Assessment Diagnosis & Treatment of Substance Use Disorders

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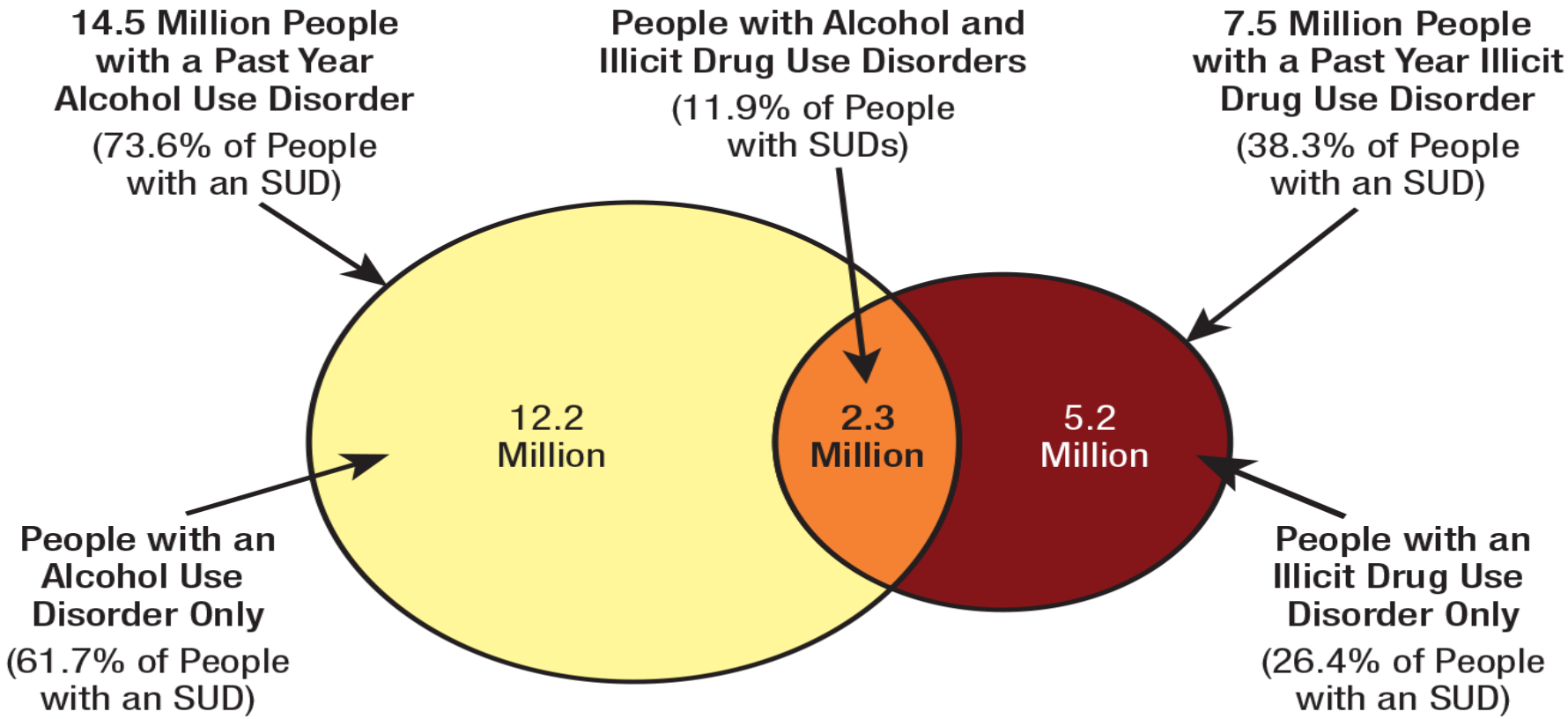
Agenda

- Substance use disorder trends
- Why all clinicians should treat SUD
- DSM 5 criteria and assessment
- Determining level of care
- Evidenced based medication and psychosocial treatments
- Later stage recovery

Substance Use Disorders

- Clinically significant impairment caused by the recurrent use of alcohol or other drugs (or both), including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Alcohol Use Disorder and Illicit Drug Use Disorder in the Past Year among People Aged 12 or Older with a Past Year Substance Use Disorder (SUD): 2017



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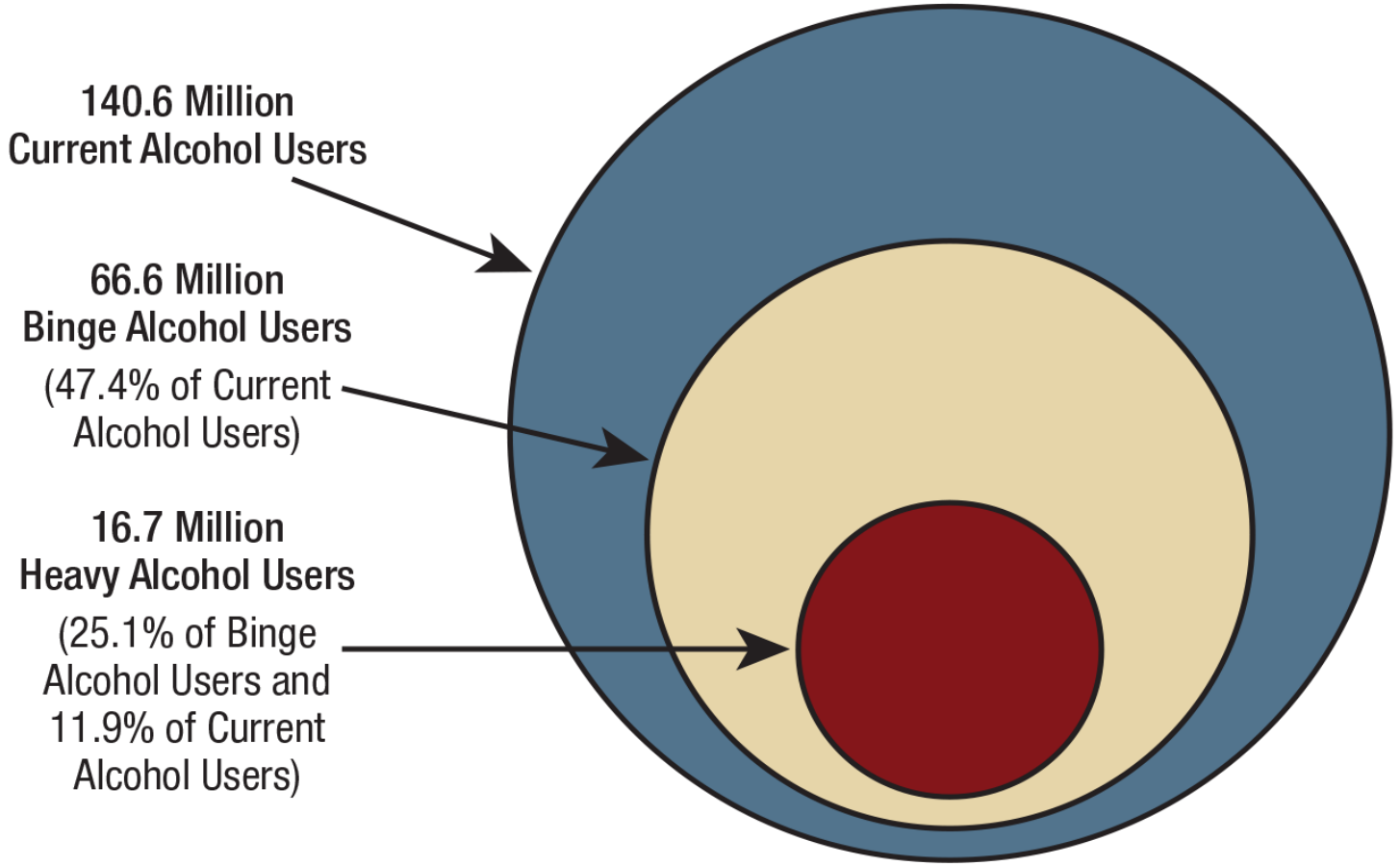
Current, Binge, and Heavy Alcohol Use among People Aged 12 or Older: 2017



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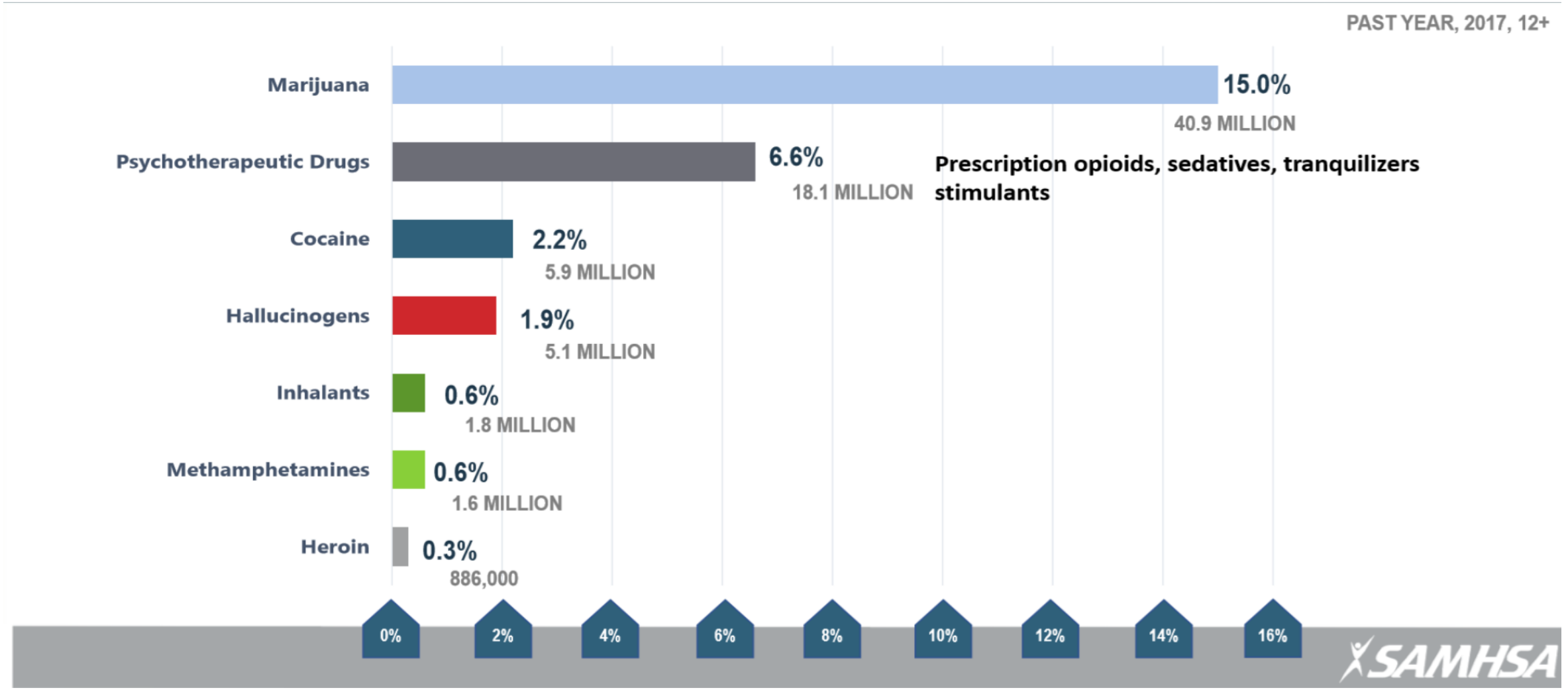
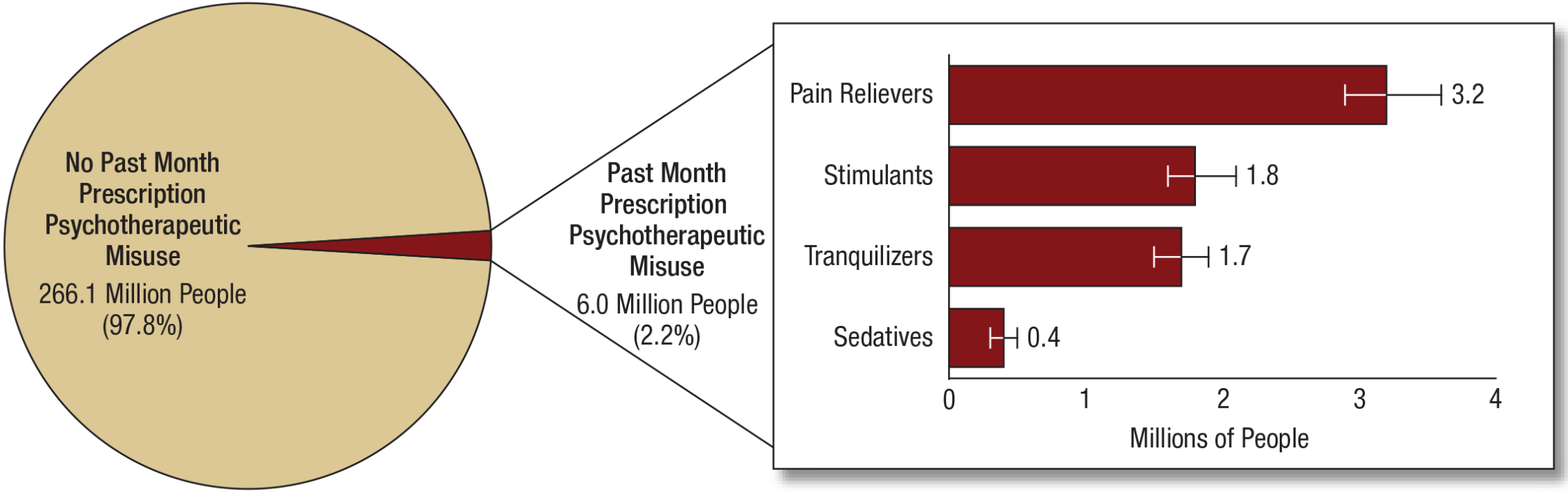
- Note: Since 2015, the threshold for determining binge alcohol use for males is consuming five or more drinks on an occasion and for females is consuming four or more drinks on an occasion.

Illicit Drug Use Disorders




DOCTOR, IVE HEARD THAT CANNABIS CAN BE USED FOR SAFE EFFECTIVE PAIN MANAGEMENT
MAYBE, BUT ALL I CAN PRESCRIBE YOU IS A DECADE OF OPIATE ADDICTION AND PROBABLY AN EARLY DEATH
SUPER STUPID FRIDAY

Numbers of Past Month Prescription Psychotherapeutic Misusers among People Aged 12 or Older: 2017

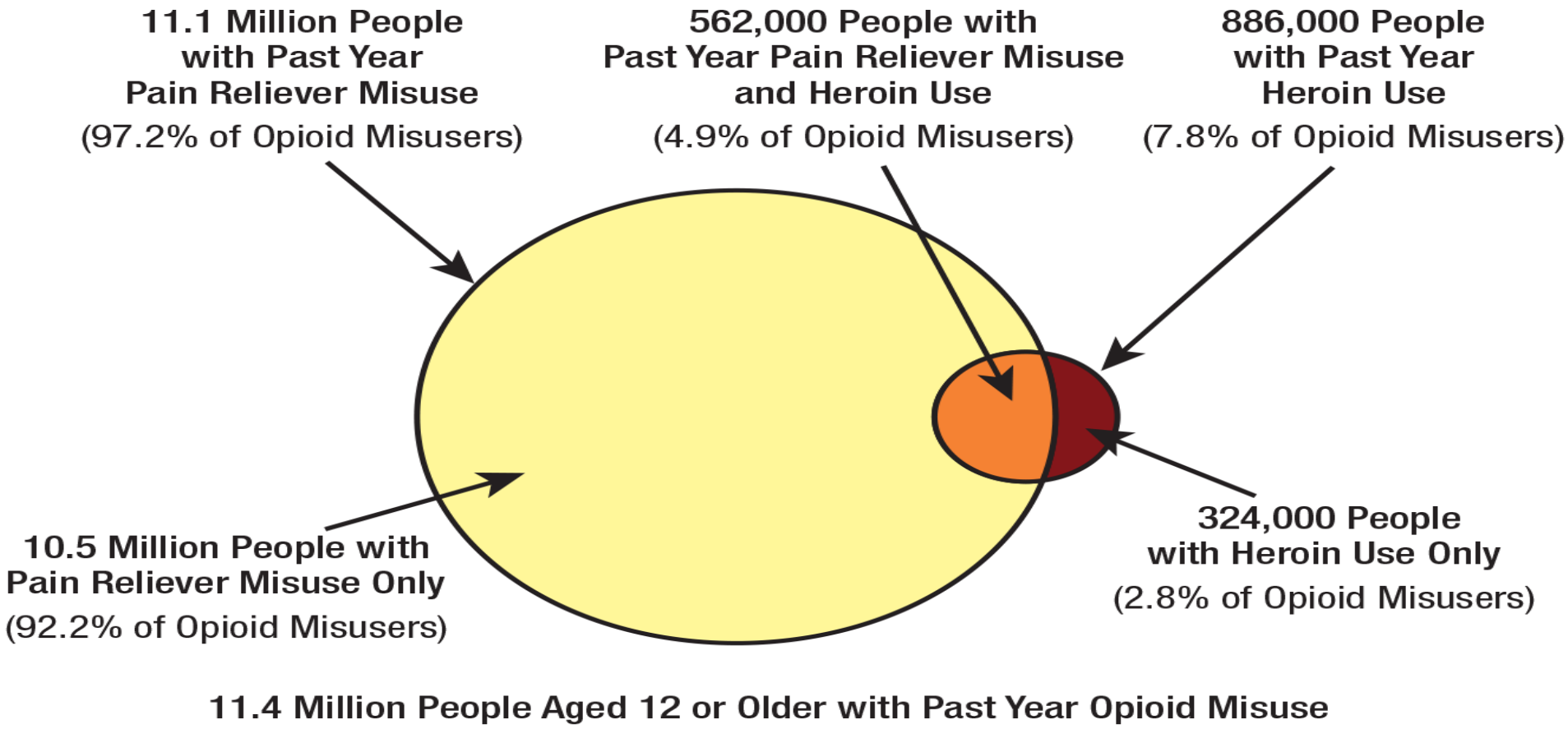


- Note: Estimated numbers of people refer to people aged 12 or older in the civilian, noninstitutionalized population in the United States. The numbers do not sum to the total population of the United States because the population for NSDUH does not include people aged 11 years or younger, people with no fixed household address (e.g., homeless or transient people not in shelters), active-duty military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental institutions, and long-term care hospitals.
- Note: The estimated numbers of past month misusers of different prescription psychotherapeutics are not mutually exclusive because people could have misused more than one type of prescription psychotherapeutic in the past month.

Drug dealers sometimes dress up as pharmacists to throw off the cops.

