MONTANA PRIMARY CARE ASSOCIATION

Basic Tool Box for Working with SUD Patients

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WORKING with SUD's:
Licensure
and
Master's Level Competencies

MONTANA and SUD's

- An estimated one in ten Montana adults is dependent upon or abusing substances.
- However, only 15,900 individuals in Montana received any form of SUD treatment between 2012-2015.
- Thus, 90% of the individuals with a SUD in Montana are not receiving treatment annually.

Montana, DOJ, Substance Use in Montana, 2017

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MONTANA: Not Enough Providers

"…there is a documented shortage of SUD treatment providers in our state that exacerbates the problem of treatment access.

Based on national estimates, approximately 10,000 individuals are likely to seek SUD treatment annually in Montana, but current state approved providers only have the capacity to serve approximately 6,100 individuals, leaving almost 4,000 SUD sufferers annually unable to access the treatment they seek.

Montana, DOJ, Substance Use in Montana, 2017

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MONTANA: EXISTING PROVIDERS

Montana continues to have a workforce shortage of treatment providers.

- 793 Licensed Addiction Counselors (LAC) 1
- 194 Dual Licensed Providers (LAC + Mental Health). 1
- 18 of Montana's 56 counties have no practicing licensed substance use providers. 2
- Need for expanded access to evidence-based, recovery oriented, culturally appropriate treatment for all Montanans. 2

1. Montana, DOJ, Substance Use in Montana, 2017
2. Addressing Substance Use Disorder in Montana, DPHHS, 2018

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PATHWAY to LICENSURE

2- Year Chemical Dependency Programs at Community and Tribal Colleges

Limitations: Lack of Supervision, Mentoring for Licensure, Lack of Mental Health Foundations

Higher Education

MSU Master's Addiction Counseling

UM Social Work LAC Tract

Other CEU Resources

- NAADAC
- ATTC Transfer Technology
- NASW
- You are here! Montana Primary Care Association

Administrative and Medicaid Rules

Montana Code Annotated 37-35-201. License required -- exceptions.

…..performed by a qualified member of a profession, such as a physician, lawyer, licensed professional counselor, licensed social worker, licensed psychiatrist, licensed psychologist, nurse, probation officer, court employee, pastoral counselor, or school counselor, consistent with the person's licensure or certification and the code of ethics of the person's profession, as long as the person does not represent by title that the person is a licensed addiction counselor. If a person is a qualified member of a profession that is not licensed or certified or for which there is no applicable code of ethics, this section does not prohibit an activity or service of the profession as long as the person does not represent by title that the person is a licensed addiction counselor.

Addictive and Mental Disorders Division Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health Effective May 1, 2018

Provider Requirements:

SUD (OP, IOP) Therapy must be provided by a state approved program or a licensed mental health professional with substance use within their scope of practice.

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Medicaid Manual Example: Requirements for Assessment

Biopsychosocial Assessment

Definition:

- A comprehensive assessment of a member's drug use history, medical, psychological, and social history based on the six dimensions of the ASAM criteria.

Provider Requirements:

- Biopsychosocial Assessment must be provided by a licensed addictions counselor who is or is employed by a state-approved substance use disorder program or a licensed mental health professional with substance use within their scope of practice.

Medical Necessity Criteria:

- The member must have been screened using an evidence-based screening instrument to identify the severity of substance use to make a determination for substance related disorders.

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Manual Example: Requirements for SBIRT

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Definition:

- An evidence-based approach to identify those members at risk for psychosocial or health care problems related to their substance use.
- SBIRT is used to determine if a complete assessment and possible referral to treatment is needed. SBIRT must include an alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention (SBI) services.

Provider Requirements:

- SBIRT must be provided by a state-approved substance use disorder program, a physician, or a midlevel practitioner……Licensed professionals who are eligible to provide this service or supervise staff providing this service must have a minimum of four hours training approved by the department related to SBIRT services, and have proof of such.

Medical Necessity Criteria:

- Any Medicaid member may be screened.

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“CONSISTANT WITH LICENSURE and CODE OF ETHICS”

NASW Standards for Social Work Practice with Clients with Substance Use Disorders

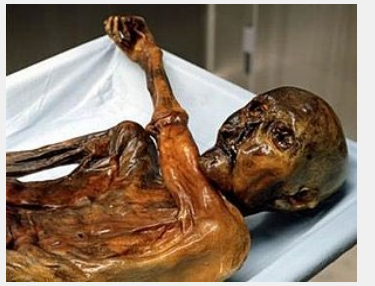
AMERICAN COUNSELING ASSOCIATION: Education and Training Requirements in Addictions

History of Substance Use

There is only one thing more painful than learning from experience and that is not learning from experience.

~Archibald MacLeish

In Our Earliest Human Records
Religious, Medicinal, Recreational



- Consumption of alcohol containing beverages predate recorded human history, while written records of its use are found in Chinese and Middle Eastern texts as far back as 9,000 years ago.
- Ötzi, the man whose frozen body was recovered in the Alps in 1991, lived about 3300 years BC, and carried in his pouch a travel pharmacy including a polypore fungus with antibacterial and hemostatic properties.
- Ethiopian priests started roasting and boiling coffee beans to stay awake through nights of prayer after a shepherd noticed how his goats were frolicking after feeding on coffee shrubs.
- The mushroom Amanita muscaria, commonly known as fly agaric, has been at the center of religious rituals in Central Asia for at least 4000 years
- Alexander the Great's death in 323 BC was precipitated by years of heavy drinking.
- Aristotle recorded the effects of alcohol withdrawal and warned that drinking during pregnancy could be dangerous

~ Crocq, M.A. (2007). Historical and cultural aspects of a man's relationship with addictive drugs. Dialogues in Clinical Neuroscience, 9(4), 355-361.

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William White Timeline

http://www.williamwhitepapers.com/addiction_history_briefs/

1600 - 1700s

- The issue of loss of control of substance use was discussed in some publications (1600s)
- Sobriety Circles (1700s)

1800s

- Inebriety Asylums – 1864 New York State
- 1879 – Dr. Leslie Keeley announces “Drunkenness is a disease and I can cure it” (the beginning of franchised, private, for-profit institutes in America)
- Freud recommends cocaine and morphine to treat alcoholism

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1900-1940

- State laws passed (1907-1913) calling for mandatory sterilization of “defectives”: the mentally ill, the developmentally disabled, and “alcoholics and addicts.”
- The Harrison Tax Act (1914) brings opiates and cocaine under federal control and places physicians as the gatekeepers for access to these drugs
- Supreme Court decisions (Webb v. the United States) declares that for a physician to maintain a person on their customary dose is not in “good faith” medical practice, and thus an indictable offense. 25,000 physicians indicted between 1919- 1935

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1935-1940

- Aversive conditioning in institutional alcoholism settings
- The first federal “narcotics farm” (U.S. Public Health Prison Hospital) [1935]
- The meeting of Bill W. and Dr. Bob S. (and Dr. Bob’s last drink) mark the beginning of Alcoholics Anonymous. [1935]
- The book, Alcoholics Anonymous, is published [1939]

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1941-1945

high. Statistics on traditional medical and religious cures are lacking, but it has been informally estimated that they are no more than 2 or 3 per cent effective on run-of-the-mine cases.

Although it is too early to state that Alcoholics Anonymous is the definitive answer to alcoholism, its brief record is impressive and it is receiving hopeful support. John D. Rockefeller, Jr., helped defray the expense of getting it started and has gone out of his way to get other prominent men interested.

Rockefeller's gift was a small one, in deference to the insistence of the originators that the movement be kept on a voluntary, nonpaid basis. There are no salaried organizers, no dues, no officers and no central control. Locally, the rents of assembly halls are met by passing the hat at meetings. In small communities no collections are taken, as the gatherings are held in private homes. A small office in downtown New York acts merely as a clearinghouse for information. There is no name on the door and mail is received anonymously through Box 658, Church Street Annex post office. The only income, which is money received from the sale of a book describing the work, is handled by The Alcoholic Foundation, a board composed of three alcoholics and four nonalcoholics.

The end—and the beginning. A. A.'s will not help a drunk unless he admits liquor has licked him as thoroughly as the man in this scene.

Deflagging. Called to a hospital bedside, A. A.'s will come any time of the day or night, because they help themselves by helping a dipsomaniac.

In Akron, as in other manufacturing centers, the groups include a heavy element of manual workers. In the Cleveland Athletic Club I had luncheon with five lawyers, an accountant, an engineer, three salesmen, an insurance man, a buyer, a bartender, a chain-store manager, a manager of an independent store and a manufacturer's representative. They were members of a central committee which coordinates the work of nine neighborhood groups. Cleveland, with more than 450 members, is the biggest of the A. A. centers. The next largest are located in Chicago, Akron, Philadelphia, Los Angeles, Washington and New York. All told, there are groups in about fifty cities and towns.

Self-Insurance Against Demon Rum

IN DISCUSSING their work, the A. A.'s spoke of their drunk-rescuing as "insurance" for themselves. Experience within the group has shown, they said, that once a recovered drinker slows up in this work he is likely to go back to drinking, himself. There is, they agreed, no such thing as an ex-alcoholic. If one is an alcoholic—that is, a person who is unable to drink normally—one remains an alcoholic until he dies, just as a diabetic remains a diabetic. The best he can hope for is to become an arrested case, with drunk-saving as his insulin. At least, the A. A.'s say so, and medical opinion tends to support them. All but a few said that they had lost all desire for alcohol. Most serve liquor in their homes when friends drop in and they still go to bars with companions who drink. The A. A.'s tipple on soft drinks and coffee.

One, a sales manager, acts as bartender at his company's annual jamboree in Atlantic City and spends his nights turking the celebrators into their beds. Only a few of those who recover fail to lose the feeling that at any minute they may thoughtlessly take one drink and skyrocket off on a disastrous binge. An A. A. who is a clerk in an Eastern city hasn't had a snifter in three and a half years, but says that he still has to walk fast past saloons to circumvent the old impulse; but he is an exception. The only hang-over from the wild days that plagues the A. A. is a recurrent nightmare. In the dream, he finds himself off on a rousing whooper-dooper, frantically trying to conceal his condition from the community. Even this symptom disappears shortly, in most cases. Surprisingly, the rate of employment among these people, who formerly drank themselves out of job after job, is said to be around 90 per cent.

One-hundred-per-cent effectiveness with non-psychotic drinkers who sincerely want to quit is claimed by the workers of Alcoholics Anonymous. The program will not work, they add, with those who only "want to want to quit," or who want to quit because they are afraid of losing their families or their jobs. The effective desire, they state, must be based upon enlightened self-interest; the applicant must want to get away from liquor to head off incarceration or premature death. He must be fed up with the stark social loneliness which engulfs the uncontrolled drinker and he must want to put some order into his bungled life.

As it is impossible to disqualify all border-line applicants, the working percentage of recovery falls below the 100-per-cent mark. According to A. A. estimation, 50 per cent of the alcoholics taken in hand recover almost immediately; 25 per cent get well after suffering a relapse or two, and the rest remain doubtful. This rate of success is exceptionally

In Chicago twenty-five doctors work hand in hand with Alcoholics Anonymous, contributing their services and referring their own alcoholic patients to the group, which now numbers around 200. The same co-operation exists in Cleveland and to a lesser degree in other centers. A physician, Dr. W. D. Silkworth, of New York City, gave the movement its first encouragement. However, many doctors remain skeptical. Dr. Foster Kennedy, an eminent New York neurologist, probably had these in mind when he stated at a meeting a year ago: "The aim of those concerned in this effort against alcoholism is high, their success has been considerable and I believe medical men of good will should aid."

The active help of two medical men of good will, Drs. A. Wiese Hammer and C. Dudley Saul, has assisted greatly in making the Philadelphia unit one of the more effective of the younger groups. The movement there had its

Continued on Page 89

- AA recruitment increases
- Article about AA in Saturday Evening Post [1941]
- National Committee for Alcoholism [1944]
- “Minnesota Model” emerges
- Antabuse introduced as an adjunct in the treatment of alcoholism in the US. (also using barbiturates, amphetamines and LSD) [approved by FDA in 1951]
- Hollywood

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Hollywood

- The Lost Weekend [1945]
- September Remembers [1945]
- Breakdown [1946]
- Devil by the Tail [1947]
- Man be Mad [1947]
- Under the Volcano [1947]

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1950-1955

- The National Institute of Mental Health establishes a special division on alcoholism [1950]
- Antabuse approved by FDA (1951)
- AMA first defines alcoholism as an illness. Recognizes “alcoholics” as legitimate patients” Hospitals urged to consider admissions [1956]
- New York City Medical Society on Alcoholism founded - today known as American Society of Addiction Medicine (ASAM) [1954]

Hollywood

- Come Back Little Sheba [1952]
- Man with the Golden Arm [1955]

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1956-1960

- Veteran's Health Administration begins developing alcoholism treatment units within VA hospitals [1957]
- American Hospital Association passes resolution to prevent discrimination [1957]
- Fordham University offers first full university course on alcoholism for credit. [1957]

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1960s

- Federal legislation begins
- Debate begins over who should treat
- E.M. Jellinek publishes *The Disease Concept of Alcoholism*.[1960]
- American Bar Association/American Medical Association Report, Drug Addiction: Crime or Disease?, calls for community based treatment programs [1961]
- American Public Health Association adopts an official statement on alcoholism identifying it as a treatable illness [1963]

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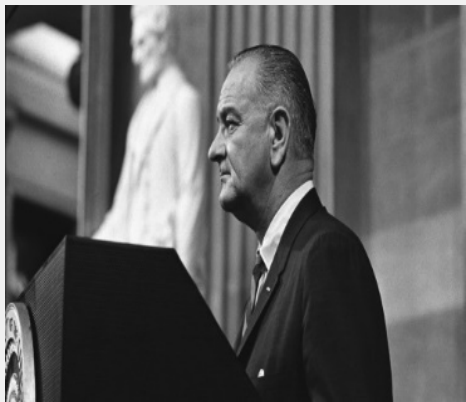
1960s

- American Public Health Association adopts an official statement on alcoholism identifying it as a treatable illness [1963]
- Insurance industry begins to reimburse treatment, which lead to expansion in private and hospital-based inpatient programs [1964-1975]
- American Psychiatric Association urges members to learn about alcoholism and urges insurance to cover treatment [1965]
- Two federal Appeals Court decision support the disease concept [1966]
- President Johnson appoints first National Advisory Committee on Alcoholism [1966]
- President Johnson address' nation…"The alcoholic suffers from a disease which will yield eventually to scientific research and adequate treatment."
- The National Center for the Prevention and Control of Alcoholism is created within the Narcotic Addiction Rehabilitation Act [1963]



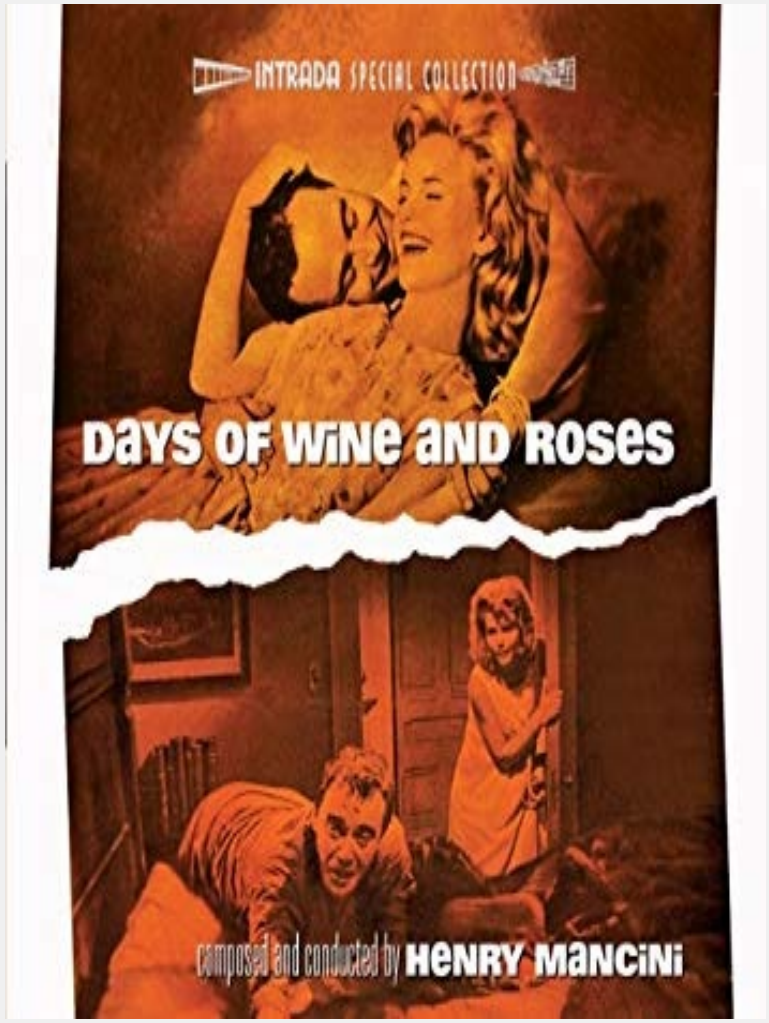
1960s - Hollywood

- Days of Wine and Roses [1962]
- Heroin

Top Rock Music Singer Found Dead In Apartment

JIMI HENDRIX

Still world's greatest rock guitarist ever



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1960s

- The American Medical Association passes resolution identifying alcoholism as a “complex” disease and a “disease that merits the serious concern of all members of the health professions”[1967]
- New York Medical Society becomes ASAM

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1970s

- U.S. first describes fetal alcohol syndrome
- First Lady Betty Ford speaks to the nation about entering recovery from addiction to alcohol and other drugs
- NY Heroin Epidemic

1970s

- Congress passes the “Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act [1970]
- Legislation establishes the National Institute on Alcohol Abuse and Alcoholism (NIAAA) [1970]
- Methadone is approved by FDA for detoxification [1970]
- National Association of Alcoholism Counselors and Trainers founded (NAADAC) [1972]
- American College of Internal Medicine includes alcoholism questions on board examinations [1971]
- Methadone is approved by FDA for maintenance [1973]
- National Institute on Drug Abuse founded [1974]
- FDA approves Narcan (1971). Narcan could counter opioid overdose effects, usually within 2 minutes. It was first made available as an injectable solution, but is now available as a nasal spray

1980s

- President Carter appoints the National Commission of Alcoholism and Other Alcohol Related Problems (only meets once)
- Mother’s against Drug Drinking formed
- Federal Block Grant Program transfers responsibility for the delivery of treatment and prevention services to the states.

1980s

- Cocaine Epidemic - Crack Cocaine focuses enormous public attention on the illegal drug problem
- Anti-Drug Abuse Act authorizes $4 billion to fight drugs, primarily through law enforcement (1986)
- American Medical Association calls all drug addictions diseases (1987) Identifying alcoholism as a complex disease that merited the serious concern of all members of the health professions.
- President Reagan formally announces a renewed "War on Drugs"; the shift away from treatment toward punishment and incarceration intensifies [1987]
- Bad Boys - https://open.spotify.com/track/4zygWIhfSQ36sDhO0vJFU7

1990s

- Erosion of treatment reimbursement benefits by insurance
- All but eliminates the 28-day inpatient treatment programs
- The American Society of Addiction Medicine publishes its ASAM Patient Placement Criteria…the criteria shifts us toward levels of care system.(1991)
- Naltrexone approved for alcoholism (1994).
- First wave of “opioid epidemic” begins
  - Pain the 5th Vital Sign

1900s

- President Clinton includes a treatment benefit for alcoholism and other addictions in his national health care reform proposal
- In the early '90s, the number of painkiller prescriptions filled at U.S. pharmacies increased by 2 million to 3 million each year, according to a National Institute on Drug Abuse study. From 1995 to 1996, the number of prescriptions jumped by 8 million
- Purdue Pharma started testing OxyContin as a long-term painkiller in 1994, and it went on the market in 1996.
- Drug Addiction Treatment Act passed (1999). This bill was introduced in 1999 to amend the Controlled Substances Act with stricter registration requirements for practitioners who dispense narcotic drugs in Schedules III, IV, or V for maintenance and detoxification treatment

2000-Present

- Drug Addiction Treatment Act of 2000 (DATA 2000) allows qualified physicians to offer Office Based Opioid Treatment (OBOT)
- FDA approves buprenorphine for clinical use. (2002)
- The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 passed. This act required insurance companies and group health plans to provide similar benefits for mental health and/or substance use treatment and services as other types of medical care.

