

## Substance Abuse and Addictions

(Part 3)



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## Matching Treatment to Individual's Needs

- No single treatment is appropriate for all individuals
- Effective treatment attends to multiple needs of the individual, not just his/her drug use
- Treatment must address medical, psychological, social, vocational, and legal problems

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## Treatment considerations

- Most people do not seek treatment in part because they refuse to acknowledge they have a problem
- When treatment is initiated compliance is low and dropout rates are high
- High comorbidity with alcoholism makes treatment more challenging

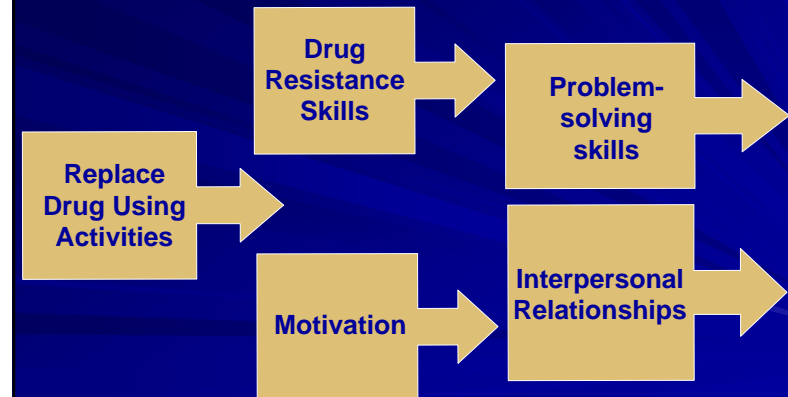
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## Treatment goals

- Abstinance vs. Moderation
  - Some treatment program's goal may be abstinance (e.g., AA), while others may believe moderate drinking is more useful
- Scope of treatment
  - Should treatment address areas such as occupational, social, or medical problems?

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## Counseling and Other Behavioral Therapies



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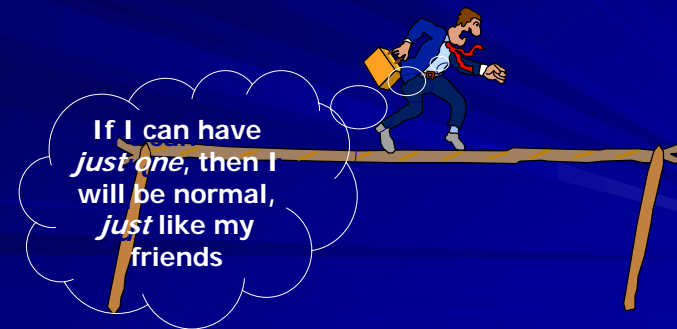
## Abstinance

- Strictly speaking, abstinance is developed, not recovered
- It is an abnormal condition, signifying an internal defect (disease)
- Addicts want to be "normal," that is, using drugs in control

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## Self-Control

- Addicts seek control, not abstinance



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## Self Help

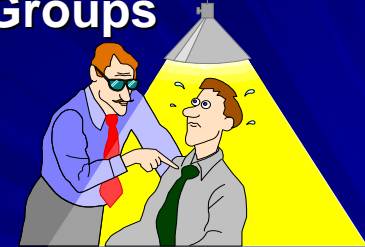
- Complements and extends treatment efforts
- Most commonly used model include 12-Step (AA, NA)
- Most treatment programs encourage self-help participation during/after treatment

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## 12-Step Groups

### ■ Myths

- Only AA can treat alcoholics
- Only a recovering individual can treat an addict
- 12-step groups are intolerant of prescription medication
- Groups are more effective than individuals because of confrontation



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## 12-Step Groups

### ■ Facts

- Available 7 days/week, 24 hrs/day
- Work well with professionals
- Primary treatment modality is fellowship (identification)
- Safety and acceptance predominate over confrontation
- Offer a safe environment to develop intimacy

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## The AA 12 Steps Programme

- Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.
- The heart of the suggested programme of personal recovery is contained in Twelve Steps
- Success of 12 step programmes generalised to other groups (Alcoholics Anonymous, Cocaine Anonymous, Crystal Meth Anonymous, Debtors Anonymous, Emotions Anonymous, Gamblers Anonymous, Marijuana Anonymous, Narcotics Anonymous, Nicotine Anonymous, Overeaters Anonymous, Sex and Love Addicts Anonymous, Sexaholics Anonymous, Sexual Compulsives Anonymous, Spenders Anonymous )

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## The AA 12 Steps Programme

1. We admitted we were powerless over alcohol - that our lives have become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.

