PSYCHOSOCIAL INTERVENTIONS

COMMON TASKS FOR PSYCHOSOCIAL INTERVENTIONS

- Addressing Motivation.
- Teaching Coping Skills.
- Changing Reinforcement Contingencies.
- Fostering Management of Painful Affects.
- Improving Interpersonal Functioning and Enhancing Social Supports.
- Fostering Compliance with Pharmacotherapy.

ADDRESSING MOTIVATION

Most substance misusers seeking treatment will have a certain degree of ambivalence regarding cessation of use. Ambivalence must be addressed if the client is to function as an active participant in treatment; if the patient perceives treatment as wholly imposed on him or her by external forces and has no clear sense of personal goals for treatment, then the treatment is likely to be of limited usefulness. Thus motivation must be 'internal' at least to some extent, rather than purely 'external'. Motivationally based treatments such as 'Motivational Interviewing' and 'Motivational Enhancement Therapy' concentrate almost exclusively on strategies intended to bolster the patient's own commitment to change. Most psychosocial interventions also include some exploration of what the patient stands to lose or gain through continued substance misuse as a means to enhance motivation for treatment and abstinence (Carroll K, 1997).

TEACHING COPING SKILLS

Social learning theory posits that substance misuse may represent a means of coping with difficult situations, positive and negative affects etc.. At the severer end of the spectrum, substance misuse may have become the only means of coping with a variety of situations, settings and states. Recognition of high-risk situations and the development of new means of coping with them through skills training or relapse prevention techniques forms the central core of cognitive-behavioural techniques in substance misuse treatment (Carroll K, 1997).

CHANGING REINFORCEMENT CONTINGENCIES

A central component of dependency is the narrowing of the social repertoire to the exclusion of all rewards other than those derived from substance misuse. Most psychosocial treatments encourage patients to identify and develop fulfilling alternatives to substance misuse, as exemplified by the Community Reinforcement Approach (CRA), which stresses the development of alternative reinforcers (e.g. fulfilling social activities with non-drug using others) and vocational rehabilitation (Carroll K, 1997).

FOSTERING MANAGEMENT OF PAINFUL AFFECTS

Difficulty in tolerating strong feelings may be a central dynamic underlying the development of compulsive drug use. To foster the development of mastery over dysphoric affects, most psychotherapies include techniques for eliciting strong affects within a structured or protected therapeutic setting, and then enhancing the client's ability to identify, tolerate and respond appropriately to them (Carroll K, 1997).

IMPROVING INTERPERSONAL FUNCTIONING AND ENHANCING SOCIAL SUPPORTS

A consistent finding in the literature on relapse to drug misuse is the protective influence of an adequate network of social supports (Longabaugh et al, 1993). Typical issues presented by drug misusers are loss of or damage to valued relationships occurring when using drugs was the principle priority, failure to have achieved satisfactory relationships even prior to having initiated drug use, and inability to identify friends or intimates who are not themselves drug users. Many forms of treatment, including family therapy, marital behavioural therapy, twelve-step approaches, interpersonal therapy and network therapy, make building and maintaining a network of social supports for abstinence a central focus of therapy (Carroll K, 1997).

FOSTERING COMPLIANCE WITH PHARMACOTHERAPY

Approaches aimed at fostering a sense of personal responsibility for compliance include diary-keeping, clear communication regarding the effects and risks of medication use (truly informed consent), contracting with the client for adherence, general education and advice regarding the effects of non-compliance. Other approaches are numerous and include pill counts, serum monitoring, positive and negative reinforcement approaches, frequent contact, written reminders for appointments or taking medication, support such as transportation or creches for children of clinic attendees (Carroll K, 1997).