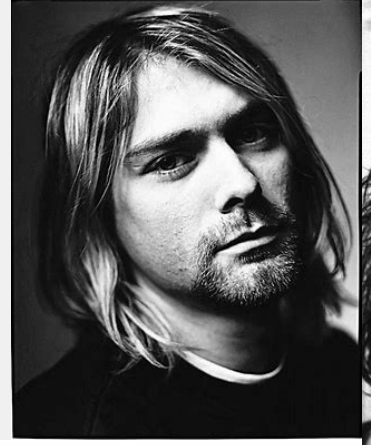
2000-Present

- The Affordable Care Act (ACA) expands coverage for addiction treatment (2010). The ACA expanded MHPAEA's criteria by making sure insurance plans offered through state health insurance marketplaces included behavioral health services, including substance abuse treatment.
- Comprehensive Addiction and Recovery Act (CARA) Allows Nurse Practitioners and Physicians Assistants to become eligible to prescribe Buprenorphine for treatment of Opioid Use Disorders (2016)
- American Medical Association petitions to drop pain as a vital sign in response to the opioid crisis and national addiction epidemic

2000-Present

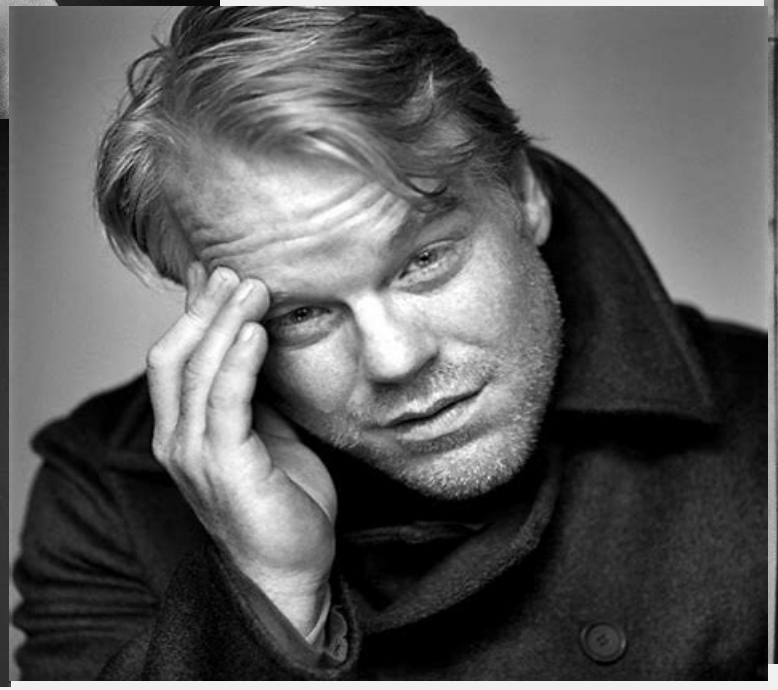
- President Donald Trump declared the opioid epidemic a national public health emergency
- Support for Patients and Communities Act signed (2018) – directs funding to make access to addiction treatment a priority

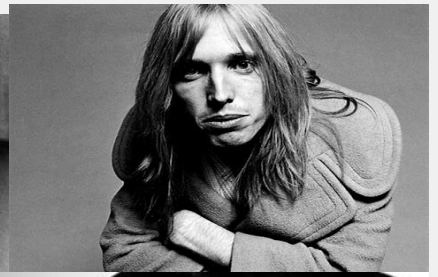
THE ANONYMOUS PEOPLE IS A FEATURE DOCUMENTARY FILM about the over 23 million Americans living in long-term recovery from alcohol and other drug addiction.
https://www.youtube.com/watch?v=bqoEtUn0Agw





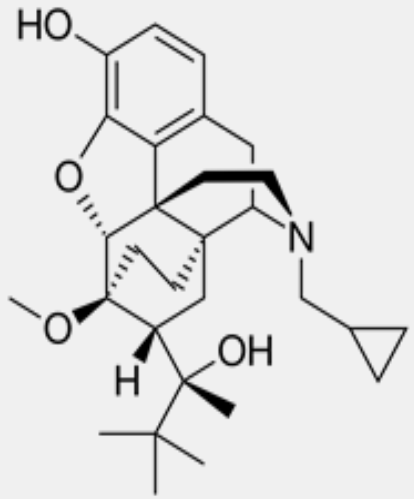





Where Do We Go From Here?

This Epidemic is DIFFERENT



- We have the medications to treat the illness
- Community is coming together
  - more disciplines –
  - partnering with community members –
  - talking across disciplines-

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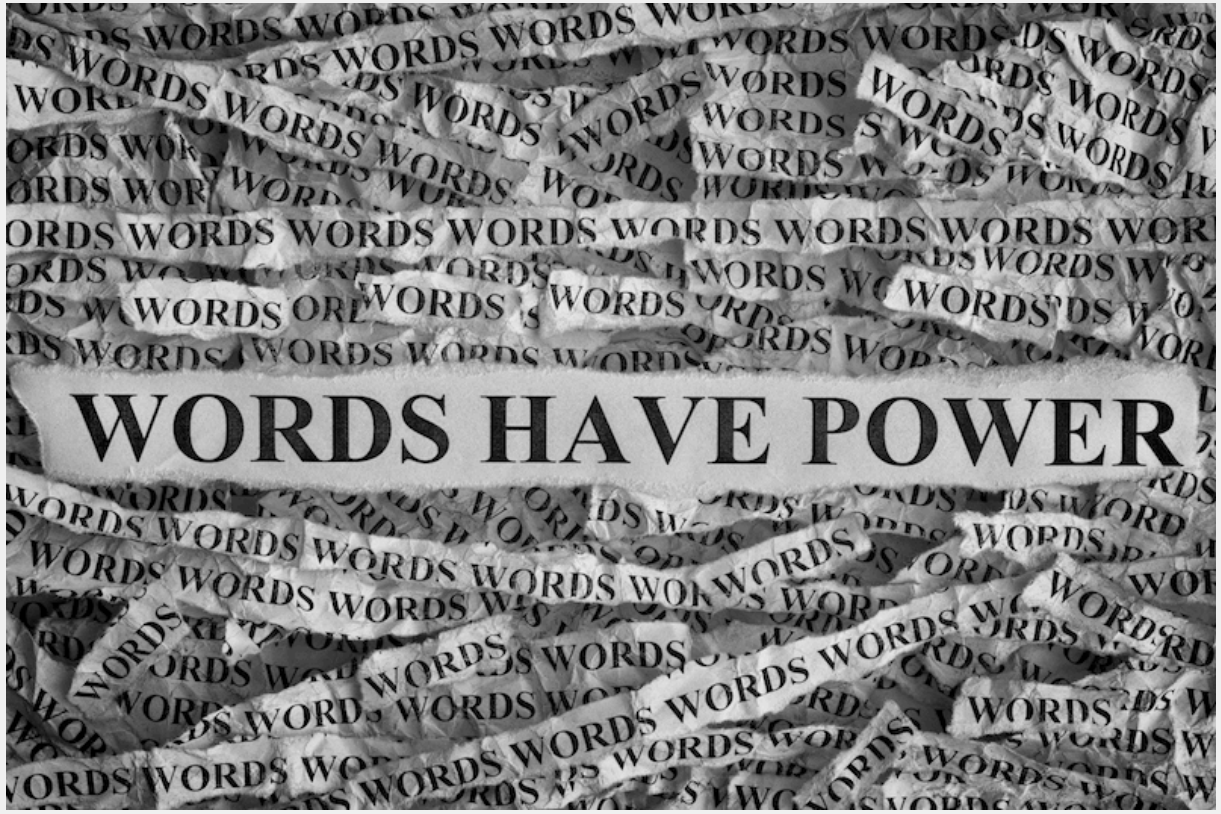
Working Together



Patient-Centered Non-Stigmatizing Language

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Health Care Providers:

View patients with SUDs differently

- Have lower expectations for health outcomes
  - Perceived Control
  - Perceived Fault

Patients who experience or expect stigma:

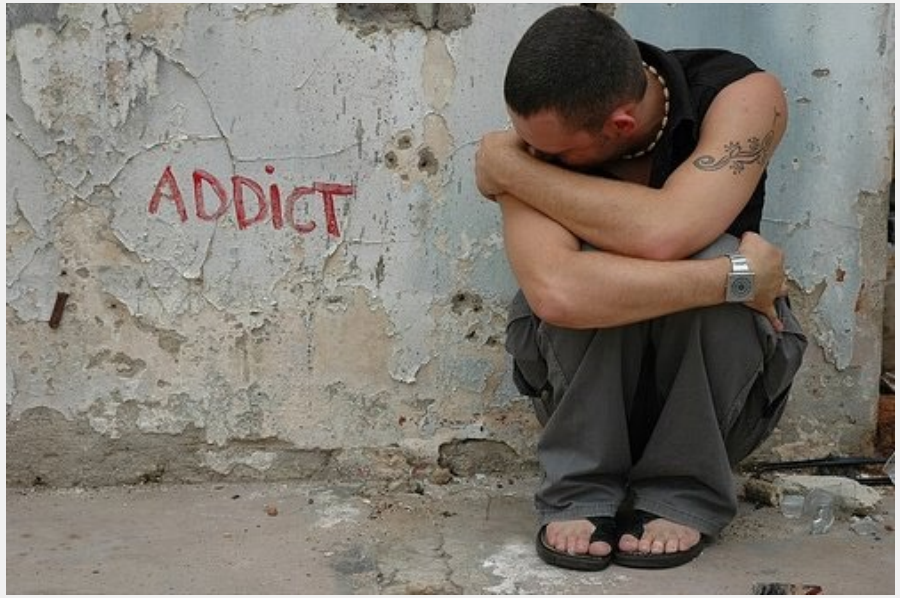
- Less likely to seek or access services
- Drop out of treatment early

Language Matters

If we want to nurture something we call it a flower….

If we want to kill something we call it a weed.

~unknown


ADDICT

Stereotype

Widely held, but fixed and oversimplified image or idea that can lead to bias

BIAS

Explicit Bias

Conscious
Speaks of it
Learned

Implicit Bias

Unconscious
Had nothing to do with it
Dangerous
Can still believe in equality

Confirmation Bias

Even with evidence proving otherwise, belief remains intact.

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Discrimination

- Withholds treatment
- Withholds medication
- Housing
- Ability to get a job
- Ability to get insurance

“If you judge people, you have no time to love them.”

– Mother Teresa

Words Matter

“Words have power. They have the power to teach, the power to wound, the power to shape the way people think, feel, and act toward others.”

~ Otto Wahl

LANGUAGE & STIGMA

Stigma creates barriers to treatment and recovery for individuals with substance use disorders. The language we use can cause or potentially perpetuate stigma. Below are examples of some of the potentially stigmatizing words that might be used and examples of different terminology that can be used instead.

WORDS TO AVOID	ALTERNATIVE/PREFERRED
Addict, Alcoholic, Junkie, Abuser	**Person with a Substance Use Disorder.**
Problem with the terms: It can be demeaning because the person is labeled by their illness and can imply a permanency to their condition, leaving no room for a change in their condition.	First person language is the accepted standard for discussing people with disabilities and/or chronic medical conditions.
Clean (When referring to recovery)	**In remission (partial-sustained)**
Problem with the term: It implies that when the person was in active addiction, they were dirty, unclean and unwanted (stigmatizing, pushing away)	Remission is a medical term that describes a period of time in which signs and symptoms of the illness have disappeared and that addiction is indeed a medical condition
Clean/Dirty (When referring to urine screen)	**Positive/negative for (substance)**
Problem with the terms: Treats the urine of a person with a SUD differently than a person with any other medical condition.	Treats the urine of the individual with a SUD in the same way that they would any other chronic illness.
Drug Overdose	**Drug Poisoning**
Problem with the terms: Implies that the individual caused the condition.	According to the CDC report, 86% of drug poisoning deaths were unintentional. Approximately 8% were suicides, while there is no precise determination of the real intent in 6% of cases.
Relapse	**Recurrence/Return to Use**
Problem with the term: Can imply a moral failing as the origin of the word states that there is a return to heresy or wrongdoing.	The terms tend to be less moralizing and carry greater hope.

Gina Pate-Terry, LCSW, LAC

June 21,2018

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Recovery Dialects

	Mutual Aid Meetings	In Public	With Clients	Medical Settings	Journalists
Addict	✓	STOP	STOP	STOP	STOP
Alcoholic	✓	STOP	STOP	STOP	STOP
Substance Abuser	STOP	STOP	STOP	STOP	STOP
Opioid Addict	✓	STOP	STOP	STOP	STOP
Relapse	✓	STOP	STOP	STOP	STOP
Medication Assisted Treatment	STOP	STOP	STOP	STOP	STOP
Medication Assisted Recovery	✓	✓	✓	✓	✓
Person w/ a Substance Use Disorder	✓	✓	✓	✓	✓
Person w/ an Alcohol Use Disorder	✓	✓	✓	✓	✓
Person w/ an Opioid Use Disorder	✓	✓	✓	✓	✓
Long-term Recovery	✓	✓	✓	✓	✓
Pharmacotherapy	✓	✓	✓	✓	✓

Language matters but can change depending on the setting we are in. Choosing when and where to use certain language and labels can help reduce stigma and discrimination towards substance use and recovery.

SOURCE: Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Substance use, recovery, and linguistics: The impact of word choice on explicit and implicit bias. Drug and Alcohol Dependence, 189, 131–138.

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LET’S PLAY !!

Rules of the Game

LISTEN FOR	REPLACE WITH
Relapse	Recurrence, return to use
Addict / Alcoholic	Person with …
Overdose	Drug Poisoning
Clean, Dirty (referring to a UDS)	Positive for, unexpected
Clean (referring to recovery)	In remission, in recovery, free from substance use

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- “Learning to stand in somebody else’s shoes, to see through their eyes, that’s how peace begins. And it’s up to you to make that happen. Empathy is a quality of character that can change the world.”

  – Barack Obama

Their Fatal Attractions and The Grip of Addiction

Substance Use Disorders

Sometimes you can only find Heaven by slowly backing away from Hell.” – Carrie Fisher

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To understand the pain connected with addictive behavior, one must first understand the pleasure side of these activities.

Pete Hamill (1994) captured this in his autobiography, A Drinking Life" he writes …

"The culture of drink endures because it offers so many rewards: confidence for the shy, clarity for the uncertain, solace to the wounded and lonely".

Nora Volkow (2010) states when asked… "Why do people take drugs?"

"First, they take drugs to feel good, to enhance their sense of pleasure. "For example, with stimulants such as cocaine, the high is followed by feelings of power, self-confidence, and increased energy. In contrast, the euphoria caused by opiates such as heroin is followed by feelings of relaxation and satisfaction. Second are people who suffer from anxiety and stress-related disorders. They maybe attracted to intoxicants to feel better. The third temptation to use drugs is to do better, such as to enhance athletic or work performance."

Thirty-six hours
Rolling in pain
Praying to someone
Free me again
Oh I'll be a good boy
Please make me well
I promise you anything
Get me out of this hell

~John Lennon
Cold Turkey

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Substance Use Disorders (SUD) are Brain Diseases

"From a neurobiological perspective, drug addiction is a disease of the brain and the associated abnormal behavior is the result of dysfunction of brain tissue."

~Christopher Cavacuiti – "*Principles of Addiction Medicine: The Essentials*"

American Society of Addiction Medicine (ASAM)

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

ABCDE

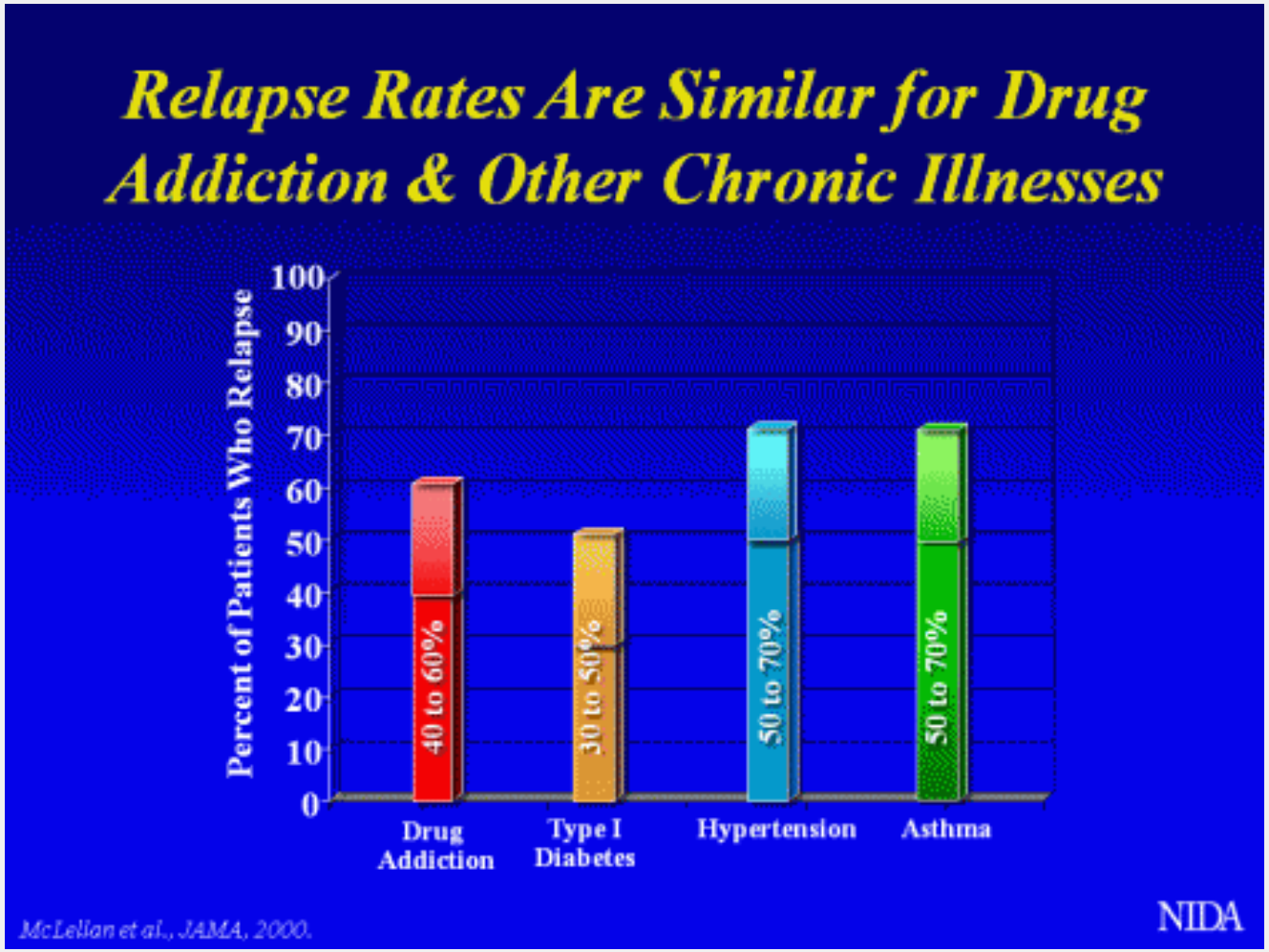
- Inability to consistently Abstain
- Impairment in Behavioral control
- Craving
- Diminished recognition of problems with behaviors and relationships
- Dysfunctional emotional response

Chronic Disease

- Discontinuation of treatment, as for other chronic diseases, is likely to result in reoccurrences
- A reoccurrence should not be interpreted as a failure of treatment, but instead as a temporary setback (can be tolerance to an effective treatment)

Chronic Disease

Rates of reoccurrence and recovery in the treatment of addiction are very similar to those of other chronic medical diseases



The idea that somehow, someday he will control and enjoy his drinking is the great obsession of every abnormal drinker.” p.30

Big Book of Alcoholics Anonymous

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Genetic Vulnerability to Addiction

- Family History - Genetic Factors – it is estimated that 40% to 60% of the vulnerability to addiction is attributed to genetic factors
- Environmental – “May include low socioeconomic class, poor parental support and drug availability” – ACE scores

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Prevalence of Alcohol Use in US – More Common than Most Think

- Lifetime exposure to alcohol is high, with nearly 88% of the US population reporting using alcohol at least once in their lifetime.
- Lifetime prevalence of developing an AUD is approximately 13%.
- There is a strong correlation with the age at which drinking begins

~ Van Wormer, Davis(2014) “Addiction Treatment: A Strengths Perspective”

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Prevalence in US – More Common than Most Think

- According to the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2015:

  24 million Americans have used illicit drugs

- Out of those

  19.6 million have had a SUD in the preceding year

- 1 in 10 Americans has a drug use disorder

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov

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The World Health Organization (WHO) (2014)

- *Many more people suffer from alcohol use disorders compared to drug use disorders, and both types are more common in men than women*
- *Alcohol causes the highest demand for treatment of substance use disorders in most world regions except the Americas, where treatment demand is mainly for cocaine use disorders.*
- *About 3.3 million net deaths, or 5.9 % of all global deaths, were attributable to alcohol consumption*

World Health Organization

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In my lowest moments, the only reason I didn't commit suicide was that I knew I wouldn't be able to drink any more if I was dead.

