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ALCOHOL AND SUBSTANCE MISUSE WORKING GROUP

COUNSELLING IN SUBSTANCE MISUSE

A REVIEW of the LITERATURE

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A REVIEW OF THE LITERATURE

1 Introduction

This literature review will examine some of the more recent work on addiction counselling and psychotherapy with the aim of informing decision-making about optimum deployment of the Eastern Region Health Authority counselling resource. We will summarise the current literature on the efficacy of counselling in general mental health settings. Initially, however, it is important to acknowledge some of the key issues which must be addressed in any counselling review.

1.1.1 Evaluation Issues

First, there is what we would call the methodological issue. This is eloquently posed by Moodley (2001), who says *"practitioners have argued that the use of objective, rational and scientific methods which tend to be favoured by researchers, sits uncomfortably in a discourse which is essentially subjective, imaginative and psychic".* Essentially, this is the argument that quantitative research in general and randomised control trials in particular are not the best way to evaluate the efficacy or otherwise of counselling. In this chapter we draw on systematic reviews and meta-analyses. These generally summarise quantitative trials which normally employ randomised or partially randomised designs. While we appreciate that such methods are not without their difficulties, it is normal practice in reviews to leave the selection of studies to the authors who have produced systematic reviews and meta-analyses. We have, however, also drawn on qualitative work and single case studies. It is our view, however, that research summary methods represent a reasonably sound source of objective evidence on process and outcome evaluation.

The second issue is sometimes referred to as the "equivalent outcomes paradox" (Stiles et al, 1986). Essentially this refers to the common finding that there is little difference between particular psychotherapeutic methods. Project MATCH (1998) is a particularly well-known recent example of this, which we will look at in some detail below. There are two points to make about this "equivalent outcomes paradox". The first is that, even if the outcomes from different *types* of intervention are similar, there are still numerous lessons which can be learnt about how the *process* of counselling can lead to better or worse outcomes. The second is that, although there is a literature on "equivalent outcomes", there is also a literature which suggests that some types of intervention are more effective than others, certainly at different stages of change, or with different types of substance misuse problem. We will summarise this data, and we suggest that this can provide important pointers, enabling service design and delivery to be informed by this evidence-base.

A third issue is the relationship between evidence and bias. It seems self-evident to us that the provision of counselling should be evidence-based. Even when people are agreed on what constitutes evidence, it is the case that in many organisations there can be (at times) some resistance among both practitioners and managers to acknowledging the significance of research.

Evidence is not always clear-cut, and differences which are found between interventions can sometimes be attributed to various forms of bias: what could be called "investigator allegiance". We are also aware that aligned to investigator allegiance is "summariser allegiance" which is a tendency for authors to lean towards some predetermined position.

With regard to the present report, although two of the authors have been trained in the cognitive behaviour tradition, the other two have not, and thus we believe we can present the evidence as objectively as possible.

A fourth and most difficult issue is what we would all the "definition question": what is counselling and how does it differ from psychotherapy? Rogers (1942) himself noted that *"there has been a tendency to use the term counselling for more casual, superficial interviews and to refer to the term psychotherapy for more intensive and long continued contacts directed towards deeper reorganising of the personality".* He went on to say, however, that *"the most intensive and successful counselling is indistinguishable from intensive and successful psychotherapy".*

Some professionals who work as counsellors are in fact trained psychotherapists. Priestley *et al* (1998) say that psychodynamic counselling uses the same theoretical framework and range of interventions as psychodynamic psychotherapy, and this makes it difficult to have a clear distinction between the two. This difficulty is also tacitly acknowledged in the UK NHS Review on Psychotherapy (NHS Executive, 1996) which also included counselling, and in the UK Department of Health report Treatment Choice in Psychological Therapies and Counselling (DoH, 2001) which, while not directly addressing the use of counselling in the field of alcohol and other drug addictions, recognises that terminology in this field is confusing. The DoH report acknowledges that counsellors can practice within the main therapeutic approaches, *eg* CBT, psychoanalytic therapy, systematic or family therapy. The DoH report adopts the usage *'that' "psychological therapy", "psychological treatments", "talking therapies" and "talking treatments" are interchangeable, representing the most generic terms. Within the broad family of therapies, there are two main traditions, psychotherapy and counselling. The distinction between the two is blurred, as they lie on a continuum, such that for each type of psychological therapy there is a corresponding form of counselling (psychodynamic therapy – psychodynamic counselling, cognitive behaviour therapy – cognitive behaviour counselling, etc* (DoH, 2001:8).

We would agree, however, with Rowan (2001) who suggests that there is a difference between the two, and our position is that it is impossible to review the literature without at least addressing this definition question.
Rounsaville and Kleber (1985) say that while psychotherapy attempts to bring about change by altering mental mechanisms believed to underpin maladaptive behaviours, counselling is more frequently based on a commonsense idea of motives and actions and there is usually no attempt to elucidate and alter counterintuitive mental forces. There can also be differences between counsellors and psychotherapists in terms of training,

tradition and background. It is more difficult, however, to isolate differences in day-to-day practice. Davidson (2001) attempts some definitions which are summarised in Table 1 (below). These definitions are an illustrative sample of a whole range of potential definitions of a wide number of psychotherapeutic interventions. There is, of course, a growing rapprochement between various families of psychotherapy; for example, Cognitive Analytic Therapy draws on both CBT and psychoanalytic approaches. Nonetheless, it is, we think, helpful to attempt some illustrative definitions. We do, however, acknowledge that the definitional question is something of a minefield which no reviewer has yet successfully traversed.

Table 1 – DEFINITIONS

Information and education	a didactic approach which provides information on the problem, medical management, coping issues and self care measures
Support counselling	support and encouragement in a caring environment in which the emotional consequences of the problem and its treatment can be expressed
Therapeutic counselling	a patient-centred process of exploration, clarification and problem solving using procedures such as active listening, reflection and empathic responding
Psychoanalytic therapy	this class of intervention is based on specific psychological theories of human functioning. It is a long term process and focuses primarily on interpretation of largely unconscious conflicts and tensions. These are often re-enacted and interpreted in the relationship with the therapist
Cognitive behavioural psychotherapy	This is an approach in which emphasis is placed on the influence of conscious thought and behaviour on feeling and emotion. It can include cognitive techniques like challenging negative automatic thoughts, visualisation, anxiety management, problem solving, cognitive appraisal and reframing, and behavioural techniques like graded exposure and activity scheduling.

As noted above, it is important to look at counselling as a process as well as a set of activities. Velleman (1992a, 2001) has developed an approach to counselling people with substance misuse problems which highlights the processes irrespective of the theoretical persuasion of the counsellor. He describes 6 stages, namely developing trust, exploring the problem, helping clients to set goals, empowering clients to take action, helping them to maintain changes, and agreeing with them when the time comes to end the counselling relationship. Velleman suggests that counsellors, irrespective of

their theoretical orientation, are responsible for ensuring that clients can pass through these processes.

One of Velleman's central arguments is that the process of counselling is what allows individuals to change their behaviour. Although he suggests many techniques that counsellors can use (some originating from within the cognitive behavioural tradition), he argues that the core of enabling people to change is the empowering relationship that the counsellor engenders.

1.1.2 Literature Search Methodology

A comprehensive review was undertaken of the international literature related to counselling, psychotherapy and psychosocial interventions within the treatment of problems arising from drug and alcohol misuse. This literature review is a companion document to the External Review of Eastern Region Health Authority Addiction Counselling Services (Velleman, Davidson, Mistral & Howse, 2001).

The Literature search was conducted using a hierarchical search, to identify systematic meta-analytic reviews that related to psychotherapy, counselling or individual psychotherapeutic practices in the treatment of substance misuse. References to previous reviews contained within these were followed up, then supplementary searches were conducted for missed reviews and for individual high quality trials. Finally, individual studies using randomised control conditions and control conditions were included. Hand searches were conducted using the last 5 years back copies of ADDICTION, as well as ADDICTION ABSTRACTS from 1998 to 2001, and DRUG AND ALCOHOL FINDINGS, from 1999 to 2001.

The databases Embase (1988-2001), Medline, Psychlit, and Psychinfo (1977-2001/05) were searched. The initial search parameters employed the terms:

1. *'Counselling' or 'talking therapies' or 'talking treatments' or 'psychotherapy' or 'psychological interventions' or 'psychological treatments' or 'psychosocial'*

and

2. *'Substance misuse' or 'substance abuse' or 'alcohol' or 'methadone' or 'opiate' or 'drug misuse' (psychlit: 3407)*

These searches were then combined to find reviews of the literature first; followed by individual studies using the following parameters.

3. *'literature review' or 'meta-analysis' or 'critical review'*

A further search was undertaken combining the search terms of 2 with the following search terms representing a sample of known treatment modalities to capture single studies that compare the impact of different psychological interventions on substance abuse outcomes.

3. *search terms of "2" and 'psychoanalytic' or 'Cognitive Behavioural Therapy' or 'Cognitive Analytic Therapy' or 'Rational Emotive Therapy' or 'Motivational Interviewing' or 'Twelve-step' to 'Motivational Enhancement Therapy' or 'Individual Counselling' or 'Brief intervention'*

or 'Brief Therapy' or 'Reality Therapy' or 'family therapy' or 'systemic' or 'client centres'

and

4. *'Evaluation' 'outcomes research' 'effectiveness' 'RCT'*

Abstracts were entered into a database and study type, therapy type, study source, treatment setting, client group characteristics, aims of therapy, methods and measures used and relevance to evaluation in terms of themes the literature addresses were noted.

Studies were excluded if the treatments were: a) carried out by physicians in primary care b) the prescribing problem of the client group was not substance misuse eg depression, trauma, managing aggression etc.

Finally, these reviews and papers were analysed in order to draw out and develop emerging themes from the literature.

1.2 General Review of Counselling

1.2.1 Research Summaries

Key Points

- *Reviews up to the mid-1990s found little evidence of benefit from generic counselling*
- *More recent, more rigorous reviews show positive effects, especially for cognitive behavioural therapy*

During the 1990s there were a number of reviews of the efficacy of counselling. Three major reviews were published in 1996, by Godber *et al,* Friedli and King, and the now seminal book by Roth and Fonagy, commissioned by the UK Department of Health, entitled "What works for whom". Each of these reviews focused primarily on the value of therapeutic or patient centred counselling in a primary care setting with groups of clients presenting with a variety of psychological morbidity. Essentially the conclusion of each of the three reviews was that there was little evidence for the benefit of such counselling over routine care. This was very much the tone of all the reviews during the mid-1990s, although the systematic reviews and meta-analyses were tending to favour Cognitive Behaviour Therapy (CBT) as the treatment of choice for most non-psychotic, psychological disorders.

Parry (1996) also produced a review of strategic policy commissioned by the UK NHS Executive, entitled "NHS Psychotherapy Services in England". This author argued that basic applied research in psychotherapy has insufficient impact on the organisation and delivery of psychotherapy services. Equally, the review concluded that there is insufficient research on psychoanalytic therapies to draw conclusions on its efficacy and, again, found little evidence to support the benefit of patient centred counselling. Essentially this important review supported the use of cognitive behaviour therapy (CBT) over other interventions, particularly for depression, anxiety disorders, panic disorder and addictions.

More recently, however, there has been a recognition of the limitations of some earlier reviews. Some of the earlier surveys included counsellors who were not appropriately trained and qualified, may have included studies with small sample sizes and employed ambiguous outcome measures. More recently, general reviews of research have been more rigorous in the selection of trials, and more optimistic in their conclusions.

A Cochrane Collaboration (1999) used very stringent inclusion criteria for counselling outcome studies. These results were more encouraging and concluded that *"patients who received counselling showed a modest but significant improvement in symptom levels compared with those who received routine care".* This was followed by the Department of Health Evidence Based Clinical Practice Guideline (2001), which again summarised the general literature. The conclusions here were *"there is evidence of counselling effectiveness in anxiety and depression, and it is most effective when used with specific client groups, eg postnatal mothers or bereaved groups".* It also found evidence that it could be used to good effect in appetitive disorders. Again, CBT was shown to be effective in a range of disorders, including problems arising from addiction. More recently in Effectiveness Matters (2001), the NHS Centre for Reviews and Dissemination in York published a brief paper on counselling in primary care. The conclusions here were that patient centred counselling was effective up to 6 months post termination of counselling. However, they concluded that evidence for longer term effects, ie after 12 months, was more difficult to glean from the existing literature.

Essentially, the Cochrane Collaboration, the DoH sponsored review, as well as a recent summary of counselling research (Mellor-Clarke, 2001), are all more positive about the potential effectiveness of counselling in general mental health settings. Evidence, however, on long term effectiveness remains elusive.

