

**A review of evidence-based interventions for the prevention and
treatment of substance use disorders**

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PART ONE: AN INTRODUCTION TO EVIDENCE BASED PRACTICES

1. What is the purpose of this report?

The purpose of this report is to describe and review evidence based practices (EBPs) for the four levels of care outlined in the Western Cape Department of Social Development's integrated service delivery strategy for substance use disorders (DOSD, 2007). These four levels of care refer specifically to prevention activities (specifically raising awareness of substance use disorders), early intervention strategies, community-based treatment, and aftercare services.

More specifically, this report will not only identify evidence-based practices and interventions for each of these levels of care, but will also provide examples of some of these EBPs and practical recommendations for how these EBPs can be implemented in local community settings in the Western Cape.

It is hoped that this review will encourage the adoption of evidence based practices in substance abuse services, which in turn will improve service quality and service outcomes for individuals with substance use disorders in the Western Cape.

Prior to outlining principles of effective practice for each of these levels of care, this report will 1) examine why evidence based care for substance use disorders is important, 2) provide a brief description of evidence based practices, and 3) will explore some of the potential challenges to implementing evidence based practices in the Western Cape.

2. Why is evidence based care for substance use disorders important for the Western Cape?

A recent review of substance abuse trends in the Western Cape highlighted the increased use of alcohol and other drugs in the province and the hefty burden these substances place on the health, social welfare and criminal justice sectors of the province (Harker, Kader, Myers et al., 2008). This evidence, together with increased calls from affected communities for additional substance abuse services, has placed pressure on the Provincial Department of Social Development (DOSD) to respond by placing additional resources into prevention and treatment services for substance use disorders.

However *service planners and policy makers within the department do not always have sufficient or objective information on the kinds of interventions that most effectively prevent the onset of substance use and treat the continuum of substance use disorders* (Myers, Louw, & Fakier, 2008). This review of evidence based practices is a response to a call from

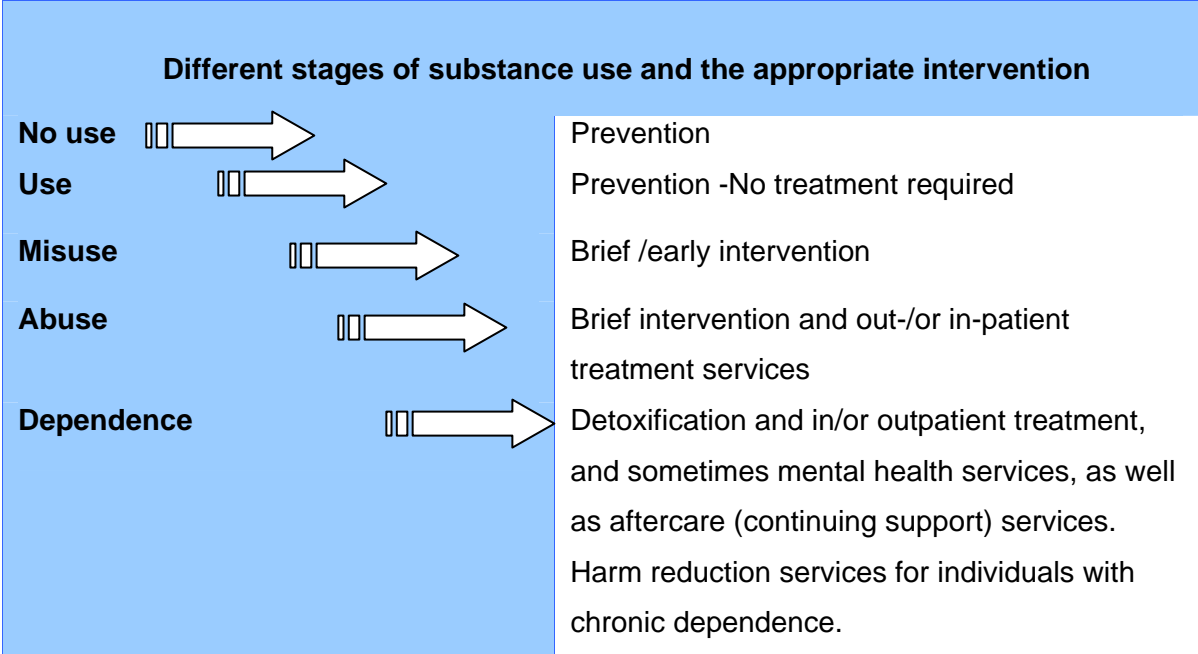
the DOSD for more information on what works best for the prevention and treatment of substance use disorders. It is the first step in ensuring that any programme implemented or supported by the Department has a sound rationale, theoretical framework and evidence for its effectiveness.

3. What are evidence based practices for substance use disorders?

3.1. The continuum of substance use disorders (SUDs)?

Substance use disorders, much like HIV/AIDS or diabetes, require psycho-social approaches to prevention and treatment, as well as medication and clinical interventions. Substance use disorders are commonly understood to occur along a continuum of severity ranging from no use through occasional/recreational use, misuse, abuse, with the end stage being dependence (NIDA, 1999). The World Health Organisation (WHO) (1993) recommends different intervention strategies for each level of severity, with interventions increasing in intensity as problem severity increases (see Figure 1). For example, universal prevention activities are appropriate for individuals with no substance use or occasional use as these activities attempt to prevent the onset of a disorder or problem use. In contrast, early interventions are appropriate for individuals with low levels of problem severity, and community based treatment services are suited to people with more severe substance use disorders.

Figure 1: Appropriate intervention strategies for each level of substance use



3.2. Understanding evidence-based practices

Evidence-based practices are practices, interventions or programmes for which there is a large body of research evidence in support of its effectiveness. Some of the criteria that are used to evaluate whether an intervention or practice is evidence-based include the following:

- **At least one randomised clinical trial has shown this practice/intervention to be effective**

These are the best research methods to test new or existing interventions.

- **The intervention/practice has demonstrated effectiveness in several replicated research studies using different population groups**

The intervention has proven to be useful for several different kinds of clients and is applicable to a range of contexts.

- **The intervention targets behaviours or has a good effect on behaviours that are generally accepted outcomes**

That is, the practice targets the outcomes that you hope to achieve. For example, a treatment model that leads to improved abstinence rates and not just improvements in quality of life.

- **The practice is based on a clear and well articulated theory of behaviour change**

Theory driven practice is preferred to eclectic, atheoretical approaches as theories are testable and lead to the generation of hypotheses. This is important when evaluating the effectiveness of an intervention.

- **The intervention/practice can be evaluated**

Evaluation or the measurement of behaviour outcomes is an essential part of research on intervention effectiveness.

- **The practice/intervention addresses cultural diversity and different populations**

The intervention should be applicable to a wide variety of client populations or be easily modified or adapted for different populations.

(The IOWA Consortium for substance abuse research and evaluation, 2003).

4. Challenges to implementing evidence-based practices (EBPs) in the Western Cape.

When considering the implementation and use of EBPs in the Western Cape, it is important to note several challenges to the uptake of these interventions. These challenges are not

insurmountable but do need to be considered when planning for the roll-out of new services- especially in traditional communities.

4.1. Language

In South Africa there are there are 11 official languages spoken and three official languages for the Western Cape. The staff at treatment centres mostly speak English and Afrikaans, while most South Africans speak one or more of the other eleven official languages of the country. There are very few African language speaking staff at treatment centres and most staff employed are fluent in only two of the official languages (namely English and Afrikaans) (Myers et al, 2005). *Translating EBPs, especially models of care, into different indigenous languages can be a huge challenge to the effective implementation of these EBPs. Translation of EBPs could prove challenging; may dilute the programme content; and may impact on the fidelity of the programme, especially if concepts are misinterpreted or wrongly translated.*

4.2. Indigenous Beliefs

In the Western Cape, people come from a range of ethnic backgrounds. Many black/African residents having strong indigenous belief systems and consequently traditional healers are sometimes the first point of contact for individuals with physical and mental health difficulties. For individuals with strong indigenous beliefs, medical treatment is only sought as a last resort and very reluctantly and suspiciously. People have more faith in traditional healers than in the medical/ western model of intervention. Currently, many substance abuse treatment centres in the Western Cape do not take cognisance of this fact and are not aware of or sensitive to these indigenous belief systems. Moreover, assessments and therapeutic interventions are also not culturally sensitive (Myers et al, 2005, Myers, 2007). *For EBPs to be effective in such a context there needs to be a good understanding of the various indigenous beliefs and practices. EBPs also need to be sensitive to cultural ways of understanding the world, health, illness, and recovery from illness.*

4.3. Family Context

In general, South African society is characterised by patriarchal family structures- particularly in black/African communities. Within families, elders (grandparents and other family members) are also consulted before important decisions are made and extended family members take an active part in raising and disciplining children and young decision is made. In essence, the child has many sets of parents. *In extended family systems such as these, it is difficult to identify the target of family-based interventions. As a result, family-based EBP can be quite difficult to implement.*

Traditional ways of communicating between parents and children can also pose challenges for implementing EBPs. In some communities, open and frank communication between parents and children is discouraged and viewed as disrespectful. *As a result, one would need to proceed with caution when teaching adolescents effective communication and assertiveness skills (as happens in certain prevention interventions and in cognitive behavioural approaches). This should only occur with the knowledge and support of extended family members.*

4.4. Environment and Social Context

An underlying assumption of systems theory is that problem behaviour develops within the context of an individual's social ecology, which includes family, peer, and neighbourhood influences. Some evidence-based interventions are delivered within the home and community context in which the problem behaviours occur. For many communities in the Western Cape (especially those that are most in need of substance related prevention and treatment services), the social-ecological context in South Africa is one of poverty, high rates of unemployment, poor housing and limited basic services. This leads to overcrowding, high levels of social and health problems (including substance use disorders, crime, and HIV). *Although implementing evidence-based interventions are important in all contexts, it is also important to address these broader structural issues as these factors impact on the availability of illicit drugs as well as the efficacy of interventions.* For example, it is often more difficult for individuals to maintain sobriety post-treatment in environments where alcohol and drug use is normalised and in environments where there are limited structures to support recovery (Myers, 2007).

Even with these challenges, EBPs for the prevention and treatment of substance use disorders should be implemented wherever possible. The following section outlines EBPs for universal prevention, early intervention, community-based outpatient treatment and aftercare.

PART TWO: AN OVERVIEW OF EVIDENCE BASED PRACTICES

1. AWARENESS AND PREVENTION

Drug prevention work in South Africa was historically based on opinion rather than evidence of effectiveness (UNODC, 2004). In more recent years, concerns have been raised about the quality of substance use prevention in the country and the need for effective, evidence-based approaches to prevention (Harker et al., 2008). In the past two decades, there have been major increases in knowledge on how best to prevent substance use disorders (SUDs). Yet it is widely recognised that *no single prevention programme will be 100% effective in preventing the initiation of alcohol and drug use* (Cuijpers, 2002). In addition, it is also recognised that prevention programmes that meet evidence-based standards can be used and applied across a variety of settings and contexts, but may *require minor adaptations to make room for cultural differences and differing socio-economic environments*. While important, these adaptations should not affect the core structure and sequence of the programme (UNODC, 2004). The aim of this section is to provide guidelines for prevention practices, with the understanding that any programme needs to be adapted to meet the cultural and socio-economic needs of a South African audience (NIDA 2003, Foxcroft et al., 2003, Tobler, 2000).

1.1. What is prevention?

1.1.1. A working definition:

- Broadly, prevention can be defined as a proactive process that creates and reinforces conditions that promote healthy behaviours and lifestyles (Atkinson, 2004).
- With regard to substance use, prevention is most often defined as any activity designed to *prevent or delay the onset of substance use and reduce its health and social consequences* (World Health Organisation (WHO), 2002).
- In its narrowest sense, prevention targets individuals and their peers, and at the broadest level it takes the form of international treaties and structural interventions.

1.1.2. Types of prevention

Prevention activities are generally categorised as universal, selective or indicated (Medina-Mora, 2005). For the purposes of this review, the emphasis will be on universal prevention strategies only, however other types of prevention will be defined to highlight differences between each of these prevention types.

1.1.2.1. Universal prevention interventions

These target the general public or a whole population. School-based prevention programmes are a popular form of universal prevention among youth as schools facilitate easy access to a large part of this population (Burkhart, 2007; Faggiano et al., 2005). Other universal interventions include educational interventions aimed at preventing the onset of substance abuse via awareness raising and information-sharing activities (Foxcroft et al., 2003). These are the most common prevention activity in South Africa.

1.1.2.2. Selective prevention interventions

Selective interventions are *aimed at subgroups of the population whose risk of developing SUDs is significantly higher than the general population.* Among young people, such interventions are mainly focused on young people at risk of leaving school early, dropouts, young offenders, and youth from high risk neighbourhoods (Arkinson et al., 2004; Burkhart, 2007). Identifiers for increased risk include falling school grades; use of alcohol and tobacco; conduct disorders; and alienation from parents, school, and positive peer groups (Burkhart, 2007; Medina-Mora, 2005).

1.1.2.3. Indicated interventions

These interventions *target individuals who are exhibiting early signs of problematic substance use and/or other problem behaviours.* This problematic substance use is then targeted through focused interventions. *Early interventions for substance misuse fall into this category of intervention.* See section 2 for more information on early interventions.

1.2. When is universal prevention an appropriate intervention strategy?

Universal prevention activities can be used to address the entire population with the main aim of delaying or preventing the initiation of alcohol and other drug use. More specifically:

- ***Universal prevention strategies are appropriate to use among individuals and at-risk-groups who have not yet started using alcohol and/or other drugs.*** Here programmes are delivered to large groups of people (national, local, community, neighbourhood or school and work settings) and the entire population is seen as at risk and capable of benefiting from the programme. Table 1 outlines appropriate target groups, strategies for and examples of universal prevention programmes.

A particularly important target group for universal prevention is children and adolescents.

Ideally, universal prevention should start prior to adolescence (Komro et al., 2008; NIDA, 2003). Views on alcohol and illicit substances change from pre-adolescence to adolescence. Therefore the best prevention initiatives give children the facts during pre-

adolescence, alert them to health and social consequences of substance use, and equip them with needed skills to prevent the initiation of substance use behaviours. Various risk factors for later substance use, such as early aggressive behaviour and low academic performance can also be dealt with and arrested during early childhood and preadolescence.

