

Non-medical Interventions

Psychosocial Interventions

THERE is a strong evidence base for the efficacy of psychosocial interventions in addressing problematic alcohol and drug use. A number of different models and approaches are outlined below. However, there are key features of psychosocial interventions that are consistent across all of these approaches.

This Chapter briefly covers the following clinical strategies:

- patient centred approaches
- decision balance
- building a therapeutic alliance
- motivational interviewing
- problem solving
- goal setting
- relapse prevention
- quality of life

PATIENT READINESS — A MODEL OF THE PROCESS OF CHANGE

People do give up harmful drug use, sometimes assisted by formal interventions, other times without such help. Having some understanding of the process of change can guide clinical effort. Prochaska and DiClemente (1986) developed a useful five-stage cyclical model of the process. While empirical support for this model is limited the model can still help structure the focus of interventions. Clinicians should use the model with caution, avoiding simplistic and rigid categorisations of patients.

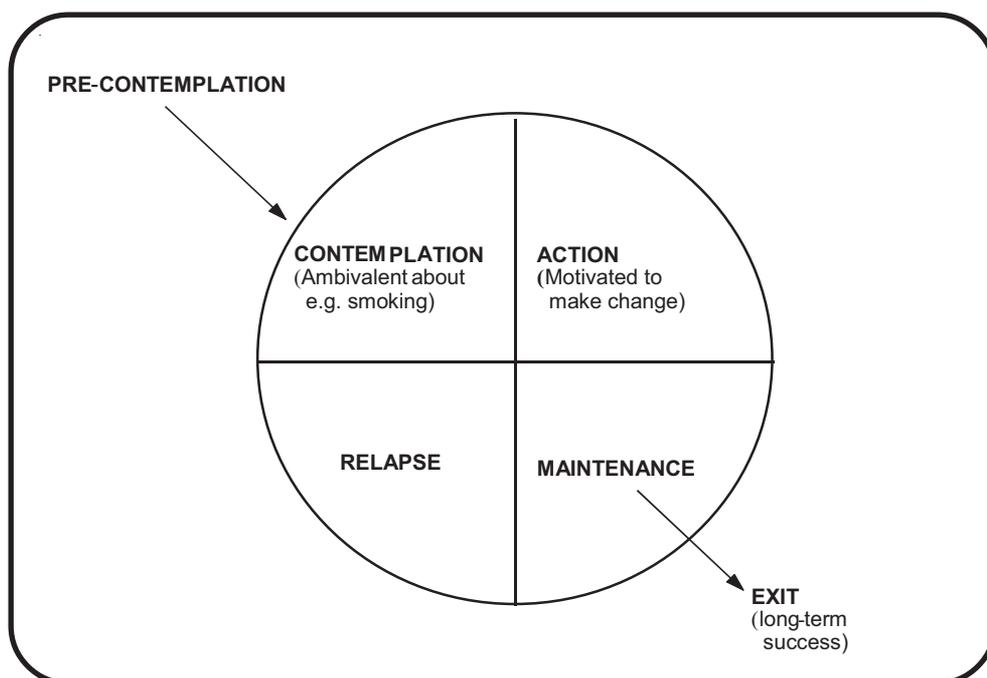


Figure 13-1
Model of the process of change (progress usually occurs in a clockwise direction)
Source: Prochaska and DiClemente (1986)

Pre-contemplation Stage

During Pre-contemplation the pros of continuing use outweigh the cons of continued drug use. Disadvantages of change outweigh advantages. You may be concerned about some consequence of your patient's drug use, but the patient may accept this as collateral damage.

Commonly, there is resistance to 'action oriented interventions' and explanations about how to 'give up', but relevant information about risks, and how to avoid or minimise them, may be well received. For example, a person injecting amphetamines might welcome information about how to avoid blood borne viruses or how to manage sleep disorders. A heroin user may be keen to get advice on how to avoid overdose.

Use motivational interviewing (see p. 172) to help the patient explore the advantages and disadvantages of current patterns of drug use.

Contemplation Stage

The balance of costs and benefits begin to shift, although there is still ambivalence about change.

'I should give up because of all the problems. But what am I going to do instead? — I'll miss it and my friends.'