1.3 Addiction Counselling – General Issues

1.3.1 Counselling in Substance Misuse

Key points

- Counselling can play an important role as part of an array of medical and psychosocial interventions

  - *Evidence points towards the effectiveness of CBT with opiate-users*
  - *All treatment, including counselling, has to consider the wider context of people's lives*
  - *Employing adequately trained, qualified, and supervised counsellors is crucial*

- *Systematic, protocol driven, manualised interventions improve outcome*

It seems clear to the evaluation team that it is important that the practice of counselling in the ERHA drug and alcohol services is evidence based, effective, and makes optimum use of available resources. This section focuses on counselling for substance misuse, as opposed to drawing an artificial distinction between counselling for alcohol misuse and drug misuse. In subsequent sections we will examine substance-specific outcomes.

Velleman (1997) has discussed the ways that counselling is undertaken within the alcohol and drugs fields within the UK. Counselling can play an important role as part of an array of medical and psychosocial interventions for substance misuse. As Jarvis et al (1995) point out, however, it is important to recognise that *'counselling alone is not usually sufficient to change the drug taking behaviour of most clients'.* The fact that an array of interventions will most probably be needed signals the crucial importance of Care Planning and Management, which also will be covered within this review.

Crits-Christoph and Siqueland (1996) in a review of psychosocial treatment in the USA report that *'Large-scale program evaluation studies surveying thousands of patients have consistently found that psychosocial treatments for substance abuse seem to yield substantial benefits* (although) … *the advantage of psychosocial treatment versus detoxification alone emerged only after 90 days of treatment'.* They go on to say that the 'active ingredient' of any specific combination of treatments within the psychosocial treatment package, is not obvious: *… the lack of specification and control of the treatment variables in these studies prevent any specific clinical recommendations about how best to treat substance abuse and dependence* (Crits-Christoph and Siqueland, 1996:750). Dale and Marsh, (2000a) in *A Guide for Counsellors Working with Alcohol and Other Drug Users* also recognise that, over the last twenty years, there has been active debate in the literature regarding the active ingredients in successful therapy, and that a typical conclusion concedes approximate equivalence among therapies.

Dale and Marsh argue, however, that while a significant advantage of one form of therapy over another has been difficult to demonstrate, research has been able to demonstrate the fundamental importance of the therapeutic relationship. A sound therapeutic relationship provides an avenue to communicate respect, understanding, warmth, acceptance, commitment to change and a corrective interpersonal experience. The skill of the counsellor is also associated with the effectiveness of therapy. Mattick, Ward and Hall (1998) argue that two important qualities contribute to the effectiveness of a counsellor:

- the ability to establish a therapeutic relationship relatively quickly; and
- the skills and specialist knowledge about how to manage the relationship once it has been established.

These findings from the addictions literature concur with those from the general literature on process of change, and the centrality of the therapeutic relationship. The findings also indicate the importance of employing

sufficiently trained and qualified counsellors, who continue to be adequately supervised. This is covered later in the present review.

In their literature review for *Evidence Based Practice Indicators for Alcohol and Other Drug Interventions,* Dale and Marsh (2000b) argue that focusing purely on substance us related issues is rarely sufficient to produce enduring change and that counsellors need to look at the wider context of clients' lives. This idea underlines the crucial importance of effective care planning and case management, a point to which this review will return below. Dale and Marsh believe that working in this should include the utilisation of a range of techniques, including:

- Goal Setting, which gives therapy a direction, provides a standard by which progress can be reviewed and gives clients concrete evidence of improvement.
- Motivational interviewing, which addresses clients' ambivalence about changing behaviour by encouraging them to consider the good and not so good aspects of drug use.
- Problem solving, which incorporates verbal instructions, written information and skill rehearsal.
- Relapse prevention and management interventions, encompassing cognitive behavioural strategies that provide clients with skills and the confidence to avoid and deal with any lapses. This often involves exploration of high risk situations, mood, thoughts, places, people, situations, and events.

1.3.1 Counselling and Methadone

Key Points

- *Counselling can effectively complement methadone maintenance programmes*

- *The process of counselling, general counsellor therapeutic competence, the attributes of counsellors, and the organisation within which they work, rather than necessarily the method of counselling, can improve outcome*

- *A number of studies which demonstrate the efficacy of generic counselling in methadone maintenance programmes*

- Psychosocial inputs are not a 'quick fix', and often the added benefits of counselling are only evident after some months

Hagman (1994) notes that counselling has been a major component of methadone maintenance programmes since their inception. He proposes a definition of professional methadone counselling as a specialised modality of addiction therapy and rehabilitation. Hagman stresses the importance of counsellor education and noted the impact of HIV and multi-drug use on the efficacy of outcome. He suggests 5 principles of methadone counselling namely:

1. Co-ordination of Care

2. Use of the Relationship
3. Attention to Stage of Change
4. Facilitation of Patient Resourcefulness
5. Social Recovery

Similarly, Magura (1999) examined patient outcomes in 17 methadone maintenance clinics. The main finding was that staff morale, training and resource are the most important determinants of outcome. These ideas emphasise that, as in the general counselling literature, the process of counselling, general counsellor therapeutic competence, the attributes of counsellors and the organisation within which they work, appear to be the important variable in improving outcome, as opposed to any particular method or type or school of counselling or psychotherapy.

There are a number of studies which demonstrate the efficacy of generic counselling in methadone maintenance programmes. For example, Altraman et al (1996) found that opiate dependent individuals with complex needs and other psychiatric diagnoses, eg major depression or anti-social personality disorder, benefited from drug counselling as an adjunct to a methadone maintenance programme. Crits-Christoph et al (1999) showed that weekly group drugs counselling, augmented by CBT, was superior to just the weekly group alone. Another study (Thornton et al, 1998) indicated that patients with more severe pre-treatment drug problems gained greater benefit from a high structure, behaviourally orientated intervention, while those with less severe problems benefited from a more facilitative counselling approach. This result has not been often replicated, however, and most notably was not found with alcohol dependent subjects in Project MATCH, the largest addiction interventions trial ever conducted (see below).

Psychosocial inputs are not a 'quick fix', and a review of psychosocial treatment in the USA reports that *'A notable decrease in regular heroin use was evident for outpatients undergoing methadone therapy and residential patients only after 1 year of treatment, and for drug-free clinic outpatients after 6 months of treatment'* (Crits-Christoph & Siqueland, 1996:750). In terms of cost effectiveness Kraft et al (1997) demonstrated a significantly enhanced outcome from what they called intermediate level of support, ie counselling 3 sessions a week, for 100 individuals starting methadone maintenance. This intensity was tested against 7 sessions a week did not improve. This implies that there is a ceiling effect beyond which counselling services supplementing methadone are no longer cost effective, and that cost effectiveness is probably maximised by making moderately intensive, well-managed counselling, and other services, available to those who it is believed will most benefit from them. Nevertheless, it must be realised that even three sessions per week is considerably more than would be normal practice in most agencies.

1.3.3 Counselling and Other Drugs

Key Points

- *Targeted counselling has been shown to be an effective intervention with multi-substance use, particularly among cocaine and alcohol users*

An important US government sponsored study (Crits-Christoph et al, 1999) mentioned above, looked at four groups, totalling almost 500 cocaine misusers. Each group received 6 months of weekly group drug counselling, with three groups supplemented by either cognitive psychotherapy, supportive expressive psychotherapy, or individual drug counselling. The groups were followed up after 9 months and there was no significant difference in outcome between those who received counselling and those who received cognitive psychotherapy or supportive expressive psychotherapy. Furthermore, there was no evidence that the psychotherapies were superior for clients with relatively severe personality or psychiatric problems (Crits-Christoph et al, 1999).

It does seem, then, that for cocaine addicts there is no clear evidence to date of extra benefit of CBT over more person-focused counselling; nor (for this group of drug misusers) that psychotherapies were superior for those individuals with relatively severe personality or psychiatric problems. It must be noted however, that this was carried out on cocaine addicts; as outlined above, these findings were not duplicated in a similarly designed study in methadone maintained opiate addicts, in which CBT was in fact superior to counselling. It does seem, therefore that we have diverse findings, depending on the preferred substance of use (Crits-Christoph et al, 1999).

Good recent evidence about the outcome and the efficacy of counselling for multi drug users has been obtained in the Drug Abuse Treatment Outcome Study (DATOS). While this concentrates generally on abstinence orientated outcomes, engagement in counselling has been associated with positive outcome. In summary the DATOS programme emphasises targeted counselling as an effective intervention particularly among cocaine and alcohol users (Hubbard et al, 1997).

1.3.4 Counselling and Alcohol issue

Key Points

- Confrontational counselling, psychoanalytic psychotherapy and educational talks and lectures have been seen to be of little use in promoting positive outcomes

- There is both effectiveness and cost-effectiveness evidence supporting the use of motivational interviewing, skills-based cognitive interventions, community reinforcement programmes, and behaviour marital therapy.

Velleman (1992b) has presented evidence that less extensively trained counsellors can achieve outcomes which are at least as positive as more traditionally trained therapists, arguing that these findings are related to the quality of supervision and support, and to the effects of mobilising community resources. William Miller and colleagues (Miller et al, 1995) conducted a major systematic review, including a cost benefit analysis, of a range of

alcohol intervention strategies. A number of traditional, commonly used strategies including confrontational counselling, psychoanalytic psychotherapy and educational talks and lectures were seen to be of little use in promoting positive outcomes.

On the other hand, interventions such as motivational interviewing, skills-based cognitive interventions, as well as community reinforcement programmes, and behavioural marital therapy all seemed to fare very well, both in terms of effectiveness and cost effectiveness. These interventions, as well as 12 Step approaches, are covered in some detail below.

1.3.5 Project MATCH

Key Points

•Project MATCH found that 12-step Facilitation, Cognitive Behaviour coping skills, and Motivational Enhancement Therapy were equally highly effective

- *Therapist training, quality and consistency was a vital component of the positive outcomes delivered by Project MATCH*
- *Motivational interviewing worked better for "angry" clients, while 12 steps seemed best for those who retained pro-alcohol using social networks*
- *After 3 years, baseline readiness to change or motivation was a better outcome predictor than initial severity of dependence*
- *This suggests that individuals in the contemplation stage (perhaps those whose drug use and lives are more chaotic) should have more access to motivational interviewing*

• Clients more actively motivated and more stable should receive a combination of behavioural and 12 step interventions.

Project MATCH is the largest addictions trial ever conducted and the 3 year follow up results from the project have only recently been published. Accordingly it is particularly important to our understanding of treatment interventions in alcohol and drug use generally. Before MATCH, almost any review of addictive behaviour concluded with comments that intervention should be matched to the needs of the client. For example, Raistrick and Davidson (1985) said that "therapy should be tailored to the individual. What is useful for one person may be singularly inappropriate for another"; Miller and Herster (1986) said that "clients should be matched to an optimal intervention"; Gossop (1996) notes that "for all types of drug problems that require treatment the intervention offered should be tailored to the needs and circumstances of the individual", and so on.

Project MATCH sought to test this hypothesis. Clients were randomly assigned to one of three treatment modalities, namely 12-stp Facilitation (TSF), Cognitive Behaviour coping skills (CB), and what was called Motivational Enhancement Therapy (MET). TSF was based on methods of

Alcoholics Anonymous, but it was only conducted for 12 sessions and did not include regular and life-long AA attendance as part of the treatment condition. CB was limited to 12 sessions of coping skills training and MET was a 4 session programme based on the principles of brief motivational counselling. All of the therapists involved were highly trained and the therapies were protocol driven and based on very well validated manuals.

A whole variety of client characteristics were assessed and there was follow up on numerous outcome measures at approximately 1 year and 3 year post-assessment. In summary, the 3 years results indicated significant sustained improvement on the range of outcome variables across the three main treatment conditions. In other words, all three interventions were more or less equally and highly effective.

There are of course criticisms of the study, which include the obvious observation that the three main interventions do not reflect the richness of therapies available to substance misusers. Furthermore, the high internal validity of the study meant that there was low ecological or external validity. That is to say, complex dual diagnosis cases, the homeless, criminals, those with personality disorders, multi-drug users and all those living on the social margins were excluded from this trial.

The number of exclusions does mean, of course, that many substance-misusers who are potential counselling clients were not included, thereby reducing real life generalisation potential. We also cannot be clear about the validity of cross-cultural application of the results: what works with the type of clients seen in US hospitals may be very different to those seen in community settings in Dublin. Furthermore, the only treatment goal was abstinence, and in Ireland as well as the UK, harm reduction methods are much better established than in the US. Nevertheless, Project MATCH is one of the best studies that can be drawn upon in reviewing outcomes, and 'what works'.

The Project MATCH 3 year follow up has produced some interesting subsidiary findings which are relevant to the delivery of treatment services. These have been summarised in a number of key papers (Project MATCH research group, 1999; Glaser, 1999; Ashton, 1999) which demonstrate that standardised, manual based treatment protocols, delivered by therapists with a high degree of supervision and training, optimise outcome, irrespective of the intervention used. The therapists were highly trained, they were video-taped, and the tapes were used during weekly supervision by staff from all leading US centres. So-called "therapeutic drift" was monitored, and Zweben et al (1998) commented that therapist quality and consistency, supported by their preparation and training was probably as important in terms of outcome as treatment modality.

