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Social Workers and Delivery of Evidence-Based Psychosocial Treatments for Substance Use Disorders

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Abstract

Social workers encounter individuals with substance use disorders (SUDs) in a variety of settings. With changes in health care policy and a movement toward integration of health and behavioral health services, social workers will play an increased role vis-a-vis SUD. As direct service providers, administrators, care managers and policy makers, they will select, deliver, or advocate for delivery of evidence-based SUD treatment practices. This paper provides an overview of effective psychosocial SUD treatment approaches. In addition to describing the treatments, the article discusses empirical support, populations for whom the treatments are known to be efficacious, and implementation issues.

INTRODUCTION

Social Workers and Addiction Treatment

Social workers have historically been, and will continue to be, among the primary service providers to individuals who experience substance use disorders (SUDs). In two studies conducted by the National Association of Social Workers (NASW) 71–87% of social workers reported working with a client who has substance use (SU) issues (O'Neil, 2001; Whitaker, Weismiller & Clark, 2006). However, despite SU being a prevailing treatment issue, addiction remains under-identified as a primary practice area for clinical social workers (Whitaker et al., 2006; National Association of Alcohol and Drug Abuse Counselors, 2003). This is particularly worrisome in an era where social workers are increasingly in demand for treating clients with SUD. Clinical social workers also report being the least interested in working with substance users compared to other health professions and are more pessimistic about substance users' prognosis and their own ability to work therapeutically with clients with SUD (Alaszewski & Harrison, 1992; Wechsler & Rohman, 1982; Peyton, Chaddick, & Gorsuch, 1980).

Notwithstanding, social workers' involvement in the SU field has seen substantial growth. DiNitto (2005) noted that in the last two decades addiction finally became a "specialty

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practice section" for NASW members; the first social work journal focused on addiction emerged and social workers themselves became leaders in addiction-related organizations. As social policy changes and new evidence-based practices (EBPs) for SUD emerge, it is increasingly necessary for social workers to take on implementation and administration of these practices.

Social Workers and EBPs for SUDs

The push for using EBPs for SUD treatment has grown in frequency and demand in the last two decades (Glasner-Edwards & Rawson, 2010) resulting in the necessity for social workers to gain familiarity with practices supported by research. Social workers have been found to be successful in implementing EBPs for other psychological disorders, such as depression, in community settings (Geron & Keefe, 2006) pointing to their potential value in delivering EBPs for SUD as well. Due to social workers spending most of their time in direct service contact with clients, they are uniquely positioned to deliver EBPs for SUDs to clients in a variety of settings. One out of five social workers who specialize in addiction are employed in behavioral health clinics, two thirds of social workers practice in a private/nonprofit organization and ten percent provide clinical services through private practice (Whitaker et al., 2006) assuring that delivery of EBPs will reach into multiple domains. Since one of the weaknesses of EBPs that has been identified by social workers is their applicability for diverse populations (Rubin & Parrish, 2007; Gellis & Reid, 2004), social workers will play a vital role in assessing the transportability and cultural relevance of addiction-related EBPs. Social workers' strength-based, culturally relevant practice, policy informed training and experience in political advocacy for marginalized groups have been identified as having important applications to the addiction field (DiNitto, 2005).

National, state and local policy changes that mandate dissemination and implementation of evidence-based treatments promote a shift by agencies to using EBPs. The long-term potential impact of these policy shifts is unknown; however they may point to future directions for social workers who deliver addiction services. For instance the June 2012 Supreme Court ruling to uphold the proposed Affordable Care Act (ACA) may hasten the need for social workers to prepare for expanded roles in providing addiction treatment. Under the Affordable Care Act (ACA) there is an anticipated increase in patient utilization of addiction services due ACA policy change requiring the mandatory provision of SU prevention, early intervention and SU treatment services. This change could increase the need for social workers trained in the delivery of these services through integrated treatment, wellness programs, and coordinated care (Ofuso, 2011; Cunningham, 2011; Reardon, 2011). In addition, social workers may enter as treatment providers for addicted clients through expanded educational opportunities including further training for non-medical professionals working in the addiction field (Ofuso, 2011; Office of National Drug Control Policy, 2012; Quinn, 2010).

Social workers are well poised to take on these expanded roles and have been tasked to serve as the critical bridge between SUD-specific and general services during the integration process as well as becoming the purveyor of SU informed assessment and treatment services into organizations that do not specialize in addiction (Steenrod, 2009). To successfully bridge the gap between SU and general social work in line with proposed policy changes, social workers need to increase their skills for serving those populations who will most likely be affected by these policy shifts, such as clients with SUDs (Gorin, Gehlert & Washington, 2010).

Challenges to Social Workers Treating Addiction—The profession of social work has a history of failing to train and prepare clinicians to work clinically with SUD. In 1986,

Schlesinger & Barg reviewed training in social work programs and concluded that social workers were underprepared for dealing with addiction. Nearly three decades later, studies demonstrate that social workers continue to lack preparedness in treating clients with SUDs, which stems from a deficit of education, training and field placements to prepare them for SU issues (Richardson, 2008). Several recent surveys of social work degree program requirements found that the majority of programs did not require SU courses, had limited SU electives or related field placements, did not have a designated SU clinical track nor offered a credentialed program in SU (Straussner, 2004; Richardson, 2008; Quinn, 2010). These limitations exist despite the fact that, when compared to other health professions, social workers were more likely than nurses or physicians to express the need for more alcohol-related training (Wechsler & Rohman, 1982). The lack of recognition, training and knowledge about SU in social work curricula was termed "*institutional denial and minimization*" (p. 10) by Quinn (2010), who concluded that major shifts in social work education needed to occur in order to better educate upcoming social workers and meet the needs of a growing body of clients.

Several steps have been taken or proposed to promote the continued growth of social workers implementing and administering evidence-based psychosocial treatments for clients with SUDs. There have been national social work training initiatives, intended to bolster social work familiarity and expertise in the domain of SU, for example, the Faculty Development Program, co-funded by the National Institute of Drug Abuse (NIDA), the National Institute of Alcohol & Alcoholism (NIAAA) and the Office for Substance Abuse Prevention. This included schools of Social Work as professional health training sites for the expansion of clinical training in SUD through increasing faculty knowledge of SU issues and dissemination of SU information to other faculty and students (Straussner & Senreich, 2002). In addition, both the National Association of Social Workers (NASW) and the Council on Social Work Education (CSWE) have policy statements emphasizing the importance of social work education and training focused on SU or the use of appropriate interventions for specialized populations (NASW, 2009; CSWE, 2008).

