Substance Abuse: Assessment and Intervention

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Introductions

Trainer introduction:

- Presenter
- Clinical experience

Participant Introductions

- Your name
- Role
- Experience with substance abuse assessment and interventions

What do you expect to get from today's training?

"One thing I'd like to get from today's session is …."

Here's What You'll Get Today . . .

-Overview of addiction

-Trends in substance use

-Assessment of substance abuse/dependence

-Stages of change and motivational interviewing

-Referral information

-Case examples and practice

What is Not Included in Training

- Administering and scoring screening/assessment instruments
- Training on clinical interviewing

We're going on a trip . . .

Let's do the "Car Game"

The "Car Game"

Letters	Challenging Aspects of Substance Abuse Work	Positive Aspects of Substance Abuse Work
A		
B		
C		
D		
E		

Defining substance abuse and dependence

- Simple definitions:
  - Abuse: intentional overuse in cases of celebration, anxiety, despair, or ignorance
  - Dependence: impaired control over drug use probably caused by a dysfunction in the brain's "pleasure pathway"
- DSM-IV-TR definitions
  - Abuse
  - Dependence

DSM-IV-TR

- Substance use disorders - defined

Addiction as a disease

- Current science indicates that major site of addicting drugs is in the Medial Forebrain Bundle (MFB)
- Neurotransmitters involved in addiction are:
  - Dopamine, serotonin, endorphins, GABA, glutamate, norepinephrine and acetylcholine

Addiction as a disease

- Psychoactive substances typically act in the "pleasure centers" by:
  - Mimicking neurotransmitters
  - Stimulating the release of neurotransmitters
  - Blocking the re-uptake of neurotransmitters
  - Changing the action potential (speed at which messages are transmitted)

Drugs and Neurotransmitters

- Dopamine – amphetamines, cocaine, ETOH
- Serotonin – LSD, ETOH
- GAGA – benzo's and ETOH
- Endorphins – opiods, ETOH
- Glutamate – ETOH
- AcH – nicotine, ETOH
- ENCB – marijuana, ETOH

Epidemiological estimates

- Drugs users who developed dependencies bases on 1992-1998 studies:
  - Nicotine – 32%
  - Heroin – 23%
  - Cocaine – 17% - crack 20%
  - Stimulants – 11%
  - Alcohol – 15%
  - Cannabis – 9%
  - Sedatives – 9%
  - Analgesics – 9%
  - Psychedelics – 5%
  - Inhalants – 4%

Anthony et al 1994; Chen & Anthony 2003; Hughes et al 2006

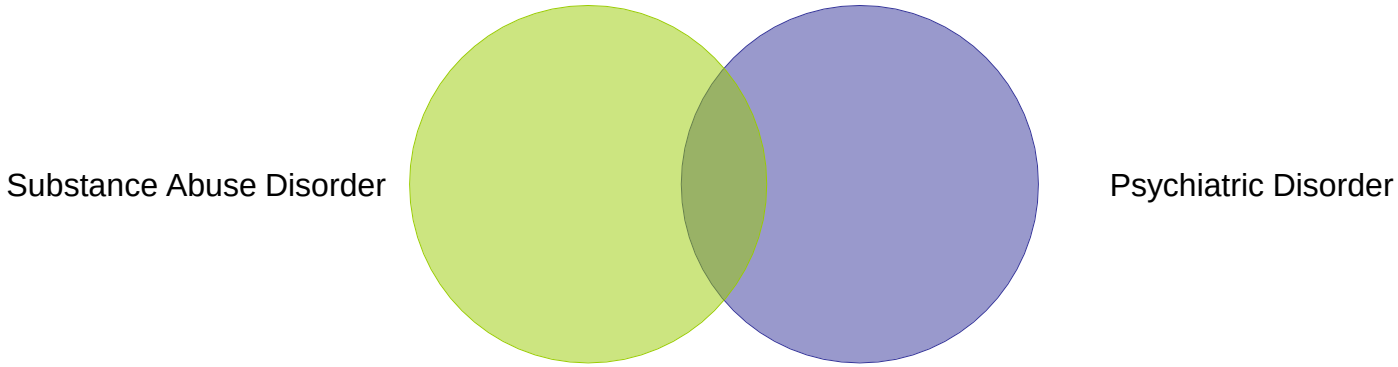
Addiction as a disease

Basic components of disease model

- Addiction is primary – it is the main problem, not secondary to something else.
- It is progressive - there are signs and symptoms of addiction
- Permanent – once addicted to a drug, always addicted and to all drugs, not just the drug of choice. If not stopped, the disease will be fatal.
- Disease is marked by impaired (loss of) control, preoccupation, adverse consequences, and denial.
- Recovery requires life long abstinence and active participation in recovery groups.
- The disease is part psychological, physical, social and spiritual. Must treat all aspects for recovery.

