

ALCOHOL AND OTHER DRUG INFORMATION FOR PROFESSIONALS

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Agenda

- History of Alcohol and Drug Abuse
- Data
- Effects of Alcohol and Other Drugs on the Brain
- Screening, Assessment, and Diagnosis
- Treatment Approaches
- Case Management

History of Alcohol & Other Drugs

- 1775: Benjamin Rush identifies inebriety as a disease process/ abstinence as solution
- 1826 Temperance Movement: Lymon Beecher
- 1840 Washingtonians: Alcoholics with no recovery plan
- 1900 Emmanuel Movement: Williams James/ Spirituality/ psychological factors for drinking/
- Courtney Baylor first alcoholism counselor

History of Alcohol & Other Drugs

- 1500 BC: EGYPTIAN PHYSICIANS KNEW OF DRUGS AND SEDATIVES SO STRONG THAT THEY ENABLED THEM TO PERFORM SKULL SURGERY
- 100 B.C. Roman senate attempts to suppress alcoholic excesses and orgies, connected with worship of Bacchus, by law
- 10th Century The marijuana controversy begins as a New Century A.D. Radical Sect of Islam, controlled by Hassan, followers were given hashish, thought they were in paradise they then followed orders which included murder
- 10th Century: Law allows hot lead to poured down the throat of an persons abusing alcohol

History of Alcohol & Other Drugs

- 1918 Oxford Groups: Frank Buchman introduces first plan of action – tenets of Oxford Group
- 1930 Carl Jung: Spiritual experience produces psychic change
- 1935 Bill W. meets Dr. Bob
- 1935, June 10: Alcoholics Anonymous is founded

History of Alcohol & Other Drugs

- 1939 Dr. William Silkworth: Doctors Opinion forward of AA text: Mental Obsession & Physical Compulsion
- Psycho-path - swearing off and return to drinking;
- Endless Denial - switches types & amounts (trying to find the right combination);
- Abstinence = Cure - after a period of abstinence returns to use;
- Manic- Depressive type - drink because they are happy and drink because they are sad
- The normal in every respect type except for the effect alcohol has upon them

History of Alcohol & Other Drugs

- 1960 Dr. Jellinek Disease Concept of Alcoholism
- Loss of control is primary symptom
- Alpha – Problem drinking
- Beta – Nutritional deficiency related to alcohol use resulting in cirrhosis and gastritis
- Gamma – Progression from psychological to physical dependence including loss of control
- Delta - Similar to Gamma but has inability to abstain rather than loss of control
- Epsilon Alcoholism periodic bouts over 20-25 years

History of Alcohol & Other Drugs

- 1984 Begleiter: Demonstrated detoxified alcoholics have a reduced amplitude of the scalp-positive wave that peaks approximately 300 milliseconds after a rare but anticipated event (P300)

History of Alcohol & Other Drugs

- 1985 David Holmes: Research on THIQ introduces brain chemistry
- Disease Concept of Alcoholism
- later changed the name to Disease of Alcoholism
- Contributed significantly to research on brain chemistry rather than the moral model

History of Alcohol & Other Drugs

- 1994 O'Connor: Heritability of P300 amplitude suggests that reduced-amplitude P300 could be transmitted from alcoholic parent to offspring
- 1996 Kenneth Blum: Reward Deficiency Syndrome emphasizing the role of dopamine
- 1996 Goleman: Presentation at world conference of addiction [all drugs of abuse activate a single circuit of pleasure in the most ancient part of the brain]

History of Alcohol & Other Drugs

- Babor 1996: The history of alcoholism typology can be divided into three periods: the prescientific period, the Jellinek era, and the post-Jellinek era
- Ball 1996: Type A & B Alcoholism has different onset, progression, and characteristics
- Clonninger 1996: Type I & II similar distinctions between groups but type is male limited

History of Alcohol & Other Drugs

- 1997 Allen Leshner (former Director of NIDA): Three Facts
- Addiction is a disease of the brain
- All diseases of the brain have behavioral symptoms
- Behavioral therapy heals brain impairments

History of Alcohol & Other Drugs

- 1997 Project MATCH releases findings indicating that Twelve Step Facilitation approaches demonstrate slightly better abstinence outcomes than Motivational and Cognitive Behavioral at 12 month follow-up
- Significant contributions of the study points to effectiveness of treatment, value of various interventions, and importance role of the counselor

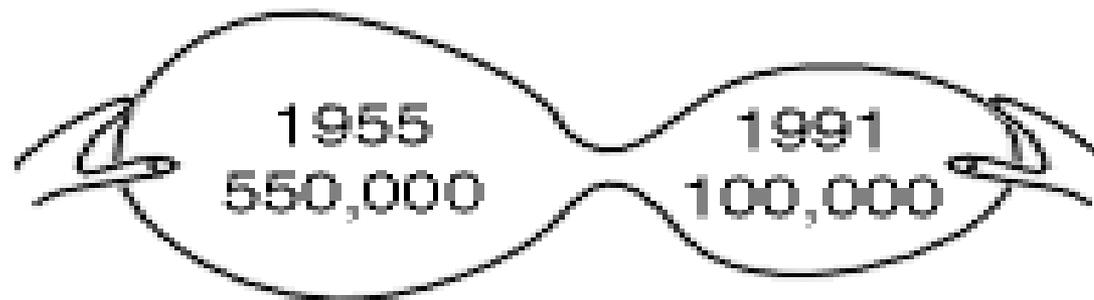
History of Alcohol & Other Drugs

- 1998 Amen: Utilizes SPECT technology to demonstrate impairments in the brain of alcoholics and addicts and how behavioral and pharmacological interventions heal these impairments
- Provides information on how specific interventions improve functioning in effected area of the brain

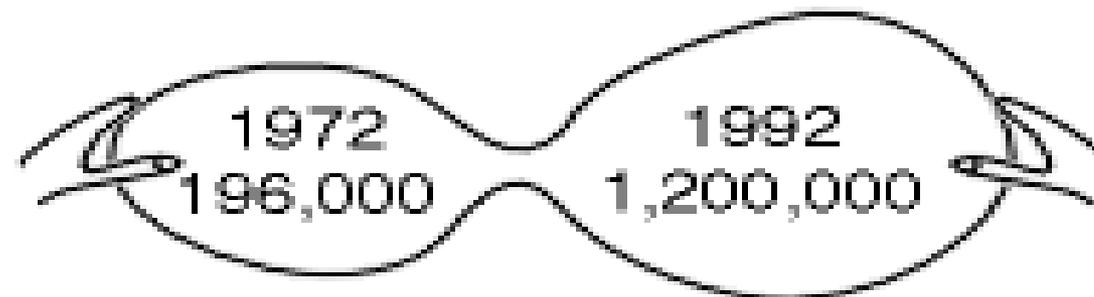
History of Alcohol & Other Drugs

- 2000 Ruden: Addiction is a result of a pattern recognition that seeks to satisfy a craving response
- Introduces scientific evidence that endorses the role of behavioral methods to treat addiction including the use of twelve step meetings

Figure 2-E.—Transinstitutionalization in the United States



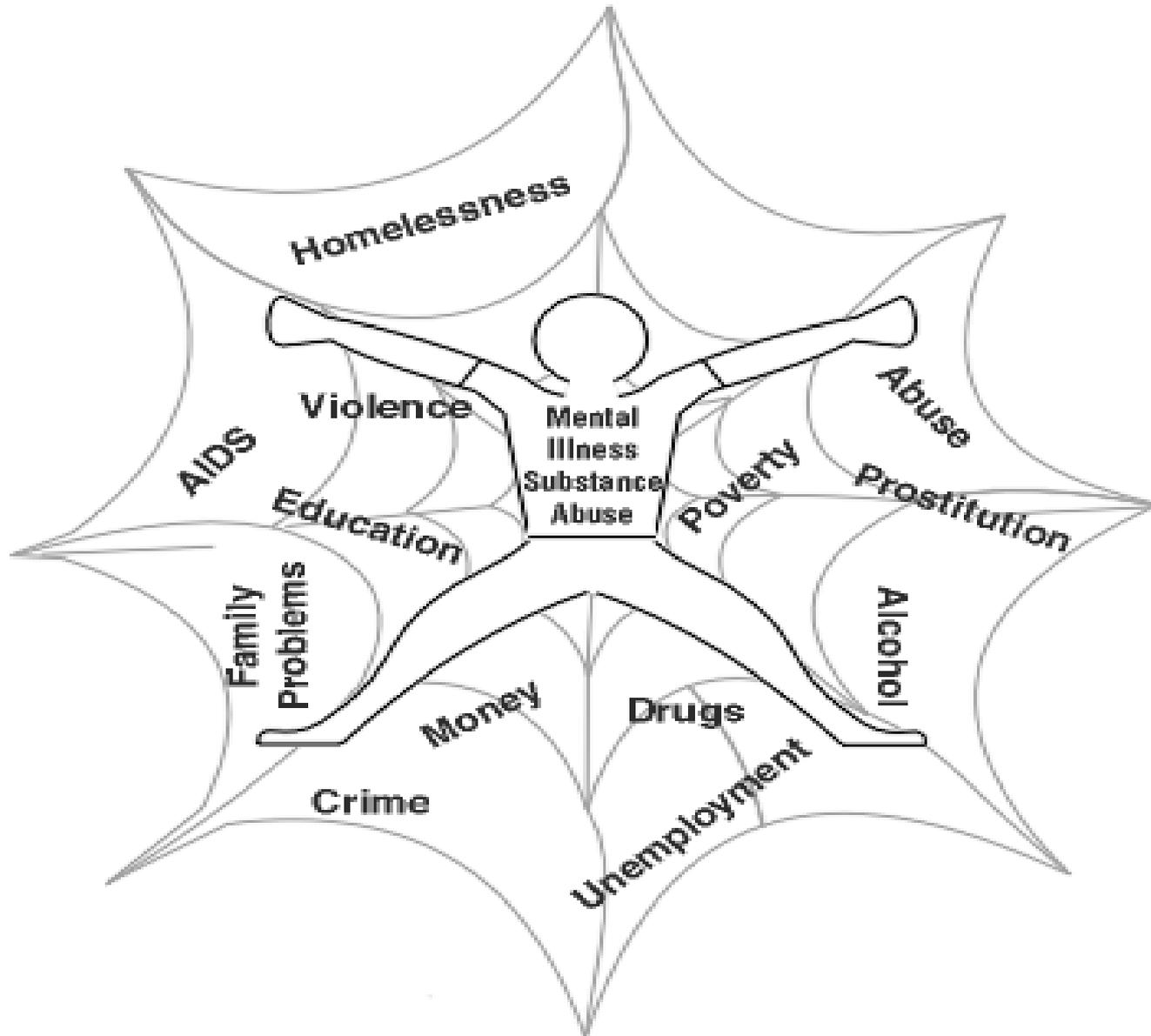
State Psychiatric
Hospital Beds



Prison & Jail

SQUEEZING THE BALLOON
Where Is Treatment?

Figure 2-D.—Caught in a Web of Social Problems



History of Alcohol & Other Drugs

- Conclusion: Despite enormous and ground breaking gains in knowledge regarding addiction the most sound method for diagnosis is behavioral observation (using criteria within the DSM-IV TR)

How Many Americans Need Help?

- Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health,
- 23.5 million persons aged 12 or older needed treatment for an illicit drug or alcohol abuse problem in 2009 (9.3 percent of persons aged 12 or older).
- Of these, only 2.6 million—11.2 percent of those who needed treatment—received it at a specialty facility.

Past Year Substance Dependence or Abuse and Serious Mental Illness among Adults Aged 18 or Older: 2011

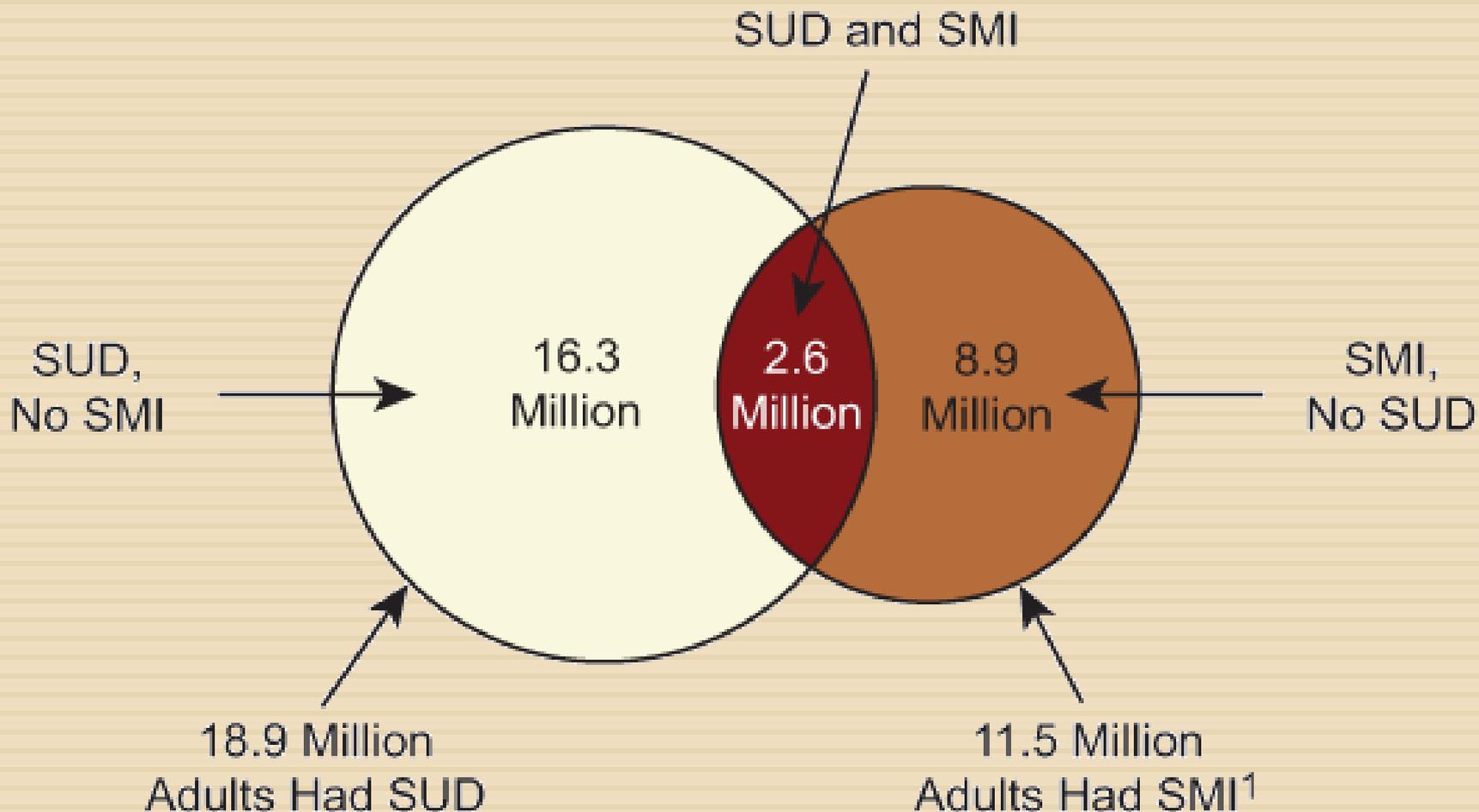
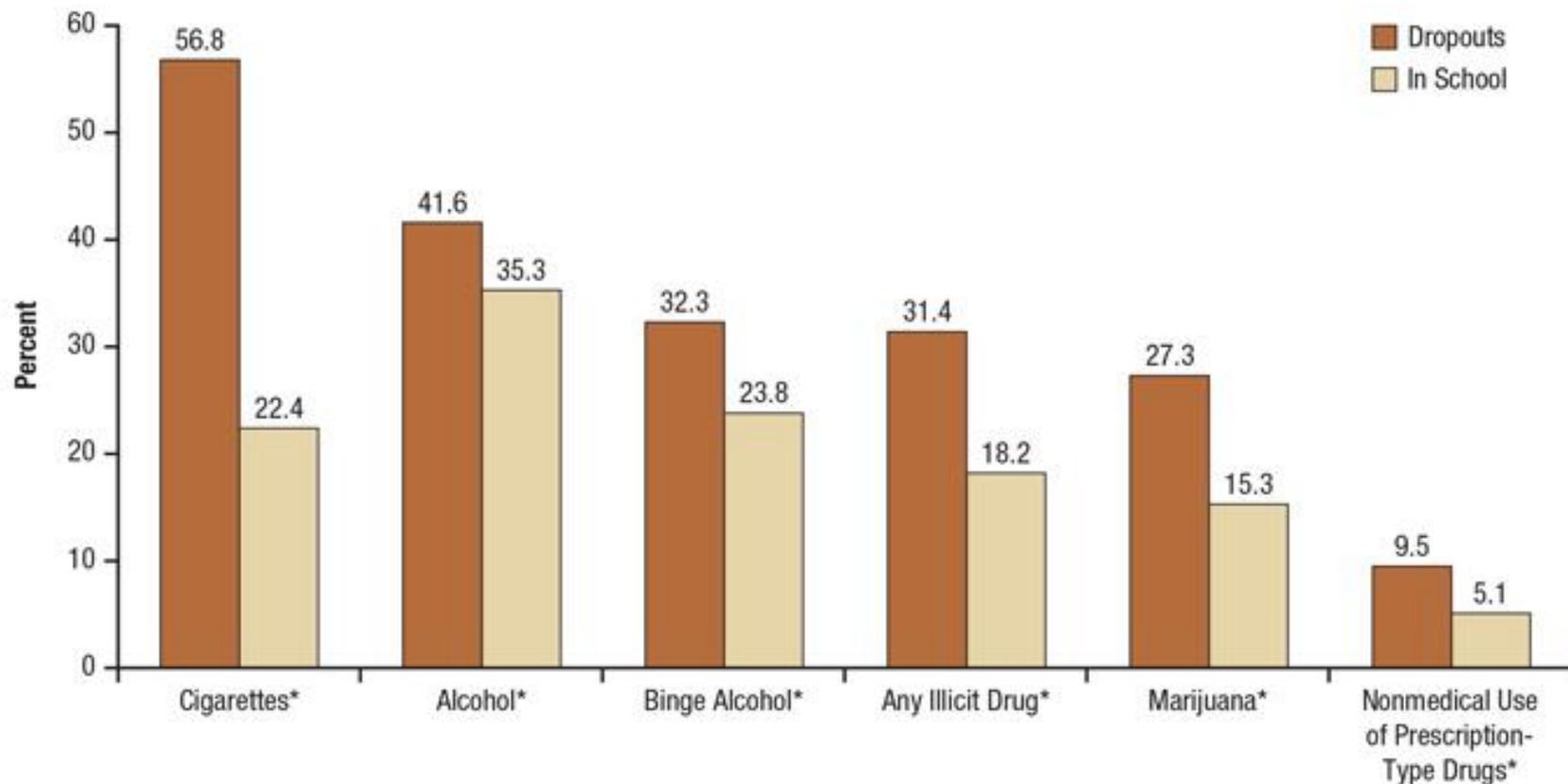


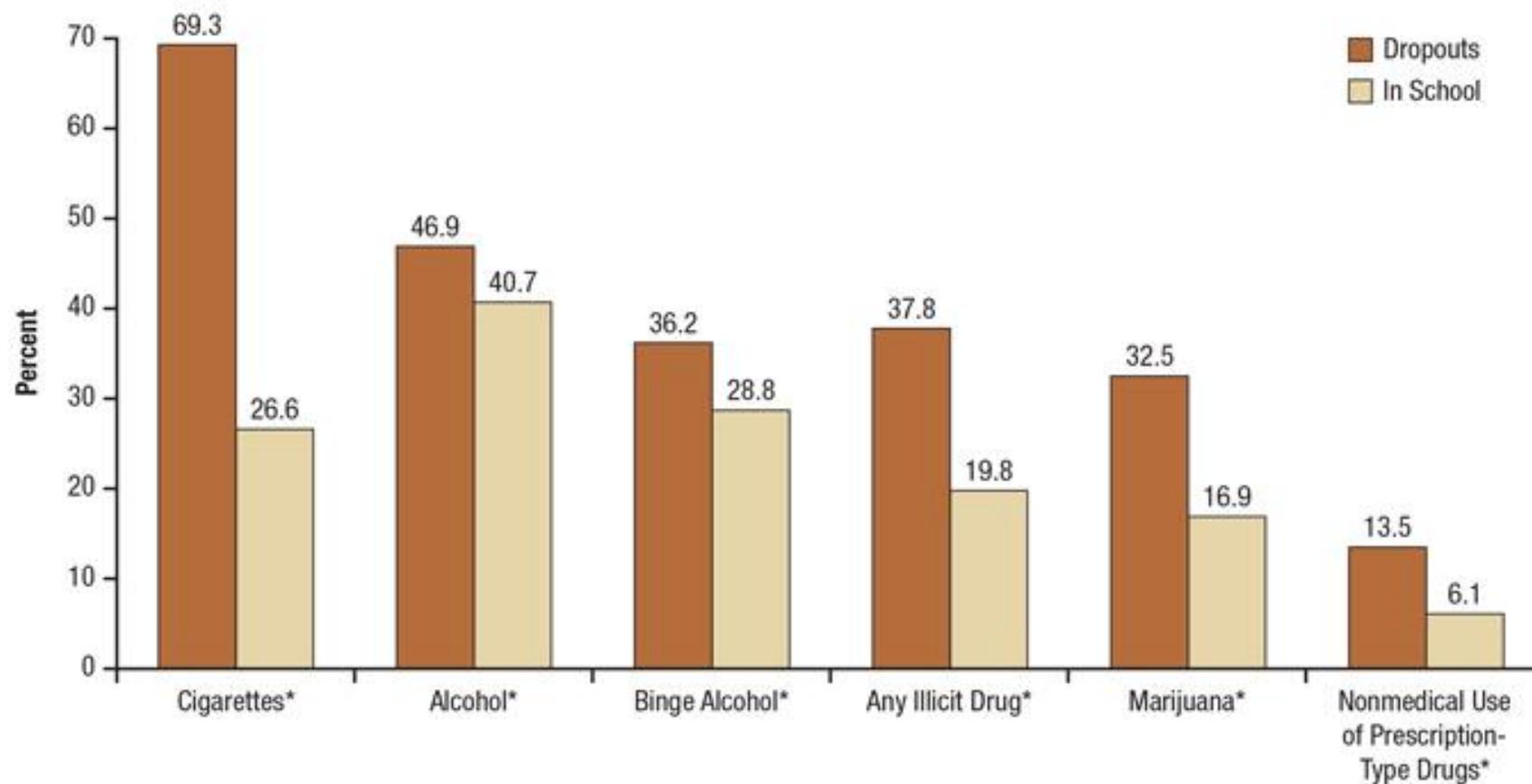
Figure 1. Past Month Substance Use among 12th Grade Aged Youths, by Dropout Status: 2002 to 2010



* Difference between 12th grade students and 12th grade aged youths who had dropped out of school is significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002 to 2010 (revised March 2012).

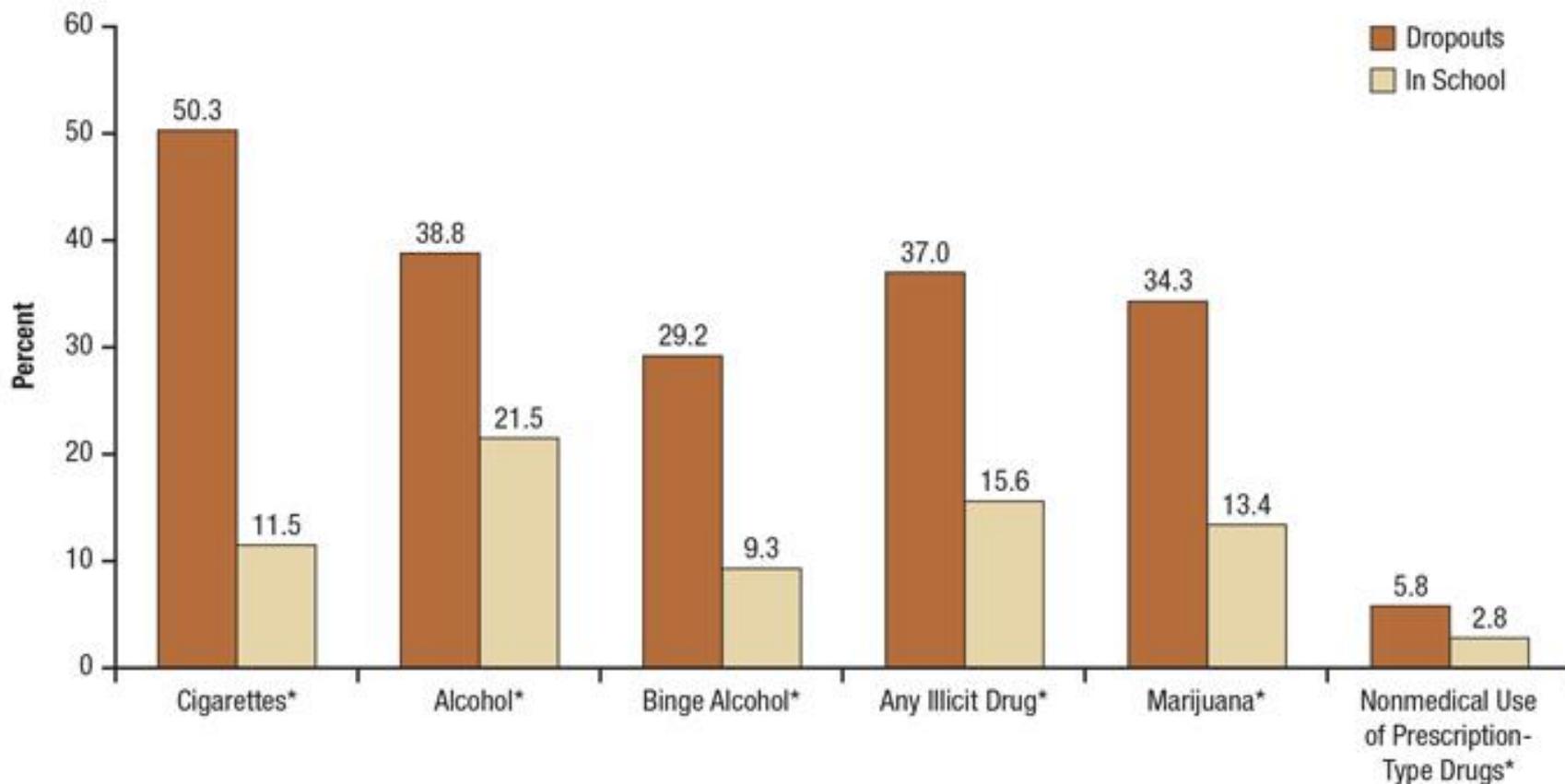
Figure 4 Table. Past Month Substance Use among 12th Grade Aged White Youths, by Dropout Status: 2002 to 2010



* Difference between 12th grade students and 12th grade aged youths who had dropped out of school is significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002 to 2010 (revised March 2012).