~ERIC CLAPTON, *Clapton: The Autobiography*

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Medical Consequences of Substance Use

CDC - Short-Term Health Risks

- *Excessive alcohol use has immediate effects that increase the risk of many harmful health conditions. These are most often the result of binge drinking and include the following:*
  - Injuries, such as motor vehicle crashes, falls, drownings, and burns.
  - Violence, including homicide, suicide, sexual assault, and intimate partner violence.
  - Alcohol poisoning, a medical emergency that results from high blood alcohol levels.
  - Risky sexual behaviors, including unprotected sex or sex with multiple partners. These behaviors can result in unintended pregnancy or sexually transmitted diseases, including HIV.
  - Miscarriage and stillbirth or fetal alcohol spectrum disorders (FASDs) among pregnant women

NIDA Alcohol's Effects on the Body

- **Brain:**
  Alcohol interferes with the brain's communication pathways, and can affect the way the brain looks and works.
- **Heart:**
  Drinking a lot over a long time or too much on a single occasion can damage the heart, causing problems including:
  - Cardiomyopathy – Stretching and drooping of heart muscle
  - Arrhythmias – Irregular heart beat
  - Stroke
  - High blood pressure
- **Liver:**
  Heavy drinking takes a toll on the liver, and can lead to a variety of problems and liver inflammations including:
  - Steatosis, or fatty liver
  - Alcoholic hepatitis
  - Fibrosis
  - Cirrhosis

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Short Term Medical Consequences of Drug Use

Short-term effects can range from changes in appetite, wakefulness, heart rate, blood pressure, and/or mood to heart attack, stroke, psychosis, overdose, and even death. These health effects may occur after just one use.

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Longer-term Effects of Drug Use

- Can include heart or lung disease, cancer, mental illness, HIV/AIDS, hepatitis, and others.
- Long-term drug use can lead to addiction.

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8 Things a Primary Care Doctor Should Know

about working with people with Substance Use Disorders (SUDs)

1. They (patients with SUDs) are not, by definition, bad people.
If your patient thinks you will judge her because of her use, she may not share important information

2. The most important thing you can do is ask what, and how much, they are using.
If you are wishy-washy about asking these questions, you communicate that you don't want to know.

3. Just as there are diagnostic tests for physical illnesses, there are research-based screening and assessment instruments for substance use.
Adopt a set of standard screens for alcohol, drug, and tobacco use

4. Long-term substance use can alter your patient's brain in ways that make it difficult to discontinue use.
Given this, stopping or reducing use is going to require more than willpower

5. Treatment for SUDs is effective.
You can be optimistic when faced with a patient with an SUD

6. Once a patient screens positive for a substance use problem, a "warm handoff" to a trained clinician is critical.
If possible, directly introduce your patient to a clinician with the time and training to address an SUD

7. SUDs are often accompanied by other psychiatric disorders or physical health problems.
Now that you know about your patient's substance use, you can determine if it is linked to other conditions

8. An SUD is usually a chronic, rather than acute, condition.

Your ongoing relationship with your patient makes you the ideal person to monitor substance use and refer to specialty treatment as needed

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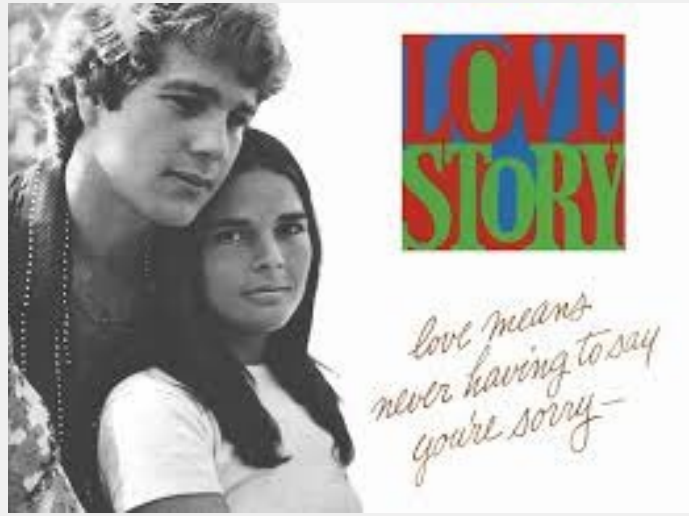
Where Do I (We) Begin?

Screening, Diagnosing

Assessment

Problem Identification

LOC and Referrals



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- Primary care settings have become the gateway to the behavioral health system.
- *Stigma* is the primary persistent barrier to high quality integrated SUD services. (NAHC Policy Paper, Aug 2018)
- Feeling judged diverts patients from asking for help.
- Integration

"Delia, I'd like you to meet one of my oldest and dearest friends."

SCREENING

To truly be committed to a life of honesty, love and discipline, we must be willing to commit ourselves to reality." *— John Bradshaw (1988) "Healing the Shame that Binds You"*

Screening

- Screening is a promising solution for decreasing negative outcomes associated with alcohol use.

- If we don't ask, they assume that we don't want to know.

AUDIT-C Plus 2

In the past 3 months...

1. How often did you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month		2-3 times a week	4+ times a week
	0	1	2		3	4
2. How many drinks containing alcohol did you have on a typical day when you were drinking?	Never	1 or 2 drinks	3 or 4 drinks	5 or 6 drinks	7, 8 or 9 drinks	10 or more drinks
	0	0	1	2	3	4
3. How often did you have **5 or more** drinks on one occasion?	Never	Less than monthly	Monthly		Weekly	Daily or almost daily
	0	1	2		3	4
4. How often have you used marijuana?	Never	Not monthly	Monthly		Weekly	Daily or almost
	0	1	2		3	4
5. How often have you used an illegal drug or a prescription medication for non-medical reasons*?	Never	Less than monthly	Monthly		Weekly	Daily or almost daily
	0	1	2		3	4

* if patient needs further explanation, "for example, for the feeling or experience it caused."

Patients who screen positive with scores below 7 are appropriate for brief intervention
Patients with high-positive scores (7-10) should have symptoms of *alcohol* use disorders elicited. They are also appropriate for ongoing brief counseling in primary care

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What is SBIRT?

Screening to identify patients at-risk for developing substance use disorders.

Brief **I**ntervention to raise awareness of risks and consequences, internal motivation for change, and help set healthy lifestyles goals.

Referral to **T**reatment to facilitate access to specialized treatment services and coordinate care between systems for patients with higher risk and/or dependence.

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SBIRT is Early Intervention…Not Looking for Addiction

- Looking for unhealthy substance use patterns
- Looking for opportunities for intervention
  - Meeting people where they are at

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Role Play

Patient name: _____

Date of birth: _____

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ○ Never ○ Currently ○ In the past

I	II	III	IV
0-3	4-9	10-13	14+

- Add the numbers associated with the corresponding answers **plus the total from the AUDIT C (3 alcohol questions on initial screen)**
- Score of 4-7 = No Further Action
- Score of 8-15 = At Risk; Conduct Brief Intervention (BI)
- Score of 16-24 = Moderate AUD; Conduct Brief Treatment (BT)
- Score of 25+ = Severe AUD; Referral to Treatment (RT)

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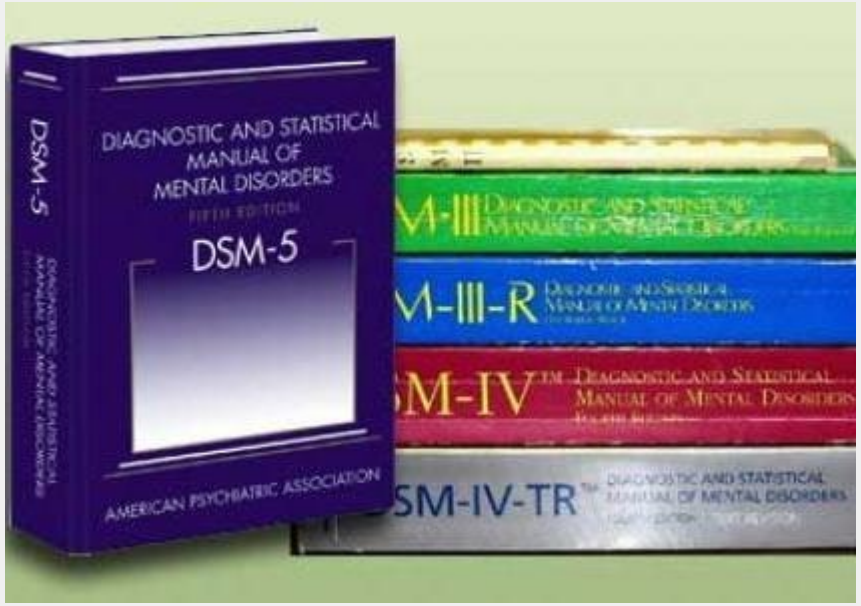

Diagnosing

Eliciting the Signs and Symptoms

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Diagnosis - DSM-5 Criteria

TABLE 4.4 *DSM-5* Criteria for Substance Use Disorder

A *mild* substance use disorder is diagnosed if 3 of the following criteria are met. People meeting 4 or 5 criteria are classified as having *moderate* substance use disorder, and *severe* substance use disorder is diagnosed in cases where 6 or more of the criteria are met.

1. Taking the substance in larger amounts or for longer than you meant to
2. Wanting to cut down or stop using the substance but not managing to
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at work, home, or school because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational, or recreational activities because of substance use
8. Using the substance again and again, even when it puts you in danger
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance
10. Needing more of the substance to get the effect that you want (tolerance)
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance

Genetic Predisposition

- Biology alone does not determine if we will develop an SUD
- It does set our trigger level

The take home –ask about Family History !!

Alcohol Symptom Checklist			Other Drugs Symptom Checklist		
In the past three months, have you:			In the past three months, have you:		
1. Had times when you ended up drinking more, or for longer than you intended?	Y	N	1. Had times when you ended up using drugs more, or for longer than you intended?	Y	N
2. More than once, wanted to cut down or stop drinking, or tried to, but couldn't?	Y	N	2. More than once, wanted to cut down or stop using drugs, or tried to, but couldn't?	Y	N
3. Spent a lot of time drinking, being sick after drinking, or getting over the after-effects?	Y	N	3. Spent a lot of time using drugs, being sick after use, or getting over the after-effects?	Y	N
4. Experienced craving — a strong need, or urge, to drink?	Y	N	4. Experienced craving — a strong need, or urge, to use drugs?	Y	N
5. Found that drinking — or being sick from drinking — often interfered with taking care of your home or family, caused job troubles or school problems?	Y	N	5. Found that using drugs — or being sick from using drugs — often interfered with taking care of your home or family, caused job troubles or school problems?	Y	N
6. Continued to drink even though it was causing trouble with your family or friends?	Y	N	6. Continued to use drugs even though it was causing trouble with your family or friends?	Y	N
7. Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?	Y	N	7. Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to use drugs?	Y	N
8. More than once, gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area or having unsafe sex)?	Y	N	8. More than once, gotten into situations while or after using drugs that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area or having unsafe sex)?	Y	N
9. Continued to drink even though it was making you feel depressed or anxious or adding to another health problem, or after having had a memory blackout?	Y	N	9. Continued to use drugs even though it was making you feel depressed or anxious or adding to another health problem, or after having had a memory blackout?	Y	N
10. Had to drink much more than you once did to get the effect you want, or found that your usual number of drinks had much less effect than before?	Y	N	10. Had to use drugs much more than you once did to get the effect you want, or found that your usual number of drinks had much less effect than before?	Y	N
11. Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, irritability, anxiety, depression, restlessness, nausea or sweating, or sensed things that were not there?	Y	N	11. Found that when the effects of drugs were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, irritability, anxiety, depression, restlessness, nausea or sweating, or sensed things that were not there?	Y	N
TOTAL:			TOTAL:		

Interpreting Symptom Checklist Results

2-3 symptoms indicate mild alcohol and/or other drug use disorder.

4-5 symptoms indicate moderate alcohol and/or other drug use disorder.

6+ symptoms indicate severe alcohol and/or other drug use disorder.

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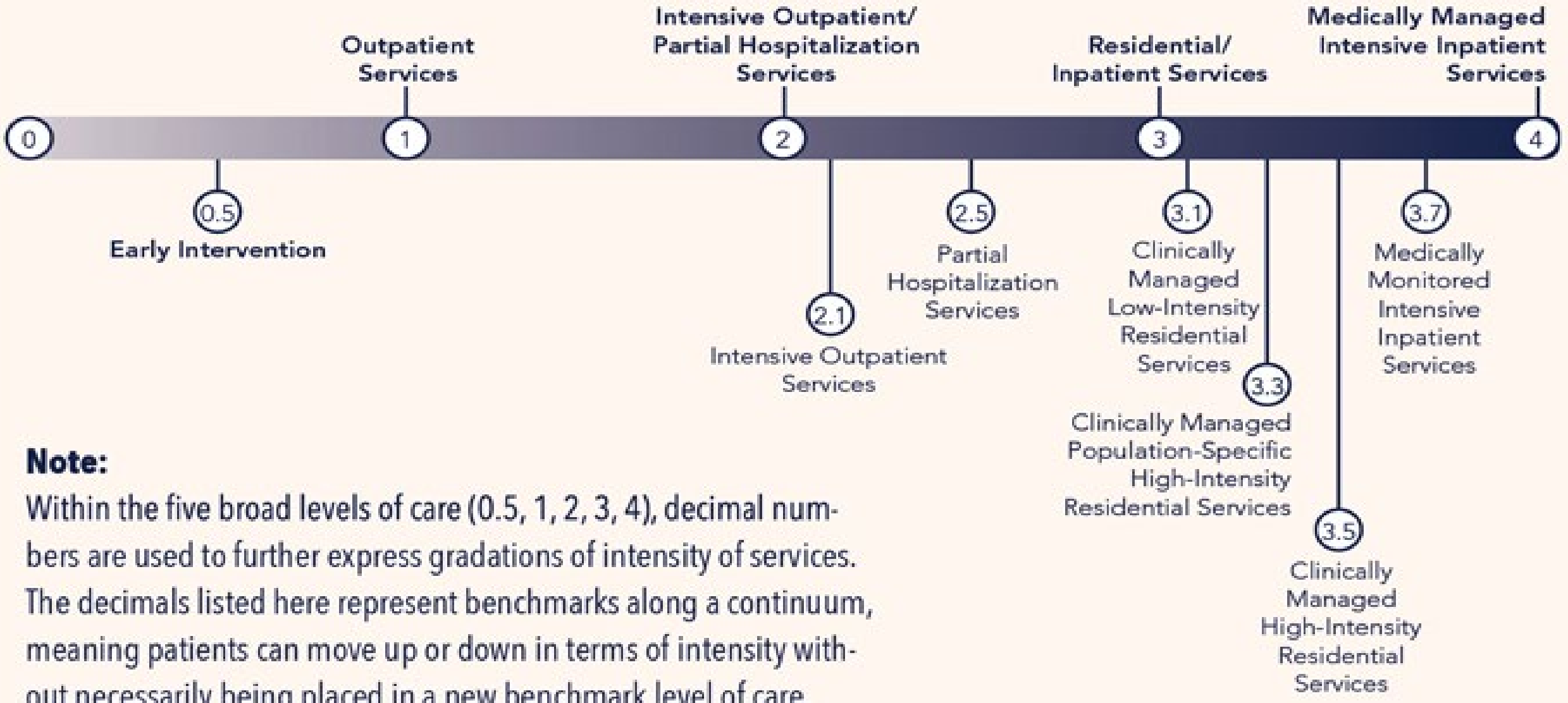
Diagnosis

ASAM Overview and Dimensional Assessment

A Holistic Biopsychosocial Assessment


Level 4
Medical Detox - Hospital Based
Level 3.7
Detox
Level 3.5
Inpatient
Level 3.1
Residential
Level II.5
Partial Hosp or Day Tx – Minimum 20 Hours Per Week
Level 2.1
Intensive Outpatient - 10 to 19 Hours Per Week
Level 1 Outpatient – 1 to 9 Hours Per Week
Education Early Intervention

REFLECTING A CONTINUUM OF CARE



Note:

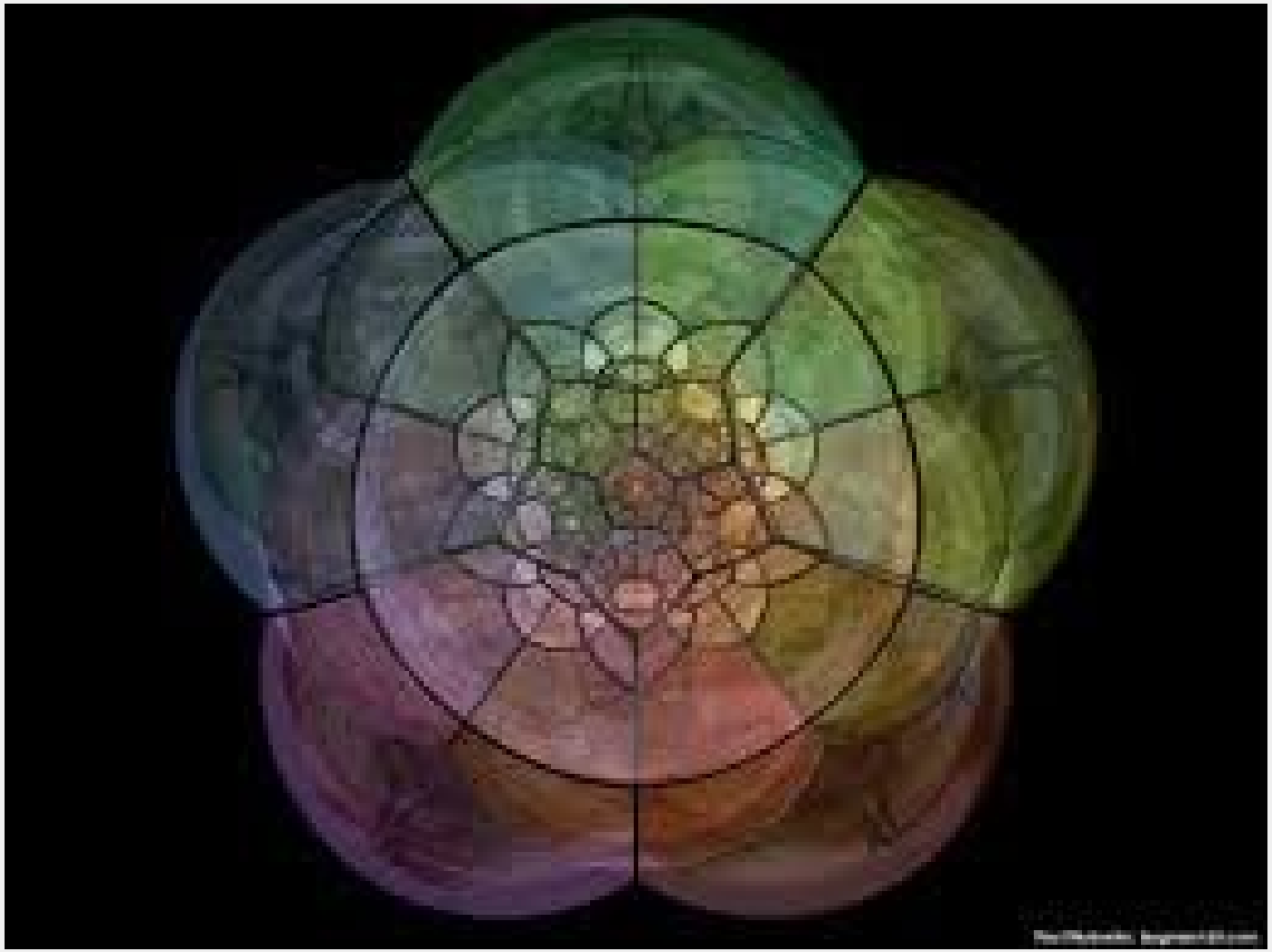
Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.