A necessary first step in meeting the need for education of social workers in SU is the identification of core competencies. In addition to courses that provide a conceptual understanding of the causes and phenomenology of addiction, practice courses should include training in the key EBPs in this field. Toward this end, this article provides an overview of evidence-based psychosocial SUD treatments.

METHOD

Selection of Psychosocial Treatments for this Review

Our goal is to offer an overview of the major evidence-based psychosocial treatments or practices for SUD and to provide Social Work educators and practitioners with sufficient information about these treatments that they can pursue further education or training. The Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP - http://www.nrepp.samhsa.gov/Index.aspx) currently lists 55 EBPs for substance abuse treatment. We also consulted the University of Washington Alcohol and Drug Abuse Institute Evidence-Based Practices for Substance Use Disorders database (http://adai.uw.edu/ebp/) that includes 37 psychosocial practices for treating SUD. We compared the two lists to categories of psychosocial treatments described in *Principles of Drug Addiction Treatment: A Research-Based Guide* (NIDA, 2009). Thirty eight of the 55 NREPP practices and 30 of the 37 ADAI database practices fell into one of the following categories covered in the NIDA guide: Cognitive-Behavioral Therapy/Relapse Prevention (CBT/RP), Contingency Management (CM), Community Reinforcement Approach (CRA), Motivational Interviewing/Enhancement (MI/

MET), 12-Step Facilitation Therapy (TSF), Family Therapy, or the Matrix Model. Practices not included in these categories varied considerably. We concluded that these practice categories, while not exhaustive, include the main EBPs with which social workers should be familiar. We refer the reader to the two EBP websites for information about other approaches.

For each type of treatment, we: 1. describe the treatment; 2. illustrate variations on the basic treatment approach; 3. point to empirical support; 4; discuss applicability of the treatment to sub-populations where information is available; and 5. describe training and implementation issues, including directing to training resources. This is not a systematic review; but where possible, we refer to recent meta-analyses or systematic reviews.

PSYCHOSOCIAL TREATMENTS

Cognitive Behavioral Therapy – Relapse Prevention

Description—Among the first to apply cognitive and behavioral theory to treating addictions was Alan Marlatt, in a series of publications including the book, *Relapse Prevention* (Marlatt & Gordon, 1985). The cognitive-behavioral model of relapse has undergone revision (Marlatt and Donovan, 2005) but it began a line of thinking about the intrapersonal and social/environmental factors maintaining addictive behavior and the coping skills needed to reduce or cease SU. Cognitive Behavioral Therapy (CBT) seeks to help people recognize the situations in which they are at risk for use, avoid these “high risk” situations, and cope effectively with temptations, cravings and stressors.

CBT treatment is time-limited (ranging from 12 to 24 sessions); can be adapted to an individual or group format; and involves a partnership with the person seeking treatment. The two primary goals of treatment, functional analysis (determining triggers and consequences of use) and skill-building, are accomplished using a variety of therapeutic techniques. These may include: didactic instruction; modeling; behavioral rehearsal or role play; personalized feedback; cognitive restructuring; cue exposure (learning different responses to situations that have been associated with drug use), and practice.

Types of Cognitive Behavioral Therapy – Relapse Prevention—A variety of different CBT approaches have been studied and codified in treatment manuals. There are CBT therapies for specific substances of abuse, such as cocaine (Carroll, 1998), for people with specific co-occurring problems, such as PTSD (McGovern et al., 2009), or for specific populations, such as criminal offenders (National Institute of Corrections, 1996). Computerized or web-based versions of CBT treatments are a recent development that can extend the efficacy of in-person substance abuse counseling (Carroll et al., 2008; 2009; Kay-Lambkin, Baker, Lewin & Carr, 2008).

Empirical support—CBT-based treatments have been extensively evaluated in controlled clinical trials. A meta-analysis of randomized controlled clinical trials (Magill & Ray, 2009) calculated a small but statistically significant effect of CBT in comparison with other conditions across study and sample characteristics and types of SU outcomes. The effect of CBT was strongest in studies of marijuana dependence, in studies comparing CBT to no treatment, and in studies of CBT combined with additional psychosocial treatment. Although some research has suggested a “sleeper effect” of CBT in which effects are stronger at longer term follow-up than immediately post-treatment (Carroll & Onken, 2005) meta-analyses find the opposite, a reduction in impact over time following treatment (Irvin, Bowers, Dunn & Wang, 1999; Magill & Ray, 2009).

To date, research supports use of CBT with alcohol- (e.g., Bennett et al., 2005), cocaine- (e.g., Carroll et al., 2004; Rohsenow et al., 2004), and marijuana-dependent (e.g., Budney, Moore, Rocha & Higgins, 2006) adults and with substance abusing or dependent adolescents (e.g., Dennis et al., 2004; Waldron & Turner, 2008).

Evidence-based for whom—Tightly controlled clinical trials are often appropriately criticized for excluding marginalized clients or for failing to provide information about efficacy with these populations. For CBT, one study (Milligan, Nich & Carroll, 2004) found no difference between African American and White substance users in efficacy of CBT versus 12 Step Facilitation Therapy. The field is in need of more information about the efficacy of CBT with marginalized racial or ethnic groups.

More study of CBT efficacy in individuals with both SUD and MH disorders is also needed, but there is limited evidence of efficacy for people with SUD and depression or anxiety (Brown, Evans, Miller, Burgess & Mueller, 1997; Hobbs, Kushner, Lee, Reardon & Maurer, 2011; Tiet & Mausbach, 2007), bipolar disorder (Weiss et al., 2007), PTSD (Hien, Cohen, Miele, Litt & Capstick, 2004; McGovern, et al., 2009; Tiet & Mausbach, 2007), or schizophrenia (Barrowclough et al., 2001; Haddock et al., 2003, Tiet & Mausbach, 2007).

Milby and his colleagues have used CBT for alcohol or drug-abusing homeless individuals. In one study comparing a combination of relapse-prevention-based day treatment, vocational training and abstinence-contingent housing to contingent housing and vocational training alone, Milby et al. (2008) found that the day treatment containing CBT resulted in greater sustained abstinence over a 12 month follow-up period. Reviews and meta-analyses of treatment for criminal justice populations conclude that CBT is an EBP during incarceration or community supervision (Prendergast, 2009; Landenberger & Lipsey, 2005).

