BASICS OF SUBSTANCE ABUSE FOR MENTAL HEALTH PROFESSIONALS

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OBJECTIVES OF TRAINING

Be able to recognize the difference between Substance Use and Mental Health Disorders.

Understand the DSM 5 Substance Use Disorder Spectrum

Learn the language of substance abuse versus the acronyms of mental health workers.

So, Who is this guy, anyway?

- Mark Miller
- Licensed Marriage and Family Therapist
- Program Director for Center for Behavioral Health for the last 9 years
- CARF Surveyor (5 years)
- President of the Board of MensWork, Inc. (8 years)
- Community Council member of SJNP (13 years)
- Husband and father of one super cute soon to be 8 year old

DRUG USE BY THE NUMBERS

- All Information per SAMSHA's Behavioral Health Barometer Kentucky, 2013
- Illicit drug use by Kentucky youth (12 and older) was lower than the national average.
- Tobacco use by Kentucky youth was almost twice that of the national average.
- Attitudes towards tobacco: more Kentucky youth believed that smoking a pack or more a day was not a problem than the national average.

DRUG USE BY THE NUMBERS (CONTINUED)

- Kentucky youth perceive marijuana as more of a risk than the national average.
- 6 in 10 Kentucky youth did not perceive having 5 or more alcoholic beverages once or twice a week as a risk, which is about the same as the national average.
- Kentucky's rate of alcohol dependence by youth is lower than the national average.
- Kentucky's rate of illicit drug use by youth is about the same as the national average.
- Kentucky's rate of alcohol use of those aged 21 or older was about the national average.

DRUG USE BY THE NUMBERS (CONTINUED)

- Only 4% of individuals 21 years of age or older who are “heavy” drinkers reported that they enrolled in treatment for their use. (5 or more drinks 5 days a week)
- 18% of those who use illicit substances enrolled in a treatment program in Kentucky.
- The number of individuals enrolled in treatment has increased by 6,000 patients in Kentucky from 2008-2012

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WHAT IS ADDICTION?

- Physiological:
  - Physiological withdrawal symptoms associated with discontinuing use of a substance.
  - Caffeine withdrawal: headaches, shakiness, irritability.
  - Other withdrawal symptoms: seizures, vomiting, nausea, gooseflesh, runny nose, muscle cramps, constipation, death.
- Psychological:
  - Over-riding compulsion to use a substance despite potential consequences.
  - Symptoms include: depression, anxiety, irritability, grief/loss.
- Can be both simultaneously

WHAT IS ADDICTION? DEPENDENCE (PER ASAM):

3 or more of the following over the past 12 months for a diagnosis of dependence:

- Tolerance (increase/decrease)
- Withdrawal Symptoms
- Increased use
- Unsuccessful cutting down or stopping use
- Increased time in drug-related activities
- Cessation of social, occupational or recreational activities
- Continued use despite physical/psychological problems

WHAT IS ADDICTION? ABUSE (PER ASAM)

***1 or more of the following over the past 12 months for a diagnosis of abuse*:**

- **Recurrent use with failure to fulfill major roles/obligations**
- **Recurrent use in situations that are physically hazardous**
- **Recurrent legal problems due to use**
- **Continued use despite interpersonal/social problems**

A BRIEF WORD ON DSM 5 CHANGES

- DSM 5 has done away with the abuse versus dependence definitions of DSM 4.
- Now, substance use disorders are classified on a continuum from mild to severe.
  - Dependence can be a normal part of the body's response to a substance, and not necessarily part of someone's addiction.
  - Addiction can therefore come into play much earlier than 6 months, depending on fitting two of eleven criteria.

DSM-5 CONTINUED

- Substance Use Disorder specifics:
  - Mild: Presence of 2-3 symptoms
  - Moderate: presence of 4-5 symptoms
  - Severe: presence of 6 or more symptoms
- What this means for how we treat Substance Use Disorder remains to be seen.
- These diagnoses will begin to take effect in 2014.
- All information from Christine Martin's *Introduction to DSM-5* training, 9/19/13.

DSM-5 CRITERIA:

A problematic pattern of use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Substance is taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects.

DSM-5 CRITERIA

4. Craving, or a strong desire or urge to use the substance.
5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home.
6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

DSM-5 CRITERIA (CONTINUED)

7. Important social, occupational, or recreational activities are given up or reduced because of substance use.
8. Recurrent substance use in situations in which it is physically hazardous.
9. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

DSM-5 (CONTINUED)

10. Tolerance, as defined by either of the following:

-A need for markedly increased amounts of substance to achieve intoxication or desired effect.