Explore this ambivalence using motivational interviewing.

Preparation Stage

The balance has shifted. The patient is preparing to take action and has confidence in their capacity to change. Change is seen as worthwhile. This is often a planning stage. Goal setting, identifying internal and external supports/resources and identifying strategies to support change can help.

Action Stage

The patient is taking steps to change. Support and specific skill training can be provided. Review initial reasons that led to the decision to change.

Maintenance Stage

Changes in behaviour maintained for six months or more are usually associated with substantial improvements in the quality of life (e.g. housing, employment, relationships, physical and mental wellbeing). Without such changes, the effort to change may not seem worth it and relapse is more likely. Encourage patients to articulate the positive reasons for maintaining change to reinforce their decisions.

CLINICAL STRATEGIES

The following set of empirically tested clinical strategies can facilitate a good therapeutic relationship, enhance quality of support provided and maximise probability of behaviour change.

Patient-centred Approach

The patient-centred approach is outlined in Table 13–1.

Decision Balance

The Decision Balance can help you to better understand the first two ingredients of change. It can help people re-assess the pros and cons of substance use. It can be used either during the consultation or completed by the patient at home.

Exercise: The patient is asked to first consider advantages and disadvantages of their current situation as a substance user. Then to think ahead to an imagined scenario when they no longer use. Consider the advantages and disadvantages of change. The health professional's role is to listen and reflect back the patient's self re-evaluation without judging or hurrying the process to a premature conclusion.



See Appendix J

Building A Therapeutic Alliance

Even when a treatment is delivered as specified, clinicians can significantly influence outcome. It is important to build a relationship, based on trust, where the patient can communicate concerns without fear of being judged.

Table 13–1
Patient-centred approach

<p>Regard the person's behaviour as their personal choice</p>	<ul style="list-style-type: none"> • acknowledge benefits as well as costs to behaviour • understanding and acknowledging the patient's choices enhances their autonomy and responsibility
<p>Let the person decide how much of a problem they have, i.e. how important it is for them to quit</p>	<ul style="list-style-type: none"> • systematically explore benefits (likes) and costs (dislikes) as perceived by the patient • use examples and issues raised by the patient • encourage the patient to rate their motivation and confidence out of 10. If score is low, explore what would increase this score. If the score is high, why?
<p>Avoid argumentation and confrontation</p>	<ul style="list-style-type: none"> • confrontation <i>within</i> the patient is the goal • separate <i>information</i> from '<i>persuasive imperative</i>'
<p>Encourage discrepancy</p>	<ul style="list-style-type: none"> • change is likely to occur when behaviour is seen to be in conflict with personal goals • use the Decision Balance to identify discrepancies
<p>Help patients re-evaluate their substance use</p>	<p>Three ingredients are necessary for any behaviour change:</p> <ul style="list-style-type: none"> • concern with current behaviour • belief that change will lead to improvement • belief that change is possible (self-efficacy)

Improved treatment adherence, treatment retention and treatment outcome result from clinical practice that:

- is empathetic
- communicates confidence and optimism
- facilitates informed choice of treatment method and treatment goal
- is non-judgmental and genuine

Empathy and reflective listening

Empathy involves:

- listening to the patient
- understanding the patient and their concerns
- communicating this understanding to the patient — formulate a brief response that captures the essence of what the patient is trying to communicate

This is to help both the patient and the clinician better understand, and to help devise action

based on this understanding (Egan, 1994). You are seeking to understand the patient's unique experience of drug use and related harm.

Listening and communicating understanding involves several micro-skills including:

Using open ended questions

Closed questions may be useful for getting factual information, but discourage exploration by the patient.

Avoid questions such as:

'Do you inject more often now?'

Instead, ask open questions such as :

'How has your injecting changed over time?'

'What can you tell me about your injecting?'

Reflective listening

Reflective listening is a way to check whether what you 'heard' is what the patient intended. It allows the patient to correct any wrong understanding and add more information. It is also a way to feed back the patient's concerns.

Some reflective listening is made as a statement rather than a question. However, sometimes a patient (e.g. a young person) could be reluctant to correct a statement by an authority figure. In this case it might be useful to use simple reflective questions (i.e. invite correction). Because many communications (verbal or otherwise) can have several levels of meaning, it is important to be tentative rather than too definitive.