Table 1. Universal prevention: an overview of target groups and prevention strategies

Type of Prevention Programme	Target group	Prevention Strategy	Examples:
Universal	Everyone (individuals, families, schools, neighbourhoods, the community, the workplace)	<ul style="list-style-type: none"> • Information sharing and awareness raising • Education • Develop and implement policies around substance use • Regulations and law enforcement interventions 	<ul style="list-style-type: none"> • One-stop resource centres • Media campaigns • Brochures • Radio/TV campaigns • Community campaigns • Targeted law enforcement and community development activities • Restriction of advertising • Taxation • Broad structural interventions (Loxley et al., 2004)
	Schools-based programmes targeting adolescents and pre-adolescent children	<ul style="list-style-type: none"> • Education (information sharing) • Encouraging healthy alternatives • Focus on developing resiliency amongst youth (see table 2) • Psychosocial Approaches (building self-esteem) • Early identification of problems and appropriate referral 	<ul style="list-style-type: none"> • Teacher Training • School drug policies • Early identification and referral • Youth leadership activities • Peer leader and helper groups • After school programmes • Community recreation and drop-in centres • Peer resistance • Life skills or social skills training (Foxcroft et al., 2003)
	Community-based interventions targeting all members of a selected community	<ul style="list-style-type: none"> • Health education/ awareness raising • Crime prevention interventions • Whistle-blowing • Injury prevention • Harm reduction initiatives 	<ul style="list-style-type: none"> • Education on general health • Life skills training • Mental health promotion and prevention • Community improvement activities

- **Selective prevention programmes are suitable for use amongst individuals at risk for alcohol and other drug abuse by virtue of them being part of a particular population segment.** In South Africa, high risk groups include street children, school dropouts or children living with substance abusing parents. Selective prevention programmes are presented to the entire subgroup that is seen to be at risk.

- ***Indicated prevention services are appropriate to use in instances where individuals are experimenting with alcohol or drugs but have not yet developed problematic patterns of use.*** The aim of indicated prevention programmes is to identify individuals who are experimenting with alcohol or drugs and to limit the harms associated with this experimentation by targeting their substance use behaviour through focused prevention programmes.
- ***Primary prevention activities are not appropriate for individuals who already have established substance use disorders*** or problems related to their use of substances (e.g. family problems). For these individuals, early interventions or more intensive treatment options are more appropriate.

1.3. Core features of “good-enough” universal prevention activities:

1.3.1. Universal prevention programmes that are sustainable

Effective universal intervention strategies often include multiple years of intervention, are sustainable over time, and are not conducted on an ad hoc basis (McBride, 2003; NIDA 2003, NREPP, 2007, Komro et al., 2008). As such, *brief once-off interventions such as “prevention talks” should be avoided. Once-off interventions that simply educate persons about the dangers of alcohol and drug use do not prevent the initiation of alcohol and drug use or elicit changes in behaviour among persons currently using substances.* The use of scare tactics and one-line blanket messages such as “Just say No” have also been proven to be ineffective (UNODC, 2004).

1.3.2. Universal prevention programmes that are interactive and rely on experiential learning methods instead of didactic teaching techniques.

The use of experiential learning techniques including visual aids, small group exercises and the use of multiple media are more effective than traditional didactic teaching techniques. *Interactive techniques encourage participants to engage with the prevention material and the content of the intervention and are associated with better retention of information than traditional didactic methods* (Cuijpers, 2002; Ennett, 2003; Midford et al., 2002).

1.3.3. Universal prevention services that are flexible and are able to adapt to meet the needs of individuals, vulnerable groups and in some cases, target communities

No single prevention programme is appropriate to all individuals, target groups or communities- especially given South Africa’s diversity. Programmes therefore must be adapted to suit target groups and communities. More specifically, prevention services should be age-appropriate (i.e. adapted to meet the developmental needs of children in specific age groups), gender-sensitive and culturally appropriate (i.e. linguistically appropriate,

contextually correct, and sensitive to cultural diversity). Even evidence-based prevention programmes need to be adapted linguistically and culturally to meet diverse national and local circumstances. This is important as programmes that attempt to impose values or practices of one group on another without considering the culture of and resources available to the target audience are destined for failure. This is especially true when the target population is comprised of adolescents (Gullotta & Bloom, 2003) as adolescents are easily alienated by programmes that are not developmentally and culturally appropriate (Barth et al., 1991).

To achieve this goal, it is important when planning universal prevention programmes to always conduct a thorough assessment of the service needs of the target group.

1.3.4. Prevention programmes that strive to follow evidence-based principles.

While recognising that internationally-developed prevention programmes need to be adapted to the South African context, *evidence-based principles of effective prevention reach beyond geographic boundaries and (with minor adjustments) are applicable to the South African context.* These principles should always be adhered to (see section 1.4 for discussion).

While one cannot assume that a programme which works in one context will work in another (Komro et al., 2008), it is more cost effective to adapt a programme from elsewhere than to develop a new programme. Section 1.4.1.2 provides guidelines and recommendations for the adaptation of programmes which should be adhered to. It is especially important not to alter the content of a programme as adjustments to the content of the programme may alter programme effectiveness.

1.3.5. Universal prevention services provided by suitably qualified, trained and resourced staff.

For prevention programmes to be effective and to enable these programmes to adhere to best practice principles, *it is essential that substance abuse prevention workers are adequately trained in substance abuse issues and also in evidence-based prevention methods and programmes, especially given the scientific complexity of these services.*

Prevention projects such as Project Northland and Project Alert all place emphasis on the training of project implementers. Accredited training in substance abuse prevention as well presentation skills is always an advantage and improves the quality of services provided (Ennett, 2003; Atkinson et al., 2004). Within the South African context there are many prevention workers who have a history of substance abuse and have committed themselves to facilitating prevention workshops and talks. In instances where prevention workers have been sober for less than the minimum recommendation of two years (Harker et al., 2008), it

is recommended that these individuals receive regular, ongoing aftercare support- not as a monitoring measure but rather as a supportive measure (Harker et al., 2008).

1.4. Evidence-based principles of effective (universal) prevention:

Over time, several evidence-based principles for effective substance abuse prevention work have been identified (Foxcroft et al., 2003; Komro et al., 2008; Nation et al., 2003; NIDA 2003; UNODC, 2002). These principles hold, irrespective of whether the prevention strategies are universal, selective or indicated. This section describes these fundamental principles in detail.

1.4.1. Prevention programmes need to be adapted to ensure they meet the needs of the target population

As risk and protective factors for the onset of substance use (as well as related service needs) differ across target groups, prevention programmes need to be adapted to ensure that they address the specific risk and protective factors as well as the service needs of particular target groups and local communities (NIDA, 2003). Adapting programmes to fit the needs of the target population helps ensure the *relevance and appropriateness* of the programme to the target population (Mentor UK, 2005). *Matching and adapting prevention programmes and services to local community settings, risk factors and needs is therefore a critical component of effective prevention.*

1.4.1.1. Recommendations for ensuring programmes meet the needs of the target population

To ensure this principle is adhered to, it is important to always conduct a *formative phase of project development prior to implementing large-scale prevention projects* (McBride, 2003). This formative phase is essentially a pilot-testing phase during which project implementers examine whether the programme is reaching the target population and addressing their specific needs. During this formative phase, project planners should examine the 1) *structure, content and organisation* of the programme to ensure it is relevant and appropriate for the target population and 2) consider the audience and whether the programme meets the audience's needs (NIDA, 2003) via *conducting needs assessments* prior to developing and implementing prevention programmes (Mentor UK, 2006). When conducting this needs assessment it is important to use relevant data from a reputable source. Policy makers and prevention workers should guard against "hearsay" or what they perceive is needed. It is always important to gain inputs from the target audience regarding their perceived needs and concerns (NIDA, 2003).

1.4.1.2. Recommendations for the adaptation of evidence-based interventions

When adapting evidence-based interventions for new settings and contexts, one should always adhere to the following guidelines to ensure an appropriate degree of programme fidelity. Kumpher et al. (2008) suggest 1) implementing a programme that only requires minor adaptations (such as minor changes to words, phrases or examples), 2) monitoring and evaluating this programme, and 3) only then embarking on a deeper process of adaptation. More specifically, *minor adaptations of programmes* refer to the process of inserting culturally appropriate greetings, phrases and activities. As such, minor adaptations to programmes should never affect the core structure of the programme (Pasarska et al., 2004). If adjustments are made to the core structure of the programme, its effectiveness cannot be guaranteed.

1.4.2. Programmes should target both licit and illicit substances

Prevention programs should target all forms of substance abuse alone or in combination, including the use of legally obtainable substances such as tobacco and alcohol, inhalants and prescription and over-the-counter medicines.

1.4.3. Effective prevention programmes are of a sufficient duration

In order to increase the chances of achieving desired outcomes, prevention programmes need to be of a sufficient intensity and duration (NIDA, 2003). Randomised controlled trials and meta analyses of prevention studies have clearly found that *long-term repeated interventions are more effective than once-off interventions* for preventing or delaying the onset of substance use (Medina-Mora, 2005; Mentor UK, 2006; Twala, 2005; UNODC, 2002). Once-off interventions that just educate people about the risks associated with substance use do not prevent the initiation of alcohol and drug use or elicit changes in behaviour among persons currently using substances. Similarly, a systematic review of 56 prevention studies found no convincing evidence of the effectiveness of prevention programmes in the short and medium term (Foxcroft et al., 2003).

1.4.3.1. Recommendations regarding the duration of prevention programmes

Where possible, prevention interventions should include multiple years of intervention, be sustainable over time, and should not be conducted on a once-off basis (McBride, 2003; NIDA 2003, NREPP, 2007, Komro et al., 2008).

1.4.4. The provision of information on substance use disorders is a necessary but not a sufficient part of effective prevention.

The provision of information on the risks of substance use and substance use disorders, while a necessary part of prevention programmes is of itself insufficient to change or prevent

the onset of substance use (Medina-Mora, 2005; UNODC, 2002). While the provision of information can help shift attitudes towards substance use and improve knowledge of SUDS, there is little evidence of their impact on behaviour (NIDA, 2003).

Effective prevention programmes while sharing accurate information about SUDs understand that information provision is only one aspect of their programmes and include other components that directly attempt to change the factors associated with the initiation of substance use (Medina-Mora, 2005; Mentor UK, 2006; Twala, 2005; UNODC, 2002).

1.4.4.1. Recommendations for the provision of information.

To ensure that the above principle is adhered to, *it is important for service providers to combine the provision of information with the development of skills to delay the onset of substance use and the delivery of services. These additional components seem to produce more effective results than programmes that raise awareness by providing information only* (McDonald et al., 2003). More specifically, programme planners should ensure that their programme content includes 1) accurate information about SUDs and the risks associated with substance use, 2) a skills development component that builds skills associated with delaying the onset of substance use (such as basic affective skills (e.g. self-esteem and self efficacy) as well as peer resistance skills), and 3) a services component that provides information about treatment and other interventions for SUDS and provides referrals to services for individuals who are already experiencing problems with substance use.

When providing information on the risks associated with substance use, it is vital that the information provided is accurate, easy to understand, does not use scare or shock tactics, and is consistent with evidence-based practice (UNODC, 2004). According to the UNODC (2002), shock tactics involve exaggeration and a focus on the extremely negative (but often rare) impacts of substance use, such as death due to overdose. Research has shown that the provision of this kind of information is often unhelpful and rarely influences behaviour positively.

1.4.5. Effective prevention programmes focus on enhancing protective factors and reversing or reducing risk factors associated with the initiation of substance use

Both international and South African research have identified a list of risk factors that increase the probability that a person will use substances problematically as well as a list of factors that protect individuals against the initiation of substance use. These risk and protective factors occur within individuals, the family, school, community and social environmental domains (see Table 2 for a summary of these risk and protective factors).

There is a large body of evidence which points to the value of focusing prevention efforts on 1) reducing the risk factors associated with the initiation of substance use as well as 2) enhancing factors that protect individuals against substance use (NIDA, 2003; UNODC, 2002). *More specifically, evidence-based prevention programmes attempt to strengthen protective factors and identify and reduce risk factors for substance use early on in a child's development before problem behaviours develop* (NIDA, 2003).

Table 2: Examples of risk and protective factors

Domain	Protective factors	Risk factors
Individual	<ul style="list-style-type: none"> • Positive personal characteristics (e.g. emotional stability, positive self esteem). • Bonding to societal institutions and values, particularly attachment to parents, school and religious affiliations. • Social and emotional competence 	<ul style="list-style-type: none"> • Inadequate life skills • Lack of self-control • Low self-esteem • Emotional and psychological problems • Favourable attitudes towards substance abuse • Rejection of values • School failure • Lack of school bonding • Early anti-social behaviour
Family	<ul style="list-style-type: none"> • Positive bonding among family • Parenting that indicates high levels warmth and consistency • An emotionally supportive parental/family milieu 	<ul style="list-style-type: none"> • Family conflict and domestic violence • Family disorganization • Lack of family cohesion • Social isolation of family • Families attitudes towards substance use is favourable • Lax, ambiguous or inconsistent rules • Poor child supervision • Unrealistic expectations
School	<ul style="list-style-type: none"> • Caring and support • High expectations from school • Clear standards and rules for appropriate behaviour • Youth participation in school 	<ul style="list-style-type: none"> • Lax, ambiguous or inconsistent rules • Favourable staff and student attitudes towards drugs • Availability of alcohol and drugs on school premises • Lack of school bonding
Community	<ul style="list-style-type: none"> • Caring and supportive • High expectations of youth • Opportunities for youth participation in community structures 	<ul style="list-style-type: none"> • Community disorganization • Lack of community bonding • Lack of cultural /community pride • Community attitudes favourable to drug abuse • Drugs readily available • Inadequate youth services • Presence of gangs • Unlicensed liquor outlets such as shebeens • Selling of alcohol and tobacco products to underage individuals
Society/environment	<ul style="list-style-type: none"> • Media literacy • Decreased accessibility to alcohol, tobacco and other drugs • Increased pricing of alcohol and tobacco through taxation • Raised purchasing age and enforcement • Stricter traffic laws 	<ul style="list-style-type: none"> • Impoverishment • Unemployment and underemployment • Discrimination • Pro-drug use messages in the media • Limited enforcement of alcohol and drug use

(Atkinson, 2004; Hawkins, 2002; Morojele et al., 2004; NIDA, 2003; UNODC, 2002).

1.4.5.1. Recommendations for addressing risk and protective factors.

To ensure that the above principle is adhered to, *it is important for service providers to identify (through a needs assessment) the risk and protective factors that are relevant to their target group and programme setting. These risk and protective factors should be built into and addressed through the content of the prevention programme* (NIDA, 2003; UNODC, 2004). Prevention programmes should also strive to address risk and protective factors in *multiple domains of functioning*. For example, community-based prevention campaigns should not only focus on addressing individual risk factors for substance use but also on community factors. In impoverished South African communities, efforts to strengthen community structures and improve neighbourhood environments so that neighbourhood disorder (characterised by poverty, dilapidated buildings, poor services, overcrowding and open drug dealing) can be addressed can be classified as effective community prevention strategies; especially as neighbourhood disorder is a significant risk factor for the initiation of substance use (Sampson & Raubenbusch, 2002).

1.4.6. Effective prevention programmes have a multiple focus.

Related to the above, research has consistently shown that prevention programmes that target multiple domains of functioning (such as the intrapersonal, family and community) are more effective than programmes that focus on one domain (such as the individual) to the exclusion of all others (NIDA, 2003; UNODC, 2002). For example, prevention programmes for adolescents that are located within both school and family settings are more effective than interventions that occur in school settings only (Cuijpers, 2002; Komro et al., 2008). Similarly, interventions for adolescents that have a family focus and include both parents and adolescents are more effective than interventions that target adolescents in isolation from their family context (Komro & Toomey, 2002).