ASAM PLACEMENT CRITERIA

LEVELS OF OF CARE CRITERIA	1. OUTPT	2. INTENSIVE OUTPT	3. MED MON INPT	4. MED MGD INPT
Intoxication/ Withdrawal	no risk	minimal	some risk medical	severe risk 24-hr acute
Medical Complications	no risk	manageable	monitoring required	med. care required
Psych/Behav Complications	no risk	mild severity	moderate	24-hr psych. & addiction Tx required
Readiness For Change	cooperative	cooperative but requires structure	high resist., needs 24-hr motivating	
Relapse Potential	maintains abstinence	more symptoms, needs close monitoring	unable to control use in outpt care	
Recovery Environment	supportive	less support, w/ structure can cope	danger to recovery, logistical incapacity for outpt	

ASSESSMENT DIMENSIONS	ASSESSMENT AND TREATMENT PLANNING FOCUS
1. Acute intoxication and/or withdrawal potential	Assessment for intoxication or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued addiction services
2. Biomedical conditions and complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services
3. Emotional, behavioral, or cognitive conditions and complications	Assess and treat co-occurring diagnostic or subdiagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services
4. Readiness to change	Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change.
5. Relapse, continued use, or continued problem potential	Assess readiness for relapse prevention services and teach where appropriate. Identify previous periods of sobriety or wellness and what worked to achieve this. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies.
6. Recovery environment	Assess need for specific individualized family or significant others, housing, financial, vocational, educational, legal, transportation, child care services. Identify any supports and assets in any or all of the areas.

DIMENSIONAL ASSESSMENT



Brief Assessment

Application:
CHC
MHC

Great for a busy practice and to get information to the team succinctly (SWCHC)

INTEGRATED CLINICAL ASSESSMENT BRIEF

Client Name: **DOB:**
Date:

PRESENTING PROBLEM / REASON FOR REFERRAL:

Primary Diagnosis:
Other Diagnoses:
Rule Out:

DIMENSIONAL ASSESSMENT:

Dimension		Risk Rating 0-4	Level of Care:
Dim 1: Acute Intoxication and/or withdrawal potential	*What Substances are of greatest concern? Last use? Other substances used? Method of use? History of withdrawal? History of seizures? Risk of current withdrawal? Diagnoses?*		
Dim 2: Biomedical Conditions and Implications	*How is their health? Any acute/chronic medical problems? Ability to access (health) care for those medical issues? Immunization? HIV/STI/pregnancy risk? Nutrition?*		
Dim 3: Emotional Behavioral or cognitive conditions and complications	*History of any mental health concerns? Any current mental health symptoms? Do they have a diagnosis and by whom? Psychotropic medications? Past history of Mental Health treatment? History of suicide or harm to others? How functional are they?*		
Dim 4: Readiness to change	*Individuals (Patients) thoughts about being here? Long term plan for substance use? Thoughts about overall situation and plan to address? What does the patient think that they need? What is the patient willing to do? What is important to the patient? Internal vs. external motivation to change?*		
Dim 5: Relapse, continued use, or continued problem potential	*How long can the patient stay substance free? How are they able to stay sober/clean? What skills does the patient have? Can the patient stay substance free if they so desire? Does the patient have prior successes in recovery?*		
Dim 6: Recovery Environment	*Who is in the patient's life? What is important to the patient? Is there any legal/child welfare involvement? (current) family issues? Patients education level? Concerns/issues related to parenting? Type*		

Brief Assessment

Page 2

INTEGRATED CLINICAL ASSESSMENT BRIEF

	of support and from whom does the patient have? How is the patient connected to the community, culture, etc.? What is the patients current housing? Employment? Financial situation?		

Goals for treatment and recovery:

Dimension 1:

Dimension 2:

Dimension 3:

Dimension 4:

Dimension 5:

Dimension 6:

_____ _____

Clinician Name Date

Signature: Date:

Clinician and Credentials:

LOC and Referrals…what is next?

LEVEL 0.5 Early Intervention	No withdrawal risk	None or very stable	None or very stable
OTP – LEVEL 1 Opioid Treatment Program	Physiologically dependent on opioids and requires OTP to prevent withdrawal	None or manageable with outpatient medical monitoring	None or manageable in an outpatient structured environment
LEVEL 1 Outpatient Services	Not experiencing significant withdrawal, or at minimal risk of severe withdrawal. Manageable at Level 1-WM (See withdrawal management criteria)	None or very stable, or is receiving concurrent medical monitoring	None or very stable, or is receiving concurrent mental health monitoring
LEVEL 2.1 Intensive Outpatient Services <20 hrs wk	Minimal risk of severe withdrawal, manageable at Level 2-WM (See withdrawal management criteria)	None or not a distraction from treatment. Such problems are manageable at Level 2.1	Mild severity, with potential to distract from recovery; needs monitoring
LEVEL 2.5 Partial Hospitalization Services >20 hrs wk	Moderate risk of severe withdrawal manageable at Level 2-WM (See withdrawal management criteria)	None or not sufficient to distract from treatment. Such problems are manageable at Level 2.5	Mild to moderate severity, with potential to distract from recovery; needs stabilization
LEVEL 3.1 Clinically Managed Low-Intensity Residential Services	No withdrawal risk, or minimal or stable withdrawal. Concurrently receiving Level 1-WM (minimal) or Level 2-WM (moderate) services (See withdrawal management criteria)	None or stable, or receiving concurrent medical monitoring	None or minimal; not distracting to recovery. If stable, a co-occurring enhanced program is required
LEVEL 3.3	At minimal risk of severe withdrawal. If		Mild to moderate severity; needs structure to focus on recovery. Treatment should be designed to address

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IMMEDIATE NEED PROFILE

Work through the six dimensions, checking "yes" or "no" to these questions and obtaining from the patient just sufficient data to assess for immediate needs.

DIMENSION 1: Acute Intoxication and/or Withdrawal Potential

a. Currently having severe, life-threatening, and/or similar withdrawal symptoms? _____No _____Yes

DIMENSION 2: Biomedical Conditions and Complications

a. Any current, severe physical health problems (eg, bleeding from mouth or rectum in past 24 hours; recent, unstable hypertension; recent, severe pain in chest, abdomen, head; significant problems in balance, gait, sensory, or motor abilities not related to intoxication)? _____No _____Yes

DIMENSION 3: Emotional, Behavioral, or Cognitive Conditions and Complications

a. Imminent danger of harming self or someone else (eg, suicidal ideation with intent, plan, and means to succeed; homicidal or violent ideation; impulses and uncertainty about ability to control impulses, with means to act on)?
_____No _____Yes

b. Unable to function in activities of daily living or care for self with imminent, dangerous consequences (eg, unable to bathe, feed, groom, and care for self due to psychosis, organicity, or uncontrolled intoxication with threat to imminent safety of self or others as regards death or severe injury)?
_____No _____Yes

DIMENSION 4: Readiness to Change

a. Does patient appear to need alcohol or other drug treatment/recovery and/or mental health treatment, but ambivalent or feels it unnecessary (eg, severe addiction, but patient feels controlled use still OK; psychotic, but blames a conspiracy)? _____No _____Yes

b. Patient has been coerced, mandated, or required to have assessment and/or treatment by mental health court or criminal justice system, health or social services, work or school, or family or significant other? _____No _____Yes

DIMENSION 5: Relapse, Continued Use, or Continued Problem Potential

a. Is patient currently under the influence and/or acutely psychotic, manic, suicidal? _____No _____Yes

b. Is patient likely to continue to use or have active, acute symptoms in an imminently dangerous manner, without immediate secure placement? _____No _____Yes

c. Is patient's most troubling presenting problem(s) that brings the patient for assessment dangerous to self or others? (See examples in Dimensions 1, 2, and 3) _____No _____Yes

DIMENSION 6: Recovery Environment

a. Are there any dangerous family, significant others, living, work, or school situations threatening patient's safety, immediate well-being, and/or sobriety (eg, living with a drug dealer; physically abused by partner or significant other; homeless in freezing temperatures)? _____No _____Yes

KEY

"Yes" answers to questions **1, 2, and/or 3 require** that the patient immediately receive medical or psychiatric care for evaluation of need for acute, inpatient care.

"Yes" answers to questions **4a and b, or 4b alone, require** the patient to be seen for assessment within 48 hours, and preferably earlier, for motivational strategies, unless patient is imminently likely to walk out and needs a more structured intervention.

For a "yes" answer to question **5a**, assess further for need for immediate intervention (eg, taking keys of car away; having a relative/friend pick patient up if severely intoxicated and unsafe; evaluate need for immediate psychiatric intervention).

"Yes" answers to questions **5b, 5c, and/or 6, without any "yes" answer in questions 1, 2, or 3, require** that the patient be referred to a safe or supervised environment (eg, shelter, alternative safe living environment, or residential or subacute care setting, depending on level of severity and impulsivity).

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Problem Identification / Treatment Planning

Treatment Plans in General

In direct relation to identified problems:

SMART Goal

- Specific (slice of the problem)
- Measurable (know when something has changed)
- Achievable (realistic)
- Relevant (has meaning to the patient)
- Time-bound (short term is better to see progress and enhance motivation)

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Where does the treatment plan live and breath?

This depends on your EHR, agency policy, rule, and preference.

- Could be a separate document
- Could be in the progress note
- Could be on master problem list
- In the patients awareness!

Follow-up each session

Treatment / Care Plans – Maintain Connection!

- Shared accountability
  - All disciplines check in with the progress of the patient
  - All disciplines continuously update the care plan
  - Provides opportunity for cross training in positions
  - Leads to a more definitive sharing and understanding of each team members roles

Specific Areas of Focus for Recovery

Cravings, Stopping Use is Not Enough, Recurrence, Emotional Regulation

Cravings

"First, they take drugs to feel good, to enhance their sense of pleasure. "For example, with stimulants such as cocaine, the high is followed by feelings of power, self-confidence, and increased energy. In contrast, the euphoria caused by opiates such as heroin is followed by feelings of relaxation and satisfaction. Second are people who suffer from anxiety and stress-related disorders. They maybe attracted to intoxicants to feel better. The third temptation to use drugs is to do better, such as to enhance athletic or work performance."

Nora Volkow

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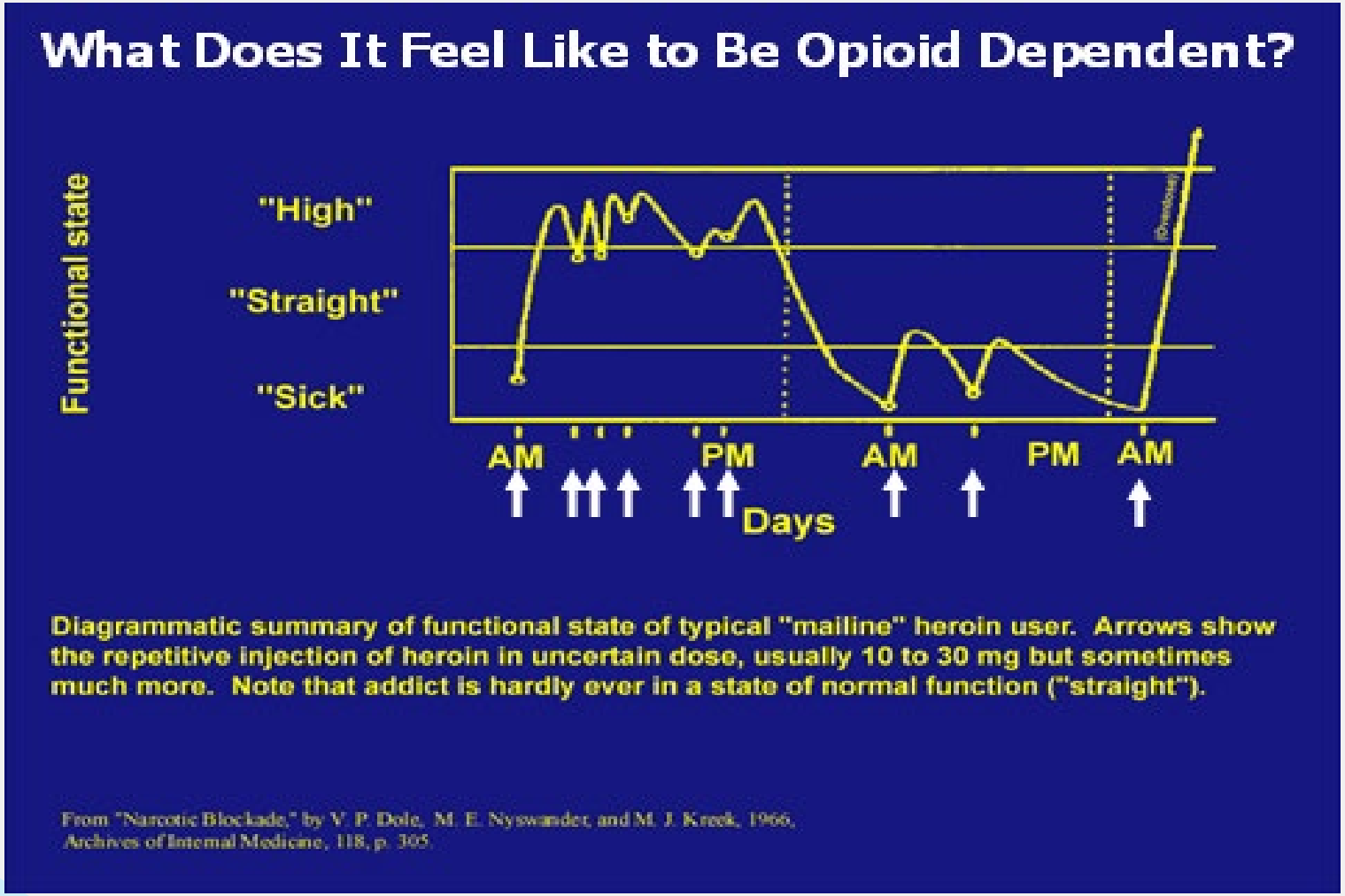
- Cravings are a programmed response to environmental signals that have been connected to use through experience. The brain is still in healing and reacts along the same neuropathways when use was active.

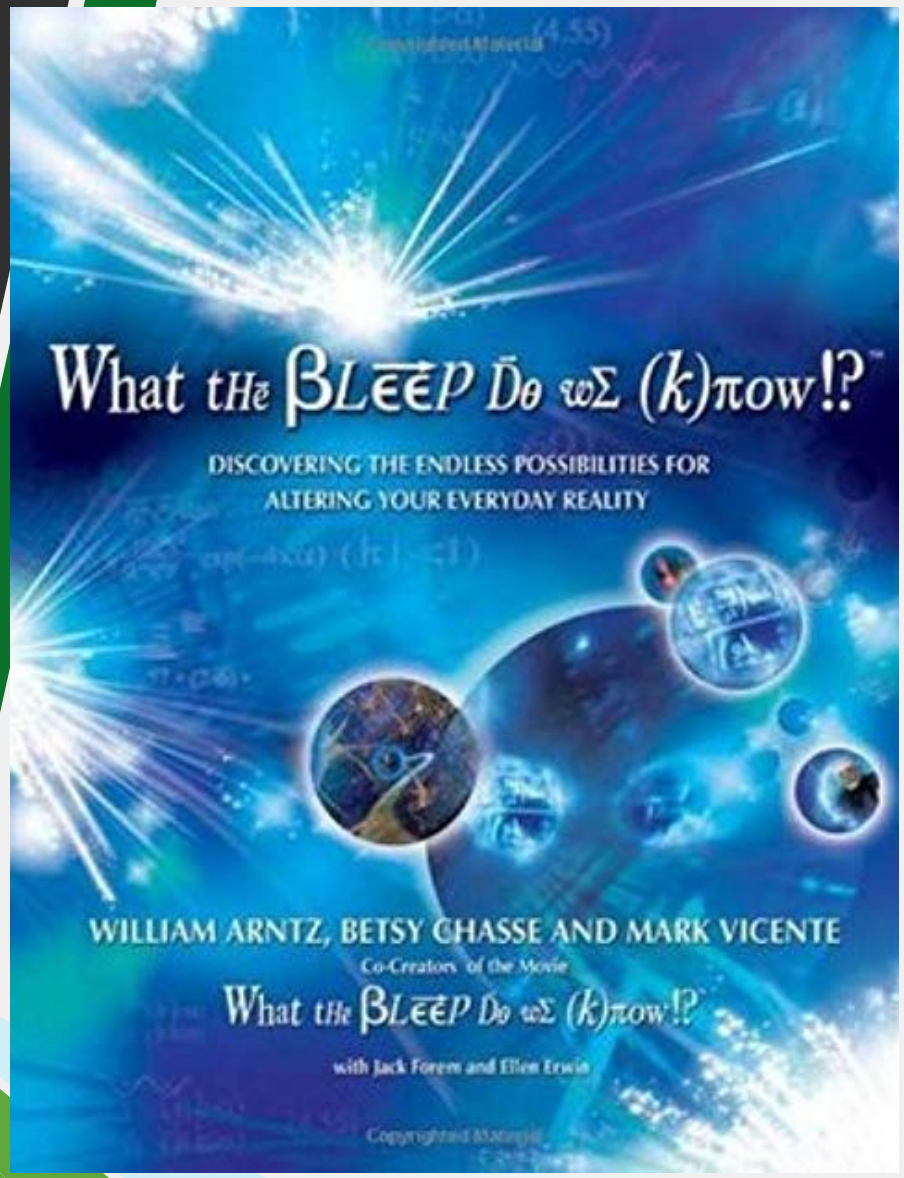
- The brain cannot differentiate between reality and fantasy

Recalling:

- Event
- Ritual
- Time Period
- Music

Life of a an individual with Heroin Addiction





What is our purpose? Where do we come from? What is reality?