Another key 3 year follow up finding of the MATCH study is that motivational interviewing is best for clients who present as "angry", while 12 step procedures seem to work best for those who retain pro-drug/alcohol use social networks. Building on these findings Holder *et al* (2000) noted in a follow up trial that low intensity motivational approaches are a safe and

economic starting point for one-to-one psychosocial therapy with individuals who are not particularly motivated to change, and do not present with complex psychological morbidity. For individuals who have severe psychiatric symptoms or who have retained drug using social networks, or where the individual is already quite motivated, CBT seems preferable to motivational approaches.

Within Project MATCH, great effort was made to engage and retain clients within the treatment programme and compliance was not seen as a feature of the person but rather as a merger between the client and the treatment. A series of compliance strategies were adopted by the MATCH researchers, resulting in under 30% attrition throughout the course of the whole study.

The model of Stages of Change emerged intact from Project MATCH trial. It would seem that after 3 years, baseline readiness to change or motivation has a significant impact on abstinence and restraint. This was a better predictor than initial severity of dependence. This is important evidence on the cycle ofo change. The transtheoretical model has been reviewed and critiqued elsewhere (Davidson, 2001, 1998). Essentially, this is a model which has significant face validity and has been an influence on the development of motivationally matched interventions over the last decade or so. The model, however, has a number of serious deficiencies. Are the changes or the stages arbitrary? Do people progress logically through them? Do most successful changers pass through all of the stages? Are stages and the movement between them universal or specific to age, gender or culture? Does stage membership predict anything meaningful? What Project MATCH has done is given us some indication for the first time that in fact staged-matched interventions may predict progress and outcome. Davidson (2001) noted that *"there is little evidence to support matching interventions to stages".* This was because so few studies had been done, and so the main practical application of the model lacked an evidence base. all of this renders the Project MATCH finding on the long term significance of staged matched interventions particularly important and highly relevant to the design and configuration of Dublin's drug counselling services.

Given the power of Project MATCH, it would lend support to the idea that individuals in the contemplation stage (perhaps those attending Treatment Centres, whose drug use and lives overall tend to be, as we understand it, more chaotic) should have access to motivational interviewing. Other clients who are more actively motivated (perhaps those in primary care settings, who have graduated from the Treatment Centres as being more stable), should receive a combination of behavioural, cognitive and 12 step interventions.

Again, this underlines the importance of care planning and management in determining an individual's movement through the various places where help is on offer within Dublin.

1.3.6 Addiction Counselling – Summary

In summary then, the review of research thus far suggests that there is a large element of treatment equivalence; with the most important issues being that:

- the engagement and retention of clients is vital, with engagement in counselling being associated with positive outcome;
- research has been able to demonstrate the fundamental importance of the therapeutic relationship. A sound therapeutic relationship provides an avenue to communicate respect, understanding, warmth, acceptance, commitment to change and a corrective interpersonal experience;
- standardised, manual based treatment protocols, delivered by therapists with a high degree of supervision and training, optimise outcome, irrespective of the intervention used;
- therapists should be highly trained, and that ongoing supervision is optimised via video-taping, with the tapes being used during weekly supervision, so "therapeutic drift" is reduced;
- therapist quality and consistency, supported by their preparation and training, is probably as important in terms of outcome as treatment modality;
- the importance of care planning and management is underlined;
- staff morale, training and resources are key determinants of outcome;
- the attributes of counsellors and the organisation within which they work, rather than necessarily the method of counselling, can improve outcome;
- more structured and organised interventions such as motivational interviewing, skills-based cognitive interventions, community reinforcement programmes, behavioural marital therapy. Alcoholics Anonymous and 12 Step approaches all seem to work somewhat better that do less structured approaches.

Nevertheless, there is some evidence that some interventions DO work better than others. The review above has already discussed the fact that

- Confrontational counselling, psychoanalytic psychotherapy and educational talks and lectures have been seen to be of little use in promoting positive outcomes
- More structured and organised interventions all seem to work somewhat better

Further areas are reviewed below.

1.4 Relative Effectiveness of Different Interventions

Key Points

- *Motivational interviewing, skills-based cognitive interventions, community reinforcement programmes, and behavioural marital therapy fare very well in terms of effectiveness and cost effectiveness*

- *Relapse prevention, using primarily cognitive behavioural interventions (CBT), is effective with poly-substance use when alcohol is one of the substances*

- *Self-efficacy is a key cognitive variable, in conjunction with social support, in predicting positive outcome*

- *AA attendance enhances outcome when it is part of an ongoing, more formal treatment intervention*

- *Evidence indicates the utility of brief interventions in communicating and implementing harm reduction strategies, but they are not so useful for more complex clients with additional psychological/psychiatric issues, clients with severe dependence, clients with poor literacy skills, or clients with difficulties related to cognitive impairment*

- *While brief intervention can result in significant gains at minimum cost, generalist workers conducting brief interventions will not replace the need for specialist alcohol and drug treatment*

- *Residential programs are more effective when a broad range of treatments and interventions are involved, including both individual and group counselling, as well as life skills training, training or employment options and recreation options*

- *Residential treatment is indicated for those whose social networks are supportive of continued drinking, or if there is a long history of chronic drinking and a high level of dependence, or if the person is homeless or needs an alternative environment for respite*

1.4.1 Motivating Interviewing

Motivational interviewing (eg Miller and Rollnick, 1991) was described by Stockwell (1992) as the most important and influential therapeutic development within the field of addiction over the previous decade. Motivational interviewing is something of a misnomer inasmuch as it has little to do with contemporary cognitive theories of motivation. Rather it seems to be an example of the phenomenological approach to change and adapts the psychology of self actualisation to the promotion of personal change among alcohol and drug abusers (Davidson, 1996). Nonetheless, motivational interviewing is an excellent example of a therapeutic system squarely based on psychological principles and tailored to individual change in addictive behaviour. The outcome literature, however, is actually fairly sparse.

Noonan and Moyers (1997) conducted a review of 11 trials that compared motivational interviewing with a range of other treatments for alcohol dependent clients. It seemed that motivational interviewing was uniquely effective if it succeeded in eliciting positive motivational responses without evoking resistance. It was not, however, particularly effective in the more severely dependent drinkers. Nonetheless, the authors concluded that motivational interviewing could be used to some effect for all groups of drinkers in the assessment interview at least, as it reduced subsequent attrition rates.

Heather et al (1996) reported a comparison between brief motivational interviewing and skills based counselling. While there was no overall difference, clients assessed at baseline as "not ready to change" responded better to motivational interviewing in the long term. Once again, this would suggest that individual drinkers in the contemplation stage of the process of change respond better than others to motivational interventions. As in all of this work there are some studies which do not demonstrate positive outcome for stage matched interventions eg Monti et al (1999). Nonetheless, on balance, it would seem that for individual substance misusers who are not particularly motivated but are low on psychological and psychiatric morbidity, there are benefits form a motivational interviewing approach.

1.4.2 CBT and Relapse Prevention

There is considerable literature and outcome evaluation of cognitive behavioural therapy (CBT) and relapse prevention interventions.

Carroll (1996) carried out a detailed review of 24 controlled trials which looked across a range of addictive behaviours, at the effectiveness of CBT in general and relapse prevention in particular. The outcome variables were primarily post treatment patterns of substance use rather than necessarily behavioural and cognitive indicators such as coping skills, self-efficacy enhancement or social adjustment. The review concluded that there was some evidence for the effectiveness of the relapse prevention and CBT approach across a range of substances, when compared with no treatment controls. It must be said, however, that its superiority over other psychological interventions was less consistent. Carroll concluded, nonetheless, that broadly cognitive behavioural approaches were of most value for clients with more severe dependence or higher levels of psychopathology.

A study designed to discover the effectiveness of group drug counselling, supplemented by either cognitive psychotherapy, supportive expressive psychotherapy, or individual drug counselling, on methadone maintained opiate addicts, found that CBT was superior to generic drug counselling (Crits-Christoph et al, 1999). Some years earlier, Woody *et al* (1983, 1995) reviewed studies on the use of psychotherapy, counselling and CBT for opiate users. In summary, those receiving cognitive therapy demonstrated somewhat greater improvement on outcome measures like employment, legal problems and psychiatric symptoms, and also in terms of extent of post treatment use of opiates. Furthermore, Woody concluded that people with what was called "high psychiatric severity", did better on both psychological morbidity and drug use outcomes in the CBT condition.

Irvine and his colleagues (1999) carried out a meta-analysis which covered 26 studies including some 10,000 drug and alcohol users, to evaluate the general effectiveness of relapse prevention. These results, like those of Carroll, indicated that relapse prevention was generally effective, particularly for alcohol problems. The authors went on to point out that relapse prevention, using primarily cognitive behaviour interventions, was most effective when applied to people with poly-substance use when alcohol was one of the

substances. The importance of self-efficacy as a key moderator psychological variable was emphasized in this meta-analysis.

Self-efficacy is a key cognitive variable, in conjunction with social support, which more and more recent studies are isolating as the best predicting positive outcome in drug dependent populations (Noone et al, 1999).

1.4.3 12 Step Interventions

Any consideration of drug and alcohol misuse treatment over the 120th century would have to note the phenomenal rise in the number of 12-step programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) (Fiorentine and Hillhouse, 2000). From its inception in 1935, AA membership in the USA and Canada had reached 1 million by 1990, and it is estimated that about 3% of Americans will attend an AA meeting at some time in their lives. NA was started by six former heroin users in 1953 and the number of groups in the USA had grown to 20,000 by 1992 (Troyer et al, 1995).

Traditionally in Ireland and the UK, 12 step interventions have been regarded by professionals as unstandardised, untested, and not particularly useful. There has been a trend however, in recent years, towards revisiting 12 step interventions in a more systematic way. Arguably because of the Project MATCH findings, the use and efficacy of 12 step interventions have been the subject of increasing debate and study over the past 4 years. This change is illustrated by two quotes from the doyen of addiction research. Edwards (1996) comments "the evidence that AA works is suggestive and rests on evidence of its popularity and seeming ability to meet demand, rather than being a matter of proven fact". Just 4 years later, Edwards' (2000) position has changed: "it is not unreasonable to conjecture that AA probably works in some way or another for not less than 50% of the troubled drinkers who make contact with it.

Traditionally, 12 step studies have been less than rigorous (Tonigan, Toscova and Miller, 1996). Many have lacked statistical or experimental controls and issues like motivational status, additional treatment and after care have not been taken into account in assessing outcome. Different comparison groups were often used, and outcome measures have not been consistent across studies. Equally there have been variable follow up lengths and a key feature is the difference between voluntary and enforced AA attendance.

A series of 12 step outcome studies has recently been carried out to rectify some of these methodological shortcomings (Best and Harris, 2001). Favourable outcomes in terms of increased abstinence have been reported in some recent studies, notably Tonigan et al (2000). A meta-analysis of 74 studies (Tonigan, Toscova and Miller, 1996) found that AA participation and drinking outcomes were more strongly related in outpatient as opposed to inpatient samples, and that better designed studies were more likely to report positive psychosocial outcomes related to AA attendance. Fiorentine and Millhouse (2000), in a treatment outcome study in Los Angeles, demonstrate that clients, mostly poly-drug and alcohol misusers, who attended drug

treatment and 12-step programs as integrated recovery activities, had higher rates of abstinence.

The overall findings from this series of studies were quite complex interactions. The studies would seem to indicate that it is affiliation with AA rather than necessarily the number of meetings attended in the years following formal treatment which best predicts positive outcome. However, in a very well controlled trial, Fiorentine (1999) followed up almost 80% of a large sample of US drug users 2 years after their outpatient treatment. A "dose effect" was found inasmuch as those who attended 12 step programmes on a weekly or more frequent basis reported greater drug or alcohol abstinence than less frequent attenders. The beneficial effect of this level of attendance was sustained even when motivational and additional treatments were partialled out of the regression equations.

The key finding, however, was that the beneficial effect of AA attendance was additive rather than independent, and AA attendance only enhanced outcome when it was part of an ongoing, more formal treatment intervention. In other words, stand-alone AA attendance in the absence of any other more formalised psychosocial interventions did not improve outcome. The key potential effectiveness of the 12 steps should be seen as an after care treatment resource and there is some merit in encouraging 12 step attendance as an adjunct to formal treatment.

Furthermore, for AA attenders, at least in the UK, belief in the "higher power mediated" steps was much less effective than the endorsement of "personal responsibility" steps.

The UK is now following the USA in that increasingly addictions staff now recommended that 12-step principles be employed simultaneously with other forms of treatment, and advocate 12-step participation as part of ongoing care towards abstinence. Polinsky et al (1995) indicated that 75% of all drug treatment programs in Los Angeles County placed some emphasis on 12-step principles.