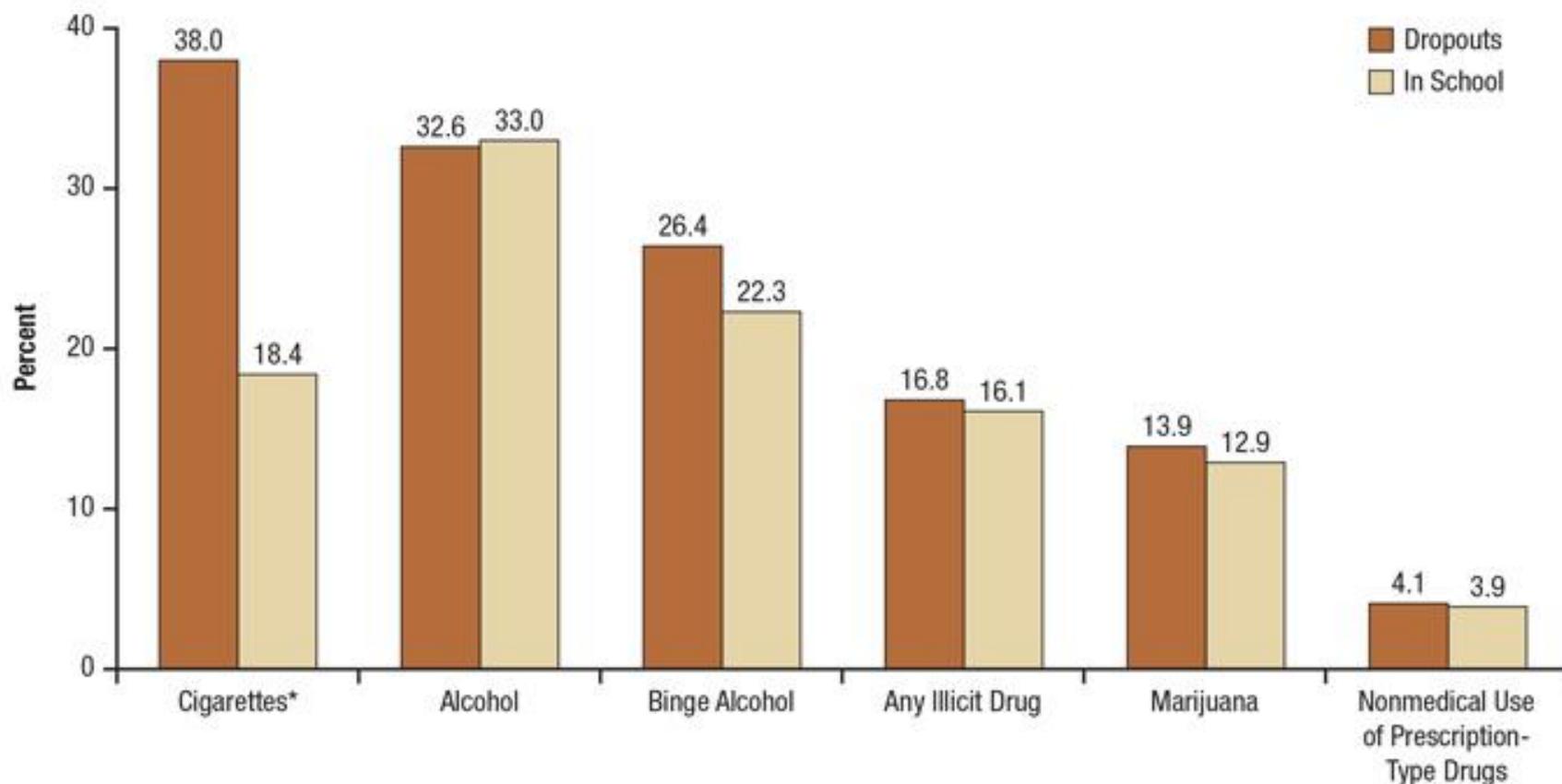
Figure 5. Past Month Substance Use among 12th Grade Aged Black Youths, by Dropout Status: 2002 to 2010



* Difference between estimate and estimate for 2011 is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2002 to 2011 (revised March 2012).

Figure 6. Past Month Substance Use among 12th Grade Aged Hispanic Youths, by Dropout Status: 2002 to 2010



* Difference between estimate and estimate for 2011 is statistically significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2002 to 2011 (revised March 2012).

Why People Who Need it Don't Seek Treatment

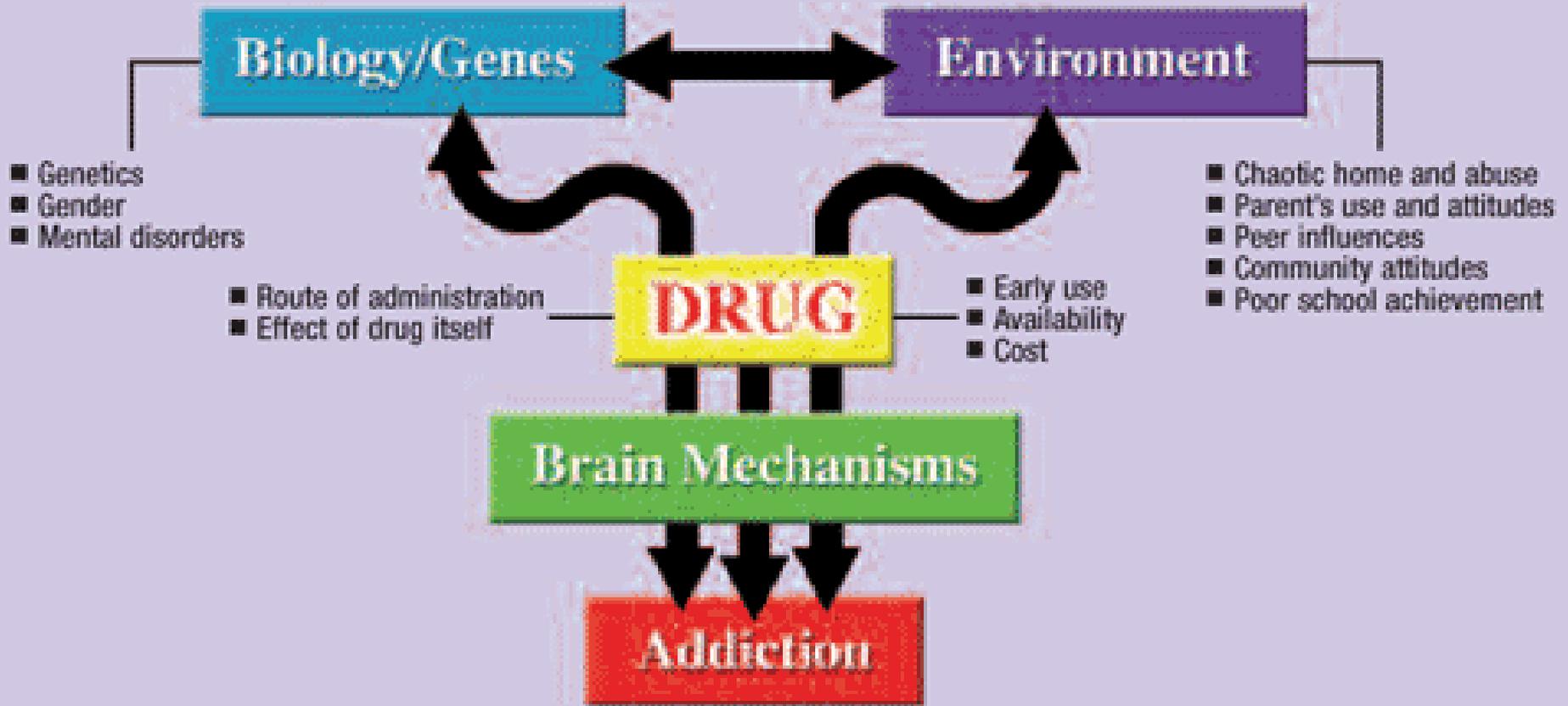
- ❑ **Perception of the Problem, e.g., isn't that bad.**
- ❑ **Perception of Self, e.g., should be able to handle this on my own.**
- ❑ **Perception of Treatment, e.g., ineffective, unaffordable, inaccessible or "for losers"**
- ❑ **Perception of Others, e.g., fear of stigma and discrimination**

Source: Cunningham, et, al, 1993; Grant 1997

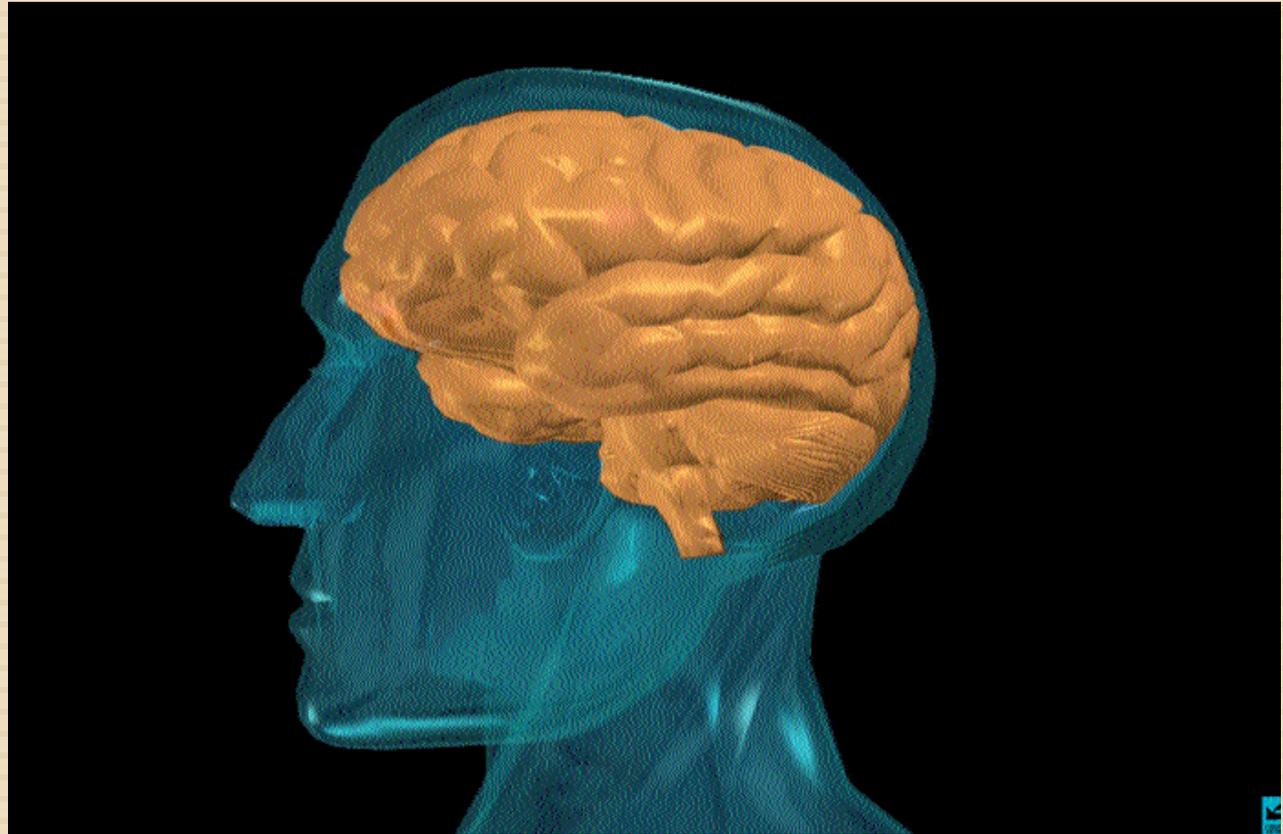


**How does someone
become addicted?**

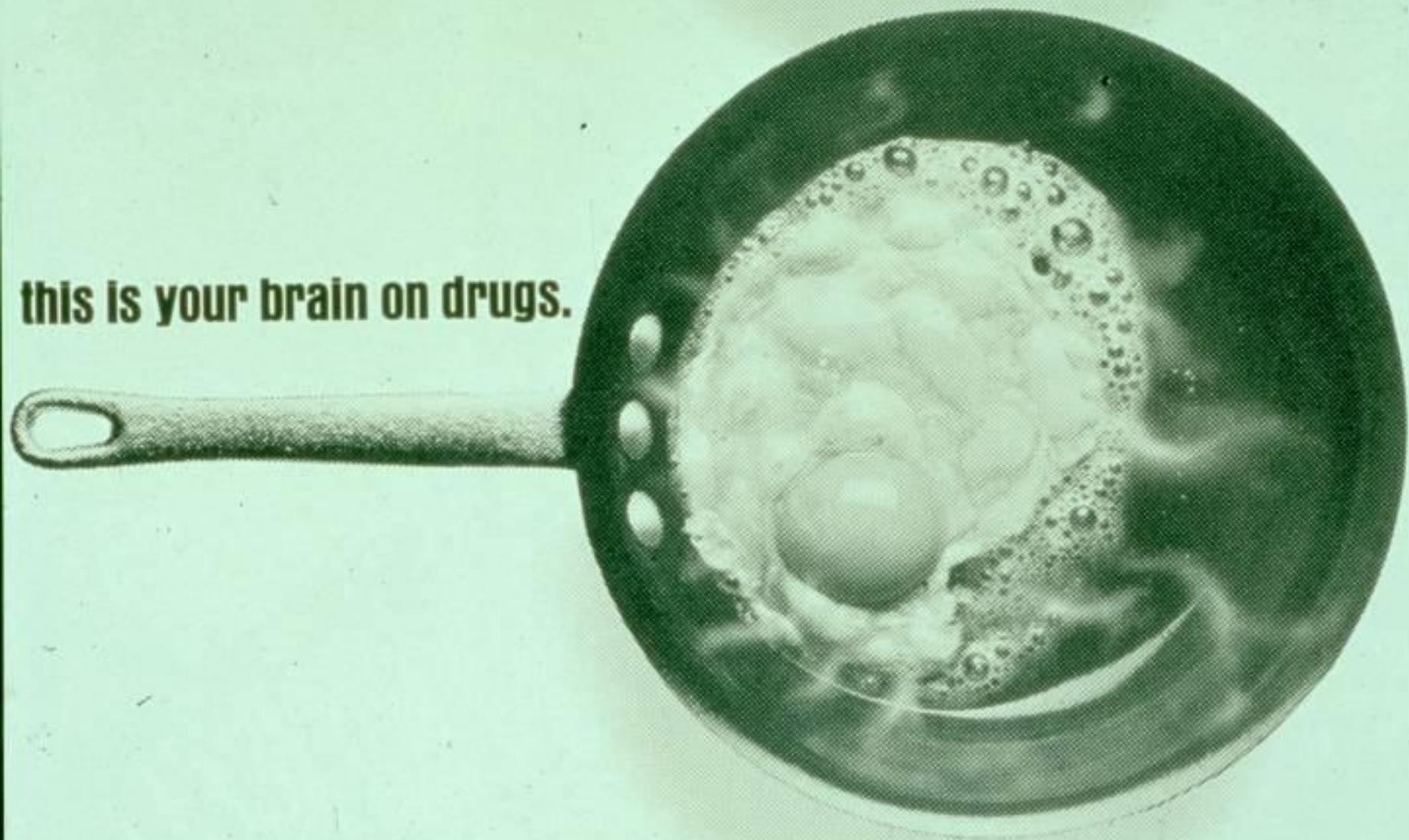
RISK FACTORS



HOW DO SUBSTANCES IMPACT THE BRAIN



this is your brain on drugs.



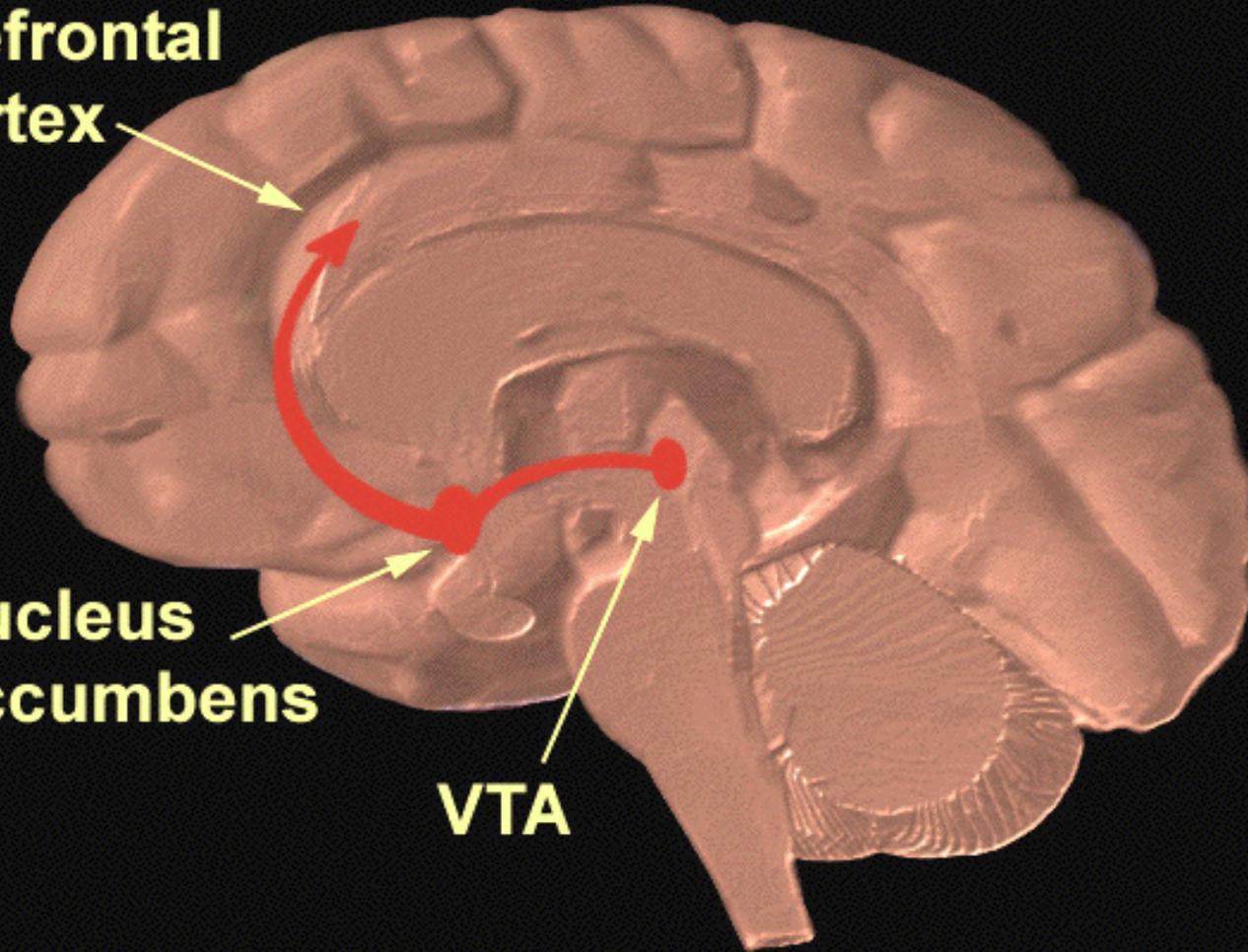
Why Study the Brain of Drug Abusers

- We don't know how much of the damage drugs do is permanent.
- We do Know: Methamphetamine abusers abstinent for a long period— 6 to 12 months—their dopamine transporter levels started to improve. This suggests that if you stop using the drug for long enough, the brain cells can actually recover.
(Linda Chang, 2007)