What the Bleep Do We Know!? takes viewers on a journey to unlock the secrets of life. Follow Amanda (Academy Award-winner Marlee Matlin), a divorced, middle-aged woman who is thrust into a world where science and spirituality converge. As her entire concept of reality is challenged, yours will be too. See for yourself why this groundbreaking movie became one of the most compelling and talked about films of the last decade.

Link is on the MPCA Website

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Stopping Use is Not Enough

Why?

- Abstinence without skills in like circling the drain….
- Primary drivers to relapse are unwanted emotional states and stress
- Rarely do children, or even adults, learn how to self sooth or regulate emotions until after painful consequences, which are part of the human experience – no one is exempt
- Pills alone are not the answer…… but can certainly be a part of it

Recurrence or Return to Use Prevention

Skill Sets:

- Relapse Prevention Plan
- Trigger Identification / Early Warning Signs
- Symptom Management
    - Craving - Urges
    - Sleeplessness
    - Irritability
- Recovery Plan – Many Roads One Journey
    - Support system: Physical, Emotional, Spiritual
    - Establish new rituals
    - Nutrition
    - Relationships
    - Self Care
- Play it all the way through - consequences

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The Power of Brief and Other Interventions

Treating SUD Like the Medical Condition that it is

Old School SUD Treatment	Medical Treatment
"Addiction is a disease."	Views addiction as a "chronic relapsing medical disorder."
Treatment begins when patient has already made behavior change or "is ready" make behavior change.	Treatment begins at or before the time when symptoms are interfering with patient health and functioning.
Views an increase in symptoms as a sign to withhold treatment.	Views an increase in symptoms as a reason to apply more or different treatment.
Not always 100% effective	Not always 100% effective
Blames patient for "failing" in treatment.	Blames treatment for failing patient.

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Brief therapy Works

Research shows 40-45 percent of depressed patients have large gains within the first two to four sessions

(Doane, Feeny, & Zoellner, 2010)

Why Brief Therapy?

- In a naturalistic study of over 9,000 patients seeking therapy, the modal number of psychotherapy visits was one (Brown & Jones, 2004)
- Clients seek treatment when psychological distress is high and stop coming when distress level drops; for most this is within 5 visits (Brown & Jones, 2004)
- 30 to 40 percent drop out of treatment without consulting their therapist (Talmon, 1990, Olfson et.al., 2009) *

Studies of the “dose-effect” Relationship

- Studied the number of therapy sessions received relative to the amount of clinical benefit experienced
  - 15 percent of clients are clinically improved before they arrive for the first session
  - 50 percent of all clients are clinically improved by the 8th session
  - To get 75 percent of clients clinically improved requires at least 26 sessions

Conclusion: Treatment beyond session 8 is no where near as cost effective as the first 8 sessions

(Howard, Kopta, Krause & Orlinsky, 1986)

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Features of Brief Interventions

- Treat every session as if it is the last session.
- Brief therapy can achieve its' goals before the client's natural tendency to drop out is realized.
- The change process begins in the first visit.
- Talking in rapid change terms is likely to induce rapid change.

Features of Effective Brief Interventions

- Clearly defined goals that are related to specific behavior change
- Active and empathetic therapeutic style
- Patients values and beliefs are incorporated into the intervention
- Measurable outcomes (utilizes rating systems, or other measures)
- Enhance patient's self efficacy
- Responsibility for change is with the patient

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“This is an addiction, this is an illness and there is help, but the help needs to be longstanding and ongoing.”

~Jamie Lee Curtis

Evidence Based Models

- Dialectical Behavioral Therapy (DBT)
- Mindfulness
- Mindfulness Based Stress Reduction (MBSR) and Relapse Prevention (MBRP)
- Cognitive Behavioral Therapy (CBT)
- Contingency Management
- Brief Therapies
  - Problem Solving Treatment (PST)
  - Focused Acceptance Commitment Therapy (FACT)
  - Motivational Interviewing (MI)

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Why Motivational Interviewing?

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Motivational Interviewing (MI) Research

- Support for empathy vs. confrontation in producing positive outcomes
- Support that it's as effective as other evidenced based approaches
- Support that it works in less time
- Support that the method of eliciting change talk is effective
- Support that it works particularly well for individuals that are angry and are least ready to change
- Change is a natural process
- A little motivation can lead to significant change
- Can be facilitated or sped up with brief interventions

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With MI Employees are HAPPIER with work !!

ASAM

American Society of Addiction medicine

"Specific attention is given…to motivational and engagement strategies, which are used in preference to confrontational approaches"

The Principles of Motivational Interviewing

- Express Empathy
- Support Self-Efficacy
- Roll with Resistance
- Develop Discrepancy

Five Assumptions in Motivational Interviewing

(Winarski, 2003)

1. Motivation is a state (a temporary condition), not a trait (a personality characteristic)
2. Resistance is not a force to be overcome, but a cue that we need to change strategies
3. Ambivalence is good
4. Our client should be an ally, rather than an adversary
5. Recovery and change/growth are intrinsic to the human experience

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1. **First Assumption:** Motivation is a State (a temporary condition), Not a Trait (a personality characteristic)

The Therapist Stance

- Must have at least a willingness to suspend an authoritarian role
- Explore client capacity rather than incapacity
- Have a genuine interest in the client's experience and perspective

Motivation:

- Resides within the person
- Part of an interpersonal process
- Fluctuates, dynamic, not static, can be increased and decreased
- Influenced by person's own belief in the ability to change
- Influenced by interviewer's expectation
- Can be evoked

Meeting People Where They Are

Meeting Them with the MI Style and Spirit

- Collaboration, not confrontation
- Respect for client autonomy and choice
- Affirming what they already know…It's up to them
- Sees a person's defensiveness or resistance as a natural and/or therapeutic process, not pathological

The Second Assumption: Resistance is Not a Force to be Overcome, but a Cue that We Need to Change Strategies

- Roll with Resistance
- Resistance is a signal to respond differently
- Resistance can be reframed slightly to create a new momentum toward change

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Resistance

What does Resistance look and feel like?

Arguing
Interrupting
Negative
Ignoring

What is it?

- A cue to change strategies
- A normal reaction to having freedom threatened
- An interpersonal process

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- When the music changes, so does the dance. - African proverb

Ways to Roll

- **Reflections** (stating the patient's statement to convey your effort to understand their point of view)
- **Shift focus** (changing the topic or focus to things the patient is less resistant to exploring and changing)
- **Reframe** (acknowledging what the patient has said, but offering a different perspective)
- **Coming alongside** (taking the side of no change as a way to foster the patient's ambivalence and elicit change talk)

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The Third Assumption: Ambivalence is Good

"Ambivalence is simultaneously wanting and not wanting something, or wanting both of two incompatible things. It has been human nature since the dawn of time."

— William R. Miller, Motivational Interviewing: Helping People Change

Ambivalence

- Normal in the process of change
- A common and defining human experience
- A precursor to positive behavioral change
- Can prevent movement toward change if it is not resolved
- Can be amplified and explored in order to resolve
- Resolving ambivalence is the key to change, but it cannot be forced

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Listener role:

Don’t try to persuade or fix anything. Don’t offer advice. Instead ask these four questions one at a time, and listen carefully to what the person says:

- Why would you want to make this change?
- If you did decide to make this change, how might you go about it in order to succeed?
- What are the three best reasons for you to do it?
- How important would you say it is for you to make this change, on a scale from 0 to 10, where 0 is not at all important, and 10 is extremely important? [
- And why are you at _____ rather than a lower number of 0?

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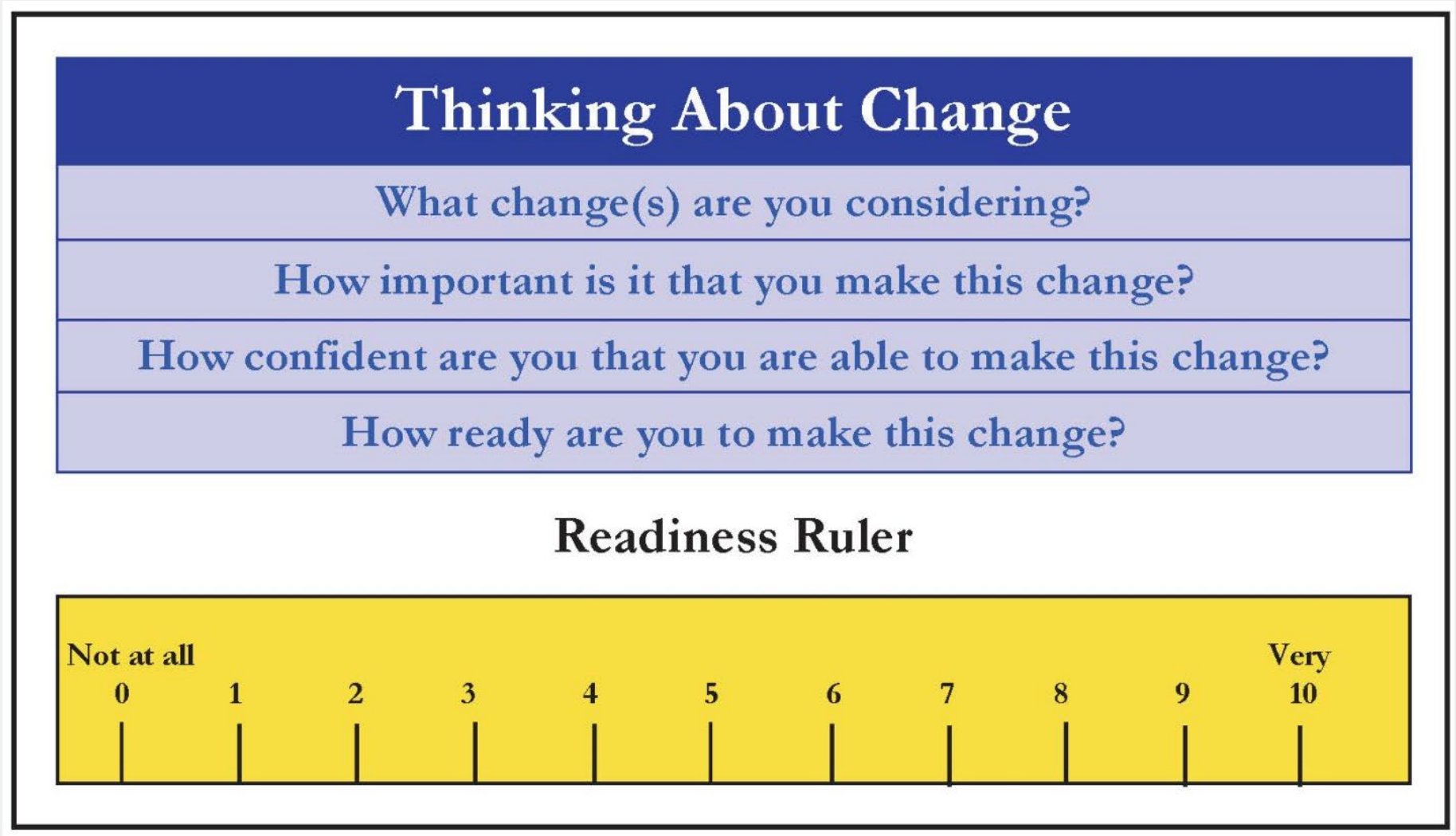

Utilize Rating Scales

The Fourth Assumption: Our Patient Should be an Ally, Rather Than an Adversary

MANY MINDS
MANY PERSPECTIVES
ONE ALLY

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The Clinician

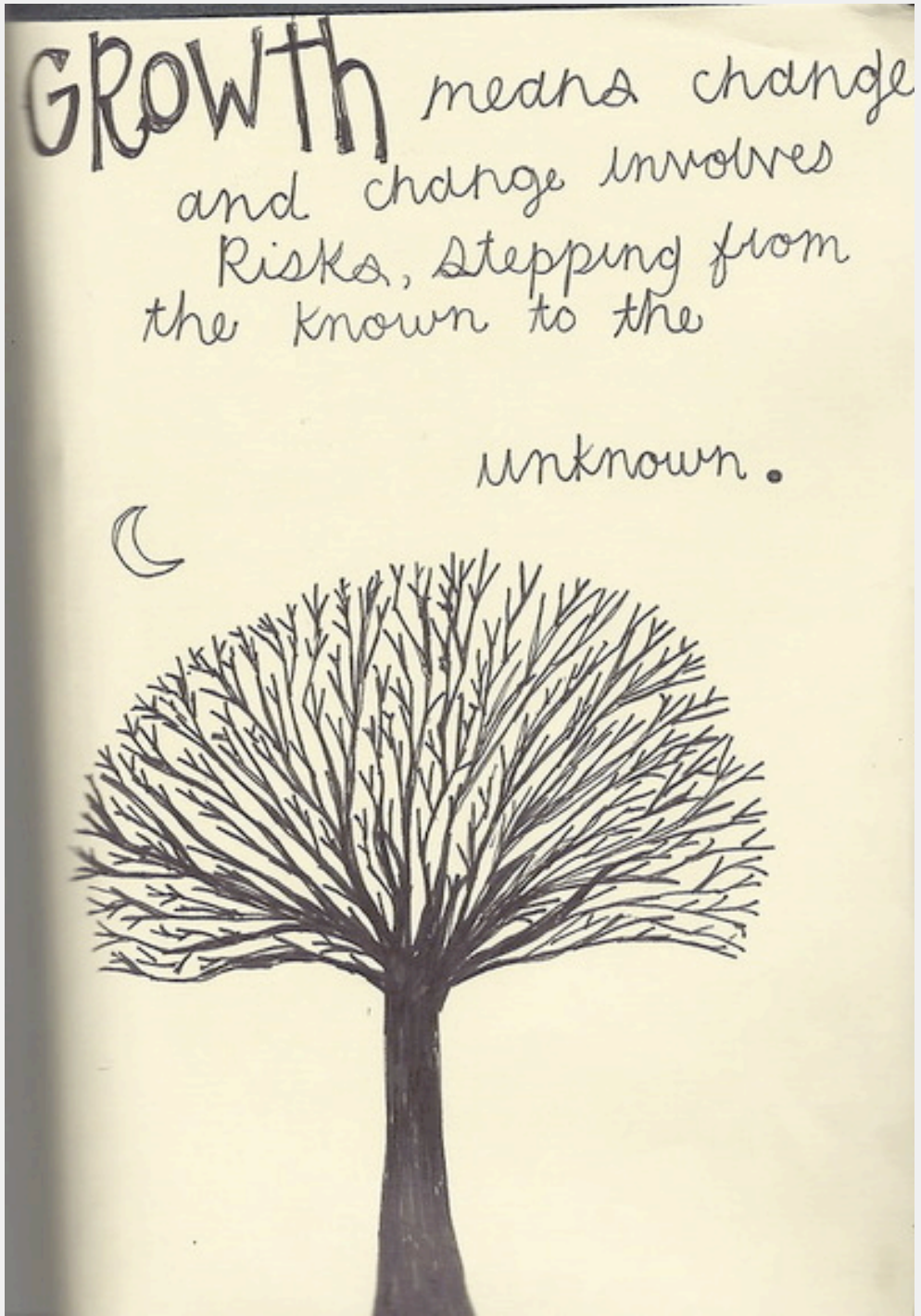
Is the significant determinant of treatment dropout, retention, adherence and outcome

~Miller & Rollnick

“Here is what we seek… a compassion that can stand in awe at what (people) have to carry rather than stand in judgement about how they carry it”

- *Fr. Greg Boyle, Tattoos on the Heart; the Power of Boundless Compassion*

The Fifth Assumption: Recovery and Change/Growth are Intrinsic to the Human Experience



“People possess substantial personal expertise and wisdom regarding themselves and tend to develop in a positive direction, given the proper conditions and support”

- Miller & Moyers, 2006

DARN-C

- Desire
- Ability
- Reason
- Need
- Confidence

OARS

- O = Open-Ended Question
- A = Affirm
- R = Reflect
- S = Summary

OARS are fundamental to engaging – general practice guidelines

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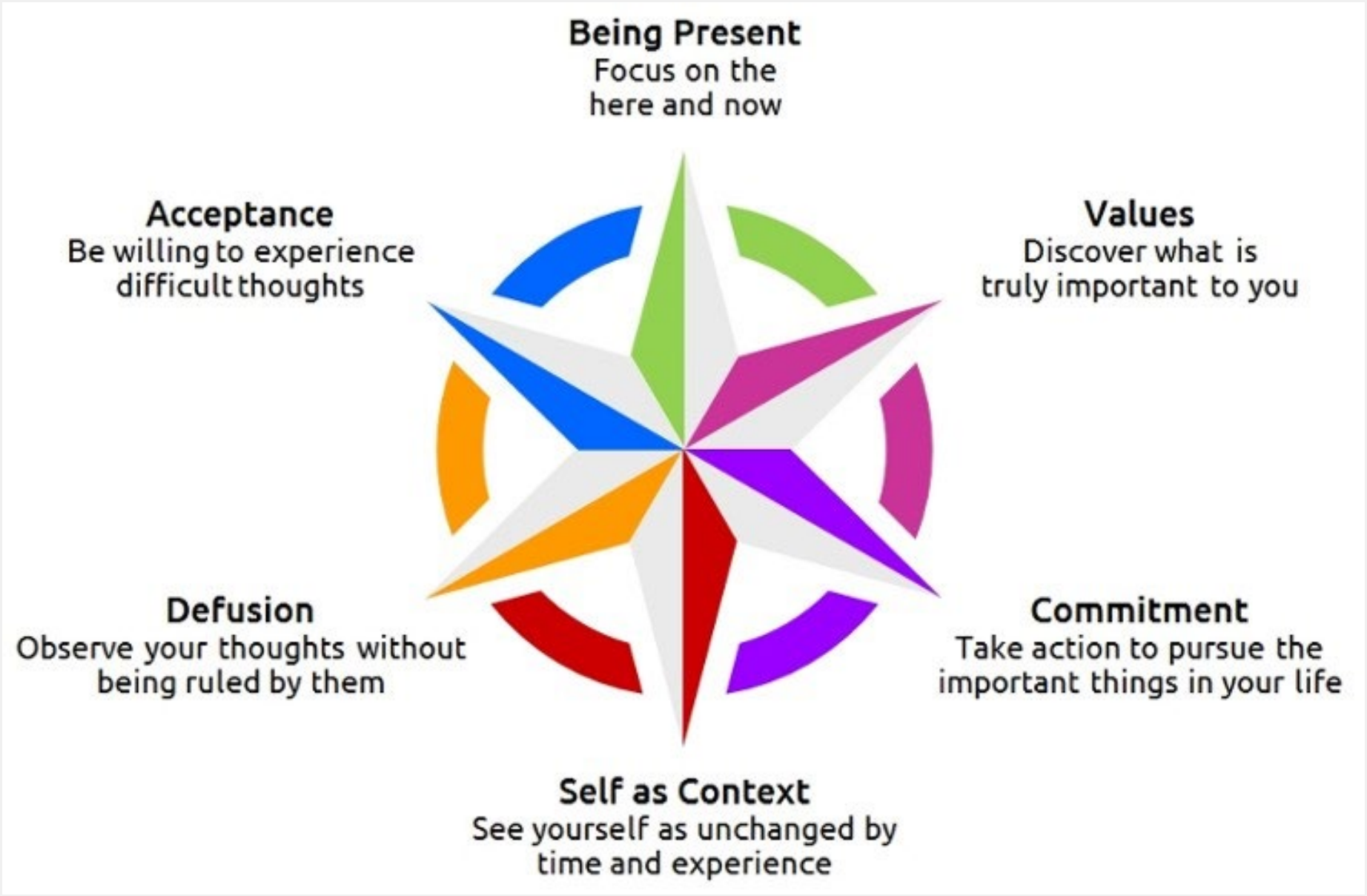
Acceptance and Commitment Therapy

We look for happiness in all the wrong places. Like a moth flying into the flame, we destroy ourselves in order to find temporary relief. Because weoften find such relief, we continue to reinforce old patterns of suffering and strengthen dysfunctional patters in the process.

