What the science shows, and what we should do about it (Part 4)

Professor David Clark describes the main recommendations from a major new book based on the views of America's leading clinicians and researchers of how treatment would look like if it were based on the best science possible.

Leading US addiction scientists met in 2004 at a 'think-tank' conference to share research findings in their respective areas and discuss possible implications for treatment and prevention interventions. They proposed a set of ten cross-cutting principles, which I have considered in recent Briefings.

These principles suggest particular directions 'in designing programs, systems, and social policy to reduce drug and associated suffering, societal harms and costs'. I will now look at the first six recommendations.

Recommendation 1: Intervention is not a specialist problem but a broad social responsibility that should be shared by many public and private sectors.

Treatment should be integrated as much as possible in one-stop health and social service settings that connect people with other services they need. As with other chronic health problems, the successful resolution of substance use problems depends heavily on long-term behavioural self-management.

The value of screening and prevention services should not be under-emphasised and they need to be integrated in the same health and social service setting. There is legitimate concern that substance use issues may get lost in chaos and be given low priority in this system. This must not be allowed to happen.

Recommendation 2: Screen for and address the full range of substance problems, not just the most severe.

There needs to be an integrated continuum of care that addresses the full range of problems, rather than a focus of attention and resources on the most severe substance use problems.

The concept of stepped care is a sensible, although relatively untested, approach. There needs to be a menu and spectrum of services to allow people to find levels and types of service that they find appropriate and attractive.

A reasonable and under-utilised approach is to offer brief motivational counselling as a first-line intervention, followed by more expensive and intensive services to people who do not respond to this brief intervention.

Recommendation 3: Understand substance use and problems in a larger life context, and provide comprehensive care.

Substance use problems rarely occur in isolation. Since substance use may be just one component of a matrix of problems and issues – psychological, medical, family, social – disrupting only one of these components is unlikely to disrupt this complex self-organising system.

'Substance use problems must be understood and addressed in the larger context of personal and social issues.'

Substance use problems must be understood and addressed in the larger context of personal and social issues. Practitioners and the system must screen and provide adequate care for common concomitant concerns, such as depression and family problems.

Prevention efforts should look beyond substance use, making use of scientific knowledge about modifiable risk and preventive factors. Particularly at-risk groups and families should be identified for early intervention.

Recommendation 4: Look beyond the individual for the causes and solutions to drug use and problems.

Many interventions for substance use problems 'have been designed to address and to focus on personal pathology, implying that the locus of the problem is within the individual or family'. This misses the reality that substance use problems are part of a broader self-organising social system.

We need to take into consideration the impact of contextual, family and societal factors in promoting and decreasing substance use problems.

A societal response to illicit drug problems that focuses on deprivation and punishment is unlikely to be successful. Attempts to prevent people from using illicit drugs are ill-fated without providing access to alternative natural sources of positive reinforcement.

For example, people experiencing social deprivation will find it much more difficult to give up drugs than those living in areas providing access to a variety of alternative sources of reinforcement.

Recommendation 5: Enhancing motivation for and commitment to change should be an early goal and key component of intervention.

Drug use is a choice among alternatives. Prevention and treatment efforts are essentially competing with an inherently rewarding behaviour.

Change begins with motivation to change. 'How to' interventions are unlikely to succeed in the absence of motivation.

Approaches that in effect tip the balance of motivation away from problem substance use are effective in changing behaviour. These include brief motivational interventions, positive reinforcement for non-use, substitute agonist medication, and enhancing access to natural sources of positive reinforcement.

Much is known about how to impact upon human motivation and commitment to change that goes beyond simplistic advice to 'just say no'. This science needs to be used to craft effective interventions.

Recommendation 6: Changing a well-established pattern of drug use begins by interrupting the pattern to produce an initial period of abstinence.

Once addiction or dependence is established, it becomes self-perpetuating. A period of abstinence helps to destabilise this self-organising pattern and can trigger change.

An initial period of abstinence can be brought about by, for example, residential care, medication, or contingency management. The longer the abstinence, the more stable it becomes.

Choice and motivation are important components in helping people to interrupt substance use and experience a period of sobriety. External enforced abstinence tends to be less effective than periods of abstinence where the individual has choice.

[to be continued]

Rethinking Substance Abuse: What the Science Show, and what we should do about it, edited by William R. Miller and Kathleen M. Carroll, Guilford Press, 2006