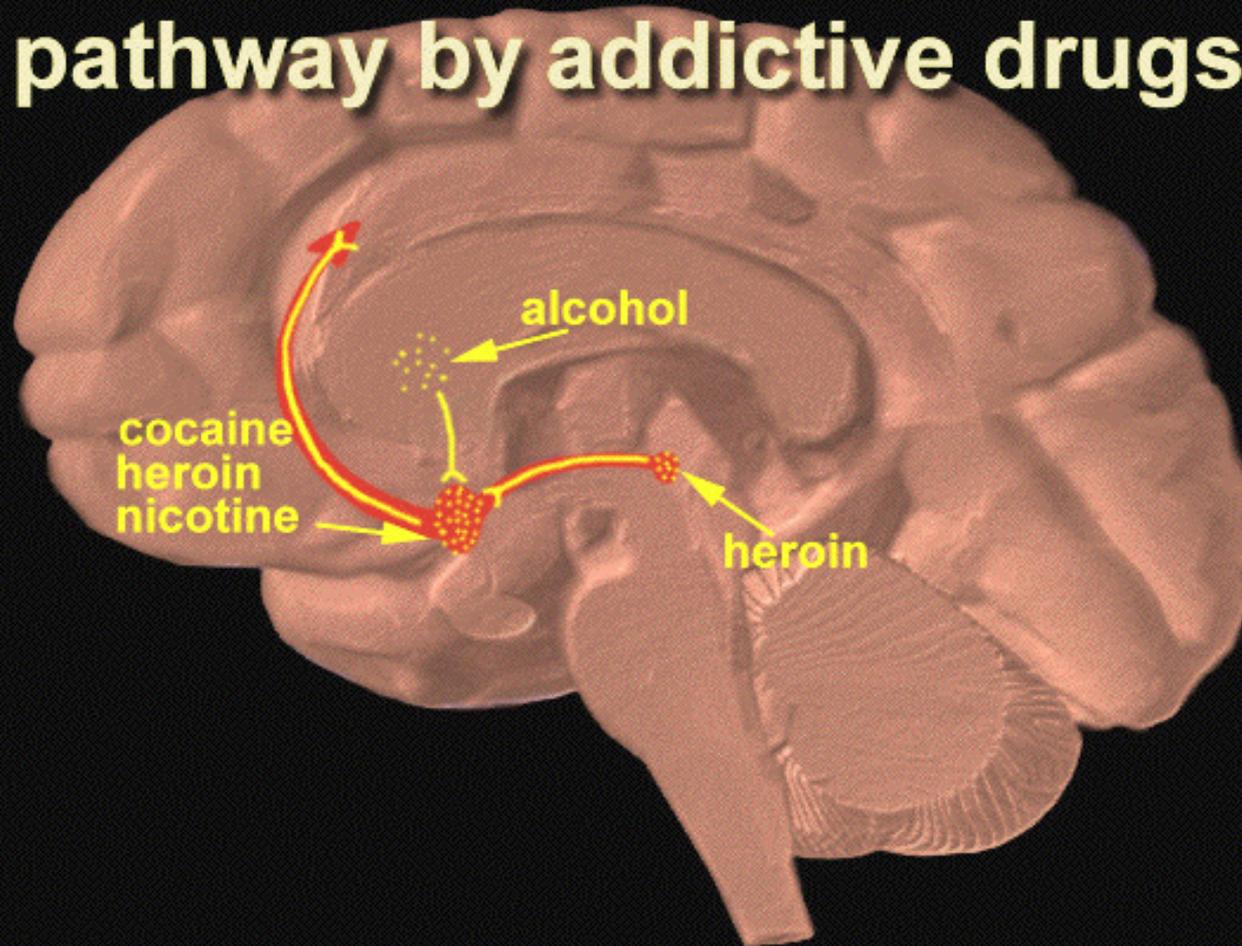
**prefrontal
cortex**

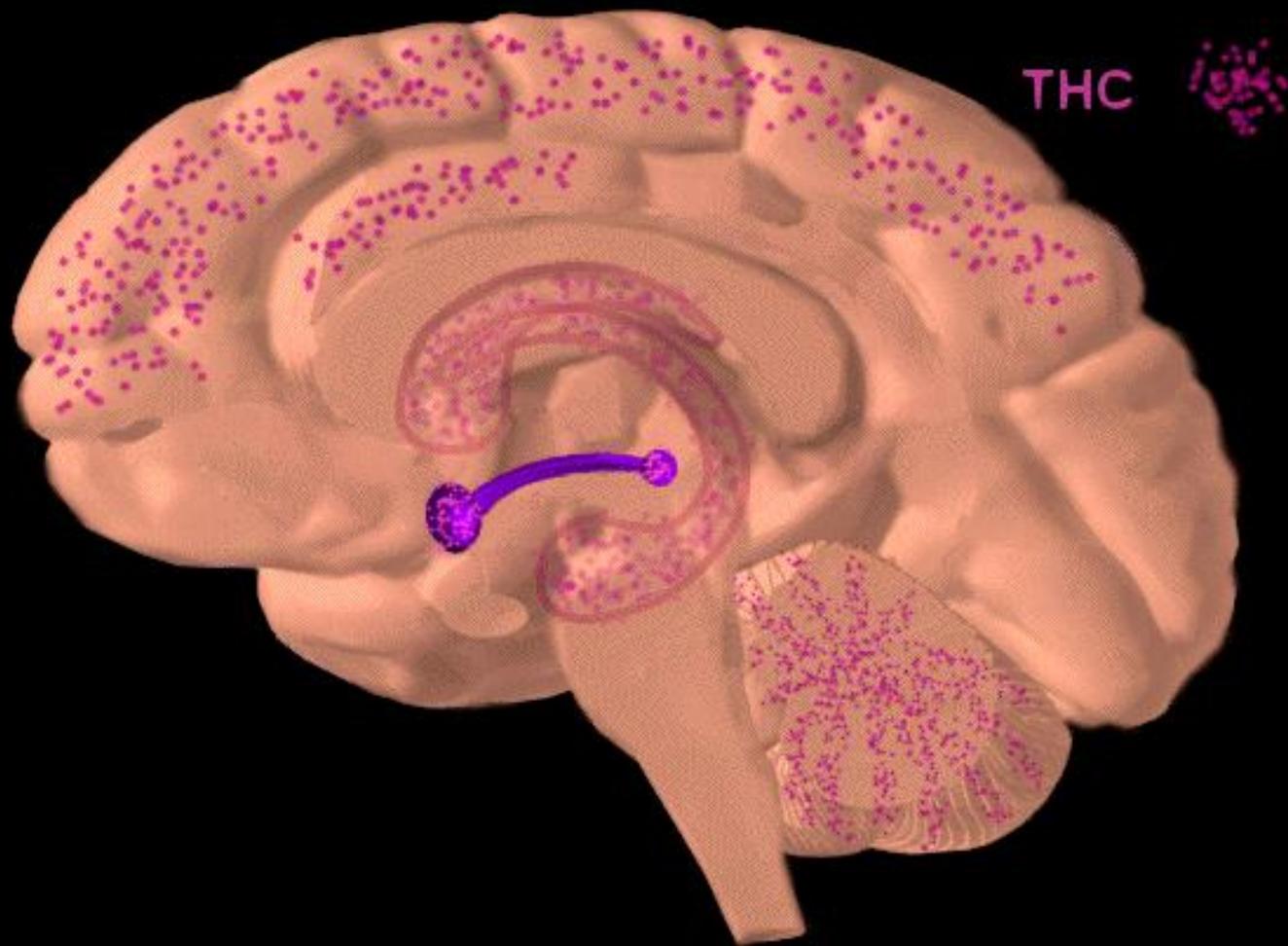
**nucleus
accumbens**

VTA

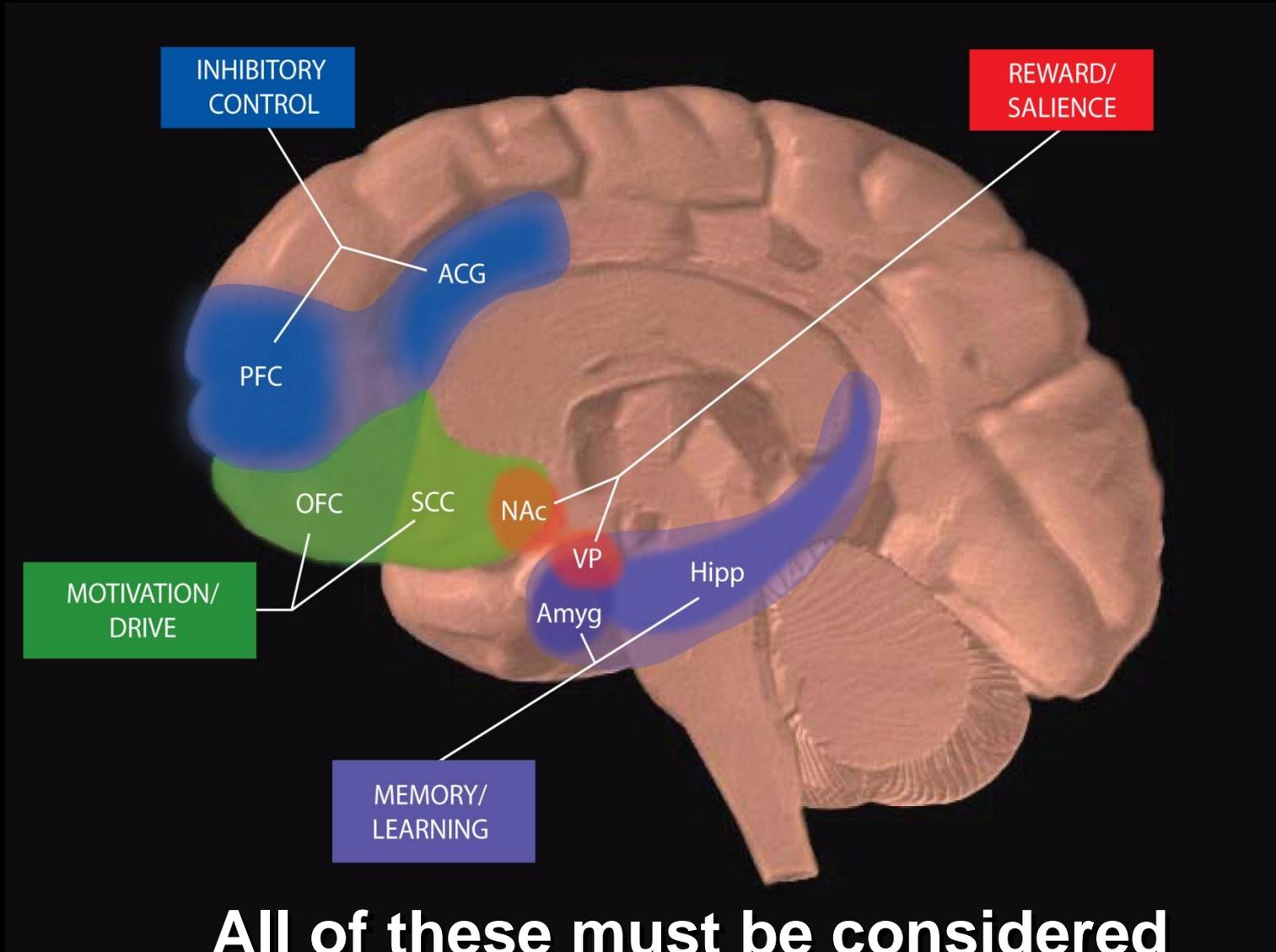


Activation of the reward pathway by addictive drugs

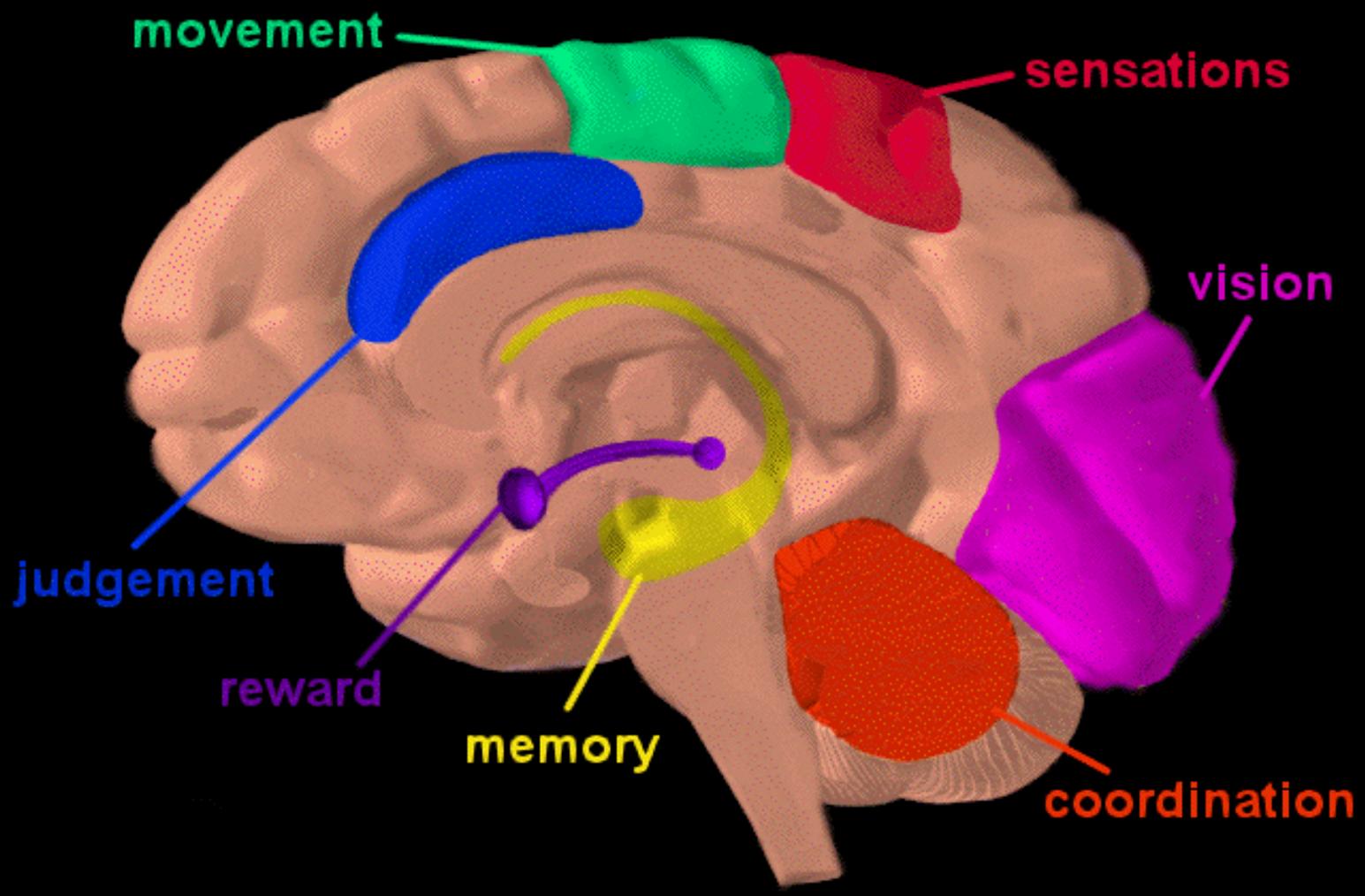




Circuits Involved In Drug Abuse and Addiction



**All of these must be considered
in developing strategies to
effectively treat addiction**



Dopamine Pathways

Serotonin Pathways

Frontal cortex

Striatum

Substantia nigra

Nucleus accumbens

VTA

Hippocampus

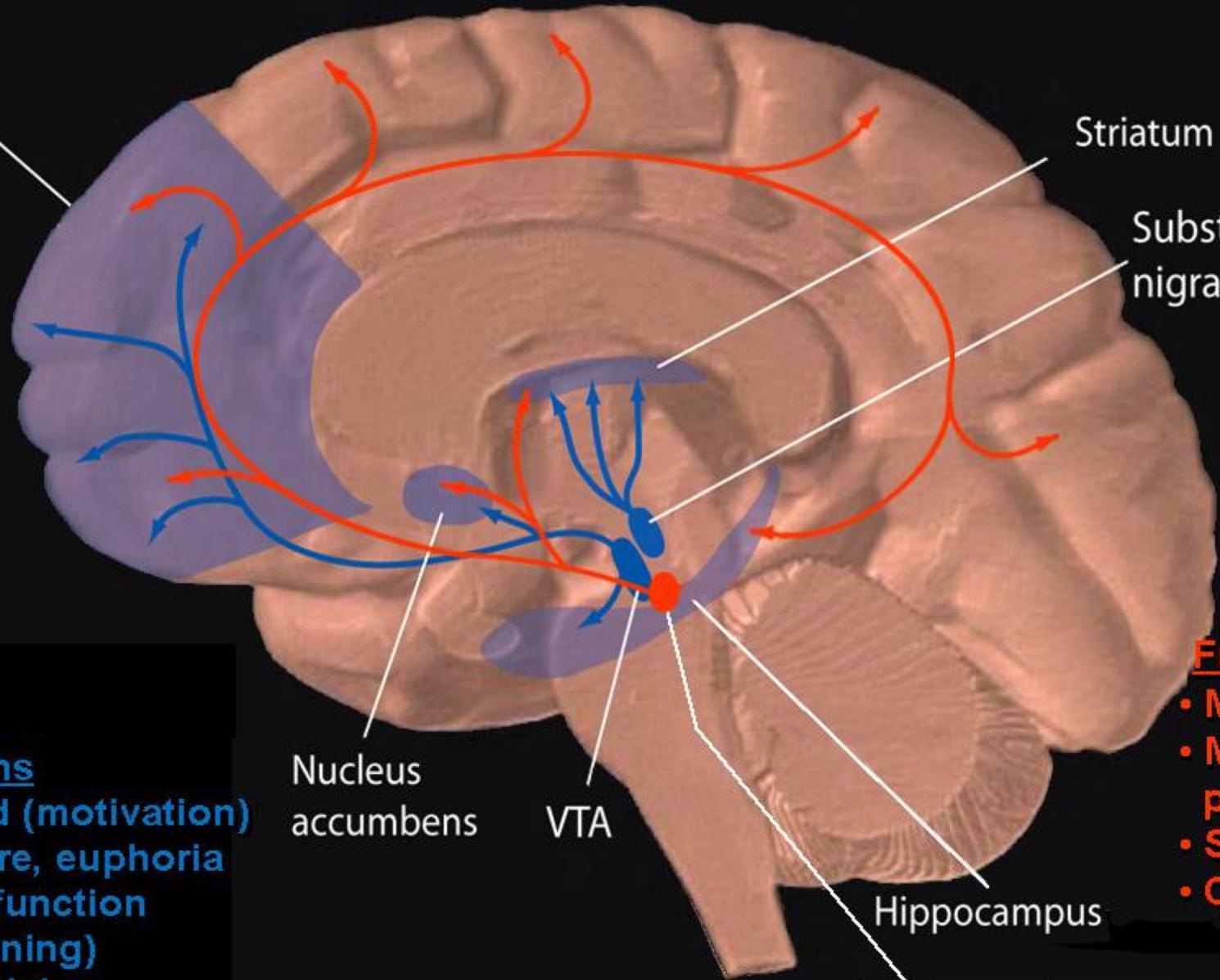
Raphe nucleus

Functions

- Reward (motivation)
- Pleasure, euphoria
- Motor function (fine tuning)
- Compulsion
- Perseveration

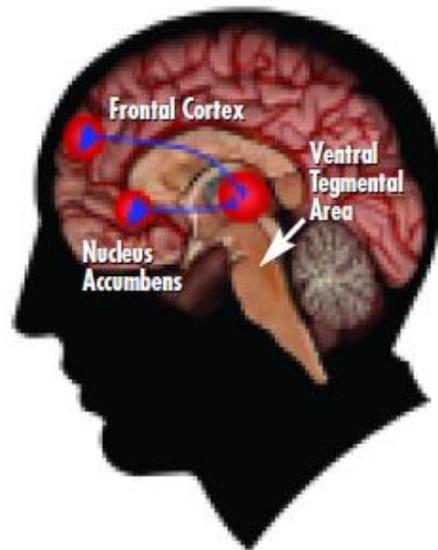
Functions

- Mood
- Memory processing
- Sleep
- Cognition



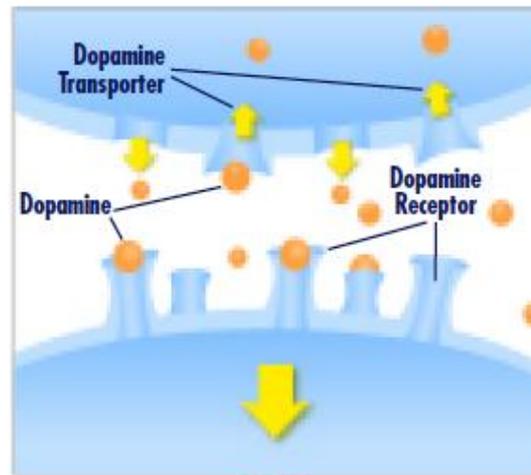
DRUGS OF ABUSE TARGET THE BRAIN'S PLEASURE CENTER

Brain reward (dopamine) pathways

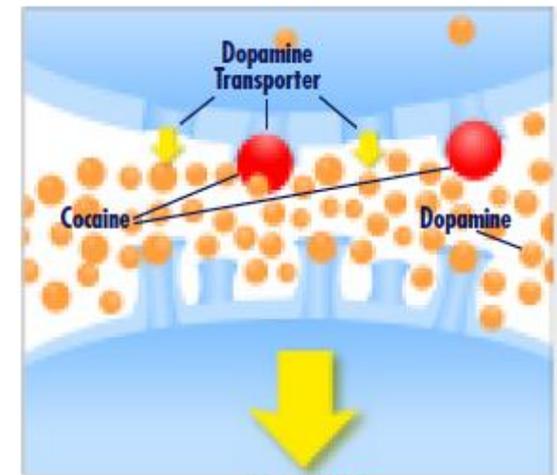


These brain circuits are important for natural rewards such as food, music, and sex.

Drugs of abuse increase dopamine



FOOD



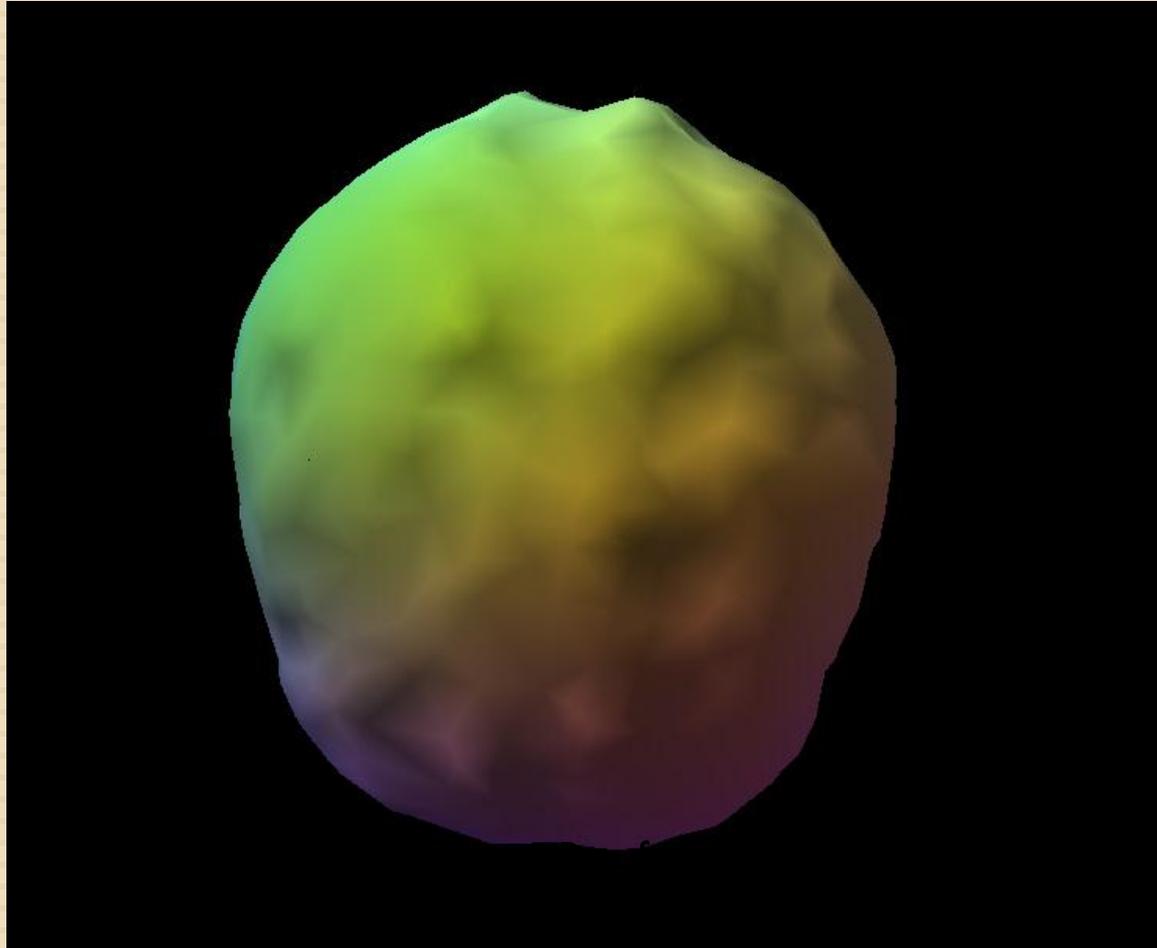
COCAINE

Typically, dopamine increases in response to natural rewards such as food. When cocaine is taken, dopamine increases are exaggerated, and communication is altered.

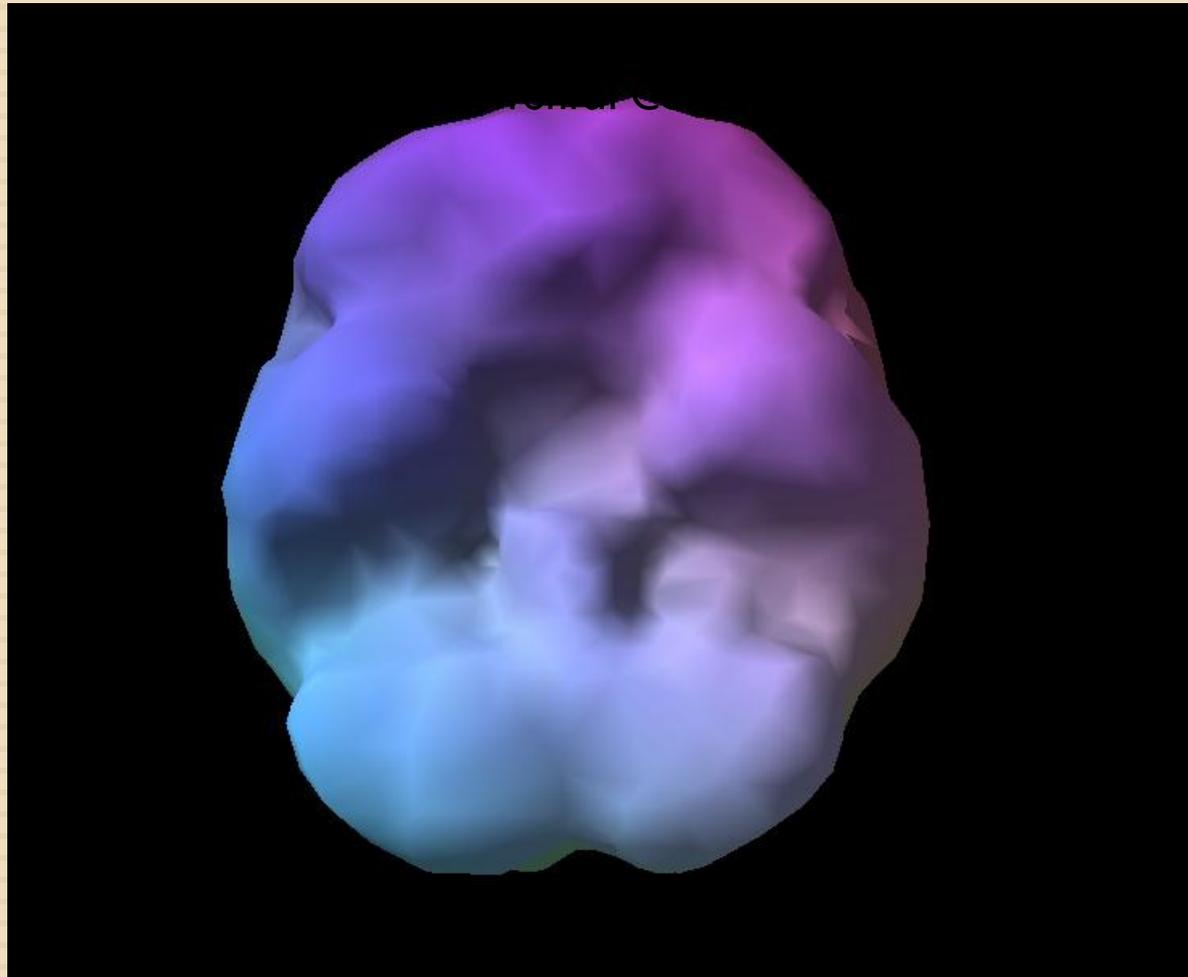
Brain Imaging

- What is SPECT?
- It is an acronym for Single Photon Emission Computerized Tomography
- Nuclear medicine method to study cerebral blood flow and indirectly at brain activity (or metabolism).
- A radioactive isotope is bound to a substance that is readily taken up by the cells in the brain

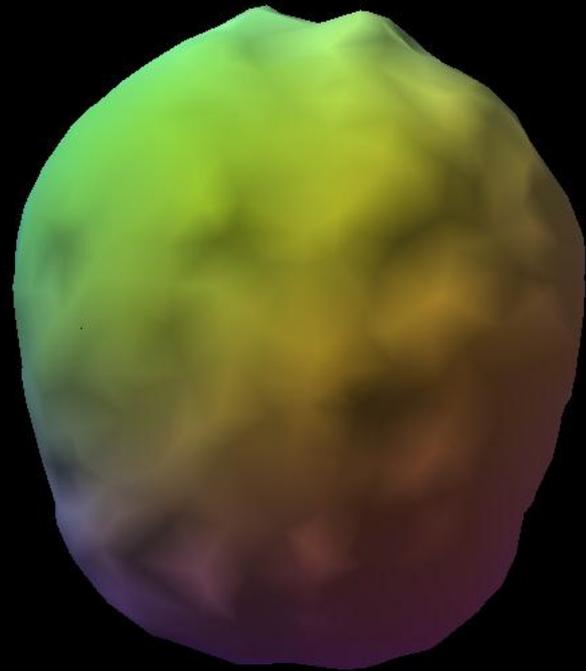
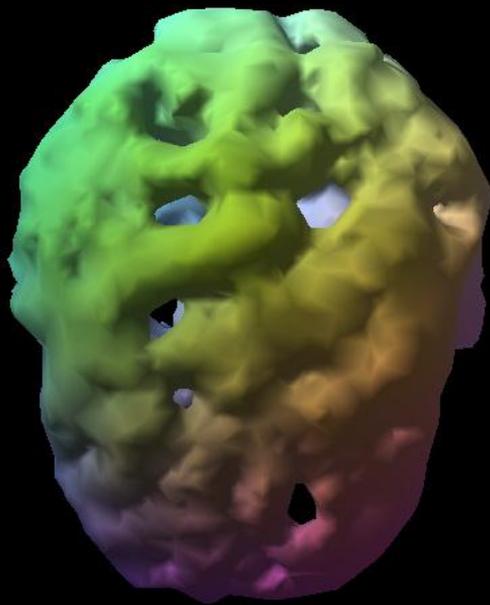
Normal Top View