Implementing CBT—Like other treatment approaches, CBT is a complex set of treatment strategies. Simpson (2002, pp. 179) maintains that, for interventions at this level of complexity, “intensive training, clinical supervision, and possibly formal certification” are needed. Training of this type is rarely available in substance abuse treatment settings (Olmstead, Abraham, Martino & Roman, 2012). Thus, clinicians must receive it either in their initial training or as continuing education. There are a number of CBT manuals for treating SUDs. For example, a manual for treating cocaine addiction (Carroll, 1998) is available through the National Institute on Drug Abuse (http://www.drugabuse.gov/TXManuals/CBT/CBT1.html), and an alcohol treatment manual (Monti et al., 2002) is commercially available. Access to a manual alone is unlikely to confer a high level of clinician competence and fidelity in delivering the treatment. Web-based and in-person training are available from a variety of sources, and it is important to provide onsite clinical supervision.

Contingency Management

Description—Contingency management (CM) is a behaviorally based treatment that entails provision of incentives as a reward for changes in a targeted behavior, namely SU. The first interventions that resembled CM cropped up in the 1960s and involved changes in environments (e.g., using work opportunities or phone privileges) to incentivize desired behaviors (Cohen, Liebson, Faillace, & Allen, 1971). Since these early beginnings, CM has evolved into a highly structured and well-studied treatment for SUD. The core tenets of all CM protocols being disseminated today involve: 1) monitoring of target behavior (e.g., through during-treatment urine drug screening); 2) immediate reward of the desired behavior (e.g., provision of incentive upon the receipt of a drug-free urine specimen); and 3) withholding the incentive in the absence of the desired behavior (Petry, 2012).

Types of CM—Variants of CM based on the above principles have arisen, differing primarily by incentive type and scheduling. For example, a distinction has been made between voucher-based (e.g., monetary or gift card incentives) versus prize-based (e.g., "fishbowl"; (Petry, Martin, Cooney, & Kranzler, 2000) incentive structures. In voucher-based structures the client earns vouchers in exchange for a drug-negative urine specimen (or another behavior, such as treatment attendance); the vouchers start at a certain value and increase or decrease in value depending upon consecutive drug tests. Prize-based incentives offer clients chances to win prizes of different sizes in exchange for negative drug screens. The research literature is flush with studies comparing various CM strategies to each other (see Stitzer & Petry, 2006 for a review) and to other psychosocial treatment like 12-Step therapy (Higgins et al., 1991) and "usual care" (Peirce et al., 2006; Petry et al., 2005).

Empirical support—Overwhelmingly, the abovementioned supports CM's efficacy in increasing the odds of abstinence at treatment completion. Meta-analytic reviews of CM support its efficacy (Lussier, Heil, Mongeon, Badger, & Higgins, 2006; Prendergast, Podus, Finney, Greenwell, & Roll, 2006), and one independent review of psychosocial treatments for SUD singled out CM as showing a stronger effect than relapse prevention or CBT (Dutra et al., 2008). Such positive results have been found in a variety of settings, including methadone maintenance programs (Griffith, Rowan-Szal, Roark, & Simpson, 2000; Lussier et al., 2006; Prendergast et al., 2006), detoxification (McCaul, Stitzer, Bigelow, & Liebson, 1982), and psychosocial outpatient clinics (Petry et al., 2005). Furthermore, CM has been shown to be efficacious with virtually all drugs of abuse (see Petry 2012 for a review).

Evidence-based for whom—We are aware of just three studies of CM outcomes that considered race or ethnicity, one in which the study used ethnicity as a covariate in predicting CM outcomes (Stitzer et al., 2007). The other two studies examined ethnic differences (Caucasian, African American, and Hispanic) among individuals assigned to standard methadone treatment or standard methadone treatment plus CM (Barry, Sullivan, & Petry, 2009; Barry, Weinstock, & Petry, 2008). In all three studies, race/ethnicity did not appear to have a significant role in treatment outcomes. Although this research suggests CM should be effective regardless of race or ethnicity, it is too soon to draw firm conclusions.

Researchers have also specifically examined CM's use with vulnerable groups including dually diagnosed and homeless individuals. Drebing et al. (2007) examined the efficacy of CM in Veterans with co-morbid SU and other psychiatric disorders from a vocational rehabilitation program. The CM group demonstrated better job search tasks than the vocational-rehabilitation-only group; SU outcomes were not as robust, with no differences between groups in abstinence at follow ups. Other research demonstrates more promising results for the impact of CM with dually diagnosed individuals (See Petry, 2012). Such research is encouraging about the versatility of CM and its potential to generalize to a variety of groups.

Implementing CM—Implementation of this EBP has been slow, despite its efficacy. Clinician concerns about applicability, whether effects are long-lasting, and the costs of providing incentives have been identified (Rash et al., 2012). Recent effectiveness trials carried out in community programs (Peirce et al., 2006; Petry et al., 2005) indicate that contingencies can be implemented in the community. Combining CM with other interventions, such as CBT or the Community Reinforcement Approach (CRA – discussed below) can address concerns about maintenance when contingencies are withdrawn. Prize-based CM has also proven to reduce costs compare to voucher-based CM.

Correctly administering CM can be challenging, and therefore is another barrier to implementation. Although conceptually simple, CM requires some degree of precision in

order to be effective at reducing SU (Petry, 2012). Incentives that are poorly timed or inconsistent undermine the effectiveness of the treatment, resulting in dissatisfied clients and clinicians alike. However, social workers interested in this psychosocial treatment have available resources to aid efforts in implementation. The Blending Initiative, a collaborative effort between the National Institute on Drug Abuse and SAMHSA's Addiction Technology Transfer Center network, developed three training products designed to help agencies learn about and implement CM (http://www.bettertxoutcomes.org/bettertxoutcomes/). Here, individuals can engage in a free, self-paced training in CM (also called Motivational Incentives). Such products can help disseminate EBPs in settings where social workers have a strong presence.