~Pema Chodron


Being Present
Focus on the here and now
Acceptance
Be willing to experience difficult thoughts
Values
Discover what is truly important to you
Defusion
Observe your thoughts without being ruled by them
Commitment
Take action to pursue the important things in your life
Self as Context
See yourself as unchanged by time and experience

Being Present

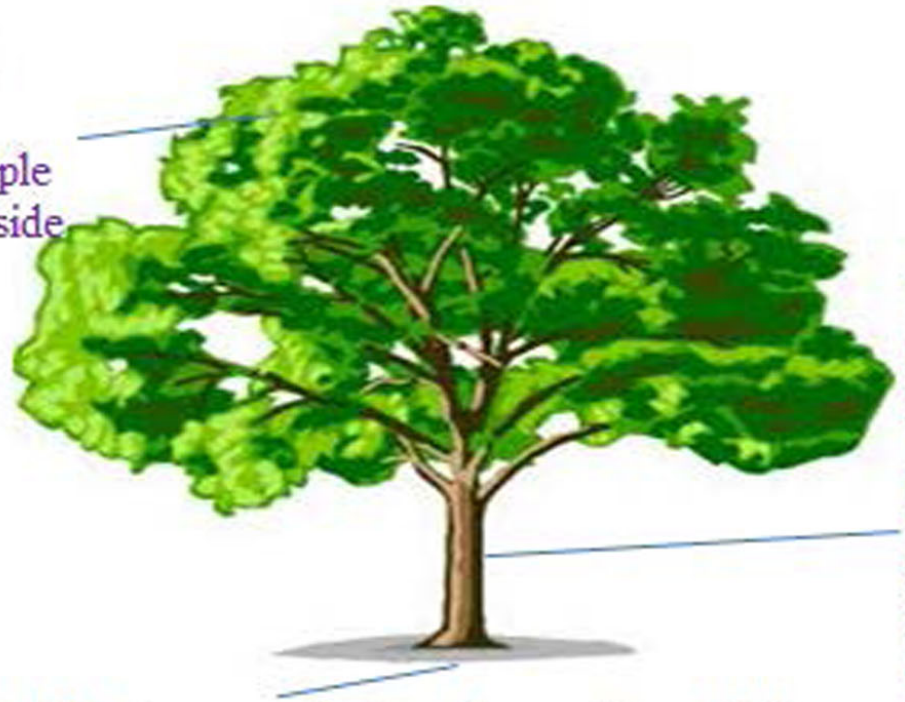
Acceptance

To be open to and allowing of things I dislike or don't want – in myself, others, and the world around me

- Confronting the Core Problem: Living to Avoid Fear and Anxiety is No Way to Live
- Discovering the Toxic Roots

Growing Our "Values Tree"

Leaves and branches: are things people see on the outside



The Trunk: our ***thoughts*** about what people see and our ***thoughts*** about who we are or want to be

The Roots: are what people can't see all the time, who we want to be – OUR *VALUES*!

"Values Tree" - Palasik et al., 2011

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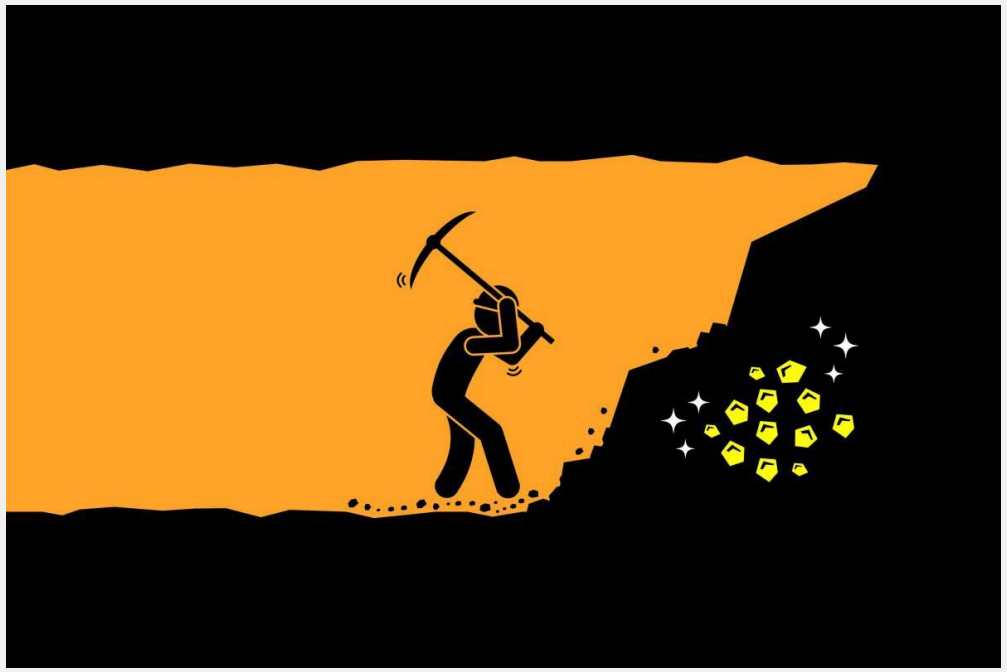
Commit To:



- BEHAVIOR CHANGE
  - Making centering exercises a part of daily routine
  - Practicing mind watching
  - Coming back to your breath…it is always there
  - Recognizing and Busting mind traps

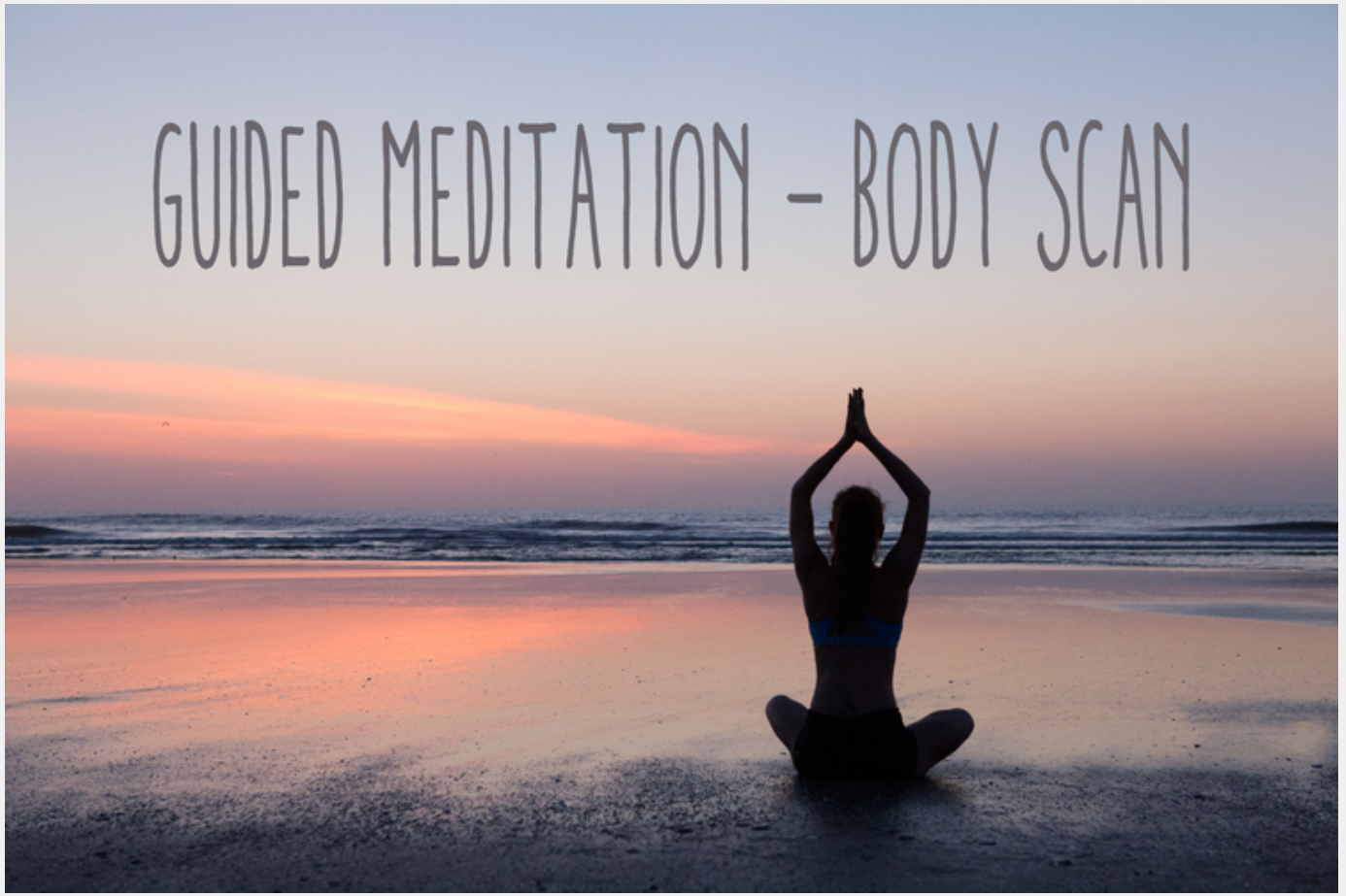
Directives

- *Validation* of emotions; validation of behaviors
- Understand and acknowledge function of the problem
- Connect pain and values

True North Worksheet (ACT)

- What are your values?
- What are your current strategies and are they working?
- What skills will you need to make the journey?

Body Scan



Mindfulness

WHAT is Mindfulness

"Mindfulness is . . . paying attention, in a particular way: on purpose, in the present moment, and non-judgmentally."

From Jon Kabat-Zinn, founder of the Mindfulness-Based Stress Reduction Programs and author of many books including *Full Catastrophe Living* and *Wherever You Go, There You Are*

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First,
“on purpose”

Having the intention to step out of “autopilot mode”

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AUTOPILOT

Fast and Intuitive
Emotional Self
Subconscious
Automatic
Everyday Decisions
Requires no Effort
Makes good decisions 80% of the time
Creativity lives here
Prone to some predictable and systematic errors
Biased

Acting on Inertia

INTENTIONAL

Slow and Logical
Conscious
Drains mental energy
Used mainly when we learn new information and when we use reason and logic.
Can be trained to turn on when it detects Autopilot System may be making error.
Mindful
Complex Decisions
Reliable

Acting Mindfully

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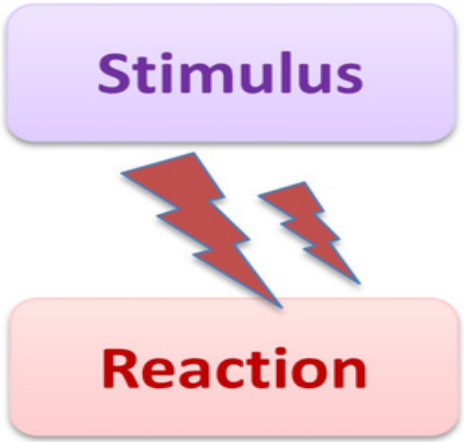
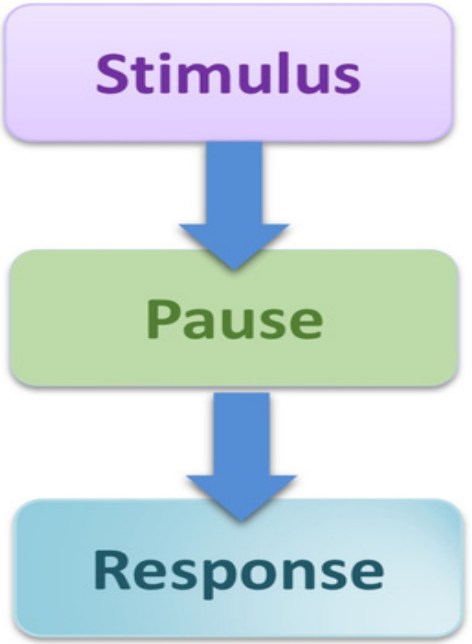
Mindful Behavior

Being mindful creates space to pause…
Replacing impulsive reactions with thoughtful responses.

Autopilot/Reactive Behavior



Mindful Behavior



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And –
“non-judgmentally”

Can we truly stop judging?

Can we become aware of the judgments our minds are making?

Can we consider that there may be another equally valid perspective?

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How might mindfulness be helpful in preventing return to use?

Mindfully preventing recurrence

- *"Paying attention"* leads to greater awareness of triggers and responses, interrupting previously automatic behavior
- *"In the present moment"* means accepting present experience, rather than using substances or behaviors to avoid it
- *"Non-judgmentally"* detaching from attributions and automatic thoughts that often lead to return to use

Mindfulness Based Relapse Prevention

What is MBRP?

- A program that integrates cognitive-behavioral relapse prevention skills and mindfulness meditation practices.
- Designed to foster increased awareness of triggers, habitual patterns, and automatic reactions, these practices cultivate the ability to pause, observe what's happening in the moment, and choose a skillful response.

What are the origins of MBRP?

- Developed by G. Alan Marlatt of the University of Washington, who
  - researched aversion therapy for alcoholism in 1970s
  - and relapse prevention using CBT in the 1980s
  - took a meditation class to deal with his own stress
  - began to experiment with meditation in RP groups
- His grad students – Sarah Bowen, Neha Chawla, and Joel Grow – are now professors who continue the research and train other MBRP facilitators

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Both MBRP and Traditional RP:

- Begin with awareness that one's substance use or other addictive behaviors are causing significant problems/distress
- Place responsibility for addressing addictive behaviors on the individual
- Offer confidential group participation for support
- Encourage developing wisdom to discern the difference between what we can and cannot control – putting (Steps 1-3 into practice)

How MBRP is different:

- Approach to abstinence – a desired goal rather than a requirement for group participation
- Group members focus on moment-by-moment experience rather than telling their stories or processing their emotions
- Less emphasis on behavior change; more on self-awareness and acceptance
- Cravings seen as based in normal human needs and conditioned response

MBRP Meditation practices

- The Body Scan
- Breath awareness
- Urge surfing
- Mountain meditation
- SOBER breathing space
- Walking meditation
- Sitting meditation

Urge surfing

Using the breath as a surfboard to ride the wave, rather than giving in to the urge and being wiped out by it

Staying with the urge as it grows in intensity, rises and crests, knowing it will subside

Remembering that urges, like waves, will eventually fade away

Who is best suited for MBRP?

- Adults who have completed residential or IOP Tx (stable)
- Are motivated to maintain treatment goals
- Willing to make lifestyle changes that support well-being and recovery
- Are seeking an alternative to traditional RP
- Also, openness to learning meditation practice
- Willingness to learn new ways of thinking about and relating to one’s experience

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What are the reported benefits of MBRP?

- Research studies reported significantly greater decreases in craving, and greater self-acceptance, and tendency to act with awareness, than TAU
- MBRP participants had greater overall reduction in substance use at 12-month follow-up than TAU or CBT – RP
- Over 80% continued to practice meditation practices immediately afterward, and majority still practicing upon 4-month follow-up

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Patients have reported:

- Increased self-awareness - including better ability to identify automatic thoughts and recognize habitual thinking patterns
- Improved ability to deal with feelings and strong emotional reactions, as well as to recognize triggers
- Fewer cravings
- Improved overall mood
- Better decision-making

To learn more about MBRP

- For summaries of research studies:

  http://www.mindfulrp.com/Research.html

- For a list of practitioners around the world, and to listen to guided meditation practices:

  http://www.mindfulrp.com/For-Clinicians.html

- MBRP teacher training:

  http://mbpti.org/mbrp-mindfulness-based-relapse-prevention/

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Cognitive Behavioral Therapy

CBT CORE THEORY

- Emphasizes how our thinking interacts with how we feel and what we do.
- Based on the view that when a person experiences depression, anxiety, or anger that these stressors can be exacerbated (or maintained) by exaggerated or biased ways of thinking
- These patterns can be modified by reducing erroneous and maladaptive beliefs

A counselor using CBT helps a client to recognize their style of thinking and to modify it through the use of evidence and logic.

CBT Principles and Elements

Focus is on cognitive restructuring, modifying behavior, and/or developing alternative coping skills.

- *Brief and Time Limited*
- *Present Centered*
- *Thought Focused*
- *Practice and Homework*
- *Sound Therapeutic Relationship*

Brief and Time Limited:

*Y*ields positive results for a client in a relatively short period of time. The average number of sessions clients receive is approximately 16. CBT is brief because it is instructional and makes use of homework assignments.

Present Centered:

What is happening with the client in the “here and now?”

Thought Focused:

Helps client recognize and understand personal thoughts that can lead to irrational fears and worries. Cognitive distortions, such as those listed on page 3, are explored by the client and counselor collaboratively.

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Practice and Homework:

Develops new skills by teaching different ways to understand situations and their responses. The counselor acts as a teacher and coach. Home work (including reading assignments) encourages the client to practice the techniques learned.

Sound Therapeutic Relationship:

Establishes a trusting relationship and builds rational self counseling skills in the client that helps the client learn to think differently. The counselor's role is to listen, teach, and encourage, while the client's role is to express concerns, learn, and implement that learning.

Advantages and Components of CBT

The advantages of using CBT include:

- Structure that reduces the possibility that sessions will become “chat sessions”, and more therapeutic work may be accomplished,
- An emphasis on getting better by learning how to recognize and correct problematic assumptions, the root cause of many problems, and
- Clearly defined goals and methods that can be evaluated using scientific methods.