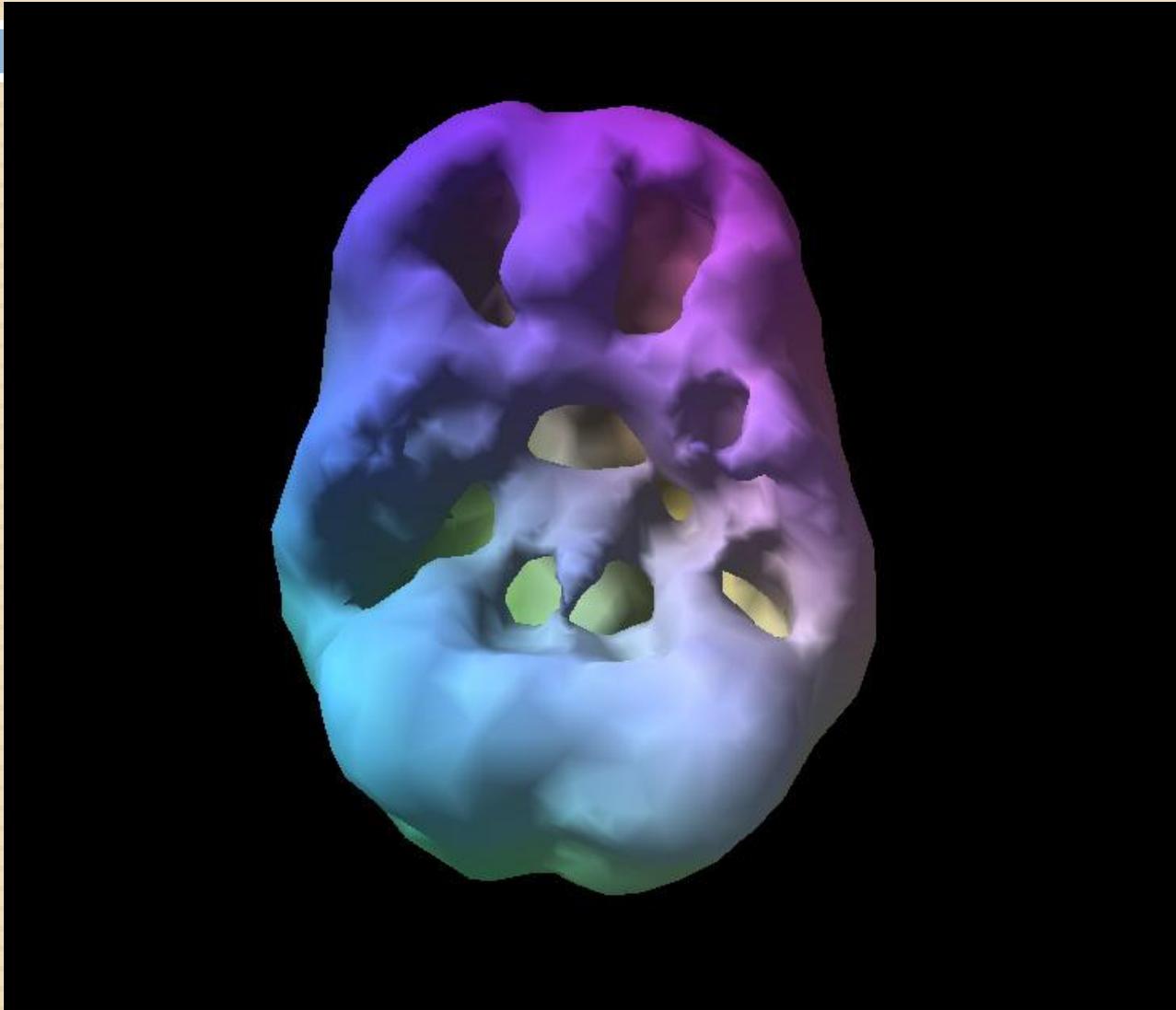
Normal Under Side



Use VS Non Use



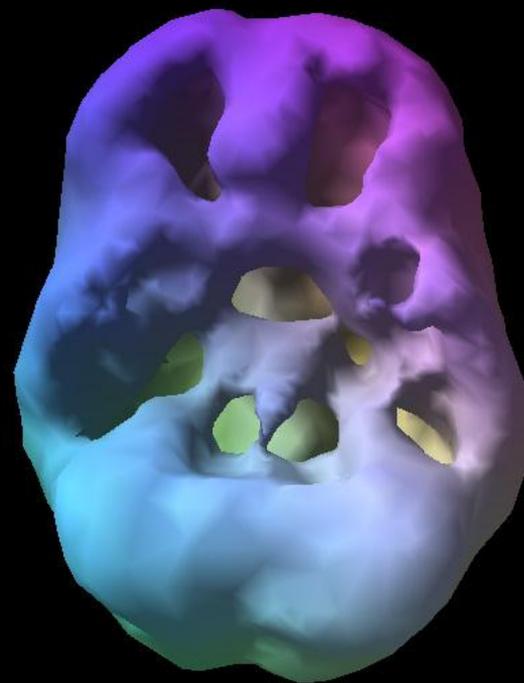
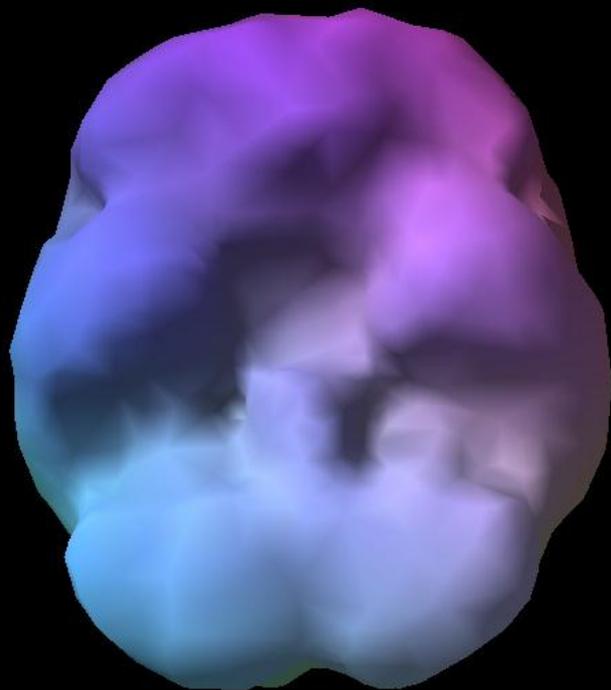
Marijuana: 16 year Old 3yrs Weekly Use



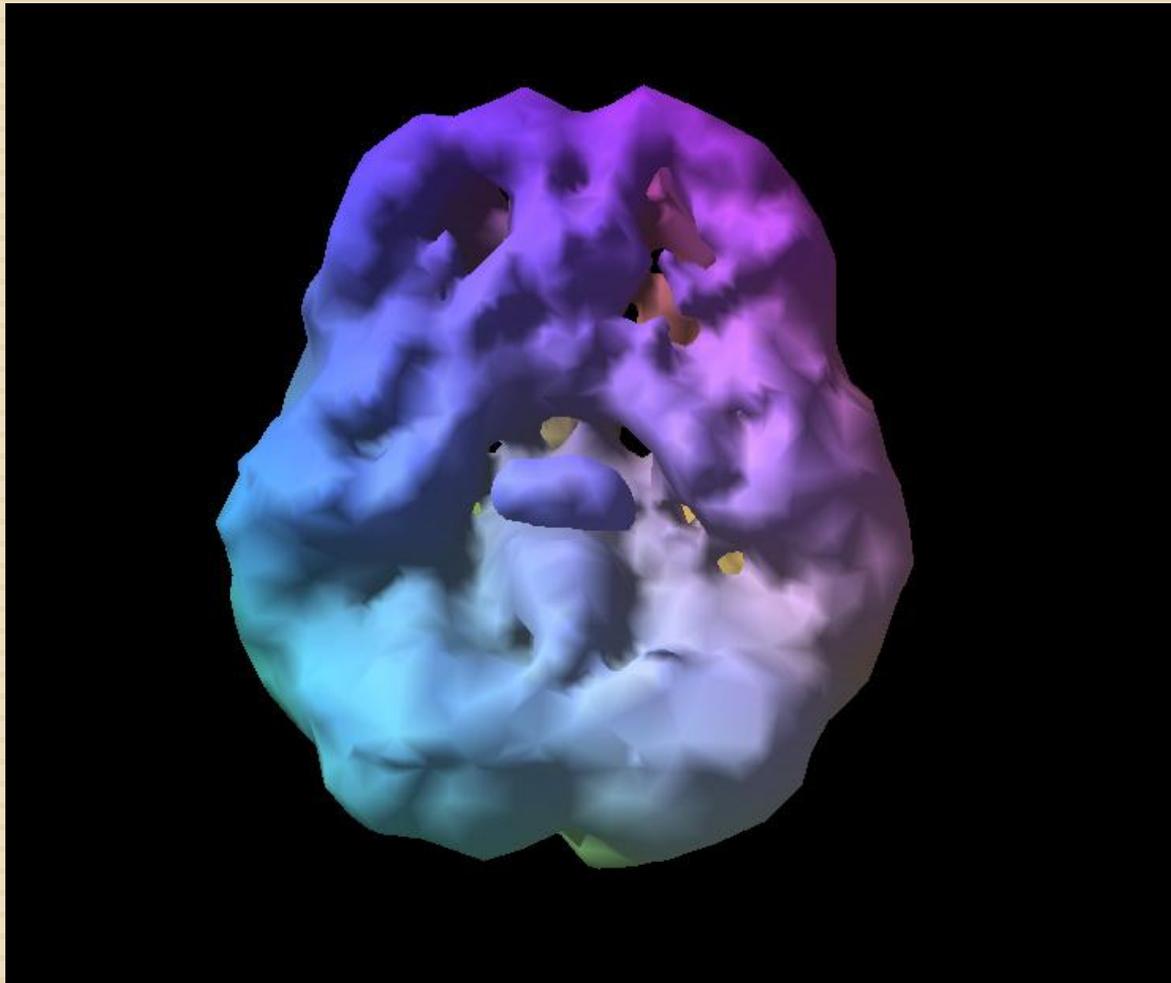
Normal

Vs

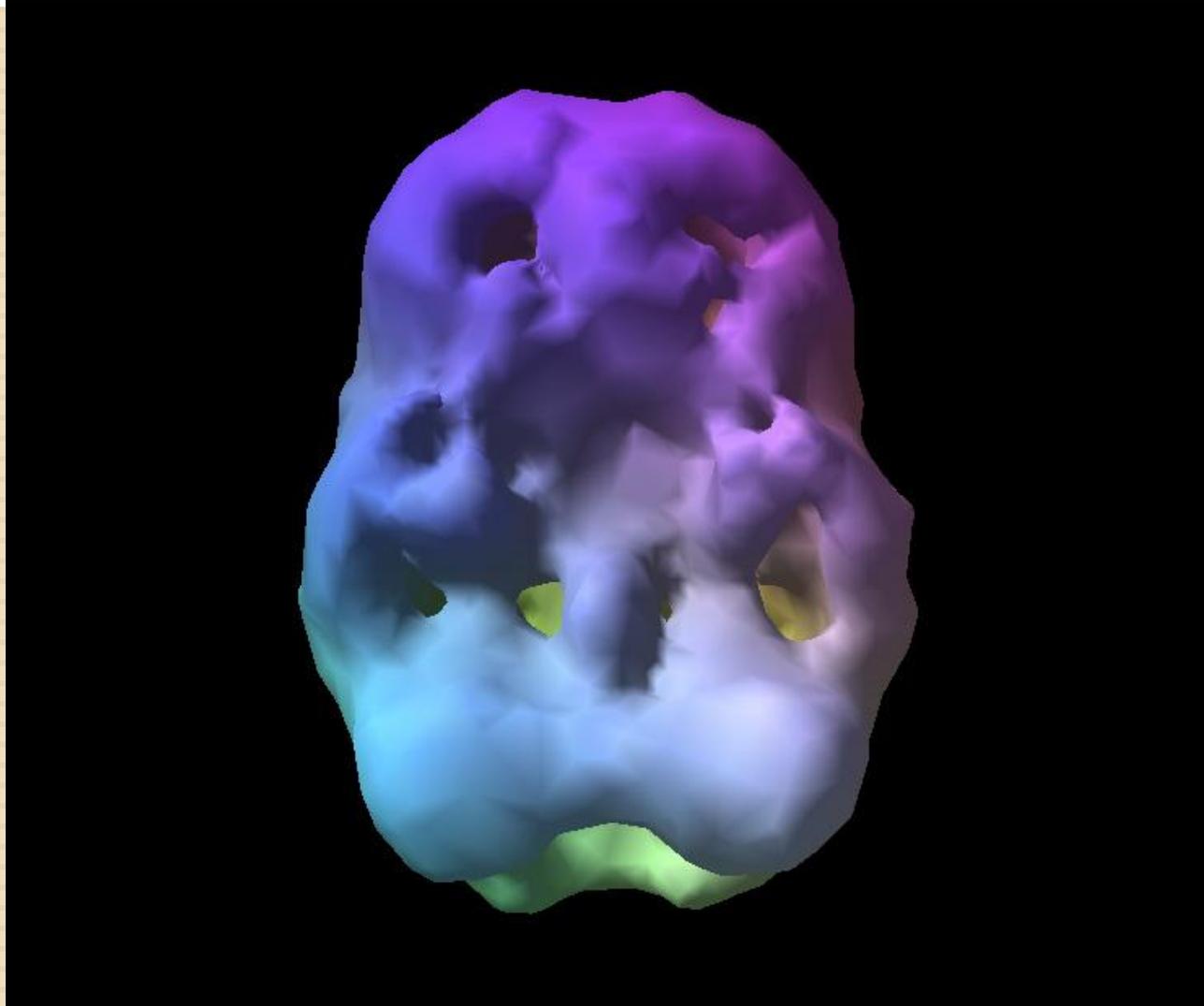
Marijuana User



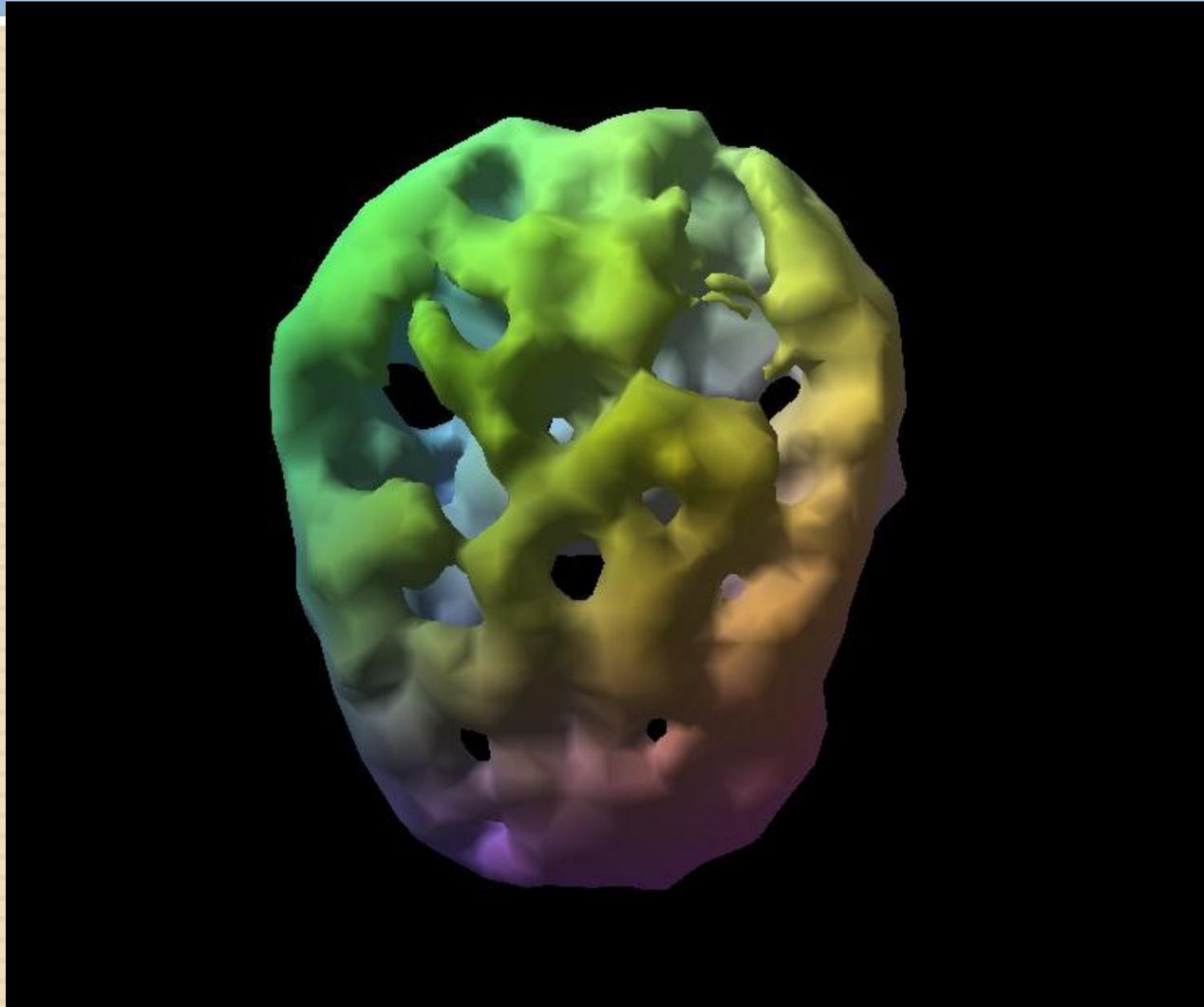
Marijuana: 28 year old 10yrs weekend use



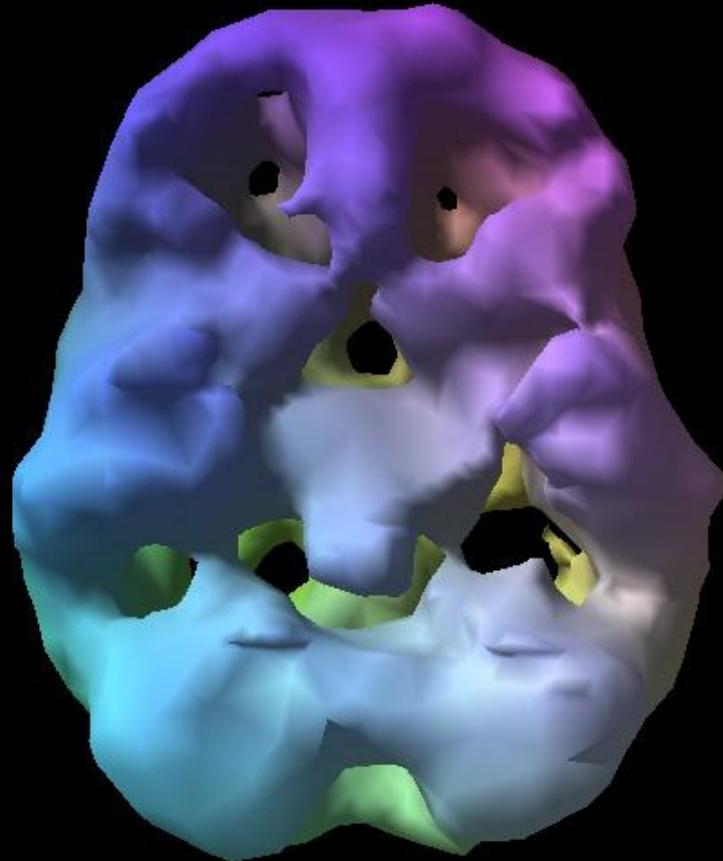
Alcohol: 45 year old 22 yrs daily use



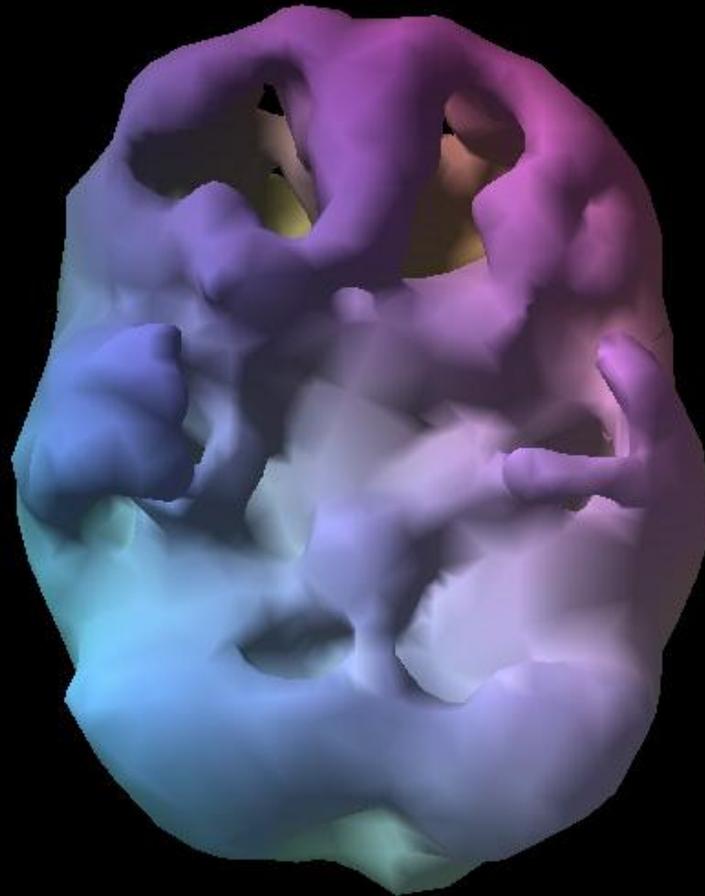
Alcohol: 38 year old 17 yrs weekend use



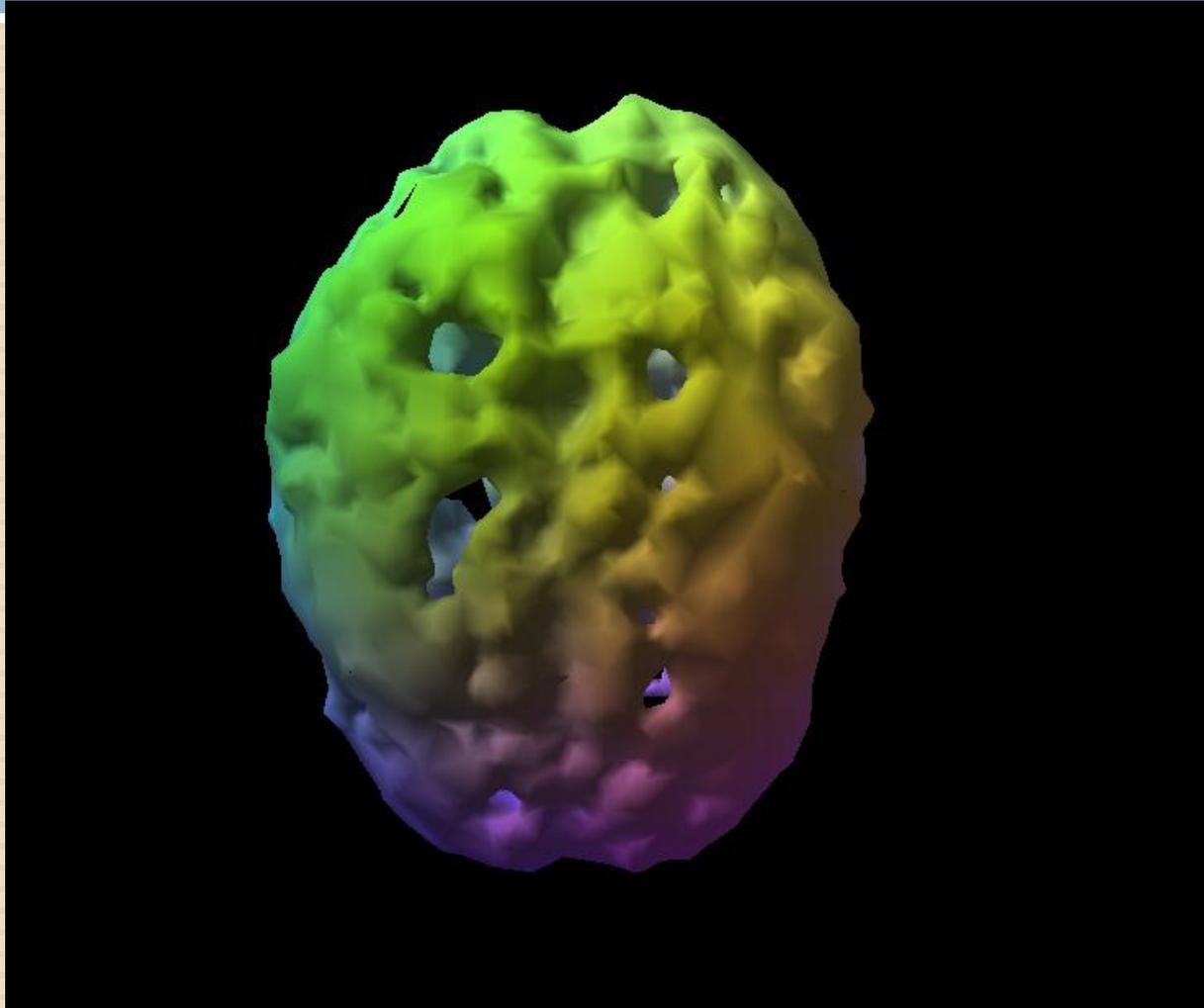
Alcohol: 38 year old 17 years weekend
use



