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Revisiting the basics of treatment

By Dwayne Simpson

The delivery of treatment is not always well matched to the needs of patients. Contrary to a one-size-fits-all approach, evidence shows a **deliberate process** of *assessment*, *planning*, and *delivery* of tailored interventions is fundamental to treatment effectiveness. The Institute of Behavioral Research at Texas Christian University (TCU) has formulated **stage models of substance abuse treatment** that focus on these interdependent issues[1-4] and for studying the implementation of evidence-based treatment innovations.[5-6] These models are considered to be generic across a variety of individual and organizational change applications.

Figure 1 offers a general blueprint of the complex process involved. The following "question and answer" format explains key elements of this comprehensive framework and how they fit together. *The goal is to help service providers adopt a "systems" perspective that emphasizes **interim stages of early engagement and change** as signposts for improving therapeutic effectiveness.*

IN THIS ISSUE

1. What are the **core ingredients** of "effective" treatment?

As summarized in **Figure 1**, patient motivation and readiness are important foundations for effective treatment, and evidence demonstrates that specialized interventions can target and raise readiness among low-motivation patients. A major step towards recovery in treatment involves early *engagement,* which is measured mainly by program participation and the formation of therapeutic relationships in the initial weeks of treatment.

Research shows that more highly motivated patients at intake are twice as likely to *participate* in treatment (e.g., attend sessions) in the first stage of care, and those with higher participation rates are twice as likely to develop favorable *therapeutic relationships* with their treatment counselors.[7] These also are primary predictors of continuing change, longer retention, and better follow-up outcomes.

Drug treatment programs frequently are structured around three phases—*orientation* (for readiness enhancement and induction), *treatment* (for delivering principal cognitive and/or behavioral therapeutic interventions), and *re-entry preparation* (for relapse prevention and social-skill transitional training). Specialized objectives tend to characterize each phase, leading to the need for sequential assessments interlaced with targeted interventions that sustain positive patient changes. This system of coordinated care is described in **Figure 2**.

> ***"Treatment is the sum of its parts—i.e., sequential assessments interlaced with targeted interventions that sustain positive patient changes."***

2. How can **treatment engagement** be established and sustained?

Stronger engagement (i.e., participation and rapport) emerges when patient problems are addressed by therapists using a positive approach emphasizing problem solving and social skills enhancements, as opposed to a punitive emphasis on program rules and strict compliance requirements.[8] The success of cognitive and behavioral interventions is consistently related to the quality of the counseling relationship, which is further reflected in higher patient ratings of *treatment satisfaction* as well.

Better assessments of patient needs and progress—accompanied by therapist feedback on normative interpretations and their clinical applications—are necessary to help monitor and guide this process. In effect, this requires an integrated approach for selecting and using empirical measures as a basis for clinical decision making and care planning.

3. What kinds of **measures** are used, and when?

There is a widespread practice of under-utilizing patient assessments. Often they are merely filed away because their feasibility, focus, and functionality were ignored. Counselors typically prefer to use brief screens to assess patient risks and major problems, along with functional assessments of psychosocial and engagement attributes that have direct (evidence-based) relevance to clinical care decisions.

As illustrated in **Figure 3**, a series of TCU instruments for measuring patient functioning provide assessment tools that can address these applications.[8-10] The *Client Evaluation of Self and Treatment (CEST)* scales capture several crucial psychosocial and readiness dimensions of the change (recovery) process. They can be selectively administered and repeated throughout treatment phases as illustrated, scheduled on the basis of therapeutic structure and planning. **Assessment Fact Sheets** also are available on the IBR Web site (at www.tcu.ibr.edu) for providing interpretive norms, and this information is expanded as new forms are added to the "menu of options."