Px3

Co-occurring Disorders



Co-occurring Disorders

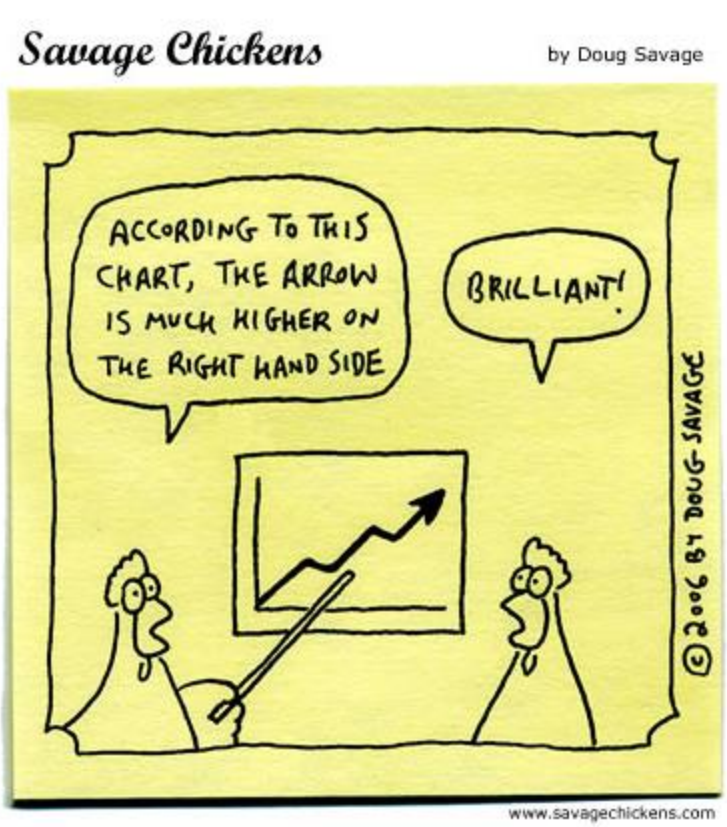
- Prevalence of co-occurring disorders – 4.2 million adults have a mental health and substance abuse disorder
  - 20% of people w/ SA disorders have at least 1 mood disorder
  - 18% have at least 1 anxiety disorder
  - 29% of people with alcohol use disorder and 48% of people with drug use disorder have at least 1 personality disorder

Co-occurring disorders

- Drugs most commonly abused by those with mental illness are alcohol, marijuana and cocaine. Prescription drugs are also commonly abused.
- Males aged 18-44 have highest incidence of drug abuse.
- Treatment issues are more complicated and people with dual disorders are more likely to have histories of violence and end up in criminal justice system

Recap

What have we said so far



Trends in Substance Use

- Prescription drug abuse
- Heroin
- Methamphetamine
- Baby-boomers

Prescription Drug Abuse

- Non medical use of prescription drugs has increased from 5.4% in 2002 to 6.4% in 2006
- Prescription pain medication (Vicodin and Oxycontin) account for greatest abuse
- According to epidemiological studies, 50 million Americans are experiencing chronic pain at any given time

Heroin

- Increase in percentage of people who inhale heroin
- Proportion of inhalers who are Hispanic grew from 26%-69% (1996-2007)
- Average age of inhalers has decreased from 30 to 27
- Time between first use and seeking treatment is 7 years compared to 15 years for injectors

“Cheese” Heroin

- Mixture of Tylenol PM and heroin – in Texas, Dallas area reports highest problem
- Users are younger – Dallas reports range from 12-19 with average age of 16
- High use reported among Hispanic males

Methamphetamine

- Meth half-life is 8-12 hours (compared to 1-2 hr for cocaine)
- Paranoia lasts 7-14 days (compared to cocaine 4-8 hr following drug cessation)
- Higher incidence of psychosis than with any other stimulant and neurotoxicity is greater

Methamphetamine

- WHO estimates that meth is most widely used illicit drug in the world (except for marijuana) with 26 million regular users (heroin at 16 million; 14 million cocaine)
- Research suggests that relapse rates are higher and treatment needs to be longer than for other substances

Baby Boomers

- By 2020, 50% of US population will be 55+
- Illicit drug use by people in their 50s has increased by 63% with greater reports of heroin and cocaine
- 60% who enter treatment are on some type of psychotropic medication

Break

- Let’s take 15 minutes

Assessment and Motivational Interviewing

- SAMHSA refers to the MI Assessment "Sandwich"
  - Top "slice" involves building rapport and using OARS to elicit discussion of client's perception of problem
    - Open-ended questions
    - Affirmations
    - Reflective listening
    - Summaries

