PSYCHOSOCIAL INTERVENTIONS FOR SUBSTANCE MISUSE

From Academic Efficacy to Real World Treatment
Pompidou Treatment
Platform Cyprus May 09

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This presentation will examine development of psychosocial interventions in the academic setting using examples from the 1980s to the present date and examining how these have translated into real world mental health and substance misuse treatment. The implications of academic research findings and follow-up randomised control trials of implementation in treatment as usual settings will be reviewed.
Evidence what evidence?

- Case report
- Cohort study
- Randomised Controlled Trial
- Systematic Review: clearly stated search terms, inclusion/exclusion criteria, quality of the studies, weighted effect size of different studies
- Meta-analysis
Literature search method

1. Literature search 1996-2006

2. Computer
   - PsychINFO & MEDLINE
     - SEARCH TERMS: Disorders & problems (e.g. depression etc.)
     - Study type: Meta-analysis & treatment etc.

   - JOURNALS
   - TEXTBOOKS
   - PROFESSIONAL GUIDELINES (NICE & APA)
   - TOCs & REF LISTS

4. Most recent & authoritative
   - 1. Meta-analysis
   - 2. Narrative review
   - 3. Controlled study

5. Evidence-based & referenced statement about effective practice
Psychosocial Intervention for patients with schizophrenia and their families

• Family intervention to reduce high expressed emotion (Leff 1984)
• Cochrane Review (Pharoah 2006)
Family Intervention for Patient with Schizophrenia and their Families

- People with schizophrenia are more likely to experience a relapse within family groups when there are high levels of expressed emotion (hostility, criticism or over involvement) within the family, compared to families who tend to be less expressive of their emotions. There are several psychosocial interventions available involving education, support and management to reduce expressed emotion within families. In this review we compare the effects of family psychosocial interventions in community settings for the care of people with schizophrenia or schizophrenia-like illnesses.

(Faroh 2006)
Family Intervention for Patient with Schizophrenia and their Families

- Studies were conducted in Europe, Asia and North America with packages of family intervention varying between studies; although there were no clear differences in study design. Results indicated that family intervention may reduce the risk of relapse and improve compliance with medication. However data were often inadequately reported and therefore unusable. As this package of care is widely employed there should be a further study to properly clarify several of the short-term and long-term outcomes.

Faroh 2006 Cochrane Review
Gold standard for Psychosocial Interventions

• Clinical Guidelines: NICE
• Systematic Reviews and Meta-analyses
• RCT: some evidence e.g. EMDR or CBCS for cocaine
• Resources and decisions
• What can we recommend to our Governments as gold standard for psychosocial interventions?
Psychosocial Interventions

- Brief Interventions (Bien 1993) (Babor 2000) (Miller 2002)
- CBT: CBCS (Carroll and Onken 2005), CET (Monti et al 1997)
- MET: (Project Match 1997) (cost effective).
- TSF: (Project Match 1997)
- CRA: (Miller) (Higgins 2000).
- CMT: contingency management (Petry 2002).
  (Miller and Wilbourne Mesa Grande 2002)
Three stages were defined

- **Stage I**: which consists of pilot/feasibility testing for new and untested treatments, including preparation of treatment manuals, development of a training programme, and development of adherence/competence measures for new and untested treatments, as well as translation of findings from basic science to clinical applications.

- **Stage II**: which consists principally of efficacy testing to evaluate treatments that are fully developed and have shown promise or efficacy in earlier studies.

- **Stage III**: which is aimed principally at issues of transportability of approaches to community settings.

Carroll and Onken J Psychiatry 162:1452-1460, 2005
The review will highlight that even with highly manualised interventions there are difficulties in training staff adequately in the theoretical and practical implications of the model and manual. The second most challenging aspect for those who work in substance misuse is engaging users in meaningful psychosocial interventions.
Brief Interventions for Alcohol

- Applied to different populations and different settings: women, polydrug users etc.
- Evidence base Meta-analysis
  Poikolainen 1999
This presentation will distinguish between those who are harmfully and hazardously using substances (ICD10) and those who are dependent on substances. It will also explore the lessons learned from Brief Interventions and the evidence base that is emerging for this approach and will ask questions as to whether there is something we can learn from the successes as well as the failures of psychosocial interventions in treating substance misusers.
EARLY INTERVENTIONS

- Hazardously using
- Harmfully abusing
- Definitions are substance specific
- Route of administration also relevant

ICD10 (WHO)
CYCLE OF CHANGE

Prochaska and DiClemente
TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment

- In Project MATCH, the largest clinical trial ever conducted to compare different alcohol treatment methods, a four-session motivational enhancement therapy yielded long-term overall outcomes virtually identical to those of longer outpatient methods. Clients varied widely in problem severity; the vast majority met criteria for alcohol dependence, and they represented a range of cultural backgrounds.