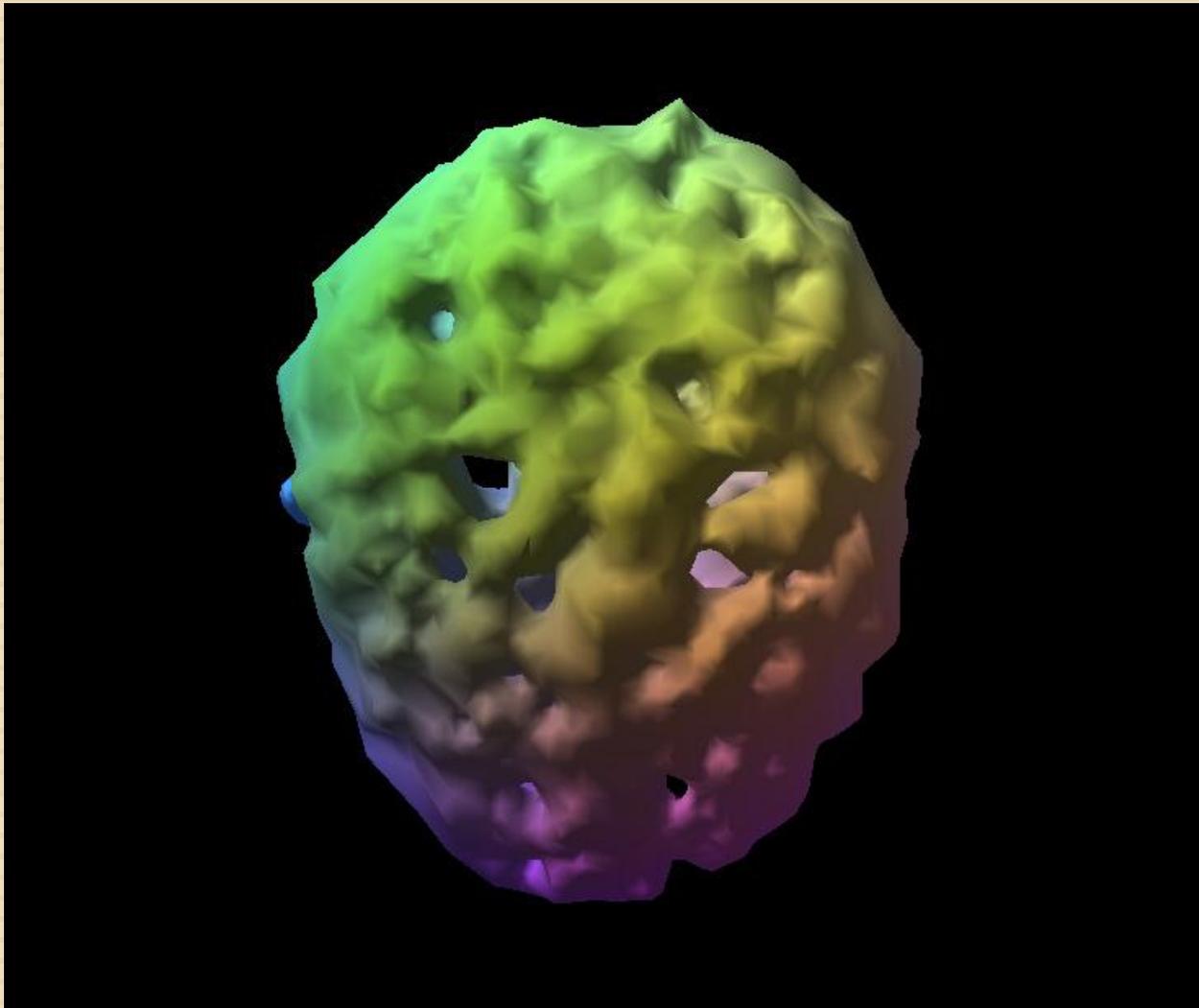
Alcohol: 44 year old 18 yrs daily use



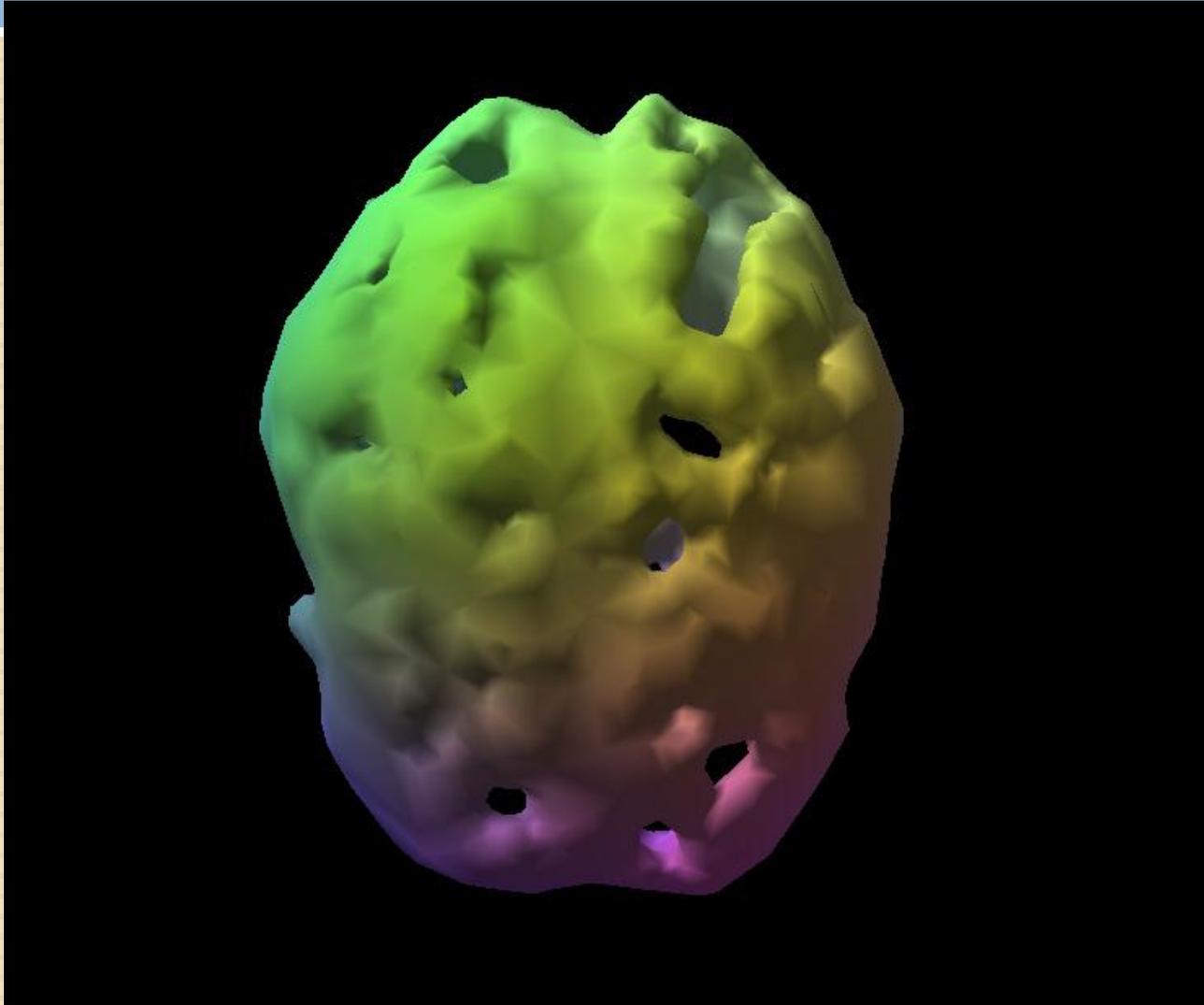
Cocaine: 24 year old 2 yrs use



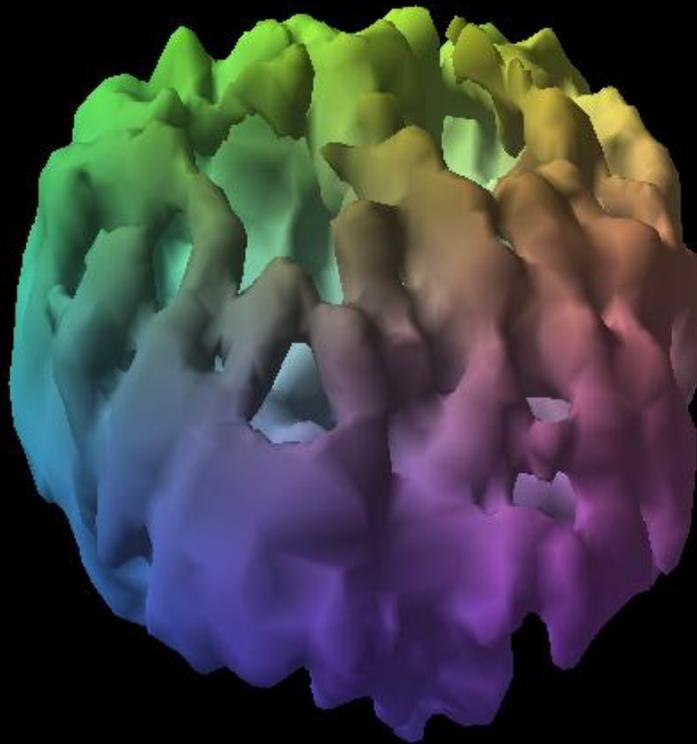
Methamphetamine: 28 year old 7 yrs use



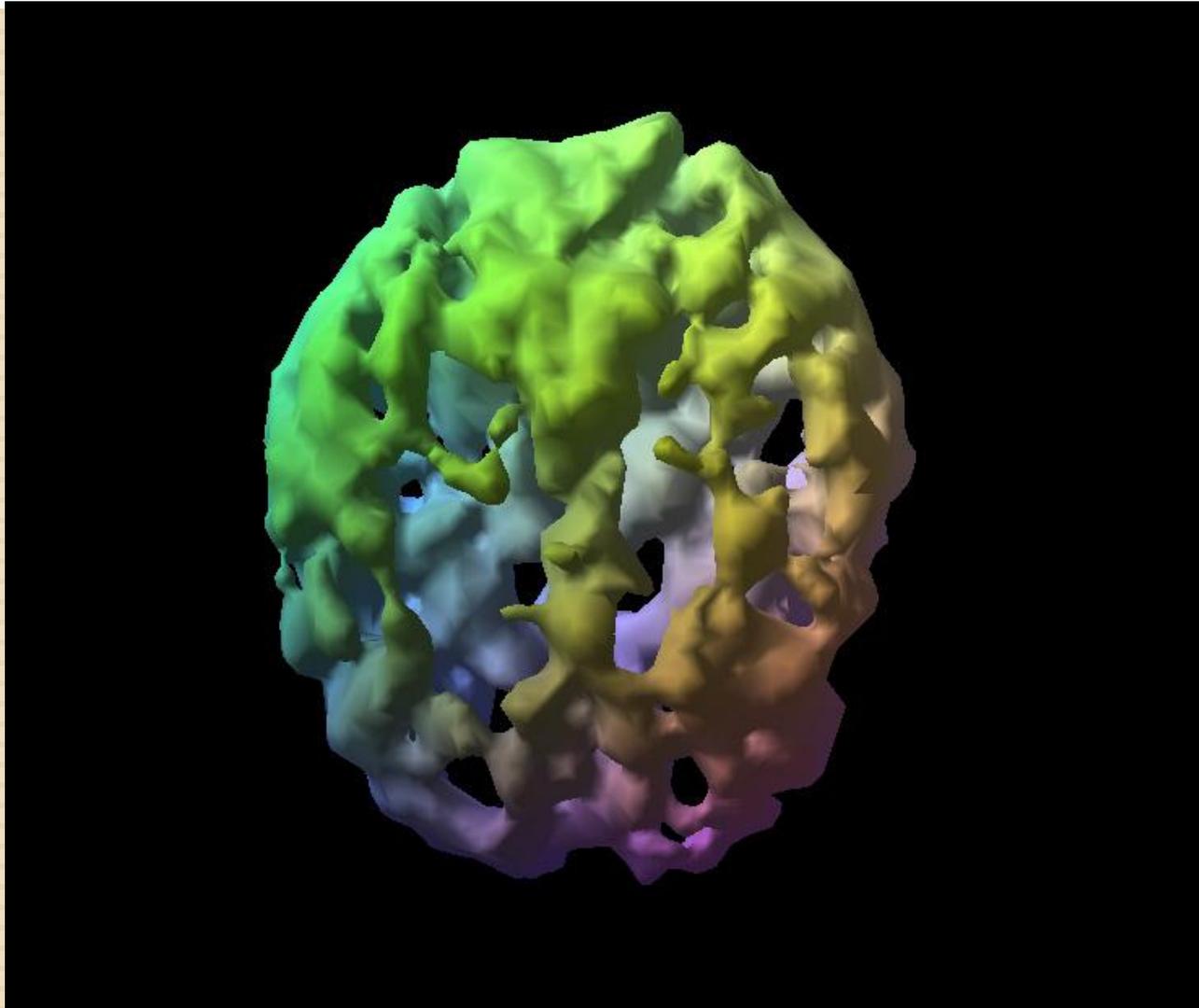
Methamphetamine: 36 year old 10 yrs use



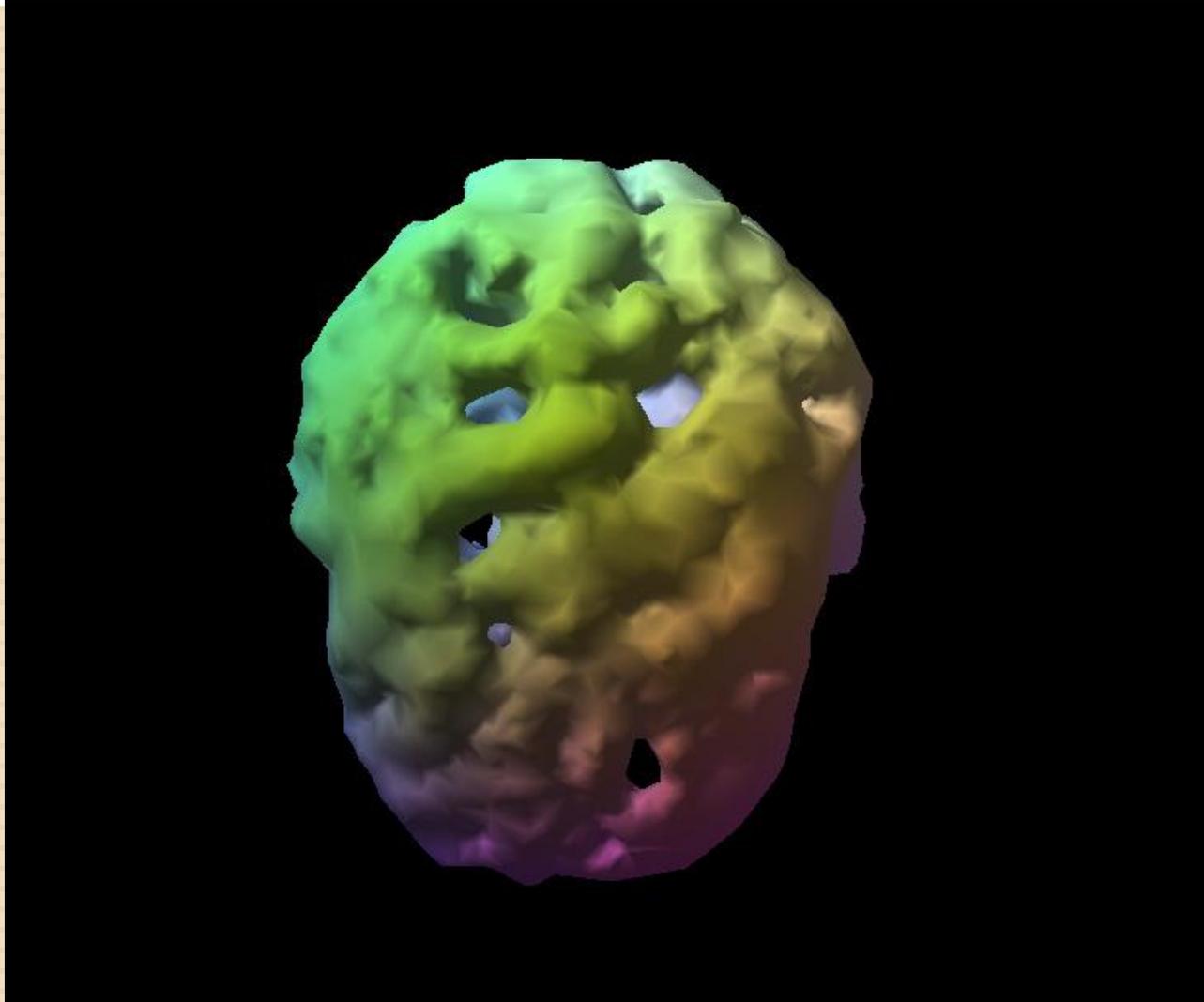
Heroin: 39 year old 25 yrs use



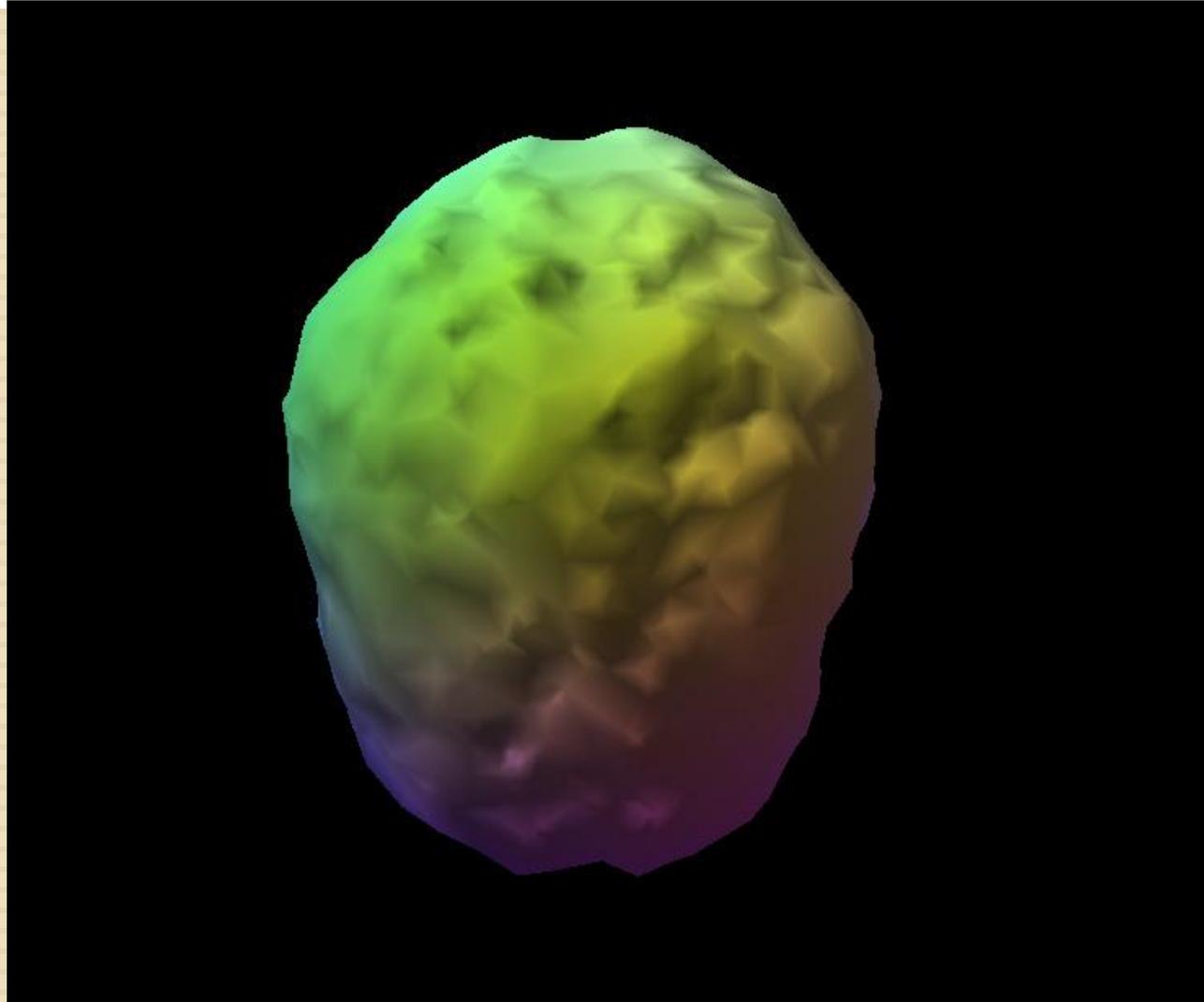
Methadone: 40 year old 7 yrs of use



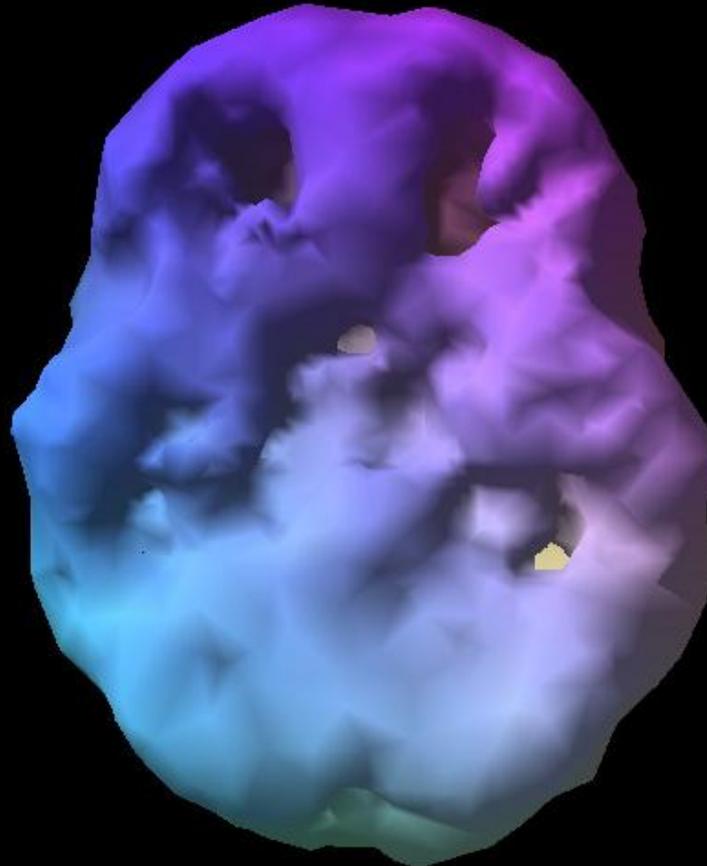
Poly-drug Abuser



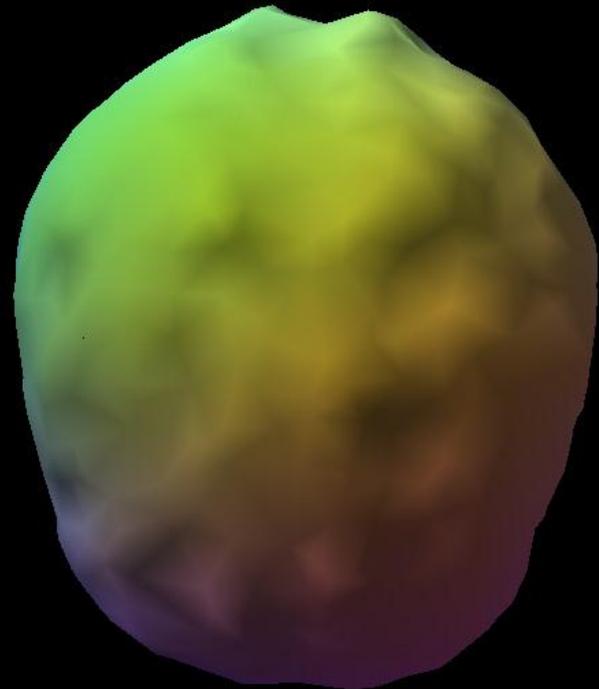
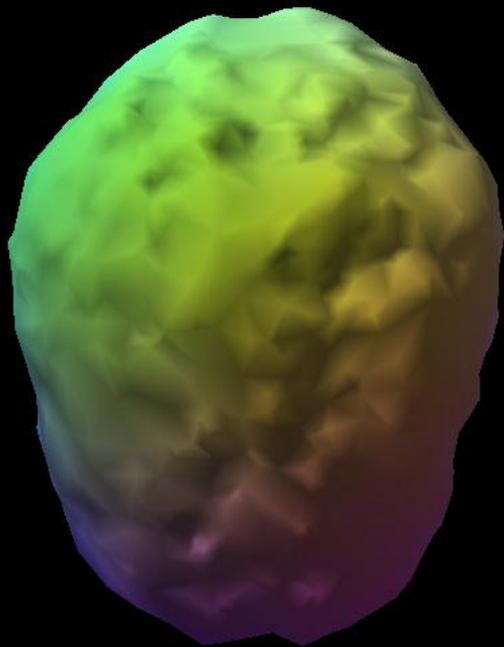
One Year Alcohol and Drug Free



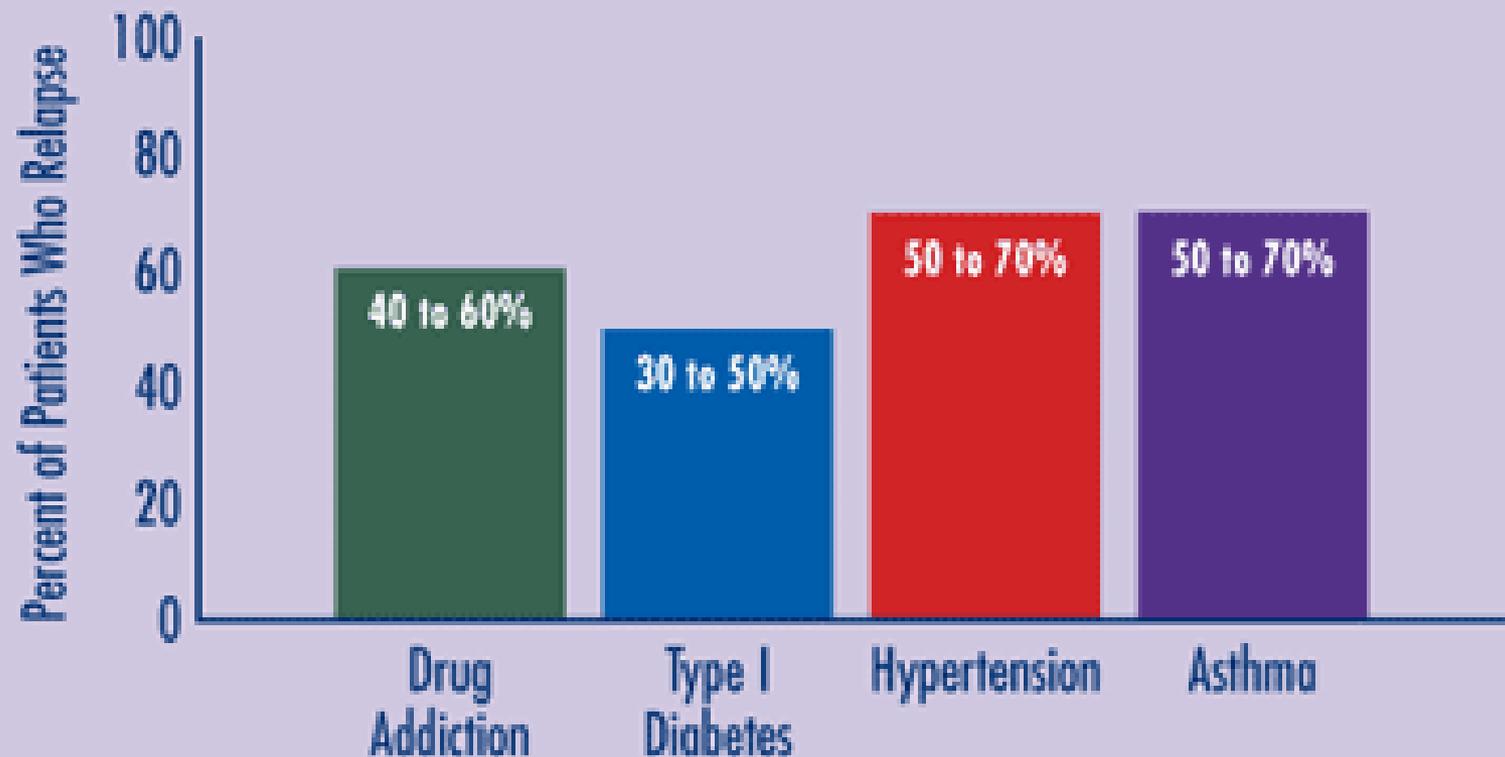
One Year Alcohol and Drug Free



Recovery VS Normal



COMPARISON OF RELAPSE RATES BETWEEN DRUG ADDICTION AND OTHER CHRONIC ILLNESSES

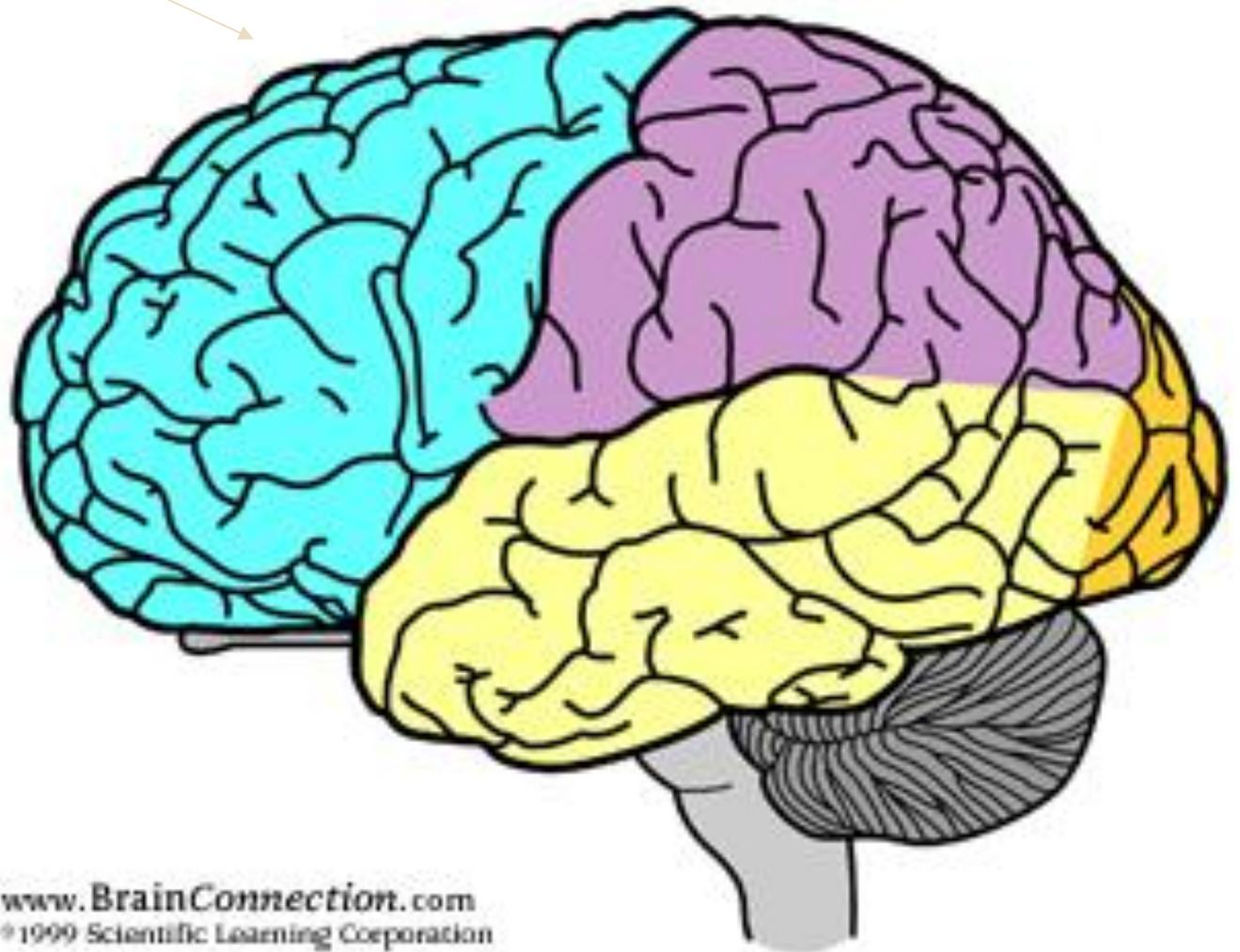


Weak Engagement & Attrition

Dropout rates between the call for an appointment at an addiction treatment agency and the first treatment session range from 50-64% (Gottheil, Sterling & Weinstein, 1997).