-A markedly diminished effect with continued use of the same amount of substance.

11. Withdrawal, as manifested by either of the following (not applicable to inhalant, hallucinogen or phencyclidine use disorders):

- The characteristic withdrawal syndrome for the substance.
- Substance is taken to relieve or avoid withdrawal symptoms.

Assessment: Typical Drugs of Abuse

- Alcohol
- Marijuana
- Methamphetamine
- Opiates—pain killers
- Opiates—heroin
- Cocaine
- Benzodiazepine and other prescription drugs
- "New" Drugs—Spice, Bath Salts, Krokidil.

Assessment: Behavioral Characteristics Associated with Substance Abuse

- Abrupt changes in work or school attendance, quality of work/output
- Unusual flare-ups or outbreaks of temper
- Withdrawal from responsibility
- General changes in overall attitude
- Deterioration of physical appearance and grooming
- Wearing sunglasses at inappropriate times
- Continual wearing of long sleeve garments
- Association with known substance abusers
- Unusual/frequent borrowing of money
- Stealing from home, employer, school
- Secretive behaviors regarding actions/possessions

Assessment: Acute Signs and Symptoms of Drug Impairment

- Acting intoxicated
- Bloodshot or red eyes, droopy eyelids
- Imprecise eye movement
- Abnormally pale complexion
- Change in speech and vocabulary patterns
- Neglect of personal appearance, grooming
- Strong use of cologne/perfume
- Odor indicative of use

Assessment: Acute Signs and Symptoms of Drug Impairment (Continued)

- What are some signs that someone is abusing alcohol?
  - Odor on breath
  - Intoxication
  - Difficulty focusing/glazed appearance of eyes
  - Passive behavior or combative/argumentative behavior
  - Flushed skin

Assessment: Signs of Alcohol Abuse

- Moodiness
- Unusual flare-ups/outbreaks of temper
- Overreaction to simple requests
- Decreased interaction/communication with others
- Lethargy
- Difficulty writing/signing
- Change in gait
- Poor eye contact

ASSESSMENT: MARIJUANA

- How do you know when someone is abusing THC?
- Rapid, loud talking and bursts of laughter
- Sleepy/stuporous presentation
- Forgetful in conversation
- Inflammation in whites of eyes, pupils unlikely to be dilated.
- Odor (similar to burnt rope)
- Distorted sense of time passage

Assessment: Methamphetamine

- Dilated pupils
- Dry mouth and nose, bad breath, frequent lip licking
- Excessive activity, difficulty sitting still,
- Irritable, argumentative, nervous
- Talkative but lacking continuity
- Runny nose, nose bleed
- Repetitive, consistent movements.
- Elevated aggression and paranoia
- “Meth bugs”

Assessment—Prescription Drugs—Benzodiazepines or Sedatives

- How do you know someone is abusing…?
- Symptoms of Alcohol Abuse without the odor
- Lack of facial expression or animation
- Flat affect
- Flaccid appearance
- Slurred speech

ASSESSMENT—NARCOTIC USE (HEROIN)

- Lethargy, drowsiness—specifically someone will be “on the nod” where they will be talking to you and, basically, fall asleep in a second.
- Constricted pupils that fail to respond to light
- Redness and raw nostrils
- Abscesses/bruises on forearms
- Slurred speech

ASSESSMENT—NARCOTIC USE (PAIN PILLS)

- Increased energy, similar to stimulate use.
- Can lead to lethargy, drowsiness.
- Constricted pupils that fail to respond to light.
- Redness and raw nostrils
- Appear to get the flu a lot—stomach flu, fevers, sweats, irritable, achy.

ASSESSMENT—NARCOTIC USE (PAIN PILLS)

- Generally, prescription pain pill users will report the increased energy first, then will report the Heroin “nod” as they use longer, before increased tolerance leads to lack of positive feelings and use only to prevent withdrawals.

ASSESSMENT—NARCOTIC USE, COMING TO ADDICTS NEAR YOU!

- Zohyro, Black Tar Heroin, Krokodil
- Zohydro: extended-release hyrocodone approximately 10 times stronger than Vicodin.
  - Pros: Better, longer lasting pain relief for individuals who suffer chronic, debilitating pain.
  - Cons: Current form of Zohydro can be injected like early forms of Oxycontin or Opana. Potential for abuse is the same if not worse as potentially stronger than earlier forms of either one.