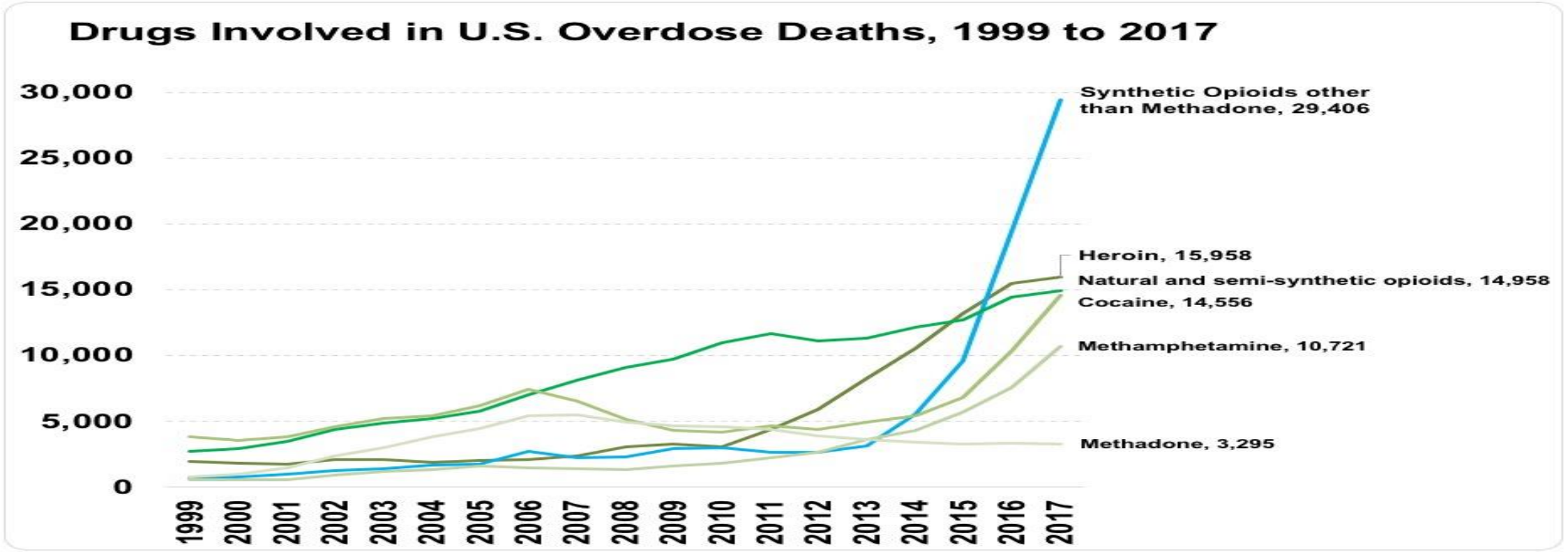
- FFR1.20

Past Year Opioid Misuse among People Aged 12 or Older: 2017

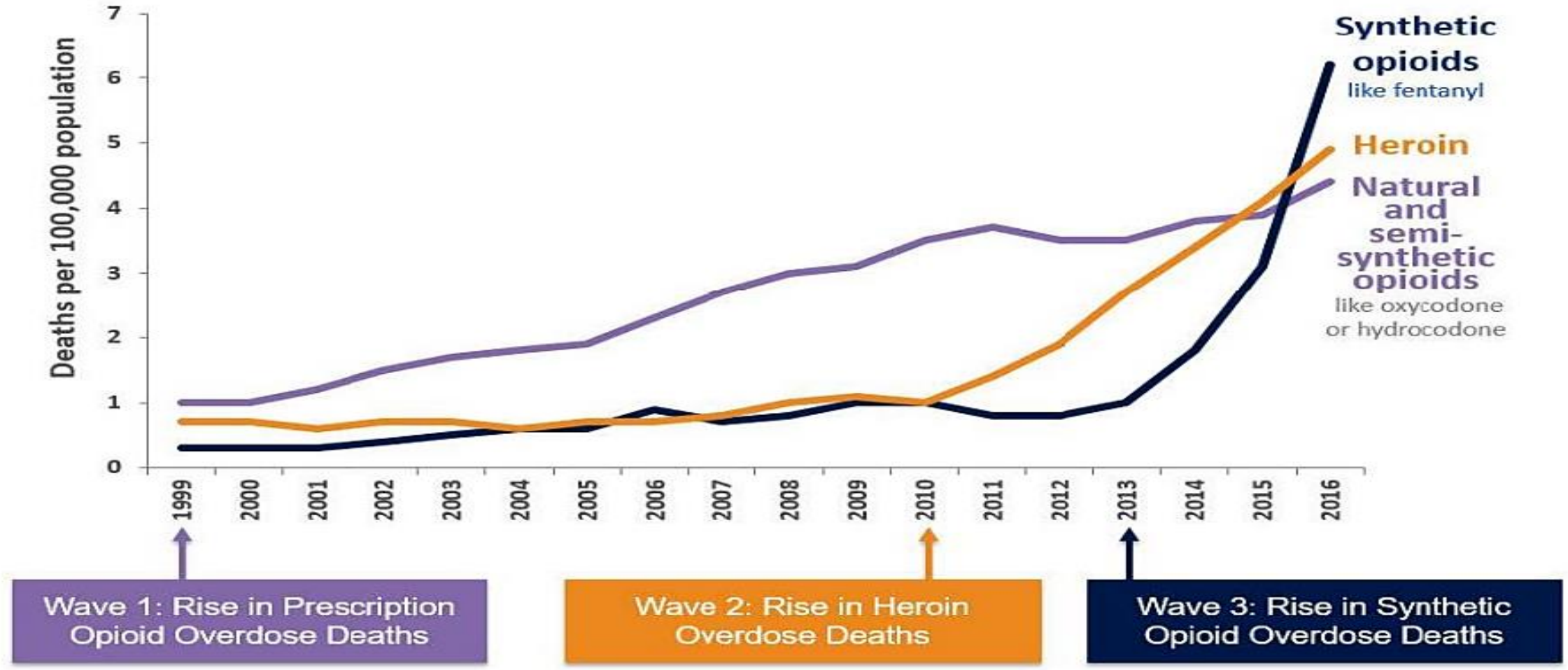


- Note: Opioid misuse is defined as heroin use or prescription pain reliever misuse.
- Note: The percentages do not add to 100 percent due to rounding.

More than 72,000 Americans Died of Drug Overdoses in 2017



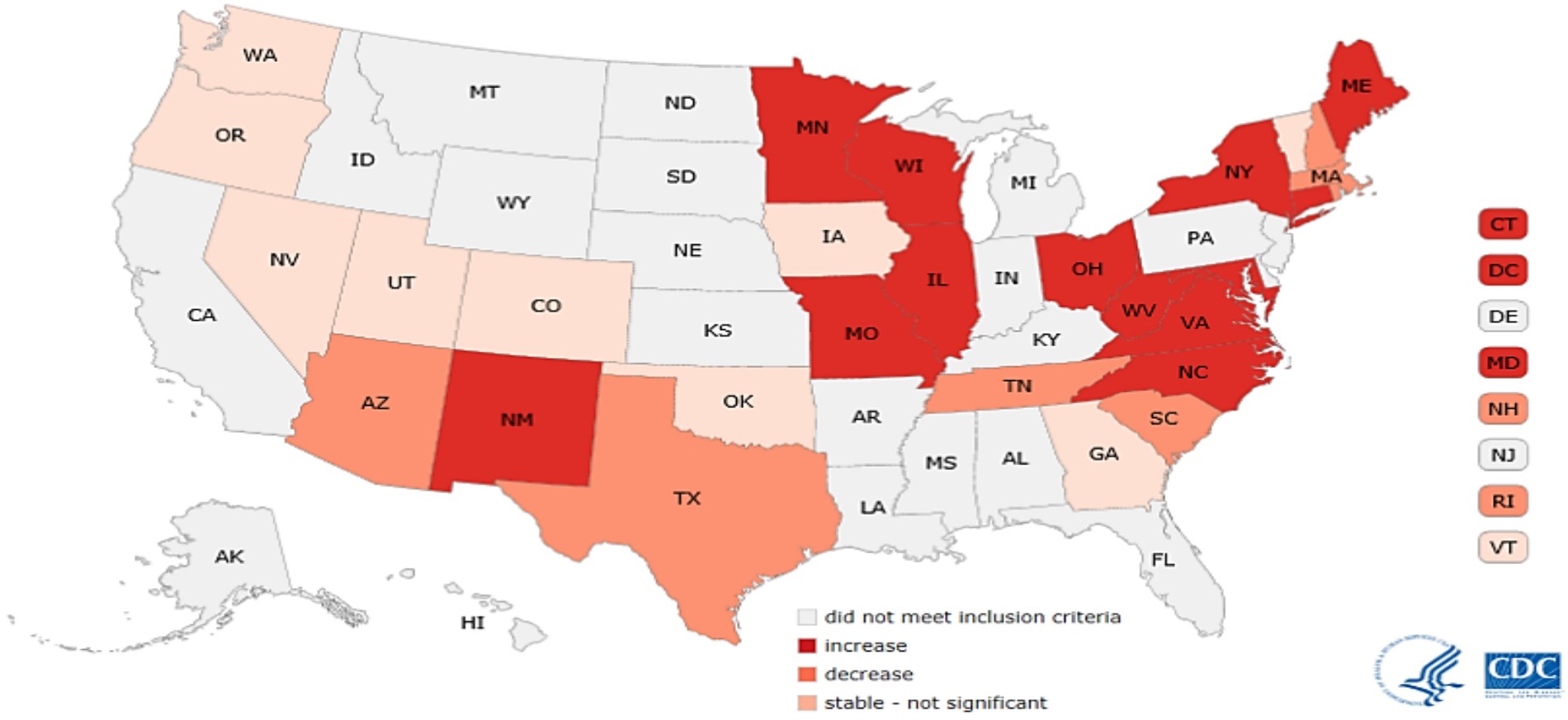
3 Waves of the Rise in Opioid Overdose Deaths



SOURCE: National Vital Statistics System Mortality File.

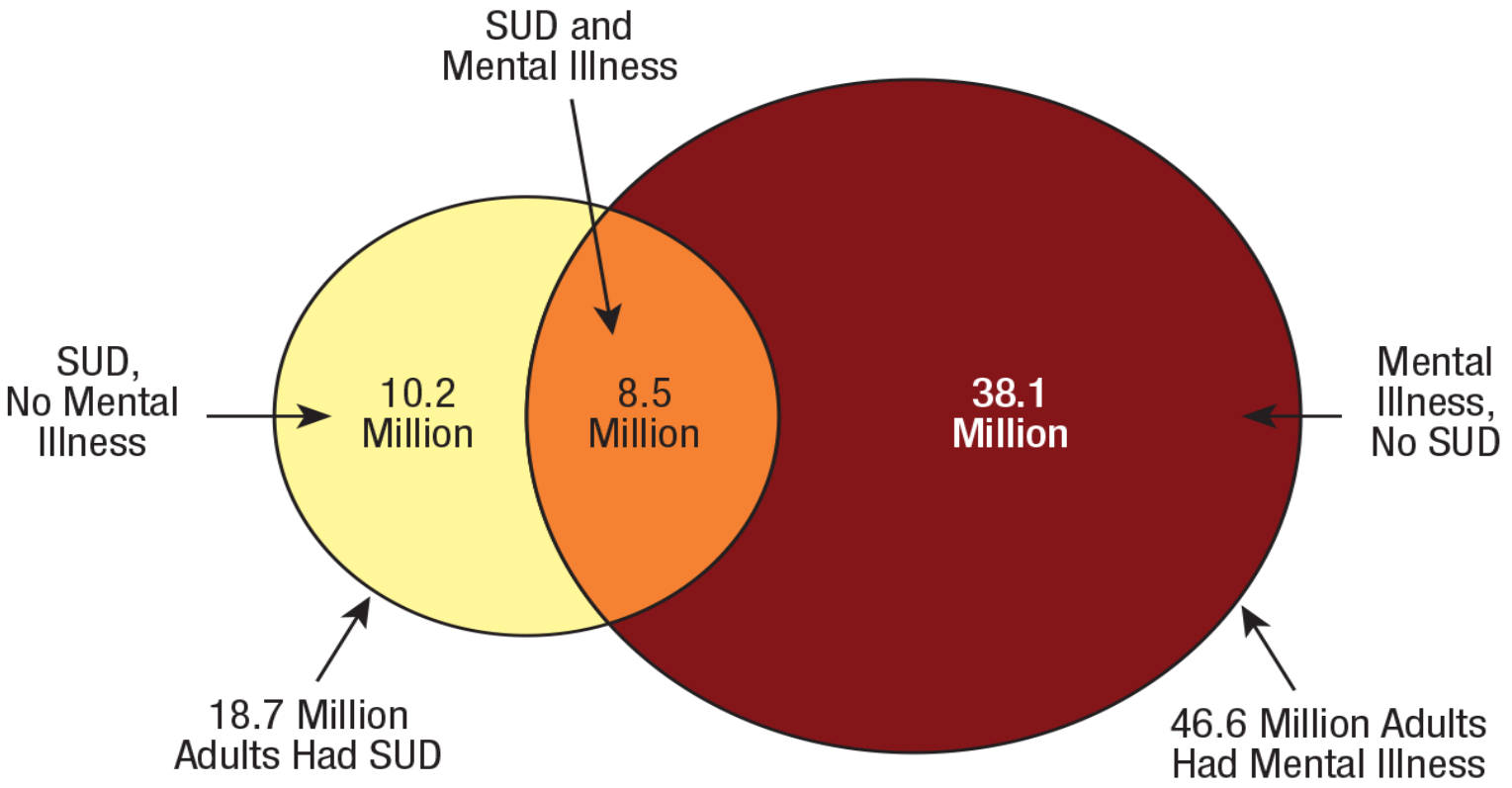

BUSINESS IS BOOMING!
FENTANYL DEALER
OVERDOSE DEATHS SKY-ROCKET
GREG PERRY

Synthetic Opioid Overdose Deaths: 2015 - 2016




Heroin
Lethal Dose
10-12mg
Fentanyl
Lethal Dose
1-2mg
Carfentanil
Lethal Dose
.02mg
LIBERTY
NOTE: Information is based on DEA data. Every person reacts differently.
Heroin in doses as little as 3mg or less have been known to cause death.

Past Year Substance Use Disorder (SUD) and Mental Illness among Adults Aged 18 or Older: Numbers in Millions, 2017



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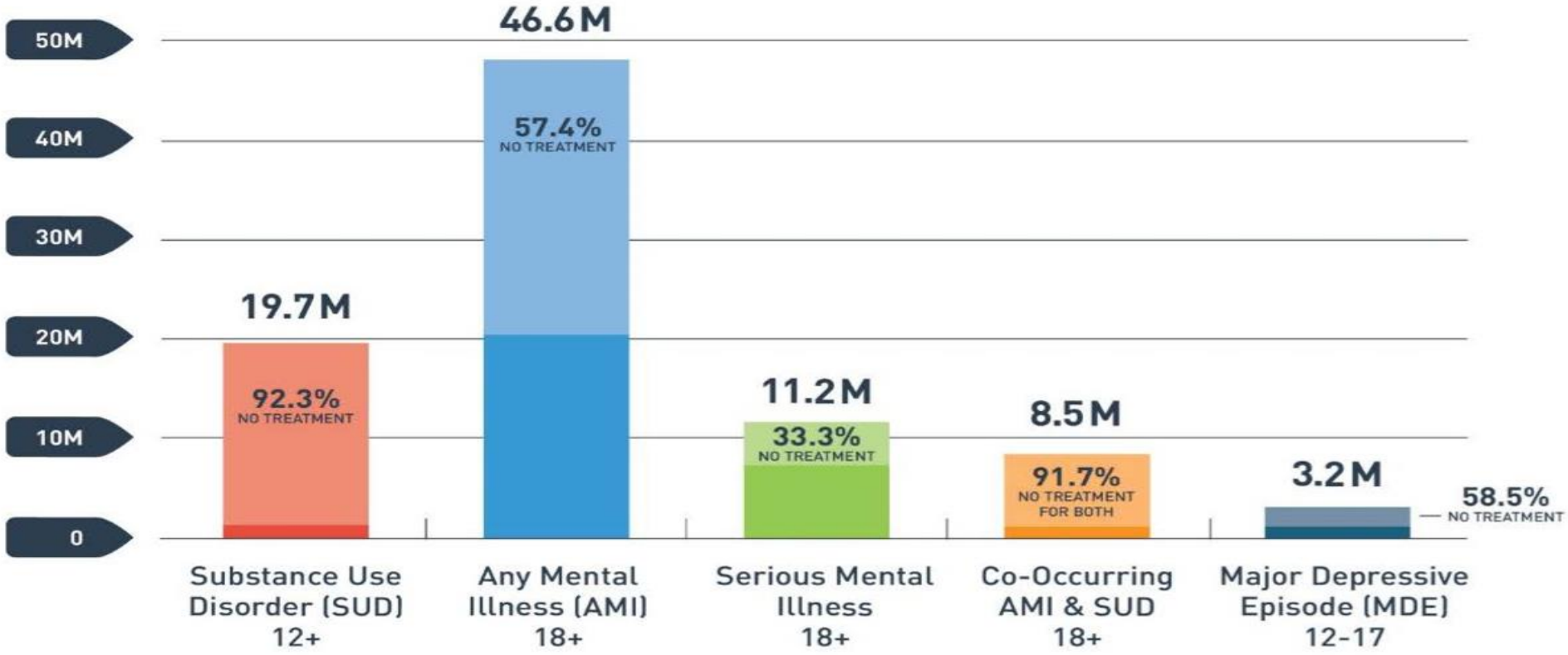
Not Receiving Treatment

PAST YEAR, 2017



See the 2017 NSDUH Report for additional information.

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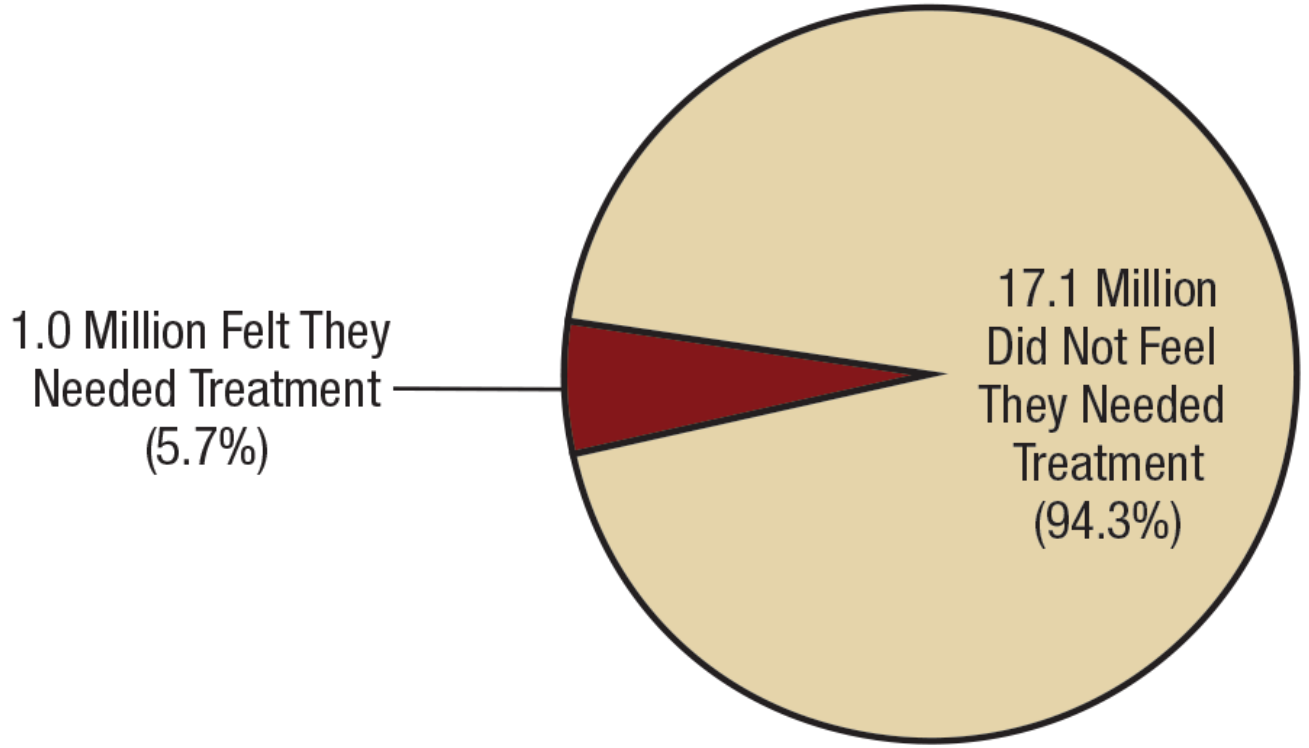
Perceived Need for Substance Use Treatment among People Aged 12 or Older Who Needed but Did Not Receive Specialty Substance Use Treatment in the Past Year: 2017



18.2 Million People Needed but Did Not Receive Specialty Substance Use Treatment

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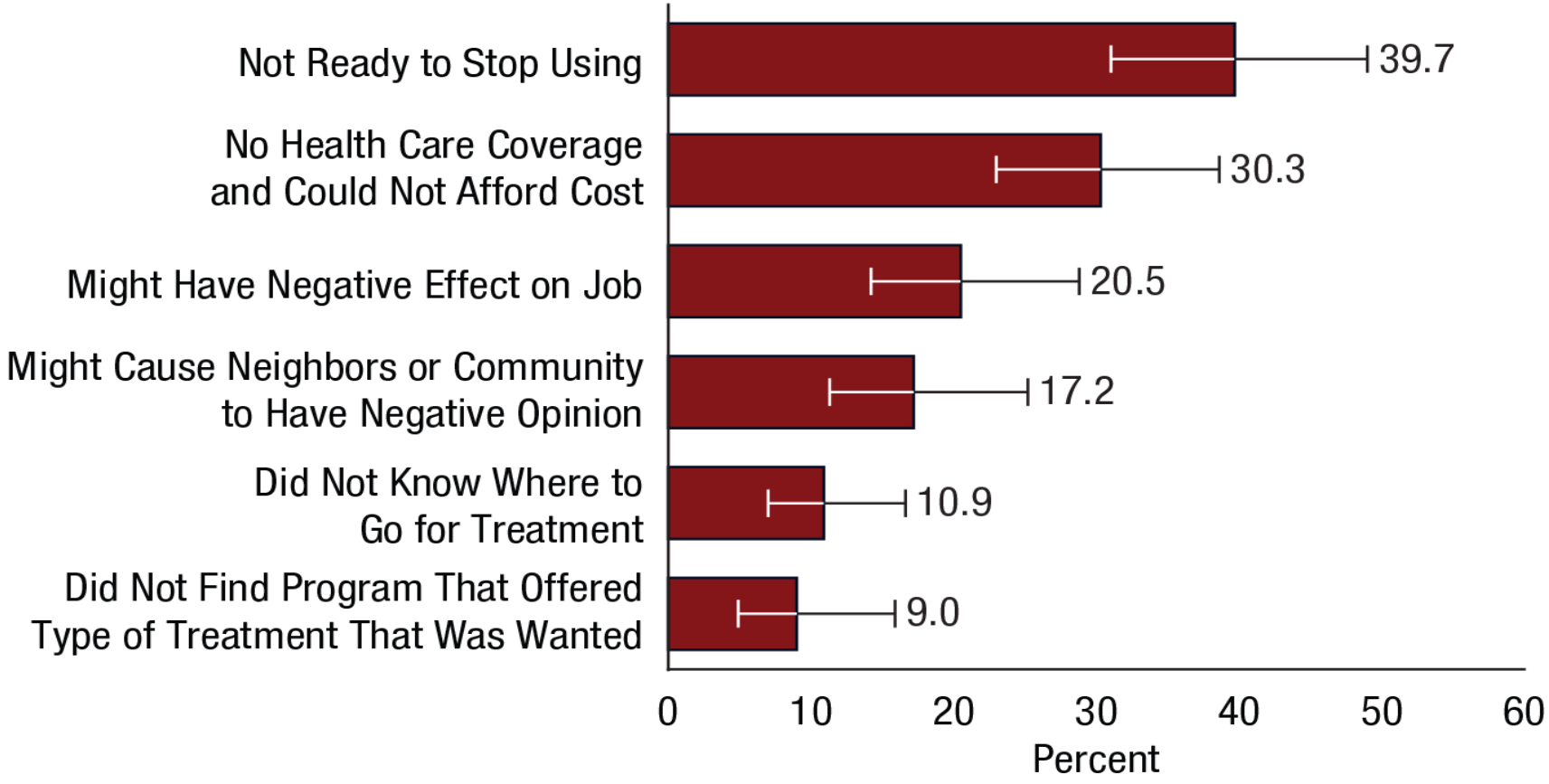
Reasons for Not Receiving Substance Use Treatment in the Past Year among People Aged 12 or Older Who Felt They Needed Treatment in the Past Year: Percentages, 2017



- Note: Respondents could indicate multiple reasons for not receiving substance use treatment; thus, these response categories are not mutually exclusive.