Community Reinforcement Approach

Description—The Community Reinforcement Approach (CRA) was first developed by Nathan Azrin for treating alcohol dependence (Azrin, Sisson, Meyers & Godley, 1982). Its use by Stephen Higgins and colleagues to treat cocaine dependence (1991) launched a profusion of research on the efficacy of CRA-based approaches to treating addiction. The theory of operant reinforcement, the basis of this approach, posits that SU is maintained by certain reinforcers, for example, the positive effects of a drug, or the ability to avoid difficult emotions by using a drug. In order to change, a person must cease to be positively (or negatively) reinforced for SU and must develop competing sources of reinforcement. In addition, they must receive positive reinforcement for abstinence. CRA is usually, but not always, combined with some form of direct reinforcement of abstinence or CM.

CRA is commonly delivered on an individual basis over multiple sessions. It is individually tailored; not all components are provided to every client. The CRA clinician is directive, collaborative and active. The client is expected to be active in sessions, as well, participating in skill practice, including behavioral rehearsal and role play. CRA is structured around helping the client bring about change in four life areas: family; recreation; social relationships; and job. CRA content, selected based on relevance to the client, may include: functional analysis of triggers and consequences of SU; self-management planning; sobriety sampling, i.e., trying a period of sobriety; communication skills training; lifestyle changes, including time management, changing social recreational patterns, social skill and problem solving training; mood monitoring, job-finding training, relaxation training, and HIV risk reduction. An important component for those with a significant other is relationship counseling, i.e., changing the way in which significant others reward SU or abstinence. For those with alcohol dependence, CRA often includes administration of disulfiram (antabuse), and, if applicable, monitoring of disulfiram adherence by one's significant other.

Types of CRA—As an individualized treatment, CRA varies from client to client. In addition, there are two main variants, adolescent CRA (ACRA) and CRAFT (Community Reinforcement and Family Training). The former is a specific adaptation to adolescents that includes developmentally appropriate material and parent involvement (Meyers, Roozen & Smith, 2011). The latter is an evidence-based behavioral intervention to help concerned family members engage substance users into treatment (Meyers, Miller & Smith, 2001; Roozen, de Waart & van der Kroft, 2010). In addition to these two, there is a web-delivered version of CRA, the Therapeutic Education System (TES), that shows promise for treating opioid-dependent individuals receiving buprenorphine treatment (Bickel, Marsch, Buchhalter & Badger, 2008) and is being tested with a heterogeneous group of substance abuse treatment clients in a large-scale effectiveness trial in the NIDA CTN (Campbell et al., 2012).

Empirical Support—Regarding comparison of CRA to Treatment As Usual (TAU) among adults (Roozen et al., 2004), CRA plus abstinence-contingent voucher reinforcement is highly effective in helping cocaine users initiate and maintain abstinence. In adult alcohol treatment, CRA compared to TAU produces fewer drinking days and may have an effect on continuous abstinence. Research with primary opioid users is limited, but CRA may be a useful adjunct to detoxification or methadone maintenance treatment (Roozen et al., 2004). For adolescents with cannabis abuse or dependence, CRA is one of several efficacious interventions (Dennis et al., 2004)

Evidence-Based for whom—There has been little attention to whether CRA is effective for different cultural, racial or ethnic groups. A number of the CRA studies have been carried out with predominantly white samples (e.g., Bickel et al., 2008; Higgins et al., 2007). One study assessed equivalence of treatment response to Adolescent CRA across African American, Hispanic, White, and "Mixed/Other" groups and found no differences (Godley, Hedges & Hunter, 2011). There is limited evidence that CRAFT, the intervention for concerned significant others, was as effective with (moderately to highly acculturated) Latino families as with European American families (Lopez Viets, 2012).

A modified group version of CRA was effective with homeless alcohol-dependent (mostly male) adults (Smith, Meyers & Delaney, 1998), and CRA was more effective than TAU at reducing SU, improving social stability and reducing depression among homeless adolescents at a drop-in center (Sleznick, Prestopnik, Meyers & Glassman, 2007).

Among pregnant and parenting women, CRA was no more effective than 12 Step Facilitation (discussed below) at achieving cocaine abstinence (Schottenfeld, Moore & Pantalon, 2011). However, both treatments were offered with contingent versus non-contingent voucher reinforcement, and contingency management did increase abstinence.

Implementing CRA—To use this effective form of treatment, clinicians need to learn a complex set of behavioral treatment skills. Interviews with community providers identified a "burdensome" and time-consuming certification process as a primary barrier to implementing ACRA in their program (Amodeo et al., 2011). Such perceptions would need to be addressed, perhaps through clarifying expectations at the beginning of the training process or through streamlining the process. For clinicians interested in learning more about CRA, NIDA published a CRA + Vouchers manual for cocaine addiction (Budney & Higgins, 1998), available at http://archives.drugabuse.gov/TXManuals/CRA/CRA1.html, and Dr. Robert Meyers' website, http://www.robertjmeyersphd.com/, lists scheduled trainings.

Motivational Interviewing – Motivational Enhancement Therapies

Description—Motivational Interviewing (MI), initially developed and studied by William R. Miller (Miller & Rollnick, 2002), places its primary emphasis on cognitive aspects of behavior change. Motivation is seen as a dynamic phenomenon that is a critical component to maintaining or changing addictive behavior. One theoretical framework important to understanding and applying MI is the Transtheoretical Model of Change (Prochaska, Johnson & Lee, 2009). According to this model, individuals may be at various stages of readiness to change behavior. MI meets the client's stage of change and uses strategies to help the individual progress and develop his or her own motivation.

In MI the clinician is supportive, empathic and directive and builds an alliance that helps the client feel comfortable exploring ambivalence. MI involves relationship-building but is also a very strategic therapy in which the clinician pays close attention to the client's discourse

and adjusts the intervention accordingly. The "spirit" of MI is thought to be an important set of ingredients, that is, the extent to which a treatment session involves collaboration with client, evocation of client ideas, and support of client autonomy. While responsibility for change rests with the client, the interaction between clinician and client is the key to whether the client's motivation to change is affected by an MI session.

MI interventions often range from one to four sessions, although there is no directive against using MI across more than 4 sessions. A form of MI called Motivational Enhancement Therapy (MET) involves giving the client feedback about either formal or informal assessments, and, in some interventions this includes use of a written feedback report. There are five primary MI skills in the clinician's toolbox: asking open questions; listening reflectively; affirming; summarizing; and eliciting change talk. The clinician may explore ambivalence through eliciting the client's perceptions of the "good" and "not so good" things about their SU. Assessing importance of change, confidence in ability to change, and readiness for change using a "readiness ruler" is also a key technique.