SPECIFIC INTERVENTIONS

- Brief Motivational Interventions – an interviewing style involving several short sessions of a few minutes aimed at increasing 'internal' motivation – good evidence of effectiveness.
- Cue Exposure – aimed at extinguishing conditioned responses such as craving – limited evidence of effectiveness in the clinical setting.
- Contingency Management – the use of positive reinforcers to increase desired behaviours – limited evidence of effectiveness in the clinical setting.
- Relapse Prevention – a cognitive-behavioural technique centered around the teaching of coping skills – widely used and good evidence of clinical effectiveness.
- Motivational Interviewing – a directive, client-centered style of counselling that helps clients to explore and resolve their ambivalence about changing - widely used and good evidence of clinical effectiveness.
- Person-centered therapy – based on the belief that clients are always engaged in a search to fulfil themselves, to actualise, to become free of problems created by substance misuse. The focus is on the present, the future and the client's own world.
- Psychodynamic therapy – aimed at facilitating the client's insight and understanding of problems through linking the past and present, and through examination of the client-therapist relationship.
- Marital and Family Therapies – examine the role of important 'others' in the addictive process; marital behavioural therapy may be particularly effective.
- Disease Model Approaches (Traditional, Minnesota Model, 12-step-oriented) - grounded in the concept of substance misuse as a spiritual and medical disease. Group work is central to the approach.
- Solution focused therapy – an approach focusing on exceptions to the problem pattern which enables clients to identify their own unique solutions to the problem.

BRIEF MOTIVATIONAL INTERVENTIONS

Ideal for use in primary care, and aimed more at the problem substance misuser than the dependent substance misuser, brief (between one and several short sessions of a few minutes) interventions are more of an interviewing style than a counselling intervention. The FRAMES acronym described by Miller et al (1991) encapsulates the essential elements of such interventions:

- **F**eedback of personal risk of impairment (through sharing of results of assessments such as cognitive testing, liver function tests).
- Emphasis on personal **R**esponsibility.
- Clear **A**dvice to change.
- A **M**enu of alternative change options.
- Therapist **E**mpathy.
- Facilitation of client **S**elf-efficacy or optimism.

Such empathic and positive approaches have been demonstrated to be associated with better outcomes than more traditional 'confrontation of denial' approaches; this may be associated with their increased propensity to foster internal rather than external motivation.

BEHAVIOURAL APPROACHES

Cue Exposure.

Based on Classical Conditioning Theory (Pavlov's dogs), Childress et al (1993) recognised that repeated pairings of substance use with particular settings, individuals, affect states, paraphernalia and so on could lead to substantial conditioned craving. They demonstrated 'cue reactivity' including both physiologic (changes in skin temperature) and subjective (withdrawal-like symptoms, craving) responses in both opiate and cocaine abusers exposed to drug-related stimuli, such as handling drug paraphernalia etc.. They then demonstrated that repeated exposure to these stimuli in laboratory settings was associated with extinction of some conditioned responses, particularly decreases in craving. However, such approaches have yet to be demonstrated as enhancing effectiveness of treatment in the clinical setting.

Contingency Management.

Based on Operant Conditioning Theory, contingency management approaches use positive reinforcement (or negative reinforcement) to promote desired behaviours. Examples of reinforcers of demonstrated efficacy include take-home methadone doses (as opposed to on-site consumption), and voucher schemes. The use of positive reinforcers is generally believed to be more effective than the use of negative reinforcement (removal of a positive reinforcer) (Stitzer et al, 1986). The context in which such programmes are run is also probably important in determining their success. The rationale of the clinic must be a supportive one, and punitive elements must be avoided; behaviours to be rewarded or otherwise must be detected and reinforced swiftly; chosen behaviours should probably be central (e.g. drug-free urine provision, absence of fresh injecting sites) rather than distal (e.g. group attendance); the reinforcers should themselves promote desired behaviours associated with a drug-free life-style (e.g. cinema tickets, vouchers for sporting goods) (Higgins et al, 1993).

COGNITIVE-BEHAVIOURAL APPROACHES

CBT is based on Social Learning Theory where substance misuse is seen as functionally related to other major problems in a client's life. From this perspective, clients who misuse substances are perceived as not having the skills to cope with other problems and thus misuse substances as a coping strategy. Emphasis is placed on overcoming skill deficits and increasing the ability to cope with difficult situations. Therefore, the main benefit of this approach is to equip clients with coping strategies and resources to fundamentally prevent relapse. Most such treatment approaches touch on the relationship between high-risk situations and substance use to some extent. CBT should also be considered for clients presenting with a dual diagnosis as it is an effective counselling technique for the management of anxiety disorders such as post traumatic distress, obsessive compulsive disorder and phobias, acute or chronic depression and personality disorders.

