



PERSPECTIVES ON DRUGS

The role of psychosocial interventions in drug treatment

Psychosocial interventions are structured psychological or social interventions used to address substance-related problems. They can be used at different stages of drug treatment to identify the problem, treat it and assist with social reintegration. Psychosocial interventions are used to treat many different types of drug problems and behavioural addictions. This analysis explains what the main psychosocial interventions are and to whom they are provided.

Psychosocial interventions are structured psychological or social interventions used to address substance-related problems. They can be used at different stages in the treatment journey, to identify the problem, treat it and assist with social reintegration. These dynamic interventions may also be used alone or in combination at different points in an individual's drug treatment journey. Often, these measures are used with clients at their first contact with health services to help them to recognise and clarify the nature of their drug problem and commit to changing their behaviour. At a later stage these interventions are used to support patients in treatment; for example, such approaches have become central in treating cannabis (EMCDDA, 2015a), cocaine and amphetamines use. These interventions are also employed, sometimes in conjunction with pharmacological treatment, in the treatment of opioid-related problems. They can also help clients to maintain behavioural goals and support treatment retention. Psychosocial interventions can also involve the family and the community during the social reintegration phase of drug treatment.

The flexible nature of most psychosocial interventions means that treatment providers can use different combinations of approaches, taking into consideration the needs of individual clients. Service providers may follow different theoretical perspectives, which can influence their selection of specific interventions. In addition, the same intervention may be used at different points in the therapeutic pathway, depending on the theoretical assumptions made by different professionals about the triggers for an individual's drug problems (Kleber, 2013). For example, if a practitioner adheres to automatic processing theories, the preferred therapeutic approach will focus on changing the individual's behaviour (EMCDDA, 2013), and controlling unconscious behaviours will be seen as central to making progress in drug treatment. Irrespective

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emcdda.europa.eu/topics/pods/psychosocial-interventions



of the theoretical basis, psychosocial interventions as a group are generally recognised as having value throughout the treatment process. In the following sections some of the main individual interventions are introduced.

Psychosocial interventions to help people to recognise their drug use problems

Motivational interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change (Miller and Rollnick, 2013). It is used to help people with different types of drug problems. Frequently, individuals are not fully aware of their drug problems or they can be ambivalent about their problems. Motivational interviewing is often referred to as a conversation about change and it is used to help assist drug users to identify their need for change. It seeks to address an individual's ambivalence about their drug problems, as this is considered the main barrier to change. It follows five stages: (1) expressing empathy for the client; (2) helping the client to identify discrepancies between their behaviour and their goals; (3) avoiding arguments with the patients about their motivations and behaviours; (4) rolling with the resistance of the patients to talk about some issues; and (5) supporting the patients' sense of self-efficacy.

Motivational interviewing is used to promote change in many different situations and settings, including in outpatient services and primary care. It is used in prisons (www.nta.nhs.uk/uploads/phemappingmanual.pdf), by social services and in the workplace. Motivational interviewing can be provided by therapists, counsellors or other specifically trained professionals. It can be used to help someone make a decision, to start and follow a pharmacological treatment or as a standalone psychological treatment. Generally, however, motivational interviewing is undertaken in multiple sessions over a period of weeks and at follow-up points during a course of treatment. The approach is supported by evidence, with a recent systematic review (Smedslund et al., 2011) of 59 studies involving 13 342 participants concluding that it can reduce the extent of substance abuse compared to no intervention. Another systematic review focused on the effectiveness of motivational interviewing for drug use among adolescents (Barnett et al., 2012) and included 39 studies, of which 67 % reported statistically significant improved substance use outcomes.

Brief interventions use the collaborative conversation style of motivational interviewing to address problematic or risky drug use, but are delivered in a shorter timeframe, ranging from 5–30 minutes. Personalised feedback is provided on a person's substance use. This enables them to understand their use in relation to other people's use. In this approach, the therapist asks for permission to talk about the possible drug or alcohol use and help the client to position him/herself on



a scale of use. Questions are asked about the benefits and harms of substance use in an attempt to elicit a motivation to change. In concluding the brief session, a plan for change and a follow-up is negotiated. Brief interventions consist of five phases, called the '5As' — ask, advise, assess, assist and arrange (Babor et al., 2007).

A study in the United States has shown that this approach is used in many different settings, including emergency departments, primary care and services for the homeless, in order to address the problems people have as a result of their substance use by getting them to reflect and consider making a change (Saitz, 2014). While brief interventions are often based on the techniques from motivational interviewing, the evidence to support their use is still developing and there is a need for further research (Taggart et al., 2013; Yuma-Guerrero et al., 2012).