1.4.6.1. Recommendations for ensuring programmes have a multiple focus.

Where possible, prevention interventions should include a multiple focus and target risk and protective factors in several domains of functioning. To ensure that this occurs in a context of scarce and limited resources, it is vital that collaboration and communication between and within local and provincial government departments, non-profit organisations and other institutions occurs. This will prevent the duplication of services and may facilitate a more even dispersion and better coverage of prevention services in the province.

1.4.7. All prevention programmes should be monitored and evaluated.

A key principle of effective practice is that prevention programmes should be results oriented, goal-driven, and measurable. These are all characteristics that are key components of programme monitoring and evaluation (NIDA, 2003). Research has emphasised the

importance and value of monitoring and evaluating substance abuse prevention programmes, not only because this helps identify areas in which services can be improved, but also because evidence of service effectiveness can inform decision-making around the allocation and distribution of prevention resources (Gulotta & Bloom, 2003). Unfortunately prevention programmes in South Africa seldom get evaluated. This raises questions about the effectiveness and quality of these programmes (Harker et al., 2008).

1.4.7.1. Recommendations related to monitoring and evaluation

To adhere to this evidence-based principle, it is important to conduct evaluations of all substance abuse prevention programmes. When implementing evidence-based programmes designed and developed in other contexts, it is also vital that these programmes are regularly monitored and evaluated to ensure that they remain effective (Komro et al., 2008). It is useful to contract in or use a professional evaluator to conduct these evaluations as external evaluators add credibility to an evaluation (Harker et al., 2008).

1.5. Guidelines for evidence-based prevention programmes in school, family and community settings

1.5.1. Guidelines for school-based prevention programmes.

- School-based prevention programmes should be *grounded in theory* on risk and protective factors for substance use (Komro & Toomey, 2002).
- The alcohol and drug information provided by school-based prevention programmes should be *developmentally appropriate*.
- These programmes should focus on *developing the following skills and attributes* among young people: self-control; emotional awareness; communication; social problem-solving, academic support and social competence (Atkinson, 2004).
- Emphasis should be placed on *addressing social norms* around alcohol and drug use. A particular emphasis should be placed on normative education that reinforces awareness that not all adolescents engage in substance abuse (Komro & Toomey, 2002).
- Within communities, *schools should be one of the many settings in which prevention occurs*. Schools should not be relied upon to be the sole provider of substance abuse education, even though the school is an appropriate setting for preventative interventions (Faggiano et al., 2005).

- *Preventions programmes should be long term.* Booster sessions aimed at strengthening the effects of the programme can assist in this regard. A meta-analysis found that 80% of effective programmes were related to the use of booster sessions (White & Pitts, 1998). However, the use of booster sessions in the absence of other evidence-based practices may not yield the same results (Cuijpers, 2002).
- Effective school-based prevention programmes *use both peer leaders and adult facilitators* (Cuijpers, 2007; Gottfredson & Wilson, 2003; Mellanby, 2000).
- School based programmes significantly *increase in effectiveness when they include components within other domains of functioning* such as parenting skills training (Cuijpers, 2002; Flay, 2000, Komro et al., 2008).
- *School-based prevention programmes should be interactive and should rely on experiential learning methods instead of didactic teaching techniques.* Interactive methods provide contact and communication opportunities for those participating in the programme (Cuijpers, 2002; Ennett, 2003; Komro & Toomey, 2002; Midford et al., 2002).

Box 1

Examples of universal evidence-based school prevention programmes

- [Project Alert](#)

This project is a two year universal program for young people aged 8-12 designed to reduce the onset and regular use of drugs among youth.

- [Life Skills Training \(LST\) Programme](#)

This programme is designed to address a wide range of risk and protective factors by teaching general, personal and social skills along with drug resistance skills and education. This program also makes use of a booster programme which is aimed to maintain the programme gains.

- [Lions- Quest Skills for Adolescence](#)

This is a commercially available universal programme that can be used in primary schools. The focus of this programme is on building self-esteem and encouraging personal responsibility, communication, decision making, resisting social influences and asserting of rights. It also increases knowledge of substance use disorders. This programme has been used in South Africa (The National Register of Evidence-Based Prevention Practices)

Three examples of effective, evidence-based school prevention programmes are provided in Box 1. For more details on these interventions see www.nrepp.com or the Appendix.

1.5.2. Guidelines for family-based prevention programmes.

A number of systematic reviews and meta-analyses have shown parenting programmes to be effective tools for changing children's behaviour (Foxcroft et al., 2006; Komro & Toomey, 2002; Petrie et al., 2007). One such review found that parenting programmes led to a significant reduction in one or more of the outcome variables measured, including alcohol and drug use among children (Petrie et al., 2007). Family skills training programmes are also an effective prevention strategy. This strategy works to strengthen strong protective factors located within family structures. Foxcroft et al. (2003; 2005; 2006) found that the positive effects of this intervention on alcohol and drug use are sustained over time.

Specific guidelines for family skills training include the following:

- Family skills training and intervention programmes should be grounded in sound theory and evidence from research (UNODC, 2008).
- Training programmes should be based on a needs assessment because the programme used should match the target group/population and the level of risk of the target population (UNODC, 2008).
- Programmes should be matched to the developmental pathways of children in the target population (Loxley et al., 2003)
- Family skills programmes should be intensive, of a sufficient duration and number of sessions.
- The emphasis should always be on strengthening positive family relationships, increasing family supervision and monitoring, consistent and positive discipline, as well as communication of family values (Komro & Toomey, 2002; UNODC, 2008).
- Family skills training programmes should be chosen based on evidence of their effectiveness.
- Programmes should be adapted to meet the cultural needs and socio-economic needs of the target population.
- Systematic monitoring and evaluation of these programmes is a necessity (UNODC, 2008).

Box 2 Example of a family-based prevention programme

[The strengthening families programme for parents](#) offers seven sessions each attended by youth and their parents, and is often conducted through partnerships. (See appendix A for a complete outline of this programme.)

See Box 2 for an example of an effective, family-based prevention programme.

1.5.2. Guidelines for community-based prevention programmes.

Community-based prevention programmes do not focus on changing the behaviour of individual drinkers but looks at changing the community structure and environment in which the person consumes alcohol or drugs (Treno & Lee, 2002). *Specific guidelines for these prevention programmes include the following:*

- *Encourage media involvement* to increase awareness of substance use within communities, provide accurate information on substance use, decrease stigma, and strengthen attitudes and norms supportive of sobriety (NIDA, 2003; Treno & Lee, 2002).
- *Mobilize the community* to make structural and systemic changes by forming coalitions with organizations within the target community who share the goal of preventing and reducing substance abuse (Komro & Toomey, 2002; NIDA, 2003).
- *Training of alcohol retail establishments*, particularly on the sale of alcohol or tobacco products to underage youth (Komro & Toomey, 2002).

- *Enforcement of the laws* of the country pertaining to alcohol and drug use (Komro & Toomey, 2002; Treno & Lee, 2002).
- *Pro-social bonding within communities* should be strengthened through the provision of structured recreational activities within communities and via encouraging and supporting pro-social institutions within communities such as religious groups and youth leadership groups (NIDA, 2003).

To summarize:

- Universal prevention strategies that include information sharing and awareness raising activities are *only one form of prevention*.
- To maximise the chance of prevention being successful, programmes should also develop *personal skills, enhance protective factors and address risk factors* for substance use within individuals, families and communities.
- *Prevention as an intervention strategy should only be used where appropriate and is not suitable for use among individuals who are already displaying signs of problematic substance use*. For these individuals, early interventions are indicated. These interventions are explored in the following section.

2. EARLY INTERVENTIONS

For individuals who misuse alcohol and drugs but do not have substance abuse or dependence disorders, early interventions are useful and appropriate strategies to use to change their substance use behaviour (WHO, 1993). Early interventions have been extensively evaluated and are particularly effective for identifying and addressing potentially harmful substance use prior to the onset of chronic problems. This section will define early interventions for substance use disorders (SUDS), outline when early interventions are appropriate to use, describe the core features of evidence-based early interventions, and provide evidence for the effectiveness of these interventions.

2.1. What are early interventions?

2.1.1. *Early interventions usually refer to the following:*

- Interventions that *occur early in the course of the substance use disorder* where the prognosis of being able to make significant and lasting changes to one's substance use is good.
- More specifically, they are interventions where a health or social welfare provider *identifies* a person who is using alcohol or drugs in a way which suggests they are in the *early stages of developing a SUD* and *intervenes* to *prevent* the onset of more severe SUDs.
- The focus is on individuals who use substances recreationally or misuse substances but who do not have substance abuse or dependence disorders.

2.1.2. *The relationship between early and brief interventions*

- There is significant overlap between the terms “early interventions” and “brief interventions”
- Early interventions refer to interventions that occur early in the course of the substance use disorder.
- Brief interventions are a particular *category* of early interventions. Specifically, they are early interventions that are *time-limited in scope*.
- As such, the goals of brief interventions are identical to those of early interventions. These shared goals are discussed in section 2.1.3.
- In this report, as in much of the literature on evidence-based practices, the terms “Brief Intervention” and “Early Intervention” are used interchangeably.

2.1.3. *The goals of early interventions*

These include the following:

- **Early detection of problematic substance use through screening and assessment.**

Early detection allows problems to be addressed at an early stage before the onset of more serious and complex problems (such as abuse and dependence).

- **To reduce the harms associated with risky drinking and problematic substance use.**

A common goal of early interventions is to detect and target people whose levels and patterns of substance use are considered hazardous or harmful¹ to their health but that do not qualify for substance abuse or dependence diagnoses. According to the World Health Organisation (2004), “risky or hazardous drinking” is defined as “more than 7 drinks per week or more than 3 drinks per occasion for women, and more than 14 drinks per week or more than 4 drinks per occasion for men.” On the continuum of substance use disorders, this falls into the substance misuse category.

Here the goal of early interventions is to *reduce* the frequency and quantity of substances used in order to *prevent* substance-related problems that arise from acute intoxication (e.g. drink driving, substance-related injuries, and substance-related sexual risk behaviours).

- **To reduce the risk of developing more severe substance use disorders or to halt the progression of an existing problem.**

This goal is achieved through the provision of brief counselling interventions that aim to reduce or eliminate risky drinking and problematic drug use. *The emphasis of these interventions is not always on abstinence (although this may be one of the goals), but is also on reducing the client’s substance intake to a low or moderate level that is not harmful or hazardous to their health (Skinner & Holt, 1983).*

For example, for a person who binge-drinks on weekends, these interventions would emphasise reducing alcohol consumption to non-hazardous levels and eliminating binge drinking rather than insisting that the person abstain from drinking.

- **To motivate clients to enter treatment and to improve engagement in treatment.**

While early interventions do not usually target people whose levels or patterns of substance use meet diagnostic criteria for abuse or dependence, these *interventions can be used to motivate a client with a more severe substance use disorder to enter or seek more intensive treatment services*. These interventions have been used to increase clients’ willingness to enter and commitment for more intensive treatment

services (Ruback, Sandback, Lauritzen & Christensen, 2005). With treatment resistant clients, they have also been used as the first stage in a “stepped care” model, in which more intensive treatment is provided if services of a low intensity (such as early interventions) have little impact on the substance use behaviour (Fleming & Manwell, 1999). Appropriate target groups for early interventions are discussed in the following section.

2.2. When are early interventions appropriate to use?

2.2.1. *With whom are early interventions appropriate to use?*

- **Early interventions are appropriate to use among individuals who are starting to experience some problems related to their substance use, but have not yet developed obvious signs of abuse and dependence** (e.g. loss of control, tolerance, withdrawal). In other words, these interventions should target individuals

Box 3 Appropriate target groups for early intervention programmes

- Individuals caught driving under the influence of alcohol/drug offences,
 - Individuals who present at trauma units with alcohol or drug-related injuries,
 - Individuals who present at health care settings with alcohol or drug-related health problems,
 - Children and adolescents caught in possession of drugs at school
 - Individuals caught in the possession of drugs for the first time
 - Pregnant women
- (Moyer and Finney, 2005)

who are beginning to experience problems related to their alcohol or drug use (i.e. substance misuse disorder) and for whom the prognosis for recovery is still good. Box 3 reflects particular target groups that might benefit from early interventions.

Early interventions should *not* be used among individuals who meet the diagnostic criteria for substance abuse or dependence.

- **Early intervention activities are not appropriate to use as a form of “low intensity treatment” among individuals who have already developed a substance dependence disorder** (Wilk et al., 1997).¹ Early interventions are not of sufficient duration or intensity to effectively address more severe SUDs such as abuse or dependence and should not be used as a substitute for treatment for individuals with these difficulties.
- **Early interventions are appropriate to use in a limited way with individuals with substance dependence disorder- but only as a strategy to increase motivation and readiness to enter more intensive treatment services.**

2.2.2. In what settings are early interventions appropriate to use?

Early interventions are appropriate to use in a wide range of settings.

- **Community settings**

As these interventions target people with low levels of problem severity and because they are brief in duration, they are *well-suited to community settings*.

- **Integrate into existing community based services**

These interventions can *easily be integrated into services that already exist in local communities* such as primary health care and social welfare services (see Box 4 for examples of appropriate settings).

Box 4 Appropriate settings for early intervention programmes

- In community and primary health care clinics where people present with alcohol or drug related health problems or alcohol/drug use is detected
 - In trauma units, where people present with injuries that are a result of their substance use (e.g. falls or fights)
 - Intake workers in district social service offices where clients present with substance-related family or other social welfare problems
 - In school settings, where young people are identified who are beginning to use substances
 - In employee assistance programs at the workplace
 - In prenatal clinics, where nurses or doctors identify women who are using alcohol or drugs while pregnant or breast feeding
 - Police stations, (by appropriately trained staff) when drivers are arrested for driving while intoxicated
- (Alcohol Alert, 2005)

- **Suitable and effective across a range of contexts and settings**

These interventions have been extensively evaluated in a variety of settings, and an overwhelming body of evidence suggests that nurses, primary health care practitioners, general practitioners, community social workers, and community mental health workers are able to effectively and efficiently deliver these interventions (Alcohol Alert, 2005; Fleming et al., 1999; Moyer et al., 2004/2005)

- **Use by referral agents**

Early interventions can be used as treatment engagement and motivation strategies by individuals responsible for referring clients with more severe problems to substance abuse treatment services. For example, intake social workers in the district social service offices could use these interventions to prepare clients for more intensive services.

A word of caution: *irrespective of the setting, the person delivering the intervention requires adequate, appropriate and ongoing training* in the detection of SUDS and early intervention strategies as well as *sufficient support and resources* to deliver the service effectively (Koopman et al., 2008).

2.3. Core features of good-enough early intervention services

2.3.1. Use of an empathic, client-centred and client-driven style rather than a confrontational therapeutic style

Service providers conducting early interventions should display empathy and concern. Early interventions should not be confrontational in nature.

2.3.2. Individual choice

While service providers should provide clients with clear advice about the effects of their substance use and the need to make changes to their levels and patterns of substance use, they should not impose their choices upon clients. For example, they should not impose a goal of abstinence on a client but should provide clients with a choice of goals. Information and advice should never be provided in a dictatorial manner.

2.3.3. Interventions should be interactive and should rely on experiential learning methods instead of didactic techniques.