Miller et al

http://www.samhsa.gov/centers/csat2002
REFERENCES


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- Stead LF, Bergson G, Lancaster T: Physicians advice on Smoking Cessation (Review) *2009 The Cochrane Collaboration*
- UKATT Research Team: Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT) *BMJ 2005 331: 541*
PREVENTION

“a stitch in time saves nine”.
Population Based Prevention

• Availability: price and licensing
• Advertising: ban to include all sponsorship including sport
• Automobile and road: drink driving limits, testing and prosecution
• Age limits on buying alcohol: shows reduction in adolescent drinking
• Advocacy: communities and governments

Edwards(1994) WHO
Population Based Interventions for Substance Abuse

- War on drugs: availability, pricing (cost)
- Harm Reduction: needle exchange, substitute prescribing with psychosocial treatments
- Preventing recruitment of young people into opiate use and addiction (Kelly (2001))
- The contagion model and social context of drug dependence
Physician advice for smoking cessation

- The systematic review identified 41 trials, conducted between 1972 and 2007, including over 31,000 smokers.
- In some trials, subjects were at risk of specified diseases (chest disease, diabetes, ischaemic heart disease), but most were from unselected populations.
- The most common setting for delivery of advice was primary care. Other settings included hospital wards and outpatient clinics, and industrial clinics.
Physician advice for smoking cessation

- Pooled data from 17 trials of brief advice versus no advice (or usual care) detected a significant increase in the rate of quitting (relative risk (RR) 1.66, 95% confidence interval (CI) 1.42 to 1.94).
- Amongst 11 trials where the intervention was judged to be more intensive the estimated effect was higher (RR 1.84, 95% CI 1.60 to 2.13) but there was no statistical difference between the intensive and minimal subgroups.
- Direct comparison of intensive versus minimal advice showed a small advantage of intensive advice (RR 1.37, 95% CI 1.20 to 1.56).
- Direct comparison also suggested a small benefit of follow-up visits.
- Only one study determined the effect of smoking advice on mortality. This study found no statistically significant differences in death rates at 20 years follow up.
Physician advice for smoking cessation

Authors’ conclusions

Simple advice has a small effect on cessation rates. Assuming an unassisted quit rate of 2 to 3%, a brief advice intervention can increase quitting by a further 1 to 3%. Additional components appear to have only a small effect (last updated 2008)

Stead LF, Bergson G, Lancaster T
(Review) 2009 The Cochrane Collaboration
Psychosocial and pharmacological treatments versus pharmacological treatments for opioid detoxification (Review)

Main results

- Nine studies involving people were included. These studies considered five different psychosocial interventions and two substitution detoxification treatments: Methadone and Buprenorphine.

- The results show promising benefit from adding any psychosocial treatment to any substitution detoxification treatment in terms of completion of treatment relative risk (RR) 1.68 (95% confidence interval (CI) 1.11 to 2.55), use of opiate RR 0.82 (95% CI 0.71 to 0.93), results at follow-up RR 2.43 (95% CI 1.61 to 3.66), and compliance RR 0.48 (95% CI 0.38 to 0.59).

2009 The Cochrane Collaboration.
Psychosocial and pharmacological treatments versus pharmacological treatments for opioid detoxification (Review)

Authors’ conclusions

- Psychosocial treatments offered in addition to pharmacological detoxification treatments are effective in terms of completion of treatment, use of opiate, results at follow-up and compliance.
- Although a treatment, like detoxification, that exclusively attenuates the severity of opiate withdrawal symptoms can be at best partially effective for a chronic relapsing disorder like opiate dependence this type of treatment is an essential step prior to longer-term drug-free treatment and it is desirable to develop adjunct psychosocial approaches that might make detoxification more effective.
- Limitations to this review are imposed by the heterogeneity of the assessment of outcomes. Because of lack of detailed information no meta analysis could be performed to analyse the results related to several outcomes.

Amato L, Minozzi S, Davoli M, Vecchi S, Ferri M, Mayet

2008