Relapse Prevention.

Many intervention packages have been devised over the years, but all CBT approaches employ some form of coping skills training to address cognitive and behavioural coping deficits. A standard set of techniques are used to teach coping skills that include identification of specific situations where coping inadequacies occur, and the use of instruction, modeling, role-plays and behavioural rehearsal. Exposure to stressful situations is gradually increased as adaptive mastery occurs. Often referred to as 'relapse prevention', skills training is typically offered in the following areas:

- **Reducing exposure to substances.**
- **Motivating by exploring positive and negative consequences of continued use.**
- **Self-monitoring to identify situations, settings, or states associated with higher risk for substance use.**
- **Recognition of conditioned craving and development of strategies for coping with craving.**
- **Identification of thought processes that can increase risk for relapse.**
- **Preparation for emergencies and coping with relapse to substance misuse.**
- **Homework assignments.**

Comprehensive reviews of treatments for alcohol problems rank CBT packages as having high evidence of effectiveness in treating alcohol dependence (Finney & Monahan, 1996), and social skills training (one form of coping skills training) emerged as the treatment rated with most evidence for effectiveness to treat alcohol dependence across all reviews. Some report that CBT is the now the dominant form of psychological intervention for the treatment of substance misuse (Morgenstern & Longabaugh, 2000).

A comparative analysis of CBT and inter-personal therapy approaches found that the outcomes from CBT were significantly higher for severely dependent substance misusers. However, inter-personal therapy (IPT) (*see over*) approaches were reported to be more effective than CBT for clients presenting with a lower dependency. The findings of this study also showed that the outcomes for severely dependent substance misusers were further improved for clients who remained in therapy for longer durations (Carroll, 1996).

In summary it would appear that both CBT and IPT approaches have a role to play in helping clients achieve positive health changes, although counsellors do need to tailor the type of approach used to the aims of the client to maximise treatment outcomes.

MOTIVATIONAL INTERVIEWING

Research has indicated that brief counselling interventions are more effective than no intervention and often as efficacious as more extensive long-term counselling (Miller & Rollnick; Harris 2001). The most common brief counselling intervention applied in substance misuse is motivational interviewing. It is based on the premise that the main obstacle to changing drug or alcohol use and associated behaviour patterns is a lack of motivation; it follows that if motivation to change can be enhanced then, then behaviour change will be more likely (Baker & Reicher 1998). It is a technique that does not require an in-depth counselling knowledge and it can, therefore, be used by most professionals specialising in substance misuse.

Motivational interviewing incorporates five general principles: empathy; discrepancy; non-confrontation; accepting resistance; and supporting self-efficacy. The role of the professional is to employ these principles in two main phases; the first of which is concerned with building motivation; while the second is aimed at strengthening commitment to change.

A study of alcohol users found that the number of clients motivated to change was increased by 77% when motivational interviewing was used (Miller & Sanchez 1999). While other brief therapy techniques have also been found to be efficacious, those involving advice or instructions were deemed to be less effective than motivational interviewing if the clients presented with little motivation to change in the first instance (Heather et al 1997).

MARITAL AND FAMILY THERAPIES

Several approaches involve family or spouse in treatment including 'family disease models' (which focus on the family's role in enabling the disease process), family systems models (which conceptualise the role of substance misuse in terms of family dynamics and roles), and behavioural models (which evaluate substance misuse in terms of family behaviours which precede or maintain it) (McCrady B & Epstein E, 1996). Marital behavioural therapy in particular and various other combinations of family approaches have demonstrated effectiveness in reducing dropout and relapse rates.

SOLUTION FOCUSED THERAPY

Solution focused work is based on an Ericksonian model of human behaviour. It argues that most interventions focus on pathological or negative aspects of a person's life. This therapy reframes the therapist role to help the client consider exceptions to the problem pattern. By focusing on the client's strengths and successes through a series of future orientated questions, the therapist and client are able to co-construct new solutions to existing problem behaviours.