BLACK TAR HEROIN

- Black Tar Heroin
  - Incredibly potent synthetic, with varying degrees of Heroin in it.
  - What's more dangerous are the morphine derivatives. The morphine derivatives, when laced with Heroin, produce a potent and potentially deadly combination.
  - Primarily found in southwestern and western United States, and generally comes from Central and South American.
  - "Cheap" distillation process that provides a very rocky, ugly product with potentially deadly side effects.

BLACK TAR HEROIN, COURTESY OF WIKEPEDIA

K IS FOR KROKODIL

Krokodil: A new form of pain pill "cooked" like methamphetamines that causes severe tissue damage in its users and has an extremely short half-life.

- So named because repeated use of the drug can lead to having rapid skin damage that looks like scales from a lizard.
- Base drug, desomorphine, is 8-10 times more powerful than morphine.
- Mixed with gasoline, paint thinner, other adulterants to create this super-powerful Frankenstein's monster hodgepodge of Heroin and Methamphetamine.

K IS FOR KROKODIL

- Heroin may last four to eight hours. Krokodil may last an hour and a half before you have to have another hit. Use is therefore like a full time job.
- The short half-life of the drug creates the need to use more frequently and intensely.

K IS FOR KROKODIL…(AND THESE ARE THE IMAGES I COULD SHOW…)

KROKODIL—URBAN LEGEND?

- Now, the DEA has not confirmed any cases in the United States.
- Primarily Russia and the former Baltic states.

ASSESSMENT: INHALANT USE

- Substance odor on breath and clothes
- Runny nose
- Watery eyes
- Drowsiness
- Poor muscle control
- Nausea
- Accelerated heart rate

ASSESSMENT: HALLUCINOGEN USE

- Extremely dilated pupils
- Warm skin, excessive perspiration, body odor
- Distorted sense of sight, hearing, touch
- Mood/behavior changes
- Depersonalization, acute anxiety, acute depression
- Suicidal ideation

ASSESSMENT: PCP USE

- Unpredictable behavior; from passive to violent behavior for no apparent reason
- Disorientation, agitation
- Fear, terror
- Rigid muscles
- Strange gait
- Deadened sensory perception
- Dilated pupils
- Mask-like facial appearance
- Floating pupils (appearing to follow a moving object)

ASSESSMENT: NEW DRUGS

- **Spice**—similar to Marijuana, only can also add stimulant-like response.
  - Teens who use have increased agitation, profuse sweating, pale skin or vomiting.
  - But what may be of the greatest concern is the loss of physical control – a kind of brain-body disconnect. This is where you may see seizures, a lack of pain response or uncontrolled/spastic body movements.
  - Can also cause dysphoria, which is the opposite of euphoria.

ASSESSMENT: NEW DRUGS

- **Bath salts**—like cocaine/amphetamine effect.
  - Users have reported experiencing panic attacks and recent news reports have linked use of bath salts with extremely out of control, violent behavior.
  - Bath salts effects last for approximately 3 to 4 hours. There are "after effects" such as tachycardia, hypertension, and mild stimulation lasting from 6 to 8 hours.

ASSESSMENT: NEW DRUGS

- Used by Offender to aid in offense:
  - Gamma-Hydroxybutyric acid (“GHB”, “Georgia Home Boy”)
  - Rohyphenol (“roofies”)
- Devil’s Breath--scopolamine.
  - Each has a different impact, but all of them impair the survivor from consenting to anything that happens. Either through an amnesic effect (GHB, roofies) or through decreasing the ability for a survivor to say “no” (Devil’s Breath).
  - Regular use of the drugs, when given by the offender, can result in impairment and inability to make any decisions without the suggestion of the person providing the drug.

Killer B's: Three Classifications of Drugs That Can Kill You If Not Medically Supervised