Early interventions should be interactive in nature. The service provider should act as a facilitator, teacher and a coach but not as an expert that imposes his/her ideas on the client. Rather the active participation of the client should be encouraged. For these interventions, to be effective, the client needs to play an active role (Miller, 1996). As such, service providers should use therapeutic techniques such as reflective listening, affirmations, and open-ended questions. In this approach, service providers facilitate change, but are not the active agents of change. The client is viewed the active agent of change (Miller, 1996).

2.3.4. Brief motivational interventions are a particular effective form of early interventions

Brief motivational interventions (BMI) are a particularly effective form of early intervention. These interventions focus on building rapport with clients, displaying empathy and actively working with clients in a partnership to help them make decisions to change. BMI have been shown to be effective in changing a wide range of health-related behaviours, including risky drinking and smoking (Miller, 1996).

2.4. Essential steps in evidence-based early interventions

A large body of research has identified steps that are essential for conducting evidence-based interventions. These steps are outlined below:

2.4.1. Screening of clients to allow for the early detection of problem substance use

Screening of clients is essential to allow for the early detection of substance abuse. All

Box 5 Basic screening, assessment and feedback strategy for patients with alcohol problems

- Emphasize [early identification](#)
- Socially stable individuals at earlier stages of problem drinking have a better prognosis
- Conduct a [systematic assessment](#) that:
 - Examines patterns of alcohol and drug use
 - Assesses the severity of the drug problem
 - Reviews medical history and psychosocial functioning
- [Review assessment findings](#) with patient and family (feedback)
- Present evidence of physical damage related to drinking/drug use (Skinner & Holt, 1983)

clients should be screened routinely for substance use. *At a minimum, screening should include questions about the quantity and frequency of alcohol and drug use.* Box 5 outlines a basic strategy for the screening and assessment of substance use problems. This strategy does however require the primary health care or social welfare provider to be trained in brief screening and assessment procedures.

During screening, the presence

of other early indicators of substance related problems

should also be explored. This

includes conducting health-related tests to screen

individuals for liver damage and other health problems

related to the use of alcohol or drugs. Box 6 outlines some

early indicators of substance-related problems that service

providers should be on the look-out for during screening.

Box 6 Early indicators of alcohol related problems

- *Heavy drinking*, often has more than six drinks per day
- *Concern* about drinking by self or family
- Eating lightly or skipping meals when drinking
- Drinks quickly, increased *tolerance*
- *Accidents* in which drinking is involved
- *Tardiness or absence from work* because of drinking (hangover)
- Most friends are heavy drinkers; most leisure activities involve drinking
- Attempts to cut down on drinking have had limited success
- Frequent use of alcohol to deal with stress, anxiety, depression
- Frequent drinking during the working day (for example, at lunch break)
- Heavy smoker
- *Health problems* related to drinking including: dyspepsia, morning nausea and vomiting, recurrent diarrhoea, pancreatitis, high blood pressure, insomnia (Skinner & Holt, 1983)

2.4.2.1. Recommendations for screening:

Screening and assessment procedures can vary in scope and intensity from only one

question to an extensive assessment using a standardized questionnaire. *To detect alcohol and drug related problems at an early stage, it is vital that all primary health and social*

welfare providers are trained to screen for and detect clients with early stage substance use disorders (Fleming, 1999). There are brief screening instruments readily available for this

purpose. For example, the AUDIT has been extensively tested and validated for use in South Africa and is widely used in both research and clinical settings in the country

(Koopman et al., 2008; Saunders et al., 1993; WHO, 2004). *Clients that screen positive should then receive feedback from this screening and some form of brief intervention.*

2.4.2. Provide feedback on results from screening

Early interventions should *provide individuals with feedback on the results of their screening* and how their current alcohol or drug use is affecting their health and well-being. The core strategy is to take steps before the person develops substance dependence. The health provider should give detailed feedback to the client concerning his/her current health status and the potential risk for future health problems if the patient continues to drink or use drugs problematically. At this stage the service provider could involve the family if there is cause for concern.

2.4.3. Emphasize personal responsibility for change and set goals for change

Early interventions should also explore the extent to which a person perceives their alcohol or drug use as problematic or as a health risk and is ready to change their behaviour. In addition, *early interventions are goal-focused and a set of goals should be developed for the client to work towards to help him/her moderate their substance abuse.*

2.4.3.1. Recommendations regarding goal-setting

Goals should not be imposed on the client by the service provider but should be developed collaboratively. As such, early interventions should assist individuals in *setting their own goals* related to changing their substance use (e.g. quitting drug use or reducing alcohol consumption). *This collaborative goal setting helps emphasise the responsibility of the patient and family for behaviour change* (Skinner & Holt, 1983).

2.4.4. Provide clear advice to change

Based on the results of the screening and assessment, early interventions need to *provide individuals with clear advice about the need to stop or reduce their alcohol or drug use.* For risky drinkers, advice should include information about sensible drinking limits. Early interventions should also target clients' sexual risk behaviours and other problem behaviours that may be associated with substance use. The intervention can be less intensive than general counselling but is more focused on the actual problem behaviour.

2.4.4.1. Recommendations regarding advice-giving

Advice should be clear and direct. This could include written or verbal advice or writing a "prescription" to reduce or stop alcohol or drug use, depending on the goals the client has set for him/herself.

2.4.5. Provide a menu or range of change options

In order to successfully meet behaviour change targets, the service provider and client need to explore strategies for meeting these goals. To aid the development of these strategies, early interventions should provide individuals with clear information about how to change their substance use. A range of possible strategies need to be presented to the client. These strategies could include brief counselling, more intensive treatment options, self-help group attendance and/or bibliotherapy (including the provision of self help manuals)(Skinner & Holt, 1983). *While clear advice about what strategies might work best may be given, it is the client's choice about what options to choose.* Providing the client with options increases the likelihood that the client will find an approach that is appropriate and acceptable to their own situation (Nilsen, Aalto, Bendsten & Seppa, 2005).

2.4.5.1. Recommendations regarding brief counselling as a change strategy

Brief counselling that is client-centred and relies on motivational interviewing techniques is a particularly important tool for behaviour change and widely used in early interventions (Miller, 1999). This counselling should focus on increasing the level of motivation of the patient to reduce or moderate their substance use. The duration of counselling sessions can range from a few minutes to several sessions spread over time (Fleming, 2002).

2.4.6. The importance of empathy

Empathy as a counselling style is an essential ingredient of evidence-based early interventions (Miller, 1996). Such a counselling style is characterised by warmth, understanding for the client's position, and support. This style is also non-threatening, non-confrontational and non-judgmental. The *principle behind the use of this counselling style is to support and motivate clients to make meaningful changes in their lives and not "condemn" them for their substance use behaviour.* This is important as often clients deny or minimise their substance use behaviour and are ambivalent about or resistant to change. In fact, *early interventions seem to be ineffective when authoritarian, coercive, controlling, or confrontational counselling styles are used.* These types of counselling approaches tend to increase client resistance to change rather than improving motivation and readiness to change (Moyer et al., 2002; Moyer & Finney, 2005; Nilsen, Aalto, Bendsten & Seppa, 2005).

2.4.6.1. Recommendations regarding therapeutic/intervention style

Always adopt a non-judgmental, warm and empathic style. In early interventions avoid authoritarian, coercive, controlling, or confrontational counselling styles at all costs.

2.4.7. Enhancing self-efficacy for behaviour change

In evidence-based early interventions, service providers play another important role- that of *supporting client's self-efficacy (or belief in their ability) to change their substance use behaviour*. In other words, service providers need to build the client's confidence in their ability to make changes to their behaviour. An important part of building this confidence is *conveying a sense of optimism and belief in the client's ability to change*. This is achieved through the use of reflection (e.g. reflecting on the positive changes the client makes to their behaviour) and via eliciting positive self-affirmations from the client (Moyer et al., 2002; Nilsen, Aalto, Bendsten & Seppa, 2005). As such, early interventions do not emphasise the client's powerlessness or helplessness over their substance use.

2.4.8. Ongoing monitoring

Ongoing monitoring of client progress and provision of support are also essential parts of evidence-based early interventions (Skinner & Holt, 1983). At a minimum, *monitoring and follow-up activities should involve 1) monitoring physical indicators of drinking, 2) tracking clients' progress in meeting their substance-related goals and 3) reassessing strategies to meet these goals* if they prove not to be successful (Skinner & Holt, 1983; Miller, 1999). As part of these monitoring activities, it is important to *keep detailed records of the client's past and current substance use*. To do this, it is useful to ask clients to keep a daily log of their drinking or drug use. Should clients not be successful in meeting their goals, referral to more intensive treatment services may be an option worth considering.

Importantly, early interventions that do not include a follow-up and monitoring component do not seem to lead to sustained reductions in drinking behaviour compared to early interventions that monitor clients routinely over sustained periods of time (Miller et al., 1989; 1996; Moyer et al., 2002).

2.4.8.1. Recommendations regarding monitoring and follow-up

Include monitoring and follow-up as an important component of early interventions. Ask clients to monitor their daily intake of alcohol or drugs and the extent to which they are able to meet their goals for behaviour change. Review the strategies used to achieve these goals regularly and change these strategies if necessary.

These essential steps in conducting evidence-based early interventions are summarised by the acronym **FRAMES**. Box 7 provides an overview of this acronym (Nilsen, Aalto, Bendsten & Seppa, 2005).

Box 7 Steps in early interventions: FRAMES

- **F** - Provide **Feedback** on results from screening and assessment
 - **R** - Emphasise that **responsibility** for change lies with the client
 - **A** - Provide clear **advice** to change and assist with goal setting
 - **M** - Provide a **menu** of change strategies (including brief counselling)
 - **E - Empathy**- use an empathic counselling style to increase motivation to change and avoid resistance
 - **S** - Support **Self-efficacy**. Convey optimism and a belief in the client's ability to make changes in their lives.
- (Nilsen, Aalto, Bendsten & Seppa, 2005)

2.5. Evidence for the effectiveness of early interventions

2.5.1. Effectively reduces alcohol and drug consumption among patients in health care settings

Research has established the *effectiveness of early interventions in decreasing alcohol and drug use among patients in health care settings*. For example, a review of randomised controlled trials of brief motivational interventions across 14 countries found that participants that received brief motivational interventions reported greater reductions in their use of alcohol and their alcohol-related problems than untreated controls (Bien et al., 1993; Fleming et al., 2002; Moyer et al., 2002; Ruback et al., 2005).

Across different studies and contexts, brief motivational interventions seem to reduce alcohol and drug consumption by 10% to 35%, irrespective of age, race or gender group (Reference). However, these early interventions seem to be *most effective for individuals with less severe substance-related problems* and are less effective for people with relatively severe problems (Fleming et al., 2002; Moyer et al., 2002; Nathan, 1988).

2.5.2. Effectively reduces alcohol and drug consumption among young people in community and college settings

Early interventions appear to be particularly effective among adolescents and young adults who have only been drinking for a short period of time. For this population group, the emphasis is on stabilising and moderating their drinking patterns (Nathan, 1988). There is a large body of research supporting this claim. Table 3 summarises some of the evidence supporting the effectiveness of early interventions for reducing problem drinking among college students and young people.

These multiple independent studies using different intervention protocols and implementation strategies show that screening and brief intervention are effective strategies for reducing drinking among young people, although the duration, magnitude, and exact nature of the effects vary. Research provides the strongest support for interventions that are delivered to

students individually and include personalized feedback about the risks associated with alcohol use (Larimer, Cronce, Lee, & Kilmer, 2002).

Table 3: Evidence in support of early interventions among college students and young people

Larimer and Cronce (2002)	Assessment and brief feedback were associated with reductions in alcohol use and/or negative consequences. Three preliminary studies showed evidence of effectiveness of computerized feedback.
Marlatt et al. (1998)	High-risk students receiving a brief motivational feedback session (consisting of information on the student's alcohol use, consequences, expectancies, and comparison of alcohol use with campus norms of use) reported reductions in use and consequences compared with control group participants. Changes were maintained at 2- and 4-year follow-ups.
Borsari and Carey (2000)	Heavy episodic drinkers (men: 5+ drinks, and women: 4+ drinks, at least twice a month) randomly assigned to motivational feedback interviews reported reductions in use at 6 weeks but no significant differences in number of negative consequences.
Murphy et al. (2001)	Heavier-drinking students receiving feedback and brief interventions reported greater reductions in drinking than students assigned to education-only or assessment-only sessions.
McNally and Palfai (2003)	Small-group normative feedback sessions were effective at reducing alcohol use among heavy-drinking students at 4-week follow-ups.
Collins et al. (2002)	Students receiving mailed feedback comparing their own drinking with their perceptions of drinking on campus reduced their alcohol consumption at 6 weeks, but not at 6 months, compared with control group students.
Neighbors et al. (2004a)	Students receiving computerized feedback about their drinking had reduced use at 3- and 6-month follow ups compared with an assessment-only control group.
O'Hare (1997)	Mandating student violators of campus alcohol policy to screening and brief intervention resulted in significant reductions in alcohol use.
Borsari and Carey, in press	Students mandated to receive brief individual motivational sessions reduced their consumption more at 3 months and 6 months than did students mandated to receive standard alcohol education.
Barnett et al. (2004)	Students who had a brief motivational feedback interview participated at higher rates in outside counseling than did students who had received an Internet-based educational intervention.
Larimer et al. (2001); O'Leary et al. (2002)	Individual skills-based or motivational enhancement interventions were effective in changing drinking behaviors.

2.5.3. Effective as a mean of improving treatment entry and engagement for more severe alcohol and drug problems

Early interventions are also an effective strategy for facilitating treatment entry and engagement in treatment for individuals with more severe alcohol and drug problems (Moyer et al., 2002; Ruback et al., 2005). Studies have found that the *probability of seeking and entering substance abuse treatment increased by 5% to 65% for participants who received brief motivational interventions* that focused on entering treatment compared to participants who did not receive these interventions (Moyer et al., 2002; Ruback et al., 2005).

To summarize:

- When evidence-based principles are followed, *early interventions are effective strategies for reducing alcohol and drug related problems among individuals with low levels of problem severity.*
- For individuals with more severe problems, these interventions are also *useful tools for increasing motivation to attend and participate in more intensive treatment options.*
- These more intensive treatment options are discussed in the following section.

3. TREATMENT

In the last decade, research into the treatment of substance use disorders (SUDs) has taken giant leaps forward and is now regarded by the World Health Organisation (WHO) as a specialty field in medicine and the behavioural sciences. A broad range of treatment services is available in the Western Cape. These services include detoxification services; inpatient treatment services that are either short term (21 to 28 days), medium term (up to three months), or longer term (greater than three months); community-based outpatient programmes that range in intensity and duration; as well as aftercare and reintegration services, which include half way houses and sober living establishments. Given the Department of Social Development's request to focus on evidence-based practices for community based outpatient treatment, this report does not review the other levels of treatment. Yet evidence-based practices apply to all levels of treatment. This section will provide a definition of community based treatment, outline core features of good-enough treatment programmes, describe evidence based practices within these programmes (including four evidence-based models), and will discuss the role of the community in treatment provision.