1.4.4 Brief Interventions

Brief intervention is appropriate when contact time and/or resources are limited, and has been described as *"any intervention that involves a minimum of professional time in an attempt to change drug use … requiring a total of between five minutes and two hours"* (Heather, 1990 cited in Ali *et al* 1992:17). Stark (1998) suggests that brief interventions can range from a one off session to approximately five sessions.

Brief interventions often include the provision of self help materials and may extend to a brief assessment, providing advice (in a one off session), assessment of the client's readiness to change (motivational interview), problem solving, goal setting, relapse prevention, harm reduction and follow up (Heather, 1995).

Research indicates that brief interventions can be useful for clients who are experiencing relatively few problems related to their substance use, have low levels of dependence, or who are not wishing to substantially reduce their use (Heather, 1995). A recent randomised controlled trial demonstrated that Brief Intervention was beneficial in treating cannabis dependence (Copeland et al, 1999). There is also a growing body of evidence indicating the utility of brief interventions as a means to communicate and implement harm reduction strategies (Jarvis, Tebbutt and Mattick, 1995; Baker et al, 1996).

Brief interventions are not considered suitable for more complex clients with additional psychological/psychiatric issues, clients with severe dependence, clients with poor literacy skills, or clients with difficulties related to cognitive impairment. In these instances, more in-depth intervention is recommended (Heather, 1995). While brief intervention can result in significant gains at minimum cost, generalist workers conducting brief interventions will not replace the need for specialist alcohol and other drug treatment (Heather, 1995; Stark, 1998; Mattick & Hall, 1993).

1.4.5 Residential Treatment Services

A range of treatment options must be available for those wishing to change their substance use. Residential treatment programs have often been considered a primary means of intervention vital to the successful treatment of alcohol and drug problems (Nagay 1994). The literature demonstrates little difference, however, between the effectiveness of residential and non residential treatment programs (Mattick & Hall, 1993; Mattick et al, 1993; Heather et al, 1989; Kite et al, 1996). Nevertheless, residential treatment services are an important mode of service delivery for certain client populations. However, even where evidence exists to support the effectiveness of residential forms of provision, individual's ability to retain the positive effects of the residential experience once they return to the community is often a major stumbling block. Again, the importance of effective care planning to cover the transition from residential to community living cannot be overemphasised.

Residential programs are more effective when a broad range of treatments and interventions are involved, including both individual and group counselling, as well as life skills training, training or employment options and recreation options (Moore, 1998; Gerstein and Harwood, 1990).

There is evidence to suggest that residential treatment is appropriate for alcohol dependence where the client is a chronic drinker with a long history of drinking and a high level of dependence, suffers cognitive damage as a result of alcohol abuse, and/or is homeless or needs an alternative environment for respite (Project MATCH Research Group, 1998; Eliany and Rush, 1992). Residential treatment is also indicated for those whose social networks are supportive of continued drinking (Project MATCH Research Group, 1998).

There is less research evidence regarding the relative effectiveness of residential and non residential treatment for other types of drug dependence (Heather and Tebbutt, 1989). Residential programs are nevertheless

indicated for those dysfunctional and long term users who suffer significant harm from use and those users whose social networks are supportive of continued drug use. There is some evidence that therapeutic communities offer an effective form of treatment for the small proportion of drug users who find them acceptable (Mattick and Hall, 1993). Clients should always be gauged as to their openness to engage in a therapeutic community before being referred to one.

1.4.6 Family Approaches

Key Points

- *Family and friends need to be treated as clients in their own rights, although they can also be treated as an adjunct to an individual's treatment*
- Relatives and friends of people with alcohol and drug use problems often experience significant stress, physical and psychological symptoms
- Theory suggests that family members should be involved in order to draw substance misusers into treatment and to ensure that changes impact on the whole system
- The types of family intervention with the best evidence to date are systemic, behavioural, unilateral, community-reinforcement and social network approaches

There are two levels of working with partners, families and friends of the drinker/drug user; as clients in their own right; or as part of an individual's treatment. Quite different issues arise as a result of the context. As a consequence of the clinical focus of much treatment, there has been little discussion on the primary need to understand the difficult task faced by families and friends. Families have voiced their frustration with this situation, and a lack of understanding of their needs. For a more detailed discussion of the development and implications of different theoretical models for this work see Hurcom et al, 1999; and Velleman et al, 1998.

Family and Friends as Clients

Relatives, and those living close to people with alcohol and drug use problems often experience significant stress which may manifest in terms of physical and psychological symptoms (Copello et al, 2000a, b). They often experience heightened levels of anxiety and depression and commonly report feeling helpless and isolated. It is, therefore, important that they be provided with appropriate support and counselling to help them cope more effectively (Orford, 1994). Goals and treatment plans for counselling should be negotiated. An alternative counsellor to the problem drinker/drug user, if they are the primary client, may be arranged as appropriate. Steinglass et al

(1988) and Helfgott (1997b) suggest that counsellors can assist the client to review their role as it relates to the problem drinker/drug user as well as assessing general life problems and developing ways to better cope with the problem drug use.

Copello et al (2000a, b) describe and report on the success of a brief 5-step intervention that has been used with relatives of alcohol and drug users in the primary care setting. This intervention, based on a stress-coping-*health model involves five steps:*

1. Listen, reassure, explore concerns
2. Provide relevant information
3. Counsel about coping
4. Counsel about social support
5. Discuss needs for other sources of specialist help.

Once a good therapeutic relationship has been established, other options can be explored and different strategies introduced to the client. As young people's drug use has continued to grow and become more complex, and significantly more of these young people are living at home, many parents are struggling to cope with all the associated difficulties.

Many of the clinical presentations exhibited by parent's result from the stress experienced when a child is using drugs. Grief is another issue common to parents with a drug using child. This applies not only to the grief associated with a child's death, but also the grief of things not working out as planned and "lost dreams".

Parents' levels of anxiety and grief should be acknowledged prior to providing advice and working on child/parent strategies. High levels of stress and anxiety and low levels of self or parent efficacy may hamper parents' receptiveness to advice and their confidence in effectively utilizing the advice provided. Therefore, the initial aim of working with parents should be to lessen their levels of anxiety and depression, feelings of isolation, raise their self awareness and increase their confidence in managing the situation. There is evidence that appropriate interventions with parents can significantly decrease their levels of anxiety and depression and their feelings of isolation and helplessness and place them in a much stronger position to provide the necessary support to the young person (Toumbourou et al 1997). Finally, working with this group can offer an opportunity to provide accurate alcohol and other drug information, which directly helps the relative or friend, and indirectly may assist the drinker/user through dissemination of information (Dale and Marsh, 2000b).

Family and Friends as an Adjunct to an Individual's Treatment

Recent research indicates that a high percentage of alcohol or drug misusers enter treatment as a result of the services initial contact with a concerned significant other (Barber and Crisp, 1995; Meyers et al, 1996). Research also indicates, however, that involving significant others in alcohol and other drug

treatment in order to confront and motivate the problem drinker/drug user into changing their behaviour, generally result in higher drop out rates, lowered self esteem, greater levels of estrangement from families and high relapse rates (Eliany and Rush 1992; Mattick et al, 1998). Counsellors therefore should not attempt to use family and friends as any form of 'leverage' to change client behaviour.

On the other hand, it is not uncommon for family members, partners or friends to contact the counsellor regarding the progress of the client. Counsellors need to be clear about issues of client confidentiality. Acknowledgement that someone is in therapy and disclosure of their progress requires prior consent to do so being obtained from the client (although there is a legal requirement to give parents of clients under eighteen years some information regarding their child).

Jarvis et al (1995) suggest that family therapy in an alcohol and other drug context should be oriented around four goals.

1. To change alcohol/drug related interactional patterns and develop interactions that support the change in drinking/drug use behaviour.
2. To help the family resolve relationship conflicts without the client resorting to problem drinking/drug use.
3. To help mend rifts in relationships that have been aggravated as a result of the alcohol or drug use.
4. To help the family or couple develop shared activities that are rewarding and do not involve alcohol and drugs.

Jarvis et al (1995) warn that counsellors should be careful to avoid blame and should not highlight the drinker/drug user as the problem. Specific skills and specialist training is required to undertake family therapy effectively. In contrast, practice that is family centred does not require specialist family therapy training and can result in family members receiving the support they need in their own right and can also be beneficial to treatment outcomes for the drug user.

Supporting parents in their parental role suing a model of empowerment means the counsellor works alongside parents to achieve the agreed goals. Previous experiences (what has worked/what hasn't worked), the parent's value system and family norms should be taken into account when providing advice and information on strategies. Advice/strategies that may be explored with parents include the following:

- Knowledge of drugs and drug use issues.
- Strengthening parenting role and parent's confidence.
- Communication skills.
- Conflict resolution.
- Negotiating guidelines/boundaries.
- Issues of attachment and commitment.
- Responding versus reacting.
- Remaining calm, consistent and credible.

- Accessing additional support (parent support groups, family therapy).
- Making time for self, other family members and friends.

Most importantly, working with parents or close friends should not be seen as an additional or conflicting task but viewed as an enhancement to therapy and a step towards maximising positive outcomes for young people and their significant others.

Family Approaches

Because the majority of people with substance misuse problems are part of extant families (sometimes as partners, sometimes as children, sometimes as parents, sometimes all three), and because systemic thinking implies that an intervention will be more likely to succeed if there is wider family involvement, a number of counselling approaches have tried to intervene by incorporating family members as participants in interventions aimed at the substance misuser. These have been recently reviewed by Velleman and Templeton (2001). Theory suggests that family members should be involved in order to draw substance misusers into treatment and to ensure that changes which are made, impact on the whole system.

The Evidence Base

There is a growing evidence-base for intervention approaches which incorporate family members into the intervention. The types of family intervention with the best evidence to date are systemic, behavioural, unilateral, community-reinforcement and social network approaches (Velleman and Templeton, 2001).

Meyers et al's (1998) study involving community reinforcement and family training (CRAFT) recruited 62 concerned significant others, 74% of whom managed to successfully engage their previously treatment-resistant drug misusing relative into treatment. This also led to a reduction in physical and psychological symptoms for the non-misusing family member. Sisson and Azrin's behavioural approach (1986) gave community reinforcement counselling to 12 relatives, with positive results on the alcohol misuser seeking treatment and reducing their drinking. McCrady's evaluation of three types of behavioural based intervention found that it was an effective way of working with couples, but that no one of the three treatments was any better than the other two (Collins, 1990). Edwards and Steinglass's (1995) review of 21 studies of interventions which involved family participation concluded that these interventions were both helpful and cost-effective. There is a similar growing evidence base for ways of working which involve the engagement of social networks. Liepman et al. (1989) recruited and evaluated 24 of thee types of social networks, finding that the alcohol misusers were more likely to enter treatment and remain abstinent.

A Systemic Approach

Many of the more recent approaches adopt behavioural or systemic standpoints (Collins, 1990), suggesting that the family 'learns' how to deal with substance misuse, or operates as a system where the actions of each person

impact on everybody else, so that particular acts function to control, encourage, or prevent substance misuse behaviour. Even negative behaviours can serve to maintain balance in such a family system.

Working with relatives in this vein can build on family interactions, and change behaviour to bring a different, more 'normal' balance to that system, to break the habits of learnt behaviours, or change reinforcement patterns so that more positive and less negative behaviours are reinforced.

An extreme version of this systemic view is the co-dependency theory, which states that spouses and partners (typically female) become 'addicted' to the relationship they are in, the drinking behaviour, and its (usually negative) consequences. This theory suggests that if the co-dependency cycle is not broken, the partner may remain in the relationship or enter another relationship with the same consequences. Many of the family or couple interventions which stem from systemic or behavioural theories suggest that the family member(s) should receive help alongside the misuser, or join concurrently running group sessions for family members and misusers.

Unilateral Family Therapy

Unilateral family therapy is a more contemporary advance in the development of family interventions. This approach also utilises the systemic model, but suggests that it is possible to alter the ways that a family works without all members of the family system being present in therapy sessions. It is possible to alter someone's substance misuse even if they never present for treatment. Working with other members of the system and helping them to change their behaviour will, it is argued, automatically impact on the user's behaviour as well. This approach was designed to be most suitable for attracting the most "unmotivated, treatment-resistant [drinkers]" (Meyers et al., 1996).

Co-operative Counselling

Yates (1988) found that problems with someone else's drinking were more likely to be reported than were problems related to personal drinking. On this basis, a 'co-operative' counselling service was established and evaluated, which worked with 'affected other' to encourage problem drinkers into treatment. Results indicate that relatives valued, and felt a great relief from, confirmation that the drinking was a serious issue, and advice on developing effective strategies to use with the drinker in order to help the situation. Working with 'affected others' brought several problem drinkers into treatment. Although seen as relatively successful, Yates' study has been little replicated in the UK. In the USA, however, such approaches are more widely available (Edwards and Steinglass, 1995; O'Farrell, 1993).