Types of MI/MET—MI is a stance and a set of strategies for working with a client around behavior change. MET incorporates MI in a more structured intervention involving assessment and feedback. MI/MET may be used as a primary intervention in a treatment setting, prior to treatment to engage a client in another form of treatment, such as CBT, or as stand-alone opportunistic brief intervention to motivate contemplation of help-seeking or change. Although MI/MET is usually delivered individually, there have been studies of group delivery (Brown et al., 2006; Michael, Curtin, Kirkley & Jones, 2006). More information is needed about the efficacy of the latter (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). Screening, Brief Intervention and Referral to Treatment (SBIRT) is a type of intervention delivered in medical or workplace settings (SAMHSA, 2012) that often incorporates MI strategies and MET-type feedback. Brief interventions delivered through interaction with a computer are another variation on MI/MET (Hester, Squires & Delaney, 2005; Ondersma, Chase, Svikis & Schuster, 2005).

Empirical Support—A recent meta-analysis of MI studies across a number of different health-related outcomes (Lundahl et al., 2010) concluded that MI "does exert small though significant positive effects across a wide range of problem domains, although it is more potent in some situations compared to others, and it does not work in all cases." (pp. 150–151). MI has had its largest effects when compared to no intervention, a waiting list control, or unspecified treatment as usual (TAU). In a number of studies, it has not been different than other active treatments, such as CBT or twelve-step facilitation (Lundahl et al., 2010). The fact that it is a briefer intervention than these other active treatments makes it potentially more cost-effective.

There is evidence of MI or MET efficacy for alcohol (Sellman, Sullivan, Dore, Adamson & MacEwan, 2001), and marijuana (The Marijuana Treatment Project Research Group, 2004) users. Results are less straightforward for other drugs, such as cocaine; efficacy may differ depending on the extent of use (Stein, Herman & Anderson, 2009) and is sometimes evident for secondary outcomes but not cocaine use (McKee et al., 2007). Adolescent substance users also benefit from MI/MET (Monti et al., 1999).

Evidence-based for whom—There are conflicting findings regarding the efficacy of MI/MET for African Americans (Lundahl et al., 2010; Montgomery, Burlew, Kosinski, & Forcehimes, 2011). However, a culturally-specific adaptation of MI for African Americans had long term positive effects on drug use (Longshore & Grills, 2000). MI/MET has been adapted for Native Americans (Venner, Feldstein & Tafoya, 2007), and MI improved drinking outcomes in American Indian DWI offenders (Woodall, Delaney, Kunitz,

Westerberg & Zhao, 2007). A recent large-scale study of MET delivered in Spanish to Hispanic Americans had results parallel to a similar study conducted with a diverse sample; MET improved SU outcomes compared to a TAU control only among primary alcohol users (Carroll et al., 2009).

For dually diagnosed individuals with serious mental illness, Cleary et al.'s review concluded, "MI had the most quality evidence for reducing SU over the short term, and, when combined with CBT, improvements in mental state were also apparent." (Cleary, Hunt, Matheson & Walter, 2009; pp.248). MI was able to improve treatment entry rates in homeless veterans (Wain et al., 2011) but has been less successful at reducing SU among homeless adolescents (Baer, Garrett, Beadnell, Wells & Peterson, 2007; Peterson, Baer, Wells, Ginzler & Garrett, 2006)

Studies of MI/MET targeting perinatal smoking, alcohol use or drug use are inconclusive (Gilinsky, Swanson & Power, 2011; Stotts, DeLaune, Schmitz & Grabowski, 2004; Tappin et al., 2005; Winhusen et al., 2008). There is not strong support for using MI/MET as a stand-alone intervention with pregnant women, but more well-controlled research is needed.

McMurran (2009) reviewed studies of MI efficacy with criminal offenders and concluded that there is evidence of promise in improving treatment retention among substance using offenders, and that MI can lead to increases in readiness to change. Regarding behavior (SU) change, however, she concluded that study results are equivocal. The review recommended "more and better research" (pp. 97) on MI with criminal justice populations.

Implementing MI/MET—Like CBT, MI is a complex intervention requiring expert training and supervision to achieve competence on the part of a clinician. The desire for widespread dissemination of MI has led researchers to conduct a number of studies of what kind of clinician training achieves the best learning and retention of MI skills. From these studies, it is clear that ongoing coaching or supervision beyond an initial workshop training is needed (Martino et al., 2010; Miller, Yahne, Moyers, Martinez & Pirritano, 2004); and that, even with good training and supervision, learning and retaining MI skills is not easy for all clinicians (Baer et al., 2009; Smith et al., 2012). An international organization of MI trainers exists (http://www.motivationalinterviewing.org/), through which nearby trainers can be identified. The NIDA/SAMHSA Blending Initiative produced *MIA-STEP, Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency* (http://ctndisseminationlibrary.org/PDF/146.pdf), materials to aid in training clinical supervisors.

Twelve Step Facilitation (TSF)

Description and Types of TSF—Attendance and involvement in the mutual recovery support programs of Alcoholics Anonymous (AA), Cocaine Anonymous (CA) or Narcotics Anonymous (NA) are an important component of recovery for many individuals with SUD. Research on the efficacy of AA demonstrates the efficacy of support group attendance (Fiorentine, 1999) and program involvement (Kelly, Stout, Zywiak & Schneider, 2006), particularly for those who participate in both formal treatment and AA (Fiorentine & Hillhouse, 2000). What is meant by involvement is active participation, (i.e., saying something at a meeting, finding a sponsor, reading Twelve Step literature, "working" the steps, or helping at meetings). Twelve-Step Facilitation (TSF) is a form of treatment that seeks to increase attendance and involvement with Twelve Step recovery.

The common elements of TSF interventions are introducing the participant to the Twelve Step program and encouraging active participation in the program. It is common to introduce and discuss the first three steps (e.g., Nowinski, Baker & Carroll, 1992): 1. Acceptance of powerlessness over alcohol/drug; 2. Surrender – believing a greater power

can restore one; and 3. Surrender – turning lives and will over to that greater power. In addition, becoming active -working the Steps, being involved in meetings - is emphasized. The Project Match TSF treatment consisted of 12 weekly individual sessions (or 10 individual and 2 conjoint sessions with a significant other). The therapist used a common format for all sessions that included reviewing the participant's journal of meeting attendance, reviewing slips, urges, and sober days, introduction of new conceptual material, and recovery task assignments.