4. Are there **counseling strategies** that can help?

The treatment effectiveness literature widely supports the use of motivational enhancement techniques, cognitive strengths-based counseling, behavioral reinforcement therapy, and social support networking approaches that are prominent in the drug treatment field.[11-12] **Figure 4** lists a comparable and comprehensive collection of interventions developed with the goal of being explicit about strategic focus and applications for promoting the various stages of therapeutic progress described earlier.[3,7]

These interventions are manual-guided and integrated through a unique cognitive-based counseling technique called TCU *node-link mapping*. Research shows that this conceptual visualization technique reduces reliance on purely verbal communication,[13] increases attentional focus, and improves memory for session content.[14] The use of TCU mapping-enhanced counseling is effective in a variety of settings and with a variety of drug treatment outcome measures.[15]

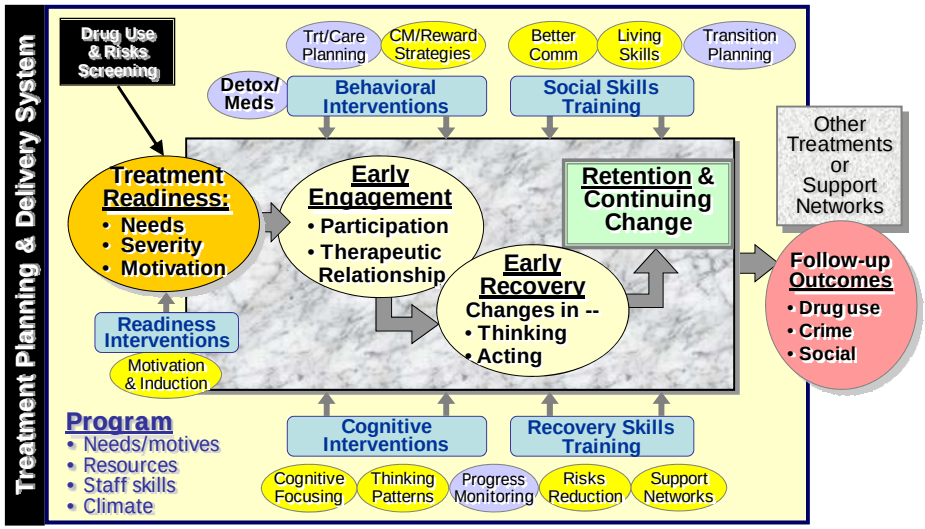
5. How do **programs** effectively implement **innovations**?

All of the TCU treatment resources described above are available for downloading at no charge from the IBR Web site. However, identifying and obtaining effective treatment assessments and interventions for adoption do not guarantee they will actually be used in clinical practice. Indeed, some drug treatment providers do a better job of engaging and retaining patients than others.[7,16] They likewise report better gains in psycho-social functioning by their patients during the course of treatment delivery and after its completion.[9,11,17]

To help understand why some programs are more effective than others, treatment process research is