Benzodiazepines

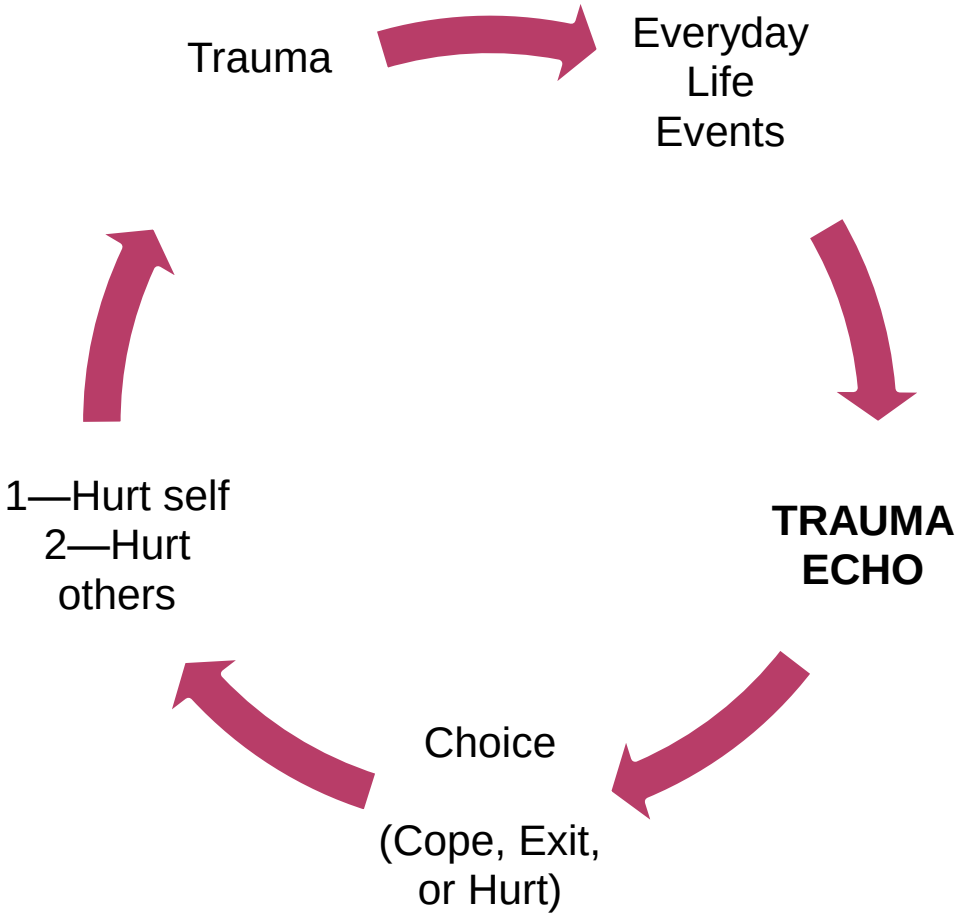
Barbituates

Booze (alcohol—yes, I cheated)

PEOPLE WHO ARE ADDICTED:

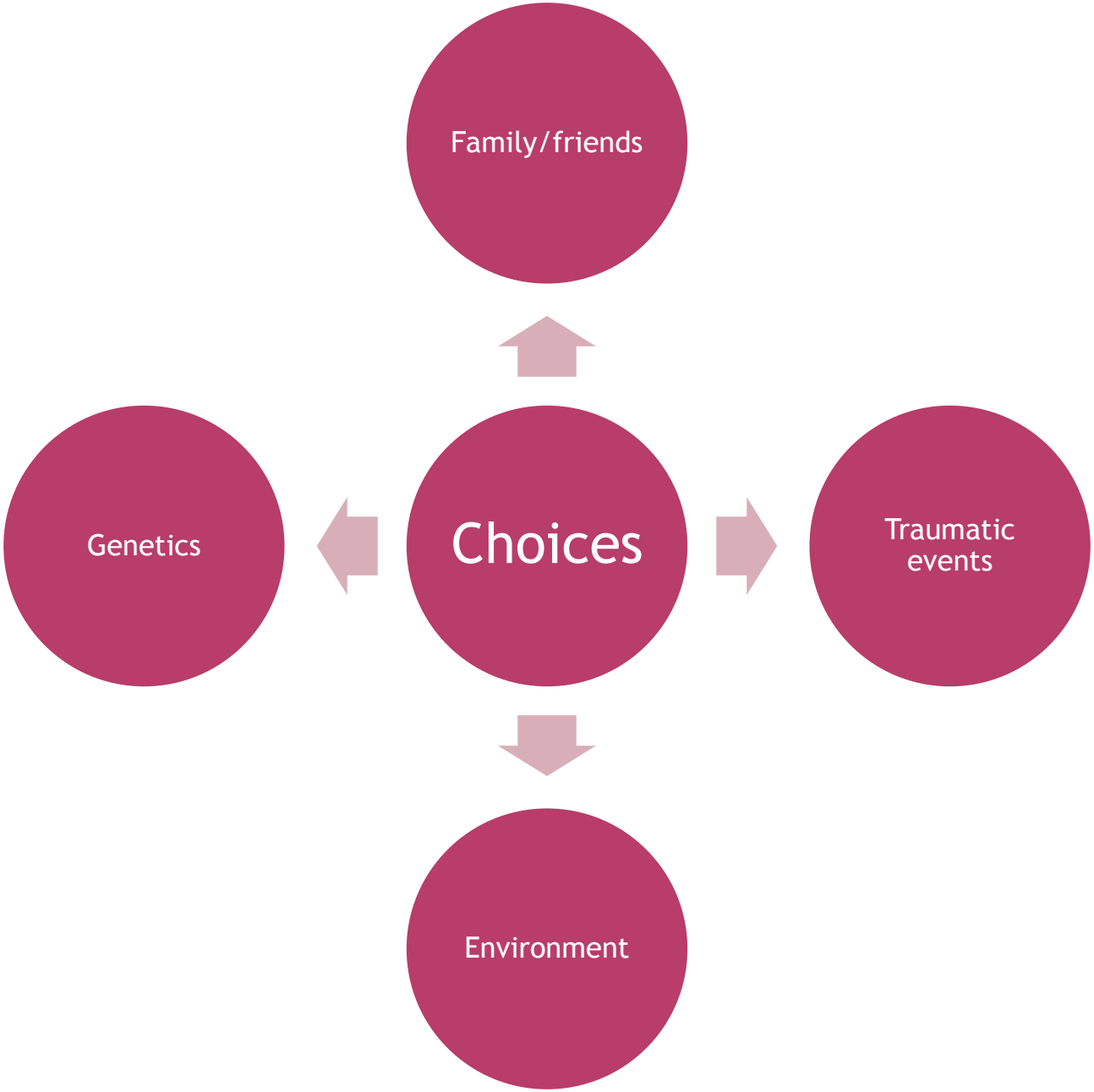
- What do people do when they are addicted?
  - What have you seen?
  - What are common drugs you have seen?
  - What are common behaviors?
    - Lying
    - Manipulating
    - Stealing
    - Aggressive behavior
    - Emotional volatility
- Why do they do what they do?

