apparent following initial assessment, during the course of therapy or on formal review of service user needs. Such services may include bereavement therapy or counselling/therapy related to physical and/or sexual abuse. The substance misuse service must have clear protocols for referral and/or shared care with these services.

Onward referral can also be considered to other modalities of care, such as substitute prescribing, residential rehabilitation or structured day programmes.

Evidence Base

Introduction

The role of psychosocial interventions in the treatment of substance misuse problems is important but not well researched. Most services, which provide treatment for substance misusers, will provide some form of structured or unstructured intervention with the possible exception of some low threshold prescribing services.

No review of the levels of skill of counsellors, training or supervision employed in the statutory and non-statutory organisations has been undertaken but it may be safely assumed that levels of competence, training and supervision vary widely across Wales. Many of the non-statutory organisations grew from self-help groups or from a genuine desire to tackle a difficult problem in a local community. They were often based on the need for practical advice and interventions to help individuals cope. Often short of money and staff, counselling training may have been low on the agenda for these agencies. In the statutory sector many staff employed are from professional backgrounds such as nursing etc, but may have had no formal training in counselling particularly when trained many years ago. But because they have a professional qualification there is an assumption that they are able to counsel clients.

In addition to these factors, in the past there has been a tension between different models of intervention. For example, the Minnesota (12-step) method relies on the concept of addiction being an untreatable illness but from which one may be in recovery. Proponents of this model may disagree with harm reduction agencies, which accept drug and alcohol use as being bio-psycho-social problems entrenched in society and for which we must try to reduce the harm done by these substances to the individual and to society. The methods of psychosocial interventions in these two examples may be very different but are attempting eventually to reach similar goals.

What works in psychosocial interventions?

Marzillier (2004) has suggested that research into psychotherapy is flawed because of the intense interpersonal relationship between the therapist and client, which is possibly the most important factor. To try to run random controlled trials for psychosocial interventions is extremely difficult because, unlike medical trials you are not treating one symptom or "illness". This is one reason why there is a paucity of good research evidence. Project Match, a very large American study that attempted to match clients for one-to-one interventions compared motivational interviewing, AA's 12-step approach and cognitive behavioural therapy. Matching effects were few and modest; motivational interviewing was best for angry clients and 12 step for those highly dependent or with pro-drinking social networks. Even with 'difficult' clients the briefer motivational therapy performed as well as more intensive therapies. All treatments seemed effective with

a range of clients; the client's readiness to change had a major positive impact on outcomes. Match also found that the therapist was as important as the treatment in successful outcomes, (Ashton, 1999).

The Task Force to Review Services for Drug Misusers 1996 (Dept. of Health 2002) found only 6 articles when they reviewed the international literature on the use of counselling in the drugs field. They found that the main points to emerge were that a) counsellor characteristics are an important factor, b) the provision of counselling with methadone prescribing improves outcomes in relation to drug use, depressive symptoms and criminal activity and c) styles of counselling vary, with less structured approaches generally used in the UK.

Many of the more structured counselling interventions used in the addiction field now are based on Motivational Interviewing. (M.I.), (Miller and Rollnick, 1991). This is a system of counselling, which encourages motivation to change, using directive and client centred methods. It helps clients to explore and resolve ambivalence. Many of the interventions described as brief interventions are based on motivational interviewing. Brief interventions were described by Hodgson (2002) as being 'up to three or four one hour sessions compared to minimal interventions which are less than 30 minutes'. Minimal interventions may be useful where contact with a problem drinker or drug user may be opportune but not ongoing, such as an A and E Department.

Alcohol

John et al (2003) found improved outcomes of participation at 6 months in self help groups after detoxification in a random controlled trial of clients receiving group treatment compared to brief motivational counselling. However this difference disappeared at 12 months. There was no difference in abstinence rates between the two groups. In a randomised controlled trial Shakeshaft et al (2002) found no differences in outcomes between brief interventions and cognitive behaviour therapy apart from brief interventions being more cost effective. In a randomised controlled trial of brief interventions compared to no interventions, with heavy alcohol users attending a needle exchange, Stein et al (2002) found that there was a decrease in drinking in both groups (an assessment effect?) but that that brief intervention group were two times more likely to report periods of 7 days or more abstinence than the control group. Wutke et al (2002) in along term follow up to brief interventions with alcohol users found that the treatment group showed significant reductions in alcohol consumption at 9 months but these differences had disappeared at a 10 year follow up.