INTERPERSONAL APPROACHES

Inter-Personal Therapy (IPT) is used here to refer to psychodynamic, person-centred, psychosynthesis, gestalt therapy and psychotherapy counselling techniques.

The **person**-centred approach is theoretically lean. What matters to the counsellor is the theory or model of the world held by the client. The counsellor approaches the client with an attitude of deep respect and acceptance of whatever the client's aims are i.e. abstinence, controlled drinking etc.. The client is offered freedom of expression (content) and experience of feelings. Person-centred counselling is also a process-oriented approach. Central is the belief that clients are always engaged in a search to fulfil themselves, to actualise, to become free of problems created by substance misuse. Person-centred counsellors are strongly influenced by existential philosophy. They are very cautious about any attempts to diagnose or categorise clients, as they believe such labels are static and deny growth or movement in the clients' lives. They are aware of using the client's frame of reference (world-view) rather than their own. Person-centred counsellors are adaptable to cultural diversity, show empathy, warmth and flexibility. The past is sometimes considered irrelevant. The focus is on the present and the future.

The **psychodynamic** counsellor is not only interested in the presenting problem that the client brings but also in the client's life-history. The relationship with the client is central to the work. The therapeutic alliance and relationship between counsellor and client fosters respect, trust, common purpose and commitment. The task of the counsellor is to facilitate the client's insight and understanding of the problems through linking the past and present; to make interpretations of the client's communication, conscious and unconscious; to highlight defence mechanisms and developmental aspects; and to interpret transferences in terms of relationships of the past and present. The psychodynamic counsellor maintains strict boundaries and the focus on the unconscious and underlying anxiety is a key feature of this approach. Dream work and hidden meanings are all explored to create greater insight and understanding for the client.

Among the most commonly cited reasons for relapse are powerful **negative affects**, and many psychodynamic clinicians have suggested failure of affect regulation is a central dynamic underlying the development of compulsive drug misuse. While psychodynamic treatments tend to emphasise the role of affect in substance misuse treatment, virtually all forms of counselling for substance misuse include a variety of techniques for coping with strong affect.

DISEASE MODEL APPROACHES (TRADITIONAL, MINNESOTA MODEL, 12-STEP-ORIENTED)

These approaches are grounded in the concept of substance misuse as a spiritual and medical disease. In their basic and original form they consist of self-help groups, that in the case of AA are widely available throughout the country. A variety of related models have evolved which range in intensity from structured outpatient to intensive, multimodal inpatient approaches of several months duration.

AA was founded in 1933 by a stockbroker (Bill W.) and a physician (Dr Bob). The basic philosophy of Alcoholics Anonymous is that of reaching out to other alcoholics to help everyone stay sober. This philosophy derived from the personal experience of Bill W, an alcoholic, who one day, on the verge of relapse to drinking, realised that he had to speak to another alcoholic in order to stop himself from drinking. The alcoholic he found to speak to was Dr. Bob. Their rationale was published in 1939 as 'Alcoholics Anonymous' also known as 'The Big Book'. It established AA for all alcoholics, including atheists and agnostics; indeed, AA is a spiritual and not a religious programme.

THE TWELVE STEPS

1 Admitted we were powerless over alcohol; that our lives had become unmanageable;

2 Came to believe that a Power greater than ourselves could restore us to sanity;

3 Made a decision to turn our will and our lives over to the care of God as we understood Him;

4 Made a searching and fearless moral inventory of ourselves;

5 Admitted to God, to ourselves, and to another human being the exact nature of our wrongs;

6 Were entirely ready to have God remove all these defects of character;

7 Humbly asked Him to remove our shortcomings;

8 Made a list of all persons we had harmed, and became willing to make amends to them all;

9 Made direct amends to such people wherever possible, except where to do so would injure them or others;

10 Continued to take a personal inventory and, when we were wrong, promptly admitted it;

11 Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out; and

12 Having had a spiritual experience (awakening) as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Additional insight into the mechanism of AA effectiveness can be gained by examining various AA slogans. These include 'One day at a time', 'Easy does it', 'Let go and let God', 'Keep it simple', 'HOW' (**h**onesty, **o**penness and **w**illingness), 'HALT' (**h**ungry, **a**ngry, **l**onely and **t**ired), 'First things first'.

