

Obstacles to Implementing Evidence Based Treatment

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Strategies for Change

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Treatment Modalities and Interventions

Studies indicate that cognitive-behavioral and psychological interventions are increasingly being used to treat alcoholism and drug addiction (Collins, 1995; Littrell, 1991; Prendergast, Podus, Chang, & Urada, 2002).

Treatment Modalities and Interventions

However, social model and 12 Step interventions continue to be the most commonly used to treat alcoholism and drug addiction with both:

Positive –

- as self help it is voluntary and free
- &

Negative –

- as treatment it is mandated
- ramifications

12-step perspective

The most commonly used definition within the treatment community is:

a progressive disease characterized by loss of control over use, obsession with use, continued use despite adverse consequences, denial that there are problems, and a powerful tendency to relapse (Inaba & Cohen, 2002).

- Condition is due to a genetic predisposition due to brain chemistry or anatomy (similar to diabetes). Not the addicts fault
- Usually triggered by experimentation and particular drug used (Jellnick, 1960)
- Only cure is abstinence

Criteria for knowing the “Truth”....someone told us!



- Authority: most common method. Has significant influencing, manipulating, and coercing capacities.

- Cannot explain why people start or how they stop!
- The Label “disease” is becoming increasingly controversial as there is no actual science to “prove” it.
- Gene M. Heyman a research psychologist at McLean Hospital and Lecturer of Psychology at Harvard Medical School states in his 2009 book *Addiction: A disorder of Choice*, “the public has been deceived by addiction experts. Individuals can be genetically predisposed to addiction, and changes can occur in the brains of addicts, but the decision to use or quit remains voluntary.”
- People do not choose to become addicts, but while most addiction experts point to changes in the brain as the underlying reason for relapse, Heyman sees the issue as primarily one of self-control. That is, no matter how an individual’s brain lights up indicating how intensely they are “feeling,” they ultimately choose a coping response.

“Medical Misnomer Addiction isn't a brain disease, Congress” (2007)

- Dr Sally Satel, staff psychiatrist, Oasis Drug Treatment Clinic (D.C), Resident Scholar, American Enterprise Institute for Public Policy Research and Dr. Scott Lilienfeld a professor of psychology at Emory University report negative consequence of labeling addiction a disease:
- It misappropriates language more properly used to describe conditions like multiple sclerosis or schizophrenia—afflictions neither brought on by sufferers themselves nor modifiable by their desire to be well.
- Brain disease rhetoric is fatalistic, implying that users can never fully free themselves of their drug or alcohol problems.
- It threatens to obscure the vast role personal agency plays in perpetuating the cycle of use and relapse to drugs and alcohol.
- Finally, dare we ask:
 - Why is stigma bad?
 - The push to destigmatize substance abuse overlooks the healthy role that shame or guilt can play, by motivating many otherwise reluctant people to seek treatment in the first place and jolting others into quitting before they spiral down too far.

Rethinking substance abuse: What the science shows and what we should do about it (Miller & Carroll, 2006)

■ Drug Use is a Chosen Behavior.

Traditionally, addiction has been viewed as deterministic in that causal factors override conscious control and rational choice. However, research indicates drug use is choice, a bad one to be sure, but a choice among many.

The treatment implication here is to treat the client as an active participant, a responsible agent in therapeutic process; not a passive agent who is incapable of rational choice and believed to need confrontation.

MOST IMPORTANT

- Research suggest that telling individuals they have a disease reduces outcomes because it decreases self-efficacy
 - (strongest client predictor of outcome)
- as well as justifies their continuing use...especially in stressful situations
[psychology today, 31 (1) 10].

The Disease Model of Addiction: When clinical beliefs harm clinical reality. Psychology Today, 31(1), 10.

- In a study of 122 people enrolled in a study to determine the causes of relapse, researcher William Miller found that one of the strongest predictors was belief in the alcoholism-as-a-disease concept.
- “Simply put, although research supports the idea of an inherited vulnerability to alcoholism, Miller states research does not support the belief in alcoholism as a disease. Unfortunately, polls indicate as much as 90% of the American public believe in this idea--a testament to the success of the 12-step movement and the National Council on Alcoholism.”

Why was belief in disease strongest predictor of relapse?

- **Resulted in decreased self-efficacy.**
- **Perceived Self-Efficacy:**
 - is the belief that one can perform a novel or difficult task, or cope with adversity -- in various domains of human functioning.

Perceived Self-Efficacy

FACILITATES:

- GOAL SETTING
- EFFORT INVESTMENT
- PERSISTANCE IN FACE OF BARRIERS
- RECOVERY FROM SETBACKS

Powerlessness vs. Empowerment

- Research suggest that from the initial stages of treatment:
- recovering individual's current negative physical and mental state needs to be normalized.
- Realistic sobriety/recovery goals need to be set.
- And belief in their ability to positively affect their own recovery needs to be supported

Rethinking substance abuse: What the science shows and what we should do about it (Miller & Carroll, 2006)

- **Drug Problems Do Not Occur in Isolation, but as Part of Behavioral Clusters.**

Traditional treatment philosophy is to deal with drug abuse first, to the exclusion of other problems. Today, we know that all drug problems are just one part of a larger cluster of problems that may include: family issues, homelessness, neglect and a host of psychological and mood problems.