3.1. What is treatment?

3.1.1. Irrespective of whether treatment occurs in inpatient or community settings, treatment services should:

- Provide *specialised* medical, psychiatric and social services to individuals with SUDs.
- Focus on *stopping, reducing, or reversing* the negative health and social consequences associated with substance abuse and dependence
- Focus on *preventing further health and social harms* related to continued substance use (e.g. harm reduction interventions to reduce HIV-risk among drug users)
- Depending on the model of treatment used, the *goals of treatment may include abstinence, reduced substance use, and/or harm reduction.*

3.1.2. Defining community based treatment:

- There are no clear and agreed upon definitions of community based treatment
- *Definitions differ according to country context.*
 - In the United States, all treatment services provided in non-correctional and non-research settings (whether inpatient or outpatient) are referred to as community based (NIDA, 1999).
 - In other settings (such as the UK and Europe) the terms “community based treatment” and “outpatient treatment” are used interchangeably (NHS, 2006).

- The South African National Drug Master plan defines community based treatment as programmes that arise from the needs of a particular community and that use existing infrastructure to meet these needs.
- In this report, community based treatment refers to outpatient services based in local community settings.

3.1.2.1. Defining community based outpatient treatment:

- Outpatient treatment programmes provide *non-residential* specialised treatment services for individuals, families or groups with SUDs.
- These services are less intensive and restrictive than inpatient treatment programmes as they allow clients to return to their usual living environment after each session. Individuals can continue with their employment, education and family responsibilities.
- Evidence-based outpatient treatment programmes involve the provision of *structured, professional*, therapeutic care.

Box: 8

Community-based outpatient programmes in the Western Cape

In the Western Cape, these treatment programmes vary in intensity and include:

- Day-patient services (where clients attend a facility on a daily basis),
- Intensive outpatient services (where services are provided 3-5 times per week), and
- Less intensive options where clients attend a facility 1-2 times per week.

Location of services:

- Generally provided in stand-alone outpatient facilities located in community settings
- Can also be provided as part of outpatient services at psychiatric facilities and other general healthcare facilities.

3.2. When is treatment appropriate?

3.2.1. When is treatment indicated?

- Treatment services are appropriate for individuals with substance abuse and dependence disorders.
- Individuals with *low levels of problem severity* (e.g. “recreational” drug users or individuals with substance misuse) *do not need specialised treatment services*. For these individuals, early interventions are more appropriate.
- *One exception*: Community based outpatient treatment services may be indicated for individuals with low levels of problem severity if early interventions were not successful in changing the substance use behaviour.

3.2.2. Evidence-based criteria for selecting community based outpatient rather than inpatient services

Some of the evidence-based criteria that are useful for deciding whether community based outpatient treatment is suitable for a particular client include the following:

- The client has *not had repeated failed treatment attempts* in outpatient settings;

- *No symptoms of withdrawal*, or withdrawal can be safely managed in an outpatient setting;
- *Health conditions are stable* enough to allow the client to participate in treatment;
- The client's *mental status* does not interfere with his/her ability to understand the information presented and participate in the treatment process;
- The client expresses a *willingness* to participate in treatment;
- The client's significant others (e.g. family), work environment, or social environment are *supportive* of the treatment and recovery process.
- Community based outpatient services are *easily accessible* to the client or the client has access to reliable and affordable transport.

(Gossop, 2006; NHS, 2006; UNODC/WHO, 2008)

3.2.3. When are inpatient services required?

If the client is experiencing withdrawal; has untreated and poorly managed health or mental health problems; does not have a supportive family work, or social environment; and previous attempts to change his/her substance use in outpatient settings have failed, then inpatient treatment services are probably needed.

3.3. Core features of “good enough” community based treatment services:

3.3.1. Treatment services that comply with human rights obligations.

Services should comply with human rights obligations and respect the dignity of all individuals. These rights include the right to the highest attainable standard of health, the right to nondiscrimination, and the right to equitable access to services (UNODC/WHO, 2008). *To ensure these rights are adhered to, treatment services should:* 1) have procedures to inform their clients of their rights, 2) obtain informed consent before initiating interventions, 3) respect the privacy of clients (by keeping client information confidential and requiring written authorisation before it is used), and 4) ensure that staff are properly trained in the provision of treatment that complies with ethical standards (UNODC/WHO, 2008)

3.3.2. Treatment services that are flexible and are able to adapt to meet the needs of individuals, vulnerable groups and in some cases, target communities

No single treatment programme is appropriate to all individuals, target groups or communities. Treatment services need to be flexible enough to adapt to the diverse needs of communities, target groups within communities, and/or specific individuals. For example, some communities may need work or vocational skills programmes in conjunction with their core substance abuse programmes. Similarly, women may need services in addition to their substance abuse treatment such as trauma counselling or parenting programmes (Wechsberg et al., 2008). More specifically, treatment should be age-appropriate (i.e.

adapted to meet the developmental needs of children in specific age groups), gender-sensitive and culturally appropriate (i.e. linguistically appropriate and sensitive to cultural diversity). Even evidence-based treatment models need to be adapted linguistically and culturally to meet diverse national and local circumstances (UNODC/WHO, 2008).

To achieve this goal, it is important when planning community-based treatment services to first conduct a thorough assessment of the service needs of substance users within the target community.

3.3.3. Treatment services that strive to be accessible to their target communities

Treatment for SUDs should be readily accessible to those who seek it. In other words, outpatient services should be located in target communities with high levels of substance-related need. Where possible, these treatment programmes should strive to limit barriers to treatment such as lengthy waiting lists, high costs, transport and other geographic access barriers, limited awareness of services, and negative perceptions about the effectiveness of treatment (Myers, 2007; NIDA, 1999). *Wherever possible, treatment services should be easily accessible to local communities with high levels of need.*

3.3.4. Treatment services that strive to follow evidence-based principles of treatment.

While recognising that internationally-developed treatment models need to be adapted to the South African context, evidence-based principles of effective treatment reach beyond geographic boundaries and are applicable to the South African context. These principles should always be adhered to (see section 3.4 for discussion). In addition, South African norms and standards for community based outpatient treatment services should be adhered to.

3.3.5. Community based outpatient services provided by suitably qualified personnel.

As SUDs are complex disorders that require specialised treatment services, all staff (whether they have had their own substance-related problems or not) should *hold relevant and appropriate qualifications*. These qualifications should include training in: ethics, basic counselling skills, substance abuse treatment models, the etiology of SUDs, and other conditions related to SUDs. Even though community based outpatient services are of lower intensity than inpatient services, these services still need to be provided by trained and skilled staff (Gossop, 2006; NHS, 2006; NIDA, 1999; UNODC/WHO, 2008).

3.4. Evidence-based principles of effective treatment:

3.4.1. No single treatment is appropriate for all individuals

As individuals have different levels of problem severity and different types of service needs, no single treatment is appropriate to all individuals. *Matching treatment settings, interventions, and services to each individual's particular problems and needs is therefore critical to positive treatment outcomes.* Some individuals are best suited to inpatient services due to their problem severity. Other individuals do not respond well to twelve-step type programmes and respond better to behavioural models of treatment that equip them with coping skills (NIDA, 1999; UNODC/WHO, 2008).

3.4.1.1. Recommendations: How to decide on the appropriate treatment

To ensure this principle is adhered to, it is important to *assess the problem severity and service needs* of each person presenting for

substance abuse treatment. This brief assessment should strive to 1) determine the seriousness and urgency of the client's problems and 2) the most appropriate type of treatment for the client. See Box 9 for issues that all brief assessments should document. Based on this assessment, decisions regarding the intensity of service needed (inpatient or outpatient) and appropriate treatment models can be made. An outcome of this assessment is that clients are offered services that are appropriate to meet their needs (NHS, 2006).

Box : 9

All brief assessments should assess:

- The nature and severity of the individual's alcohol and drug problems,
- The client's motivation to enter and complete treatment
- Current risk factors (e.g. for suicide or self harm of harm to others, or of harm from others),
- The urgency with which treatment is needed, and
- The client's responses to previous treatment services (NHS, 2006).

3.4.2. Treatment needs to be readily available

SUDs can be treated effectively if people have access to a continuum of available and affordable treatment services in a timely manner (UNODC/WHO, 2008). Avoiding lengthy waiting periods for treatment places is important as individuals with SUDs may be uncertain about entering treatment. An important window of opportunity can be lost if treatment is not immediately available or not readily accessible (Myers, 2007; NIDA, 1999). To ensure the effective treatment of SUDs, all barriers limiting access to treatment need to be minimised so that people have obtain the services that best meet their needs (NIDA, 1999).

3.4.2.1. Recommendations to address barriers to treatment availability

South African studies provide several recommendations for limiting barriers to treatment access and availability. Three of the main recommendations centre on geographic accessibility barriers, affordability and awareness barriers.

- **Geographic accessibility**

First, in order to address geographic accessibility barriers (e.g. travel distances and travel time) we need an *evenly dispersed network* of services across the province. Other recommendations include providing clients with *shuttle services* or tokens for public transport to and from treatment and using *outpatient mobile clinics* as service points. Mobile clinics reduce the distance required to travel to treatment, the costs associated with public transport, and the costs associated with buildings and other infrastructure.

- **Affordability**

To address affordability barriers, the number of low cost treatment services needs to be increased and some basic treatment services need to be within reach of people with low or little income (Myers, 2007). Apart from this, targeting *competing financial priorities* may also reduce affordability barriers for poor clients. Interventions that provide *tangible support* to persons wanting treatment also may reduce the impact of competing financial priorities (such as the need to provide foods and shelter) on treatment access (Myers, 2007).

- **Awareness**

To address barriers to treatment access, we also need to increase community awareness of existing services and the process of accessing these services by introducing more community-based outreach and awareness programmes. These programmes can increase awareness of *when* treatment is needed and *where* and *how* to access help (Myers, 2007). This knowledge of how the treatment system operates might ease some of the difficulties that people experience when trying to access needed services (Myers, 2007; UNODC/WHO, 2008).

3.4.3. Effective treatment addresses the multiple needs of the individual not just his/her substance use

Most individuals with substance abuse or dependence disorders have multiple service needs that cannot only be addressed through substance abuse treatment (NIDA, 1999; UNODC/WHO, 2008). These include *the need for additional health services*, due to the high prevalence of health problems and infectious diseases associated with substance use disorders; *the need for psychiatric care*, due to the high prevalence of co-occurring mental health problems; the need for *vocational training and education services*; the need for *family services* (including parenting skills); and the *need for legal services*, due to many clients having been in trouble with the law (Gossop, 2006). When these multiple needs are not addressed, the risk of relapse and poor treatment outcomes increases (Gossop, 2006; NHS, 2006).

For treatment to be effective, it is therefore important to ensure that the multiple service needs that clients have are identified and addressed during the course of substance abuse treatment (NIDA, 1999).

3.4.3.1. Recommendation: Comprehensive assessments to aid in the identification of multiple service needs.

To ensure this evidence-based principle is followed, it is important to complete a comprehensive assessment for each client. This assessment process should examine

Box : 10

Comprehensive assessments should examine:

- The nature of the client's alcohol and drug problems (including severity),
- Co-existing health and medical problems,
- Co-existing psychiatric difficulties (current psychiatric symptoms and past psychiatric problems),
- Co-existing social and interpersonal problems (among family, friends and within the workplace),
- Co-existing legal problems
- Environmental and developmental factors,
- Family history and relationships,
- Social and cultural circumstances, and
- Previous substance abuse treatment history (NHS, 2006; UNODC/WHO, 2008).

several key domains (see Box 10 for a description of these domains of functioning). As this assessment spans several domains, it should be conducted by a multidisciplinary team as specific competencies are required to assess particular types of need. For example, a psychologist will be required for a psychological assessment and a doctor for a medical or health assessment (NHS, 2006).

Action steps to ensure this occurs

include: 1) developing clinical protocols which specify that comprehensive assessments are required for each client, 2) training staff in screening, assessment, and diagnosis of SUDS and associated problems; and 3) ensuring appropriately qualified staff complete the medical and psychiatric components of each assessment.

The value this assessment holds for treatment is two-fold. First, an adequate assessment is the first step in developing a therapeutic alliance that can be used to engage the client in treatment (NHS, 2006; UNODC/WHO, 2008). Second, by identifying clients' service needs in multiple domains, this assessment forms the foundation for an effective treatment plan to address these needs.

3.4.3.2. Recommendation: Develop treatment plans to address multiple needs.

Based on findings from the assessment, it is good practice to produce an *individualised treatment plan* for each client. This involves the client and service provider setting jointly agreed-upon goals (based on identified needs) and identifying possible intervention strategies that can be used to meet these goals. At the minimum, this plan should document: 1) the roles and responsibilities of both the client and the service provider, 2) shared and agreed-upon goals, and 3) strategies to attain these goals, and 4) progress

towards these goals. *This plan is an essential element of structured and effective treatment.* By ensuring that clients' most immediate needs are identified and met, treatment plans 1) promote positive therapeutic alliances between clients and the service provider and 2) facilitate engagement in treatment, as engagement improves when clients feel their needs are being met (NHS, 2006).

3.4.3.3. Recommendation: Develop integrated care pathways in community settings to ensure multiple needs are met during the course of treatment

Community based services should provide the client with a comprehensive menu of services that target individual needs. While it is not always possible to make comprehensive services available to meet the multiple needs of clients in individual treatment centres, the development of *integrated care pathways* (ICPs) in community settings make the provision of comprehensive services across a range of organisations possible (Myers, 2007; NHS, 2006). ICPs are essentially networks of service providers in the substance abuse and associated fields (health, mental health, vocational training, and family support). Service level agreements between organisations are developed that provide 1) a definition and description of the types of services provided by each organisation, 2) aims and objectives of services to be provided, 3) definitions of the client group served and target groups that receive priority services (such as pregnant women), 4) descriptions of eligibility criteria for services, 5) describe the referral pathways between services, 6) outline screening procedures and the treatment process, and 7) specify how care will be coordinated between organisations (NHS, 2006). By utilising pre-existing resources and services within local communities, these *ICPs help ensure that clients receive the services they need and address many of procedural difficulties that clients face when attempting to access services* (Myers, 2007).

3.4.4. An individual's treatment plan must be assessed continually and adapted as needed to ensure that the plan meets the person's changing needs

As the client progresses through the course of treatment, *treatment plans should be revised and reassessed* (NIDA, 1999) both routinely and as changes in a client's circumstances make it necessary to do so (NHS, 2006; UNODC/WHO, 2008). This is important as new needs and concerns may arise during the course of treatment and other concerns may become less pressing. For example, a client may require varying combinations of services during the course of treatment and recovery. In addition to counselling or psychotherapy, at different times during treatment a client may require medication, other medical (including psychiatric) services, family therapy, parenting skills training, vocational training, and social and legal services (NIDA, 1999). *Therefore, it is important to view client assessment and the development of treatment plans as part of an ongoing process rather than a single event that occurs during treatment entry.*

3.4.4.1. Recommendation: Re-assess clients' needs and revise treatment plans accordingly.

To ensure this evidence-based principle is adhered to, service providers should assess clients' needs on a continuous basis to ensure that clients' current needs are being met by the treatment plan and to revise the plan to meet new needs. *Action steps to promote this principal include* the development of clinical protocols that specify, document and standardise 1) client progress, 2) client monitoring procedures, and 3) revisions to the written treatment plan (UNODC/WHO, 2008). This will help ensure ongoing engagement in treatment, positive outcomes, and client satisfaction with services (NHS, 2006; UNODC/WHO, 2008).