Psychosocial interventions for treating drug problems

Cognitive behavioural therapy (CBT) is an umbrella term that encompasses cognitive therapy on its own and in conjunction with different behavioural strategies. Cognitive therapy is based on the principle that the way individuals perceive and process reality influences the way they feel and behave. As part of drug treatment, cognitive therapy helps clients to build self-confidence and address the thoughts that are believed to be at the root of their problems. Clients are helped to recognise the triggers for substance use and learn strategies to handle those triggers. Treatment providers work to help patients to identify alternative thoughts to those that lead to their drug use, and thus facilitate their recovery. Generally, cognitive therapy is provided after a client has been diagnosed as having drug dependence problems. Cognitive therapies are delivered by licensed psychotherapists in outpatient settings, and sessions can also be available in residential treatment facilities and prisons. A meta-analysis of studies on the use of cognitive therapies found positive

results in terms of the reduction in substance use (Magill and Ray, 2009).

Family therapy is used to treat drug use and the problem behaviours that can be associated with it. It is particularly relevant during adolescence, when substance misuse typically causes a group of problems including psychiatric symptoms, problems at school and high-risk sexual behaviour. Both family therapy and couples therapy are supported by a wide theoretical basis (Gurman and Kniskern, 1991). Family therapy is usually provided when a young person’s drug problem, and the means of treating it, are considered best addressed using a systemic approach.

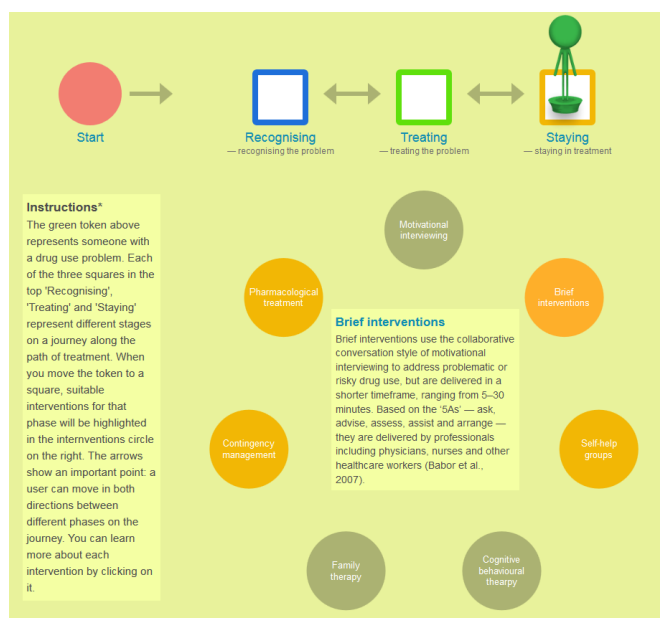
Here, the underlying idea is that treating an individual in isolation would not solve the problems with the family system that are resulting in the drug use. Family therapies can be delivered by specialists in outpatient settings, but can also be provided in the client’s home (Rigter, 2012). Evidence in support of multidimensional family therapy (EMCDDA, 2014) and couple-based therapy (McHugh et al., 2010) in reducing drug use and related problems is accumulating; and the use of family-based interventions (e.g. Strengthening Families) for both prevention and treatment of adolescent substance misuse is also well evidenced.

Psychosocial interventions for helping people to follow treatment and achieve social reintegration

Contingency management refers to a set of interventions involving concrete rewards for clients that achieve target behaviours. This approach is based around recognising and controlling the relationship between behaviours and their consequences (Petry et al., 2001). Initially introduced in the treatment of alcohol-related problems (Higgins and Petry, 1999), contingency management can be applied to drug users with different types of problems in a variety of settings. It has been used, for example, with opioid and cocaine users, as well as with homeless clients. Contingency management is used to maintain abstinence by reinforcing and rewarding alternative behaviours to drug use with the aim of making abstinence a more positive experience. Contingency management programmes can, for example, be used during drug treatment to reward a user remaining abstinent or to incentivise a user’s presence at work in a social reintegration programme.

A recent systematic review commissioned by the EMCDDA concluded that contingency management might be helpful in retaining patients in treatment, and that it helps patients to abstain from cocaine use during treatment, and helps patients to maintain abstinence (EMCDDA, 2015b).

Interactive element



Interactive: psychosocial interventions on a drug user’s treatment journey available on the EMCDDA website: www.emcdda.europa.eu/topics/pods/psychosocial-interventions

Self-help groups are voluntary not-for-profit organisations where people meet to discuss and address shared problems, such as alcohol, drug or other addictions. Participants seek to provide support for each other, with senior members often mentoring or ‘sponsoring’ new ones. Prominent examples include Alcoholics Anonymous and Narcotics Anonymous, and there is a range of other groups with similar purposes. As well as helping drug users, some self-help groups exist to support the family members of people with alcohol- and drug-related problems. Self-help groups can be used to help people to recognise their drug-related problems and can be a support during drug treatment, and they can help users to maintain abstinence and prevent relapse. The groups aim to create a drug-free supportive network around the individual during the recovery process and provide opportunities to share experiences and feelings. Self-help groups are usually led by former drug users (but groups led by professionals also exist) or other peers in a range of places within the community, and in healthcare and prison settings. For various reasons, including privacy concerns, there are few studies that assess the evidence for and impact of self-help groups.