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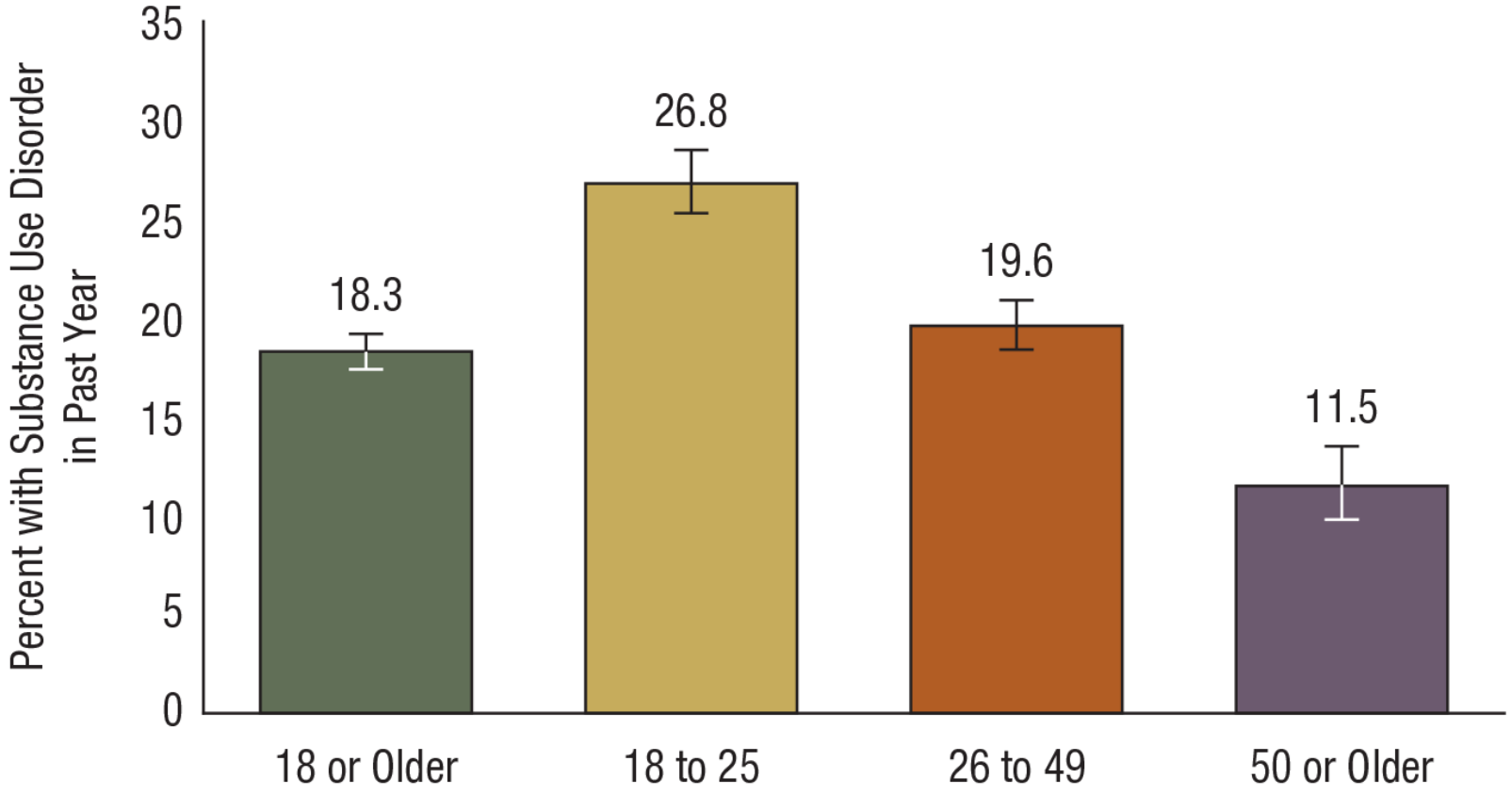
"Reality. It's been my one terrible blind spot for years."

Why all clinicians should be well versed in treating SUD

SUDs are particularly common among people who seek help for other types of mental disorders.

Past Year Substance Use Disorder among Adults Aged 18 or Older with Any Mental Illness in the Past Year, by Age Group: Percentages, 2017



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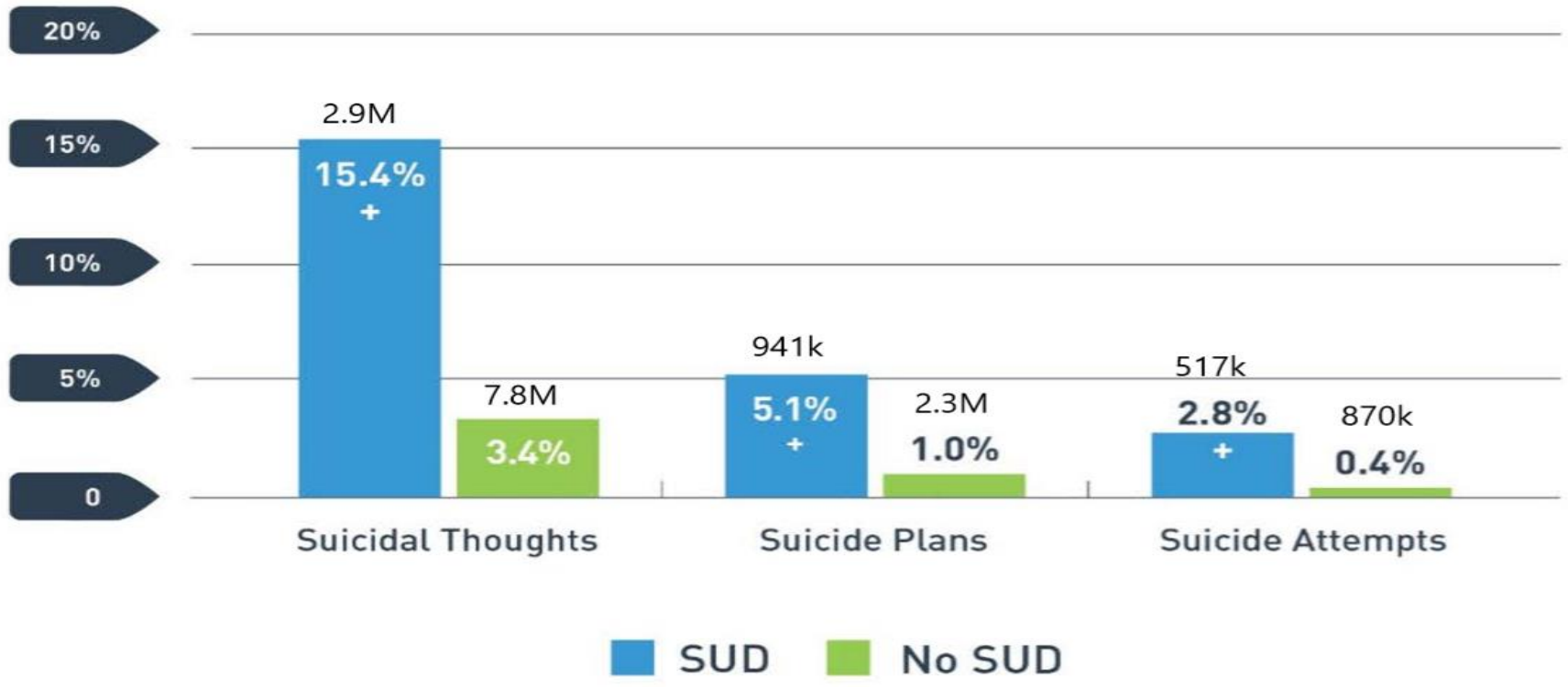
Increased Risk for Suicide

PAST YEAR, 2017, 18+



Special analysis of the 2017 NSDUH.

+ Difference between this estimate and the estimate for adults with no SUD is statistically significant at the .05 level.

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Why all clinicians should be well versed in treating SUD

Psychiatrists and other mental health providers often do not receive specific training in identifying, assessing, and treating SUD.

- 40% of patients stated that their physician missed the diagnosis, and only 25% were involved in their decision to seek treatment.
- Less than half of individuals who graduate with a masters in clinical or counseling psychology take a course on substance use disorders.

Why all clinicians should be well versed in treating SUD

Well trained clinicians already possess the necessary therapeutic skills.

Working with patients with SUDs can be extremely gratifying.

Office practitioners are in an excellent position to intervene with patients who are developing serious problems.

Multidimensional Assessment

Arguably the most critical phase, as it sets the tone and determines if the patient is going to be engaged in the process.

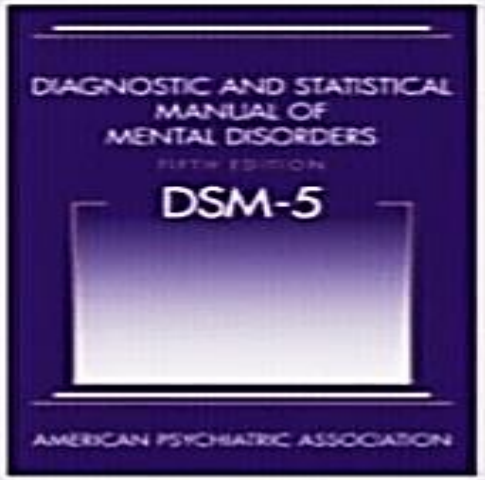
DSM 5 Criteria for Substance Use Disorders

Substance use disorders span a wide variety of problems arising from substance use, and cover 11 different criteria.

DSM-5 Substance Use Disorder Criteria

(Impaired control)

1. Use in larger amounts or longer than intended
2. Desire or unsuccessful effort to cut down
3. Great deal of time using or recovering
4. Craving or strong urge to use



(Social impairment)

5. Role obligation failure
6. Continued use despite social/interpersonal problems
7. Sacrificing activities to use or because of use

(Risky use)

8. Use in situations where it is hazardous
9. Continued use despite knowledge of having physical or psychological problem caused or exacerbated by use

(Neuroadaptive/physiologic)

10. Tolerance
11. Withdrawal

DSM-5 Severity and Specifiers

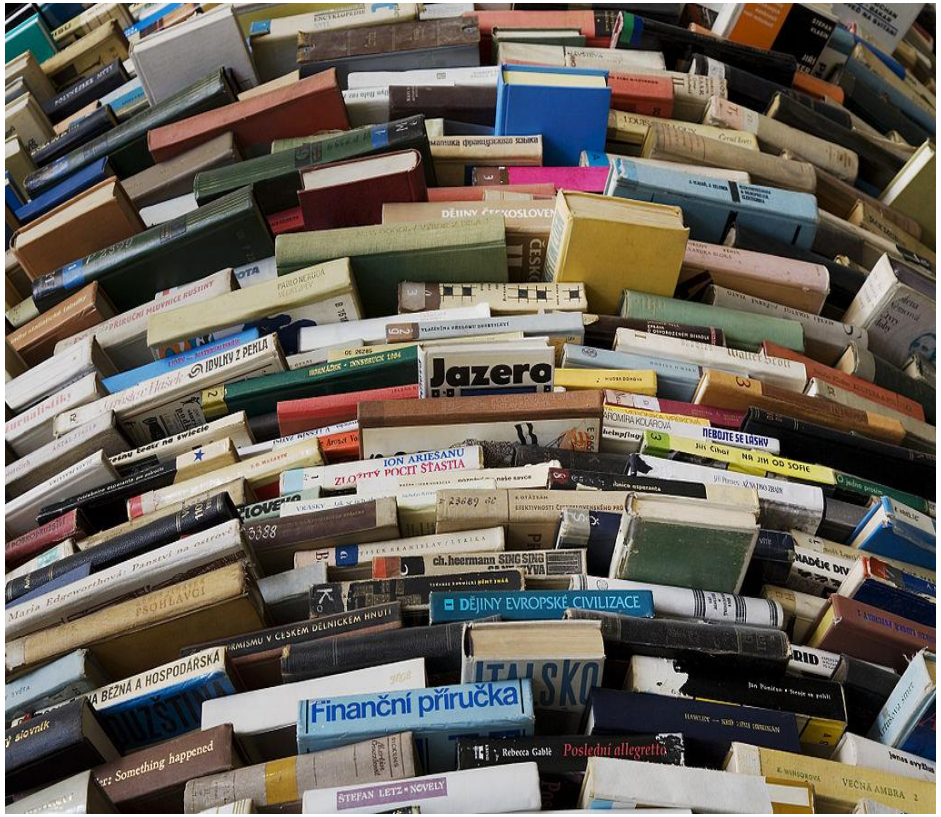
- Severity ranges from mild to severe based on the number of symptoms

  Mild: two to three symptoms
  Moderate: four to five
  Severe: six or more

- Course specifiers
  - "In early remission"
  - "In sustained remission"
  - "On maintenance therapy"
  - "In a controlled environment"

"I'm right there in the room, and no one even acknowledges me."

SUD Assessment



How you breach the topic of alcohol and drug use matters.

The Clinical Interview

- Reasons for seeking help
- Nature and extent of substance use
- Positive and negative consequences of use
- Developmental history with focus on substance use issues
- Other addictive and compulsive behaviors
- Prior treatment
- Family history of SUD
- Role of family in current use

Why Now?

What is happening at this point in time?

Questions should be done with an attitude of curiosity and interest.

Nature and Extent of Substance Use

Current alcohol or drug use (how they describe this is important)

Simultaneous or sequential use of all substances

Typical episodes of use

Amounts with legally manufactured vs. illicit

Patterns of use

Ask the follow up Questions- Its important

- Ask: "How much do you typically drink?"
  - Follow-up questions: What type (of beer or liquor)? What size? How many? How often? What else? When was your last drink?
  - Most patients will report number of containers, not number of standard drinks.
  - Many patients will report their liquor consumption but not their beer consumption or vice versa.
  - Listen for inconsistencies which may suggest under-reporting.

“I have two or three beers.”

What you picture:

Two 12-oz regular beers = 2 Standard drinks

“I have two or three beers.”

What they mean:

Four 24-oz malt liquors = 13 Standard drinks

Positive and Negative Consequences of Use

- Ask about the positive effects before asking about the negative
- Substances produce positive effects in the early stages
- Functional and self-medication aspects of use
- Negative consequences serve two main functions


IT MUST BE AN ADULT BINKY - THEY FREAK OUT WHEN THEY CAN'T FIND IT.

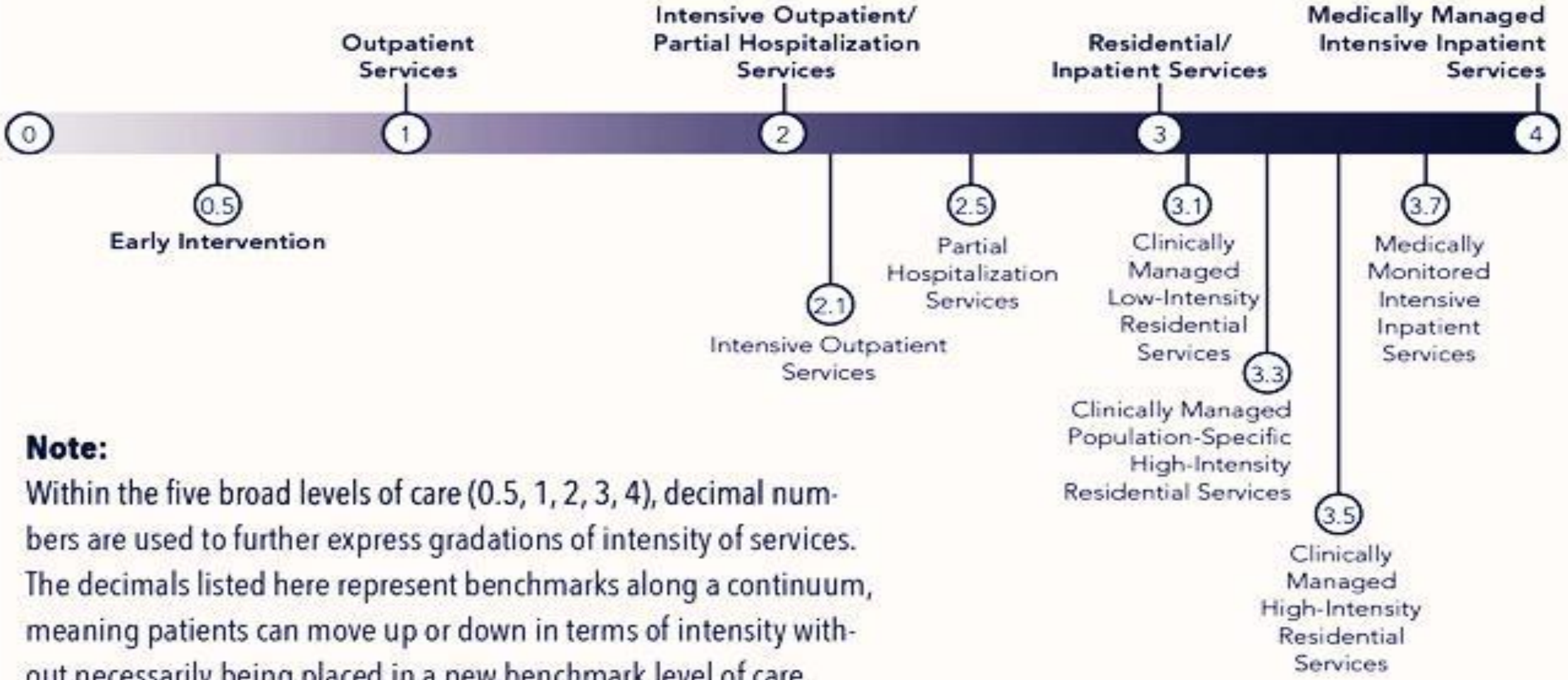
Determining Level of Care

What Treatment Options are Recommended?