3.4.5. Staying in treatment for an adequate period of time is critical for treatment effectiveness.

There is a large body of research which supports the claim that the longer the duration of treatment for SUDs, the better the treatment outcomes (Hubbard et al., 1989; UN, 2002; UNODC/WHO, 2008). As most people in treatment have chronic and diverse problems, it is not surprising that the longer one remains in treatment, the greater the likelihood of benefits and that change will be consolidated. The appropriate duration of substance abuse treatment depends on the individual's problems and needs. However, research consistently indicates that, for most clients, *the minimum time threshold to attain significant improvement is about three months* (Gossop et al., 1989; Grella et al., 1999; Hubbard et al., 1989). After this threshold is reached, additional time spent in treatment can produce further progress and facilitate positive and sustained behaviour change (Gossop, 2006; NIDA, 1999).

3.4.5.1. Recommendations for ensuring treatment is of a sufficient duration.

These findings have implications for the development of effective treatments for SUDs. As people with SUDs often leave treatment programmes (especially community-based outpatient programmes) prematurely, programmes should include strategies to engage and keep clients retained in treatment. Some of these strategies are discussed under effective treatment approaches and may include the use of incentives for remaining in the programme and the use of non-confrontational therapeutic styles.

However, not all treatment programmes need to be three months in duration. *Stepped-down care approaches can also be used to ensure that treatment is of a sufficient duration to have a sustained impact on clients' behaviour.* It is completely appropriate to have reductions in the intensity of services over time, as long as the client continues to show positive treatment outcomes and remains engaged in the treatment process. For example, a client may enter short-term (21 day) inpatient treatment programme, following this programme s/he may move

to intensive (five times per week) outpatient services for 60 days or more, after which the client may graduate to less intensive outpatient services once or twice a week (UN, 2002).

3.4.6. Counselling (individual and/or group) and behavioural therapies are essential components of effective treatment

Access to counselling and therapies targeting behaviour change is an essential component of effective treatment for SUDs (NIDA, 1999; UNODC/WHO, 2008). Over the last twenty years, many of the psychosocial treatment models for SUDs have been evaluated and several meet the criteria for evidence-based treatment approaches (NIDA, 1999; UNODC/WHO, 2008).

This section presents four examples of evidence-based treatment approaches for community-based outpatient programmes. These are among the most widely researched and promising psychosocial interventions for individuals with SUDs. These models are used in a range of contexts, countries (developing and developed) and population groups (adolescents and adults). They are particularly suited to community-based outpatient settings. As such, this list of evidence-based treatments is *not* exhaustive. There are other evidence-based approaches targeted at specific population groups (e.g. homeless crack addicts and adolescent-specific programmes) and designed for inpatient treatment only. The approaches can be used as stand alone programmes and in some cases can be used to supplement and enhance existing treatment programmes.

3.4.6.1. Relapse prevention.

Relapse prevention is a cognitive-behavioural therapy that was developed for the treatment of problem drinking and adapted later for cocaine and other drug use. It can be used as a stand alone treatment or as a component of a more comprehensive treatment programme. It can be used in inpatient or community-based outpatient settings.

- **Core components and key ingredients**

This approach is based on the theory that learning processes play a critical role in the development and maintenance of maladaptive patterns of behaviour. Relapse prevention provides individuals with several cognitive-behavioural strategies that facilitate abstinence and provide help to people who experience relapse (Carroll et al., 1994; Marlatt & Gordon, 1985).

This approach combines behavioural skills training, cognitive interventions, and lifestyle change procedures (Marlatt & Gordon, 1985). Its primary goal is to teach drug users who are trying to change behaviour how to *identify, anticipate and cope* with the pressures and

problems that may lead towards a relapse (Marlatt, 1985). For example, individuals are taught to identify cognitions, negative moods, and external (e.g. interpersonal and situational) events that trigger thoughts, urges and cravings for alcohol and drug use (Gossop, 2006; Gossop et al., 2002). Individuals are also taught *cognitive, avoidance and distraction strategies* to enhance self-control and to cope effectively with high-risk situations and stressors. *Specific techniques* include exploring the positive and negative consequences of continued use, self-monitoring to recognise drug cravings early on and to identify high-risk situations for use, and developing strategies for coping with and avoiding high-risk situations and the desire to use (Carroll, Rousaville, & Keller, 1991; Marlatt & Gordon, 1985).

- **Evidence for effectiveness**

There is a large body of evidence supporting the effectiveness of relapse prevention (RP) approaches. For example, a review of controlled clinical trials of RP concluded that, for a range of different substances of abuse, there is evidence for the effectiveness of RP over no-treatment control conditions. RP was found to be as effective, but not superior to 12-step facilitation and MET approaches (Carroll, 1996).

RP may be particularly valuable for reducing the intensity and duration of relapse episodes, if they occur (Gossop, 2006). Also, studies comparing RP to standard counselling approaches have found sustained main effects or delayed emergence of effects for RP. This suggests that clients receiving RP may show sustained or continued improvement in their coping skills and treatment outcomes compared to clients who did not receive RP training (Gossop, 2006). This claim is supported by research that indicates that the skills individuals learn through RP therapy remain after the completion of treatment. In one study, most people receiving this cognitive-behavioural approach maintained the gains they made in treatment throughout the year following treatment. They also had significantly better treatment outcomes at one year follow up compared to those who received non-RP treatments (Carroll et al., 1994).

3.4.6.2. The Matrix Model.

The Matrix Model is an eclectic model that combines elements of several evidence-based treatment approaches (i.e. motivational interviewing, cognitive-behavioural therapy and 12-step facilitation) into a single framework. It was initially developed for the treatment of stimulant (cocaine and methamphetamine) dependence but has been adapted and is effective for the broad range of substances of abuse (including alcohol and opiates). It is a stand alone treatment designed to be used in community-based outpatient settings. It includes separate programmes for adolescent and adult and criminal justice populations (NIDA, 1999; UNODC/WHO, 2008). It is a highly structured programme, with detailed

manuals for assessment and treatment. The treatment manuals contain work sheets for each core component of the programme. These components are discussed below:

- **Core components and key ingredients**

The Matrix model provides a comprehensive framework for engaging individuals with SUDs in treatment and helping them achieve abstinence. Borrowing heavily from RP, this approach combines *behavioural skills training, cognitive interventions, and lifestyle change* procedures. Its *primary goals* are to 1) engage and retain individuals in treatment, 2) facilitate early abstinence from drugs (called early recovery) and 3) prevent relapse through equipping these individuals with skills to identify, anticipate and cope with situations that may lead to relapse (Huber et al., 1997; Rawson et al., 1995).

The *core components* of this approach include 1) psycho-education, during which patients learn about issues critical to addiction and relapse (especially the effect of substances on the neurochemistry and functioning of the brain, the development and recovery from substance dependence and triggers and high risk situations); 2) manualised and structured group counselling sessions, specifically early recovery groups during which strategies to achieve early recovery are discussed and relapse prevention groups; 3) individual counselling sessions where they receive direction and support from a trained therapist; 4) exposure and participation in 12-step self-help programmes during the course of treatment; and 5) participation in social support groups during the course of treatment. Much of the focus of this approach is on group work. The programme also includes family education and conjoint/family counselling sessions for family members affected by the SUD. In addition, all individuals are monitored for alcohol and drug use by breath and urine testing (Rawson et al., 1995).

In this model, the *therapist-client relationship is seen as a key element* for client retention and positive behaviour change. Borrowing from motivational interviewing, the therapist functions simultaneously as a teacher and coach. The therapist fosters a positive, encouraging relationship with the client and uses this relationship to reinforce behaviour change. The interaction between the therapist and the client is realistic and direct but is never confrontational. Therapists are trained to conduct treatment sessions in a way that promotes the client's self-esteem, self-efficacy in their ability to change, dignity, and self-worth (Rawson et al., 1995).

- **Evidence for effectiveness**

Several evaluations of the Matrix Model have been conducted over the past 15 years. These range from open trials with few controls to controlled clinical trials. Findings from these

evaluations demonstrate that participants treated with the Matrix model show statistically significant reductions in drug and alcohol use, improvements in psychological indicators, and reductions in sexual risk behaviors associated with HIV transmission (Huber et al., 1997; NIDA, 1999; Rawson et al., 2002).

The most compelling evidence for the effectiveness of the Matrix Model comes from the Methamphetamine Treatment Project. This project compared the Matrix Model of treatment with other treatment methods available (treatment-as-usual [TAU]) at eight different sites. Across sites, this study found significantly better retention and treatment completion rates for individuals assigned to the Matrix model compared to the TAU group. Across sites, individuals assigned to the Matrix model also had more reductions in their drug use, better abstinence rates, and longer periods of abstinence than individuals assigned to the TAU condition (Galloway et al., 2000; Huber et al., 2000; Rawson et al., 2002; Rawson et al., 2004). Together these reports provide a body of empirical support for the use of the model.

3.4.6.3. Motivational enhancement therapy (MET).

MET is a structured therapeutic approach that is largely based on the therapeutic style, key components, strategies and techniques of motivational interviewing (Miller, 1983; Miller and Rollnick, 1991). It was initially developed for the treatment of problem drinking, but has since been applied to the treatment of illicit substance dependence (Gossop, 2006). It can be used as a stand alone treatment or as a supplement to pre-existing treatment programmes. It can also be used successfully in community-based outpatient as well as inpatient settings (NIDA, 1999; UNODC/WHO, 2008). The key components of this evidence-based approach are discussed below:

- **Core components and key ingredients**

MET is a *client-centered* counselling approach for initiating behaviour change by helping clients to resolve ambivalence about engaging in treatment and stopping their use of alcohol and drugs. In this approach, the *therapist-client relationship is seen as a key element* for client retention and positive behaviour change. The therapist functions simultaneously as a teacher and coach. The therapist fosters a positive, encouraging relationship with the client and uses this relationship to reinforce behaviour change. The interaction between the therapist and the client is realistic and direct but is never confrontational. Therapists are trained to conduct treatment sessions in a way that promotes the client's self-esteem, self-efficacy in their ability to change, dignity, and self-worth (Miller & Rollnick, 1991).

The *primary goal* of this approach is to evoke rapid and internally motivated change in the client, rather than guiding the client stepwise through the recovery process. The *core components* of this therapeutic approach include an initial comprehensive assessment

session followed by two to four individual treatment sessions with a therapist. This comprehensive assessment includes a thorough medical and psychological assessment. The first treatment session focuses on providing feedback generated from the initial assessment. This feedback is designed to stimulate discussion regarding personal substance use, to identify the advantages and disadvantages to changing current substance use, and to increase readiness to change behaviour through the individual identifying the need for change and self-motivational statements in their ability to change (Gossop, 2006; Miller et al., 1996). Motivational interviewing principles are used to strengthen motivation and build a plan for change. As part of developing an action strategy for change, coping strategies for high-risk situations are suggested and discussed with the client. In subsequent sessions, the therapist monitors change, reviews cessation strategies being used, and continues to encourage commitment to change or sustained abstinence (Miller et al., 1996).

- **Evidence for effectiveness**

This approach has been used successfully with individuals with alcohol and other drug dependence (Budney et al., 1996). Several evaluations of MET have been conducted over the two decades. Findings from these evaluations demonstrate that participants treated with MET were more likely to be retained in treatment (Ball et al., 2007; Carroll et al., 2001), had greater commitment to treatment goals and better treatment compliance, and had fewer drug related problems and relapses (Lincourt et al., 2002; Saunders et al., 1995; Stephens et al., 2000; Winhusen et al., 2007) than participants assigned to control groups. Similarly, persons with co-occurring SUDs and depression assigned to an MET treatment group were more likely to remain in treatment, complete treatment, and have fewer post-treatment psychiatric problems than those assigned to a treatment as usual programme (Daley et al., 1998). Recently, MET has also been shown to be an effective treatment for methamphetamine dependence (Galloway et al., 2007).

3.4.6.4. Contingency management approaches (CM).

Contingency management (CM) is a behavioural treatment that is used to encourage behaviour change. It is designed to make continued drug use less attractive and abstinence from drugs more attractive (Stitzer et al., 1989; Robles et al., 1999). It involves the systematic delivery of rewards (incentives) or punishing consequences (disincentives) contingent on a targeted response, and the withholding of these consequences in the absence of the targeted response (Cameron & Ritter, 2007; Higgins & Silverman, 1999). These are interventions where clients receive tangible positive reinforcers for evidence of desired behaviour change (Petry, 2006). CM approaches are rarely used as stand alone treatments and are largely used to enhance pre-existing treatment programmes. They are oriented towards community-based outpatient programmes and have been used to increase

client retention in treatment, increase compliance with treatment requirements, and improve drug use outcomes (NIDA, 1999; Silverman et al., 1996; UNODC/WHO, 2008).

Different types of reinforcers may be used in CM programmes to promote desirable behaviour changes. In treatment for SUDs, reinforcers often include the offer of monetary incentives or vouchers for clean urines or desired treatment outcomes (Silverman et al., 1996). Several evidence-based approaches based on CM principles have been developed and evaluated. One such evidence-based approach is the community reinforcement approach (CRA). The key components of this approach are discussed below:

- **Core components and key ingredients of the Community Reinforcement Approach (CRA) Plus Vouchers.**

The CRA is an intensive 24-week outpatient therapy for the treatment of substance dependence. The *primary goals* of this approach are to achieve abstinence long enough for clients to learn new life skills that will help sustain abstinence and to reduce alcohol consumption for patients whose drinking is associated with other drug use (Higgins et al., 1994).

The *core components* of this approach are as follows: 1) clients attend one or two individual counselling sessions per week, where they focus on improving family relations, learning a variety of skills to minimize drug use, receiving vocational counselling, and developing new recreational activities and social networks; 2) clients who also abuse alcohol receive clinic-monitored disulfiram (Antabuse) therapy; 3) clients submit urine samples two or three times each week and receive vouchers for drug-negative samples. The value of these vouchers increases with consecutive clean samples. These vouchers can be exchanged for retail goods that are consistent with a substance-free lifestyle (Higgins et al., 1994; Silverman et al., 1996). The *rationale* for using incentives to improve treatment outcomes with drug users is that rewarding abstinence or other prosocial behaviours will encourage further treatment success (Cameron & Ritter, 2007).

- **Evidence for effectiveness**

The substantial research base for CM approaches began in the early 1980s and has continued to expand (Cameron & Ritter, 2007). Research shows that CM facilitates engagement in treatment and systematically help clients to achieve substantial periods of abstinence (NIDA, 1999). Several evaluations of CRA and other CM approaches have been conducted. The approach has been tested in urban and rural areas and used successfully with cocaine-dependent clients, in outpatient detoxification of opiate-addicted adults, and with inner-city methadone maintenance patients who have high rates of intravenous cocaine

abuse, and among stimulant users (Higgins et al., 1995; Higgins et al., 2000; Higgins et al., 2004; Lussier et al., 2006; Petry et al., 2006; Silverman et al., 1996).