Two EBPs that incorporate 12-Step philosophy are the manual-based Individual Drug Counseling (IDC) (Mercer & Woody, 2004) and Group Drug Counseling (GDC) (Daley, Mercer & Carpenter, 1998). In the most recent study of these treatments (Crits-Christoph, Connolly Gibbons, Ring-Kurtz & Present, 2009), IDC was delivered twice a week for one month and once a week for two months; GDC consisted of 12 weekly sessions. Both drug counseling treatments treat addiction as a disease and encourage mutual support group participation.

Quite a different approach to TSF is the group-delivered intervention, *Making Alcoholics Anonymous Easier (MAAEZ*) (Kaskutas, Subbaraman, Witbrodt & Zemore, 2009). Instead of focusing on the 12 Steps themselves, the 6-session intervention seeks to overcome potential barriers to participation and explain how to make use of AA. Session topics are*: Introduction; Sprituality, Principles Not Personalities, Sponsorship, and Living Sober*. Recovering counselors deliver MAAEZ using a combination of lecture, discussion and homework assignments.

Yet another approach to TSF is interventions that use an intensive referral and "buddy system" to engage individuals in their first meetings (Timko, DeBenedetti & Billow, 2006). Typically, a counselor will assist a client in making a connection with a volunteer active self-help group member who agrees to meet the client at a meeting.

Empirical Support—There is strong research support for the ability of TSF interventions to increase attendance and active involvement in 12 Step fellowships, to improve drinking or other SU outcomes, and to have long-lasting effects (Carroll et al., 2000; Donovan & Floyd, 2008; Project Match Research Group, 1997; Timko et al., 2006; Timko & DeBenedetti, 2007). For stimulant users (cocaine or methamphetamine), there are mixed results of TSF. In the Cocaine Collaborative Treatment Study (Crits-Christoph et al., 1999) IDC plus GDC were superior to GDC-only and to individual cognitive or supportive-expressive therapy combined with GDC. Among alcohol and cocaine dependent adults, Carroll et al. (2000) found both TSF and CBT superior to a clinical management condition at reducing during-treatment alcohol and cocaine use. A recent study comparing TSF added to TAU to TAU-alone found that stimulant users receiving TSF were more likely to be abstinent during treatment than those in TAU, but among those who were not abstinent, TSF participants used stimulants on more days (Donovan et al., 2012). For alcohol dependence, TSF was comparable to MET and CBT in Project Match (Project Match Research Group, 1997). The Timko et al. (2006) study of intensive referral was with a heterogeneous substance abuse treatment sample.

Evidence-Based for whom—Racial or ethnic differences in response to TSF have been evaluated. In Project Match, Hispanic clients did less well in TSF than in other therapies, unlike non- Hispanic clients (Arroyo, Miller & Tonigan, 2003). As previously mentioned, there were no differences between African American and white cocaine abusers in their response to TSF versus CBT (Milligan et al., 2004).

Implementing TSF—In treatment settings that are 12-Step oriented or that already encourage 12-Step participation among clients, TSF constitutes a more structured approach than the one typically used. Among clinicians who already adhere to a 12 Step approach in treatment, the main barrier to learning TSF would not be attitude toward the approach but learning the specific structure of the treatment, whether this entails learning to deliver treatment sessions from a manual or to structure initial contacts between a client and a community volunteer. In addition, for clinicians not steeped in 12-Step philosophy, learning about the evidence supporting the positive effects of mutual recovery support participation is likely to remove barriers to learning and implementing TSF. The Project Match TSF manual is available at http://dionysus.psych.wisc.edu/CourseWebsites/PSY411/Articles/NowinskiJ1999a.pdf, and the manual for combined group and individual TSF that includes both 12-Step information and intensive referral (Donovan et al., 2012) can be found at http://ctndisseminationlibrary.org/display/888.htm.

Family-Based Treatments

Description and types of family-based treatments—While family members can influence the development and maintenance of SUD, they can also play a role in successfully intervening and helping an individual achieve abstinence. Researchers discuss the idea that the relationship between substance abuse and relationship distress is transactional, as opposed to linear, citing evidence indicating that SU increases relationship distress, and conversely, that relationship distress may lead to increased levels of SU behavior (Birchler, Fals-Stewart, & O'Farrell, 2005; Fals-Stewart, Lam, & Kelley, 2009). The idea that family issues are important in the context of substance abuse treatment has meant that family-based approaches to substance abuse treatment are increasingly gaining attention and empirical support. Rowe's (2012) recent review of family therapy for drug abuse highlights this shift when she concludes that family-based approaches are "consistently recognized among the most effective approaches for treating both adults and adolescents with drug problems" (p. 59).

"Family-based approaches" for SUD encompasses a number of separate treatments, each with their own conceptual framework and evidence base. Five specific therapies appear to have the strongest empirical support. 1) Behavioral Couples Therapy (BCT; O'Farrell & Fals-Stewart, 2006) is a couples therapy based on the behavioral conceptualization of substance abuse and works "directly to increase relationship factors conducive to abstinence" (Birchler, et al., 2005, p. 256). 2) Brief Strategic Family Therapy (BSFT; Szapocznik, Hervis, & Schwartz, 2003) is grounded in family systems theory and targets adolescents' substance abuse and other problematic behavior by facilitating changes in the family's patterns of interaction. 3) Multidimensional Family Therapy (MDFT; Liddle, 2002) also targets adolescent substance abuse and behavioral problems; this approach addresses SU and problematic behavior by intervening at a number of levels (e.g., the individual adolescent, parent, family environment, and extra-familial influences). MDFT integrates developmental psychology, the ecological perspective, and family therapy. 4) Multisystemic Therapy (MST; Henggeler & Borduin, 1990) operates from a social ecology perspective, recognizing the many systems in which an adolescent exists (e.g., family, peer group, school, and neighborhood), and addressing risk/protective factors that influence SU behavior. 5) Functional family therapy (FFT; Alexander & Parsons, 1982) is derived from both behavioral and systems-oriented theoretical frameworks, designed with the goal of enhancing communication and supportiveness while also changing maladaptive familial patterns.