2 Critical Components Include:

- Functional analysis
- Skills Development

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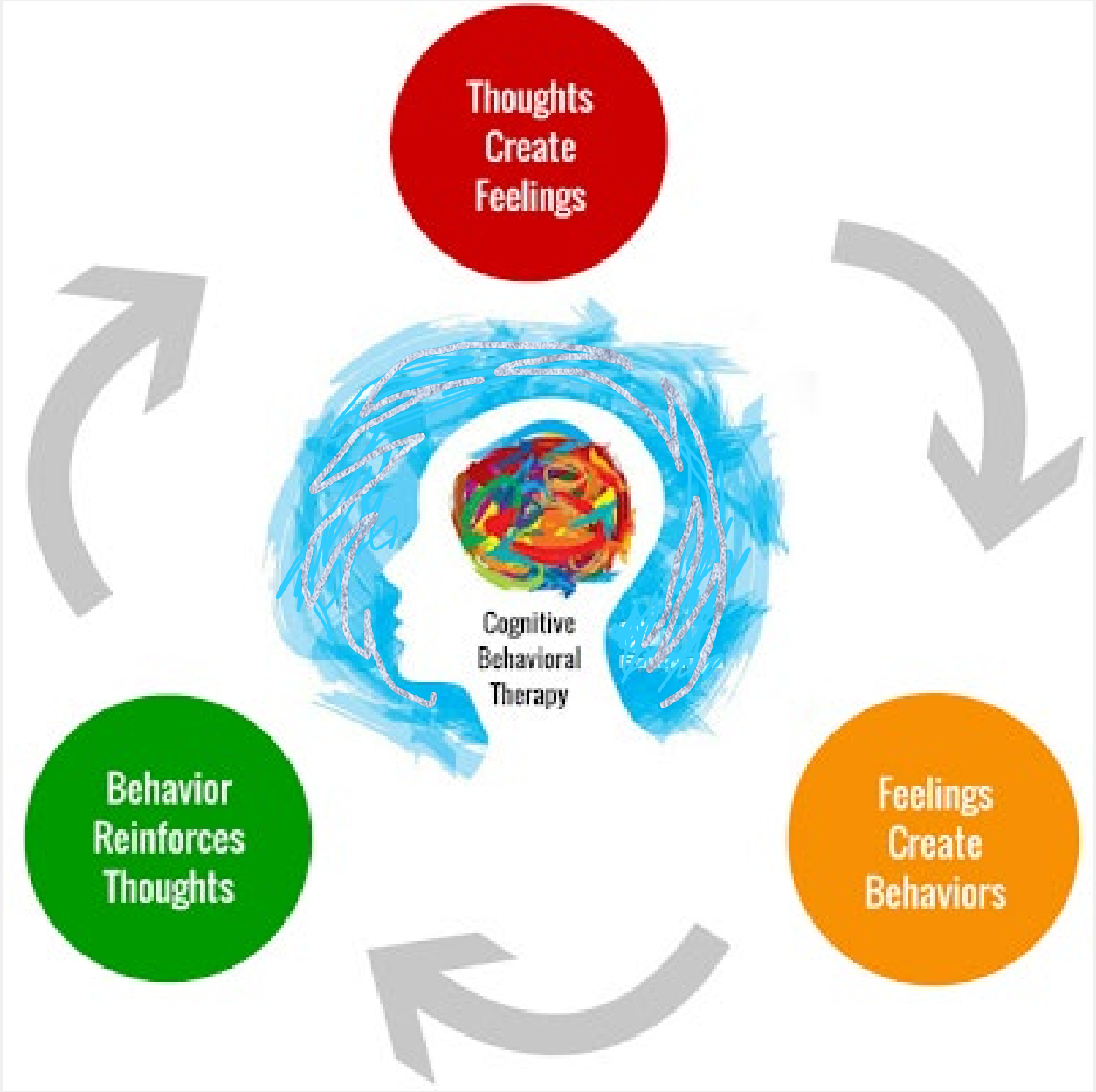
Thoughts Create Feelings
Cognitive Behavioral Therapy
Feelings Create Behaviors
Behavior Reinforces Thoughts

CBT Critical Tasks

- *Foster motivation for abstinence*. CBT methods such as functional analysis, which clarifies what the client stands to lose or gain by using substances, can enhance the client's motivation to stop use.
- *Teach coping skills*. This is the core of CBT to help clients recognize the high risk situations in which they are most likely to use substances and to develop other, more effective, means to cope
- *Change reinforcers*. CBT focuses on identifying and reducing habits associated with drug use by substituting positive activities and rewards
- *Foster management of painful feelings*. CBT skills help the client recognize and cope with urges to use substances and learn to tolerate other strong feelings such as depression and anger
- *Improve interpersonal relationships and social supports*. CBT trains the client in interpersonal skills and strategies to help them increase their support networks and build healthy relationships

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Psychoeducation.

Teaching skills designed to improve management of negative emotions.

Identification of maladaptive thinking patterns that may be related to returning to substance use.

Functional analysis – Helping patients better understand the function of their substance use.

Identifying triggers to use drugs; increase coping skills that help patients manage emotions.

Enhancing interpersonal functioning.

Increasing recovery-focused activities.

Promoting behavioral activation, i.e., activities that improve mood & increase pleasure.

Enhancing drug refusal and problem solving skills.

CBT for SUD

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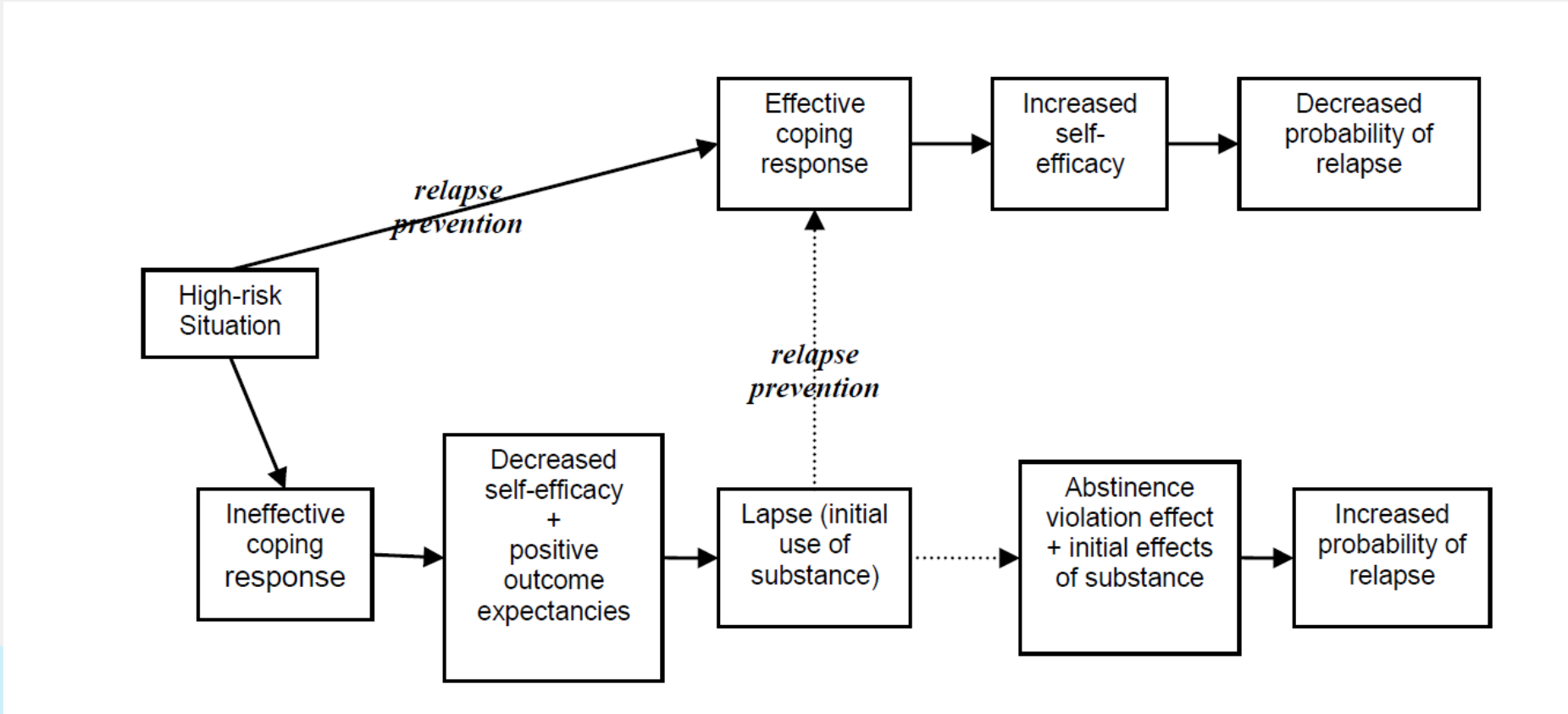
Why people return to using

According to research*, what we know about why people return to using:

- Self-efficacy
- Outcome expectancies
- Motivation
- Coping (skills for managing high risk situations, active vs. inactive coping)
- Emotional statuses (negative affect, positive)
- Craving
- Social support

Returning to use: The cycle

"Cognitive Behavioral Model of Relapse"

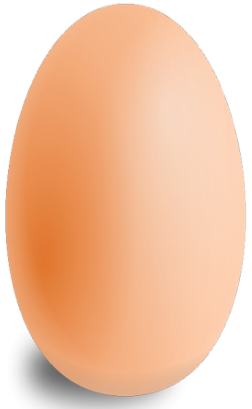


Hatching a CBT-informed Tx plan

https://www.recoveryanswers.org/resource/stages-of-recovery/

PRECONTEMPLATIVE

In this stage, individuals are not even thinking about changing their behavior. They do not see their addiction as a problem: they often think others who point out the problem are exaggerating.



CONTEMPLATIVE

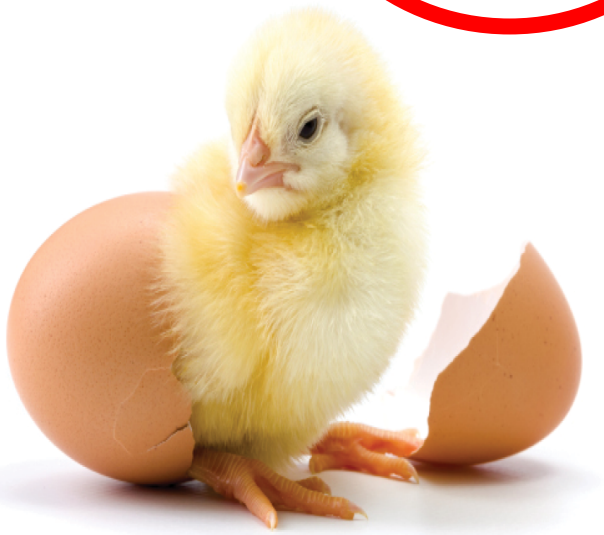
In this stage people are more aware of the personal consequences of their addiction & spend time thinking about their problem. Although they are able to consider the possibility of changing, they tend to be ambivalent about it.

PREPARATION

In this stage, people have made a commitment to make a change. This stage involves information gathering about what they will need to change their behavior.

ACTION

In this stage, individuals believe they have the ability to change their behavior & actively take steps to change their behavior.



MAINTENANCE

In this stage, individuals maintain their sobriety, successfully avoiding temptations & relapse.

Best done when brain not on fire.

CBT is prefrontal cortex intensive

DIALECTICAL BEHAVIORAL THERAPY

DIALECTICAL BEHAVIOR THERAPY (DBT) TEACHES MANY DISTRESS TOLERANCE SKILLS THAT HELP PEOPLE LEARN HOW TO SIT WITH POTENTIALLY DISTRESSING EMOTIONS OR THOUGHTS WITHOUT ENGAGING IN SELF-DESTRUCTIVE BEHAVIORS (E.G., SELF-HARM, SUBSTANCE ABUSE, ETC.) OR UNNECESSARILY INCREASING SUFFERING.

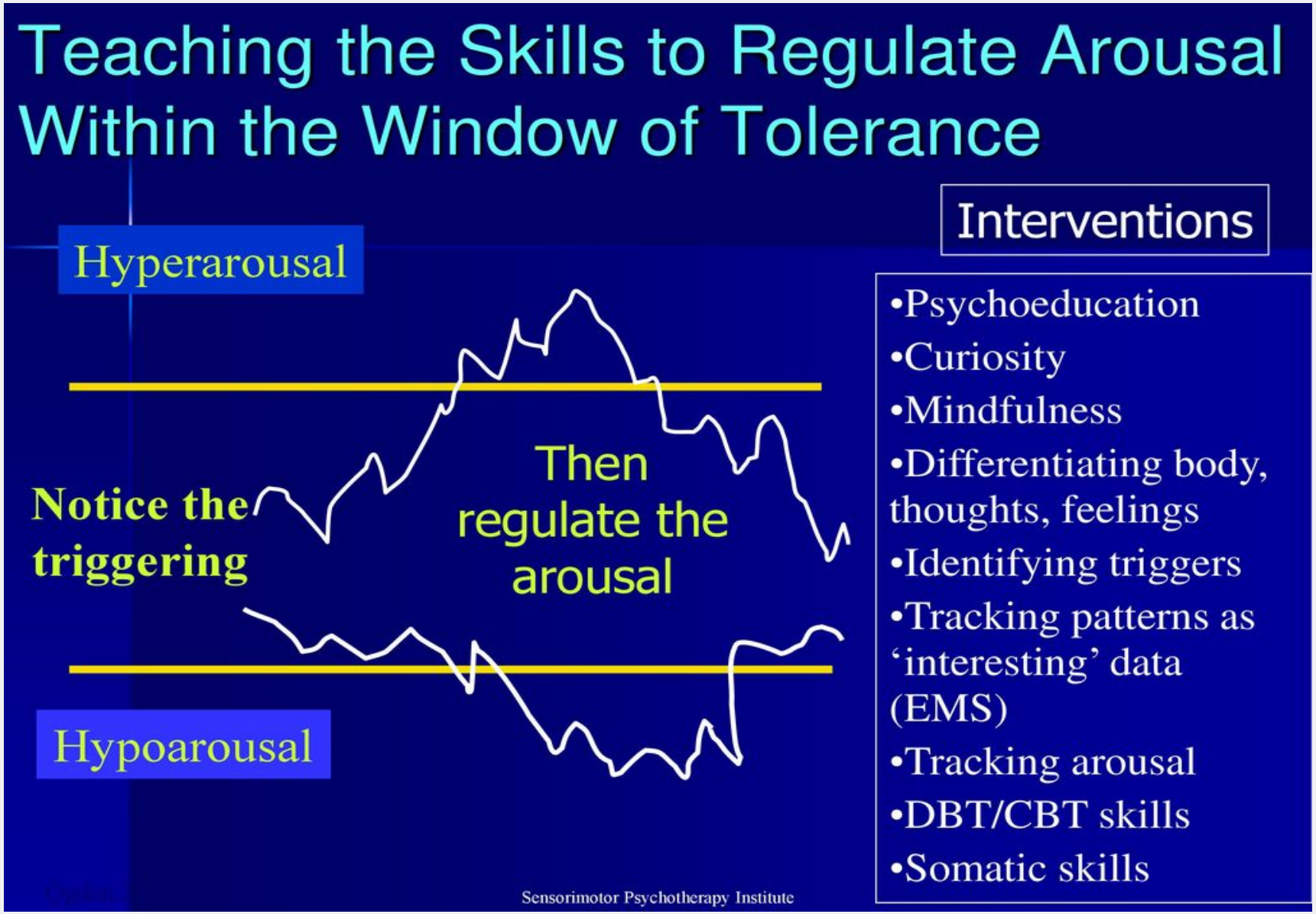
DBT – Dialectical Behavioral Therapy

- Developed in the 1980's – University of Washington – Marsha Linehan
- DBT combines standard cognitive behavioral techniques for emotion regulation and reality-testing with concepts of distress tolerance, acceptance, and mindful awareness largely derived from Buddhist meditative practice.
- DBT is based upon the biosocial theory of mental illness and is the first therapy that has been experimentally demonstrated to be generally effective in treating BPD

DBT Definitions

- **Dialectics**: represent the mind's way of understanding concepts by understanding and appreciating their polar opposites
- **Theory:** some people are prone to react in a more intense and out-of-the-ordinary manner towards certain emotional situations, primarily romantic, family, and friend relationships.
- Some people's arousal levels in emotional situations can increase far more quickly than others, attain a higher level of arousal, and take longer to return to normal levels (Window of Tolerance).

Teaching the Skills to Regulate Arousal Within the Window of Tolerance



Interventions

- Psychoeducation
- Curiosity
- Mindfulness
- Differentiating body, thoughts, feelings
- Identifying triggers
- Tracking patterns as 'interesting' data (EMS)
- Tracking arousal
- DBT/CBT skills
- Somatic skills

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WINDOW OF TOLERANCE- TRAUMA/ANXIETY RELATED RESPONSES:

Widening the Comfort Zone for Increased Flexibility

HYPER- AROUSED

Fight/Flight Response

- *ANXIETY
- *OVERWHELMED
- *CHAOTIC RESPONSES
- *OUTBURSTS (EMOTIONAL OR AGGRESSIVE)
- *ANGER/ AGGRESSION/ RAGE

- *RIGIDNESS
- *OBSESSIVE-COMPULSIVE BEHAVIOR OR THOUGHTS
- *OVER-EATING/RESTRICTING
- *ADDICTIONS
- *IMPULSIVITY

CAUSES TO GO OUT OF THE WINDOW OF TOLERANCE:

- ***Fear of ...**
  Unconscious Thought & Bodily Feeling: Control, Unsafe, I do not exist, Abandonment, Rejection
- ***Trauma-Related Core Beliefs about self are triggered:**
  Emotional & Physiological Dysregulation occurs

Widening the window for psychological flexibility

COMFORT ZONE

EMOTIONALLY REGULATED

Calm, Cool, Collected, Connected

ABILITY TO SELF-SOOTHE

ABILITY TO REGULATE EMOTIONAL STATE

Staying within the window allows for better relationship interactions

TO STAY IN THE WINDOW OF TOLERANCE:

- *Mindfulness—Being Present, in Here-n-Now
- *Grounding Exercises
- *Techniques for Self-Soothing, Calming the Body & Emotional Regulation
- *Deep, Slow Breathing
- *Recognize Limiting Beliefs, Counter with Positive Statements About Self, New Choices