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## The AA 12 Steps Programme

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we try to carry this message to alcoholics and to practice these principles in all our affairs.

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## Medical Detoxification

Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.

- High post-detoxification relapse rates
- **Not a cure!**
- A preparatory intervention for further care

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## Medications

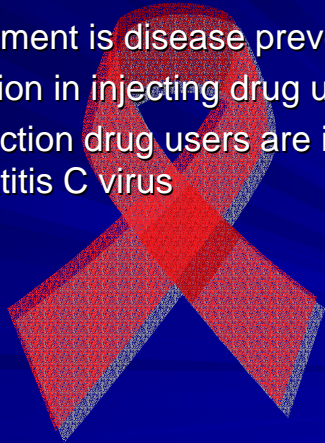
Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.

- **Alcohol:** Naltrexone, Disulfiram, Acamprosate, Odansetron
- **Opiates:** Naltrexone, Methadone, LAAM, Buprenorphine
- **Nicotine:** Nicotine replacement (gum, patches, spray), bupropion
- **Stimulants:** [None to date]

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## Public Health

- Drug treatment is disease prevention
- HIV infection in injecting drug users
- >90% injection drug users are infected with Hepatitis C virus



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## How Long Should Treatment Last ?

- Depends on patient problems/needs
- Less than 90 days is of limited or no effectiveness for residential/outpatient setting
- A minimum of 12 months is required for methadone maintenance
- Longer treatment is often indicated

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## Coercion

Treatment does not need to be voluntary to be effective.

- Court-Ordered Probation
- Family Pressure
- Employer Sanctions
- Medical Consequences



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## What is Recovered in Recovery ?

- Abstinence
- Sense of Responsibility
- Range of Emotions
- Intimacy

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## Compounding Issues in Recovery

- Socio-economic
- Single parent
- Ethnicity
- Matriarch/  
Patriarch
- Gender
- Religion
- Treatment
- Co-dependency
- Employment
- Domestic violence
- Living situation
- Extended family

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## Dual-Diagnosis

- **Mood Disorder+:** For those with mood disorders, 24-40% have a co-occurring substance abuse disorder
- **Alcoholism+:** 65% of females and 44% of male alcoholics have co-occurring mental health disorder(s)
  - THE MAJOR ONE = DEPRESSION
  - 19% of female alcoholics, 4x the rate for men
- **Addiction+:** 30-59% of women in treatment have PTSD, 2-3 times the rate for men

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## Treatment Effectiveness

- Drug dependent people who participate in drug treatment
  - Decrease drug use
  - Decrease criminal activity
  - Increase employment
  - Improve their social and intrapersonal functioning
  - Improve their physical health
- Drug use and criminal activity decrease for virtually all who enter treatment, with increasingly better results the longer they stay in treatment.

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## But...For How Long?

- One Year After Treatment
  - Drug selling fell by nearly 80%
  - Illegal activity decreased by 60%
  - Arrests down by more than 60%
  - Trading sex for money or drugs down by nearly 60%
  - Illicit drug use decreased by 50%
  - Homelessness dropped by 43% and receipt of welfare by 11%
  - Employment increased by 20%

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## How Long...?

### ■ Five Years After Treatment

- Users of *any* illicit drugs reduced by 21%
  - Cocaine users by 45%
  - Marijuana users by 28%
  - Crack users by 17%
  - Heroin users by 14%

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## How Long...?