Reflective listening can include:

- simple reflection back to the patient:

'You don't see why your amphetamine use is a problem when your friends use more than you and they don't seem to have any problems.'

- amplified reflection attempts to elicit the other side of the patient's ambivalence by amplifying or exaggerating (not in a sarcastic way):

'So if your friends don't have any problems, there's nothing for you to worry about.'

Clearly you need to be cautious using such a strategy.

- double sided reflection:

'I can see how this might be confusing. On the one hand you're here because you have some concerns about your amphetamine use. On the other hand, you don't seem to be using more than your friends.'

Summarising

An effective clinician can attend to, understand and summarise information. This skill can involve the ability to:

- highlight main discoveries
- encourage exploration of more detail
- give patients the opportunity to hear their own concerns or reasons for change
- highlight ambivalence (to change or stay the same)

Roadblocks to empathy

There are a number of common 'roadblocks' that can prevent empathy (Jarvis et al., 1995). These include:

- ordering or commanding
- warning or threatening
- arguing or persuading
- moralising
- ridiculing or labelling
- giving advice or providing solutions

It is also important to avoid:

- insincerity
- repetition
- clichés
- using jargon
- collusion



See Jarvis et al. (1995) for more detail of these skills.

Motivational Interviewing

Many patients are strongly attached to drug use. This attachment to behaviours that cause harm perplexes many clinicians. As a result, some confront patients, only to find it unsuccessful, often generating more resistance. Motivational interviewing has been proposed as a method to work with ambivalence and help patients explore *their* reasons to change drug use.

Elements of motivational interviewing

Motivational interviewing involves the following (Miller & Rollnick, 1991):

- express empathy
Motivational interviewing consists of more listening and less ‘telling’.
- develop discrepancy
Focus the patient’s attention on discrepancy:

*‘I like using heroin, **but** I hate the hassles with my family and the police.’*

This can include raising awareness:

‘How do you see the connection between your smoking and your poor respiratory health?’

- avoid argumentation

The *patient*, and not the clinician, is encouraged to argue for change.

- roll with resistance

Try *not* to provide solutions. Provide opportunity for the patient to identify solutions (sometimes with the clinician’s help). If the patient resists, this may be an indication that you are taking a wrong approach. Help the patient consider issues from other perspectives. For example:

- ask the patient their view of your clinical findings
- ask the patient what they think the view of a significant other might be etc.

- support self-efficacy

The patient’s confidence in their ability to implement and sustain changed behaviour will influence whether or not they attempt and persist with efforts to change.

Guidelines for motivational interviewing

In motivational interviewing you:

- explore positive and negative consequences of drug use
- provide opportunity to explore the patient’s specific concerns
- use reflective listening and summaries to understand and communicate understanding
- elicit self-motivational statements:

‘What are the things you like and don’t like about your cannabis use?’

‘What have other people said about your drinking?’

‘What makes you think you might need to change?’

- help the patient decide whether to change:

'Where does this leave you now?'

'What does this mean for your drug use?'

Avoid:

- arguing with a patient
- imposing a diagnostic label on them
- telling them what they must do
- trying to break down denial with confrontation

It should never feel as though you are confronting the patient. It should feel you and the patient are confronting the problem(s) together.

Brief Motivational Interviewing

Brief motivational interviewing and opportunistic interventions are well researched (Rollnick et al., 1999). Two factors are central and clinically useful:

- importance — e.g. some think it is important to quit smoking but are not clear how they can do it
- confidence — e.g. some are confident they can change, but it is not important to them

Brief motivational interviewing consists of the following seven components:

Scaling questions

Ask questions such as:

'On a scale of 0–5 how important is it for you to give up smoking?'

'On a scale of 0–5 how confident are you about giving up?'

You can use scaling to help quickly identify the most important areas to work on. You can then use this information:

'Why is it so high?' (Even if a '1' 'Why isn't it a zero?')

'What will help keep you at this level?'

'What will help you move higher?'

'How high does it have to be before you make an attempt to change?'

'What can I do to help?'

Exploring importance

'What are the benefits of your cannabis use?'

'What are some of the less good things?'

Summarise

'Where does that leave you now?'