Common objections to attendance can be addressed as follows:

Religiosity:

AA is spiritual and not religious; the requirement is a belief in a Higher Power, rather than a God, and atheists are welcome at groups.

Talking in groups:

There is no requirement to talk at AA; members can say 'pass' when it is their turn.

Anonymity:

This is protected rigorously.

Drinking:

The only requirement is a desire to stop drinking, rather than actual sobriety.

There is no one individual in charge of AA meetings, and over the early years, meetings were often chaotic to the extent that the organisation's survival was threatened. In response to this some organising principles evolved which became known as the 'Twelve Traditions' (*appendix 12*, page 155).

Outcomes for AA attenders are mixed, as with all forms of treatment for addiction. Drop-out rates are high, and approximately half those who attend AA have left within three months (Anonymous, 1989). Despite this high drop-out rate, for those who remain, the abstinence rate is excellent – the average length of sobriety amongst active members is approximately six years (Anonymous, 1996). Indeed, one of the most consistent and robust findings is that of a correlation between AA attendance and positive drinking outcomes. In one study of over 8000 patients attending treatment programmes in the USA, those who were also attending AA at one-year follow-up were 50% more likely to be abstinent than those who were not attending AA (Hoffman & Miller, 1992). There are many studies replicating these results and similar results have also been reported for NA involvement (Christo & Graney, 1995). However, a recent meta-analysis of the role of AA in treatment outcomes found only a modest correlation between AA involvement and drinking outcomes (r=0.21) (Tonigan, Toscova & Miller, 1996). Some studies also demonstrate that the more involved one is with the process, the better the drinking outcome (Tonigan, Toscova & Miller, 1996). Abstinence rates for 12-step treatment programmes (rather than AA) are quite good, with 50% abstinence at 12 months being a typical outcome figure (Hoffman & Miller, 1992).

Narcotics Anonymous.

NA was formed in 1947 in response to the discomfort many narcotic and other drug addicts felt when attending AA meetings. The Twelve Steps are the same as AA's but with the word alcohol replaced by addiction or addict where appropriate. The approach is abstinence from all drugs including alcohol. NA has its own 'Big Book' entitled 'Narcotics Anonymous' (1983). Another group based on the same principles has also developed over the last 25 years: **Cocaine Anonymous (CA)**.

Al-Anon.

One Gallup poll found that 24% of people interviewed said that their life had been affected by an alcoholic in some way (Robertson, 1988). The oldest **family-based group** is Al-Anon, and was started by the wife of Bill W. The central theme is one of addiction as a family disease, and that relatives of the alcoholic person must focus on their own need for help, rather than on the alcoholic person. This simple philosophy was (and is) revolutionary for people who have spent most of their energy and time concentrating on the alcoholic. Additionally, the relative must learn to free themselves of feeling responsible for the alcoholic's disease; the concept of 'tough love' is central to various attitudes which must be learnt:

- **Not to suffer because of the action or reactions of other people;**
- **Not to allow ourselves to be used or abused in the interest of another's recovery;**
- **Not to do for others what they should do for themselves;**
- **Not to manipulate situations so others will eat, go to bed, get up, pay bills etc.;**
- **Not to cover up another's misdeeds or mistakes;**
- **Not to create a crisis;**
- **Not to prevent a crisis if it is the natural course of events.**

Al-Ateen **is an off-shoot of Al-Anon for teenagers**.

Contact details for AA and similar groups can be found in *appendix 12*, page 155.

SETTING: RESIDENTIAL AND COMMUNITY PSYCHOSOCIAL SERVICES

Residential services differ from many community psychosocial services in that the former almost always exclude clients who are actively using substances either controlled or prescribed. As such, residential services will almost exclusively form part of an aftercare package, whilst community psychosocial services may cater for clients at all stages of the cycle of change.

- Residential services may produce improved outcomes as compared to community aftercare services.
- The essential component of success seems to be completion of the residential programme, rather than the duration of the programme or the particular style of intervention. As such, services that are more successful in retaining clients in treatment tend to produce improved outcomes.