### ■ Five Years After Treatment (continued)

- Numbers engaging in illegal activity significantly reduced
  - 56% fewer stealing cars
  - 38% fewer breaking and entering
  - 38% fewer injecting drugs
  - 30% fewer selling drugs
  - 34% fewer homeless
  - 23% fewer victimizing others

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## Treatment outcomes

### ■ Consistent findings across studies

- Although improvement usually persists after treatment, relapse is not uncommon
- Limited evidence indicating that one form of treatment is best
- Improvements in general health, social and occupational functioning usually accompany reduction in drug use
- Positive long-term outcomes are most favourably for individuals who have a high degree of coping resources, available social support, and low stress situations

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## Myths of Addiction Treatment

### ■ Myth of Self-Medication

- Treating just the “underlying” disorders tends not to work
- Depression doesn’t make you drink
- BUT drugs do make you feel good (however, less and less over time)

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## Myths of Addiction Treatment

- Myth of Character Weakness
  - Weakness or will power has little to do with becoming addicted
  - Educated, strong people succumb to the best drugs in the world

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## Myths of Addiction Treatment

- Myth of Detoxification
  - Getting sober is easy
  - Staying that way is incredibly difficult
- Myth of Brain Reversibility
  - Addiction produces permanent neurotransmitter and chemical changes

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## Facts of Addiction Treatment

- Chronic disorders require multiple strategies and multiple episodes of intervention
- Treatment works in the long run
- Treatment is cost-effective

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## Treatments for Alcohol Abuse



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## Alcohol Abuse

- 90% of population drink alcohol routinely
- 28% men and 11% of women exceed safe levels regularly (especially binge drinking)
  - Safe levels of units per week
    - Men, 21, women, 14
- 1-2 % of UK population have alcohol use problem
- Lifetime prevalence rate (US) of 20% for men 5% for women
- At present 200,000 people in UK are “alcohol dependent”

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## Socio-medical alcohol related problems

- 33,000 premature deaths per year in UK
- 20-30% of all hospital admissions
- 80% of suicides
- 50% of murders
- 80% death from fires
- 40% RTAs
- 30% fatal RTAs
- 15% drownings

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## General Psychosocial Risk Factors

- Men x 2 more likely than women
  - However, gap narrowing with 50% increase in women drinking over safe limits in last 2 years
- Particular occupations more at risk
  - Medics/military/brewing & catering
- 1/3 of homeless have alcohol dependency problem
  - caused by? result of? Many have a mood disorder un-diagnosed, e.g. PTSD in ex-military

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## Recognising problem drinking pattern

- Consumption over safe limits
- Time of first alcohol drink of the day
- Presence of withdrawal symptoms
  - Morning shakes/nausea
- CAGE questions
  - Have you ever felt the need to **C**ut down
  - Have people **A**nnoyed you by criticizing your drinking
  - Have you ever felt **G**uilty about your drinking
  - Have you ever had a drink to steady your nerves in the morning (**E**ye opener)
    - “Most efficient screening tool”  
Journal of Royal Society of Medicine, Feb 2002

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## General Management Issues

- 1/3 change behaviour without professional help
  - Change in stressors e.g. relationship/work etc.)
- 20% reduction in consumption by “problem drinkers” through GP giving educational advice
  - However 80% of problem drinkers won't be known to GP
- General inpatient/outpatient services:
  - Variable evidence for effectiveness
  - ? Lack of insight
    - Treatment enforced by other
      - Partner
      - Services
      - Legal requirement
  - Therefore low motivation for change

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## Treatment Approaches

- Biological
  - Detoxification
    - either in stages or by use of drugs to nullify symptoms
    - Relapse rates high if no psychotherapy
  - Antagonistic drugs
    - Block effects of addictive drug, e.g. Antabuse for alcohol
    - Produces nausea/dizziness etc. if taken with alcohol, therefore also form of behavioural (aversion) therapy
- Behavioural
  - Developing alternate behaviour, e.g. meditation/assertiveness to manage peers etc.
  - Relapse rate high if not combined with biological/cognitive

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## Range of support needed

- Individual and Group approaches
  - Outpatient
  - Inpatient
- General Support groups
- Residential self-help/therapeutic communities
- Carer support
- Community prevention programmes

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## Pharmacological treatments

- Disulfiram/Antabuse
  - In pill form; by prescription only
  - Inhibits *aldehyde dehydrogenase* (ALDH)
    - Body can't break down alcohol
  - When in system (lasts up to 3 days), alcohol use produces strong aversive physical reaction
  - Must be taken daily
    - Compliance is major drawback
    - Some drinkers don't take pill because of its effect
  - discourages drinking – conditioned aversion