Building confidence

'In the past, what has been helpful when you have tried to change your drug use?'

'Is there anything you can learn from these past attempts?'

'Is there anything you can learn from other people's attempts to change?'

Exchanging information

How you share information and your expertise is important.

'How much do you already know about the risks of injecting?'

'Some people find that ...how about you?'

'How do you see the connection between your amphetamine use and your sleeping problems?'

'Is there anything more you'd like to know about injecting?'

Reducing resistance

Express empathy, especially about the difficulty of changing.

Emphasise personal choice and control.

Don't try to provide solutions — invite the patient to collaborate in providing a solution. The onus is then on the patient, *not you*, to make a decision to change.

Summarise and invite action

'What do you think you should do about your cannabis use?'

(Based on Mason, 1997).

Problem Solving

The ability to respond effectively to problems is associated with improved treatment outcome. Supporting development of problem solving skills can be clinically useful and is best achieved through:

- a combination of verbal and written information
- demonstration (when possible)
- learning through practice and feedback

Developing problem solving skills can consist of identifying occasions when the patient has solved other problems and noting the steps they took.

Effective problem solving consists of five steps that can be learned:

1. Orientation

Stand back from the problem; view it as a challenge, not a catastrophe. How might someone else solve this?

2. Define the problem — it is important to be specific

Patient: *'My wife and I do not get on'*

Clinician: *'Give me an example of what you mean'*

Patient: *'She doesn't like me being out on Friday nights'*

3. Brainstorm solutions

At this stage, anything goes. Identify as many solutions as possible — discourage evaluation and a search for quality.

4. Decision making

The patient (with the help, but not direction, of the clinician) reviews the positives and negatives of each of the options, and their ability to implement them, and makes an informed choice of the best option(s) to embrace.

5. Implementation

A plan of action is developed and the option is implemented. Sometimes it is useful to rehearse the option (where possible) to test out the viability of the strategy and to increase self-efficacy (confidence).

It is not your responsibility to solve the patient's problems, but to teach a skill that he or she can use in a variety of circumstances.

Goal Setting

Effective goal setting is:

- consistent with the patient's 'stage of change' (e.g. a 'pre-contemplator' may resist a goal of total abstinence, but may embrace reducing the risk of infection)
- negotiated. Negotiation is not bestowed on a patient. It is a strategy to influence behaviour. Negotiated goals are more likely to generate patient commitment and adherence
- realistic
- specific and achievable. A broad therapeutic goal may be broken down into several component parts

- short-term; so that progress can be monitored and success quickly realised
- solution-focused, or defined in positive terms. Changing behaviour will be more successful if couched in positive terms of acquisition, rather than reduction; presence, not absence (e.g. increasing the number of days without heavy alcohol use as opposed to decreasing the number of drinking days)

Relapse Prevention

Relapse is a common experience when changing drug using behaviour. Research evidence indicates that major predictors of relapse risk are belief systems consistent with disease models (*'I'm an addict and can't stop'*), and the absence of coping skills.

The following strategies are useful in preventing and managing relapse:

- enhance commitment to change (e.g. use motivational interviewing)
- identify high-risk situations (e.g. When does the patient use heavily? What situations have been associated with relapse in the past?)
- teach coping skills (e.g. problem solving; social skills; self-management skills; self-monitoring of drug use and drug-related harm)
- develop strategies that can be part of a relapse drill
 - what should the patient do in the event of a lapse occurring?
 - where can they get support?
 - what role can friends/family provide?
 - How soon should the patient make an appointment to come back to your practice?

Quality of Life

Successful maintenance of change is associated with factors such as employment, the quality of relationships, financial security, housing and spiritual support (variously defined). You cannot be expected to address all these factors, but you may be able to facilitate access to a range of advice and support services.

These might include, but are not limited to:

- housing services
- financial support services
- legal advice
- employment, education and training

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Alternative Therapies

THE TERM 'alternative therapies' or 'complementary and alternative medicine' is applied to a diverse collection of non-orthodox therapeutic practices, including:

- acupuncture
- herbs
- homeopathy
- therapeutic massage
- traditional oriental medicine
- faith healing
- hypnosis
- chiropractic
- music therapy

The alternative therapies that have been most commonly applied to the treatment of substance use are acupuncture and hypnotherapy.