For many of our clients, stopping drug use is not a high priority when other life problems are consistently prevalent. Treatment needs to determine which of the issues is causing the most problems and direct interventions accordingly.

Historical & Scientific Trends related to addiction treatment

- “Harm done in the name of help” has a long tradition in addiction treatment
- Many current mainstream treatment practices lack scientific evidence of their effectiveness, and others have been shown to be potentially harmful.
- Responses to all self-help groups vary from: individuals who fully respond, partially respond, and fail to respond- a finding that reinforces the importance of person-support fit.
- Client motivation and transfer of learning from therapeutic to natural environments is enhanced by client choice in the treatment and recovery support process.
- **When given a choice, individuals tend to choose the goal that is the most appropriate (for them).**

The movement to expand client choice-making in addiction treatment is also being fueled by the development of new service technologies:

- Motivational interviewing
- Contingency management
- Recovery coaching

These provide frameworks for facilitating client choice and the use of special aids to enhance recovery-conductive decision-making.

This historical and scientific evidence directly conflicts with the assumptions previously held true in traditional substance abuse treatment.

Assessing Current Approaches to Treatment

- Lack of comprehensive theory for substance abuse treatment (Inaba & Cohen, 2002)
- Most counselors approach treatment based on education, training and experiential background (National Institute for Drug Abuse, 1999)
- Most common theory used
 - Personal recovery process

Treatment supported by clinical trials

- Cognitive-behavioral treatment
- Community reinforcement approach
- Motivational interviewing
- Relapse prevention (cognitive-behavioral)
- Social skill training

Miller, W. R., Zweben, J. & Johnson, W. R. (2005). Evidence-based treatment: Why, what, where, when and how? *Journal of Substance Abuse Treatment*, 29, 267-276.

Treatment shown by clinical trials to be ineffective

- Educational lectures and films
- Exploratory psychotherapies
- Undifferentiated counseling
- Confrontation
- Mandated 12-step meetings
- Time in milieu (inpatient/residential)

Miller, W. R., Zweben, J. & Johnson, W. R. (2005). Evidence-based treatment: Why, what, where, when and how? *Journal of Substance Abuse Treatment*, 29, 267-276.

Most Commonly Practiced Treatments?

- Minnesota Model
- Confrontation
- Education
- Films
- General Counseling
- Group Therapy
- Mandated AA
- Milieu Therapy (residential, TCs)

Miller, W. R., Zweben, J. & Johnson, W. R. (2005). Evidence-based treatment: Why, what, where, when and how? *Journal of Substance Abuse Treatment*, 29, 267-276.

- The gap “could hardly be larger if one intentionally constructed treatment programs from those approaches with the least evidence of evidence efficacy.”

- Miller, Wilbourne & Hettema (2003) Handbook of Alcoholism Treatment Approaches: Effective Alternatives

Craft vs. scientific model

- - craft model linked to non-degree holding AOD counselors who follow 12-step approach wherein critical analysis may be discouraged in favor of loyalty to the craft
- - one survey found that of 99 tx center directors face-to-face interactions (informal channels) were preferred over the use of scientific books, journals, and conferences (formal workshops or training).

- "Those who endorse a 12-step model or identify themselves as being in recovery have tended to express less interest in and use of evidence-based behavioral and pharmacotherapies. (McGovern et al., 2004; Moyers & Miller, 1003; Thomas, Wallack, Lee, McCarty, & Swift, 2003) in Miller, Sorenses, Selzer, & Brigham (2006) Disseminating evidence-based practices in substance abuse treatment: A review with suggestions.

Additional Obstacles

- EBT is not addressed (in that it is not required for students to take) in substance abuse in internship and degree programs
- structure of service delivery, i.e. smaller programs may not have medical staff (meds) or clinicians able to screen for mental disorders
- Funding - little support for practitioners to learn new approaches (training that does occur favors the status quo & is on site)
- Corrections and corrections related personal and policy makers unaware or uninformed as to what is evidence based and what is myth or opinion.
- Correction want significant control of how a program is implement when can reduced its effectiveness.
- Corrections need to know often impedes effective treatment implementation fidelity especially around confidentiality.

Some Solutions

- EBT needs to be included in academic curriculum in substance abuse in internship and degree programs (MFT, psychology, social work, etc.)
- The importance EBT needs to be demonstrated by treatment providers- helped with extrinsic incentives: funding for EB practices, paid time off for training, promotions contingent on developing competence in EBT, preferential hiring of those proficient in EBT.
- when training practitioners in an EBT ongoing training, coaching and supervision need to be provided -increased communication and collaboration b/w researchers, clinicians, and corrections policy makers program supervisors
- Corrections personal need to be included in the training on EBT
- clearer guidelines are needed to help providers distinguish EBT's from craft based treatment or myth driven approaches.
- interventions are needed at both the systematic and practitioner level