Levels of Care

- Early intervention
- Outpatient services
- Intensive outpatient services
- Partial hospitalization
- Residential services
- Medically managed intensive inpatient services

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.

AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

1	DIMENSION 1	**Acute Intoxication and/or Withdrawal Potential** Exploring an individual's past and current experiences of substance use and withdrawal
2	DIMENSION 2	**Biomedical Conditions and Complications** Exploring an individual's health history and current physical condition
3	DIMENSION 3	**Emotional, Behavioral, or Cognitive Conditions and Complications** Exploring an individual's thoughts, emotions, and mental health issues
4	DIMENSION 4	**Readiness to Change** Exploring an individual's readiness and interest in changing
5	DIMENSION 5	**Relapse, Continued Use, or Continued Problem Potential** Exploring an individual's unique relationship with relapse or continued use or problems
6	DIMENSION 6	**Recovery/Living Environment** Exploring an individual's recovery or living situation, and the surrounding people, places, and things

Evidenced Based Substance Use Disorders Treatment

Treatment Strategies that Can Help Address the Dangers of Substance Use and Opioid Addiction in the US

- Efforts to de-stigmatize addiction and treatment
  - Education and public awareness
- Increasing access to evidence based treatment
  - Reimbursement, insurance coverage, number of treatment programs
- Expanding medication assisted treatment
  - (suboxone, naltrexone, methadone)
  - Number of providers willing to treat and provide these medications
- Increased psychosocial and recovery support
  - Counseling, mental health, family involvement, monitoring services for extended periods of treatment
- Ongoing research to evaluate current treatment strategies and help direct future care
- Increased availability and utilization of Naloxone to reduce the number of opioid related overdose deaths

Why Medications?

- SUDs are chronic brain diseases
  - Multifactorial, like other chronic diseases
  - Respond best to comprehensive treatment
  - Require long-term treatment
- Medications improve treatment outcome over psychosocial interventions alone
  - Prevent medical complications of substance withdrawal
  - Facilitate engagement in psychosocial treatment
  - Reduce craving and risk of relapse
  - Protect against opioid overdose
  - Can reduce overall mortality by more than 50% in opioid use disorders

Luis Sordo et al. BMJ 2017;357:bmj.j1550

Compliance and Relapse in Chronic Medical Disorders

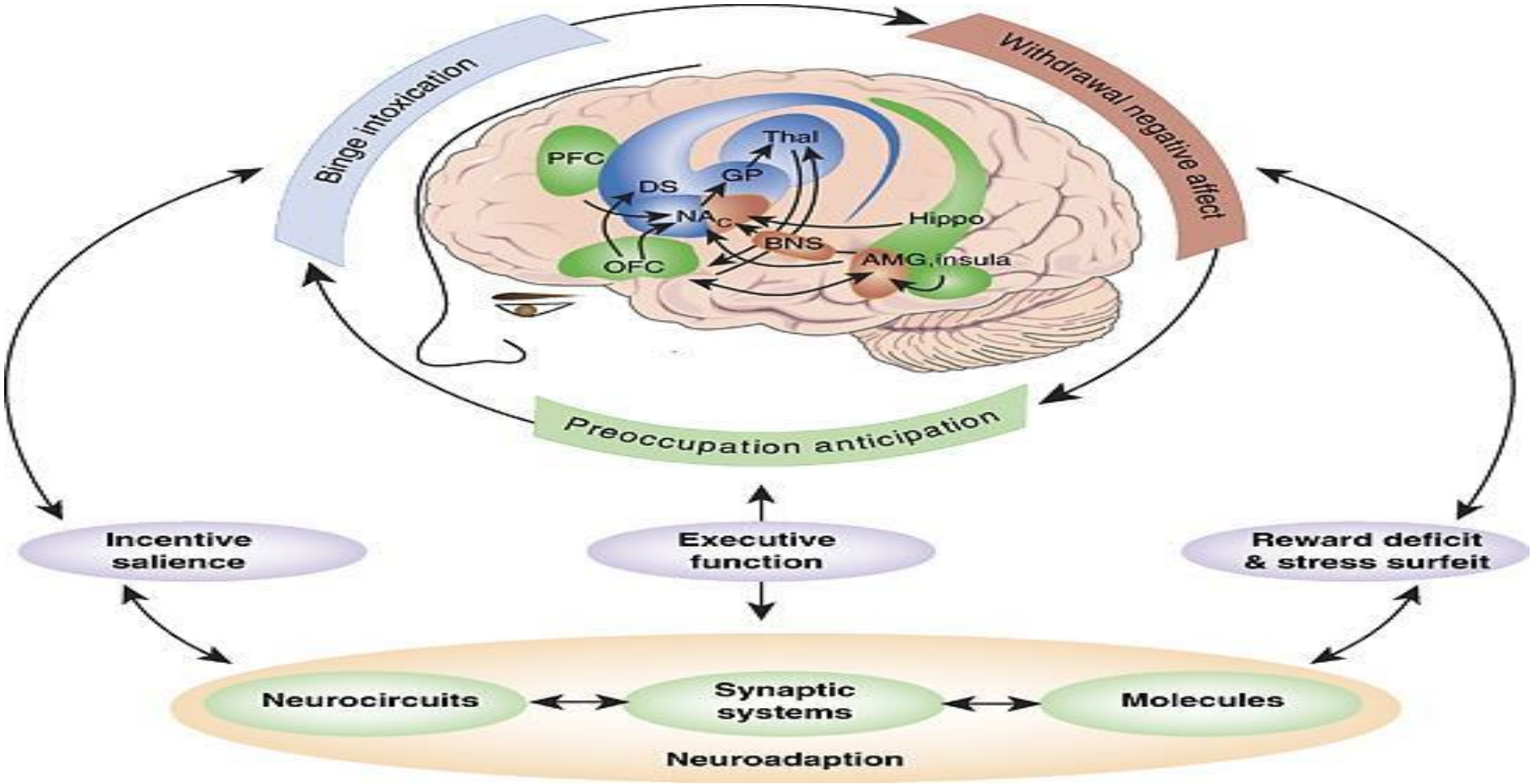
- **Insulin-dependent diabetes**
  - Compliance with medication <50%
  - Compliance with diet and foot care <30%
    - Retreated within 12 months 30 – 50%

- **Medication-dependent hypertension**
  - Compliance with medication <30%
  - Compliance with diet <30%
    - Retreated within 12 months 50 – 60%

- **Substance use disorders**
  - Compliance with treatment attendance <40%
    - Retreated within 12 months 10 – 40%

O'Brien CP, McLellan AT. *Lancet*. 1996;347:237-240.

Interconnected Networks Mediating Motivation and Decision-making

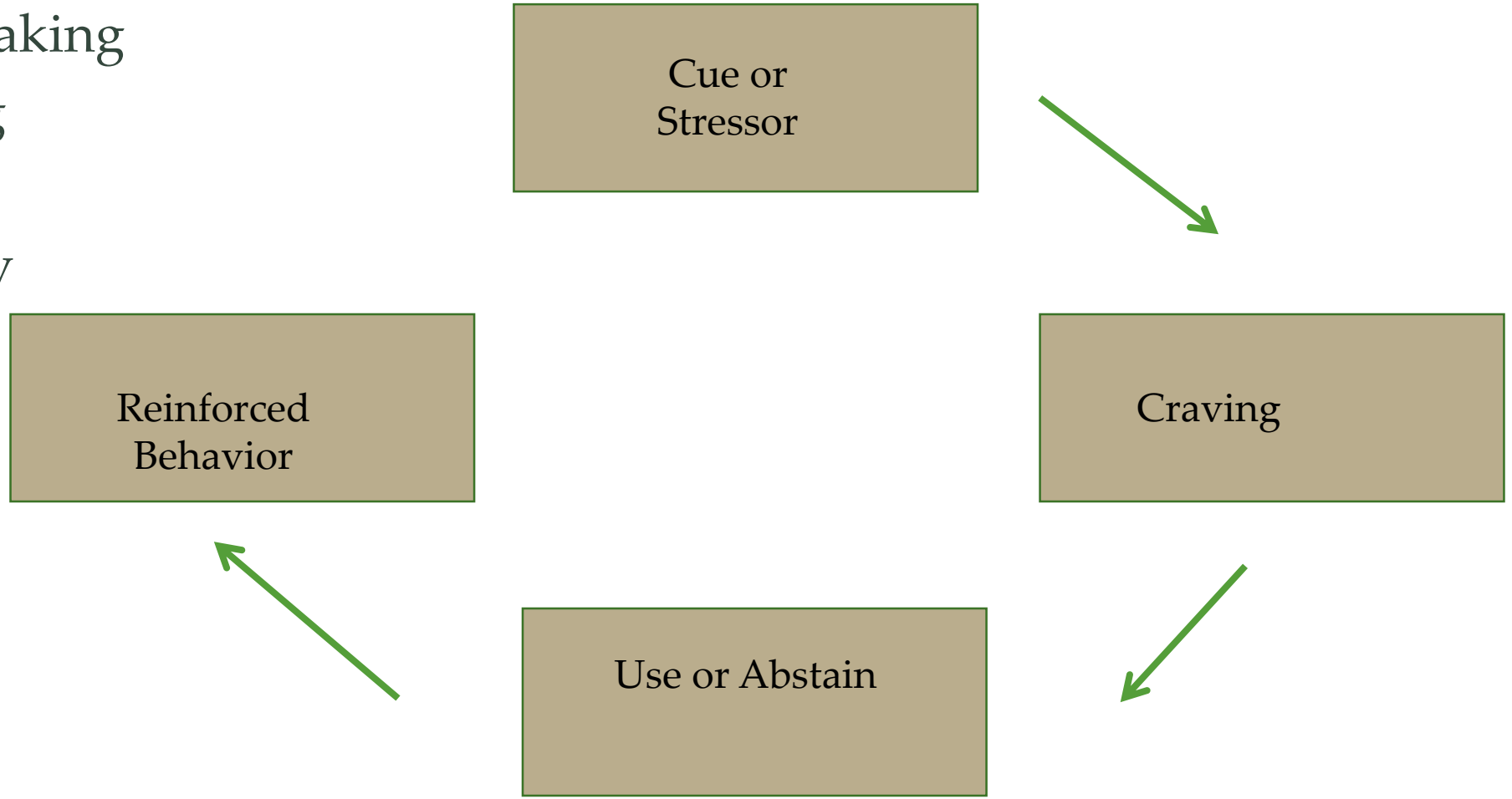


George Koob, PhD (2013)

My prefrontal cortex made me do it!

Current Neurobiological Understanding of SUDs

- Impaired decision-making
- Conditioned learning
- Can be influenced by psychopharmacology



Ernst & Paulus (2005)

Medications for SUDs

- **Alcohol use disorder:**
  - Acamprosate (Campral®)
  - Disulfiram (Antabuse®)
  - Naltrexone (Revia®, Vivitrol®)

- **Opioid use disorder:**
  - Methadone
  - Buprenorphine/naloxone (Suboxone®, Subzolv®, Bunavail®)
  - Naltrexone (Vivitrol®)

- **Tobacco use disorder:**
  - Nicotine replacement (transdermal, gum, spray)
  - Bupropion (Zyban®, Wellbutrin®)
  - Varenicline (Chantix®)

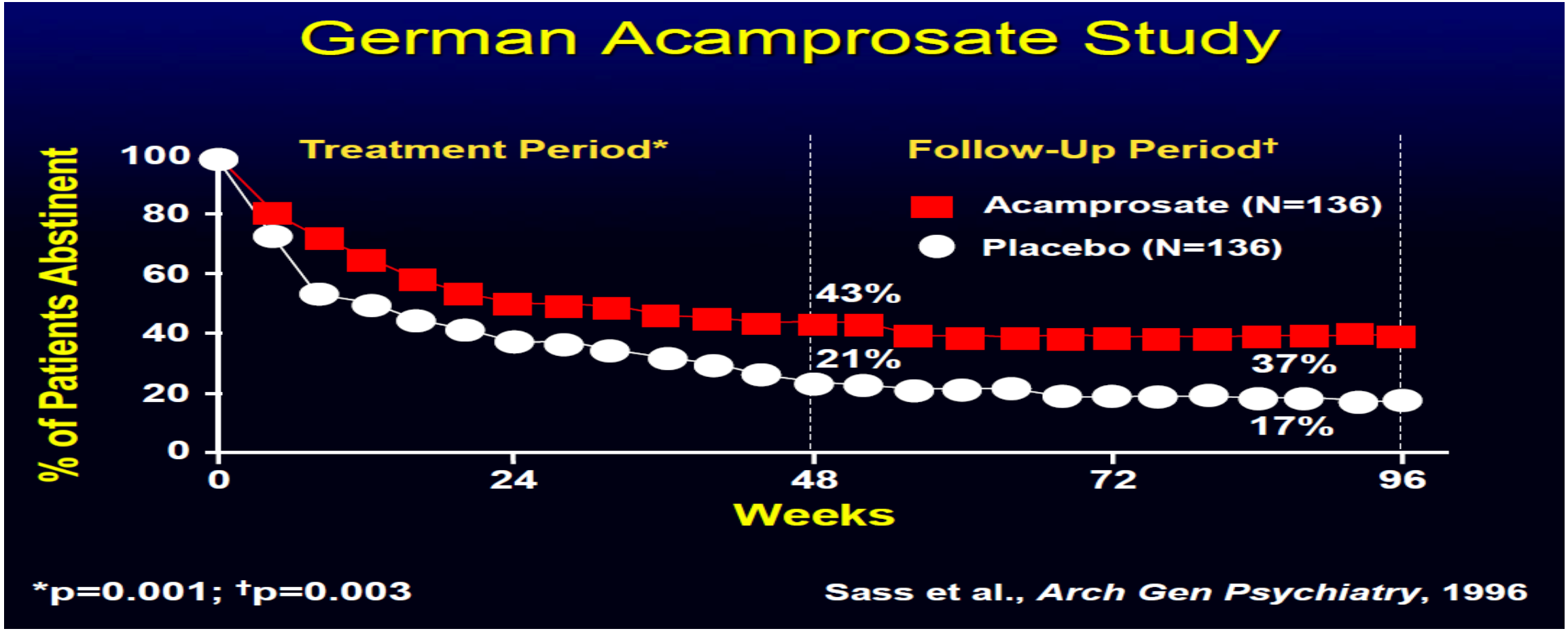
- **Opioid overdose reversal**

  Naloxone (Narcan)

Acamprosate (Campral®)

- Mechanism of action: Modifies glutamate NMDA receptor function
  - Reduces withdrawal relief craving
  - Eliminated through the kidney
- Note: Alcohol abstinence at treatment initiation improves results.
- Usual dose: 333mg: 2 tablets 3 times daily
- Adverse events:
  - Rare: suicidal ideation and behavior
  - Common: diarrhea, sleepiness

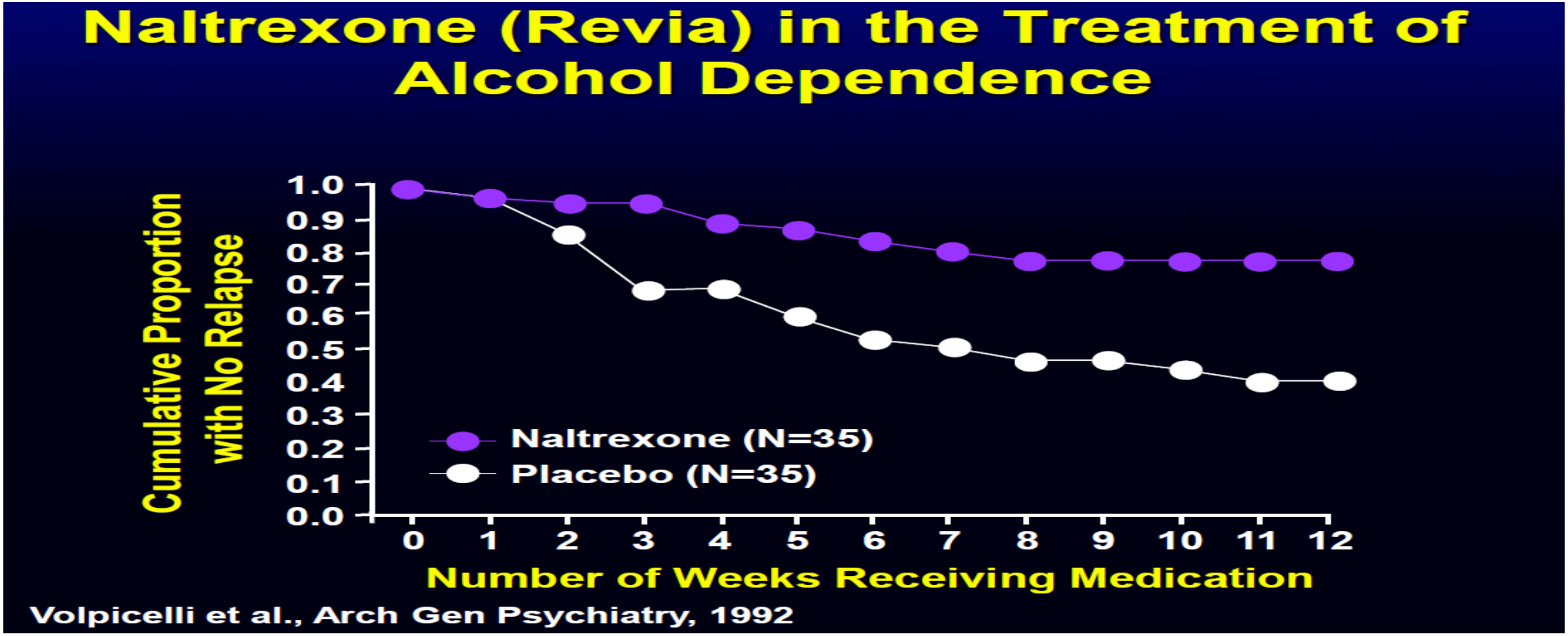
Acamprosate (Campral®)



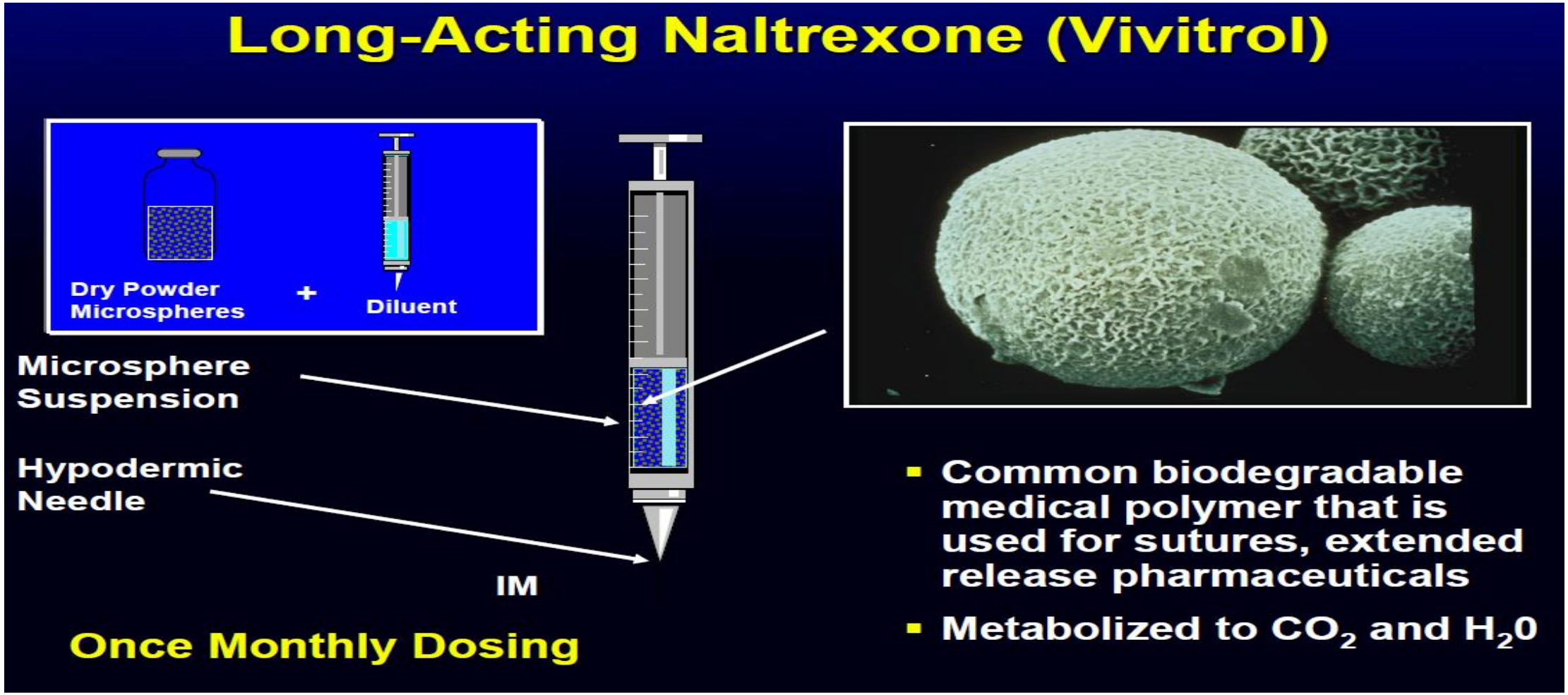
Naltrexone (ReVia®, Vivitrol®)