## Pharmacological treatments

### ■ Naltrexone

- In pill form; by prescription only
- Blocks opioid receptors in the brain
- 2 main effects
  - Decreases rewarding experience of alcohol
  - Reduces craving
- Must be taken daily
  - Compliance is major drawback

## Behavioural Treatments for Alcohol Abuse

- Self-help groups – Alcoholics Anonymous – AA and the 12 step program – no systematic evaluation, claims 75% success rate of AA
- Individual treatment
- Group therapy
- Couples therapy
- Family therapy
  - In most cases, can occur as inpatient or outpatient

## Treatments for Alcohol Abuse

### ■ Coping and Skills Training

- Drinking conceptualized in terms of deficits in interpersonal and coping skills
  - Condition more adaptive responses to drinking cues
  - Focus on new coping skills
    - Functional analysis, relapse prevention, cue exposure, refusal skills

## Treatments for Alcohol Abuse

### ■ Community Reinforcement Approach

- Based in Cognitive/Behavioral theory
- Sobriety through use of support systems:
  - Examine interaction between environment & drinking
  - Uses skills training
    - Functional analysis
    - Mood monitoring
    - Vocational counseling
    - Drink refusal training
    - Compliance monitoring
    - Buddy systems

## Treatments for Alcohol Abuse

### ■ Motivational Interviewing

- Brief intervention tradition
- Non-confrontational
- Client-centered
- Focus on motivation/readiness to change
- Techniques include:
  - Feedback of risk/impairment
  - Responsibility for change
  - Advice to change
  - Menu of alternative change options
  - Therapist empathy
  - Facilitation of client self-efficacy

■ <http://motivationalinterview.org/clinical/>

## Cognitive Behavioural Approach

### ■ CBT: behavioural self-control

- Tends to be most effective for misuse problems
- Need to be in combination with detox for dependence

### ■ Key components:

- Education on alcohol
- Contract
- Identify triggers and coping strategies
- Develop Goals: e.g.
  - Keep to agreed (realistic) limits
    - Possible for controlled drinking at some point with misuse, dependence less likely to succeed
  - Develop assertiveness skills

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## CBT & alcohol management: Case TL

- TL: 26 yrs Male
- Promising career in law
- Following mild TBI difficulty progressing in work/studies
- “drifted” into drinking ++
- Lost work/relationship
- Living with parents
- For 1 at least year binged for 3 – 4 days over weekend
- Parents end of coping
- TL: occasionally suicidal
  - “drink only pleasure”
    - Pub, home
  - No purposeful activity left
- Keeping diary
  - Identify vulnerable times/triggers
    - Peer
    - Money
    - Worries over future
    - Alcohol = disinhibit therefore, less control to control drinking

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## CBT & alcohol management: Case TL

- Insight re:
  - Alcohol &
    - Fatigue
    - Irritability
    - short term tension release/ Long term guilt cycle & depression
    - Health issues
- Agreed self-rules
  - Reducing stress with relaxation
  - Limit hours in pub/money
  - Increase non-alcohol activities
  - Cut off point
  - Pacing drinking/pacers
  - Building in rewards
- 6 Months of treatment
  - Individual
  - Group work
  - Decrease no. sessions over time
- Outcome:
  - Managed reduced intake 2 of 4 weekends
  - On graphics art course
  - Ongoing support through local group

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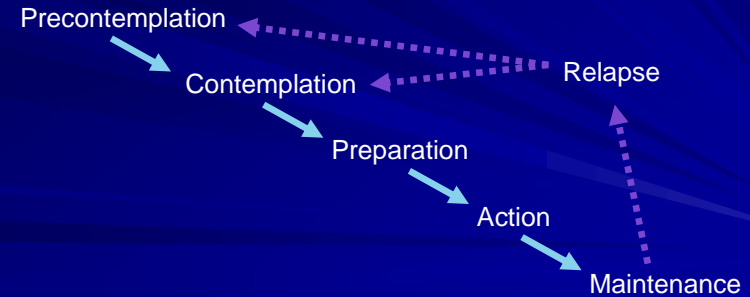
## Relapse prevention



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## Stages of Change

- The stages of change model developed by Prochaska et al. (1992) provides a model of the process of stopping substance abuse – allows for relapse.