Community Reinforcement Training and Social Networks

Community Reinforcement Training (Meyers et al., 1996), first developed in the 1970s, is another example of an approach that aims to work with 'concerned others' to reinforce non-drinking behaviour through a positive reinforcement process. A related way of working is the ARISE intervention (Garrett et al., 1998), which utilises family and other network links to

encourage substance misusers into treatment, whilst also trying to help the family in its own right. Galanter's cognitive behavioural network therapy (1993a,b) also involves the engagement of social networks to help the substance misuser and the wider family. Here, the misuser, a key significant other (usually, but not necessarily, a relative) and other relatives, friends and significant others (for example, a work colleague or other professional) are all engaged in work on someone's substance misuse. The family is seen as central to co-attend therapy sessions with the misuser, to introduce and maintain the misuser into treatment, and then to prevent relapse. This work has recently been extended in the UK by Copello et al (2001).

1.5 Complex Issues

1.5.1 Women

Key Points

- With regard to drug and alcohol misuse there are physiological, psychological and social differences between men and women

- Special consideration should be given to women's issues in mixed gender services

Given that men make up the largest proportion of the potential treatment population, there has been debate as to whether services specific to women are warranted (Wodak, 1992). The Final Report of the Select Committee into the Misuse of Drugs Act 1981 (1998), on the basis of a review of research and consultation with practitioners, supported the notion of women receiving gender specific services. It was noted also that special consideration should be given to women's issues in mixed gender services. The literature cites a number of issues that services need to be conscious of when working with women in a substance misuse context. These issues drive from the notion that harmful drug use is embedded in physiologically, psychologically, and socially different life contexts for men and women (Thomas, 1997).

There are physiological differences between men and women in terms of the effects of drug use. For example, women drinkers develop liver cirrhosis more quickly than men, may suffer reproductive and sexual dysfunctions, and are more likely to die from medical conditions related to alcohol use (Dunne 1988; Baily 1991). Hence, it is important that counsellors working with women be well informed as to the specific risks associated with drug use.

Research also indicates that depression, anxiety and somatic and personality disorders are particularly prevalent among women engaging in treatment (Darke et al, 1992). Hall et al (1998) found that 46% of women with a substance use disorder also met the criteria for either an anxiety or affective disorder. Other research has demonstrated poor self esteem and self image, high rates of suicide attempts and co-morbid eating disorders as being particularly common to women with substance use issues (Klee et al, 1991; Copeland, 1993).

Some research suggests that women's drug use needs to be viewed systemically, in relation to the roles and expectations placed on women by society (Copeland, 1993; Jarvis et al, 1995; Jarvis et al, 1998; Swift & Copeland, 1998). Thomas (1997) argues that society considers it much more unacceptable for women than men to have drug and alcohol problems, especially when the drug use is illegal. As a result women in alcohol and drug treatment may be more likely to suffer greater levels of shame, stigmatisation and powerlessness. All these issues need to be acknowledged and addressed during the course of treatment.

Histories of sexual abuse and assault are also common in women with substance use problems (Covington 1986; Jarvis et al, 1995, 1998; Rohsenow et al, 1988; Swift and Copeland 1998; Swift et al, 1996).

The literature suggests that women be offered the option of a female counsellor, and where appropriate be provided with information and/or referral regarding women only alcohol and drug services. Research also suggests that women perform better in women only groups.

The literature also suggests that treatment with female clients is more likely to be successful if any underlying issues (eg depression or anxiety) are treated directly, rather than treatment focusing primarily on drug use (Connexions, 1994). Research also confirms the importance of social support to successful treatment outcomes. Where appropriate, treatment programs should link women to social support groups and expand their support networks.

Pregnant Women and Mothers
While the issues relevant to working with women in general are also applicable to working with pregnant women, there are issues specific to this latter population. Due to the health risks associated with drug use during pregnancy, it is important that counsellors facilitate clients' engagement with appropriate medical personnel. Counsellors also need to be aware of the increased levels of shame and stigmatisation that drinking/drug using pregnant women may suffer (Dale and Marsh, 2000a). Mothers with alcohol or drug use problems also can have huge concerns with regard to Social Services raising child protection issues and possibly taking their children into care (Kaur and Mistral, 2000).

1.5.2 Men

Key Points

- There is a strong link between male substance misuse (especially drinking) and violence
- Males have higher rates of completed suicide attempts than females
- There is some evidence that mixed gender counselling groups evoke better responses from men

It has been argued that men respond better to more concrete, action oriented treatment approaches. Therefore, cognitive behavioural techniques have been recommended, but treatment should not be limited to this approach. Research also supports a strong link between substance misuse (especially drinking) and violence. Anecdotal evidence also suggests physical, emotional and sexual abuse in male clients seeking alcohol and drug treatment is not uncommon. As with women, this creates feelings of shame, guilt and powerlessness, which are often compounded by the feelings associated with dependency. It is also important to remember that males have higher rates of completed suicide attempts than females. Counsellors need to be aware of these issues and consider referral to an appropriate service when necessary (Dale and Marsh, 2000b).

There is some evidence that men perform better in mixed gender groups. Therefore, in order to respect the recommendations for working with women, it is recommended that men participate in mixed gender groups with women who also choose to be in mixed gender groups.

1.5.3 Sexual Abuse

Key Points

- There is a significant relationship between childhood sexual abuse and substance dependence
- There is a high prevalence of Post Traumatic Stress Disorder in survivors of sexual abuse
- Substance use often decreases PTSD symptoms. When substance use is decreased, the severity of PTSD symptoms may increase. Clients need, therefore, better coping strategies

A review of the literature by Jarvis et al (1998) demonstrates a significant relationship between childhood sexual abuse and substance dependence. While rates of sexual abuse in men presenting to alcohol and drug treatment are not expected to be as high as that for women, anecdotal evidence nevertheless indicates that male sexual abuse is not uncommon. Herman (1992) emphasises the importance of counsellors creating a safe environment where clients feel comfortable in disclosing sensitive information.

The literature demonstrates a high prevalence of Post Traumatic Stress Disorder (PTSD) in survivors of sexual abuse (McFarlane and Yehuda, 1996). One study showed that up to 50% of rape victims in the community develop PTSD (McFarlane and Yehuda, 1996).

It is possible that PTSD prevalence may be higher in people presenting to alcohol and drug treatment as substance use often decreases PTSD symptoms. Consequently when substance use is decreased, the severity of PTSD symptoms may increase. Therefore, clients need to increase their coping strategies as they gradually decrease their substance use. The literature recommends a number of treatment approaches that are suitable for PTSD although few have received empirical support. Cognitive behavioural

therapy is often considered useful for treating PTSD symptoms that have only been in effect a short period of time, and are the result of a discrete incident. There is no evidence demonstrating therapy efficacy with long term sufferers of PTSD nor individuals who developed more complex PTSD as the result of repeated prolonged trauma.

Herman (1992) and Van er Kolk (1996) have written extensively on the treatment of sexual abuse and stress the importance of long, slowly paced therapy which continually establishes safety, and which is guided by the client. They argue (as does Towers, 1999) that providing separate treatment for sexual abuse and drug misuse is unlikely to be successful, and may even lead to an exacerbation of client distress.

1.5.4 Dual Diagnosis

Key Points

- The majority of alcohol and drug treatment clients have multiple issues which can combine to create a complex case

- Clients may exhibit any of a range of psychiatric disorders, from mild anxiety to severe psychosis

It has become increasingly clear that drug dependence commonly co-exists with other psychological and psychiatric disorders and, as the above examples indicate, it is well recognised that the majority of clients presenting to alcohol and drug treatment agencies have a number of surrounding issues which can combine to create a complex case. Such issues may include lack of accommodation, impending legal action, having a child placed in care due to parental alcohol and/or other drug abuse, and psychological disorders (e.g. anxiety, depression or personality disorders) or more severe co-existing psychiatric disorders requiring psychiatric intervention.

The DSM IV (1994) cites a broad range of diagnoses associated with substance dependence including anxiety disorders, mood disorders (depression or bipolar disorder), amnestic disorders (memory disturbance) and psychotic disorders (schizophrenia and delusional disorder). Clients presenting for alcohol and drug treatment may exhibit any one of a range of disorders along this continuum, ranging from mild anxiety disorders to severe psychosis.

The combination of substance abuse with psychological, psychiatric disorders, and social difficulties may contribute to treatment resistance and poor outcomes, making this a particularly challenging client group. As with all clients, a holistic approach is recommended when working with clients with complex issues, with attention being given to the personal and social issues and the impact they may be having on the client's substance abuse problem. Counsellors need to liaise with appropriate social welfare agencies, medical and psychiatric practitioners services where required (see Case Management).

1.6 Care Planning

1.6.1 Care Planning – General Issues

Key Points

- A clearly developed care plan should form the basis of all interventions
- Case management is particularly useful in alcohol and other drug treatment, as clients generally present with a myriad of issues that need to be addressed
- Setting goals is an important aspect of care planning and case management

Dale & Marsh (2000a) note that a clearly developed treatment plan should form the basis of all intervention with clients. This should contain a detailed overview of the planned intervention, set practical realistic goals, and have strategies for achieving these. Treatment plans are developed following comprehensive assessment, consideration of the client's current circumstances, strengths and weaknesses, and the likely impact of intervention on the client's ability to meet certain goals. Treatment plans ensure that therapy remains focused and offers the client support and options in the face of their many (and sometimes insurmountable) difficulties. It is recommended that all counsellors develop treatment plans for each client on the basis of assessment and goal setting. Treatment plans should be:

- Clearly articulated and highly detailed;
- Agreed by both client and counsellor;
- Derived from the results of assessment, goal setting and client choice;
- Contain practical, realistic goals and the strategies for achieving these goals; and
- Include parents, partners, family and friends where appropriate.

Treatment plans should contain:

- A review of the individual's current situation.
- An assessment of the individual's strengths and needs.
- Objectives and practical Strategies for achieving these.
- An assessment of the constraints and opportunities for meeting needs.
- An assessment of the support needed to achieve desired objectives.
- Methods of recording progress.
- Methods for evaluating outcome (Dale & March, 2000a)

1.6.2 Case Management/CPA

Case management is a particularly useful model of intervention for alcohol and other drug treatment (Mejta et al 1997; Siegal, 1998). Substance users generally present with a myriad of additional issues that need to be addressed during the course of treatment. These issues include general health, living issues, psychological or co-existing psychiatric disorders, employment, education and skills training, legal issues and family difficulties.

The general tasks of case management are to:

- identify clients' needs;

- locate service options;
- link clients with appropriate services;
- monitor clients' progress in treatment; and
- evaluate services provided to clients.

A case management approach ensures that clients receive specialist assistance where needed. Case management should offer the client a single point of contact with health and social services, and be

- driven by client need
- community based
- pragmatic
- anticipatory
- flexible
- culturally sensitive

1.6.3 Shared Case Management

Shared case management involves several (often interagency) professionals who work collaboratively as a team in order to provide multiple services for clients on a case by case basis (Siegal, 1998). While each member of the team provides a specialist service to the client (eg from mental health services, alcohol and drug treatment services, counselling/psychotherapy service, social services) the team works together and shares information in order to integrate and co-ordinate services in response to the client's needs. The responsibility for meeting the client's needs is shared, although accountability for the provision of each service remains with the relevant agency/individual. The services would be expected to communicate frequently and share information pertaining to client progress, barriers impeding progress, aims of treatment, and short term goals. This open communication should ensure the client receives a co-ordinated and complementary overall service from all agencies. Other common examples of combined case management include addictions counsellors working with sexual abuse counsellors; medical practitioners; child protection services and schools.

Effective case management involves:

- Clear and open communication between the professionals involved.
- Clarification of the requirements and boundaries of each specialist.
- Clear boundaries of confidentiality and what will be communicated with the case manager (or team).
- Knowledge of other professionals involved and the nature of their involvement in the case.
- Having a contract (written or verbal) that outlines the expectations and boundaries of service provision (Dale and Marsh, 2000a).

Other important ingredients for good case management include:

- ensuring continuity of services during staff turnover;
- clear lines of authority and control over the case management process;
- providing a formal record of agencies agreements and responsibilities; and
- holding agencies accountable.

1.6.4 Goal Setting

Setting goals is an important aspect of care planning and case management. Goal directed therapy has a long history in therapeutic intervention and is particularly important in terms of outcomes. Jarvis, Tebbutt and Mattick (1995) state that goals act as concrete signposts to guide counselling and measure progress over time. Indeed, Allsop (1997) maintains that goal setting is important to allow clients to experience success, thus countering the learned helplessness that is common to many drug users.