Assessment and MI

- “Middle” of the sandwich – this is gathering the details of the substance use
  - H
  - A
  - L
  - T
  - B
  - U
  - M
  - P

F
A
T
A
L
D
T

Matching

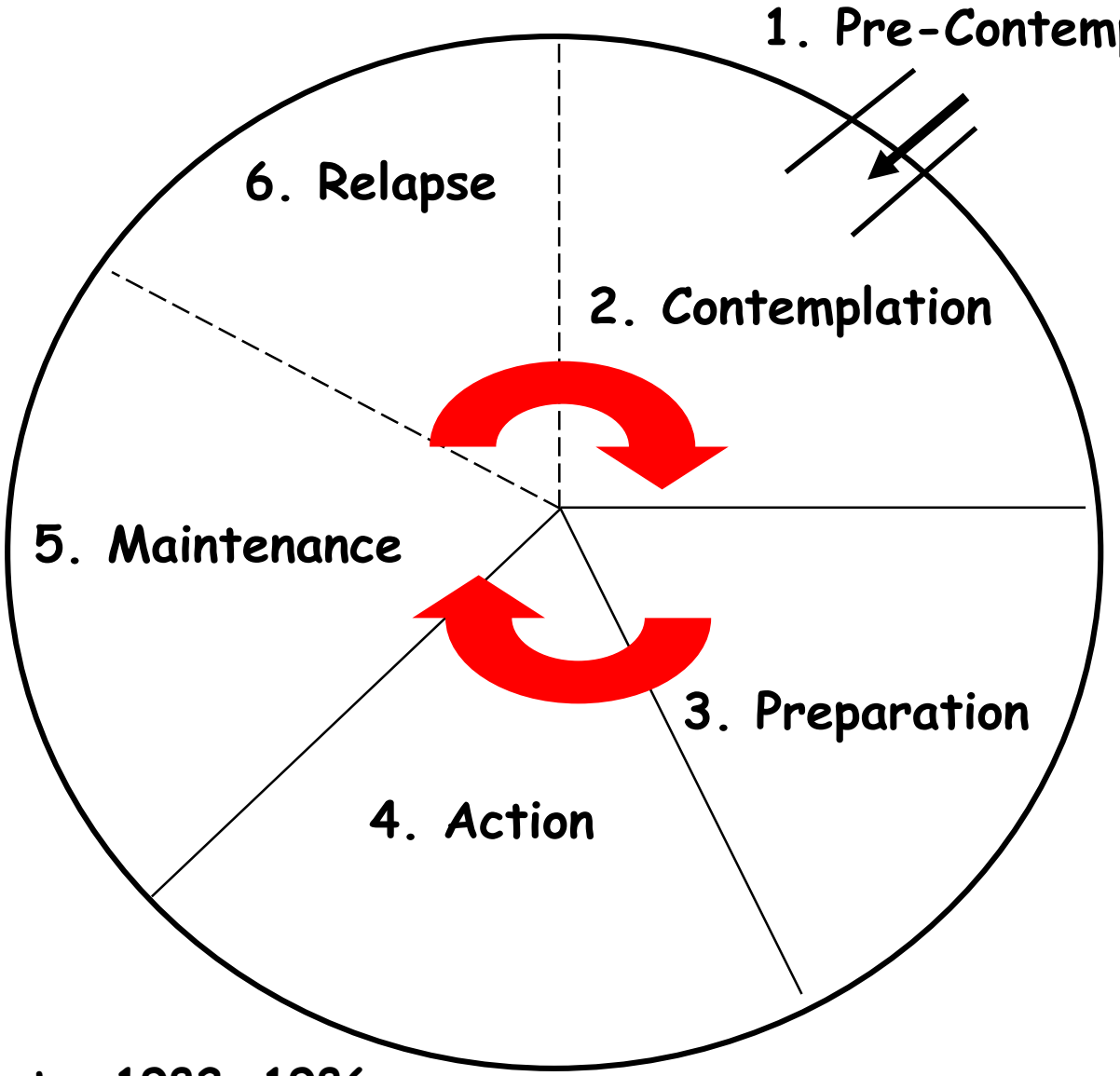
- ASAM Client Placement Criteria
- Maslow's Hierarchy of Needs
- Client factors + program factors = treatment referral


The need for self-actualisation
Experience purpose, meaning and realising all inner potentials.
Esteem Need
The need to be a unique individual with self-respect and to enjoy general esteem from others.
Love and belonging needs
The need for belonging, to receive and give love, appreciation, friendship.
Security Need
The basic need for social security in a family and a society that protects against hunger and violence.
The physiological needs
The need for food, water, shelter and clothing