- Mechanism of action: Mu opioid antagonist
  - Craving reduction
  - Decreased euphoria (may enhance extinction)
  - Reduces risk of opioid overdose if slip occurs
- Usual dose: Oral - 50 to 100 mg once daily, Intramuscular - 380 mg/month
- Nota bene:
  - Pretreatment abstinence from alcohol improves response (48 hours or more).
  - Some patients experience dramatic craving reduction, some none.
- Adverse events:
  - Nausea, abdominal cramps, muscle aches
  - Opioid withdrawal (in patients with recent opioid use)
  - Renders opioid pain medications ineffective
  - Injection site reactions for extended-release injectable naltrexone

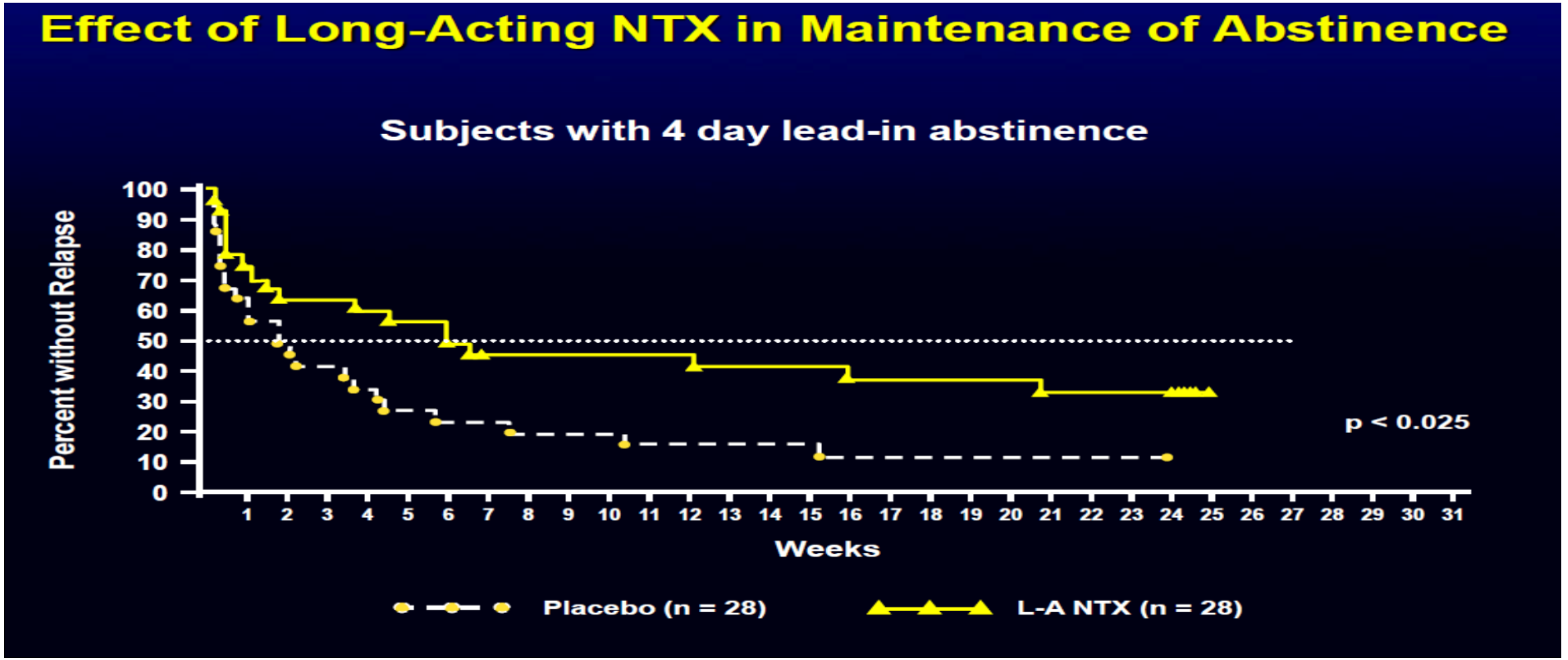
Naltrexone (ReVia®, Vivitrol®)



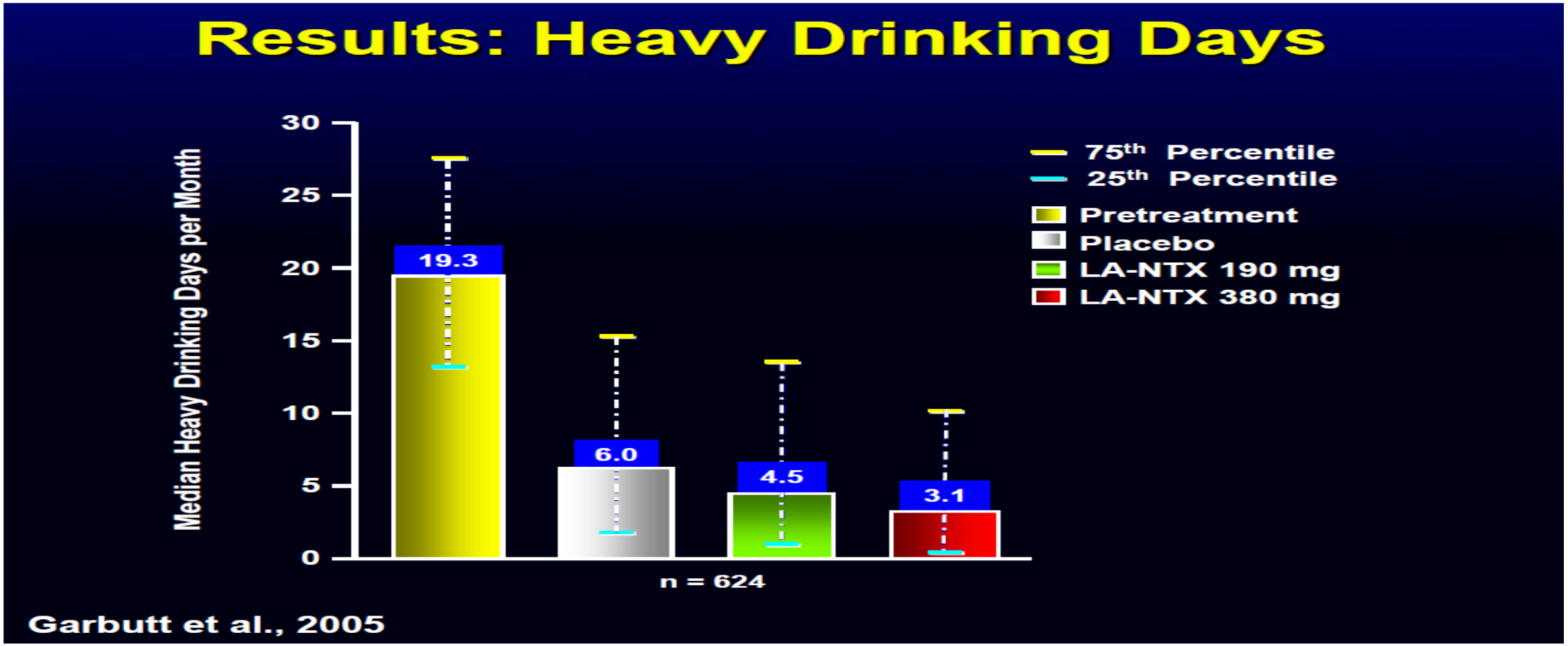
Long-Acting Naltrexone (Vivitrol)



Long-Acting Naltrexone (Vivitrol)



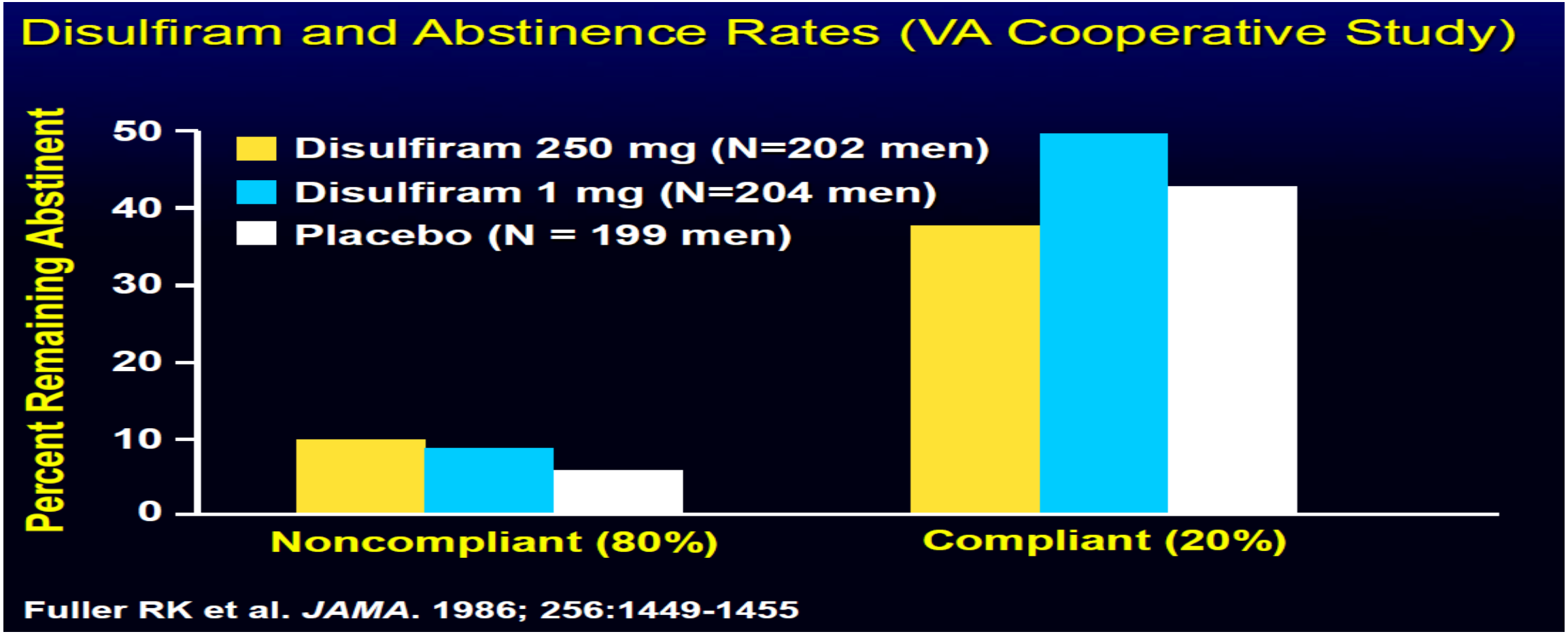
Long-Acting Naltrexone (Vivitrol)



Disulfiram (Antabuse®)

- Inhibits aldehyde dehydrogenase → build-up of toxin (acetaldehyde)
  - Active for up to 2 weeks.
- Usual dose: 250 mg once daily
- Adverse reactions:
  - Common:
    - Metallic or garlicky taste
    - Drowsiness
    - Rash
  - Serious:
    - Alcohol-disulfiram reaction
    - Hepatitis
    - Neuropathy
    - Psychosis

Disulfiram (Antabuse®)

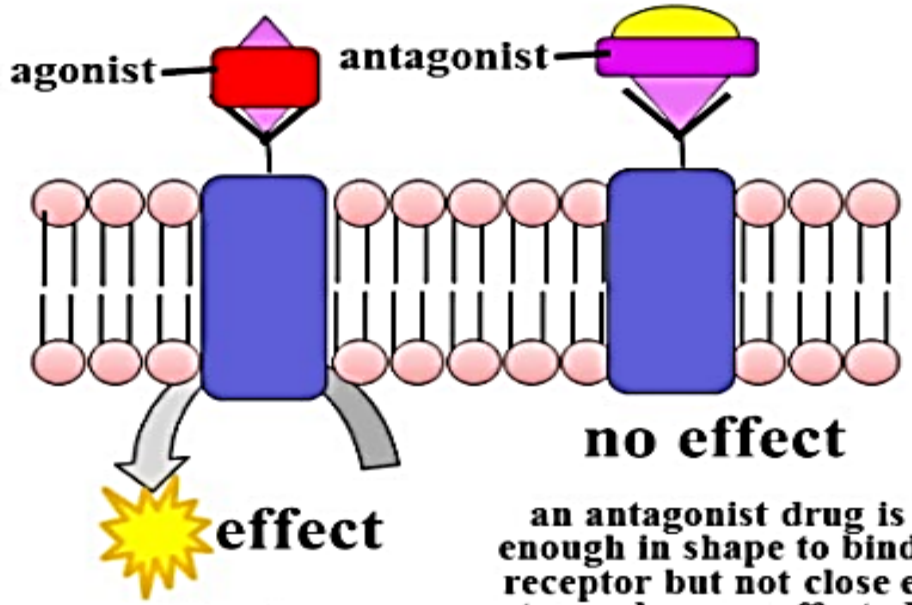


Opioid Use Disorder

- High mortality[1] – 581 male admits to California Civil Addict Program (CAP)
  - Average age at entry = 25 years
    - 10-year mortality = 14%
    - 20-year mortality = 28%
    - 30-year mortality = 49%
- Insufficient evidence that counseling alone is effective
- Medications:
  - Opioid Agonist Therapy (OAT) is recommended as first-line:
    - **Methadone** (in an OTP)
    - **Buprenorphine/naloxone**
  - If OAT is contraindicated, unavailable, unacceptable, or discontinued:
    - **Extended-release injectable naltrexone**
  - Insufficient evidence to recommend for or against oral naltrexone for OUD.

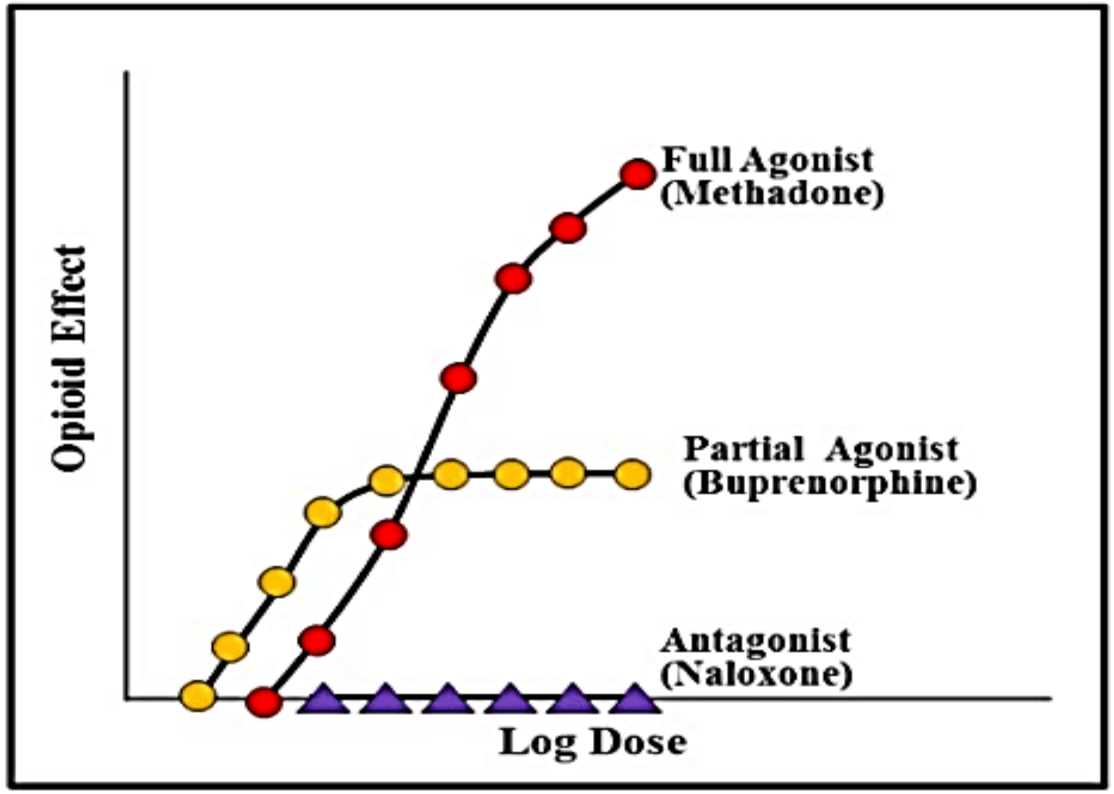
[1]Hser (2001) Arch Gen Psych 58:503-508

Full and Partial Agonists vs Antagonists Treatment Strategies for Opioid Addiction



an agonist drug has an active site of similar shape to the endogenous ligand so binds to the receptor and produces the same effect

an antagonist drug is close enough in shape to bind to the receptor but not close enough to produce an effect. It also takes up receptor space and so prevents the endogenous ligand from binding