Terms and definitions

Psychosocial interventions are structured psychological or social interventions used to address substance-related problems. They can be used at different stages of drug treatment to identify the problem, treat it, and assist with social reintegration.

Motivational interviewing is a collaborative conversation style aimed at strengthening a person's motivation and commitment to change (Miller and Rollnick, 2013). It is used in many situations where someone needs to be helped to take a decision, and it can be provided by therapists, counsellors or other specially trained professionals.

Brief interventions use the collaborative conversation style of motivational interviewing to address problematic or risky drug use, but are delivered in a shorter timeframe, ranging from 5–30 minutes. Based on the '5As' — ask, advise, assess, assist and arrange — they are delivered by professionals including physicians, nurses and other healthcare workers (Babor et al., 2007).

Self-help groups are voluntarily not-for-profit organisations where people meet to discuss and address shared addiction problems and to provide support for each other, with senior members often mentoring or 'sponsoring' new ones. Self-help groups are usually led by former drug users or other peers in a range of places within the community, and in healthcare and prison settings.

Cognitive behavioural therapy (CBT) helps clients to build self-confidence and address the thoughts that are believed to be at the root of their drug problems, and learn to recognise and handle what triggers them. Following a diagnosis of drug dependence, cognitive therapies are delivered by licensed psychotherapists in outpatient settings, and sessions can also be available in residential treatment facilities and prisons.

Family therapy is used to treat drug use and the problem behaviours that can be associated with it, especially during adolescence, such as psychiatric symptoms, problems at school, delinquency and high-risk sexual behaviour. Family therapy can be delivered by specialists in outpatient settings, and can also be provided in the patient's home.

Contingency management refers to a set of interventions involving concrete rewards for clients that achieve target behaviours. It involves rewarding and reinforcing behaviours other than drug use and can, for example, be used during drug treatment to show that a user is remaining abstinent or to incentivise a user's presence at work in a social reintegration programme.

Conclusions

Psychosocial interventions are now well established as part of the processes of drug treatment and recovery, and ongoing research in support of their use is accumulating. They continue to play an important role in treating a range of drug problems and addictive behaviours. Psychosocial interventions are widely used in the treatment of people with cannabis problems, and are key interventions in the treatment process for cocaine and methamphetamine users, where other measures, such as pharmacotherapies, are still under development. In addition, substitution treatment often in combination with psychosocial interventions is the most common treatment for opioid dependence in Europe. The available evidence supports this combined approach for keeping patients in treatment, as well as for reducing illicit opioid use, drug-related harms and mortality.

Psychosocial interventions can help drug users to identify their drug-related problems and make a commitment to change, help clients to follow the course of treatment and reinforce their achievements. They can also have a role in supporting family members and creating a network to help facilitate the recovery process. In a broader perspective, they are being used at different points in the treatment pathway of a wide range of clients, and their role is expanding through their use in Internet-based drug treatment modalities.

Contingency management in focus

Contingency management refers to a set of interventions involving concrete rewards for clients that achieve target behaviours. This approach is based around recognising and controlling the relationship between behaviours and their consequences (Petry et al., 2001). The EMCDDA has recently conducted a systematic review of studies on contingency management, which highlighted the diverse application of this approach in a range of settings for a variety of drug problems (EMCDDA, 2015b). For example, participants enrolled in the studies being reviewed had a broad spectrum of drug problems, from cannabis use to stimulant (amphetamines, cocaine), opioid and polydrug use. Contingency management was used alone, as a support for other psychosocial interventions or in conjunction with other pharmacological treatments. It was also used to reinforce different behaviours. These included relapse prevention, supporting abstinence, attendance at psychosocial therapy groups or to maintain compliance with a pharmacological treatment course. Several types of reinforcement techniques were used in the studies examined, such as monetary incentives, the possibility of taking home the substitution treatment medication, or extending the

period of therapeutic workplace attendance. The review identified 38 studies, 34 of which were conducted in the United States, three in China and one in Malaysia. Overall, the study provided an insight into the many ways in which contingency management is currently being used to assist drug users at different stages of their treatment process.



