

Substance Abuse and Addictions

(Part 2)

Dr. Howard Fine



1

How do psychological factors lead to substance abuse? Psychological theories

Tension-reduction theory

- Substance abuse to cope with or regulate negative mood
 - Rats isolated increase consumption of alcohol – Roske et al. (1994)
 - Carney et al. (2000) - people who experienced more negative interpersonal events report more frequent substance abuse.
- Mixed support for the theory
 - **Some** people consume alcohol to reduce tension and some do not
 - Participants who think they are drinking alcohol, whether they were or not, show greater loss of control (Lang et al., 1975)
 - **Some** drinkers drink alcohol to enhance positive emotions- Carney et al. (2000)

2

Psychological theories 2

- Social learning theory
 - Learning by observing others (models)
 - Models can be direct (parent, peer, or sibling) or indirect (through the media).
 - Grube & Wallach (1994) found that children in Yrs 5 & 6 were aware of beer TV ads and had more favorable beliefs about the consequences of drinking.
 - Watching people smoke creates the norms of behavior. It is a group process of in-group and out-group. Peers' smoking behavior is a strong predictor of an individual's future smoking behavior – generalisable?
 - The mere belief of a heavy drinking norm is related to more positive attitudes toward alcohol use.
 - Children model on their parents' drink behavior and what is portrayed in the media.
 - Positive expectations of alcohol use is related to an increased likelihood of drinking (Sher et al., 1996).

3

Psychological theories 3

- Cognitive theory – the affect of toxins on psychological states is related to physiological effects
 - Impaired cognitive functioning
 - Reduces self-awareness and anxiety
 - Alcohol use increased antisocial and aggressive behavior

4

Psychological theories 4

- Personality – mostly correlation studies
 - Substance abuse is associated with high rates of anxiety and extroversion (Kessler et al., 1997).
 - Longitudinal studies have indicated that personality traits can predict future alcohol use (i.e., Bates & Labouvie, 1995)

5

What are some strategies for preventing abuse?

- Just say No?
 - Which target population? – usually college students
 - Use of skills training – Relaxation and moderate use reduces overall consumption use (Kiviland et al., 1990).
 - Early intervention and use of feedback concerning ones level of consumption
 - Public policy and laws to limit use

6

Factors that affect treatment success

- 75% recover on their own but some need help.
- Current level of dependence
- Medical Problems
- Treatment History
- Previous Quit Attempts
- Social Support Systems
- Personal resources
- Other psychological problems
- Attitudes about treatment
 - Information: <http://www.addictioncareoptions.com/>

Harm Reduction Vs. Zero Tolerance

Zero tolerance

- Based on idealism i.e. unrealistic
- Often associated with moral model of drug use
- Any form of level of drug use is not tolerated
- Creates a dichotomy between use and no use
- Focuses on penal measures over treatment and prevention
- Has so far failed to eliminate or decrease drug use

8

Zero Tolerance

At service level:

- Commitment to total abstinence as a prerequisite to treatment entry – ‘high threshold’ service
- Life-long total abstinence as the only goal for treatment
- Even one relapse can be penalised by discharge from service

9

Zero Tolerance

At policy level:

- Criminalising of individual drug use
- Higher emphasis on law-enforcement over treatment e.g. “war on drugs”
- Aim of supply reduction and demanding reduction policies

10

Harm Reduction

- The philosophy and public health approach aimed at reducing the harmful consequences of drug use for both at the users and the wider community
(Marlatt, 1998; Marlatt et al, 1997)

11

Harm Reduction

- First developed in response to the AIDS epidemic of 1980s
- Any change that reduces harm or risk of harm is encouraged and accepted
- A pragmatic and compassionate approach that except drug use whilst not condoning it
- Whilst abstinence remains the ultimate goal, recognises that many behaviour change attempts and treatment episodes may take place before stable abstinence is achieved, if it occurs at all

12

Harm Reduction

- Relaxing abstinence requirement removes a known deterrent to treatment entry and is responsive to often chronic, relapsing nature of substance abuse
- Harm reduction approach: most notable in Europe. In the USA, abstinence-orientated model still dominates.

13

Harm Reduction

And service level:

- Improving access to addiction services e.g. outreach and in-reach programmes
- Expanding range of services and interventions available to service users e.g. health education, psychosocial interventions, vocational training, legal advice and housing, medical substitute prescription of addictive substances, safe injecting rooms in clinics, needle-exchange programmes, condom distribution
- Client-centred: meeting drug users “when there at” and not “when they should be”
- Service user empowerment

14

Harm Reduction

At policy level:

- Decriminalising individual drug use
- increasing proportion of spending on treatment as opposed to law enforcement (currently, majority of funds spent on the latter)
- Making treatment available upon demand

15

Harm Reduction

Research evidence indicates positive effects in terms of:

- Reducing drug-related harms e.g. reduced rates of HIV transmission through needle exchange programmes, medical substitution of addictive substances (UK: Carrell et al, 1990); methadone by bus service (Holland: Burning et al, 1990)
- To increasing from our activity associated with drug use
- In reaching inaccessible segments of drug abuse of communities

(Marlatt, 1998; NIH, 1997)

16

The National Treatment Outcome Research Study (NTORS)

- Conducted by the National Treatment Centre, Maudsley Hospital (1996 – ongoing publication)
- First large-scale multi-site prospective (naturalistic) follow-up study of drug misuse conducted in the UK
- Commissioned by the Department of Health Task Force set out to assess the evidence for the effectiveness of existing national drug misuse treatment services
- Recruited over 1000 people entering drug misuse services (residential: inpatient and rehabilitation programmes / community-based: methadone and maintenance and reduction programmes) throughout England in 1995
- 54 treatment programmes participated
- One year and five year follow-up results available in addiction journals and website

17

NTORS – Key Findings

- At follow-up, substantial reduction in the use of heroin, cocaine and other drugs
- Where clients are using drugs at follow-up, improvement seen both in terms of quantity and frequency of use
- Reduction in the numbers of clients injecting drugs and sharing injecting equipment
- Disappointing results in terms of alcohol use, many clients still drinking heavily at follow-up, need for services to address this issue
- Number of improvements in both physical and psychological health

18

NTORS – Key Findings

- Economic costs imposed upon society were largely due to their criminality (most acquisitive crime). Crime costs prior to treatment greatly outweighed all of the treatment costs
- At follow-up, marked reduction in criminal activity is estimated savings society worth £5.2 billion a year
- For every extra £1 spent on drug misuse treatment, a return of more than £3 in terms of cost savings associated with victim costs of crime and reduced demands upon the criminal justice system
- Substantial improvements made after treatment by people with serious and long-term drug problems

19

NTORS – Key Findings

- Overall message:
- Treatment works!
 - It is worth increasing funding for drug addiction treatment (by diverting funding for law enforcement, which have generally been ineffective in reducing drug use and drug-related problems)
 - See www.doh.gov.uk/ntors

20

UK Drug Strategy

- In 1998, the Government developed a 10-year drug strategy, *Tracking Drugs to Build a Better Britain*
- The strategy has for overarching aims:
 1. Young People: To help young people resist drug misuse in order to achieve their full potential in society
 2. Communities: To protect our communities from drug related antisocial and criminal behaviour
 3. Treatment: To enable people with drug problems to overcome them and to live healthy crime free lives
 4. Availability: To stifle the availability of illegal drugs on our streets

21

UK Drug Strategy

- The UK Drug Strategy identified a doubling the availability of drug treatment as a key target:

“To increase the participation of problem drug misusers in drug treatment programmes by 55% by 2004, by 66% by 2005, and by 100% by 2008”
- NSF for addiction services implemented 2004

22

UK Drug Strategy

- The Select Committee on Home Affairs produced a third report in May 2002 to review and determine the effectiveness of the Government Drug Policy. Some key findings and recommendations (out of 24 points listed):
- Drugs policy should primarily be addressed when dealing with the 250,000 problematic drug users (who account for around 99% of the annual economic and social costs of drug misuse to society; £11,000 each Vs. £20 for non-problematic users)
 - Rejecting decriminalisation of drugs, but recommend reclassifying
 - Cocaine should remain a Class A drug due to the risks, but the number of treatment places for Cocaine and crack uses should be substantially increased
 - Substantial increase should be made in the funding for treatment for heroin addicts and ensure that methadone treatments and complementary therapies are universally available to those who need them
 - Evaluate pilot programmes of safe injecting houses for heroin users should be established, and if successful, to be extended across the country (Swiss & Dutch success models)

23

Summary

There are many models of substance abuse, relating to both positive and negative effects. Not all negative effects are related to the pharmacology of the substance per se – many are due to consequences of ‘illegality’ i.e. drug-prohibition effects. Understanding the above leads to:

- Policy
 - Move away from Criminal Justice approach to Public Health approach
 - Move away from zero tolerance to harm reduction
- Legally
 - Move away from prohibition/criminalisation to decriminalisation (leading to legalisation, either with or without medical control)

24

Summary

- Treatment
 - Move away from total abstinence to harm reduction approach
- Philosophy
 - Move away from unrealistic idealism to realistic and pragmatic approach i.e. harm reduction
 - Move away from moral emphasis to compassion / humanistic approach
- However, important to consider the cost-benefits for the individual verses society as a whole
- Need for a rational debate and a balanced approach
- The gap between scientific knowledge on the one hand, and government drug control policy / delay views of addiction, on the other, narrowing?

25

Controversial issues

- Can alcoholics have controlled drinking?
 - Controversy about social drinking
 - Persons under 40 have better success for controlled drinking especially with stable marriage and short history of alcohol abuse (< 10 years) and not suffer severe withdrawal symptoms – Miller & Hester (1980)
 - Abstinence leads to lower relapse rates (return to abuse levels) than controlled drinking.

26