Nationally, more than half of clients admitted to addiction treatment do not successfully complete treatment (48% “complete”; 29% leave against staff advice; 12% are administratively discharged for various infractions; 11% are transferred) (OAS/SAMHSA 2005).

The Prefrontal Cortex



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Prefrontal Cortex

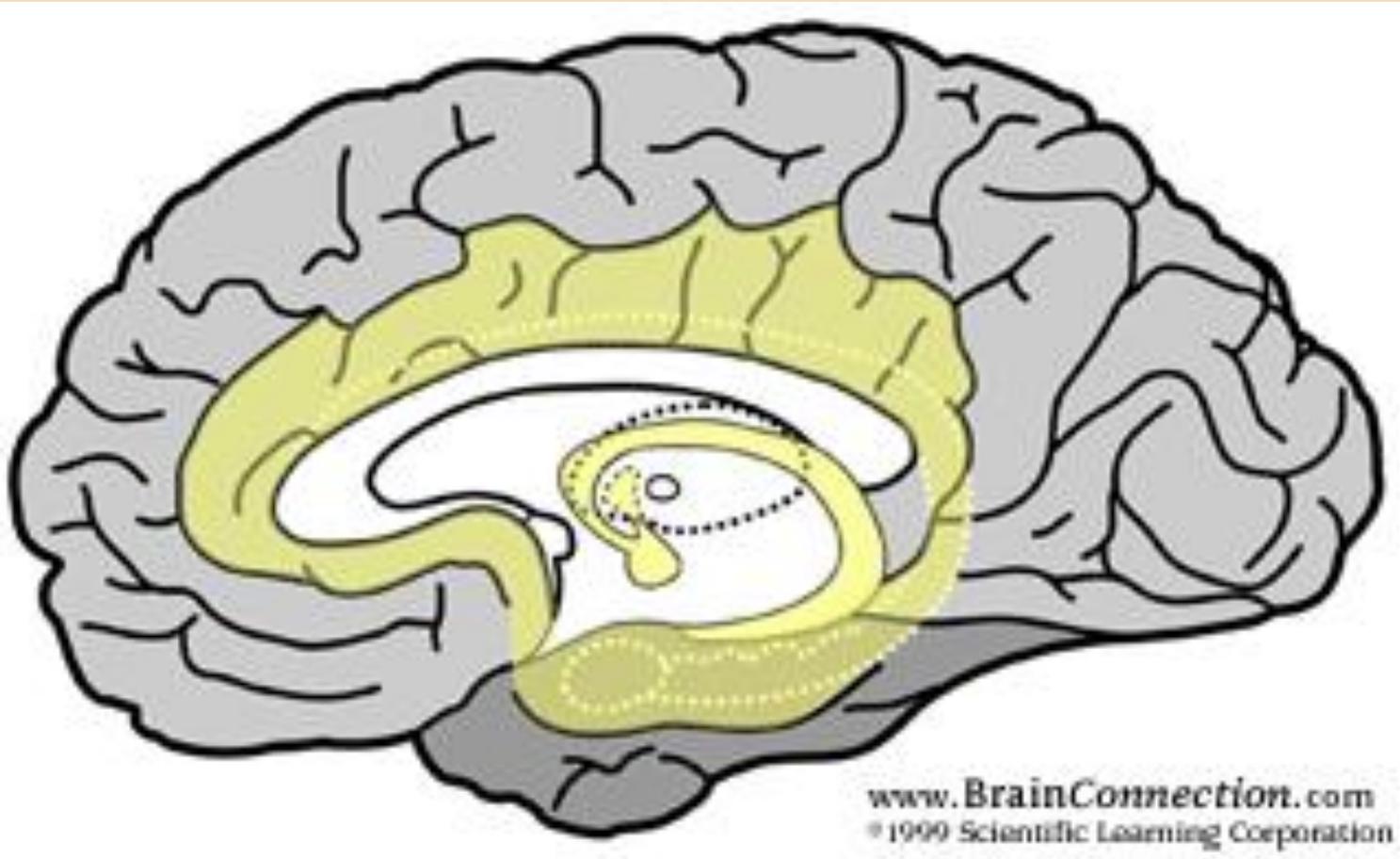
FUNCTIONS

- Attention Span (focus)
- Perseverance
- Impulse Control
- Self Monitoring and Supervision
- Problem Solving
- Critical thinking
- Organization
- Forward thinking
- Learning from experience
- Ability to feel and express emotion
- Judgment (supervisor)
- Empathy
- Interaction with limbic system

PROBLEMS

- Short attention span (distractibility)
- Lack of perseverance
- Impulse control problems
- Hyperactivity
- Chronic lateness and poor time management
- Disorganization
- Procrastination
- Trouble learning from experience
- Unavailability of emotions
- Poor judgment (Misperceptions)
- Short-term memory problems
- Social and test anxiety

The Deep Limbic System



Deep Limbic System

FUNCTIONS

- Sets the emotional tone of mind
- Filters external events through internal states (emotional color)
- Tags events as internally important
- Stores highly charged emotional memories
- Modulates motivation
- Controls appetite & sleep cycles
- Promotes bonding
- Directly processes sense of smell
- Modulates libido

PROBLEMS

- Moodiness, irritability, clinical depression
- Increased negative thinking
- Perceive events in a negative way
- Decreased motivation
- Flood of negative emotions
- Appetite and sleep problems
- Decreased or increased sexual responsiveness
- Social isolation

Basal Ganglia



Basal G

Basal Ganglia

FUNCTIONS

- Integrates feeling & movement
- Shifts and smoothes fine motor behavior
- Suppression of unwanted motor behaviors
- Sets the body's idle or anxiety level
- Enhances motivation
- Pleasure/ecstasy

PROBLEMS

- Anxiety, nervousness
- Panic attacks
- Physical sensations of anxiety
- Tendency to predict the worst (awfulizing)
- Conflict avoidance
- Muscle tension, soreness
- Tremors
- Fine motor problems
- Headaches
- Low or excessive motivation

Cingulate Gyrus



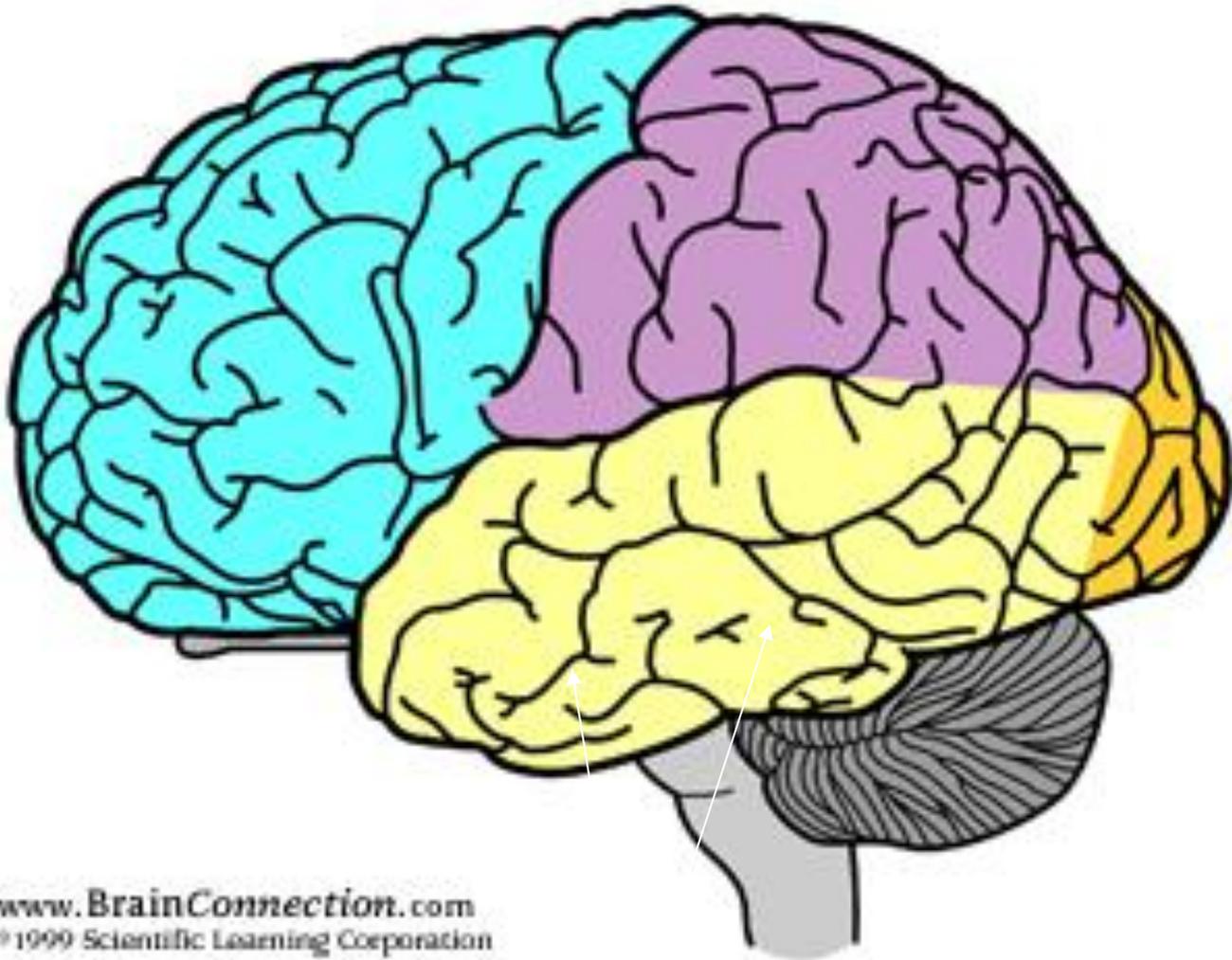
Cingulate Gyrus

FUNCTIONS

- Allows shifting of attention
- Cognitive flexibility
- Adaptability
- Helps the mind move from idea to idea
- Gives the ability to see options
- Helps you go with the flow
- Cooperation

PROBLEMS

- Worrying
- Holds onto hurts from the past
- Stuck on thoughts (obsessions)
- Stuck on behaviors (compulsions)
- Oppositional behavior, argumentative
- Uncooperative, tendency to say no
- Addictive behaviors
- Cognitive inflexibility
- OCD spectrum disorders
- Eating disorders, road rage



Temporal Lobes

Temporal Lobes Functions

Non-dominant Side (usually the right)

FUNCTIONS

- Recognizing facial expression
- Decoding vocal intonation
- Rhythm
- Music
- Visual learning

PROBLEMS

- Difficulty recognizing facial expression
- Difficulty decoding vocal intonation
- Implicated in social skill struggles

Temporal Lobes Problems

▣ **Either/Both Temporal Lobe Problems**

- ▣ Memory problems, amnesia
- ▣ Headaches or abdominal pain without a clear explanation
- ▣ Anxiety or fear for no particular reason
- ▣ Abnormal sensory perceptions, visual or auditory distortions
- ▣ Feelings of déjà vu or jamais vu
- ▣ Periods of spaciness or confusion
- ▣ Religious or moral preoccupation
- ▣ Hypergraphia, excessive writing
- ▣ Seizures

Problems With Either or Both Temporal Lobes

- Periods of spaciness or confusion
- Religious or moral preoccupation
- Excessive writing
- Seizures

Brain Regions and Drug Effects

BASIL GANGLIA

Anxiety,
nervousness

Panic attacks

Awfulizing

Conflict avoidance

Muscle soreness

Headaches

PREFRONTAL CORTEX

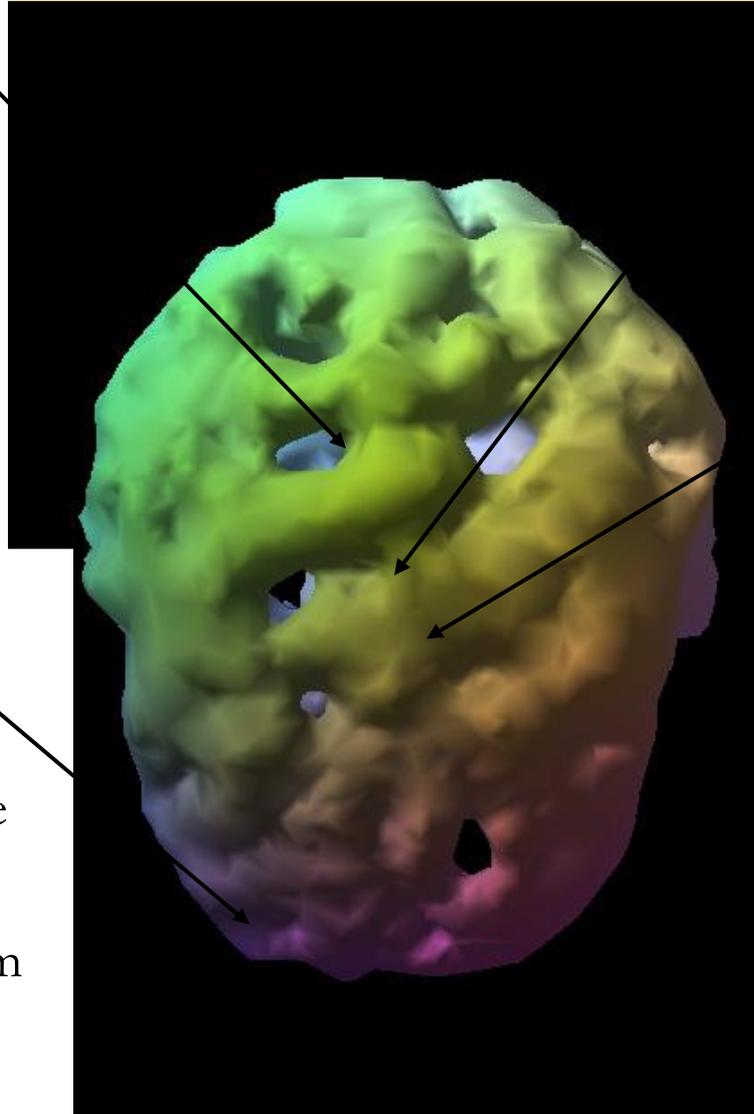
Short attention span

Lack of perseverance

Chronic lateness a

Trouble learning from
experience

Poor judgment
(Misperceptions)



LIMBIC REGION

Moodiness, irritability, clinical
depression

Flood of negative emotions

Social isolation

CINGULATE GYRUS

Worrying

Holds onto hurts

Obsessions/Compulsions

Oppositional behavior

Argumentative

TEMPORAL LOBES

Aggression

Dark or violent thoughts

Sensitivity to slights, mild
paranoia

Emotional instability

Traditional Treatment Design

Notice how the flow is most intensive during period of greatest impairment

Group, individual, lectures,
long writing assignments
during period of poorest
brain function

Intensive
Services in
first
2-4 weeks

Less intensive services
Months 1-3

No to little services
Months 6-12

Logic Model View Based on Healing Process

Fewer services with focus on stabilizing behavior & 12 steps

Weeks 2-6

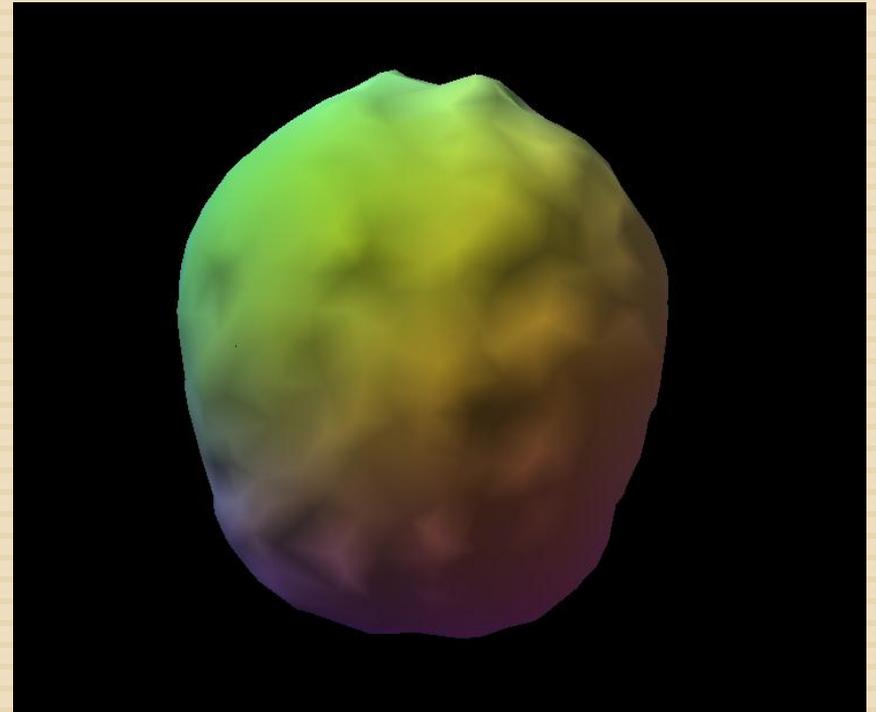
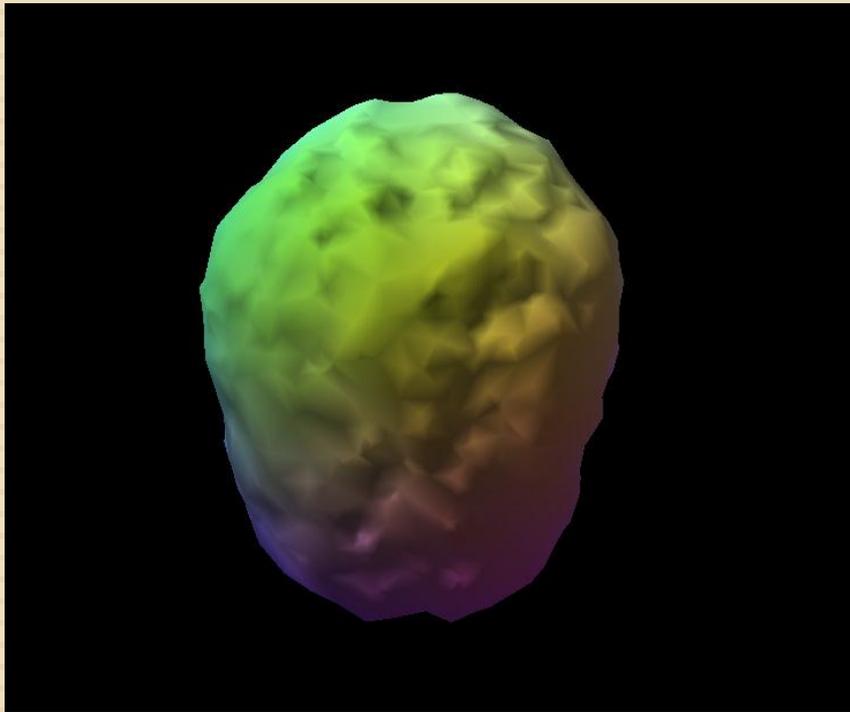
Increased counseling services with focus on problem solving
More Step Work

Months 1-3

Introduction of more intensive therapy for issues such as trauma
Family Therapy, and Other Emotional or Personality Issues

Months 6-12

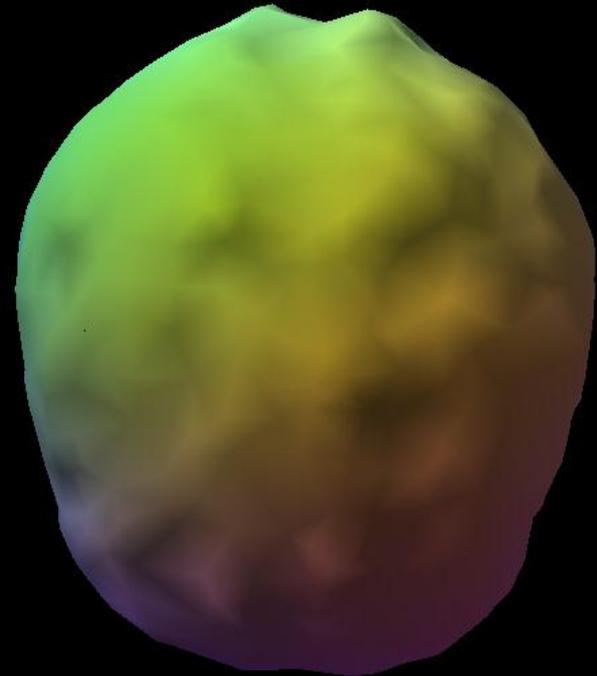
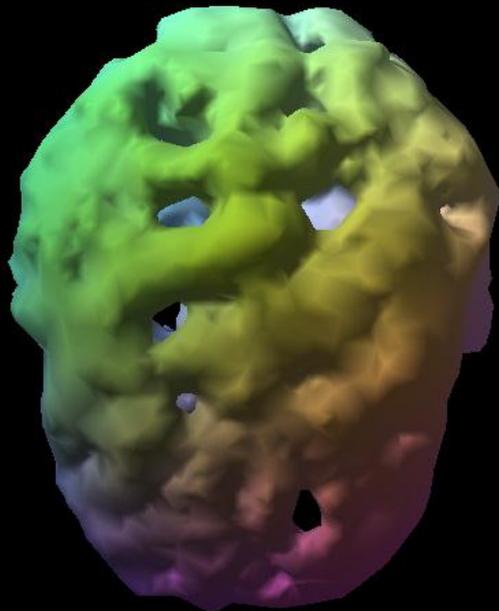
Recovery VS Normal



Use

VS

Non Use



Signs & Symptoms

- **Signs - What you observe**
- **Symptoms - What the individual reports**

WHAT DO PROFESSIONALS
NEED TO LOOK FOR?