Findings from these evaluations demonstrate that CM approaches effectively reduce continued drug use among outpatient populations (Lussier et al., 2006; Petry et al., 2006; Silverman et al., 1996; Strain et al., 1999) and increase treatment attendance (Jones et al., 2001; Kidorf et al., 1994). CM has also been shown to be a useful treatment for non-responsive clients. Even with unresponsive clients, a substantial number can be motivated to stop their drug use when the reward value is sufficiently high (Robles et al., 2000). However the provision of rewards should not be delayed- immediate and mixed (immediate and delayed) intervals seem to lead to a greater treatment response than when rewards are delayed. To ensure the effectiveness of this approach, it is also important to routinely and regularly monitor drug use outcomes via urine testing. These tests should be conducted at least three times per week (Griffith et al., 2000). More recently CM approaches have been shown to have promise as a component of treatment for methamphetamine dependence (Roll et al., 2006).

3.4.7. Medications are an important element of treatment for many patients, especially when combined with counselling and behavioural therapies.

3.4.7.1. How is medication used?

Prescribing substitution medication (such as methadone) for sustained periods to substitute for illicit opiates (e.g. heroin), medications to manage withdrawal, medications to prevent relapse to alcohol or illicit opiate use, and prescribing medications to manage psychiatric symptoms (especially among stimulant users) are all key elements of effective treatment (NHS, 2006). There is a large body of research supporting the use of medication as an *aid* to *achieving and maintaining abstinence* from illicit drug use (Gossop, 2006).

3.4.7.2. When is it useful to use medication?

The use of medication is a key component of effective treatment, *but it is only really useful if combined with interventions that target behaviour change* (NIDA, 1999). The provision of substitution medication alone does not constitute drug treatment. The use of medication is only really effective in the long-term when it forms part of a treatment package that addresses the multiple needs of individuals with SUDs and provides access to counselling and other psychosocial interventions (such as the provision of social support) (NIDA, 1999; Wechsberg, 2007).

3.4.7.3. The role of medication during the course of treatment

Nonetheless, the appropriate use of medication is a *useful treatment aid*. Used during the course of substance abuse treatment, it facilitates engagement and retention in treatment by

easing some of the physical and psychiatric symptoms (such as anxiety) that make it difficult for people to engage in treatment and remain abstinent for any length of time (Gossop, 2006).

3.4.7.4. What kinds of medication are available?

There are a range of maintenance medications with proven efficacy in preventing relapse for people with heroin dependence. Methadone and buprenorphine (*Subutex*) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence (NIDA, 1999; UNODC/WHO, 2008). While buprenorphine is registered and available in South Africa for those who can afford to pay for the medication, methadone is not registered with the Medicines Control Council in a form that can be used for long term methadone maintenance therapy. Buprenorphine is not available in the public health sector. In addition, psychiatric medications (such as antidepressants, mood stabilizers, and neuroleptics) may be critical for treatment success when patients have co-occurring psychiatric disorders, such as depression, anxiety disorder, bipolar disorder, or psychosis (NIDA, 1999; UNODC/WHO, 2008).

3.4.8. Individuals with SUDS and other co-existing mental disorders should have both disorders treated in an integrated way

As many individuals with SUDs also have other co-occurring psychiatric disorders (such as affective, anxiety and personality and psychotic disorders), individuals presenting for treatment for either condition should be assessed and treated for the co-occurrence of the other type of disorder (NIDA, 1999; UNODC/WHO, 2008; UN, 2002).

Within the context of treatment for SUDs, the provision of integrated care for individuals with SUDs and co-occurring psychiatric disorders is important for treatment outcomes. Research has shown that the diagnosis and treatment of co-occurring psychiatric disorders improves retention and treatment outcomes of clients receiving substance abuse treatment (UNODC/WHO, 2008). In contrast, untreated and severe psychiatric symptoms are reliable predictors of dropout and poorer substance abuse treatment outcomes (Alterman, 1994; Gossop, 2001; UN, 2002).

3.4.8.1. Recommendations for improving the integration of services

Substance abuse treatment services can improve their effectiveness by *screening all clients for the presence of co-occurring psychiatric disorders and providing clients who screen positive for these disorders with appropriate pharmacological treatment and counselling* (UNODC/WHO, 2008). At the very least, we need to improve the integration of the different

systems of care for SUDs and psychiatric disorders. This can be achieved by making better inter-system arrangements (such as clarifying referral pathways and by developing inter-institutional service level agreements that prioritise and fast track the provision of care for individuals with both SUDs and psychiatric disorders (Myers, 2007). These efforts may help improve access to care for individuals with co-occurring psychiatric difficulties (Myers, 2007).

3.4.9. Medical detoxification is only the first stage of treatment and by itself does little to change long-term substance use

3.4.9.1. What are the goals of detoxification?

Medical detoxification is only the first stage of treatment for SUDs and by itself does little to change long-term alcohol and drug use. Medical detoxification safely manages the acute physical symptoms of withdrawal associated with the cessation of heavy and persistent alcohol and drug use. The main goals of detoxification are to safely manage medical complications during withdrawal and to attain abstinence. As such, detoxification is a medical process and should only be undertaken by qualified medical personnel. Detoxification can also provide useful opportunities to increase motivation for further treatment (Mattick & Hall, 1996). Consequently, detoxification is viewed as a precursor of treatment that is not designed to address the psychological, social, and behaviour problems associated with SUDs. As such, detoxification alone does not typically produce lasting changes to behaviour.

3.4.9.2. When is detoxification required?

While detoxification alone is rarely sufficient to help individuals with substance dependence attain long-term abstinence, for some it is a strongly indicated precursor to effective substance abuse treatment (NIDA, 1999; UNODC/WHO, 2008). More specifically, medically supervised detoxification is a prerequisite for individuals who are heavily dependent on alcohol, opiates such as heroin, benzodiazepines, barbiturates and other sedative/hypnotic substances as these individuals are more likely to experience high levels of discomfort or complications during the withdrawal process and untreated withdrawal may be medically dangerous or even fatal (Kleber, 1996; UNODC/WHO, 2008).

3.4.9.3. Recommendations regarding detoxification and its relationship to substance abuse treatment

To ensure that this evidence-based practice of viewing detoxification as a first step in a treatment process is adhered to, all detoxification services should incorporate formal processes of assessment, preparation for, and referral to subsequent substance abuse treatment aimed at maintaining abstinence and promoting rehabilitation (Kleber, 1996; Mattick & Hall, 1996). *Detoxification should always be followed by a more comprehensive*

treatment programme. It should be timed so that the individual engages in their treatment programme as soon as possible after detoxification is complete.

3.4.10. Treatment does not need to be voluntary to be effective

Strong external motivation can facilitate the treatment process. Sanctions or push factors from the family, employer, or criminal justice system can increase significantly treatment entry and retention rates and the success of substance abuse treatment (Gossop et al., 2006; NIDA, 1999).

3.4.10.1. Legal pressure to enter treatment can be an effective strategy.

More specifically, individuals who enter treatment under legal pressure have outcomes as good as those who enter treatment voluntarily (Rawson et al., 2002). Increasingly, research is demonstrating that treatment for drug-dependent offenders during and after incarceration can have a significant beneficial effect upon future drug use, criminal behaviour, and social functioning (Gossop et al., 2006; Hubbard et al., 1998; Wexler et al., 1990). The case for integrating substance abuse treatment approaches with the criminal justice system is compelling. Combining prison- and community-based treatment for offenders with substance use disorders has been shown to reduce the risk of both recidivism to drug-related criminal behaviour and relapse to substance. For example, one study found that prisoners who participated in a therapeutic treatment program in the Delaware State Prison and continued to receive substance abuse treatment in a work-release programme after prison were 70 % less likely than non-participants to return to drug use and be rearrested (Wexler et al., 1997). Apart from the provision of prison-based programmes, positive treatment outcomes have also been associated with the criminal justice system diverting non-violent offenders to treatment and stipulating treatment as a condition of probation or community supervision (Gossop, 2006; Hiller et al., 1996; NIDA, 1999).

3.4.11. Possible substance abuse during treatment must be monitored.

Possible substance use during treatment must be monitored continuously as lapses to substance use can occur during treatment. The objective monitoring of a client's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the client withstand urges and cravings to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be revised and adjusted accordingly (NHS, 2006; NIDA, 1999; UNODC/WHO, 2008). While monitoring of drug use during treatment is a core element of treatment, this monitoring should not be used for punitive purposes. It is important to provide supportive feedback to clients who test positive for illicit drug and positive drug urines should not be used to kick a person out of a treatment programme (UNODC/WHO, 2008).

3.4.11.1. Recommendation regarding client monitoring

To ensure this evidence-based principle is followed, it is *important to routinely monitor clients' alcohol and drug use during the course of treatment*. All treatment centres should regularly (at *least three times a week*) test clients' urine for the presence of drugs. Clients' should be tested for the broad range of substances as it is not uncommon for clients to replace the use of one drug (e.g. heroin) with another (e.g. cannabis). Breathalysers can be used to test for recent alcohol use. *Client monitoring should be used as a tool to assess client progress and to adjust treatment programmes accordingly rather than as a device to punish clients for non-compliance.*

3.4.12. Treatment programmes should include assessment for HIV/AIDS, Hepatitis B and C, Tuberculosis and other infectious diseases, and counselling to help patients change behaviours that place themselves at risk of infection

Testing clients for infectious diseases and blood borne viruses and providing clients with counselling that targets high risk behaviours (such as injection drug use) for infectious disease can help prevent new infections and can also help people who are already infected manage their illness (NIDA, 1999). This counselling could include advice and information on how to prevent the transmission of blood borne viruses and other infections, advice and support for safer injecting practices, counselling related to HIV testing, and advice and support for preventing overdose and drug related death (NHS, 2006; UNODC/WHO, 2008). These initiatives should be integrated into all substance abuse treatment programmes and incorporated into treatment plans as needed; especially as these interventions have demonstrated effectiveness in preventing the transmission of HIV/AIDS and blood-borne infections among individuals with SUDs (UNODC/WHO, 2008). *At the very least, testing and counselling for HIV should be encouraged and made available to all clients entering substance abuse treatment.*

3.4.13. Recovery from substance dependence can be a long-term process and often requires multiple episodes of treatment

As substance dependence is typically a chronic disorder characterised by occasional relapses, short-term, once-off treatment often is not sufficient to facilitate sustained changes in behaviour. As with other chronic illnesses, relapses to substance use can occur during or after successful treatment episodes. The difficulty that people experience in achieving and maintaining abstinence is partly due to the fact that long-term drug use results in significant changes in brain functioning that last long after the individual stops using drugs (NIDA, 1999). As a result of these high levels of relapse, *many individuals with SUDs require prolonged and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning.* Participation in self-help support and aftercare programmes following

treatment often is helpful in maintaining abstinence (Moos, 1999; NIDA, 1999). Despite this, successful outcomes may require more than one treatment experience (Gossop, 2006; NIDA; 1999). In addition, good outcomes require adequate lengths of treatment. Generally, for community-based outpatient treatment, clients should participate for at least 90 days to show any benefits and longer involvements in treatment are often required (Gossop, 2006).

3.5. Evidence for the role of the community in community based treatment

There is overwhelming evidence that for community based treatment to be effective, these services should not merely be based in local community settings, but should promote and facilitate the active involvement of local communities in their structure and functioning. In other words, there should be a degree of *community ownership*, where communities play an active role in the services that are designed to meet their substance abuse treatment needs (UNODC/WHO, 2008). To establish community ownership, community based treatment requires the *active involvement* of local stakeholders (including the state, NGO and private sector; community leaders; religious organisations and traditional healers), community members, and representatives of target populations. This community ownership is essential for ensuring that the target community uses and values the available service (UNODC/WHO, 2008).

3.5.1. What form should this active role take?

Community participation and involvement in community based treatment services refers to the following:

- **Active involvement of clients in decision making processes** regarding their treatment and recovery processes. This helps promote individual responsibility for behaviour change and ownership of their treatment process. This is important for the achievement and maintenance of positive treatment outcomes (Miller, 1999; NIDA, 1999; UNODC/WHO, 2008).
- **Provide services that are accountable to the community and target their needs.** It is increasingly being recognized that service delivery processes need to be accountable to the target community. This accountability relates to the extent to which treatment services a) target specified community needs and interests and b) are effective in meeting these targeted needs and interests (UNODC/WHO, 2008).
- **Establish linkages (ICPs) between drug treatment services and other services available in local settings.** By establishing these linkages, community based services are more likely to be able to provide comprehensive substance abuse services that

meet the multiple needs of their clients and the larger community. These services provide ongoing support to local communities and individual clients within these communities (NHS, 2006; UNODC/WHO, 2008).

3.5.2. Recommendations to promote community involvement in community based treatment services:

- **Ensure that target populations, community members and other local community-based organisations are actively involved in the planning, implementation, and monitoring of treatment.** This does not mean that local community members should provide the services, but they can provide inputs into whether the service is useful, effective and well-received. Community members inputs into the monitoring and evaluation of service quality is particularly valuable for improving existing services (Hallfors et al., 2002).
- **Integrate community based services for SUDs into a network of services available in local communities (ICPs).** It is particularly important for these services to be integrated with other public health and social welfare networks available in the community. This will smooth referral pathways for community members and increase access to and the use of services based in local communities (Hallfors et al., 2002; Myers, 2007).
- **Ensure that clients, their family members and concerned community members are actively involved** in improving drug problems within their communities by challenging and helping to change stigma towards and negative perceptions of substance abuse treatment services. Stigma is an important barrier to the use of services located within in local communities (Myers, Fakier, & Louw, in press). It is important to address this factor in order to ensure that treatment services are accepted into local communities and that the services that are offered by organizations are used to their full capacity.
- **Implement sound, evidence-based and sustainable long term education and awareness strategies aimed at local communities.** This strategy should promote the concept that substance use disorders are brain diseases and should educate communities about the value and availability of evidence-based treatments for these disorders (UNODC/WHO, 2008)

To summarize:

- When evidence-based principles are followed, community based outpatient services can effectively reduce alcohol and drug use as well as the harms associated with substance use disorders
- *Evidence-based criteria* for deciding whether a person should attend inpatient or outpatient services were provided.
- Several *evidence-based principles that apply to both community based outpatient and inpatient services* were outlined.
- *Four evidence-based treatment models proven to be effective in community settings were described* with evidence for their effectiveness: the matrix model, relapse prevention models, motivational enhancement and contingency management approaches
- The *role of the community* in community based services and recommendations to improve community participation were given.

4. AFTERCARE.

The chronic and relapsing nature of substance abuse points to the need for continuing care after a primary phase of treatment. The importance of post-treatment aftercare is widely accepted (Ouimette et al., 1998). The period after leaving treatment has a very high risk of relapse and adequate support should be provided to the client during this period so that the positive progress made during treatment is not lost (Gossop et al., 2007). This is because substance abuse treatment by itself is often not of a sufficient duration to ensure that a person is able to maintain the progress they have made. Consequently, aftercare is an essential component of successful substance abuse treatment that allows a person to continue to receive support, but is much more cost-efficient than the ongoing use of primary treatment services.