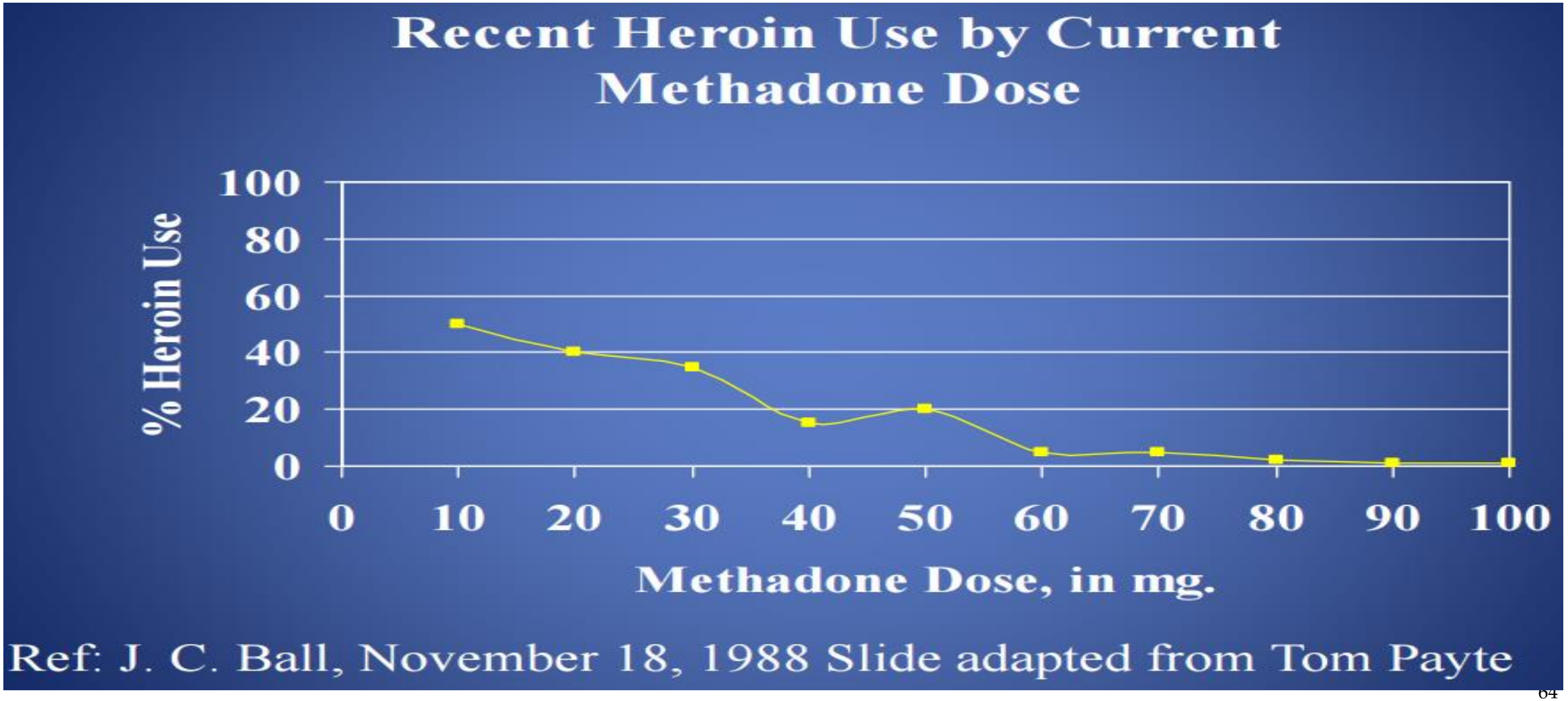


Methadone

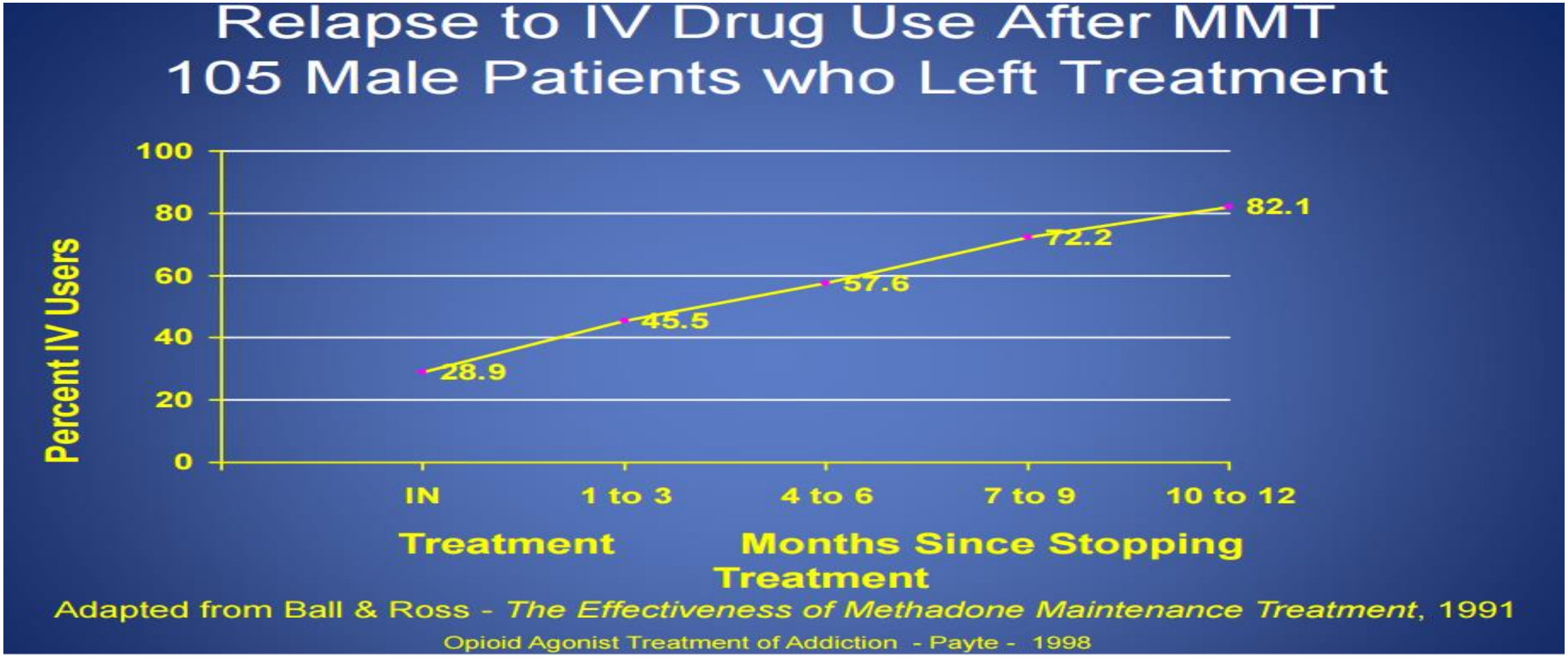
- Mu opioid agonist
- Usual dose: 60 - 120 mg once daily
- Efficacy: 1.72 (high dose vs low dose (<60 mg)
- Must be administered through Federally Regulated Opioid Treatment Program
  - Methadone can be continued for patients hospitalized for treatment of a medical condition other than narcotic addiction (including alcohol use disorders).
- Adverse reactions:

  - Common:
    - Constipation
    - Drowsiness
    - Low testosterone
    - Hyperalgesia
  - Serious:
    - Cardiac arrhythmias
    - Sudden cardiac death

Methadone


Recent Heroin Use by Current Methadone Dose
% Heroin Use
100
80
60
40
20
0
0
10
20
30
40
50
60
70
80
90
100
Methadone Dose, in mg.
Ref: J. C. Ball, November 18, 1988 Slide adapted from Tom Payte

Methadone


Relapse to IV Drug Use After MMT
105 Male Patients who Left Treatment
Percent IV Users
100
80
60
40
20
0
28.9
45.5
57.6
72.2
82.1
IN
1 to 3
4 to 6
7 to 9
10 to 12
Treatment
Months Since Stopping Treatment
Adapted from Ball & Ross - The Effectiveness of Methadone Maintenance Treatment, 1991
Opioid Agonist Treatment of Addiction - Payte - 1998

Methadone

Treatment Outcome Data: Methadone Maintenance

- 4-5 fold reduction in death rate
- reduction of drug use
- reduction of criminal activity
- engagement in socially productive roles
- reduced spread of HIV
- excellent retention
- (see: Joseph et al, 2000, Mt. Sinai J.Med., vol 67, # 5, 6)

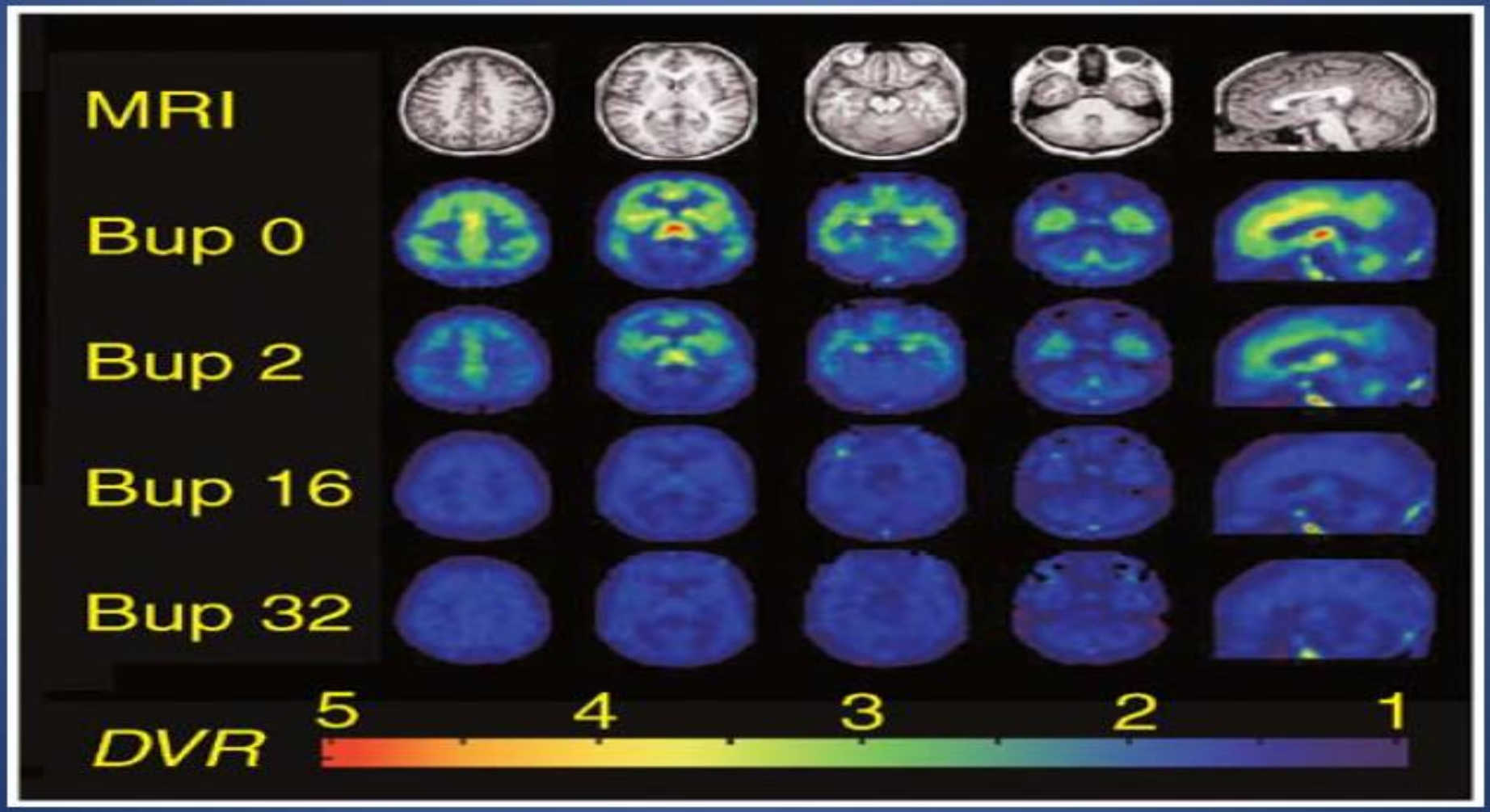
Buprenorphine (Suboxone®)

- Partial μ opioid agonist
- Usual dose: 4 - 24 mg once daily
- Efficacy: >8mg daily similar to methadone
- Adverse reactions:
  - Common:
    - Drowsiness
    - Constipation
    - May precipitate opioid withdrawal
  - Serious:
    - Cytolytic hepatitis

Mu Opioid Receptor Availability Decreases with Increasing Doses of Buprenorphine

PET/11 Carfentanil Label of Mu Receptors

Greenwald et al. 2003 Nearly all mu receptors are occupied by BUP 16 mg

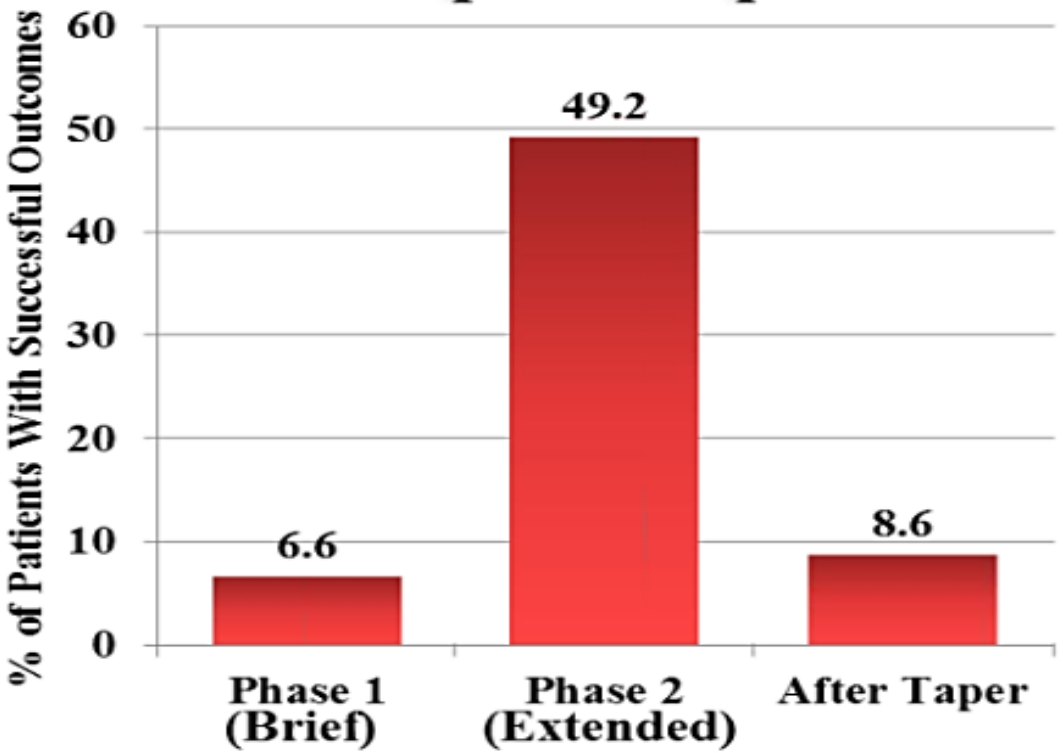


Short Buprenorphine Taper versus Extended Buprenorphine

- Multisite randomized trial- 2-phase adaptive treatment research design
  - 653 treatment-seeking outpatients dependent on prescription opioids
  - Randomized to Standard Medical Management (SMM) or SMM plus counseling
  - Phase 1: Two week stabilization, 2-week taper, 8-week post-medication follow-up
    - Successful patients exited study; thoMethodsse who returned to opioid use entered Phase 2
  - Phase 2: Twelve week treatment, 4-week taper, 8-week post-medication follow-up
- Results:
  - Phase 1: 43 of 653 (6.6%) had successful outcomes
  - Phase 2:
    - 177 of 360 (49%) achieved success at week 12, no group differences
    - 31 of 360 (8.6%) maintained success 8 weeks post-medication
    - Chronic pain did not affect outcome
    - History of heroin use predicted poorer outcome during Phase 2 medication.

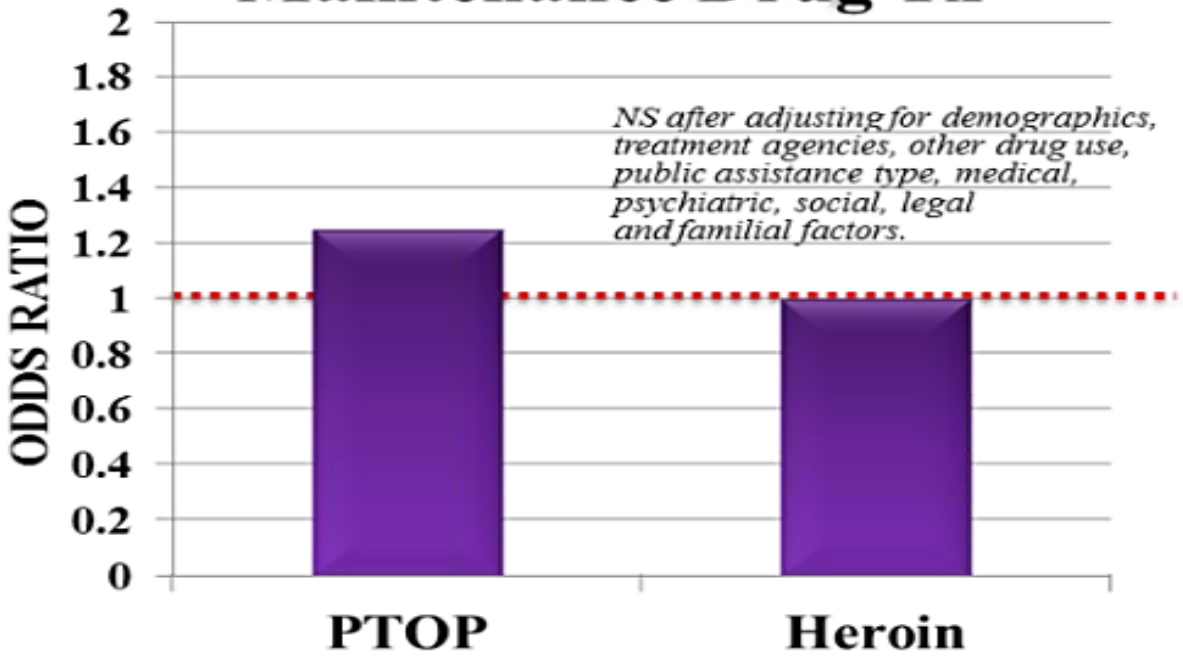
Treatment for Addiction to Opioid Medications

Brief and Extended Buprenorphine-Naloxone Tx for Rx Opioid Dependence



Weiss RD et al., Arch Gen Psych 2011;68(12): 1238-1246.

Retention In Methadone Maintenance Drug Tx



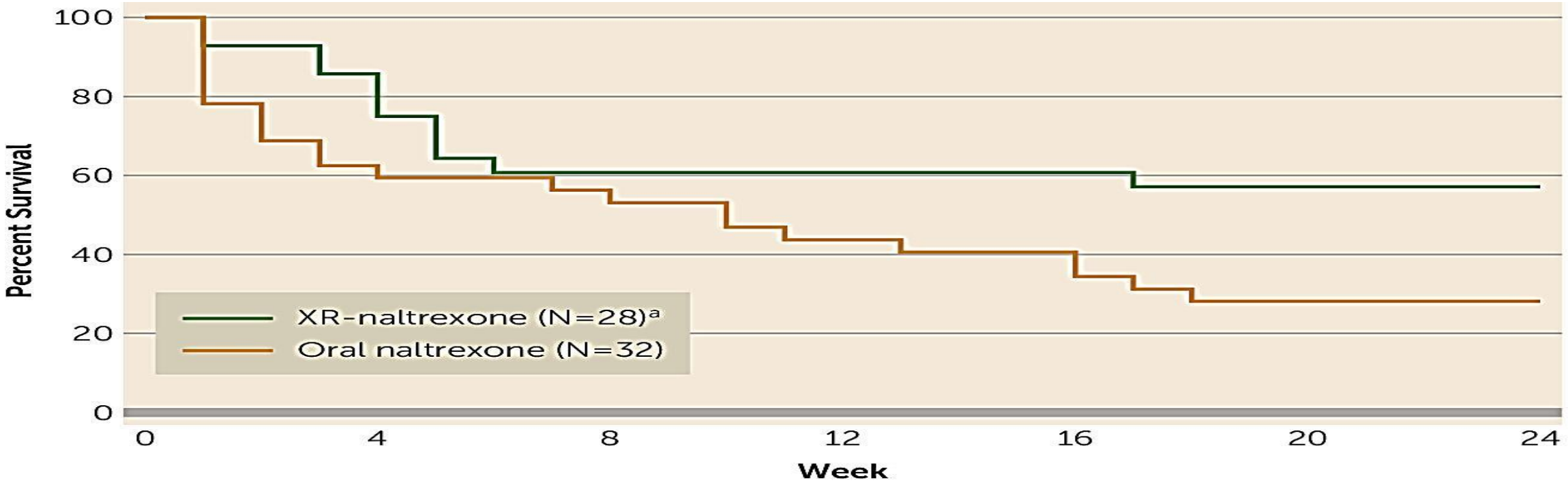
Prescription Opioid Abusers can be treated at MMT facilities at least as effectively as heroin users in terms of treatment retention.

Banta-Green CJ et al., Addiction 2009; 104(5): 775-783.