Signs

- Family problems
- Going on the wagon
- Psychological or physical changes
- Manipulation
- Anger that is beyond a normal response
- Tremors & Shakes

Signs

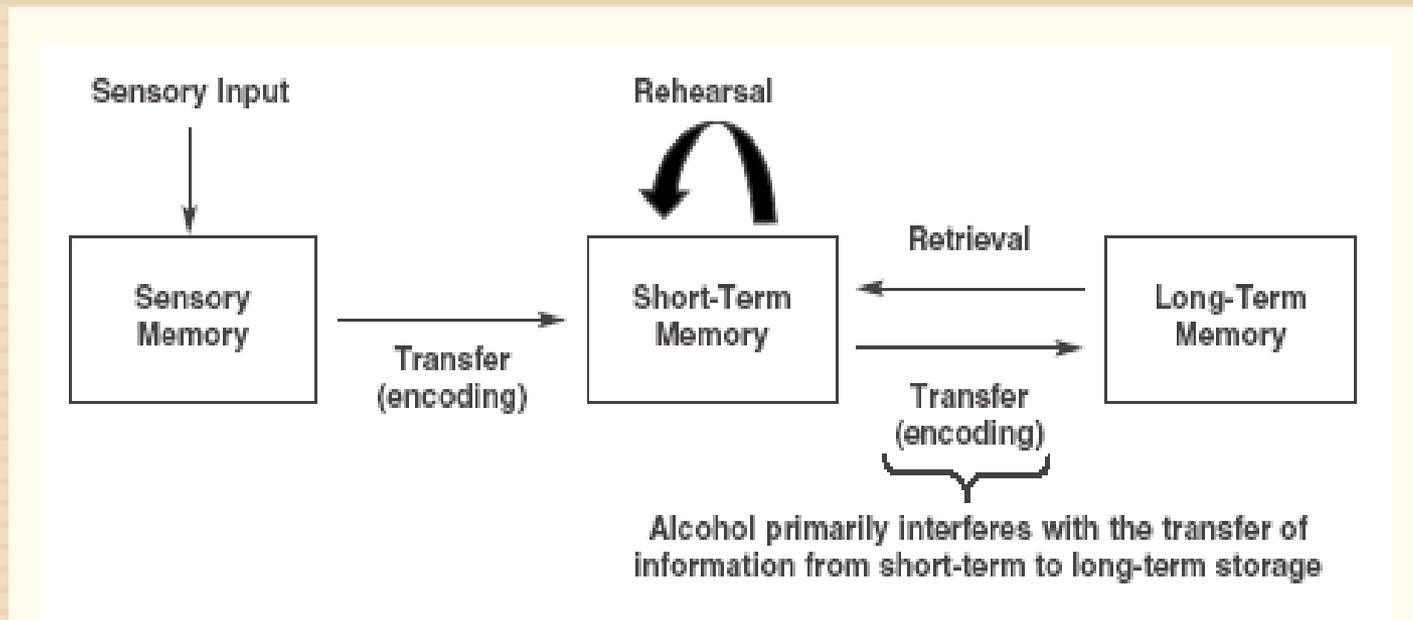
- Legal Problems (80% of prisoners report use of alcohol or drugs during the month they committed their crime).
- Job Problems
- Alibi's (dishonesty sometimes a outright lie or more often failure to include important details

Symptoms

- Tolerance - Requires more to get same effect of diminished effects using same amount
- Loss of control - Inability to consistently predict what will happen, how much they will use, or the consequences of use

Symptoms

- **Blackouts** - No memory of certain events while using alcohol/drugs



Symptoms

- Loss of interests in important activities
- Seeking counseling or help
- Feeling of paranoia, intense jealousy, or need for religious intervention
- Tremors & Shakes

Signs & Symptoms

- Behaviors will continue and progressively become more problematic until appropriately treated
- Structure may improve problems temporarily
- Addicts & alcoholics rarely experience natural recovery or spontaneous remission but they do change drugs

Screening & Assessment

Screening a brief process used to:

- Determine presence of a problem
- Substantiate reason for concern
- Identify need for further evaluation

- Screening **can** and **should** occur in any setting

Screening & Assessment

Screening Interviews

- Should be Non Threatening
- Should be Confidential
- Should be Coupled with Instruments
- Is Not Diagnostic

Drug Screens, Surveys, and Collateral Data

Key Considerations

1. Conduct screening on at risk persons, using a variety of settings & professionals
2. Collaboration instruments, processes, techniques
3. Instrument sensitivity race, gender, culture, etc.
4. Screening should be brief
5. Get collateral information

CAGE

Have you ever felt you should **CUT** down on your drinking?

Have people **Annoyed** you by criticizing your drinking?

Have you ever felt bad or **Guilty** about your Drinking?

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**Eye-opener**)?

CAGEAID

Have you ever felt you should **CUT** down on your drinking *or drug use*?

Have people **Annoyed** you by criticizing your Drinking *or drug use*?

Have you ever felt bad or **Guilty** about your Drinking *or drug use*?

Have you ever had a drink/*drug* first thing in the morning to steady your nerves or get rid of a hangover *or get the day started (Eye-opener)*?

Assessment



A process to determine (diagnose) the nature and complexity of the individuals spectrum of drug abuse and related problems

ASSESSMENT is DIAGNOSTIC

Purpose of Assessment

1. Identifies those having alcohol/drug problems or who have progressed to addiction
2. Examines the full spectrum of problems that will require attention in treatment
3. Plans appropriate interventions
4. Involves important others in the individuals treatment
5. Evaluates the effectiveness of the interventions that are implemented

Purpose of Assessment

Assessment should include gathering information from various sources

- The Patients own words and statements
- Previous Records
- Significant Others (Family, Friends, & Professionals)

Core Elements of Assessment

- History of use
- Social Support and Social Roles
- Employment/Educational History
- Medical History
- Psychiatric History
- Legal History

Other Relevant Factors

- Gender
- Ethnic/Cultural
- Language
- Sexual Orientation/Identity
- Religious/Spirituality
- Physical Disability
- Collateral Information

Purpose of Assessment

- Assessments should always be interpreted by a trained **professional**
- Assessment information is used to develop the Treatment plan
- The Treatment Plan dictates the course of treatment

Diagnosis

DSM-IV Criteria is widely accepted as the method for diagnosing Substance Dependence or Abuse

- (1) Recurrent drinking resulting in a failure to fulfill major role obligations at work, school, or home
 - (2) Recurrent drinking in situations in which it is physically hazardous
 - (3) Recurrent alcohol-related legal problems
 - (4) Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol
- B. The symptoms have never met the criteria for alcohol dependence.

DSM-IV Criteria

- 1. Tolerance, as defined by either of the following:**
 - a. A need for marketedly increased amounts of the substance to achieve intoxication or desired effect.
 - b. Marketedly diminished effect with continued use of the same amount of substance.

- 2. Withdrawal, as manifested by either of the following:**
 - a. The characteristic withdrawal syndrome for the substance
 - b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

DSM-IV Criteria

3. The substance is often taken in larger amounts or over a longer period than was intended
4. There is persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problems that is likely to have been caused or exacerbated by the substance

DSM-IV Criteria

Severity

Mild: Few if any symptoms in excess of those required to make a diagnosis; symptoms result in no more than mild impairment in social, occupational, recreational, or relational functioning (**SORRF**)

Moderate: Symptoms are between mild and severe, some serious impairment in one of the (**SORRF**) areas.

Severe: Many symptoms in excess of those required to make a diagnosis; symptoms markedly interfere with (**SORRF**)

Treatment

- Detoxification
- Inpatient
- Intensive Outpatient
- Residential Transitional
- Various Transitional Treatments
- Halfway House

Evidenced Based Practice for Substance Use Disorder

What's Popular

General Counseling

Lectures/Films

Confrontation

Relaxation

Milieu Therapy

Group Psychotherapy

What's Evidenced Based

Social Skills Training

MET/MI

CRA

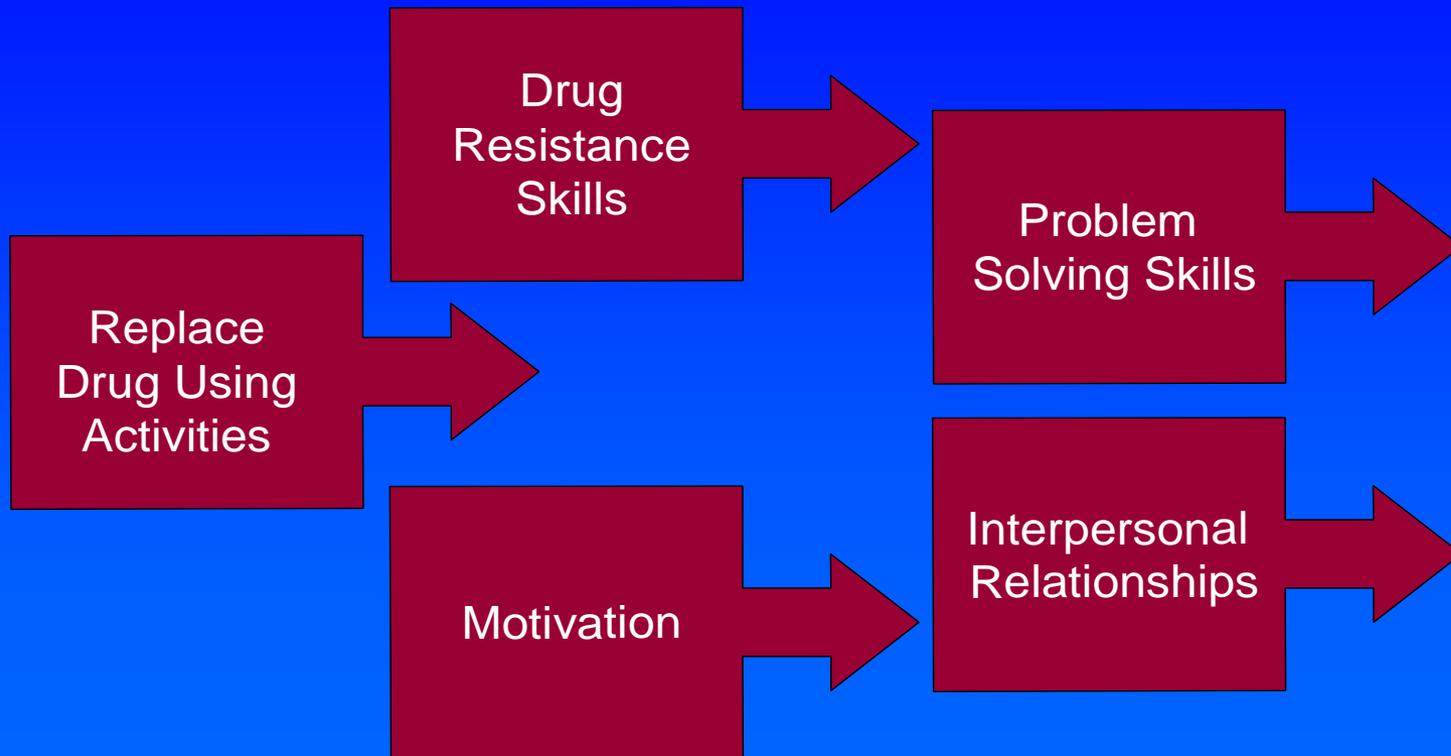
CBT

Relapse Prevention

Modified Therapeutic
Community

TSF

Counseling and Other Behavioral Therapies



INTRODUCTION TO TREATMENT ISSUES

- Detoxification – The process of helping an individual to safely stabilize both physiologically and psychologically as the body becomes free from alcohol or drugs.

Detoxification is not treatment

Three types of detoxification

Medical Detoxification

- Occurs in a hospital type setting
- May involve the use of medication to gradually reduce the drug levels until withdrawal is not life threatening.
- Very Common

Three types of detoxification

- Social Detoxification – Non-medical setting completely drug free and generally staffed with paraprofessionals. Very common
- Out Patient Detoxification – A medically monitored approach where the individual does not stay overnight. Not as common (risky)

Treatment Settings

Inpatient

- Residential setting
- Involves lengths of stay from 10 to 28 days.
- This is the oldest modality dating back to 1950 (Hazelden, Wilmar State Hospital).
- Very often focus is on relapse prevention and twelve step involvement

Treatment Settings

Intensive Outpatient

- An outpatient approach involving anywhere from 2-4 hours of treatment three to four days a week.
- Average length of treatment is six weeks.
- Sometimes called partial Hospitalization.
- Very often requires a family members participation
- Focus on RP and TSF

Treatment Settings

Residential Transitional

- Generally considered long-term anywhere from 90 to 365 days.
- Typically as the name suggests the major focus in treatment is acquisition of skills and support needed for stabilization and re-integration.
- Range of Therapies RP, TSF, & CBT
- Clients working full-time prior to exit

Transitional Treatment

Various Transitional Treatments

- Women's programs will include children living in the facility
- Correctional Programs may provide on-site PNP officer
- Dual Diagnosis programs tend to have more diverse staff (Psychiatric Social Workers and Alcohol and Drug Counselors)

Transitional Treatment

Advantages of Transitional Treatment

- Less expensive and longer in duration
- Opportunity to experience outside world incrementally
- Instills structure & routines
- Reduces relapses and severity of relapses
- Length of treatment is associated with better drinking drug use outcomes

Treatment Settings

Halfway House

- Not necessarily a counseling component but more of a supportive environment where working a job and attending self-help are the primary elements.
- Usually requires adherence to minimum rule set (curfew, chores, abstinence).
- Counseling may not occur at all
- RP and TSF counseling in some cases

Treatment Methods

Treatment Approaches

- Twelve Step Facilitation
- Cognitive Behavioral Therapy
- Motivational Enhancement Therapy
- Relapse Prevention

Treatment Approaches



- Motivational Enhancement Therapy
- Twelve Step Facilitation
- Cognitive Behavioral Therapy
- Relapse Prevention

MI intervention overview (big picture)

- MI targeted behavior: Create and sustain engagement in an adherence change plan.
 - Follow Doctor's recommendations
- Meditational: Different than actual treatment adherence.
- Key point: MI is behavior specific

MI is highly strategic

- Advanced counselors are more strategic...
- Strategic: More efficient (briefer) and effective
- Client state is continually assessed
 - ▣ Navigational map
- Counselor utterance is a strategic response
 - ▣ Few client states
 - ▣ Relatively few MI strategies
 - ▣ Memorize

RESEARCH ON MI: Meta Analysis

Important distinction from Hettama (p. 108)

MI does NOT communicate
“I have what you need.”

BUT RATHER

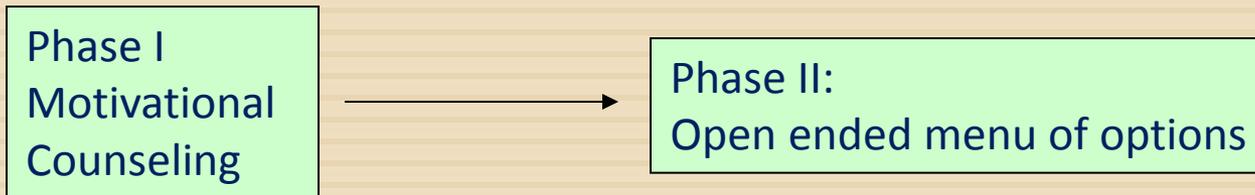
“You have what you need, and together we
will find it.”

Research on MI:

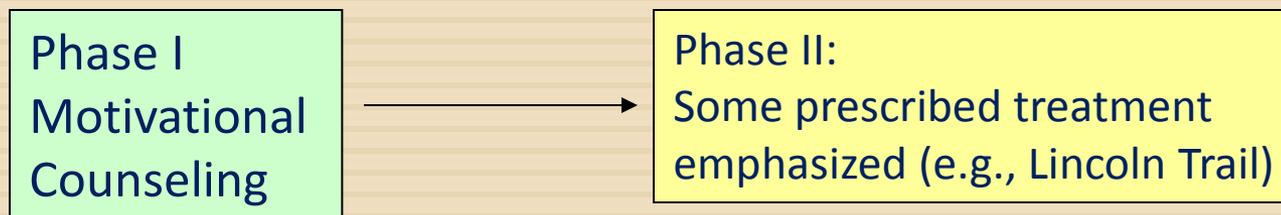
Works as Standalone or Front End

117

- Phase I vs. Phase II
 - Before and after commitment to change.
- MI works as a standalone intervention



- As a front end for some other intervention to increase treatment adherence



Twelve Step Facilitation

Twelve Step Facilitation (TSF)

- Short-term individual counseling approach
- Twelve to Fifteen sessions
- Pharmacotherapy
- Focus on an abstinence goal

Twelve Step Facilitation

Sessions

- Directive and individual
- Counselor and Client both talk
- Assignments important in sessions
- Family therapy important component
- Focus on concepts surrounding steps work and not necessarily the steps
- Focus on acceptance, surrender, and getting active in the program

Twelve Step Facilitation

Counselor's Behaviors Proscribed

- ❑ Sessions with an intoxicated client
- ❑ Attend AA or NA with the client
- ❑ Act as a sponsor
- ❑ Threaten reprisals for noncompliance
- ❑ Advocate controlled drinking/drug use
- ❑ Allow therapy to drift excessively onto collateral issues, i.e. marital or job conflict

Twelve Step Models

Minnesota Model

- Multidisciplinary team approach began in 1950's
- Staff: Counselors, psychologists, nurses, and clergy.
- Therapy: Treat the disease w/abstinence goal.
- Emphasizes working the Twelve Steps & AA.
- Theoretical rationale:
 - Changing beliefs about relationship,
 - Develop self-reflection
 - Coping Skills

Twelve Steps

1. We admitted we were powerless over alcohol-- that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God, as we understood Him.

Twelve Steps

4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.

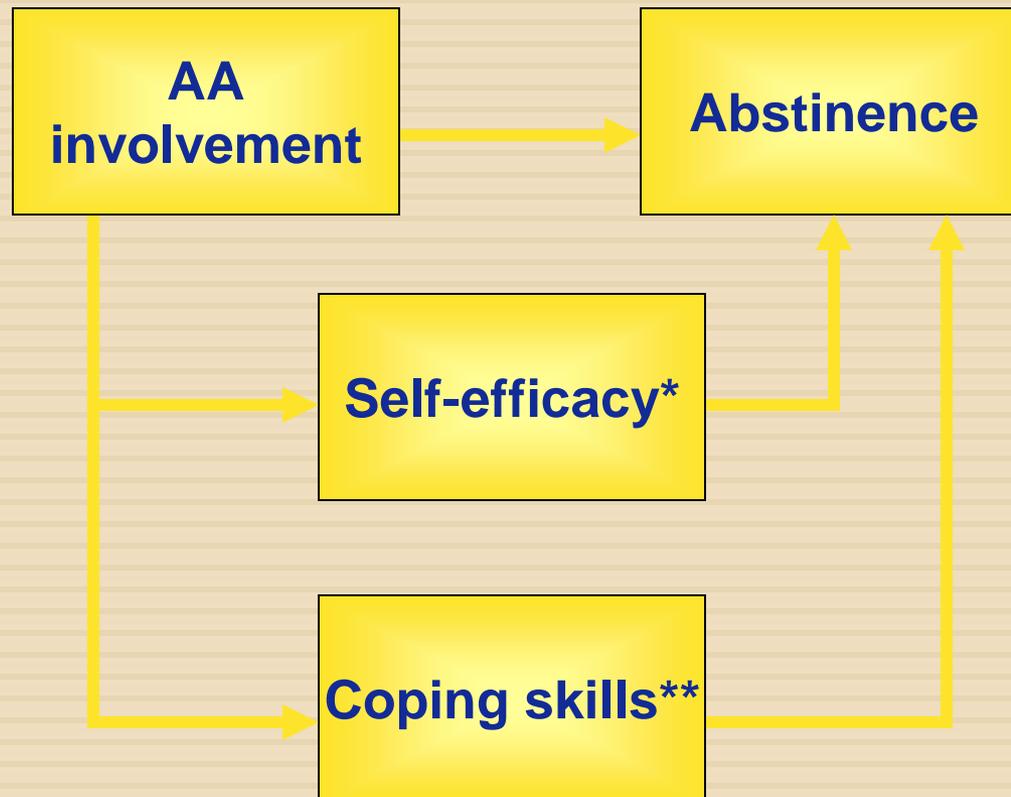
Twelve Steps

8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.

Twelve Steps

11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Evidence of mechanism: cognitive behavioral



*1Morgenstern et al., *J Consult Clin Psych* 1997

*2Kelly et al., *J Stud Alcohol* 2002

**1Timko et al., *ACER* 2005

**2Humphreys et al., *Ann Behav Med* 1999

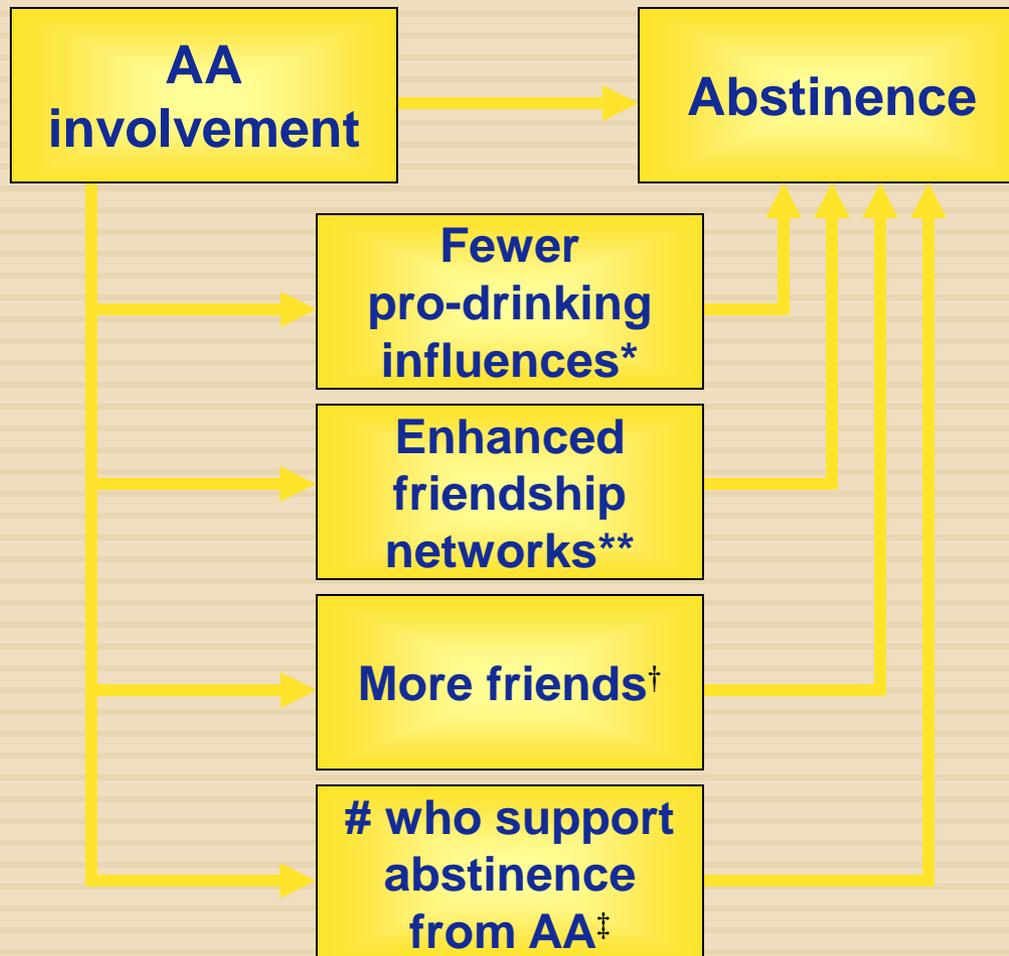
*1 Resi or IOP
n = 100

*2 adolescent inpatients
n=74

**1 initially untx PDs
n=466

**2 male VA inpatients
n=2,337

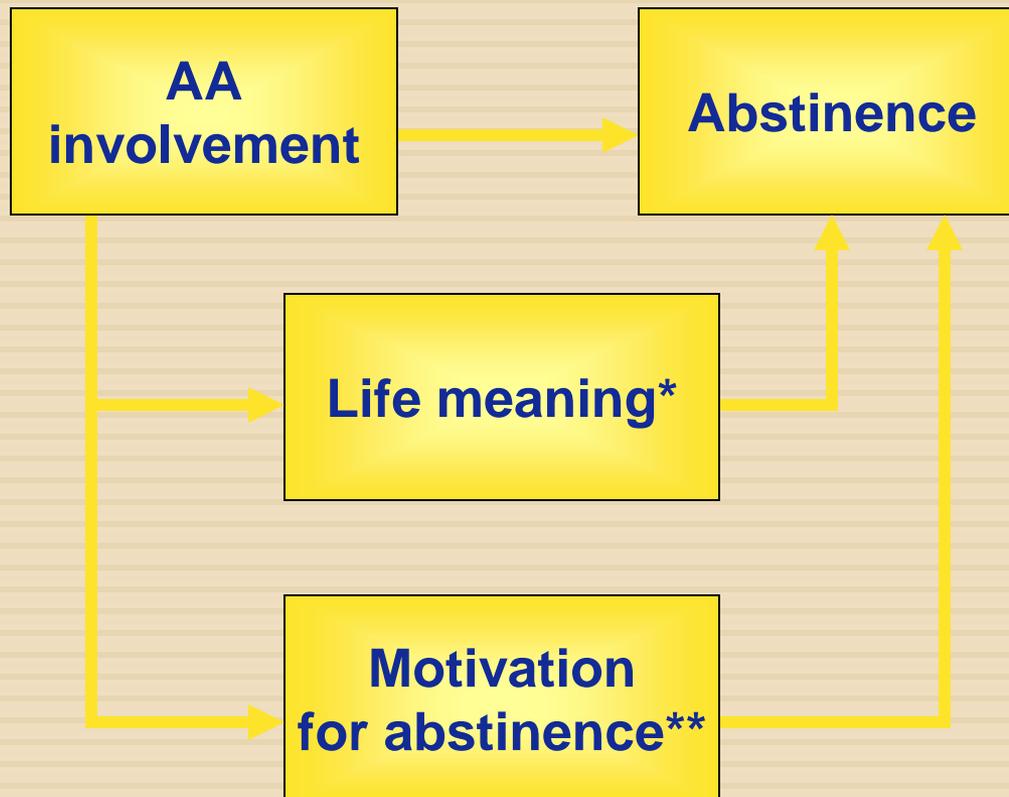
Evidence of mechanism: social learning



* treated n = 722 ** male VA inpat. n=2,337 † init. untx. PDs n=466 ‡ treated n=655

*Kaskutas et al., *Addiction* 2002
**Humphreys et al., *Ann Behav Med* 1999
† Timko et al., *ACER* 2005
‡ Bond et al., *J Stud Alcohol* 2003

Evidence of mechanism: psychodynamic

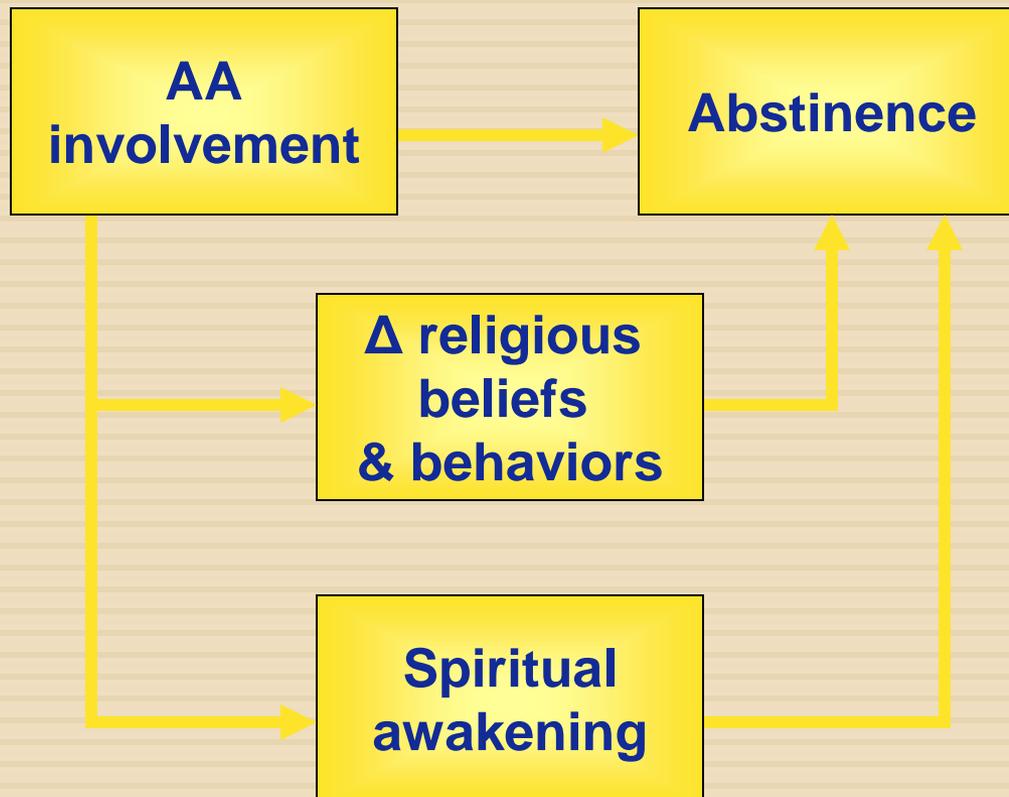


*In recovery
n = 354

**adolescent inpatients
n = 74

*White & Laudet, *CPDD* 2006
**Kelly et al., *J Stud Alcohol* 2002

Evidence of mechanism: spirituality



Day Hosp & Residential, managed care
n = 537

Initially attending frequent meetings:
Abstinence at 1 & 8 yrs.