TRAUMA OUTCOME PROCESS

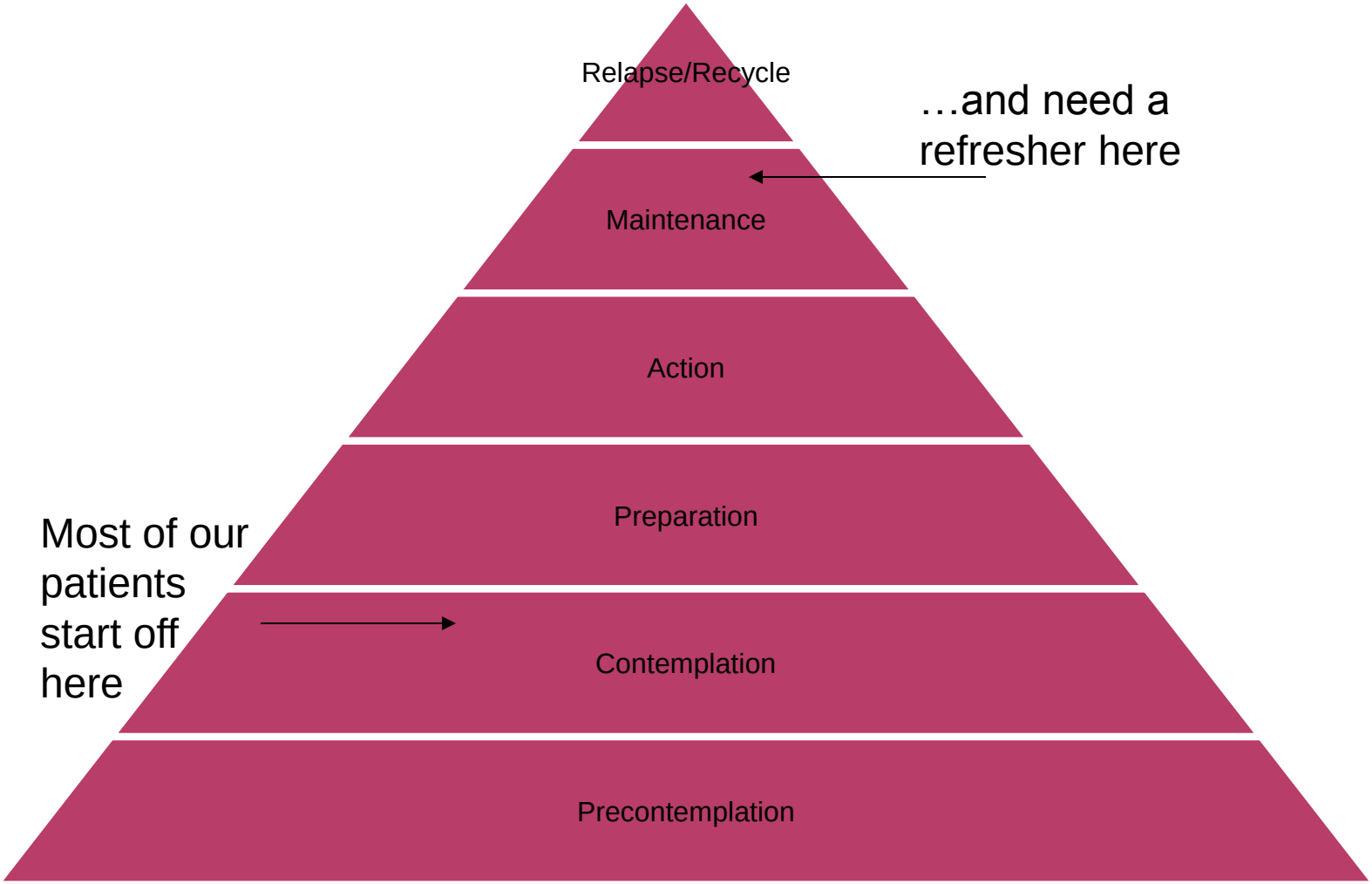


CHOICES:

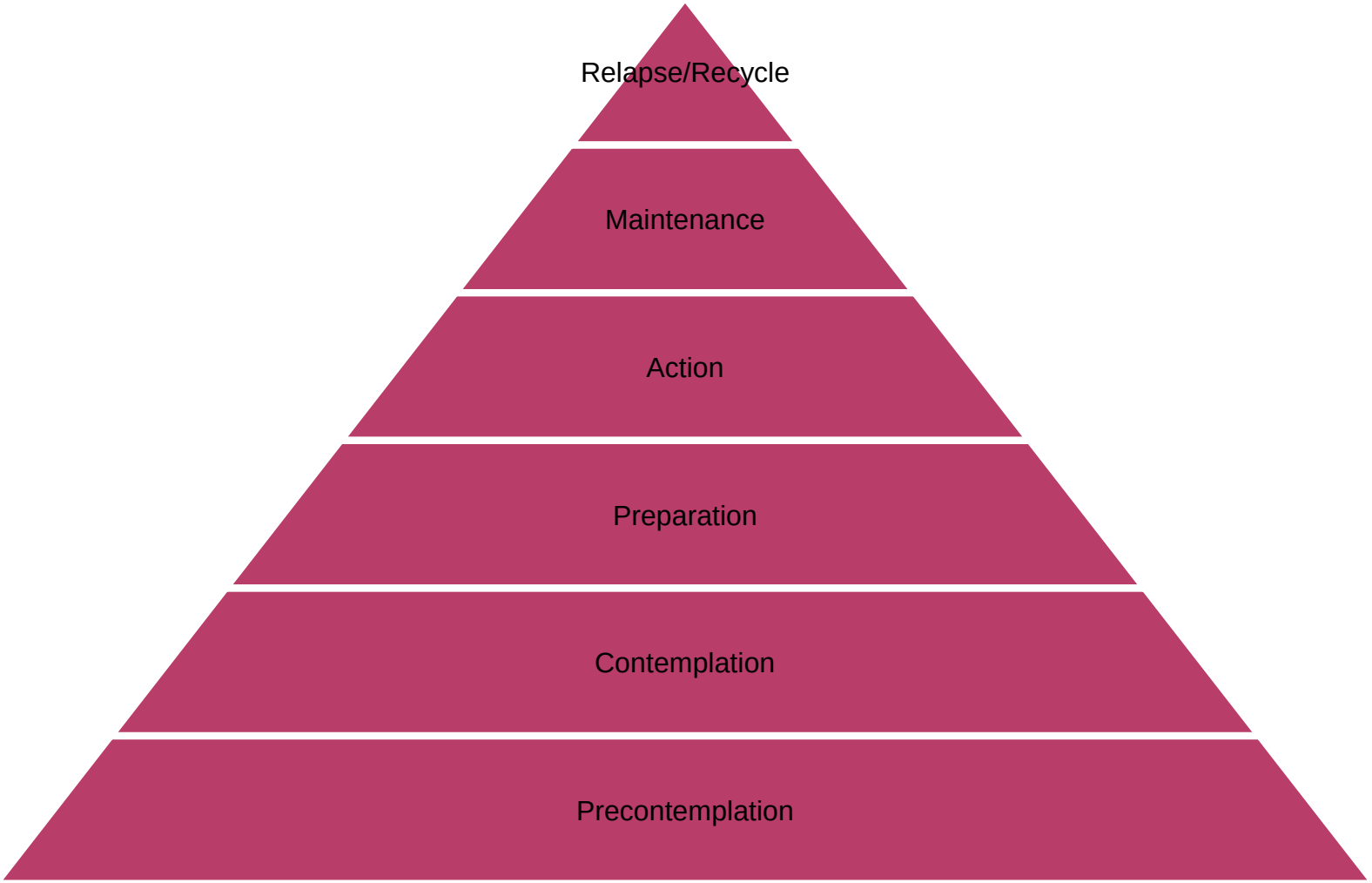
- Why is this one so important?
  - A: Because, without choices, we would have no control over what we did.
- However, our choices are influenced by the people, places, and things we hang out with and by the events that have occurred in our lives.