References

- | Babor, T. F., McRee, B. G., Kassebaum, P. A., et al. (2007), 'Screening, Brief Intervention, and Referral to Treatment (SBIRT): toward a public health approach to the management of substance abuse', *Substance Abuse* 28(3), pp. 7–30 (PM:18077300).
- | Barnett, E., Sussman, S., Smith, C., Rohrbach, L. A. and Spruijt-Metz, D. (2012), 'Motivational interviewing for adolescent substance use: a review of the literature', *Addictive Behaviors* 37(12), pp. 1325–34 (PM:22958865).
- | EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) (2013), *Models of addiction*, EMCDDA Insights, Publications Office of the European Union, Luxembourg (www.emcdda.europa.eu/publications/insights/models-addiction).
- | EMCDDA (2014), *Multidimensional family therapy for adolescent drug users: a systematic review*, EMCDDA Papers, Publications Office of the European Union, Luxembourg (www.emcdda.europa.eu/publications/emcdda-papers/multidimensional-family-therapy-review).
- | EMCDDA (2015a), *Treatment of cannabis-related disorders in Europe*, EMCDDA Insights, Publications Office of the European Union, Luxembourg.
- | EMCDDA (2015b), *Contingency management for substance-dependent patients in treatment*, EMCDDA Papers, Publications Office of the European Union, Luxembourg (in press).
- | Gurman, A. S. and Kniskern, D. P. (1991), *Handbook of family therapy, volume 2*, Taylor and Francis, London.
- | Higgins, S. T. and Petry, N. M. (1999), 'Contingency management: incentives for sobriety', *Alcohol Research and Health* 23(2), pp. 122–7 (PM:10890806).
- | Kleber, H. D., Weiss, R. D., Anton, R. F., et al. (2006), 'Psychosocial treatments' in part B: background information and review of available evidence in American Psychiatric Association Work Group on Substance Use Disorders', *Practice guideline for the treatment of patients with substance use disorders*, second edition, American Psychiatric Association, Washington DC, p. 275 (psychiatryonline.org/guidelines).
- | Magill, M. and Ray, L. A. (2009), 'Cognitive-behavioral treatment with adult alcohol and illicit drug users: a meta-analysis of randomized controlled trials', *Journal of Studies on Alcohol and Drugs* 70(4), pp. 516–27 (PM:19515291).
- | McHugh, R. K., Hearon, B. A. and Otto, M. W. (2010), 'Cognitive behavioral therapy for substance use disorders', *Psychiatric Clinics of North America* 33(3), pp. 511–25 (PM:20599130).
- | Miller, W. R. and Rollnick, S. (2013), *Motivational interviewing*, The Guilford Press, New York, London.
- | Petry, N. M., Petrakis, I., Trevisan, L., et al. (2001), 'Contingency management interventions: from research to practice', *American Journal of Psychiatry* 158(5), pp. 694–702 (PM:11329388).
- | Rigter, H., Henderson, C. E., Pelc, I., et al. (2012), 'Multidimensional family therapy lowers the rate of cannabis dependence in adolescents: a randomised controlled trial in Western European outpatient settings', *Drug and Alcohol Dependence* 130(1–3), pp. 85–93 (doi: 10.1016/j.drugalcdep.2012.10.013).

- | Saitz, R. (2014), 'Screening and brief intervention for unhealthy drug use: little or no efficacy', *Frontiers in Psychiatry* 5, p. 121 (PM:25228887).
- | Smedslund, G., Berg, R. C., Hammerstrom, K. T., et al. (2011), 'Motivational interviewing for substance abuse', *Cochrane Database of Systematic Reviews* 5, CD008063 (PM:21563163).
- | Taggart, I. H., Ranney, M. L., Howland, J. and Mello, M. J. (2013), 'A systematic review of emergency department interventions for college drinkers', *Journal of Emergency Medicine* 45(6), pp. 962–8 (PM:24063880).
- | World Health Organization (2009), *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence*, WHO, Geneva.
- | Yuma-Guerrero, P. J., Lawson, K. A., Velasquez, M. M., et al. (2012), 'Screening, brief intervention, and referral for alcohol use in adolescents: a systematic review', *Pediatrics* 130(1), pp. 115–22 (PM:22665407).

Further reading and relevant websites

- | SBIRT: Screening, Brief Intervention, and Referral to Treatment: www.integration.samhsa.gov/clinical-practice/SBIRT
- | What is CBT? www.beckinstitute.org/cognitive-behavioral-therapy/
- | Contingency management for drug users: www.emcdda.europa.eu/best-practice/social-reintegration/drug-treatment
- | Cochrane reviews on psychosocial interventions: www.cochranelibrary.com/app/content/browse/page/?context=editorial-group/Drugs%20and%20Alcohol%20Group
- | William Miller on motivational interviewing (video): www.youtube.com/watch?v=cj1BDPBE6Wk
- | A session of family therapy (video): www.youtube.com/watch?v=6JjcliCJaDo