AA meetings	Abstinence	
	Year 1	Year 8
No AA	21%	35%
2-4 mtgs/week	43%	57%
5+ mtgs/week	61%	73%

The Role of AA Affiliation in Alcoholism Treatment

Tonnigan 2006

- Focus on abstinence in therapy has a main effect on outcome, but does not explain TSF benefit
- Stressing loss of control and adverse alcohol related conseq. in TSF may have limited value..
- Facilitating AA engagement is an active therapeutic mechanism of TSF explaining TSF benefit
- AA engagement is more than AA attendance.
- Spiritual gains have a function in AA, they appear to sustain AA participation which, in turn, predicts increased abstinence
- Self efficacy gains occur among AA exposed persons, which accounts for later abstinence

The Role of AA Affiliation in Alcoholism Treatment

Humphreys, Mavis, & Stoffelmayr, 1994 In spite of allegations to the contrary, recent studies confirm A.A. affiliation and recovery rates for women, people of color, young people, and people with co-occurring psychiatric disorders (including those on medication) are comparable to those reported for general A.A. membership

Fiorentine & Hillhouse, 2000 Completion of addiction treatment AND participation with recovery mutual aid groups is more predictive of long-term recovery than either alone

Clinician Guidelines

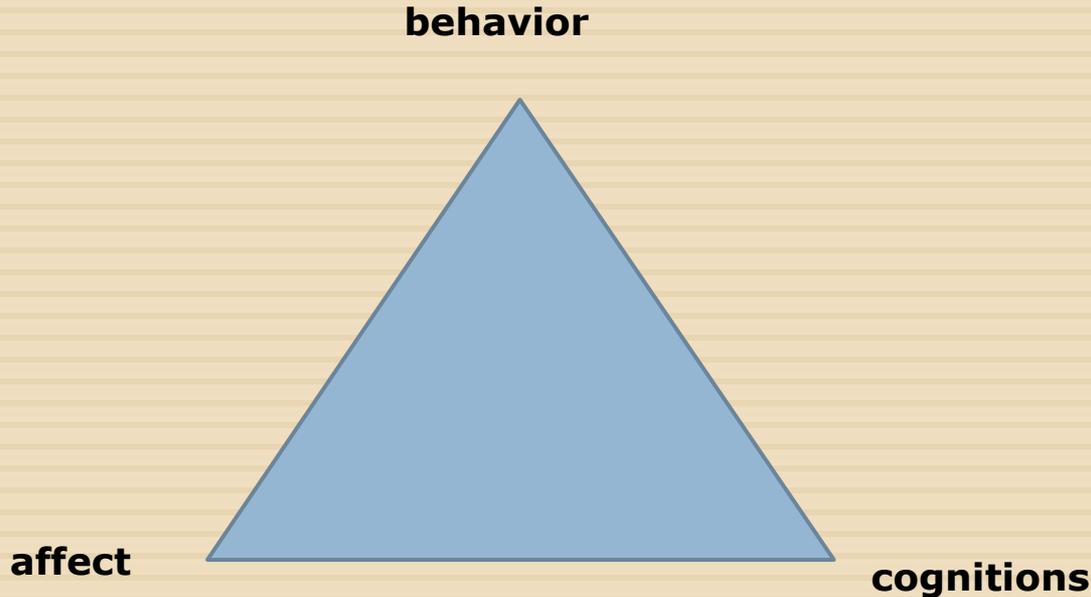
We need to prepare clients for 12 Step program participation and refer them to 12 Step groups.

- ❑ Learn the 12 Steps and principles associated with 12 Step recovery
- ❑ Learn the language and culture of 12 Step programs
- ❑ Learn about Twelve Step Facilitation Therapy
- ❑ Distinguish religion from spirituality
- ❑ Address myths associated with 12 Step groups
- ❑ Help clients find appropriate 12 Step groups
- ❑ Encourage active membership and attendance at least three times a week
- ❑ Encourage long-term attendance

Cognitive-Behavioral Theory

Triad of 1) Behavior, 2) Cognitions, and 3) Affect

Changing any one will change the other two, but it is easier to target Behavior and/ or Cognitions EXCEPT that psycho-active drugs will target Affect directly



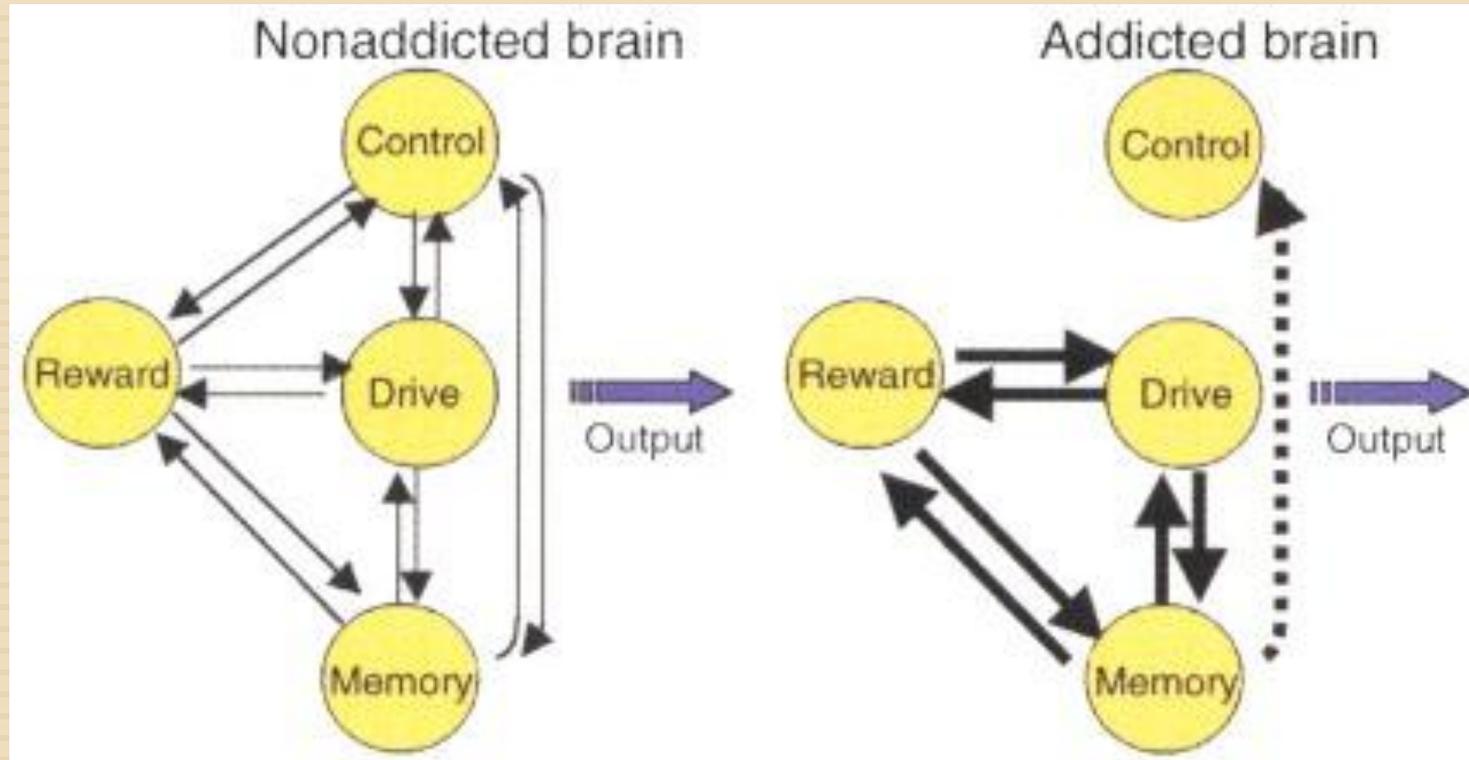
Cognitive-Behavioral Theory

Basic Facts

1) Behavior and/or Cognition are easier to target for conscious control than Affect

2) Behavior targets should be simple and clear

3) Cognitive interventions: must be short and sweet



Model proposing a network of four circuits involved with addiction: reward, motivation/drive, memory, and control. These circuits work together and change with experience. ..

From: Volkow: J Gin Invest, volume 111(10).May 2003.1444-1451

Cognitive Behavioral Coping Skills Therapy(CBST)

CBST

- Refers to a family of related treatment approaches that aim to improve cognitive behavioral skills for changing problem behavior
- Social Cognitive Theory- deficits in coping lead to return to behavior
- Utilizes teaching tools of instruction, modeling, role play, and behavioral rehearsal
- Effectively used in conjunction with TSF

Community Reinforcement Approach (CRA)

CRA

- Philosophy is to rearrange person's life so that abstinence is more rewarding than drinking/drugging
- Eliminate positive reinforcement for use
- Enhancement of positive reinforcement for sobriety

Community Reinforcement Approach (CRA)

CRA Strategies:

- Initiating trial period of sobriety
- Performing Functional Analysis
- Increasing positive reinforcement
- Rehearsing new coping behaviors

Drug Refusal Skills

The Funneling effect

- The longer a person drinks or drugs the more narrow the social relationships.
- Elimination of sober friends
- Peer group primarily consists of people who support use.

Drug Refusal Skills

Associated problems

- ❑ Overt and covert pressure to drink or drug
- ❑ Conditioned cravings associated with people, places, activities, and emotional states
- ❑ Increased positive outcome expectation about the effect
- ❑ Increased access/availability of drugs and alcohol

Drug Refusal Skills

Components of Functional Analysis

- Discovering Triggers (places, persons, situations that may set off an urge)
- Identifying persons, places, & situations least likely to use
- Identifying places persons, places, & Situations most likely to use

Drug Refusal Skills

No should be the first thing you say.

Tell the person not to ask you now or in the future if you want to drink alcohol or use drugs.

Use appropriate body language

Make good eye contact; look directly at the person when you answer.

Your expression and tone should clearly indicate that you are serious.

Offer an alternative (if you want to do something else with that person) that is incompatible with alcohol or drug use.

Change the subject

Drug Refusal Skills

Rate each area according to how well the individual demonstrated the skill

1. not well
2. somewhat
3. not sure
4. well
5. very well

RELAPSE PREVENTION

Pat McKiernan PhD

Relapse Prevention

Popularized by Terence Gorski provides a comprehensive method for preventing the addicted client from returning alcohol and drug use after initial treatment.

- Endorses the disease model
- Focuses on identifying warning signs
- Relapse intervention plan
- Theoretical basis is cognitive and behavioral

The Developmental Model of Recovery



Transition Stage – Recognition that control is no longer possible

Stabilization Period - major cause of inability to abstain during the stabilization period is the lack of stabilization management skills.

The Developmental Model of Recovery

Early Recovery Period

Primary cause of relapse during the early recovery period

- lack of effective social skills
- Lack of effective recovery skills necessary to build a sobriety-based lifestyle.

This period last approximately 1- 2 years

The Developmental Model of Recovery

Middle Recovery Period

Major cause of relapse during the middle recovery period is the stress of real-life problems.

Allow time to:

- Re-establish relationships with family,
- Set new vocational goals,
- And expand social outlets

The Developmental Model of Recovery

Late Recovery Period

Major cause of relapse during the late recovery period

- Either inability to cope with the stress of unresolved childhood issues
- Or an evasion of the need to develop a functional personality style

The Developmental Model of Recovery



Late Recovery Period Problems are generally not experienced until in recovery 3 to 5 years no matter when recovery begins.

In others (non-using) these unresolved childhood issues surface in their mid twenties

The Developmental Model of Recovery

Maintenance Stage

Major causes of relapse during the maintenance stage

- ❑ Failure to maintain recovery program
- ❑ And encountering major life transitions
- ❑ Any use of alcohol or drugs during the maintenance stage will reactivate physiological, psychological, and social progression of the disease.

The Developmental Model of Recovery

Stuck Points in Recovery

A “stuck point” can occur during any period of recovery

- Usually caused by lack of skills
- Or lack of confidence in one's ability to complete a recovery task.

The Developmental Model of Recovery

Other problems

- Situations (physical, psychological, or social) that interfere with the ability to use recovery supports (such as changing job, having children, major illness).

The Developmental Model of Recovery

When recovering people encounter stuck points,

- They either recognize they have a problem and take action,
- Or they lapse into the familiar coping skill of denial that a problem exists
- These lapses can occur in the form of alcohol and drug use or behaviors that lead to use.

The Developmental Model of Recovery

- Effects of lapses
- Without specific relapse prevention skills to identify and interrupt denial, stress begins to build. Becoming Chronic and Inescapable
- Eventually, the stress will cause the patient to cope less and less well. This will result in relapse.

Post Acute Withdrawal

Some of the symptoms of withdrawal from alcohol or drugs are the result of the toxic effects of these chemicals on the brain.

Physical conditions that worsen PAW

- ❑ Combined use of alcohol and drugs or different types of drugs
- ❑ Regular use of alcohol or drugs before age 15 or abusive use for a period of more than 15 years
- ❑ History of head trauma (from car accidents, fights, falling, etc.)

Post Acute Withdrawal

Physical conditions that worsen PAW

- Parental use of alcohol or drugs during pregnancy
- Personal or family history of metabolic disease such as diabetes or hypoglycemia
- Personal history of malnutrition, usually due to chemical dependence
- Physical illness or chronic pain.

Post Acute Withdrawal

Psychological and social conditions that worsen PAW:

- Childhood or adult history of psychological trauma (participant in or victim of sexual or physical violence)
- Mental illness or severe personality disorder
- High stress lifestyle or personality
- High stress social environment.

Addictive Preoccupation

- Exposure to alcohol or drugs or associated paraphernalia
- Exposure to places where alcohol or drugs are used
- Exposure to people with whom the patient has used in the past or people the patient knows who are actively using
- Lack of a stable home environment
- Lack of a stable social environment
- Lack of stable employment

What Is Relapse?



Relapse is not an isolated event. Rather, it is a process of becoming unable to cope with life in sobriety.

Studies of life-long patterns of recovery and relapse indicate that not all patients relapse.

What Is Relapse?

- Approximately 1/3 achieve permanent abstinence from their first serious attempt at recovery.
- 1/3 have a period of brief relapse episodes but eventually achieve long-term abstinence.
- 1/3 have chronic relapses that result in eventual death from chemical addiction.

Classification of Recovery

Chemically dependent people can be categorized according to their recovery/relapse history.

These categories are as follows:

- ❑ Recovery-Prone
- ❑ Briefly Relapse-Prone
- ❑ Chronically Relapse-Prone

What Is Relapse Prevention Treatment?

- Relapse prevention is a systematic method of teaching recovering patients to recognize and manage relapse warning signs.
- Relapse prevention becomes the primary focus for patients who are unable to maintain abstinence from alcohol or drugs despite primary treatment

What Is Relapse Prevention Treatment?

- Recovery is defined as abstinence plus a full return to bio/psycho/social functioning
- Relapse episodes are usually preceded by a series of observable warning signs.
- Typically, relapse progresses from bio/psycho/social stability through a period of progressively increasing distress that leads to physical or emotional collapse.

Fragility of Early Recovery

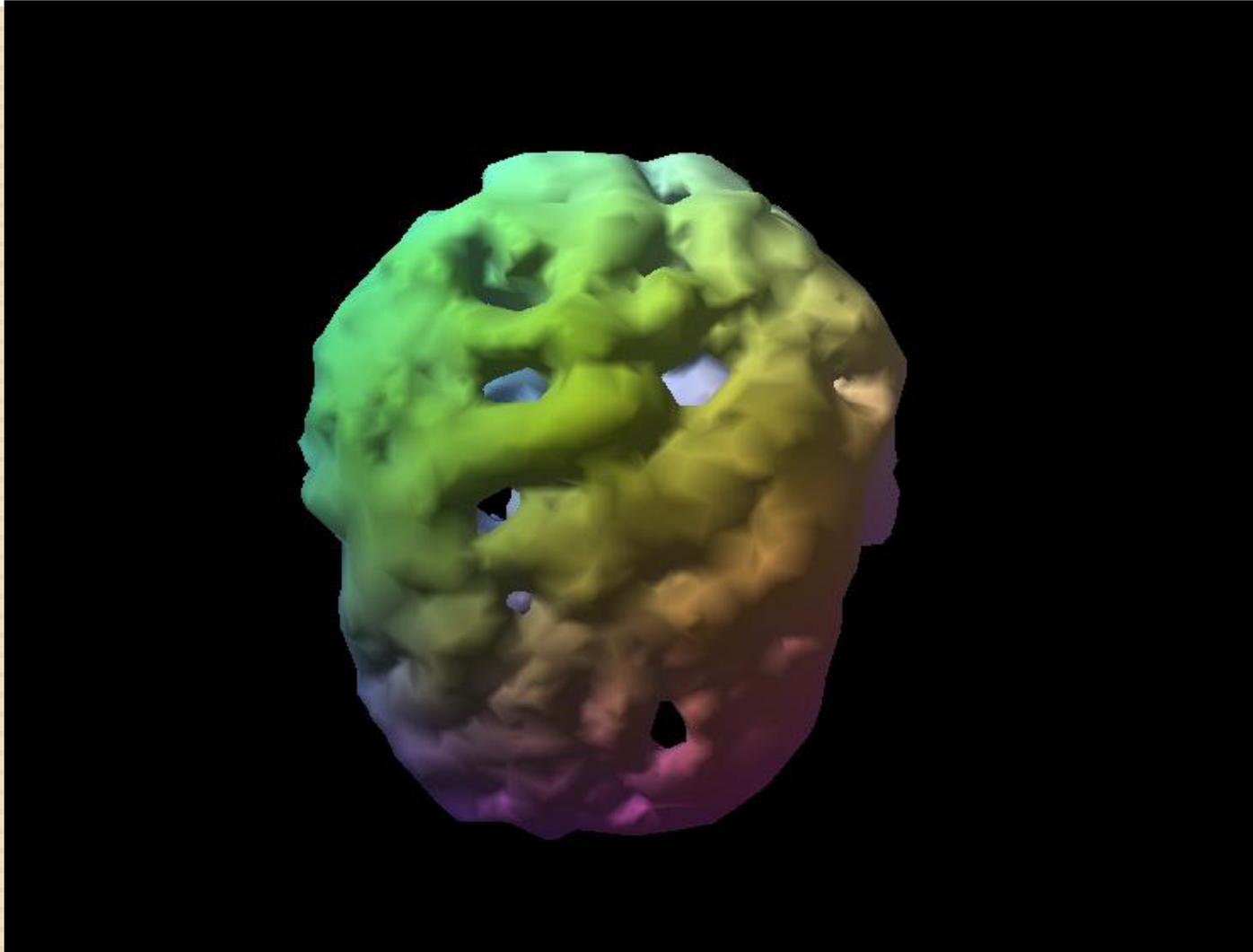
Individuals leaving addiction treatment are fragilely balanced between recovery and re-addiction in the hours, days, weeks, months, and years following discharge (Scott, et al, 2005).

Recovery and re-addiction decisions are being made at a time that we have disengaged from their lives, but that many sources of recovery sabotage are present.

Relapse Prevention

- Technologies to help prevent Relapse
- Altusday2day.org
- PeerSOS.org

Poly Substance Abuser



Five Critical Components of Effective Treatment

Assessment

- Uses diagnostic instruments and processes
- Determines an individual's needs and problems
- First step in determining the possible causes of addiction for the person and the most appropriate treatment modality for his or her needs

Five Critical Components of Effective Treatment

Patient-Treatment Matching

- Ensures that an individual receives the type of treatment corresponding with his or her:
 - Personality,
 - Background,
 - Mental condition,
 - And the extent and duration of substance abuse determined by the assessment.

Five Critical Components of Effective Treatment

Comprehensive Services

- Range of services needed in addition to specific alcohol or drug treatment can Include:
- Health ,
- financial and legal,
- psychological problems,
- and many others.
- Effective treatment must help people access the full extent of additional services needed to make their lives whole.

Five Critical Components of Effective Treatment

Relapse prevention

- Addiction is a chronic and relapsing disorder
- Relapse prevention strategies assess:
 - individual's "triggers"—those situations, events, people, places, thoughts, and activities—that re-ignite the need for drugs.
- Strategies for coping with these when they occur are then developed.

Five Critical Components of Effective Treatment

Accountability

- Treatment programs participation in evaluation is crucial for determining the success of specific approaches and modalities.
- Evaluation should include:
 - need for the program,
 - its integrity,
 - and its results, including abstinence, social adjustment, and reduction of criminal behavior

Model Treatment Program Components

- **Assessment,**
- **Same day intake,** to retain the patient's involvement/interest
- **Documenting findings and treatment,** for case management
- **Preventive and primary medical care,** provided on site
- **Testing for infectious diseases,**
- **Weekly random drug testing,** ensure abstinence & compliance
- **Pharmacotherapeutic interventions,**
- **Basic substance abuse counseling,**

Model Treatment Program Components

- **Practical life skills counseling,**
- **General health education,**
- **Peer/support groups,**
- **Liaison services** with immigration, legal aid, and CJ system
- **Social and athletic activities,** retrain in social interaction
- **Alternative housing,** to prevent homelessness
- **Relapse prevention,** including immersion in 12-step programs
- **Outcome evaluation,** to enable refinement and improvement

Recovery Process

- One – Five years of abstinence
- Return to Self Esteem
- Sustained employment
- Engagement in healthy social activities
- Development of fulfilling relationships (romantic or friendship)
- Establishment in support system
(self help, church, peer)

Rationale for Long Term Treatment

- Lack of ability to sustain abstinence
- Lack of adequate social/family support
- Lack of coping skills
- Sustained bonding disruption
- Inability to sustain employment
- Co-existing Axis I or II disorders
- Criminal Justice Involvement

CASE MANAGEMENT OF ALCOHOL AND DRUG DEPENDENT CLIENTS



Case Management Principles

Single Point of Contact

- Consolidation of services occurring at multiple agency
- Replaces haphazard process with uniformity
- CM's are obligated to both the client and service providers
- CM's are familiar with protocols and procedures of service organizations
- CM's mobilize needed resources, negotiate with formal and informal services, including self-help

Case Management Principles

Client Driven and Driven By Client Need

- Clients need come first in identifying resources
- CM's use expertise to identify options emphasizing client self-determination
- Based upon client need CM's assist in accessing services
- CM's seek the least restrictive level of care

Case Management Principles

Advocacy

- CM's promote the clients best interests
- CM's educate non-treatment providers
- CM's must negotiate agency rules to gain access
- CM's are prepared to challenge agencies policy and force service provision
- CM's are prepared to recommend sanction and consequences to encourage motivation and compliance

Case Management Principles

Community-Based

- CM's integrate formal and informal services
- CM's work with the family and support systems
- CM's know the lay of the land and culture
- CM's knowledge assists with developing trust
- CM's assist the institutionalized client with re-integration
- CM's help to remove and smooth obstacles

Case Management Principles

Pragmatic

- Begins where the client is by obtaining tangible needs such as food, shelter, etc.
- CM's must maintain balance help that is positive and behavior that may impede TX
- CM's teach clients living skills through implicit education or modeling

Case Management Principles

Anticipatory

- CM's know the natural course of addiction and recovery to foresee problems
- CM's are prepared to intervene directly
- CM's allow other professionals to intervene
- CM's work with the team to lay the foundation of the next phase of treatment

Case Management Principles

Flexible

- CM's must adapt to situations and factors such as HIV, mental health, lack of resources
- CM's must evaluate interventions based upon various factors and circumstances not ruling out potential resources

Case Management Principles

Culturally Sensitive

- CM's approach must recognize diversity
 1. Valuing Diversity
 2. Conducting a cultural self-assessment
 3. Understanding dynamics of culture
 4. Incorporating cultural interaction
 5. Adapting practices to diversity present in a given setting

Practice Knowledge

- Understand a variety of models and theories
- Ability to describe best practices and outcomes
- Recognize importance of family
- Understand diverse cultures
- Understand the value of interdisciplinary approach

Practice Skills

Referral

- Establish and maintain relationships with agencies, groups, government entities
- Continuously assess and evaluate referral sources
- Differentiate between when client should self-refer and counselor should refer
- Explain in clear and specific language necessity for and process of referral
- Exchange relevant information with agencies
- Evaluate outcome of referral

Practice Skills

Service Coordination

- Initiate collaboration with referral source
- Obtain, review, and interpret all measures and plans
- Confirm clients eligibility and readiness
- Compete necessary administration procedures
- Establish realistic treatment and recovery
- Coordinate all treatment activities

Practice Skills

Consulting

- Summarize clients personal and cultural background
- Understand terminology, procedures, and roles
- Contribute as part of the team
- Apply confidentiality
- Demonstrate respect and non-judgmental attitudes towards clients and professionals



Recovery-oriented Systems of Care

Recovery-oriented systems of care (ROSC) are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by severe substance use disorders. The *system* in ROSC is not a treatment agency but a macro level organization of a community, a state or a nation.

Recovery Management

“Recovery management” (RM) is a philosophical framework for organizing addiction treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality of life enhancement for individuals and families affected by severe substance use disorders.

Treatment (Acute Care Model) Works!

Post-Tx remissions one-third, AOD use decreases by 87% following Tx, & substance-related problems decrease by 60% following Tx (Miller, et al, 2001).

Lives of individuals and families transformed by addiction treatment.

Treatment Works, BUT...

High Extrusion as a Motivational Filter

High AMA and AD rates constitute a form of “creaming” e.g., view that “Those who really want it will stay.”

The reality: those least likely to complete are not those who want it the least, but those who need it the most—those with the most severe & complex problems, the least recovery capital, and the most severely disrupted lives (Stark, 1992; Meier et al, 2006).

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