Empirical support—As a group, the family-based psychosocial treatments have undergone a sharp increase in clinical trials yielding promising results. For example, the

empirical backing for BCT is quite strong. BCT outcome studies done with both alcohol and drug users indicate the efficacy of this treatment over individual therapy in terms of SU outcomes, relationship outcomes, relationship aggression, and cost-effectiveness (for a review, see Fals-Stewart, Lam, et al., 2009). Family approaches appear to be the gold standard for treating adolescent substance abuse, and evidence for family-based models continues to grow and strengthen. A recent meta-analysis of four family therapies targeting adolescent substance abuse (i.e., BSFT, FFT, MDFT, MST) indicated that these therapies had statistically significant effects compared to TAU or an alternative therapy (Baldwin, Christian, Berkeljon, Shadish, & Bean, 2012). While the effects shown in this meta-analysis were relatively small, other meta-analyses support the use of these treatments as efficacious for targeting SU with adolescents (Rowe, 2012). Taken together, the established family-based approaches have gained a strong evidence base, and they are an important class of psychosocial treatments for SUDs.

Evidence-based for whom—BSFT, MDFT and MST all demonstrate strong potential for working well with ethnic minority youth and their families. Of note, BSFT originated in a setting where a high proportion of immigrant Hispanic families were served (Szapocznik & Williams, 2000). Perhaps owing to its development with the unique treatment needs of Hispanic youth and families in mind, studies have showed that BSFT is efficacious with this group (e.g., Santisteban et al., 2003). Reviews of family-based interventions targeting adolescent substance abuse indicate that the researchers testing these interventions take care in examining these treatments' differential effects on marginalized groups. For example, Hogue and Liddle (2009) note that, of the majority of the controlled trials for adolescent substance abuse they reviewed, at least 50% of the sample was comprised of racial or ethnic youth. Another review (e.g., Rowe, 2012) shows support of MDFT, BSFT, FFT, and MST for their use with specific minority groups. Research testing BCT does not have the same emphasis on differentiating treatment effects with various ethnic minority groups. However, BCT researchers have reported clinically notable gender effects, such that with opposite gendered couples, female substance abusing partners tend to have a need for more relationship oriented interventions, whereas substance abuse focused interventions appear to be more important when working with substance abusing male partners (Birchler, et al., 2005). Results from a study testing BCT with gay and lesbian alcohol abusing patients indicate that participants in the BCT group had better SU and relationship-focused outcomes than those in individual treatment (Fals-Stewart, O'Farrell, & Lam, 2009). Finally, there is some evidence to suggest the use of BCT with individuals diagnosed with a SUD and combat-related PTSD (Rotunda, O'Farrell, Murphy, & Babey, 2008).

Implementing family-based treatment—While the empirical support for family-based approaches is promising, the considerable challenges in implementing them may preclude their use in certain settings where social workers practice. To administer family therapies, social workers need not just be trained in the specific EBP; they also need more general and comprehensive training in family therapy and its theoretical underpinnings. Whittinghill (2002), pointed out that many substance abuse treatment providers are undertrained in family therapy techniques. Researchers who develop and test family-based treatments for SUDs obviously have a stake in the uptake of these therapies, and therefore they appear to be attending to the research-practice gap. Rowe (2012) summarizes dissemination efforts put forward by the MST, MDFT and BCT teams, highlighting strategies designed to increase the likelihood that the therapies will be administered with fidelity and improve client outcomes. The accompanying research on dissemination and implementations of these therapies seems promising.

The Matrix Model

Initially developed for stimulant abusers, the Matrix model (Rawson et al., 1995) is an example of how psychosocial treatments come about within a context of larger social influences. This treatment was developed during the crack epidemic of 1980s, a time when treatment facilities were largely geared towards inpatient treatment of alcohol use disorders (Obert et al., 2000). Arising out of a need to provide outpatient treatment to primary cocaine abusers, developers of the Matrix model attempted to combine elements of empirically supported treatments that would accommodate the unique treatment needs of stimulant users in an outpatient setting. The treatment was further refined and made relevant by the sharp increase in methamphetamine use during the late 1990s; simultaneously responding to changes in SUD treatment systems, namely that treatment duration be shortened (Obert, et al., 2000). The resulting treatment is the 16-week, manualized protocol known as the Matrix Model.

Description—The Matrix Model combines elements from evidence-based psychosocial treatments already discussed in earlier sections including relapse prevention (a key component), 12-step facilitation, and family approaches (Obert, et al., 2000; Rawson, Obert, McCann, & Ling, 1991). The novelty of this approach lies in how these components are amalgamated and codified, as well the Matrix Model's emphasis on and unique integration of peer and family supports. In its current iteration, the Matrix outpatient program consists of three individual or conjoint family sessions, and 52 group sessions spanning 16 weeks; clients are counseled to participate in Matrix social support groups weekly during the aftercare phase (Center for Substance Abuse Treatment, 2006; Obert, et al., 2000). The Matrix Model begins with an intensive phase (weeks 1–4), which involves education of clients and their families about stimulant addiction, skills groups for achieving and maintaining recovery, and encouragement to engage in a 12-step recovery program. The family or other support people are considered crucial to the model; family members are encouraged to participate in individual/conjoint sessions and family education group sessions. During weeks 5–16, family education groups can be continued, but are significantly scaled back. Instead, the client continues to work on relapse prevention skills, attend 12-step meetings, and transitions to social support groups. Clients are exposed to peer support early on given that some skills groups are co-led by clients advanced in the program. Social support groups (also considered continuing care) start as the intensive phase of treatment begins winding down. Although led by a counselor, these groups are focused on helping clients resocialize with other individuals in recovery, while allowing those farther along in recovery to act as role models for newer members.

Empirical support—The first controlled trial comparing the Matrix model to referral to "other available community resources" showed that those in the Matrix group demonstrated a strong positive relationship between the dose of treatment received and cocaine negative urine results; this was not the case for the control group (Rawson, et al., 1995). Matrix participants also demonstrated positive dose-response associations with other psychosocial outcome variables, namely improvements in ASI employment and family composite scores. The next step in determining efficacy of the Matrix model was a multisite study comparing it to treatment as usual (TAU) in eight community treatment programs in three U.S. regions (California, Montana, and Hawaii; Rawson et al., 2004). This endeavor, called the Methamphetamine Treatment Project (MTP), was the largest randomized clinical trial targeting methamphetamine dependence at the time of its introduction in 1998. Resulting data from this project indicated no significant differences between Matrix and TAU groups in terms of SU and psychosocial functioning at both discharge and 6-month follow-up (Rawson et al., 2004). However, Matrix model participants had better treatment retention and completion rates than TAU participants.