RESIDENTIAL SERVICES

The 'Effectiveness Review' (1995) identifies four modalities of residential service:

- **Therapeutic communities.**
- **Twelve-step Minnesota Model houses.**
- **General houses including those with a Christian-based philosophy.**
- **In-patient treatment.**

The first three of these share a number of key features:

- **Residents must be drug free (apart from tobacco); some services provide in-house detoxification (especially the 12-step houses).**
- **They provide a structured programme of psychological, educational and social therapy, which aims at preparing the drug misuser to manage better a drug-free life back in society.**
- **Programme lengths of between 6 weeks and 9 months (most commonly 3 to 6 months).**

In-patient treatment is more medically based and provides detoxification and counselling (individual and/or group work). Lengths of stay are rarely over 2 months with an average of four weeks. Services are based in hospital psychiatric wards, specialist in-patient units and the voluntary sector. The average size of such units is 12 beds.

As for in-patient detoxification, residential psychosocial rehabilitation appears to present a higher probability of successful outcome than does community based rehabilitation; this is however, very different from saying that one setting is more or less cost-effective than the other. In the current political context it seems probable that the push to create increased treatment places with limited resources may occur at the expense of residential placements.

A 1996 follow-up study, conducted as part of the National Treatment Outcome Research Study (NTORS) reported the following (Gossop M et al, 1999):

- During 1995, 1075 drug users (as distinct from alcohol users) entered 54 residential services. 405 subjects entered the 15 residential rehabilitation units and 8 in-patient units that were included in the NTORS study. Of these subjects, 75% were heroin users, but poly-drug use was the norm.
- 275 subjects were re-interviewed one year later. At this time 37% had been abstinent from opiates, stimulants and benzodiazepines over the past three months, 19% were drinking excessively compared to 33% at intake, stimulant use fell from 71% to 32% including a halving of crack use, the proportion of those injecting was roughly halved, the proportion of those committing crime was roughly halved.
- Half of the clients did not complete the full period of residential care. Compared to early leavers, those retained at least 28 days in short programmes, and 90 days in longer ones were four times less likely to use opiates 9-12 months later; they were also far less likely to use other drugs, commit crimes, or inject. In shorter term residential units, 64% of clients stayed for the critical period. In longer term units, only 40% stayed for the critical period. In inpatient units, only 20% stayed for the critical period. Early leavers still improved, most noticeably in stimulant use and sharing injecting equipment.
- Clients of the 25% of projects with the poorest retention rates had not cut their heroin use at all.

There are several implications of the above results.

- When compared to the community services in the NTORS project, residential services achieved comparable drug misuse outcomes, but were treating clients with more severe patterns of substance misuse, thus indicating possible greater effectiveness of residential as compared to community services. Additionally they had a greater impact on infection risk, and acquisitive crime rates.

- There was a clear relationship between retention in treatment and outcome. Retention was best in shorter-term residential rehabilitation units and worst in in-patient units. US research has shown that cutting stays or providing therapeutic community regimes on a non-residential basis does not impair outcomes when completion rates are maintained. Retention in treatment is thought to be an important mediator of effectiveness in all settings; however, without randomisation it is difficult to exclude motivation as an obvious confounding factor for this effect.

- One interpretation of these findings is that it is not the setting (community or residential) or the duration of treatment that matters, but rather engaging the client effectively, leading to completion of the treatment programme.

Clients whose main problem drug is cocaine form 6% of UK treatment admissions, a proportion which has doubled in three years. Amphetamine is the main drug for 8% of clients, while approximately 20% of clients use cocaine and 15% amphetamine as part of poly-drug misusing pattern. Residential care is an effective option for clients presenting with stimulant misuse, especially when clients stay at least one month in short programmes and three months in longer ones.

The issue of retention is central to effectiveness, and can be seen as a function of how the service relates to its clients, rather than the reverse. Services which actively engage with clients, provide supportive environments and well structured programmes, which are clear about their policies and their therapies, and which tailor their activities (or at least allow residents to do so) to individual needs produce better outcomes (see *appendix 1,* page 114: Key Characteristics of Effective Services).