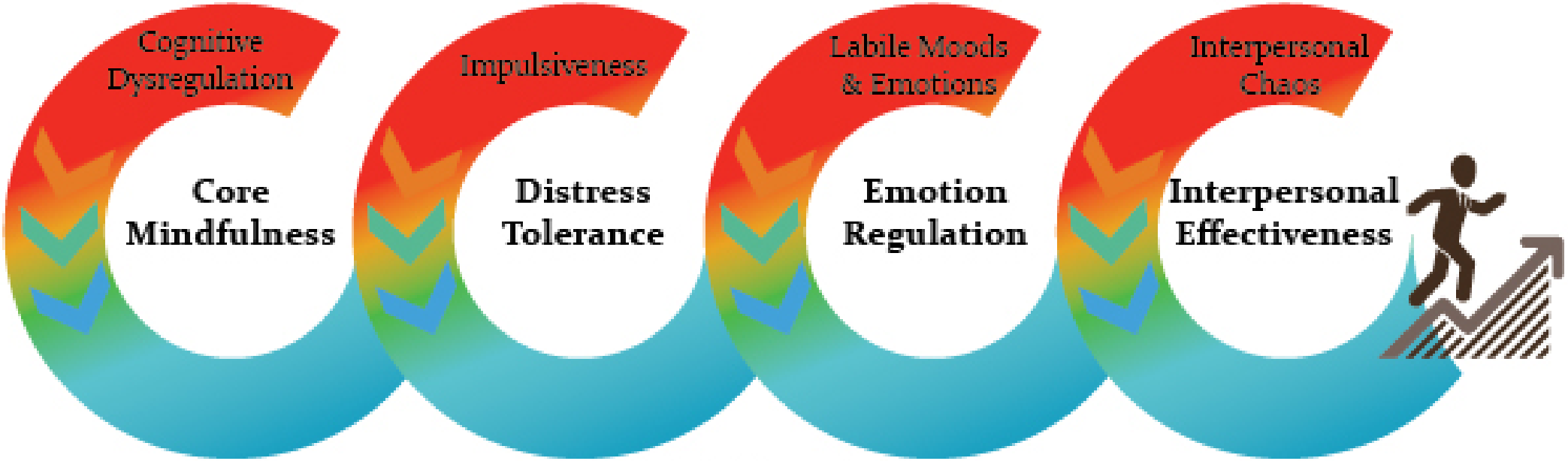
HYPO-AROUSED

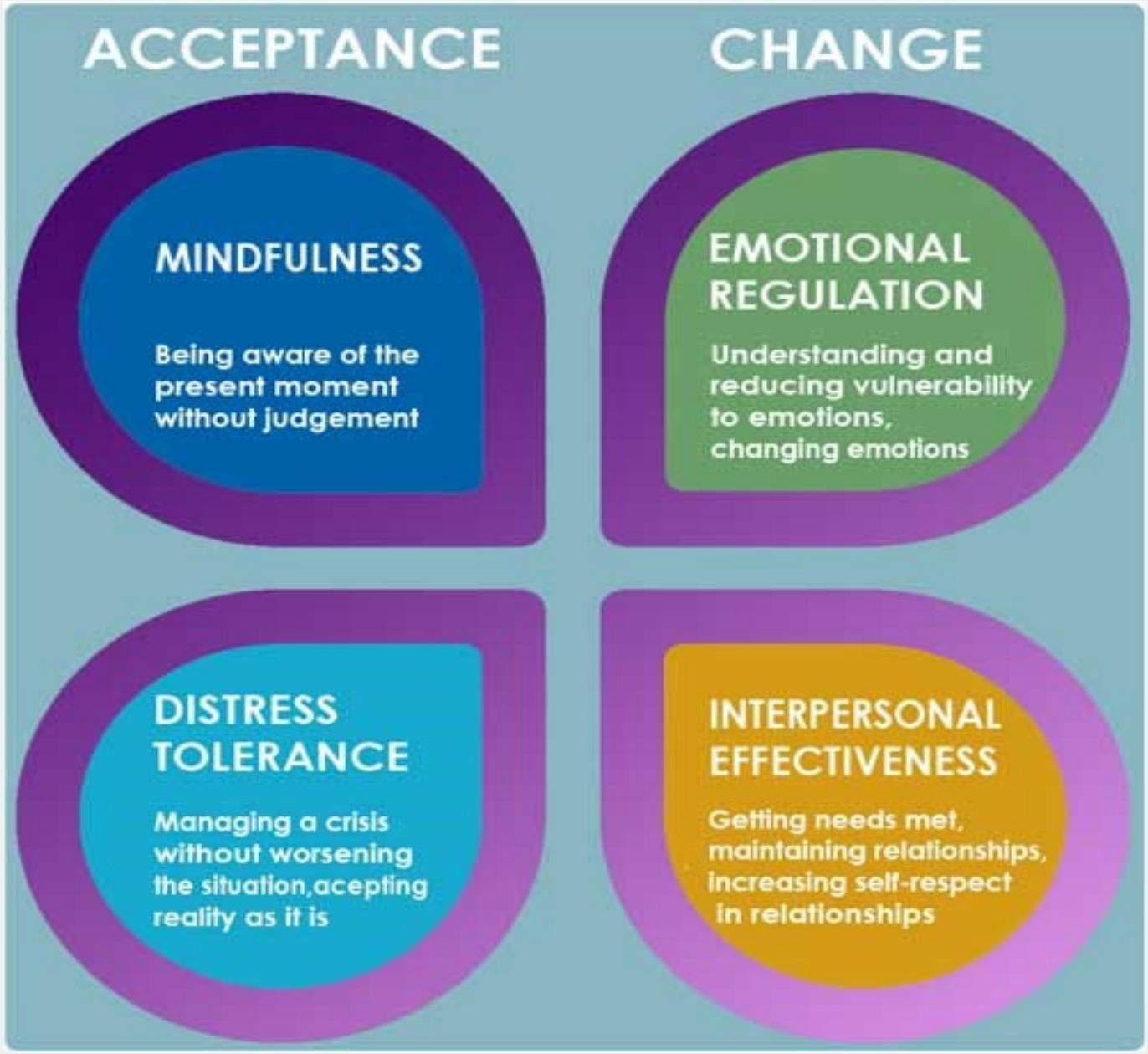
Freeze Response

- *FEIGN DEATH RESPONSE
- *DISSOCIATION
- *NOT PRESENT
- *UNAVAILABLE/ SHUT DOWN
- *MEMORY LOSS

- *DISCONNECTED
- *AUTO PILOT
- *NO DISPLAY OF EMOTIONS/ FLAT
- *SEPARATION FROM SELF, FEELINGS & EMOTIONS

DBT - Dialectical Behavior Therapy




ACCEPTANCE
CHANGE
MINDFULNESS
Being aware of the present moment without judgement
EMOTIONAL REGULATION
Understanding and reducing vulnerability to emotions, changing emotions
DISTRESS TOLERANCE
Managing a crisis without worsening the situation,acepting reality as it is
INTERPERSONAL EFFECTIVENESS
Getting needs met, maintaining relationships, increasing self-respect in relationships

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Why is DBT important?

- **To reduce suffering**
  - Improving quality of life
- **To calm and centre yourself in stressful situations**
  - Quietening the body (racing heart, fast breathing, muscle tension, etc.) reduces intense emotions
- **To reflect on and better understand your emotions**
  - Lowering stress levels reduces impulsive behaviour
- **To improve self-respect**
  - Validating the way you feel and improving your relationship with yourself leads to higher self-esteem
- **To improve your communication skills**
  - Avoiding power struggles and taking things personally results in better relationships with others
- **To be more effective in meeting goals**
  - Mindfulness leads you towards your goals and away from distracting emotional tangents
- **To make Wise Mind easier to find**
  - Using practical skills that are empirically supported lead to creating healthy habits

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Distress Tolerance Skills: Getting Through Painful Moments Without Making Them Worse

Distract with ACCEPTS

Activities
Contribute
Comparisons
Emotions
Push Away
Thoughts
Sensations

IMPROVE the Moment

Imagery
Meaning
Prayer
Relaxation
One thing in the moment
Vacation (brief)
Encouragement

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Distress Tolerance Skills

- Pros and Cons
  Positive and negative things about not tolerating stress
- Radical Acceptance
  Letting go of fighting reality
- Turning the Mind
  Turn toward acceptance stance. Use w/Rad Acc
- Willingness vs. Willfulness
  Willing and open to do what's effective

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Emotional Regulation Skills

- Identify and label emotions
- Identify obstacles to changing emotions
- Reduce vulnerability to *emotion mind*
- Increase positive emotional events
- Increase mindfulness to current emotions
- Take opposite action
- Apply distress tolerance techniques
- Understand and name emotions
- Change unwanted emotions
- Reduce vulnerability
- Manage extreme conditions
- Understand the ‘story’ of emotions

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Emotional Regulation Skills

PLEASE

Physical I**l**lness (treat)
Eating (balanced)
Avoid using
Sleep (balanced)
Exercise

- Build Mastery
- Opposite Action
- Problem Solving
- Letting go of Emotional Suffering

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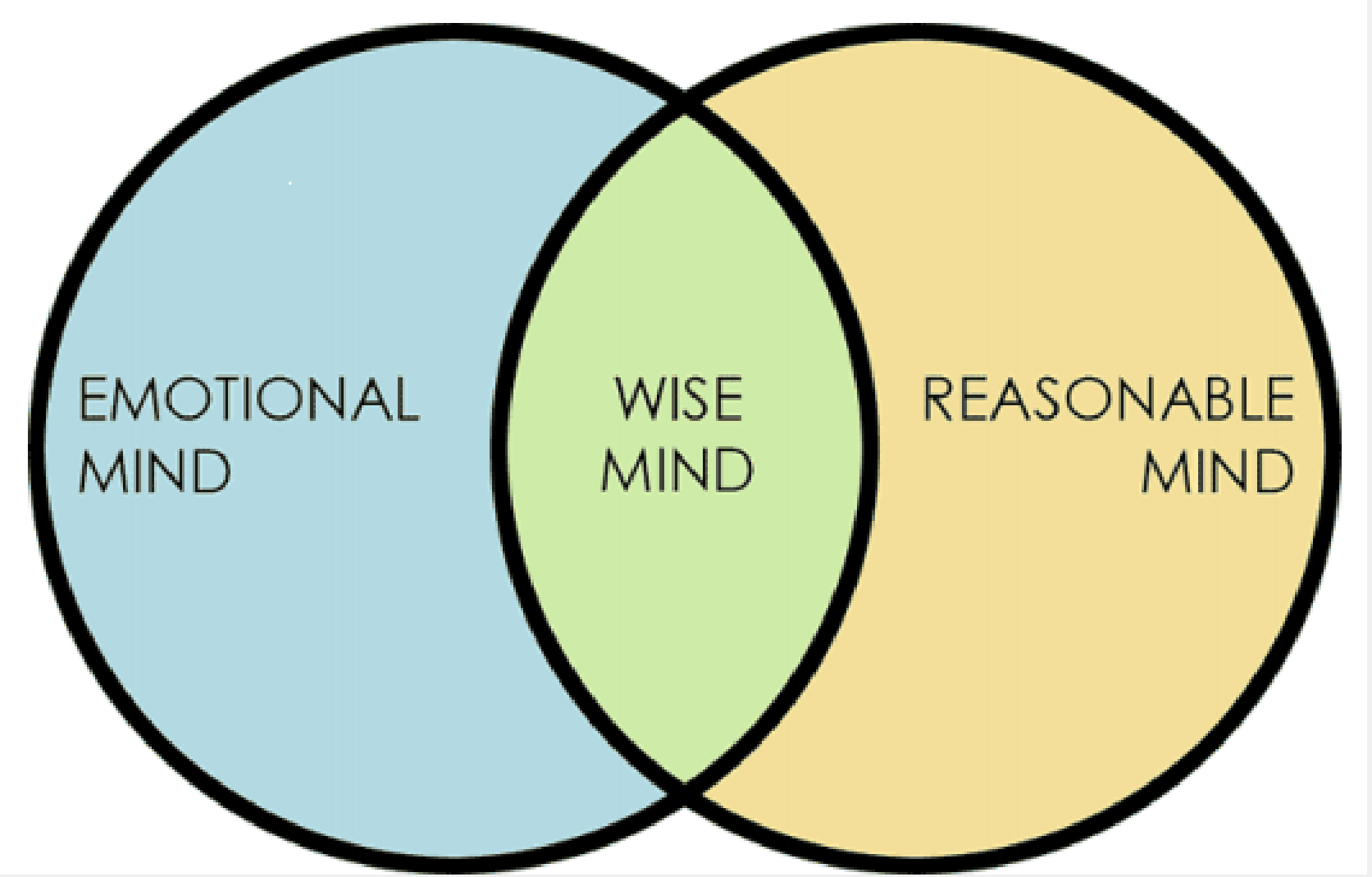
Interpersonal Effectiveness:

Three Main Goals:

- To help ask for something effectively
  Get what you want
- To help keep a good relationship
  Keep what you want
- To help keep self-respect while in a relationship
  Build self-respect and like yourself


D
• Describe what you want clearly
E
• Express your feelings
A
• Assert what you want to say
R
• Reinforce others positively when they respond well
M
• Stay Mindful of the purpose of interaction
A
• Appear confident in your body language
N
• Negotiate about what you want
F
• Be Fair to yourself and others
A
• don't be Apologetic
S
• Stick to Values
T
• Be Truthful
G
• Be Gentle- dont attack or threaten during interactions
I
• Show Interest in listening to what others have to say
V
• Validate other persons thoughts and feelings
E
• Be Easy in your attitude

OVERALL GOAL



Harm Reduction

Harm Reduction Model

- Accepts that drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being–not necessarily cessation of all drug use–as the criteria for successful interventions and policies.

~ Harm Reduction Coalition

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Harm Reduction Model

- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

~Harm Reduction Coalition

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Harm Reduction—not a new concept in integrated health care

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Harm Reduction

- The best should never be allowed to be the enemy of the good!
- Approach is person-centered, meet people where they are.
- Reduce harms of SUDs to individuals and communities
- Improved health and functioning of the individual is primary goal or outcome
- Harm reduction interventions should be integrated into the continuum of SUD prevention and treatment, which occurs in many venues

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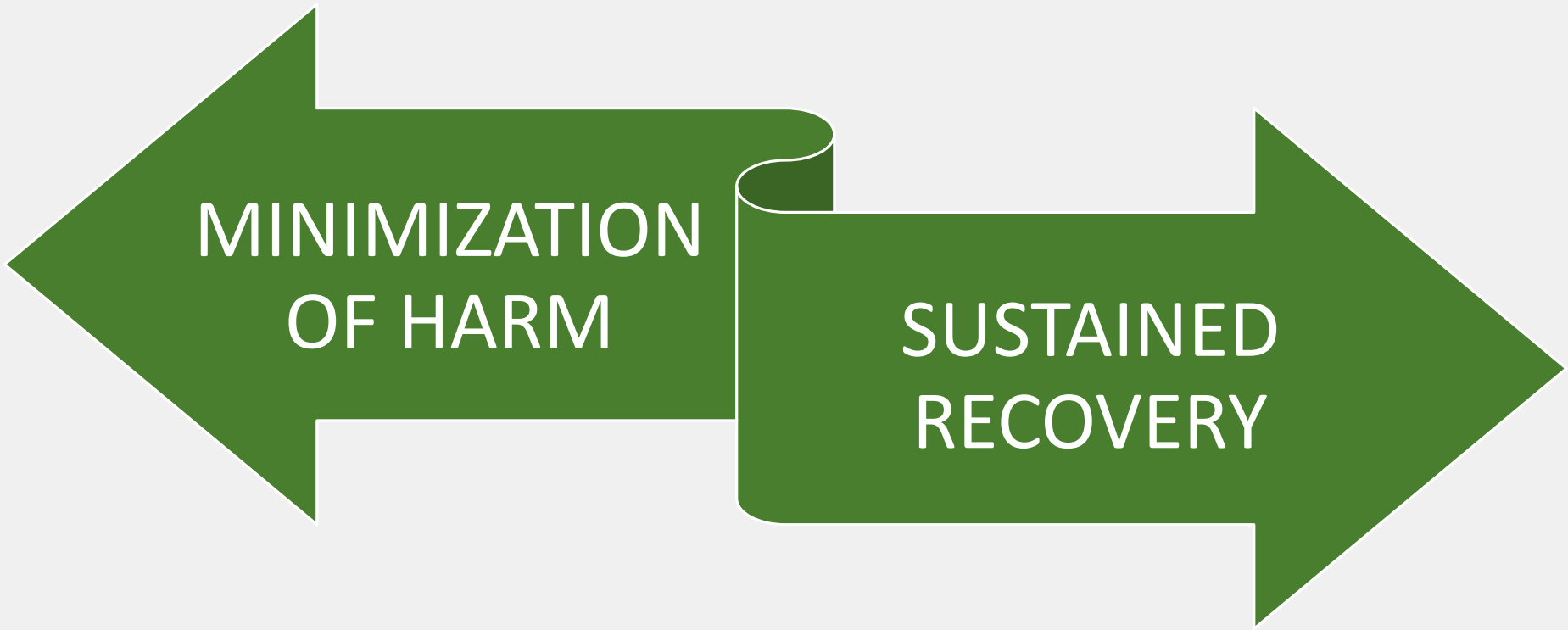
TREATMENT GOALS

- Variable based on degree of ambivalence
- Stage of change not the same for each identified problem
- A harm reduction approach will apply to some problems and a comprehensive therapeutic approach to others
- Engagement long term develops trust and an opportunity to facilitate change e.g., resolve ambivalence and facilitate determination

TREATMENT GOALS—a Continuum



MINIMIZATION OF HARM

- Accept less engagement
- Accept less compliance
- Accept less adherence
- Accept the use of other substances
- Define the minimum, realizing the challenge for team buy-in

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SUSTAINED RECOVERY

- More engagement and broadening of social supports
- Compliant/committed/motivated/self actualizing
- Abstinence
- Growth and stability across multiple domains and determinants of health
- Lapses/relapses are the results of mistakes, not failures, and create learning opportunities and potential enhanced recovery

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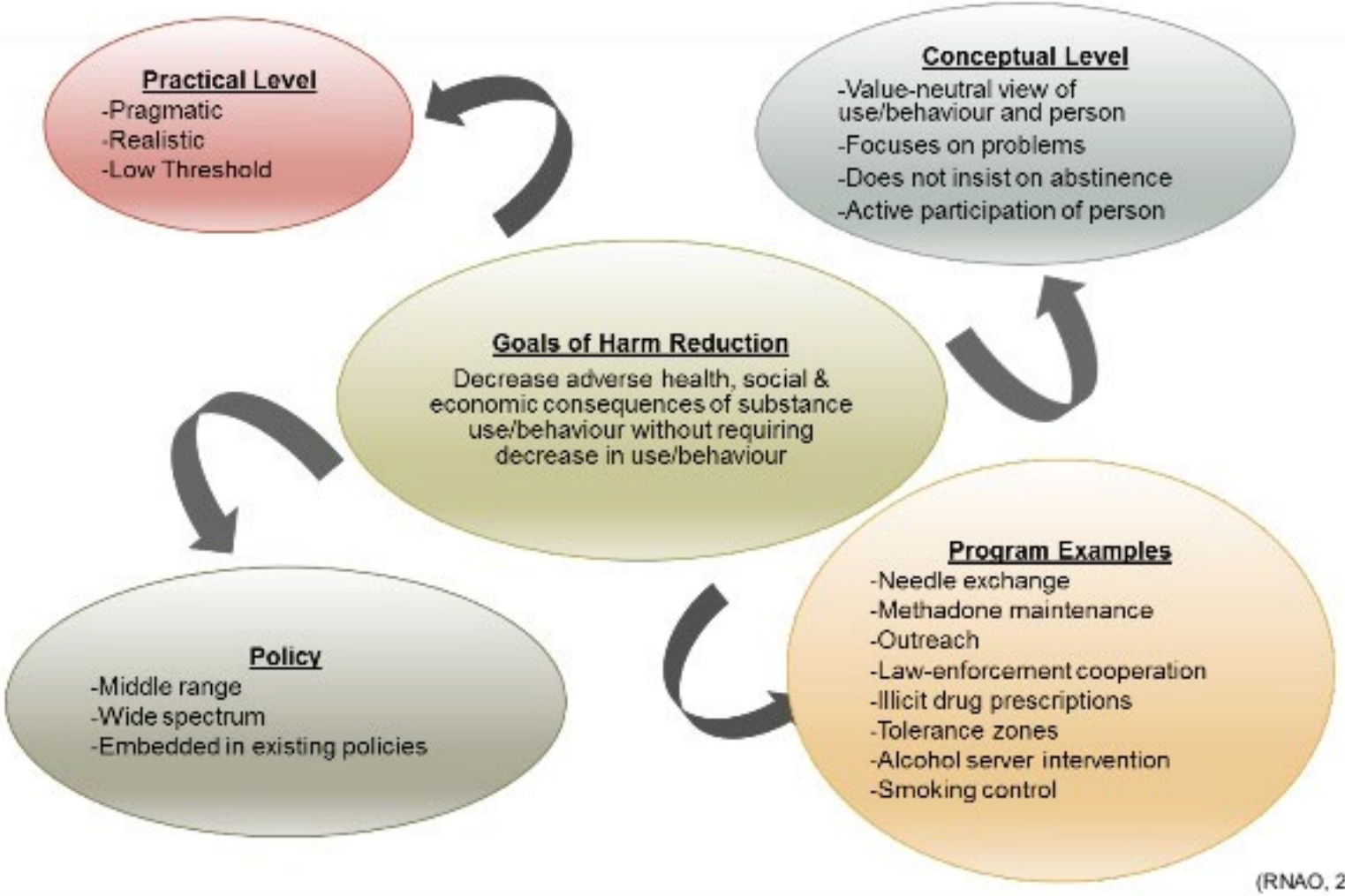
HARM REDUCTION MODEL



(RNAO, 2009)

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What can you and your team tolerate???

- Think about the care provided other chronic diseases, like diabetes and the continuum of harm minimization to comprehensive care management
- What happens in AA? **“Keep coming back”**--regardless of abstinence—harm reduction through continued engagement
- What constitutes abandonment especially when relapse can be **LETHAL**?
- UDTs: are positive results deal breakers? Therapeutic opportunity or punitive action?
- **Functional status,** is always the benchmark for potential intervention, especially with co-occurring patients

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DISCUSS

WRAP

THANK YOU FOR COMING !!!!!!!