Family/friends
Genetics
Choices
Traumatic events
Environment

MODEL OF CHANGE (PROCHASKA, DICLEMENTE, & NORCROSS, 1992)



WHERE WOULD YOU PUT THE FAMILIES YOU SEE?



SO…

- Mom (Janet) has lost 3 jobs in 6 months as she can't focus and is always jittery, spacy, and impulsive after coming back from her breaks—which she can't take enough of. She has missed work either due to stomach flu or "feeling like crap" at least once a week for several months now.
- Kiddo #1 (Steve) has a short attention span, is hyperactive, and has a hard time following directions in his kindergarten class. Steve had a black eye that no one could explain when he showed up for school one Monday.
- Kiddo #2 (Bruce) has a seriously aggressive temper and has absolutely "destroyed" his bedroom several times.
- Dad (Hank) hasn't had a job since 2010, is physically overweight, and doesn't do much but yell at the TV during your home visit. Every time he raises his voice, you notice Janet cringes.

WHAT'S GOING ON?

- What do you think is going on with the parents?
- With the kids?
- How might you intervene with them?

AND THIS IS THE REST OF THE STORY…

- Mom's (Janet) addicted to Heroin, causing her to use every 4-6 hours or she can't function.
- Kiddo #1 (Steve) was born opiate and marijuana positive.
- Kiddo #2 (Bruce) was born opiate and cocaine positive.
- Dad (Hank) drinks Early Times from the time he wakes up until he passes out and has verbally and physically abused Janet.

WHAT ARE SOME OF THE ISSUES IN THIS FAMILY?

- Substance abuse: Hank/Dad
- Substance abuse: Janet/Mom
- Emotional Violence: Hank/Dad
- Survivor Issues: Janet/Mom, Steve/Bruce (Kids)
- Possible ADHD: Steve
- Anger control issues: Bruce
- School problems: Steve and Bruce
- Unemployment: Hank and Janet

WHAT DIAGNOSES DO THOSE LOOK LIKE?

- Reactive Attachment Disorder
- Borderline Disorder
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder
- Depression
- Bi-Polar Disorder
- Conduct Disorder

WHAT DO I DO NOW?

- Now that you are an expert in addiction treatent, how do you use this in your treatment of individuals with addiction or who might have addiction?
  - Clear, concise directions
  - Strong, consistent boundaries
  - Patience and the ability to remember that it is not an addict speaking to you but that person in front of you is a human being with an illness that needs your help.
  - Evaluate with the family which approach will work best—and make sure you are familiar and comfortable with it before you use it!

A WORD ON DIAGNOSING…

- Who can diagnose?
  - Someone with appropriate training, experience, and credentials.
  - Someone with appropriate training and experience under the supervision of someone with appropriate credentials.
- What does it take to diagnose someone?
- Psychiatrist versus psychologist
  - Psychiatrist on staff here.
- Labels versus tools to help us better understand and treat our patients
  - Diagnosis shouldn't automatically equal medication
  - Diagnosis should help in informing how we might treat someone.
  - Case example: PTSD versus ADHD.

A FEW MORE RANDOM THOUGHTS ON WORKING WITH PATIENTS…

- Regardless of what environment you are working in: Report the behavior you are seeing.
  - No matter how inconsequential, it is all “grist for the mill” for the team you are working with.
- Be aware of behaviors you are not seeing.
  - Most substance abusing patients will mis-report their use.
  - I’ve seen individuals state more or less use, depending on what they think I want to hear.
  - Always try to back check, circle back, and assess what’s really going on.

