

Treating Substance Use in Mandated Clients

What treatments have the best evidence?

Substance use is an important risk factor for continued criminal behavior. Nearly two-thirds of probationers are alcohol or drug involved, and half of probationers were under the influence at the time of the offense. People who continue to use substances typically have worse probation outcomes. Because of this, substance abuse treatment is a common requirement for people in the criminal justice system. Sometimes agencies automatically assign treatment as result of a person's charge, such as DWI or possession of a controlled substance. Other agencies conduct a substance abuse assessment regardless of the charge to determine whether a person should attend treatment. People with low levels of substance involvement might be required to attend educational or self help groups; people with more severe problems might be required to attend individual or inpatient treatment. The American Society of Addiction Medicine recommends a set of criteria for matching clients to different levels of substance abuse treatment. At low levels of substance use severity, early interventions or outpatient services are recommended, while for high levels of substance use severity, residential or medically-monitored treatment are more appropriate.

Within these general recommendations, it is not always clear which treatments are most appropriate for which kind of person, particularly in high-volume probation systems. One way to answer this question is to look at treatments that are *generally* more effective than others. Miller and Willbourne (2002) conducted the largest review of substance abuse treatment to date. They reviewed 361 published studies of alcohol treatment that randomized clients to groups, and included at least one measure of drinking outcome. They considered both the quality of the study, as well as the evidence that the treatment was effective at reducing drinking. They used this information to arrive at a *cumulative evidence score*--the strength of evidence for different treatment approaches. Overall, they found very good evidence for the effectiveness of motivational and cognitive behavioral treatments. Three of the most evidence-based approaches involved changes in a person's social network—social skills training, community reinforcement approach, and behavioral marital therapy. They also found good evidence for two medications—naltrexone and acamprosate—that can be used alongside counseling approaches. The strength of evidence for these approaches is partly a result of the strong effect on drinking outcomes, and partly a result of the volume of research on these approaches.

One of the most surprising things about the Miller & Willbourne (2002) review is that many treatments that are commonly used in the criminal justice system, such as educational lectures and mandated AA attendance, were the least effective approaches. When compared head-to-head against other treatment approaches, these programs typically resulted in poorer outcomes. For instance, educational lectures and films are frequently used as sanctions for low-level offenders. However, there is virtually no little evidence that knowledge of the effects of substance use is either a predictor of substance use, or a mechanism of behavior change. As a result, treatment approaches that rely primarily on providing information, particularly in a group setting, generally have little to

no effect on substance use. In fact, some research has found that groups that aggregate high-risk adolescents can actually make clients worse as a result (Dishion, McCord, & Poulin, 1999). In the same way, self-help groups like AA rely on the assumption of personal interest in change. AA may not be well suited to people who lack motivation to make changes in substance use.

What's the evidence for 12-step approaches like AA?

Recent articles have criticized AA and other 12-step approaches for their supposed lack of evidence, claiming that “researchers have debunked central tenets of AA doctrine and found dozens of other treatments more effective” (Glasser, 2015). On the face of it, this claim is surprising given the preponderance of 12-step approaches in the recovery movement. AA alone has more than 2 million members worldwide and nearly 115,000 active groups. At their best, 12-step approaches provide social support, expose people to a structured recovery program, and encourage personal or spiritual growth. Most research has found that people involved in 12-step approaches have better substance use outcomes than people who are not involved. For instance, in one study of people discharged from residential treatment, the frequency of NA/AA attendance predicted substance use outcomes 5 years later (Gossop, Stewart, & Marsden, 2008). People who attended NA/AA at least once a week were much more likely to be abstinent from drugs and alcohol, compared to people who attended less or not at all. Another large study of cocaine users found that 12-step *participation* was more important than meeting attendance in predicting outcome (Weiss et al., 2005). Greater participation in any given month predicted less cocaine use in the following month. This body of research suggests that NA/AA can be very beneficial for people who actively engage in the program. Twelve-step programs are free, widely available, and have been helpful to millions of people throughout the world.

How do we explain the disconnect between these studies, which show a positive effect of AA, and the Miller & Willbourne (2002) review, which found that AA was less effective than other treatments? When AA is compared to another treatment in a clinical research study, participants are typically randomized to different approaches. Likewise, some courts require people to attend AA as part of their sentence. When people are *mandated* to attend AA, outcomes are generally not as good as other treatments that address motivation or skills. This is particularly true for people who have lower motivation to make changes. On the other hand, when people *choose* to participate in AA, they tend to find the program helpful. That is, 12-step approaches seem to work well for most people who embrace the program philosophy and actively work the system. In fact, AA describes itself as a mutual self-help program that is based on members' attraction to the program philosophy, and specifically states that AA “does not furnish initial motivation to recover” (AA Word Services, undated).

What's the best way to use 12-step approaches?

While 12-step approaches are best suited to people who are open to sobriety or are ready to engage in the program, it is possible to use evidence-based counseling approaches

alongside self-help groups. Approaches such as motivational interviewing (MI; Miller & Rollnick, 2012) focus on building motivation to make changes in substance use. MI has an excellent track-record at preparing people to engage in alcohol and drug treatment (Lundahl & Burke, 2009), and for some people 12-step attendance is an important part of the treatment process. In addition, some individual counseling approaches such as Twelve Step Facilitation (TSF; Nowinski, Baker, & Carroll, 1999) specifically encourage people to engage in 12-step activities. A large study comparing TSF, cognitive behavioral therapy, and motivational enhancement therapy found that the three were equally effective at reducing drinking throughout a 5-year follow-up (Project MATCH Research Group, 1998). TSF was slightly more effective for clients who were low on psychopathology or lacked social support for sobriety, while motivational enhancement therapy was slight more effective for clients who were low on initial motivation to change. This suggests that any referral to AA/NA, particularly for people who are less ready to change, should be supplemented by an evidence-based counseling approach that can build recognition and motivation to change.

From Miller & Willbourne (2002). Examples of evidence-based treatments.

- Brief interventions that combine advice, personalized feedback, and an empathic counselor style.
 - Motivational enhancement approaches that build client motivation for change.
 - Medications including opioid antagonists (e.g., naltrexone) and GABA agonists (e.g., acamprosate), sometimes used in combination with in-person counseling.
 - Behavioral approaches such as social skills training or community reinforcement that involves friends or loved ones.
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