There is evidence for effectiveness in motivational interviewing (e.g. Bien et al, (2003) who conducted a meta analysis of effectiveness of MI with alcohol interventions, CBT (Project MATCH study group 1997), Relapse prevention, (meta analysis by Irvine et al, 1999). General alcohol counselling (a combination of psycho education and humanistic approaches) was found to be effective compared to no treatment or waiting list but less effective than CBT or a 12-step approach.

Drugs

In working with opiate users MI and CBT have both been shown to be effective (e.g. Pollack et al 2002, Saunders et al 1995). McLellan et al (1993) found that counselling together with methadone treatment produced better results than methadone alone in reducing opiate use. Woody et al (1995) found that time limited, focused psychotherapy with clients receiving methadone maintenance therapy found that the clients used less cocaine, required less methadone and maintained their gains more than clients receiving drug counselling. However, this study is probably irrelevant given the almost total lack of psychotherapy services in the drug field.

In the treatment of stimulant users a relapse prevention programme was found to have positive outcomes maintained at one year compared to pharmacotherapy, (Carroll et al, 1994). This must be viewed against the fact that there are no pharmacological interventions for use with cocaine users compared with methadone treatment for opiate users. Crits-Christoph et al (1999) found in a comparison of 4 treatments that all treatments were effective but that clients receiving 12 step individual counselling were more likely to achieve and maintain abstinence. In an unpublished study for the Dept. of Health, McBride et al (2003) using a random controlled trial of Dexedrine prescribing for amphetamine users that both groups improved, both groups received motivational counselling.

All of the studies cited in the drug and alcohol section used gold standard of random controlled trials or controlled trials.

Conclusions

There is a dearth of good, reliable studies investigating psychosocial interventions in substance misuse especially looking at comparative effects of different treatments. However, there is evidence that some form of counselling is better than none, and that whatever the form of psychosocial intervention it should be a subject of training within the agency and be adequately supervised.

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Glossary

Brief Interventions

Brief interventions refer to a short-term time limited intervention with a client. This may be as short as one 10-minute session giving objective feedback or advice to the client or advice, or may be 6 half hour sessions. The important difference from other therapies is that it is time limited and of brief duration over a prescribed period of time.

Cognitive Behavioural Therapy

Cognitive Behavioural Therapy or "CBT" is an approach that has grown out of behavioural therapy, which involved trying to alter the behaviour of a person with prescribed methods. The recognition that humans have thought processes and emotions and that these affect our behaviour or interpretation of events led to the development of CBT. This form of therapy is used widely with people suffering from depression and anxiety and the therapist helps the client explore those thought processes and cognitions and challenges misperceptions.

Counselling

Counselling is a generic term for interventions based on the verbal interaction between counsellor and client aimed at helping the client gain an understanding of their problems. Counselling is not about the giving of advice or education but is a process of helping the client to reach solutions themselves. Most counselling is based on a Rogerian model of listening and reflection.

Family Therapy

Family Therapy works on the principle that the problem is product of a malfunctioning system (such as a family) and that, the most effective way of solving this is by working with that system i.e. the whole family. This will involve bringing together all the relevant family members (where possible) for therapeutic sessions.

Gestalt therapy

Gestalt therapy is a specialist form of therapy rarely seen in the field of substance misuse. It is based on the belief that mental processes cannot be broken down into constituent parts but that we need to achieve Gestalt (wholeness) by including all aspects of a persons cognitive functioning. The client needs to see all sides of their problems in this approach.

Motivational Approaches

Motivational approaches are a counselling style that aims to elicit behaviour change by helping clients explore and resolve ambivalence. It is directive and client centred. It helps clients increase their "readiness to change" and to understand their resistance to change.

Psychosocial interventions

This is a broad term used to denote interventions that use talking therapies as opposed to the prescription of medication. They are aimed at the client gaining an understanding of their social situation and psychological stresses or needs.

Twelve Step Counselling

Twelve step approaches are usually based in the self help movement around the philosophy of Alcoholics Anonymous. This incorporates a set of 12 beliefs about the individuals ability to accept the problems they have with alcohol (or drugs) and the fact that they need a higher "power" to help them maintain sobriety. It is also based on the belief that the individual is not cured but is in recovery with relapse always a possibility.