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## Relapse signs and symptoms 1

- **Experiencing Post Acute Withdrawal**, e.g. having problems with thinking, emotional overreaction problems, sleep disturbances, memory difficulties, becoming accident prone, and/or starting to experience a serious sensitivity to stress.
- **Return To Denial**, e.g. Convincing self or others that everything is all right, when in fact it is not.
- **Avoidance And Defensive Behaviour**, e.g. avoiding people who give honest feedback leading to irritability and anger.
- **Starting To Crisis Build**, e.g. becoming overwhelmed by ordinary activities; inability to problem solve.
- **Feeling Immobilised (Stuck)**, e.g. believing that there is nowhere to turn and no way to solve problems.

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## Relapse signs and symptoms 2

- **Becoming Depressed**
- **Compulsive And/Or Impulsive Behaviours (Loss Of Control)**, e.g. becoming reliant of displaced behaviours such as food, sex, caffeine, nicotine, work, gambling; impulsive behaviours without thought out consequences.
- **Urges And Cravings (Thinking About Drinking/Using)**
- **Chemical Loss Of Control (Drinking/Using)**, e.g. return to substance abuse to solve my problems, "it's all over 'till I hit bottom, so I may as well enjoy this relapse while it's good."

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## Common relapse dangers

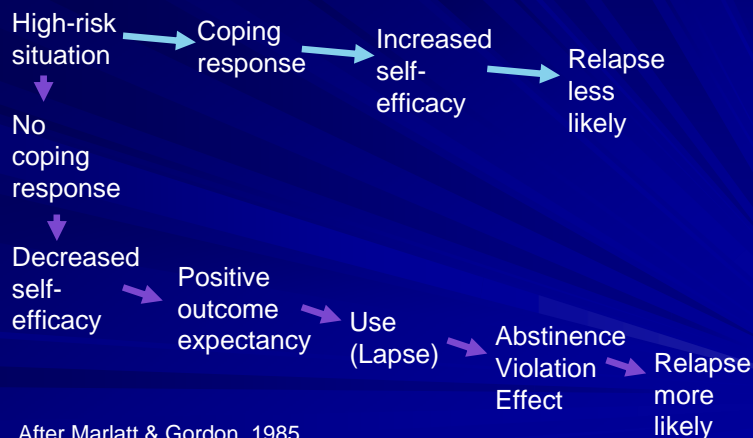
- Being in the presence of drugs or alcohol, drug or alcohol users, or environments associated with substance abuse.
- Perceived negative feelings, e.g. anger, loneliness, guilt, fear, and anxiety.
- Positive feelings which encourage celebration.
- Boredom.
- Getting high on any drug.
- Physical pain.
- Using prescription medication that can have intoxicating effects even if used appropriately.
- Complacent – belief that one is no longer stimulated by substance, therefore safe to use occasionally.

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## Relapse Prevention

- Marlatt & Gordon (1985) – CBT Relapse prevention model
- Relapse begins with a high-risk situation
  - withdrawal
  - stressful situations
- Relapse depends on
  - The availability of non-drug coping strategies
  - Self-efficacy
  - positive outcome expectancies following use
- There is, as yet, little evidence as to the effectiveness of relapse prevention.

## The relapse process



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## Relapse prevention includes a variety of components

- Self-monitoring of high-risk situations
- Rehearsing positive self-statements
- Distraction
- Reviewing the pros and cons of abstinence/relapse
- Covert modelling of coping with high-risk situations
- Preparation for dealing with lapses
- Graded practice/exposure

## Controversies: Controlled drinking or abstinence?

Helzer et al. (1985): controlled moderate drinking was rare (1.6%) in 5-7 year follow up

- 15.1 % were abstinent, while 66.5% were still alcoholic.
- A further 4.6% alternated between moderate drinking and periods of abstinence.
- 12.2% were defined as heavy non-problem drinkers. No evidence of health or legal problems but had drunk more than 7 drinks on four or more days in a single month.

Rosenberg (1993) reviewed predictors of successful controlled drinking.

- Severe dependence is associated with less success at controlled drinking
- Beliefs as to the importance of abstinence are also important.

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