Velleman (1992a, 2001) in *Counselling for Alcohol Problems* argues the importance of counsellors setting achievable goals with clients, and this is supported by Dale and Marsh (2000a) in the *Guide for Counsellors Working with Alcohol and Other Drug Users: Core Counselling Skills.* Goals give therapy a direction, give a standard by which progress can be reviewed, and give clients concrete evidence of their improvement. Goals should be:

- geared towards a client's stage of change
- negotiated with the client
- defined in clear, specific and achievable terms eg I will have three alcohol free days per week
- short term: set an overall goal for therapy, then break it down into its smallest components set on a weekly basis
- described in positive terms, and should focus on skill acquisition eg "I will increase the number of drug free days to five out of seven", rather than "I will reduce drug use to two days per week".

Goals should not be limited to clients alcohol and/or other drug use, but formulated across a range of areas, for example:

- Improving physical health;
- Improving psychological health;
- Reducing criminal behaviour;
- Improving social adjustment and functioning;
- Reducing drug use; and
- Minimising the harm associated with drug use (Dale & Marsh, 2000a)

1.7 Professional Issues

1.7.1 Assessment

Key Points

- *The assessment interview is probably the single most important means of data collection*

- *Counsellors should be trained to use formal standardised assessment tools such as questionnaires, in order to avoid misinterpretation of test results, mislabelling of clients, and inappropriate feedback to the clients*

- *Informal assessment is an ongoing process between the counsellor and the client*

- *Assessment procedures are the same irrespective of drug type*

- *All assessment should inform a client's treatment programme, and the client should be informed of this rational*

Groth-Marnat (1997) argues that the assessment interview is 'probably the single most important means of data collection', and suggests that assessment can be informal or formal.
The literature supports the importance of both types of assessment when working with clients having problems with drugs or alcohol (eg Winters, 1999; Winters and Zenliman, 1995)

Formal Assessment
Formal assessment involves the collection of information via standardised tools such as questionnaires. It is important that counsellors are trained to use standardised assessment tools, as their inappropriate use may be detrimental to the client in terms of misinterpretation of test results, mislabelling of clients, and inappropriate feedback to the clients.

Informal assessment
Informal assessment is an ongoing process between the counsellor and the client, with initial meetings primarily devoted to engaging with the client, assessing the client's current difficulties and treatment needs. Helfgott (1997) suggests that there are five important functions that the assessment phase can fulfil:

- Developing a therapeutic relationship based on trust, empathy and a non-judgmental attitude.
- Helping the client to accurately reappraise his/her drug use, which may facilitate a desire for change.
- Helping the client to link their current problems with their drug use.
- Facilitating a review of the client's past and present and linking these to current drug use.
- Encouraging the client to reflect on the choices and consequences of drug using behaviour.

Research does not support the distinction between alcohol and other drug services in terms of assessment. Therefore, assessment procedures are the same irrespective of drug type. The literature indicates that standardised assessment should be completed upon entry into and exit from a treatment program, as well as at follow up (Mattick & Hall, 1993; Winters, 1999). Test results can provide useful clinical information as well as outcome measures demonstrating treatment efficacy. The key areas for assessment include the measurement of quantity and frequency of drug use, dependence, employment, criminality, self-esteem, social functioning and psychological health. All information should be used as a foundation for an individual's treatment programme, and the client should be informed of this rational (Dale & Marsh, 2000b).

1.7.2 Supervision

Key Points

- *High quality supervision from well-trained supervisors is vital*

- *Supervision has a number of characteristics and functions. It is formal, regular, and provides an opportunity for the counsellor to develop and explore their skills and understanding, their self-awareness, and issues and difficulties in their practice as counsellors as they arise*

- *Supervision also provides protection for the client and the agency by monitoring the counsellor's work*

Both Dale and March (2000a) in *A Guide for Counsellors Working with Alcohol and Other Drug Users,* and Velleman (1992a, 2001), have a great deal to say about supervision for counsellors. A supervisor acts as a mentor, even to quite experienced counsellors, in order to facilitate growth and development. Supervision is not therapy. Supervision is about enhancing standards of practice, and has three functions which aim to meet professional, personal and agency objectives:

1. managing or administrative;
2. educative or teaching; and
3. supportive or enabling.

Supervision has a number of characteristics:

- *It is formal.* It is not ad hoc, or a chat when the participants feel like it, or when there happens to be someone around with the time to supervise. It is a scheduled time with a supervisor who has been selected because he or she has the skills and experience to be able to offer a high-quality service.
- *It is regular.* If counsellors see a number of clients on a regular basis, issues will certainly arise which need to be dealt with. Alcohol Concern, the National alcohol agency within England, insists on one hour of supervision for ever four of counselling. For many full-time counsellors that would prove to be a very demanding degree of regularity. Whatever the frequency decided by the agency, regularity must be ensured.
- The supervision *provides an opportunity* for the counsellor to *develop and explore* in a number of ways, including to:
    - develop the skills and understanding of his or her counselling work;
    - develop self-awareness, in so far as this affects the quality of the counselling work;
    - *explore counselling issues and difficulties for counsellor or clients as they arise in sessions;*
    - provide protection for the client and the agency by monitoring the counsellor's work.

These characteristics imply that supervision should be taken up with a number of tasks. Velleman argues that supervisors should utilise the same process model that he suggests should be used in counselling itself:

- Effective support and supervision is based on trust. The counsellor must feel able to disclose things during supervision which he or she might not tell other people – for example, feelings of incompetence, mistakes made, annoyance with the agency.

- The supervisor needs to explore what the issues and concerns are that a counsellor has, rather than imagining he or she knows what those concerns are.
- The supervisor needs to help the counsellor focus on the issues, rather than skirting around the edges. For example, many supervisors allow the counsellor to recount, at great length, the case history which the counsellor has painstakingly extracted from the client, as opposed to getting the counsellor to focus on the issues that this client has thrown up for him or her. The supervisor could examine these by asking questions such as, 'What are you actually doing with this client?'; 'What are you plans?'; 'What are the difficulties which have emerged for you in the sessions so far?' Or the supervisor might focus on the counsellor's understanding of the problem as opposed to his or her goals; or focus on the counsellor's feelings for the client and how these might interact with the work which is being attempted.
- The supervisor needs to help the counsellor to take action in a counselling session by helping him or her to plan out how to implement the strategies and ideas which have emerged during the supervision meeting.

Supervision style should include a balance of support, feedback, problem solving and instruction. The supervisor needs to trust the supervisee enough to let them make their own mistakes, while at the same time being able to guide and develop the practice of the supervisee. Supervision involves exploration of the way that the supervisee works with clients. It is regular, systematic and carries with it a responsibility to ensure quality of practice.

Velleman (1922a, 2001) in *Counselling for Alcohol Problems* points out the necessity of having trained supervisors. While supervisors should be experienced counsellors, being a good counsellor does not necessarily mean that the person will make a good supervisor. Alcohol Concern (1992) has issued guidelines that describe effective supervision in detail.

<u>What makes good supervision?</u>
The Curtin University Intervention Unit Study Manual (1999) suggests that good supervision consists of a clearly developed contract stating the purpose of supervision, plus the expectations of both supervisor and supervisee. It should be developed via negotiation and mutual agreement, it should contain the focus, content, methods and arrangements for supervision, and be renewed or revised at agreed intervals.

The supervisor should tailor the level of supervision to the supervisee's current level of practice. Dryden and Thorne (1991) suggest that there are a number of styles of supervision, differentially appropriate for the level of the supervisee:
- Reflection on the content of the counselling session.
- Exploration of the strategies and interventions used by the counsellor.
- Exploration of the counselling process and relationship.
- Focus on both the counsellor's and supervisor's counter-transference.

- Focus on the here and now process as a mirror or the there and then process *i.e.* issues occurring in supervision reflecting issues that occurred during therapy.

Once the structure for supervision has been set, other elements of good supervision include the following:

- Clear open communication
- Active listening and attending skills
- Proactive agenda setting
- Clear professional boundaries
- Giving and receiving constructive and corrective feedback
- Knowledge and skills of the alcohol and drug arena and the process of supervision
- An understanding of the dynamics of the mirroring process (*e.g.* a client trivialising drug use in counselling and then the supervisee trivialising the issue in supervision).

Group and individual supervision

Group supervision offers a number of advantages including the development of a team atmosphere, a greater pool of resources and skills (from the increased number of members of the group) and a greater level of support for counsellors. Counsellors should also have access, nevertheless, to regular individual clinical supervision.

Obligations of the supervisee

Supervisee's share half of the responsibility in terms of the effectiveness of supervision. The responsibilities of the supervisee include:

- Helping to draw up a contract for supervision.
- Being clear in their expectations of supervision.
- Being clear and open in their communication with the supervisor.
- Being conscious of, and clearly communicate, changing supervision needs.
- Being honest in all interactions with your supervisor.
- Being honest about the process of supervision. If needs are not being met, it is the right and responsibility of the counsellor to voice this.
- Being open to constructive feedback.
- Doing any homework tasks set by the supervisor.

1.7.3 Professional Development

The Irish Association of Alcohol and Addiction Counsellors (IAAAC) notes that addiction counselling is a professional occupation with a clearly defined body of knowledge, experience and skills.

Boyne (1995), in *Psychotherapy in Ireland*, argues that the very diversity of psychotherapy has made it difficult for a coherent profession to emerge. Some argue that psychotherapy should be an ancillary activity of other professionals such as medical doctors, psychiatrists and psychologists, while others see it as a profession in its own right. Boyne sees the emergence of the Irish Council for Psychotherapy, and the Irish Association of Counselling and Therapy (IACT) as steps along the route to professionalisation.

Professional development is an important aspect of any treatment service, and supervision has a role to play in the maintenance and improvement of counsellors' standard of practice. Evidence based practice requires staff to integrate knowledge from the research and professional field as well as their own experiences, into their clinical practice. This process requires:

- a range of learning opportunities both on and off the job to update skills and knowledge;
- effective and supportive supervision to build a climate of continuous learning and support;
- organisational structures which allow for reflective practice to integrate acquired knowledge and skills into the workplace; and the ability to use both successes and mistakes as learning opportunities (Dale & Marsh, 2000a).

1.8 SUMMARY: KEY ISSUES IN THE LITERATURE REVIEW

- *It is important to be clear about the definition of counselling and the methodological issues in assessment of its efficacy*

- Reviews and meta-analyses of counselling for general psychopathology up to the mid-1990s were notpartic8larly favourable

- More recent reviews of the effectiveness of counselling have been much more positive. In general these reviews have been more rigorous in the inclusion criteria for entry of trials into the meta-analyses

- Research has been able to demonstrate the fundamental importance of the therapeutic relationship. A sound therapeutic relationship provides an avenue to communicate respect, understanding, warmth, acceptance, commitment to change and a corrective interpersonal experience

- The process of counselling, general counsellor therapeutic competence, the attributes of counsellors, and the organisation within which they work, rather than necessarily the method of counselling, have all been shown to affect outcome

- Staff morale, training and resources are key determinants of outcome

  Therapist quality and consistency, supported by their preparation and training, is probably as important in terms of outcome as treatment modality

  A clear, credible intervention delivered with explicit quality control will maximize treatment compliance

  Employing adequately trained, qualified, and supervised counsellors is crucial; ongoing supervision is optimised via video-taping, with the tapes being used during weekly supervision to minimize "therapeutic drift"

Systematic, protocol driven, manualised interventions improve outcome; outcomes are optimised by the use of standardised, manual based treatment protocols, delivered by therapists with a high degree of supervision and training

- A number of studies demonstrate the efficacy of generic counselling in methadone maintenance programmes

- Targeted counselling has been shown to be an effective intervention with multi-substance use, particularly among cocaine and alcohol misusers

- There is both effectiveness and cost-effectiveness evidence supporting the use of motivational interviewing, skills-based cognitive interventions, community reinforcement programmes, and behavioural marital therapy
  There is broad support in the literature for the effectiveness for cognitive psychotherapeutic interventions for drug users; Such cognitive interventions should be used for those groups who have more severe psychopathology and/or dependence

  It appears that cognitive interventions are differentially effective across different classes of drugs, with evidence for the effectiveness of CBT with opiate-users

  Motivational interviewing is effective, particularly for those drug and alcohol users who are in the contemplation stage of the process of change

  12 step interventions are particularly effective when used as an aftercare resource. Any positive effect of 12 step intervention is additive, not independent

  Project MATCH found that 12-step Facilitation, Cognitive Behaviour coping skills, and Motivational Enhancement Therapy were equally highly effective. Therapist training, quality and consistency were vital components of the positive outcomes delivered by Project MATCH

- More structured and organised interventions such as motivational interviewing, skills-based cognitive interventions, community reinforcement programmes, behavioural marital therapy, Alcoholics Anonymous and 12 Step approaches all seem to work somewhat better that do less structured approaches

  Evidence indicates the utility of brief interventions in communicating and implementing harm reduction strategies, but they are not so useful for more complex clients with additional psychological/psychiatric issues, clients with severe dependence, clients with poor literacy skills, or clients with difficulties related to cognitive impairment

While brief intervention can result in significant gains at minimum cost, generalist workers conducting brief interventions will not replace the need for specialist alcohol and other drug treatment