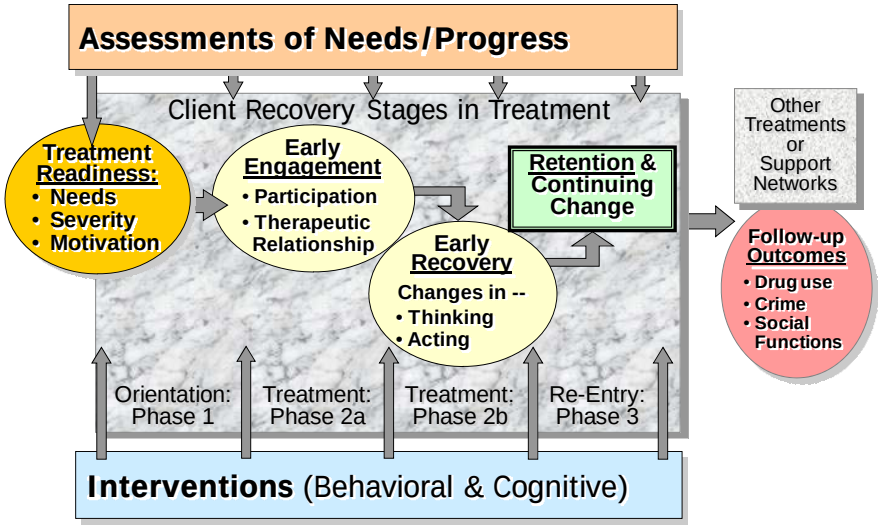
Continued on page 4

1. TCU Treatment Process Model
(for Stage-based Assessments & Interventions)

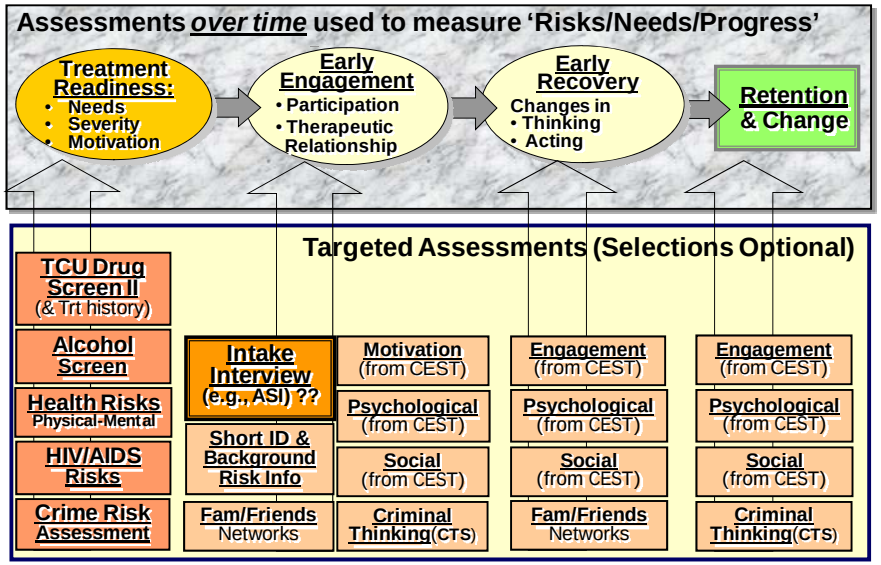


Based on Simpson,1995, 2001, 2004, 2006

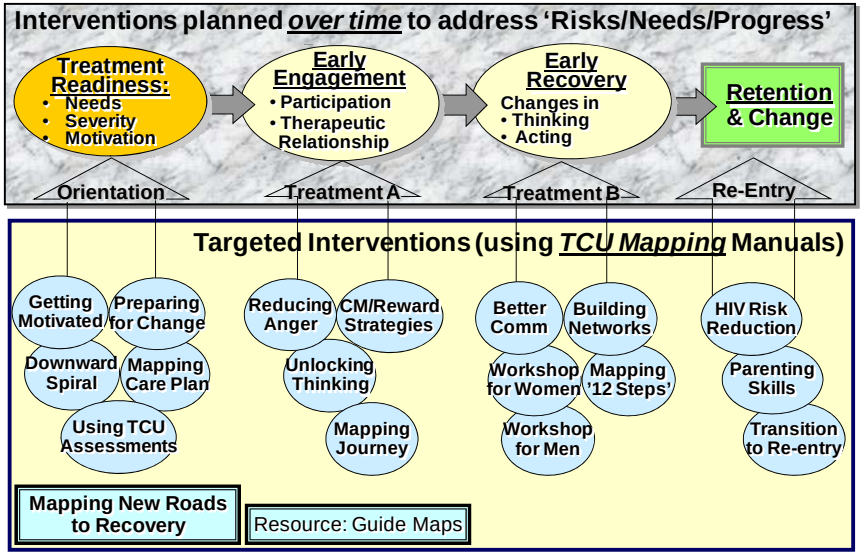
2. Coordinating Treatment Phases with Assessments & Interventions



3. Assessing Risks/Needs/Progress



4. Planning Strategic Interventions



Figures 1-4. Citation: Simpson, D. D. (2008). Revisiting the basics of treatment. *Research Reports from IBR, 17*(2).
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Continued from page 2

beginning to give systematic attention to organizational aspects of service settings and related staff characteristics.[5-6,18-20] Reviews of the available evidence note that adoption and implementation of innovation is a process, not an isolated event. In particular, research shows that organizational climate is predictive of treatment quality as measured by patient engagement and response to intervention services.

It is therefore important to address organizational issues as well as to identify patient needs for shaping treatment regimens that can improve patient functioning. As innovations and new procedures become more complex and comprehensive, the process of change becomes progressively more challenging. Treatment policy makers, leaders, and providers can benefit from using a systematic approach to delivering evidence-based practices.

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