Evidence-based for whom—The geographic areas included in the MTP reflected special populations: rural, Native Americans, Hawaiians and gay and bisexual men (Freese, Obert, Dickow, Cohen, & Lord, 2000). These populations were differentially affected by an influx of methamphetamine into their communities. The Matrix Institute has developed specific trainings and handouts that are culturally adapted for use with American Indian/Alaskan Natives (AI/AN; Matrix Institute on Addictions, 2012). In terms of evidence about the efficacy of the Matrix model with this target group, Dickerson et al. (2011) found that the AI/AN group had similar treatment outcomes to a comparison group; however, these authors did not separate the Matrix and TAU conditions. A specialized version of the Matrix model that added components addressing risky sexual behavior was also developed for gay and bisexual men, (Freese, et al., 2000). The tailored version of the approach showed reductions in risky sexual behavior (Shoptaw et al., 2005; Shoptaw, Frosch, Rawson, & Ling, 1997).

Implementing Matrix—The Matrix Model in its entirety may be difficult to implement depending on the constraints of the clinical setting. The Matrix Institute developed a certification process for programs wanting this designation, and the requirements may be outside the time and resource constraints of many publicly funded agencies. Furthermore, the Matrix Model specifies that certain groups are co-led by advanced clients. Having client-facilitators may present certain logistical challenges, and therefore represent another barrier in implementation of this treatment. Finally, like with family approaches, the Matrix model's inclusion of clients' families requires social workers to have skill in working with families.

Social workers interested in learning and implementing the Matrix model can utilize the free, online version of the manual (http://kap.samhsa.gov/products/manuals/matrix/index.htm.; Center for Substance Abuse Treatment, 2006). They should have previous training in group and individual therapy approaches, would benefit from previous training in basic CBT, and should have a high level of familiarity with the treatment of addictive behaviors. For this, as with other interventions, social work training programs should systematically integrate training in SU issues, better preparing social workers for adopting EBPs.

CONCLUSIONS

We have discussed the major, most-researched, EBPs in addiction. There are certainly other, less-well researched approaches, such as case management (Rapp et al., 2008), and emerging approaches, such as mindfulness-based interventions (e.g., de Dios et al., 2012), that we chose not to include but that could enhance social work practice in the addictions. In addition, it is necessary to consider the context in which one of these treatments might be delivered. Said context might include case management services in addition to delivery of the EBP; it may involve sequential or simultaneous delivery of more than one of the described EBPs, such as MI and CBT; and where efficacious medications exist, it might include both psychosocial treatment and medications (discussed elsewhere in this journal issue). In practice, clinicians use elements from a variety of EBPs (Gifford et al., 2012), and there is limited evidence for the efficacy of some combinations of the practices discussed here (McHugh, Hearon & Otto, 2010). Effective practice necessitates an understanding of the evidence-based psychosocial treatments and how these fit within holistic work with an individual. Also important is the ability to work within and across behavioral health and medical (primary care, emergency care, or hospital-based care) settings and systems to select, advocate, or deliver these EBPs.

In addition, SUDs are increasingly understood as chronic relapsing conditions requiring continuous monitoring, ongoing relapse prevention efforts, and a return to more intensive treatment when for some clients (McKay & Hiller-Sturmhofel, 2011). Many of the treatments discussed here have demonstrated short- but not long- term effects, and this makes sense when SUD is considered as a chronic condition. To be effective, treatments must be delivered in a system in which ongoing monitoring and support can take place and in which re-introducing a treatment strategy or changing treatment strategies can be done to accommodate client needs.

Next steps in social work education

The CSWE Educational Policy and Accreditation Standards (2008), and Center for Substance Abuse Treatment (CSAT) Addiction Counseling Competencies (2006) can together lay the groundwork for education of social workers in evidence-based psychosocial treatments for SUD. Both sets of standards reference research evidence as a basis of competent practice. These standards must be applied in dynamic interaction with emerging evidence in order to create a specialized curriculum geared towards addiction policies and services. Efforts to increase social work education in SUD treatment will ideally include course-work, practicum, and continuing education initiatives. They may also require collaboration with professionals outside of social work schools, such as SUD treatment researchers, SAMHSA-funded Addiction Technology Transfer Centers, and behavioral healthcare providers. Current standards and the body of intervention research support the enhancement of social work practice in the addictions, and it is incumbent upon individual institutions to determine how best to utilize these resources.

Next steps in social work research

Dissemination to, and adoption/implementation of EBPs by treatment organizations or systems is a complex process, and research on dissemination and implementation of SUD EBPs is in its early stages. Models and implementation research methods are just beginning to be applied to SUD treatments (Damschroder & Hagedorn, 2011). The ability to translate research to on-the-ground practice is a reciprocal process between researcher and practitioner social workers. Both these types of social workers will play key roles in translation science (Fong & Pomeroy, 2011). Social workers have long been identified as a primary professional group moving forward new practices and adaptations through innovative translational methodologies such as mixed methods and community engagement (Palinkas & Soydan, 2012); methodologies that are rooted in social work's distinctive strength based, culturally relevant practice and social justice framework (DiNitto, 2005). Continued social work involvement in translational research in the area of addiction will greatly enhance existing efforts.

Another way in which social workers can play a key role in EBP research is to focus on underserved populations. For each psychosocial treatment discussed above, we have identified some information about efficacy for underserved or marginalized populations; however, this information is difficult to locate, and in many cases it is lacking. Social work researchers are uniquely positioned to strengthen the evidence base by taking a closer look at these treatments and their applicability across communities and populations. In cases in which interventions do not exist that meet the needs of marginalized communities or populations, social work researchers again have the tools to develop or tailor and test new or adapted interventions.

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In summary

- There is an increased potential role for social work in developing policy and delivering addiction-related treatment services.
- Current social work education does not emphasize knowledge needed by social workers for this role.
- Evidence-based psychosocial practices for SUD exist that should be part of a social work practice armamentarium.
- There is a need for curriculum development for social workers in addiction.
- The evidence-base would be improved by greater social work research involvement in looking at how EBPs apply across communities and populations.
- It would also be improved by greater social work research involvement in developing, tailoring, and testing interventions.