Naltrexone (Revia/Vivitrol)

- Opioid antagonist with high affinity for mu-opioid receptors and lower affinity at kappa- and delta-opioid receptors
  - Effectively blocks the effects of heroin and other opioids
- Long half-life can be administered 3x week in doses of 100-150 mg
- Generally well tolerated, side effects can include:
  - GI distress, headaches, rare liver toxicity
- Poor adherence suggest use of injectable formulation
- Only given when acute withdrawal has been completed

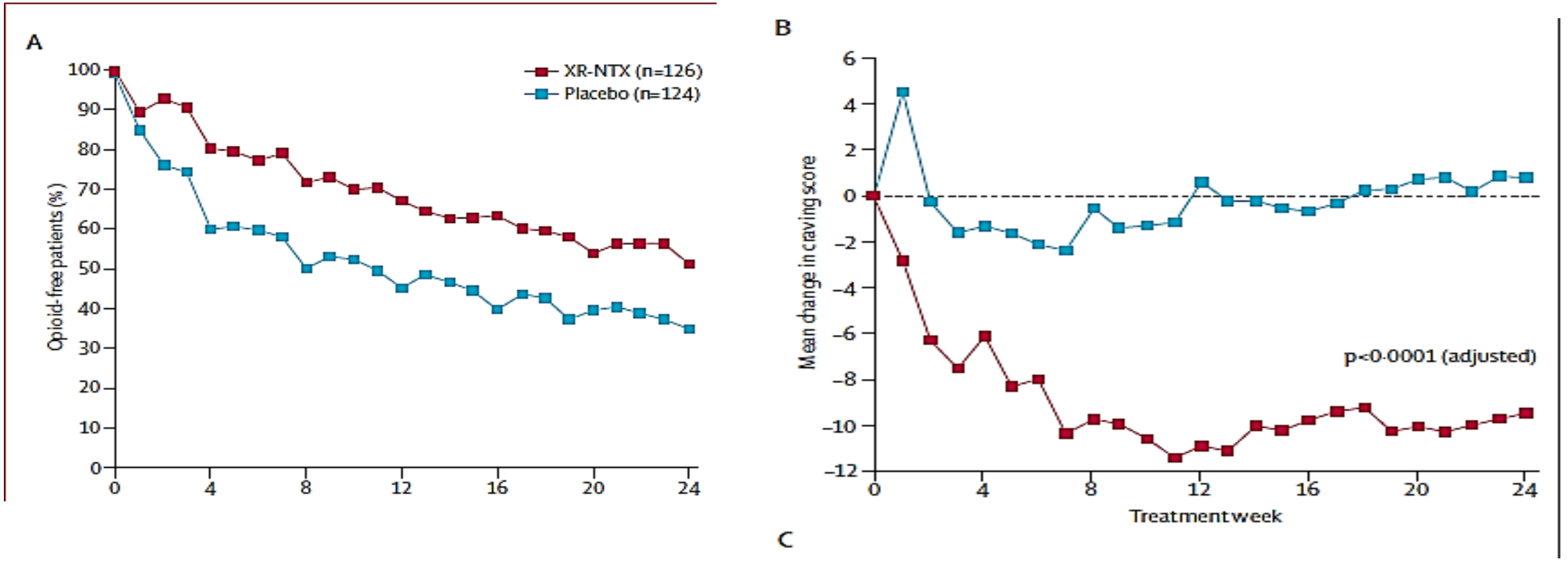
Time to Dropout for Participants Receiving Oral Naltrexone or Extended-Release Injectable Suspension Naltrexone



	Week						
Percent Survival (N survived)	0	4	8	12	16	20	24
XR-naltrexone (N=28)	100.0% (28)	85.7% (24)	60.7% (17)	60.7% (17)	60.7% (17)	57.1% (16)	57.1% (16)
Oral naltrexone (N=32)	100.0% (32)	62.5% (20)	53.1% (17)	43.8% (14)	40.6% (13)	28.1% (9)	28.1% (9)

SOURCE: Sullivan MA et al. Am J Psychiatry. 2018. doi: 10.1176/appi.ajp.2018.17070732.

Improved Abstinence from Opioids and Reduced Craving with Extended-Release Naltrexone (XR-NTX) vs Placebo



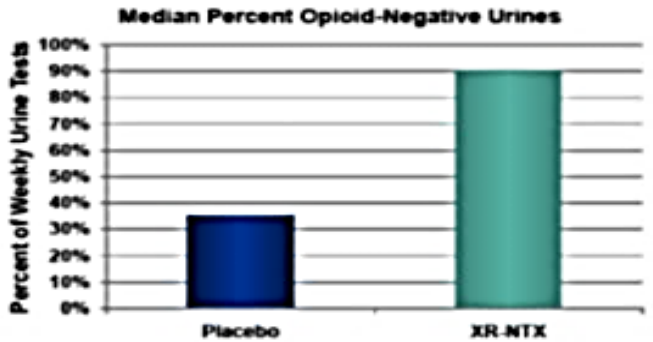
2011-Krupitsky et al-Lancet- 377:1506

Long-Acting Injectable Naltrexone

XR-NTX: Positive Phase 3 Results
Opioid Dependence

Primary Endpoint	
Rates of opioid-free urine tests	P=0.0002

Placebo: N=124
XR-NTX: N=126

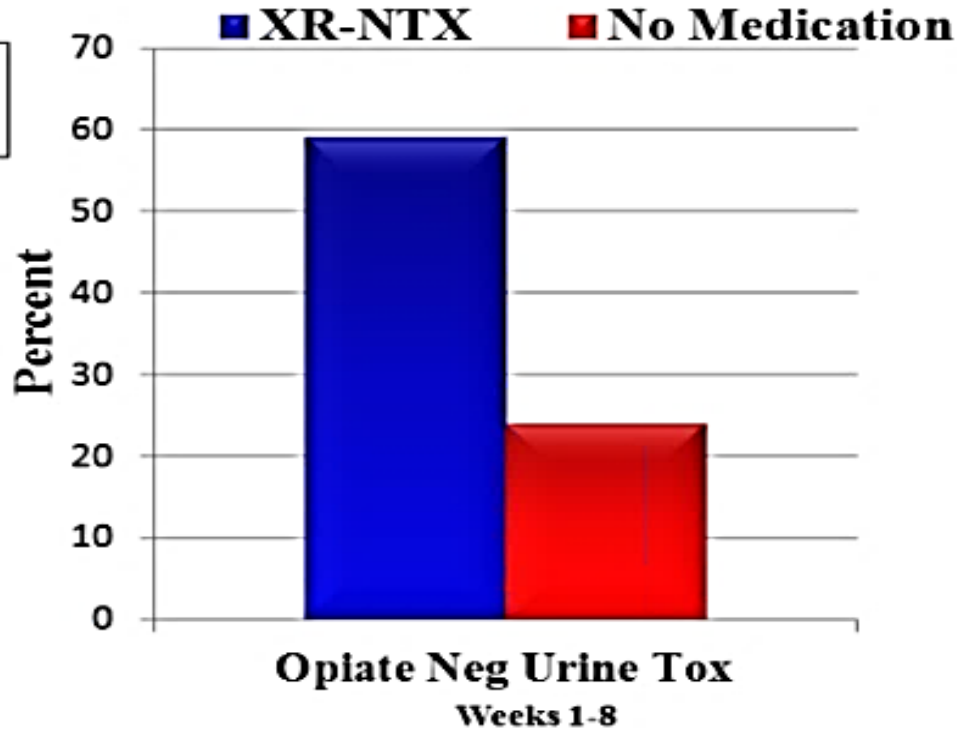


IM Injection every 4 weeks for 24 weeks

Secondary Endpoints: XR-NTX vs. Placebo	
Improved study retention during 6-month study period	P=0.004
Lower opioid craving scores	P<0.001
Less incidence of relapse to physiologic opioid dependence	P=0.017
Less self-reported opioid use	P=0.003

Krupitzky et al., Lancet 2010

Post Prison-Release Outcomes



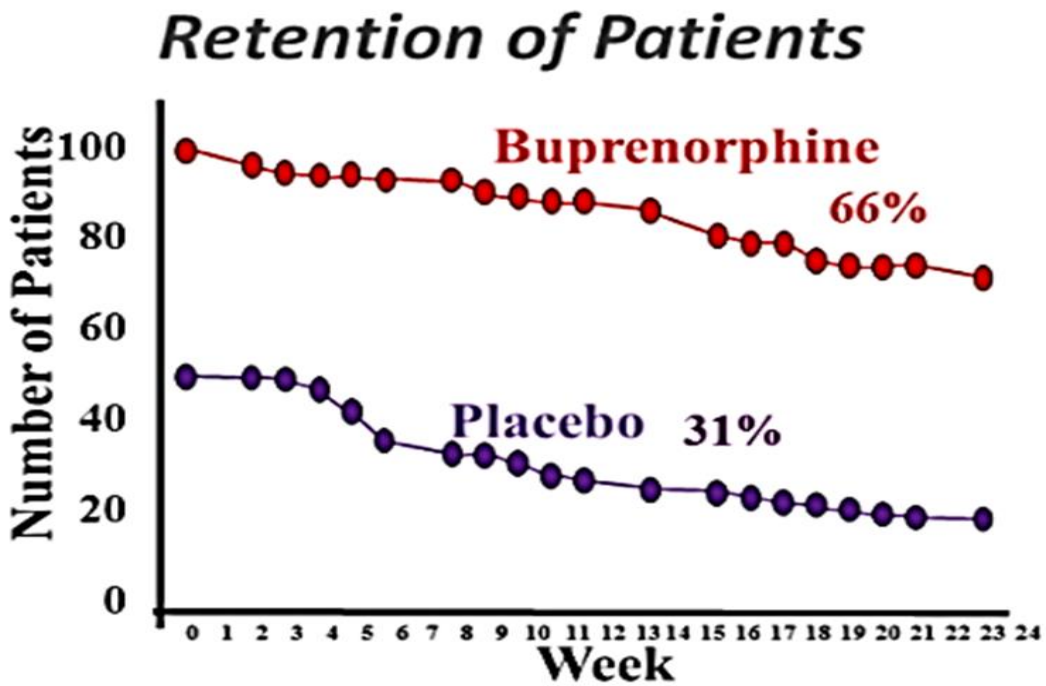
Lee JD et al., Addiction 2015;100:1008-1014.

NEW THERAPEUTICS for Opioid Use Disorders

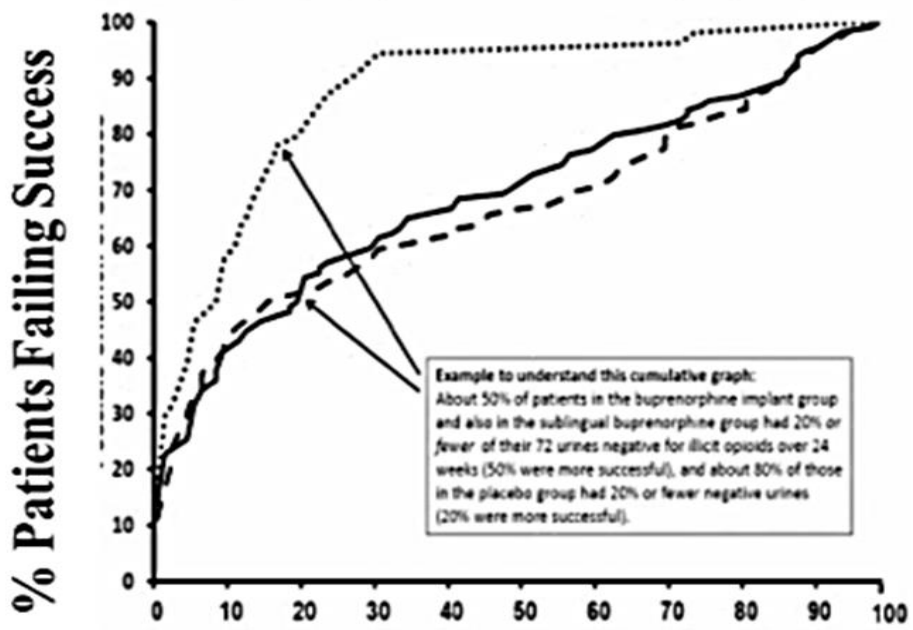
- **Extended release medications (improve compliance)**

IMPLANTABLE Buprenorphine Probuphine™(6 months)

26 mm long,2.5mm diameter



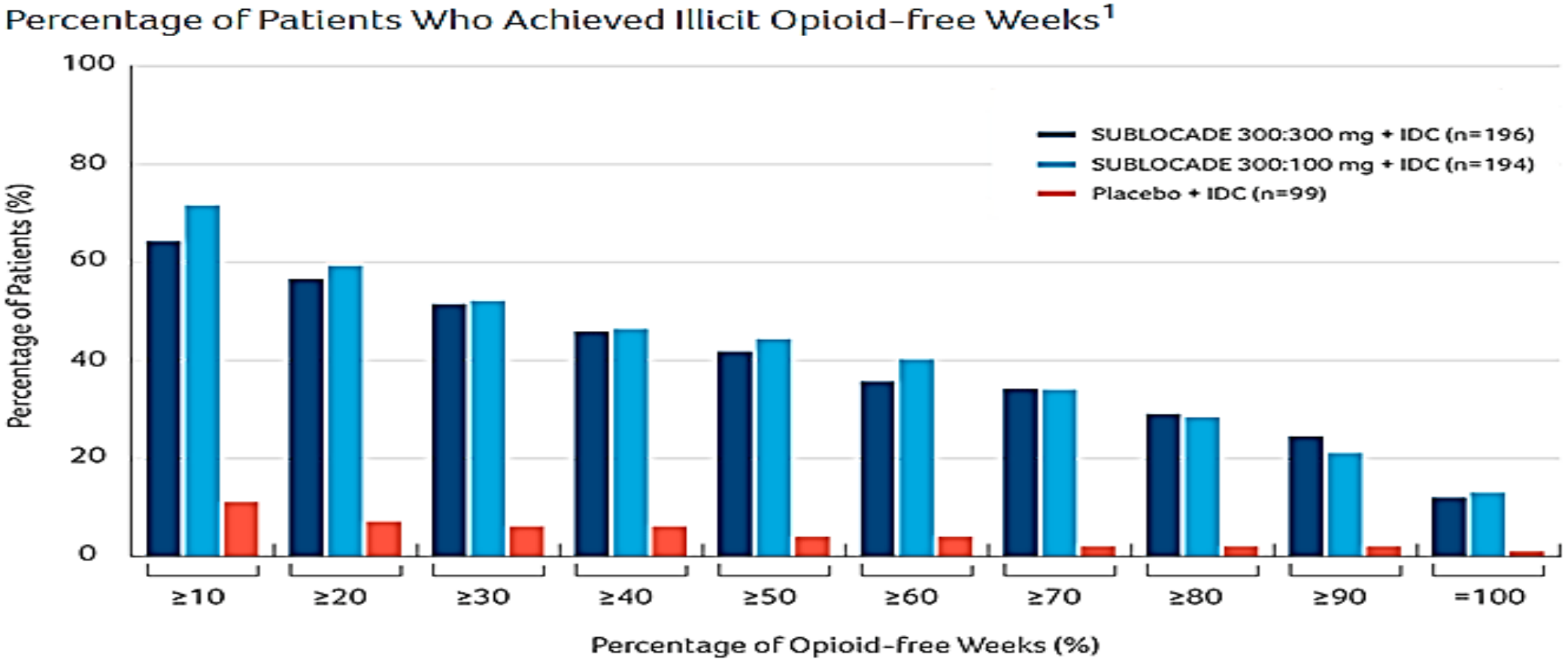
Ling, W. et al. JAMA 2010



% Urines Negative (out of 72) Weeks 1 to 24

Rosenthal RN et al., Addiction 2013;105: 2141-2149.

SUBLOCADE is a once-monthly injection designed to deliver sustained buprenorphine plasma concentrations ≥2 ng/mL[1,2]



One strategy to mitigate opioid drug overdose deaths includes increasing the accessibility and utilizing of Naloxone

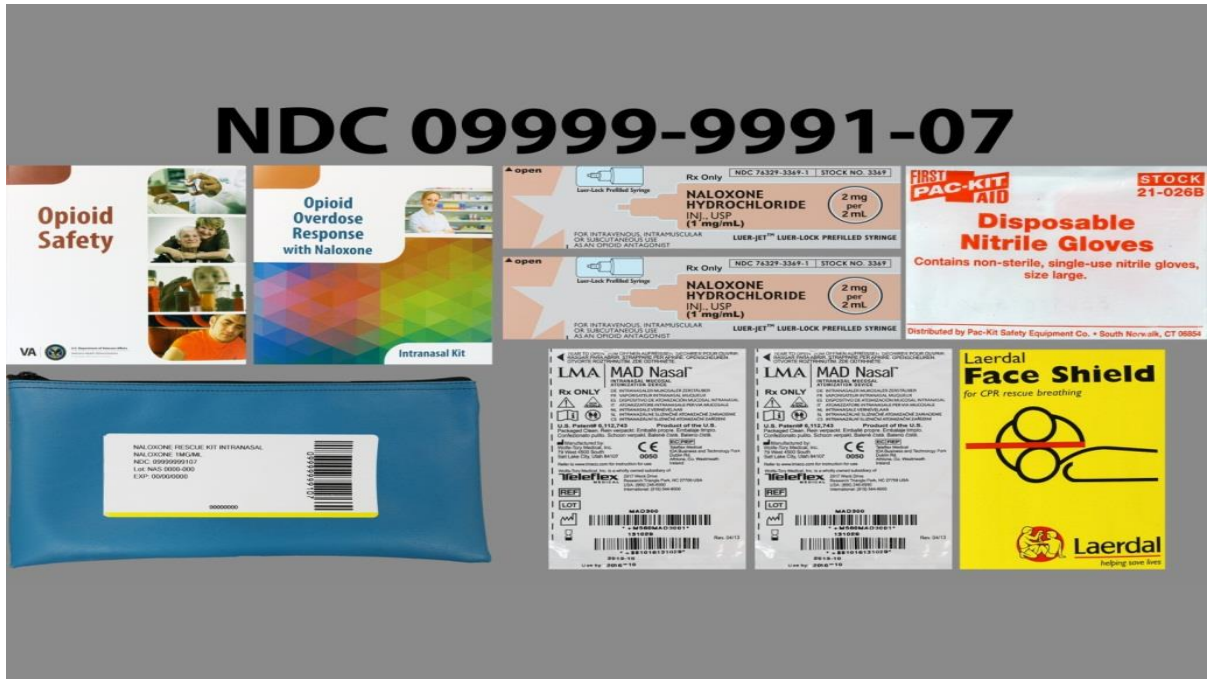
- Naloxone is a safe and effective antidote for opioid-related overdose that has been used for more than 40 years.

- Naloxone has no abuse potential and can reverse a life-threatening overdose by blocking the opioids effects, restoring breathing and preventing death.