In the South African context, the value of aftercare has been downplayed and there has been relatively little emphasis on aftercare in either research or practice. More recently, the importance of aftercare has begun to be recognised and more emphasis has been placed on investigating 1) what constitutes effective aftercare and 2) how best to implement effective aftercare services in local community structures. While the aim of this section is to provide guidelines for evidence-based aftercare practices, *it should be noted that most aftercare services have not been extensively evaluated and very little evidence exists as to what works best in aftercare settings.*

4.1. What is aftercare?

4.1.1. *Aftercare services generally refer to the following:*

- Aftercare involves the *provision of ongoing support and counselling* to the individual once they complete structured inpatient or outpatient treatment services.
- Aftercare is the *stage in the treatment chain* following discharge, when the individual no longer requires services at the intensity needed during primary treatment, but still requires ongoing support.
- As such, aftercare is often seen as a second stage of treatment and not as a separate entity.
- However, aftercare services are *less intensive* than either inpatient or outpatient treatment services
- Aftercare provides the "... structure needed to maintain and extend the gains of treatment" (Brown et al., 2001, p. 186).

4.1.2. The goals of aftercare services

The overriding goal of aftercare services is to *support the individual to reintegrate into their families and communities and to assist them in remaining abstinent* from their alcohol and drug use. More specific goals include the following:

- To provide *continuity of care and ongoing support* for the individual during their recovery
- To *maintain the positive progress* individuals have made during the course of their treatment by providing individuals with additional tools to equip them to maintain their treatment gains.
- To *support and assist individuals to reintegrate into their communities* and return to their daily lives while remaining drug-free and sober
- To support individuals and further develop their skills to lead a pro-social, sober lifestyle and consequently to *avoid relapse* to alcohol or drug use.

(Gossop et al., 2007; Ouimette et al., 1998).

4.1.3. Types of aftercare services

The following types of services are generally categorised as aftercare or continuing care services:

- Assistance with *safe housing* in environments conducive to recovery. This is also known as “Sober living” services.
- Provision of *ongoing education and vocational training services* to aid reintegration into society and the rebuilding of lives
- Ongoing provision of *(low intensity) counselling and support related to relapse prevention*
- Provision of *additional counselling services related to problems in other domains of functioning that may impact on recovery processes*. These may include ongoing mental health services, social support services, or family services.
- Participation in *self-help support groups*.

4.1.4. Settings in which aftercare services typically occur

In South Africa, aftercare services are generally provided in the following types of settings:

- *Formal treatment services*- typically by service providers providing ongoing relapse prevention counselling of lower intensity. Only a small number of programmes have sufficient resources to provide any form of aftercare and generally clients are referred to other organisations and to self-help groups for these services.
- *Halfway houses and sober living establishments* (e.g. secondary and tertiary care facilities) that provide some low intensity counselling and support services or access to these services

- *Self-help /mutual-help support groups* in community settings that consist of individuals at various stages of recovery and who act as a source of support to each other. As these groups are the most common form of continuing care in South Africa, they are discussed in more detail below:

4.1.4.1. Self-help support groups

- In the Western Cape, the most common self-help organisation is the *twelve-step support groups*. *These groups are based on the principles of Alcoholics Anonymous (AA)* and are found worldwide.
- These *community-based groups* provide support for the individual with the alcohol or drug problem via their 12-step programme.
- There are derivatives of these groups available that provide support services for families affected by alcohol and / or drugs (see Box 11 for an outline of some of the 12-step support groups available).
- These twelve-step groups have literature available in four South African languages, standard meeting formats, are non-religious, community-based, and free of charge.
- Because of their self-supporting nature, twelve-step groups provide a form of aftercare at *no cost* to existing treatment services or to the individual (Gossop et al., 2007).
- In South Africa, *twelve-step groups are a feasible aftercare option and provide a social support network that aids individuals in maintaining their sobriety*.
- Apart from these twelve-step support groups, there are also other support groups run by faith based organisations, such as CAD (Christelike Afhanklikheids Diens), and secular organisations, such as Tough Love. The effectiveness of these other kinds of support groups has not been established.

Box : 11 Types of 12-step support groups in the Western Cape

Alcoholics Anonymous (AA) for people who think they have a drinking problem and have a desire to stop

AlAnon Family Groups for people who have a family member or friend who has a problem with alcohol

Alateen for teenagers affected by parents drinking

Narateen for teenagers affected by parents' drug use

NarAnon Family Groups for people who have a family member or friend who has a problem with drugs

Narcotics Anonymous (NA) for people who think they have a drug problem and have a desire to stop

4.2. When are aftercare services appropriate to use?

- ***Aftercare services are appropriate for individuals who have already successfully completed a treatment episode.***

For these individuals, it does not matter whether this treatment episode occurred in an inpatient or outpatient setting. It is however important that the individual has been able to achieve abstinence during the course of treatment.

- ***Aftercare is not appropriate for individuals who need more intensive services.***

For individuals who have completed a treatment episode but have been unable to achieve abstinence, additional ongoing treatment services are needed rather than less intensive aftercare services (Fiorentine & Hillhouse, 2000).

- ***Aftercare services are not appropriate to use as a substitute for treatment.***

Individuals who have been unable or unwilling to enter primary treatment should not be referred to aftercare services. Self-help groups in particular are best viewed as a form of continuing care rather than as a substitute for acute treatment services (Fiorentine & Hillhouse, 2000).

- ***Twelve-step self-help support groups are often used as an aftercare resource, but these may not be appropriate for some individuals.***

These programmes may not be appropriate for individuals with major psychiatric disorders, those with substance abuse rather than substance dependence diagnoses, and those uncomfortable with the religious or spiritual emphasis of these programmes.

4.3. Evidence-based principles of aftercare services

4.3.1. ***Clients should interact with other individuals with similar kinds of problems***

Interaction with persons at different stages of recovery facilitates the development of new social networks that are substance-free as well as the development of positive sources of *social support*. This also promotes group cohesion. *The provision of social support to individuals in recovery has been shown to be a key ingredient in both achieving and maintaining abstinence over time* (Moos et al., 2001). In addition, the development of these substance-free social networks can help *maintain abstinence* via changing perceptions around alcohol and drug use norms within society and local communities (Fiorentine & Hillhouse, 2000).

For example, AA and NA offer peer groups that support efforts to achieve and maintain abstinence. Members of these peer groups share the same problems, but also share a goal to remain abstinent from alcohol and drugs and thus actively support each individual in his or

her recovery journey. They also share a commitment to learning of new, prosocial behaviours (Gossop, Green, Phillips, & Bradley, 1990). These groups are a powerful source of support for individuals trying to recover from substance dependence.

4.3.1.1. Recommendations regarding participation in support groups

Even if formal aftercare services are provided in treatment settings, service providers should link clients to self-help groups so that clients may access these available support networks. This is important as these organisations provide clients with ongoing support for abstinence, especially when the formal aftercare programme has been completed and there is an identified need for continuous support. Clients can also attend more structured formal services and twelve-step meetings simultaneously (Fiorentine & Hillhouse, 2000).

4.3.2. Effective aftercare services allow clients to share long-term sobriety experiences with each other.

The sharing of recovery and sobriety experiences is an important component of effective aftercare services. Individuals with many years of sobriety and long periods of abstinence from alcohol and drugs can act as mentors or sponsors and sources of support for individuals with relatively little recovery experience (Fiorentine & Hillhouse, 2000; Magura, 2007). This mentoring fulfills several functions. Firstly, the *more experienced mentors can act as role-models for the less experienced by modelling and sharing appropriate and desirable behaviours* associated with abstinence, *their experiences and knowledge* of the aftercare programme, and *methods of maintaining recovery* and avoiding relapse (Magura, 2007). While individuals celebrate their successes and explore the day to day issues that confront them during their recovery journey, mentors can provide them with insights, practical guidance and feedback on their progress (Crape, Latkin, Laris, & Knowlton, 2002). Secondly, the more experienced mentors can act as personal guides and sources of emotional support by conveying optimism around the recovery process, communicating hope and thus building individuals *self-efficacy or belief in their ability to maintain abstinence* (Magura, 2007; Moos et al., 2001).

4.3.2.1. Recommendations regarding sharing of sobriety experiences

Service providers should always refer clients to self-help support groups as these are valuable forums that allow clients to learn from other people's recovery experiences. For example, assisting new members in their recovery process through the sharing of

Box :12. Principles of Narcotics Anonymous

- Admitting there is a problem
 - Seeking help
 - Engaging in thorough self examination
 - Confidential self-disclosure
 - Making amends for harms done
 - Helping other drug addicts who want to recover
- (<http://www.na.org.za>)

experiences and the provision of mutual support is a core principle of the twelve-step support groups. This is illustrated in Box 12.

4.3.3. Effective aftercare programmes are tailored to meet the individual's needs.

Effective aftercare programmes provide services that target the individual's needs, as outlined during the initial assessment process (Gossop et al., 2007). A treatment and aftercare plan tailored for the individual increases their participation in the programme and enhances treatment outcomes (Moos et al., 2001; NHS, 2006). Due to limited resources, aftercare services generally struggle to provide services that meet the multiple needs of clients. However, services need not be provided directly. Service providers can use *case management techniques* to refer clients to additional services that may enhance their recovery.

4.3.3.1. Recommendations regarding the tailoring of aftercare services

Where possible, aftercare services should be tailored to meet the individual's needs. At the minimum, these services should be adapted to take into account the individual's social circumstances, age, gender, and culture (NIDA, 2003). In resource scarce settings, *case management techniques* (e.g. making referrals to additional services and securing safe housing on behalf of the client) are useful ways in which client's individual needs can be met without having to meet these needs directly. These techniques may enable the client to access needed resources, which will facilitate the client's reintegration into society.

4.3.4. Effective aftercare programmes are structured and goal-directed.

Evidence points to goal-directed aftercare programmes that offer structured activities that target specific goals having better outcomes than programmes that are unstructured and less directed (Moos et al., 2001; Sannibale et al., 2003). To meet this principle, aftercare programmes should have a structured content that aims to address specific needs and issues identified as important to the individual in their recovery process.

4.3.4.1. Recommendations regarding the structure of aftercare programmes

Aftercare programmes must be goal directed and sufficiently structured with clear programme content. Issues addressed in structured aftercare programmes typically include: intrapersonal issues associated with recovery and relapse, relationships and marital issues that impact on recovery and relapse (e.g. coping with substance using peer and social networks), and environmental factors and concerns associated with recovery (such as obtaining vocational skills, finding employment, securing safe housing and a sober living environment) (Moos et al., 2001).

4.3.5. Aftercare services should only be provided by suitably qualified personnel.

Formal aftercare services that involve continued individual and/or group counselling services that address issues such as mental health concerns, family issues and relapse prevention need to be run by suitably qualified professionals (e.g. psychologist or social worker). These professionals can be assisted by individuals in recovery or support counsellors. This is important as evidence points to these services being more effective when run by well-trained professionals than when run by persons with limited skills or experience (Moos et al., 2001). Self-help groups are an exception to this, but generally these self-help groups do not provide counselling services.

4.3.5.1. Recommendations regarding staff providing services

In formal aftercare programmes, service providers need to be skilled and well trained. Apart from the provision of structured aftercare services, the counselor or service provider should also take on a case management role and actively link clients to other services that may be needed during the course of their recovery. These could include mental health services, vocational skills training, and family services (Gossop et al., 2007).

4.3.6. Effective aftercare services involve the family

Effective aftercare services involve the family in some form. This principle recognises that family units are important sources of support in the recovery process (Moos et al., 2001) and that family involvement in treatment and aftercare is key to enhancing this support (Ouimette et al., 1998). While the twelve-step self-help groups, such as AA and NA, typically do not include family members directly in their programmes, they do have separate programmes for family members of individuals with alcohol and drug problems.

4.3.6.1. Recommendations regarding family involvement

Where possible, family members should be included in the aftercare programme. At a minimum, family members should be educated about the importance of providing support and helpful ways in which to provide this support. Where this is not possible, family members should be referred to twelve-step support groups that address these issues, such as NarAnon or AlAnon.

4.4. Evidence for the effectiveness of twelve-step support groups as a form of aftercare

Even though substance abuse treatment literature consistently cites the importance of aftercare, general research on aftercare is limited (Pelissier, Jones, & Cadigan, 2007). Twelve step programmes are the only form of aftercare that has been thoroughly researched and evaluated (Magura, 2007). As such, this review of the effectiveness of aftercare will

focus on the value of twelve-step programme participation (such as AA and NA) as a form of aftercare.

- **These approaches are useful tools for maintaining long-term abstinence and are associated with improved treatment outcomes over time.**

For example, Fiorentine (1999) found that regular and continuous participation in a twelve-step programme after intensive substance abuse treatment is *effective in maintaining long-term alcohol and drug abstinence*. Other studies have also found that individuals who reported post-treatment involvement in twelve-step support groups had better treatment outcomes than individuals with no involvement in these support groups (Etheridge et al., 1999; Fiorentine & Hillhouse, 2000; Humphreys et al., 1999; Moos et al., 2001).

- **Even where other aftercare services are provided, twelve-step participation seems to hold an added benefit in terms of maintaining treatment outcomes.**

For example, Ouimette, Moos and Finney (1998) investigated the impact of aftercare among individuals in treatment for substance abuse who chose to attend one of three types of aftercare groups (outpatient treatment only, twelve-step groups only, and outpatient treatment plus twelve-step groups) as well as individuals who did not participate in aftercare. Results indicated that participants who received no aftercare had the poorest outcomes. Participants who attended both outpatient treatment plus twelve-step groups achieved the best outcomes at follow-up.

- **The greater the individual's involvement in the twelve step programme the greater the benefits.**

Ouimette et al (1998) also found that individuals *who attended twelve-step groups more frequently or were more involved in twelve-step activities had better outcomes*. Other studies found that length of membership was positively linked to improved psychological health outcomes and greater reductions in alcohol and drug use (Christo & Franey, 1995; Humphreys, 2004).

- **Effective form of aftercare for adolescents.**

Participation in twelve-step groups is also an effective form of aftercare for young people. For example, Alford, Koehler and Leonard (1991) found that post-treatment AA / NA attendance was significantly related to abstinence at 2-year follow-up for adolescent clients. Also, several studies conducted by Brown and colleagues (e.g. Brown, 1993; Vik, Grizzle, & Brown, 1992) concluded that twelve-step group attendance was associated with favourable outcomes at 1-year follow-up for adolescents with SUDs.

To summarize:

- There is *limited information available* on evidence-based practices for aftercare services
- *Aftercare is a necessary component of effective services as it helps ensure individuals maintain the progress made in treatment* by providing them with support and additional skills.
- Core features of effective aftercare services include sharing of experiences and knowledge in support groups.
- *Twelve-step self help groups* are the only form of aftercare readily available in South Africa and the only form of aftercare that has been extensively examined in relation to treatment outcomes.
- These groups are NOT a substitute for treatment
- Research has shown that individuals who participate in these groups after treatment was completed have *better treatment outcomes and lower rates of relapse* over time than individuals who do not participate in these groups.

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