Family and friends need to be treated as clients in their own right, although they can also be treated as an adjunct to an individual's treatment. Involving family members can draw substance misusers into treatment and ensure that changes impact on the whole system. The types of family intervention with the best evidence to date are systemic, behavioural, unilateral, community-reinforcement and social network approaches

Confrontational counselling, psychoanalytic psychotherapy and educational talks and lectures have been seen to be of little use in promoting positive outcomes amongst alcohol misusers

Psychosocial inputs are not a 'quick fix', and often the added benefits of counselling are only evident after some months

- In any review of treatment it must be clear that drug dependence is not necessarily an idiographic, psychological deficit. There is no doubt that patients' long term access to good quality social and community support and non-drug using networks will influence the trajectory of dependence

  Dependence can be seen as a functional way of relating to one's environment which means that treatment should be tailored not only to individual needs, but also mapped onto the context in which the individual finds him or herself: all treatment, including counselling, has to consider the wider context of people's lives

  Two key predictors of outcome and long term success are cognitive ones: one is self-efficacy; the other is baseline motivation or readiness to change

- High quality supervision from well-trained supervisors is vital

  Supervision has a number of characteristics and functions. It is formal, regular, and provides an opportunity for the counsellor to develop and explore their skills and understanding, their self-awareness, and issues and difficulties in their practice as counsellors as they arise

  Supervision also provides protection for the client and the agency by monitoring the counsellor's work

  The majority of alcohol and drug treatment clients have multiple issues which can combine to create a complex case. Accordingly, care planning and management is vital: a clearly developed care plan should form the basis of all interventions

Case management is particularly useful in alcohol and other drug treatment, as clients generally present with a myriad of issues that need to be addressed

- Setting goals is an important aspect of care planning and case management

REFERENCES

Alcohol Concern (1992) Training Volunteer Alcohol Counsellors – the Minimum Standards. *Alcohol Concern: London.*

Allsop, S. (1997) Goal setting. In S. Helfgott (ed). Helping change: The addiction counsellors training program. *Western Australian Alcohol and Drug Authority: Perth.*

Ali, R., Miller, M., Cormack, S. (1992) Future directions for alcohol and other drug treatment in Australia. *Australian Government Publishing service: Canberra.*

Altraman, A., Rutherford, M., Cacciola, J., McKay, J., Woody, G. (1996) Response to methadone maintenance and counselling in antisocial patients with and without major depression. Journal of Nervous Mental Disorder, *185 (11), 695-702.*

Ashton, M. (1999) Project MATCH: unseen colossus. Drug and Alcohol Findings, *1,1.*

Baily, S. (1991) Planning prevention strategies for alcohol and other drug related problems among women. *Sydney; Alcohol and Drug Directorate, NSW Health Dept.*

Baker, A., Heather, N., Stallard, A., O'Neil, K., Woda, A. (1996) A manual of cognitive behavioural techniques aimed at reducing HIV risk taking behaviour in infecting drug users. *National Drug and Alcohol Research Centre, University of New South Wales: Sydney.*

Barber, J. & Crisp, B. (1995) The 'pressures to change' approach to working with the partners of heavy drinkers. Addiction*, 90, 269-276.*

Best, D., Harris, M. (2000) Dissemination day for the first United Kingdom investigation of the integration and effectiveness of twelve step treatment in NHS treatment populations. *Conference papers and lectures, National Addiction Centre, London.*

Boyne, E.F. (ed) (1995) Psychotherapy in Ireland 2nd Edition. *Columbia.*

Carroll, K. (1996) Relapse prevention as a psychosocial treatment: a review of controlled clinical trials. Experimental and Clinical Psychopharmacology, *4, 46-54.*

Cochrane Review. (2001) Counselling for depression in primary care. *Issue 1, Oxford Update Software.*

Collins, R. (1990) Family treatment of alcohol abuse: behavioural and systems perspectives in Collins, R., Leonard, K. & Searles, J, (1990) (Eds) Alcohol and the Family: Research and Clinical Perspectives. *New York: Guildford Press.*

Connexions (1994) Unequal equality: Substance abuse and women. Journal of Drug and Alcohol Issues, *Feb/Mar, Vol 14.*

Copeland, J. (1993) A review of the literature on women's substance use, dependence and treatment needs. *Report Commissioned by Queensland Department of Health: Australia.*

Copeland, J., Swift, W., Rees, V. (1999) A randomised controlled trial of brief intervention for cannabis dependence. *Paper presented at the Annual APSAD Conference, 8-10 November, 1999.*

Copello, A., Orford, J., Hodgson, R., Tober, G., Barrett, C. (2001) Social Behaviour and network therapy: basic principles and early experiences. Addictive Behaviours, *26, 1022, in press.*

Copello, A., Orford, J., Velleman, R., Templeton, L. & Krishnan, M. (2000) Methods for reducing alcohol and drug related family harm in non-specialist settings. Journal of Mental Health, *9(3), 329-343.*

Copello, A., Templeton, L. & Krishnan, M., Orford, J., Velleman, R. (2000) A treatment package to improve primary care treatment for relatives of people with alcohol and drug problems. Addiction Research, *8(5), 471-484.*

Covington, S. (1986) Facing the clinical challenges of women alcoholics: physical, emotional and sexual abuse. Focus on Family, *3, 10-11.*

Crits-Christoph, P. & Siqueland, L. (1996)Psychosocial Treatment for Drug Abuse. Selected Reviews and Recommendations for National Health Care. Arch Gen Psychiatry, *53, 749-756.*

Crits-Christoph, P. Siqueland, L., Blaine, J., et al (1999) Psychosocial treatments for cocaine dependence: national institute on drug abuse collaborative cocaine treatment study. Archives of General Psychiatry, *56, 493-502.*

Dale, A., Marsh, A. (2000a) A Guide for Counsellors working with Alcohol and Other Drug Users: Core Counselling Skills. *Best Practice in Alcohol and Other Drug Interventions Working Group: School of Psychology, Curtin University of Technology: Perth, Australia.*

Dale, A., Marsh, A. (2000b) Evidence Based Practice Indicators for Alcohol and Other Drug Interventions: Literature Review. *School of Psychology, Curtin University of Technology: Perth, Australia.*

Darke, S., Hall, W., Heather, N., Ward, J., Wodak, A., (1992) Development and validation of a multidimensional instrument for assessing outcome amongst Opiate users: the Opiate Treatment Index. British Journal of Addictions, *87, 713-742.*

Davidson, R. (1996) Motivational issues in the treatment of addictive behaviour. In Edwards, G. and Dare, C. (Eds) Psychotherapy, psychological treatments and the addictions. *173-188. Cambridge, United Kingdom: Cambridge University Press.*

Davidson, R. (1998) The transtheoretical model: a critical overview. In Miller, W., Heather, N. (Eds). Treating Addictive Behaviours. *2nd Edition. Plenum Press.*

Davidson, R. (2001) the psychology of cancer. In Spence, R. and Johnston, P. (Eds) Oncology. *Oxford, Oxford University Press.*

Davidson, R. (2001) The cycle of change: a thematic review. Drug and Alcohol Findings. *5(2), 19-25.*

DoH/Department of Health (2001) Treatment choice in Psychological Therapies and Counselling: Evidence Based Clinical Practice Guideline. *London: Department of Health.*

Dryden, W., Thorne, B. (1991) 'Approaches to the training of counsellors'. In Dryden W, Thorne B (Eds). Training and Supervision for Counselling in Action. *Sage: London.*

Dunne, F. (1988) Are women more easily damaged than men? British Journal of Addictions, *83, 1135-1136.*

Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. (1994). Washington D.C; American Psychiatric Association.

Edwards, G. (1996) Alcoholics Anonymous. In Psychotherapy, Psychological Treatments and the Addictions. *Cambridge University Press, Cambridge. p235.*

Edwards, G. (2000) Alcohol: the ambiguous molecule. *Penguin Science Health, London. p117.*

Edwards, M. and Steinglass, P. (1995) Family therapy treatment outcomes for alcoholism. Journal of Marital and Family Therapy, *21, 475-509.*

Effectiveness Matters (2001) Counselling in Primary Care. NHS Centre for Reviews and Dissemination, *Vol 5, 2.*

Eliany, M., Rush, B. (1992) How effective are alcohol and other drug prevention and treatment programs? A review of evaluation studies. *Health and Welfare Canada: Ottawa.*

Fiorentine, R. (1999) After drug treatment: are 12 step programmes effective in maintaining abstinence? American Journal of Alcohol Abuse, *25, 93-116.*

Fiorentine, R., Hillhouse, M.P. (2000) Drug treatment and 12 step program participation. The additive effects of integrated recovery activities. Journal of Substance Abuse Treatment, *18, 65-74.*

Friedli, K. and King, M. (1996) Counselling in general practice – a review. Primary Care Psychiatry, *2(4), 205-216.*

Galanter, M. (1993a) Network Therapy for addiction – a model for office practice. American Journal of Psychiatry, *150, 28-36.*

Galanter, M. (1993b) Network Therapy for substance misuse – a clinical trial. Psychotherapy, *30, 251-258.*

Garrett, J., Landau, J., Shea, R., Stanton, M.D., Baciewicz, G. & Brinkmansul, D. (1998) The ARISE intervention – Using family and network links to engage addicted persons in treatment. Journal of Substance Abuse Treatment, *15, 333-343.*

Gerstein, D., Harwood, H. (1990) Treating drug problems. Volume 1: A study of effectiveness and financing of public and private drug treatment systems. *National Academy Press: Washington DC.*

Glaser, F. (1999) The unsinkable Project MATCH. Addiction, *94 (1), 34-36.*

Godber, E. (1996) Is counselling in primary care growing too fast? A clinical, economic and strategic assessment. *Institute for Health Policy Studies: University of Southampton.*

Gossop, M. (1996) Cognitive and behavioural treatments for substance misuse. In Edwards, G. and Dare, C. (Eds). Psychotherapy, psychological treatments and the addictions. *pp139-157. Cambridge University Press: Cambridge, United Kingdom.*

Groth-Marnat, G. (1997) Handbook of psychological assessment. *Chichester: John Wiley & Sons.*

Hall, W., Teeson, M., Lynskey, M., Degenhardt, L. (1998) The prevalence in the past year of substance abuse and ICD-10 substance use disorder in Australian adults: Findings from a national survey of mental health and wellbeing. *Sydney; National Drug and Alcohol Research Centre, University of New South Wales.*

Hansell, A., Bonnet, J. (1999) Literature review to inform purchasing of counselling in general practice. Cochrane Collaboration, 29.

Hagman, G. (1994) Methadone maintenance counselling. Definition, principles, components. Journal of Substance Abuse Treatment, *5, 405-413.*
Heather, N. (1995) Psychology and brief interventions. British Journal of Addiction, *84, 357-370.*

Heather, N., Tebbutt, J. (eds) (1989) The effectiveness of treatment for drug and alcohol problems: an overview. *Canberra: Australian Government Publishing Service.*

Heather, N., Rollnick, S., Bell, A., Richmond, R. (1996) Effects of brief counselling among male heavy drinkers identified on general hospital wards. Drug and Alcohol Review, *15, 29-38.*

Helfgott, S. (1997a) 'Assessment'. In S. Helfgott (ed). Helping change: The addiction counsellors training program. *Western Australian Alcohol and Drug Authority: Perth.*

Helfgott, S. (1997b) Counselling Significant Others. In: S. Helfgott (Ed) Helping change: the addiction counsellors training program. *Perth; Western Australia Alcohol and Drug Authority.*

Herman, J. (1992) Trauma and Recovery: from domestic violence to political terror. *Basic Books: USA.*

Holder, H., Eisler, R., Longabaugh, R., et al (2000) Alcoholism treatment and medical care costs from Project MATCH. Addiction, *95(1), 999-1013.*

Hubbard, R., Craddock, S. J., Flynn, P. M., Anderson, J., Ehteridge, R. (1997) Overview of 1 year follow up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). Psychology of Addictive Behaviours, *11, 261-278.*

Hurcom, C.A., Copello, A., Orford, J. (1998) The family and alcohol: effects of excessive drinking and conceptualisation of spouses over recent decades' substance-misuse. (in press).

Irvine, J., Bowers, C., Dunn, M., Wang, M. (1999) Journal of Consulting and Clinical Psychology. *67(4), 563-570.*

Jarvis, T., Copeland, J., Walton, L. (1998) Exploring the relationship between child sexual abuse and substance use among women. Addiction, 93(6): 865-866.