WHERE MIGHT YOU BE SEEING THESE FAMILIES?

- Child Welfare worker
- Inpatient treatment technician
- Group home direct line staff
- Outpatient substance abuse counselor

DIRECT INTERVENTIONS

- Line staff:
  - Games—and monitor their behavior. Who cheats? Who loses well? Who loses poorly? Who follows the structure of the game? Who can continue to stay focused?
    - Chess
    - Card games—uno, “war”, blackjack
    - Other?
  - Structure & routine—why this is so important. Children with trauma respond so much more positively to structure and routine.

Direct Interventions—Play Therapy

- Always talk to the counselors about what you want to do.
- Face masking—using paper-mache, have the kids do it then have them decorate their masks.
- "Attune to your body"—tapping.
- Breathing techniques
- Yoga
- Reward positive behaviors.

DICTIONARY OF SUBSTANCE ABUSE TERMS YOU SHOULD KNOW

- Voluntary and involuntary
  - Why does it matter?
  - What is different about approaching involuntary and voluntary patients?
- "Drop"
  - UDS
  - Mouth Swab
  - Hair follicle
  - Voluntary patients in treatment who HAVE to receive UDS to be in treatment…How do you reconcile that?

DICTIONARY OF SUBSTANCE ABUSE TERMS YOU SHOULD KNOW

- Inpatient
  - Full, partial, intensive programs.
- Outpatient
  - Office-based.
  - Daily, weekly, biweekly, monthly
- Supportive recovery communities
  - 12 step programs.
- Medically Assisted Treatment Programs
  - Methadone
  - Buprenorphine
  - Naltrexone

DICTIONARY OF SUBSTANCE ABUSE TERMS YOU SHOULD KNOW

- Denial
  - When is denial a good thing?
  - When is it a bad thing?
  - What types of denial do you deal with?
    - For patients?
    - For their families?
    - For the communities we live and work in?
  - How can we work to overcome that denial for substance abuse and mental health issues?

DICTIONARY OF SUBSTANCE ABUSE TERMS YOU SHOULD KNOW

- 30 in 30
- 13th step
- One's too many, 100's never enough
- "Trudging"
- What other terms have you heard that you would like me to explain?

TWO POSSIBLE TREATMENT STYLES

- "Old School"/Classic Chemical Dependency
- Harm Reduction
- Type of treatment that will work will depend primarily on the patient in question.
  - Do they need someone to tell them what to do versus someone to help them work out what to do?

"Old School"/Classic Chemical Dependency

- Break down the patient to build them up.
- Hold them accountable for every action.
- Focus on their addiction and only their addiction.
- Emphasize recovery communities, complete withdrawal, responsibility for actions.
- Relapse as part of recovery.

HARM REDUCTION

- Are the individuals in our care better off now then when they were on their streets?
- Relapse is part of the treatment process and to be learned from.
- Progress takes time, and allow patients the time to make mistakes, learn new skills, and move forward in their lives.

WHICH WILL WORK FOR MY PATIENTS?

- Do they respond better to having someone tell them what to do or with the right support, can they function autonomously?

THOSE WHO NEED SOMEONE STANDING OVER THEM

- External constraints can help one get into treatment and potentially kickstart the process of discontinuing from illicit substances.
- In the process of following these external constraints, the hope is that the patient will internalize those skills to prevent relapse.
- If your patient will only respond to the most concrete of goals and the most strict deadlines, probably are going to use the Classic version of substance abuse treament.
- Especially when there are other factors to consider: degree of criminal behavior, safety of others, safety of that individual.

AND SOMETIMES YOU HAVE TO GIVE THEM A CHANCE TO GET IT RIGHT…OR WRONG

- You decide that you want to quit smoking cigarettes because of that nasty cough each morning.
- You realize that drinking 5 cups of coffee a day may have an impact on your blood pressure.
- You wake up, don't have any pills, and go into withdrawal. You realize you've spent your inheritance, lost your job, and your SO left you the other day when you were too "out of it" to talk to them about how you felt. Your dog left you, you lost your truck, and your house is in foreclosure. You are a country music song.
- These patients are ready to make a shift because of something internal, not an external source making pronouncements.

NOW:

- What are you going to do with Kiddo #1, Kiddo #2, Mom and Dad?

Questions….?