EVIDENCE OF EFFECTIVENESS

There are variable levels of evidence in regard to alternative therapies. Assessing effectiveness is made difficult by the:

- small number of studies (particularly controlled studies)
- small sizes of studies
- considerable heterogeneity in participants
- interventions and outcome measures

Perhaps in part because of these factors, results of studies are frequently contradictory (Linde et al., 2001).

Acupuncture

Acupuncture is a family of procedures involving stimulation of anatomical locations on the skin by a variety of techniques (Smith et al., 1997). The most studied form employs penetration of the skin by thin, solid, metallic needles, which are manipulated manually or by electrical stimulation. Acupuncture points may also be stimulated by pressure, heat, and lasers (NIH, 1997).

For the treatment of substance abuse, five points on the ear are most commonly used (McLellan et al., 1993).

Most research into the effectiveness of acupuncture relates to smoking cessation. In a systematic review of 18 studies of acupuncture for smoking cessation White et al. (2000) concluded that there is no clear evidence that acupuncture is effective for smoking cessation. This review looked at abstinence from smoking both early (up to 6 weeks) and late (6 to 12 months) after acupuncture treatment.

They found that:

- acupuncture was not superior to sham acupuncture, or any other anti-smoking intervention, at any time point after treatment
- acupuncture did appear to be superior to no intervention at the early follow-up, but this difference was not sustained

The US National Institute on Drug Abuse also concluded that there is no clear evidence that acupuncture is effective compared to placebo

or to existing treatments in:

- the detoxification
- primary rehabilitation
- relapse prevention of opioid or cocaine dependence

Conversely there is very little evidence that acupuncture is not effective in the treatment of these conditions (McLellan et al., 1993).

Two subsequent randomised controlled trials have also failed to identify either benefits or harms from acupuncture as an adjunct treatment for cocaine users (Bullock et al., 1999; Otto et al., 1998) or alcohol dependent out-patients (Sapir-Weise et al., 1999).

However, in a randomised controlled trial Avants et al. (2000) compared acupuncture to a relaxation control and a needle-insertion control for the treatment of cocaine-dependent methadone-maintained patients. The trial found that the acupuncture group was more likely to provide cocaine-negative urine samples than either of the two control groups. These researchers went to some effort to identify sham acupuncture sites with sufficiently low level of activity to be used as a control, supporting the view that selection of sham sites may be a factor influencing outcomes (NIH, 1997); however, the benefit of reduced cocaine use in the acupuncture group was countered by significantly lower rates of retention in treatment — the mean survival time was 5.2±3.0 weeks for the acupuncture group, 6.7±2.5 weeks for the needle-insertion control and 7.0±2.3 weeks for the relaxation control group.

Adverse Effects of Acupuncture

Recent surveys of acupuncture practitioners identified bleeding and pain at the needle site as the most common adverse effects. Aggravation of symptoms, fainting, nausea and vomiting, psychological and emotional reactions also occurred but much less frequently (MacPherson et al., 2001; White et al., 2001).

Hypnosis

The exact definition of hypnosis is a matter of debate, but a generally accepted description would be 'a state of awareness that permits the patient to accept suggestions without censoring them' (Temes, 1999). It appears that hypnosis is generally seen as an aid in the treatment of substance use problems, and not a treatment in itself. A role it might play is in the reduction of anxiety, relaxation training, and in helping patients to learn to manage negative emotional states (Hall, 1999). Hypnosis may also help patients become more responsive to a treatment approach (Stoil, 1989).

Again most of the research into the effectiveness of hypnotherapy relates to smoking cessation. This research was the subject of a systematic review by Abbot et al. (2000) who were unable to show that hypnotherapy has a greater effect on six month quit rates than any other interventions or no treatment.

Conclusions

Research evidence is scarce and confounded, but suggests that acupuncture and hypnotherapy are no more effective than placebo or existing approaches in the treatment of problematic substance use. However the risks of adverse effects are low. Consequently these approaches may be useful for some patients as part of a comprehensive management program (NIH, 1997). Indeed, it may be that any adjunct treatment will be beneficial for some patients (Richard et al., 1995).

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