Jarvis, T., Copeland, J., Walton, L. (1995) Exploring the relationship between child sexual abuse and substance abuse among women. *National Drug and Alcohol Research Centre, University of New South Wales: Sydney.*

Jarvis, T., Tebbutt, J., Mattick, R. (1995) Treatment Approaches for Alcohol and Drug Dependence; an introductory guide. *Chichester: John Wiley & Sons Ltd.*

Kaur, K. & Mistral, W. (2000) An Evaluation of Devon Probation Service Fast Track Programme. *Mental Health R& D Unit: University of Bath.*

Kite, F., Pearson, J., Schofield, K. et al (1996) Review of long term residential treatment for people with alcohol and other drug use problems. *Commonwealth of Australia.*

Klee. L., Schmidt, C., Ames, G. (1991) Indicators of women's alcohol problems: What women themselves report. International Journal of the Addictions, *26(8), 879-895.*

Kraft, M., Rothbard, A, Hadley, T. (1997) Are supplementary services provided during methadone maintenance really cost effective? American Journal of Psychiatry, *154, 1214-1219.*

Liepman, M., Nirenberg T. & Begin A. (1989) Evaluation of a program designed to help family and significant others to motivate resistant alcoholics into recovery. American Journal of Drug and Alcohol Abuse, *15, 209-221.*

Magura, S., Nwakeze, P.C., Kang, S.Y., Demsky, S. (1999) Program quality effects on patient outcomes during methadone maintenance: a study of 17 clinics. Substance Use & Misuse, *34, 9, 1299-1324.*

Mattick, R., Hall, W. (eds) (1993) A treatment outline for approaches to opioid dependence: quality assurance project. *Australian Government Publishing Service: Canberra.*

Mattick, R., Baillie, A., Grenyer, B. et al (1993) An outline for the management of alcohol problems: quality assurance project. *Australian Government Publishing Service: Canberra.*

Mattick, R., Ward, J., Hall, W. (1998) The role of counselling and psychological therapy. In: Ward, J., Mattick, R.P. & Hall, W. (Eds.) Methadone maintenance treatment and other replacement therapies. *Harwood Academic Publishers: Netherlands.*

McFarlane, A. C., Yehuda R. (1996) Resilience, vulnerability, and the course of post traumatic reactions'. In van der Kolk BA, McFarlane AC, Weisath L (eds.). Traumatic stress: The effects of overwhelming experience on mind, body and society. *Guildford Press: New York.*

Mellor-Clarke, J. (2001) Counselling in primary care in the context of the NHS quality agenda. The facts. *British Association for Counselling and Psychotherapy. Psychological Therapies Research Centre: Leeds.*

Metja, C., Bokos, P., Mickenberg, J., Maslar, M., Senay E (1997) Improving substance abuse treatment access and retention using a case management approach. Journal of Drug Issues *27(2), 329-340.*

Meyers, R., Dominguez, T. & Smith, J. (1996) Community reinforcement training with concerned others. In: V.B. van Hasselt & M. Hersen (Eds.) Sourcebook of Psychological Treatment Manuals for Adult Disorders. *Plenum Press: New York.*

Meyers, R., Miller, W., Hill, D. & Tonigan, J. (1998) Community reinforcement and family training (CRAFT): engaging unmotivated drug users in treatment. Journal of Substance Abuse, *10, 291-308.*

Miller, W., Brown, J.M., Simpson, T. L., Hanmaker, N.S., Bien, T.H., et al *(1995) What works? A methodological analysis of alcohol treatment outcome literature. In Herster, R. K. and Miller, W. (Eds),* Handbook of alcoholism treatment approaches: affective alternatives (2nd edition). *Allyn and Bacon: Boston.*

Miller, W., and Herster, R. (1986) The effectiveness of alcoholism treatment methods. What research reveals. In Miller, W. R., and Herster, R. (Eds). Treating addictive behaviours, processes of change. *pp4-37. New York: Plenum.*

Miller, W. and Rollnick, S. (1991) Motivational Interviewing: Preparing People to Change Addictive Behaviour. *London; New York: Guildford.*

Monti, P., Roshenaw, D., Hutchinson, K. et al. (1999) Brief interventions for harm reduction with older alcohol-positive adolescents in a hospital emergency department. Journal of Consulting and Clinical Psychology, *67(6), 989-994.*

Moodley, R. (2001) Researching for a client in 2 different worlds: mind the research practice gap. Counselling and Psychotherapy Research. *1(1), 18-23.*

Moore, D. (1998) Substance use disorder treatment for people with physical and cognitive disabilities. (Treatment Improvement Protocol (TIP) Series 29) *Substance Abuse and Mental Health Services Administration: Rockville, MD.*

Nagay, P. (1994) Intensive outpatient treatment for alcohol and other drug abuse. (Treatment Improvement Protocol (TIP) Series 8.) *Substance Abuse and Mental Health Services Administration: Rockville, MD.*

NHS Executive (1996) NHS Psychotherapy Services in England. *HMSO, London.*

Noonan, W. & Moyers, T. (1997) Motivational interviewing. Journal of Substance Misuse, *2, 8-16.*

Noone, M., Dua, J., Markham, R. (1999) Stress, cognitive factors and coping resources as predictors of relapse in alcoholics. Addictive Behaviours, *24(5), 687-693.*

O'Farrell, T. (Ed.) (1993) Treating Alcohol Problems: Marital and Family Interventions. *New York; Guilford Press.*

Orford, J. (1994) Empowering family and friends: a new approach to the secondary prevention of addiction. Drug and Alcohol Review, *13, 417-429.*

Parry, G. (1996) NHS psychotherapy services in England. Review of strategic policy. *NHS Executive. Summary Report.*

Polinsky, M. L., Hser, Y., Anglin, M.D., Maglione M. (1995) Drug Treatment Programs in Los Angeles County *(available from UCLA Drug Abuse Research Centre, 1640 S. Sepulreda Birch, Suite 200, Los Angeles, CA 90025).*

Priestley J.S., Rassool, G.H., Saffer, D., Ghodse, H.A. (1998) Psychodynamic psychotherapy and counselling: what contribution can it make to the treatment of addiction? Journal of Substance Misuse, 3, 234-239.

Project MATCH Research Group (1997) Project MATCH secondary a prior hypotheses. Addiction, *92(12), 1671-1698.*

Project MATCH Research Group (1998) Matching alcoholism treatments to client heterogeneity: Project MATCH three year drinking outcomes. Alcoholism: Clinical and Experimental Research, *22, 1300-1311.*

Project MATCH Research Group (1999) Summary of Project MATCH. Addiction *94(1), pp31-34.*

Raistrick, D. and Davidson, R. (1985) Alcoholism and Drug Addiction. *Churchill Livingstone: London.*

Rogers, C. (1942) *Counselling and Psychotherapy.* Boston: Houghton Middleton Co., New York.

Roth, A. & Fonagy, P. (1966) *What works for whom. A critical review of psychotherapy research*. New York: Gilford Press.

Rohsenow, D.J., Corbett, R., Devine, D. (1988) Molested as children. A hidden contribution to substance abuse. *Journal of Substance Abuse Treatment,* 5(1), 13-18.

Rounsaville, B. & Kleber, H. (1985) Psychotherapy/counselling for opiate addicts: strategies for use in different treatment settings. *International Journal of the Addictions,* 20, 6&7, 869-896.

Rowan, J. (2001) Counselling and psychotherapy – different and the same. *Counselling and Psychotherapy Journal,* 12 (7), 22-25.

Select Committee into Misuse of Drugs Act 1981 (1988) *Finding the Right Balance – working together as a community to prevent harm from illicit drugs and to help individuals and families in need.*

Siegal, H. (1998) *Comprehensive case management for substance abuse treatment. (Treatment Improvement Protocol (TIP) Series 27.)* Substance Abuse and Mental Health Services Administration: Rockville, MD.

Sisson R. & Azrin N. (1986) Family-member involvement to initiate and promote treatment of problem drinkers. *Journal of Behavioural Therapeutic Experimental Psychiatry Journal of Behavioural Therapeutic Experimental Psychiatry,* 17, 15-21.

Stark R (1998) Brief interventions. *Working with Drug Use: A workshop for SAAP Workers Module Two.* Western Australian Alcohol and Drug Authority: Perth.

Stockwell, T. (1992) Models of change, heavenly bodies and weltanschauugs. *British Journal of Addiction,* 87, 830-831.

Stiles, W., Shapiro, D., and Elliott, R. (1986) Are all psychotherapies equivalent? *American Psychologist,* 41, 165-180.

Swift, W., Copeland, J., Hall, W., (1996) Characteristics of women with alcohol and other drug problems: findings of an Australian Survey. *Addiction,* 91(8):1141-1150.

Steinglass, P., Bennett, L.A., Wolin, S.J., Reiss, D.C. (1988) *The alcoholic family: drinking problems in a family context.* London; Hutchinson.

Swift, W., Copeland, J. (1998) Treatment needs of women with alcohol and other drug problems: experience and views of Australian treatment personnel. *Drug and Alcohol Review,* 17, 59-67.

Thomas, S. (1997) 'Working with women'. In Helfgott S (ed). *Helping change: The addiction counsellors training program.* Western Australian Alcohol and Drug Authority: Perth.

Thornton, C., Gottheil, E., Weinstein, S., Kerachsky, R. (1998) Patient treatment matching and substance abuse drug addiction severity. *The Journal of Substance Abuse Treatment,* 15(6), 505-511.

Tonigan, J., Toscova, R., Miller, W. (1996) Meta-analysis of the Literature on Alcoholics Anonymous: Sample and Study Characteristics Moderate Fundings. *Journal of Studies on Alcohol,* January, 65-72.

Tonigan, J., Miller, W., Connors, G. (2000) Project MATCH client impressions about Alcoholics Anonymous: measurement issues and relationship to treatment outcome. *Alcoholism Treatment Quarterly,* 18(1), 2000

Toumbourou, W., Blyth, A., Bamberg, J., Bowes, G., Douvos, T. (1997) Behaviour exchange systems training: The BEST approach for parents stressed by adolescent drug problems. *ANZ Journal of Family Therapy*, 18 (2), 92-98.

Towers, T. (1999) *Complex clients – complex systems.* Presented at the 10th International Conference on the Reduction of Drug Related Harm: Geneva.

Troyer, T.N., Acampora, A.P., O'Connor, L.E. & Berry, J.W. (1995) the changing relationship between therapeutic communities and 12-step programs: a survey. *Journal of Psychoactive Drugs,* 27, 177-180.

Van der Kolk, B. (1996) The complexity of adaptation to trauma, self regulation, stimulus discrimination and characterological development. In: Van der Lolk B, McFarlane A, Weisath L (eds). *Traumatic stress: The effects of overwhelming experience on mind, body and society.* Guildford Press: New York.

Velleman, R. (1992a) *Counselling for Alcohol Problems.* Sage: London.

Velleman, R. (1992b) The use of volunteer counsellors in helping problem drinkers: community work in action? *Journal of Mental Health,* 1, 301-310.

Velleman, R. (1997) Counselling people with alcohol and drug problems, in Palmer, S. and McMahon, G. (Eds.) *The Handbook of Counselling, Second Edition,* London; Routledge, (Chapter 26, pp435-456.

Velleman, R. (2001) *Counselling for Alcohol Problems, 2nd Edition.* Sage: London.

Velleman, R., Copello, A. and Maslin, J. (1998) (Authors/editors) *Living with Drink: Women who live with problem drinkers.* London; Longmans, pp 228, plus xv.

Velleman, R. & Templeton, L. (2001) Family interventions in substance misuse. In: A. McBride & T Peterson (Eds) *Working with Substance Users,* London: Routledge, in press.

Winters, K. (1999) *Screening and assessing adolescents for substance user disorders. (Treatment Improvement Protocol (TIP) Series 31)* Substance Abuse and Mental Health Services Administration: Rockville, MD.

Winters, K., Denliman, J. (1995) *Simple screening instruments for outreach for alcohol and other drug abuse and infectious diseases. (Treatment Improvement Protocol (TIP) Series 11)* Substance Abuse and Mental Health Services Administration: Rockville, MD.

Wodak, A. (1992) She who pays the pipe calls the tune. *Drug and Alcohol Review,* 11: 107-109.

Woody, G.E., :Luborsky, L., McLellan, A.T., O'Brien, C.P., Beck A. T., Blaine, J., Herman, I. & Hole, A. (1983) Psychotherapy for opiate addicts: does it help? *Arch Gen Psychiatry,* 40, 639-645.

Woody, G.E., McLellan, A.T., O'Brien, C.P. (1990) Research on psychopathology and addiction. *Drug and Alcohol Dependence,* 25, 2, 121-123.

Woody, G.E., McLellan, A.T., Luborsky, L., O'Brien, C.P. (1995) Psychotherapy in community methadone programs: a validation study. *Am J Psychiatry,* 192, 1302-1308.

Yates F. (1988) The evaluation of a 'Co-operative Counselling' alcohol service which uses family and affected others to reach and influence problem drinker. *British Journal of Addiction,* 83, 1309-1319.

Zweben, A., Barrett, D., Carty, K. (1998) (eds). *Strategies for facilitating protocol compliance in alcoholism treatment research.* Project MATCH Monograph Series 7. NIAAA.