Assessment and MI

- Bottom “slice” of the sandwich focuses on strategies for eliciting change or managing resistance
  - Focus on competencies and strengths
  - Individualize treatment plan
  - Shift away from labeling
  - Partnerships for change
  - Continuum of problems/continuum of care

Consider "Stages of Change"



Prochaska & DiClemente, 1982; 1986

Stages of change and appropriate MI strategies

Preparation	Establish rapport Raise doubts/concerns – exploring meaning of events; perception of problem; feedback about assessment findings; discrepancies between client and others' perception of behavior
Contemplation	Normalize ambivalence Decisional balance sheet Elicit self-motivational statements of intent
Preparation	Clarify client's goals and strategies Offer menu of options for change/treatment Collaborate on treatment plan Explore barriers to change Enlist social support Explore expectations
Action	Support realistic view of change through small steps Acknowledge difficulties Identify high-risk situations and practice coping strategies Assist in finding new reinforcers of positive change Evaluate and strengthen support systems

Stages of Change and MI Strategies

Maintenance	Increase new reinforcers Support lifestyle changes Affirm resolve and self-efficacy Help practice new coping strategies Maintain positive supprt Develop “fire escape” plan for relapse Review long-term goals with client
Recurrance	Help client reenter the change cycle Explore meaning and reality of recurrence as a learning opportunity Assist client in finding alternative coping strategies Maintain support contact

Effective Catalysts for Change

- Consciousness raising – new information
- Self-reevaluation – feelings/thoughts related to problem behavior
- Self-liberation – choosing and committing to act; believing in ability to change
- Counter conditioning – strategies for coping such as relaxation, positive self-statements
- Stimulus control – avoiding high risk situations

Effective Catalysts for Change

- Reinforcement management – rewards for making changes *
- Helping relationships – support systems
- Emotional arousal and dramatic relief – e.g. - role playing, psychodrama
- Environmental reevaluation – how does problem behavior impact personal environment
- Social liberation – increasing alternatives for non problematic behavior

Movie time!

- Let’s watch some clips and see if we can spot what the counselor is doing wrong!

What doesn’t work

- Labeling – attempting to get client to accept a label or diagnosis
- Shaming/blaming/criticizing
- Being the “expert” – telling someone what to do/lecturing
- Being in a hurry
- Arguing for change
- Claiming preeminence – I know what’s best

When goals collide

- Do you -
  - Give up? “… come back when you’re ready”
  - Negotiate? Find a starting point of agreement
  - Approximate? Look for a step in the right direction
  - Refer? Find a better treatment match

Special cases

- Mandated clients
- Family members

Mandated clients – special considerations

- Interventions must be made at the appropriate stage of change, most often precontemplation
- Decontaminate the referral process – “I’m sorry you came into our services this way”
  - Honor the anger and sense of dehumanization
  - Avoid assumptions about the type of treatment needed
  - Make clear that you will help the client with what he/she believes is important
  - Clearly explain consent and confidentiality

Family members

- Assessing needs
  - Safety first
  - How long has this been a problem
  - Why now
  - What have they tried and how did that work

Stages of change and the family

- Precontemplation – User just has to stop using
- Contemplation – Maybe they don’t really have a problem but we really need to do something
- Preparation – Family is actively looking for solutions
- Action – Steps taken to bring about change
- Maintenance – Family adjusts to life without the substance and re-structures itself with user in recovery

off the mark by Mark Parisi www.offthemark.com

Referral

- Support groups
  - Beyond 12-step groups are other types of programs such as Secular Sobriety (SOS), SMART Recovery, Women for Sobriety, Rational Recovery and Moderation Management, Good Chemistry
- Harm Reduction Programs
  - Methadone maintenance
  - Suboxone or other medication

Referrals

- Treatment programs
  - Traditional programs
  - Therapeutic community models
  - Contingency management models
  - Cue exposure (for relapse prevention)
  - Holistic models

Practice

- Worksheet #1 – with a partner, identify examples of high level skills and low level skills
- Role play and observation using Worksheet #2

Questions

- Further information: ecoccia@austincc.edu; 223-3207

Additional information

- The following is not a complete list of references but will give you a starting place:
  - www.utexas.edu/research/asrec
  - Enhancing Motivation for Change in Substance Abuse Treatment; TIP 35; SAMHSA www.samhsa.gov
  - American Society of Addiction Medicine (1996) Patient Placement Criteria for the Treatment of Substance-related Disorders, 2nd edition. Chevy Chase, MD, ASAM
  - SAAS Update; State Association of Addiction Services Update, Vol. V, No. 12. September, 2007
  - Dual Diagnosis: Substance Abuse and Mental Illness; NAMI; http://www.nami.org