COMMUNITY SERVICES

Community aftercare services come in various forms including 'drop-in' and counselling services. 'Structured day programmes' are a relatively new package of treatment providing a more rigorous and intensive intervention, and will tend to require regular attendance 4 to 5 days weekly and engagement with a structured programme of care which lasts anywhere between 6 and 24 weeks. They provide a new alternative to residential rehabilitation for clients who are not prepared to contemplate a long period away from their home environment. Paradoxically, the main requirement for maintenance of change for many clients will be removal from their drug-using environment for a period of time. There are five main types of structured day care service that have developed to date:

- **Drug-using offender programmes.**

- **Primary crack cocaine and stimulant user programmes.**

- **Programmes run by residential rehabilitation units.**

- **12-step based programmes.**

- **Programmes with a vocational and educational focus.**

See *appendix 1,* page 114 for SCODAs quality standards for structured day programmes.

THERAPISTS AND COUNSELLORS

One finding of the 'Effectiveness Review' was that certain professional characteristics of counsellors were probably more important than the particular form of therapy: best results were achieved by counsellors with high levels of organisation and who closely adhered to chosen counselling programme rules (McClellan et al, 1994).

The BAC Code of Ethics and Practice for Counselling (amended 1996) provides the basic framework for counsellors to adhere to. The specifications provided by the BAC for accreditation can be used to determine the minimum qualifications and practice experience required for a person to be classified as capable of providing counselling. This includes four hundred and fifty hours course work on counselling theory with an equal amount of time spent in counselling practice. The amount of theoretical work hours equates to that provided by most counselling Diploma courses. The BAC offers guidance on the minimum amount of supervision required for a counsellor to remain in practice: one and a half hours counselling supervision each month. Where a person is acting in a dual capacity (i.e. providing nursing duties with some clients while taking on the role of counsellor with others), the counselling supervision should be separate from the supervision of their other duties. The BAC Code of Ethics and Practice for Supervision of Counsellors (1996) provides comprehensive details and these should be used by all counsellors and supervisors within substance misuse services.

The British Association for Counselling (BAC) has historically preferred to perceive 'counselling' as a distinct entity from 'counselling skills', the former referring to those circumstances where the practitioner and client explicitly contract to enter into a counselling relationship and the latter applying to those situations where the practitioner uses counselling skills as a part of their other professional duties. **'A client can be deemed to be receiving counselling if they are being seen by a person who has taken on the role of counsellor and who is not acting in another professional capacity with that client'**. Drawing on this position, it seems reasonable to assume that many health and social care professionals will not be in a position to provide counselling unless they are seeing a client solely for that purpose. **From the perspective of substance misuse services, professionals providing counselling will need to ensure that a client's other health and social needs are addressed by different team members.**

- Clients of all specialist services will benefit from access to formal counselling.
- The best results are achieved by counsellors with high levels of organisation and who closely adhere to chosen counselling programme rules.
- Care coordinators should use counselling skills in their encounters with clients, but formal counselling should be delivered by a professional other than the care coordinator.
- Structured counselling should be delivered by qualified counsellors who are receiving supervision.

CONCLUSION

- No single counselling approach is appropriate for all clients. Matching counselling techniques to a client's aims is crucial in determining successful outcomes. Counsellors should employ motivational interviewing when clients present showing no or little commitment to change. Once a client has demonstrated a commitment to change and has low levels of anxiety, CBT should be considered as the preferential technique used for those clients in maintenance programmes. However, IPT approaches may be regarded as the most appropriate counselling style for those clients with a low dependency.

- Counselling should be used to address the multiple needs of a client, not just their substance misuse.

- Counselling is most effective when it is combined with other treatments such as methadone prescribing.

- Research indicates that, for most clients, the threshold of significant improvement is reached at about 3 months in counselling. After this threshold additional treatment or counselling may produce further progress towards recovery in some cases.

- Substance misusers with a dual diagnosis should have both disorders treated in an integrated way, except in circumstances where a client has a profound mental health problem.

- Counselling should be provided by professionals who have the necessary qualifications and experience for BAC accreditation. Counsellors should operate in accordance with the BAC codes for both 'counselling' and 'supervision'.

- Professionals should use 'counselling skills' with clients for whom they are providing other services. Formal counselling should only be provided by a professional who is not responsible for provision of other services.