



RESPONSE: TIPSTERS WEIGH IN: PUTTING GOOD SCIENCE TO WORK

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Richard A. Rawson chaired and Felipe Castro and Ewa Stamper served on the 15-member consensus panel that created SAMHSA's TIP 33: Treatment for Stimulant Use Disorders.

Richard A. Rawson: The paper struck me first of all as a valuable personal account of a treatment program achieving positive outcomes with methamphetamine abusers. There has been a pervasive, unsubstantiated rumor that meth abusers do not respond to treatment. Recent studies (e.g., Hser, Evans, and Huang, 2005; Rawson et al., 2004; Roll et al., 2006) have begun to dispel that myth and prove that community treatment can produce results. The Prairie Ridge experience provides a clear instance of that.

I am pleased that Mr. Hansen felt that the TIP enhanced the tools and strategies they were using, and that it got a positive response from the staff.

Ewa Stamper: In my opinion, the program used the TIP extremely appropriately. They understood the most important thing, which was the client-centered, nonrigid approach. They also adopted the TIP's way of looking at relapse as a normal phenomenon in early recovery rather than treatment failure, and the need for a rest period before starting treatment. They got the key concepts; the details aren't so important.

Felipe Castro: Prairie Ridge seems to have done a good job of taking good science and modifying it as necessary to make it work in their circumstances. Unfortunately, other programs sometimes change things they don't like, take things out that aren't convenient, and end up with a watered-down rendition of the treatment that is unlikely to be effective. I call that mis-adaptation, as opposed to adaptation.

Rawson: We didn't intend the document to be a treatment manual. Our idea was to introduce ideas and concepts and allow clinicians to employ those they found useful. In that light, Mr. Hansen's struggles to apply TIP 33 with mixed groups of patients, not all of whom abused meth, were very instructive to read about. While there is good agreement that the patient-centered approach applies to all drug treatments, there have not been a lot of comparative studies on whether a particular set of protocols that was designed to treat one set of patients can also be used successfully with another. Without those data, I think clinicians logically should determine for themselves which strategies to apply widely and which only narrowly.

Castro: It is inevitable that clinical judgment will come into play in these situations, but it is important that these decisions aren't made haphazardly. Ideally, we should be able to teach clinicians how to make adaptations based on their local situation without removing the treatment from the context of the original, evidence-based approach.

Stamper: I was especially impressed by the spirit of continuing education and openness to new ideas among the staff at Prairie Ridge. Unfortunately, I don't think that's typical of rural or smaller centers. At least here in Hawaii, treatment providers sometimes tend to distance themselves from the research community and to be entrenched in what they know and what works for them.

Neurobiological and gender issues

Rawson: I found it very encouraging that the author made use of the information on the neurobiological effects of the drug on

the brain. For many treatment programs, the idea that neurobiology is relevant to treatment and recovery is revolutionary. I also was gratified that Prairie Ridge utilized the information on the sexual effects of meth abuse. I think that is an understudied area, despite its obvious importance to drug abuse treatment.

Stamper: The author's remark that there is inevitable discomfort when counselors talk about sexual issues made me sad, though it's understandable. It will be best for everyone if this discomfort is eliminated. Frankly, the more counselors are prepared and knowledgeable and practiced in talking about these issues, the less discomfort there is for both parties.

Castro: Most drugs cause sexual problems, either fueling or suppressing sexual drive. These problems may be more pronounced with stimulants than with other drugs.

I've been conducting research in a community residential program where we see only men. Almost all our patients have sexual problems and also problems with their families, where their role as protector and provider has been damaged by their drug abuse. The program addresses sexual issues as an important part of these broader gender and relationship issues that must be faced in treatment. In many cases, addressing sex and gender issues is a necessary step in helping patients return to society and their families, where there is a need to reconnect after the relationship has been damaged.

Stamper: Sex means different things for different genders. For female users, sexual issues are very often intertwined with issues of trauma, sexual abuse, and violence. They may also involve exchanging sex for drugs

(the dealer “boyfriend”), as well as prostitution. These things do tie together and they need to be addressed more and more.

Evaluation: Always recommended, always possible

Castro: I was disappointed that the author believed they couldn’t evaluate their innovations because they were unable to implement the TIP with absolute fidelity. I think we can always evaluate, albeit with varying degrees of precision. All programs should be committed to some level of monitoring so that corrections can be made during the treatment process. Even asking a very simple set of questions in an exit interview, such as, “How much did the client like the information?” or “How effective did the client find it on a scale from 1 to 5?” can give a broad, but useful, idea of the efficacy of treatment.

Rawson: Consumer and staff satisfaction surveys are useful and relatively straightforward to do. In our program, when we implement new strategies and treatments, we monitor whether or not they improve retention. That is useful because people who stay in treatment longer do better. Drug screens can be used in a similar manner. A program can look at the 50 patients they treated before the change was implemented and the first 50 patients after and compare the results of their urine screens.

Stamper: I especially like the retention measure. It is certainly doable, and it’s also immediately practical, through its connection to reimbursement. However, we do need to acknowledge that even the simplest measures require at least some invest-

ment of time and money. Everybody in a treatment program is overworked and usually no special funds are available for someone to sit and crunch these numbers. So the reality of the situation is: the simpler, the better.

Next steps

Stamper: I have been advocating for a revision to TIP 33 for several years. We know much more today than we did when we were writing it. A revision could incorporate new knowledge on issues such as special populations and neurobiology, as well as new evidence from clinical trials. I would also like to see an acknowledgment in the TIP that the majority of patients in treatment centers abuse multiple drugs. We could advise clinicians such as Mr. Hansen on how to deal with this issue, which he rightly treated as a major concern.

Castro: NIDA’s big developments in neuroimaging research should be included in a revision.

Rawson: I would second that idea. The brain imaging work has taught us a lot about how some areas of the brain that meth impacts recover with abstinence, how that influences people’s behavior during recovery, and what kinds of treatment techniques can be useful. We also now have a significant amount of clinical treatment outcome literature on both cocaine and methamphetamine, so there is a wealth of new information we could use to expand treatment recommendations (Rawson, Gonzales, and Ling, 2006).

Stamper: In addition to updating the TIP, I would suggest that we try to improve

our methods of dissemination. The TIP has not had much of an impact in my community.

Rawson: We’ve received very little feedback about the TIP. I have heard from programs in Iowa, which has mandated its use as a guide for treating methamphetamine abuse. The reports have been mixed. Some people, like Mr. Hansen, appear to have programs where people are open to new ideas. Other places have told me, “We don’t see anything new about this. It’s what we’ve always done.” That’s a response I’ve been hearing for 30 years from people who base their treatment approach on their personal values and beliefs and don’t want to be confused with information. Luckily, there is increasing awareness of the term “evidence-based practices” and the need to do things differently.

Stamper: Researchers and technology transfer groups need to find ways to disseminate science-based practices that fit counselors’ cognitive styles. Among the Hawaiians in my community, and I imagine some other ethnic groups, the oral tradition is very strong. They will welcome face-to-face presentations with in-depth learning opportunities, but probably won’t pick up a thick book. Counselors with less formal education tend to think very concretely. For them, a less conceptual, more cookbook-like presentation might work better. You don’t need to have a broad conceptual framework to assimilate information creatively. &

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