Naloxone Rescue Kit Contents

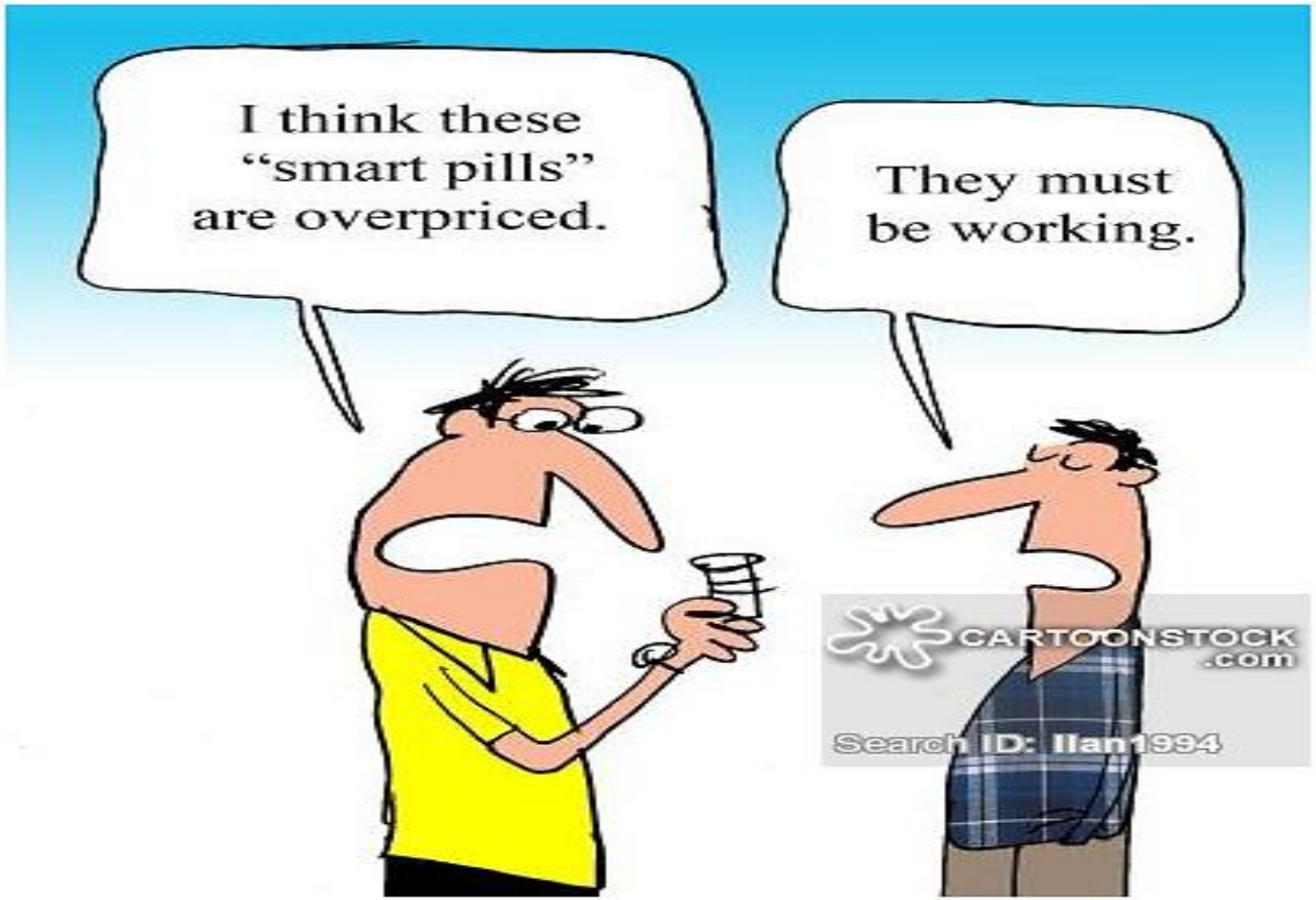
- Naloxone Rescue Kit IM

- Naloxone Rescue Kit Nasal



Naloxone Autoinjector- Evzio®

- Video available at Evzio® website: http://www.evzio.com/hcp/


I think these "smart pills" are overpriced.
They must be working.
CARTOONSTOCK .com
Search ID: Ilan1994

Improving OD Treatments: Naloxone for Overdose

- **Lay-friendly administration: intranasal naloxone**

- ***AntiOp*, developing disposable naloxone nasal spray. Product could be on the market 2015**

- ***Lightlake Therapeutics*, conducting clinical trials with intranasal naloxone for binge eating disorder will test this for opioid overdose**

BMJ

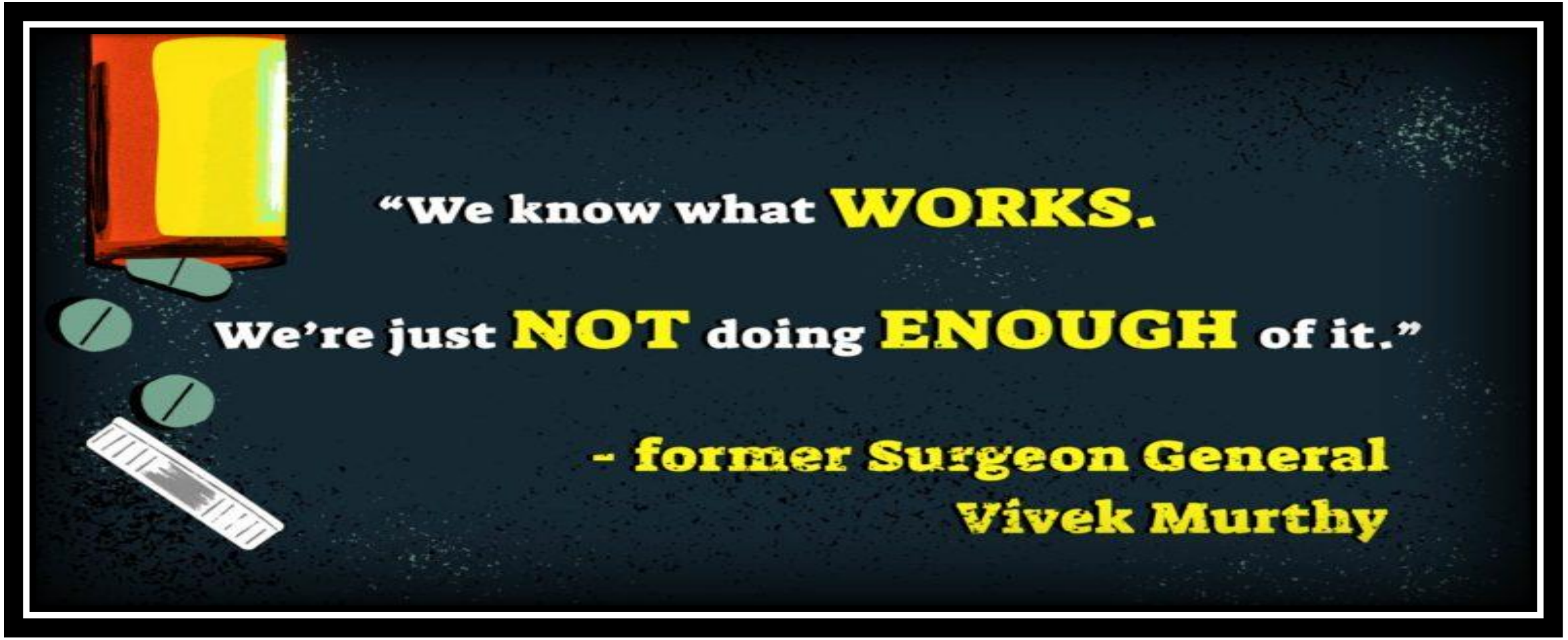
Published 31 January 2013

RESEARCH

Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis

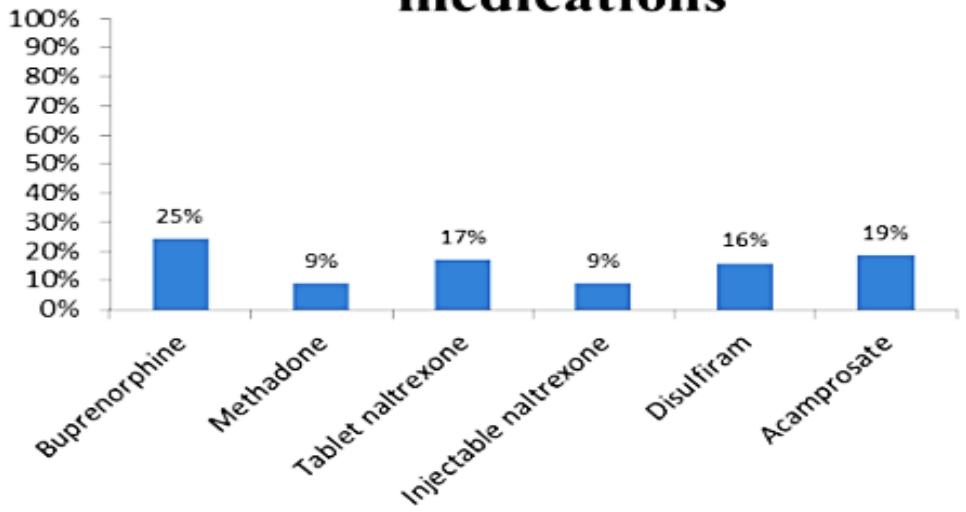
Alexander Y Walley *assistant professor of medicine, medical director of Massachusetts opioid overdose prevention pilot*[1 3], Ziming Xuan *research assistant professor*[2], H Holly Hackman *epidemiologist*[3], Emily Quinn *statistical manager*[4], Maya Doe-Simkins *public health researcher*[1], Amy Sorensen-Alawad *program manager*[1], Sarah Ruiz *assistant director of planning and development*[3], Al Ozonoff *director, design and analysis core*[5 6]

Medication Assisted Treatments



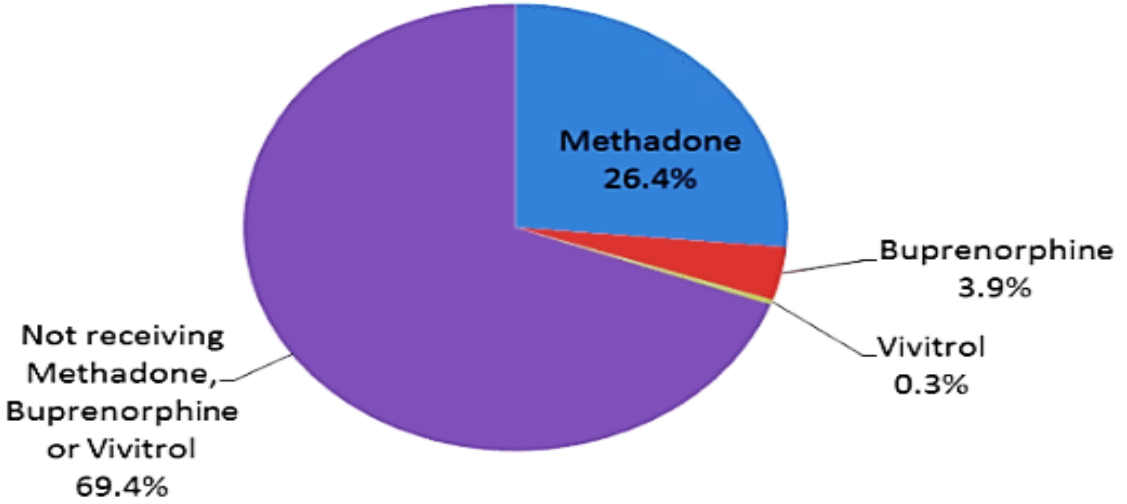
Improving Implementation of Medication Assisted Treatments: Addiction

% Treatment Programs Offering FDA-approved SUD medications



Knudsen et al., J Addict Med 2011.

% OTP patients receiving methadone, buprenorphine, or vivitrol



2012 N-SSATS Data, SAMHSA


MY DEALER KEEPS ASKING ME THESE STUPID QUESTIONS!
PSYCHOTHERAPY
CARTOONSTOCK .com
Search ID: kamn255
KAMAGURKA

“Hey there’s one simple way of never being in that position. Don’t take [the drug]. But there’s probably a million different reasons you do.”

- Keith Richards, LIFE

Most Effective Psychosocial Treatments for Substance Use Disorders

- Motivational Interviewing
- Contingency Management
- Cognitive Behavioral
- Mindfulness Based Approaches
- 12-step Facilitation
- Behavioral Couples & Family Therapy

Motivational Interviewing

"Change is the essence of life; being willing to surrender who you are for what you could become."

~Unknown

Motivational Interviewing

Having more effective conversations about changing substance use

Definition

MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.

Miller & Rollnick 2013

History of MI

- Influenced by early treatment of substance use disorders
- Created in an effort to provide an alternative to confrontational treatment approaches
- Based on natural occurrence of ambivalence
- Research and use has expanded to many fields and situations that require behavior change

The Spirit of Motivational Interviewing

"If you treat an individual as he is, he will stay as he is, but if you treat him as if he were what he ought to be and could be, he will become what he ought to be and could be."

Johann Wolfgang Von Goethe

The Spirit of Motivational Interviewing

The Righting Reflex

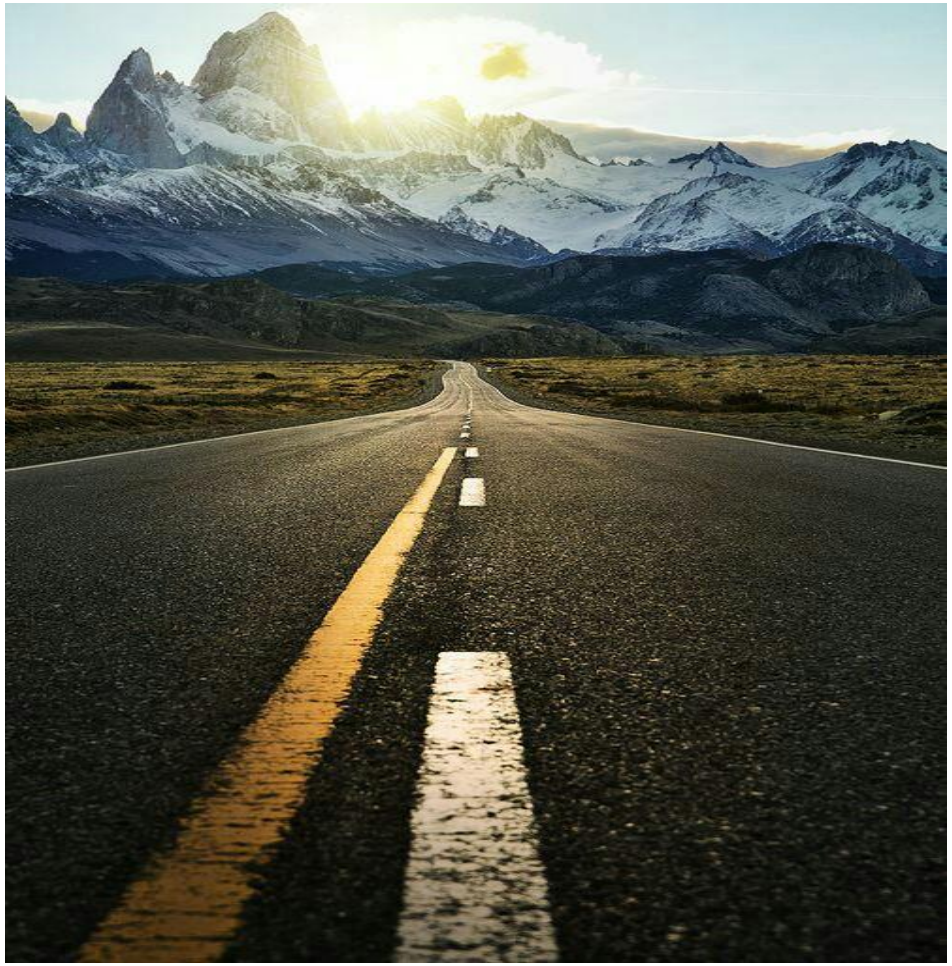
- The desire to fix what seems wrong with people and to set them promptly on a better course, relying in particular on directing.
  - Should want to change
  - Either motivated or not
  - Now is the right time to change
  - A tough approach is best
  - If the person does not decide to change, the consultation failed

- What could possibly be wrong with that?

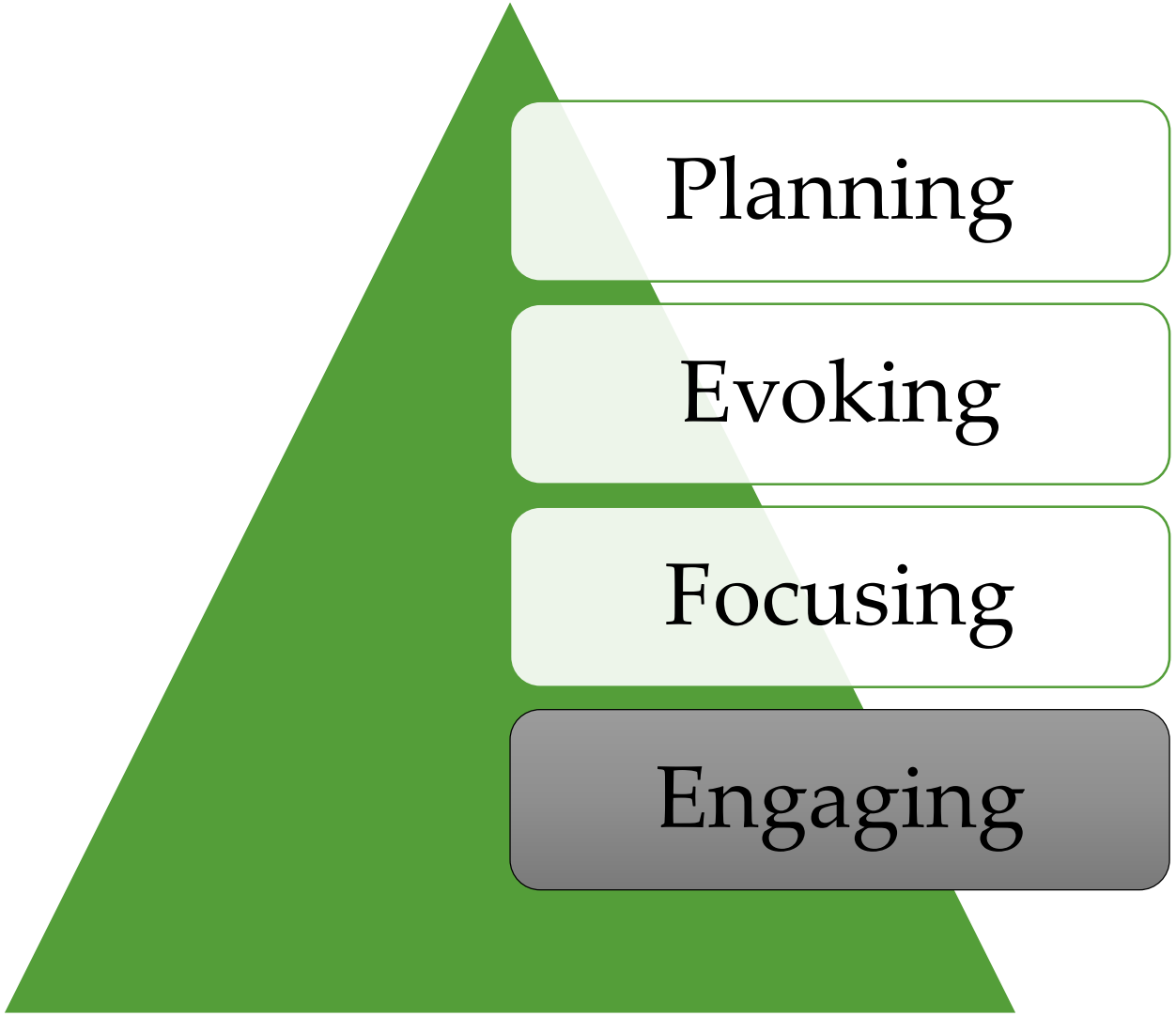
Ambivalence - getting stuck on the road to change

- Simultaneously wanting and not wanting something, or wanting both of two incompatible things.

- We hear change talk and sustain talk mixed together.
  - Getting stuck in ambivalence.
    - Think about changing… think about not changing… stop thinking about it.



4 Processes of MI



Contingency Management

A behavioral approach to reinforce abstinence from substance use

The goal is to provide patients with a period of abstinence

Contingency Management

- Based on principles of operant conditioning
  - Positive reinforcers increase probability of behavior
    - Raises/awards, allowances/privileges, treats/food
  - Punishers decrease probably of behavior
    - Poor evals/demotions, detention/grounding

Contingency Management

- Positive reinforcement is more effective than punishment for lasting behavior change.

- Behavior will increase if it is followed by a reward.
  - Behavior to increase when reward is immediate, tangible, consistent, and unique to the target behavior
  - Natural rewards for abstinence are delayed, intangible, and inconsistent

How Does CM Work?

- Set specific target behavior (abstinence from specific substance)
- Measure this target behavior frequently and objectively (2x/week UDS testing)

How Does CM Work?

- Provide immediate, tangible, desirable rewards when the target behavior occurs (fishbowl draws for negative UDS results)
  - Increase size of reward for consistent performance of target behavior (increased # of draws up to 8)
  - Withhold the reward when the target behavior does not occur – based on UDS only
  - Reset the size of reward for next occurrence of target behavior

Contingency Management

- The fishbowl contains 500 prize slips:
  - 250 (50%) “Good Job!” = $0
  - 209 (41.8%) “Small” = $1
  - 40 (8%) “Large”= $20
  - 1 (0.2%) “Jumbo” = $100
- Earn 1 draw for the first negative sample and increase up to 8 draws with consistent abstinence
- When abstinence is not verified, no draws are earned, and draws reset to 1 for the next negative sample

Contingency Management

- 12 week protocol - excused and unexcused absences
- Patients earn an average of about $240 over the 12 weeks
- Can be utilized with other target behaviors (e.g., attendance)
- Can be implemented by LIPs and non-LIPs
- Few contraindications – can be used in conjunction with other treatments
- Fun treatment for providers and patients

Cognitive Behavioral Approaches

- Widely studied and implemented approach

- As an umbrella term, CBT covers interventions that target intrapersonal and interpersonal triggers for relapse, provide coping skills, drug refusal skills, and increase nonuse related activities
  - Social Skills Training
  - Stress Management Training
  - Cognitive Therapy
  - Relapse Prevention

Relapse Prevention

A cognitive behavioral approach addressing the process in order to prevent relapses and minimize harm of relapses that do occur.

Relapse Prevention

Relapse is not viewed as an "end-state," but rather as a process that begins before use of the substance and continues afterward.

Meaning of a Relapse

- Lapse is an initial return to the problem behavior, “a slip up” in the maintenance of change.
- Relapse is a more elaborate, longer lasting return to use.
- Prolapse is a return to the change process, getting back on track and returning to abstinence or whatever the goals might be.

Abstinence Violation Effect

"Once I use any amount, then I have failed so I might as well use excessively."

Seemingly Irrelevant Decisions

- Small, seemingly minor thoughts and actions that actually increase the probability of a lapse (Marlatt 2002).

- Each choice might seem inconsequential at the time but the sum of these added up can create predicaments that can tax the coping skills of anyone trying to get better.

High Risk Situations

Interpersonal Triggers

General conflict

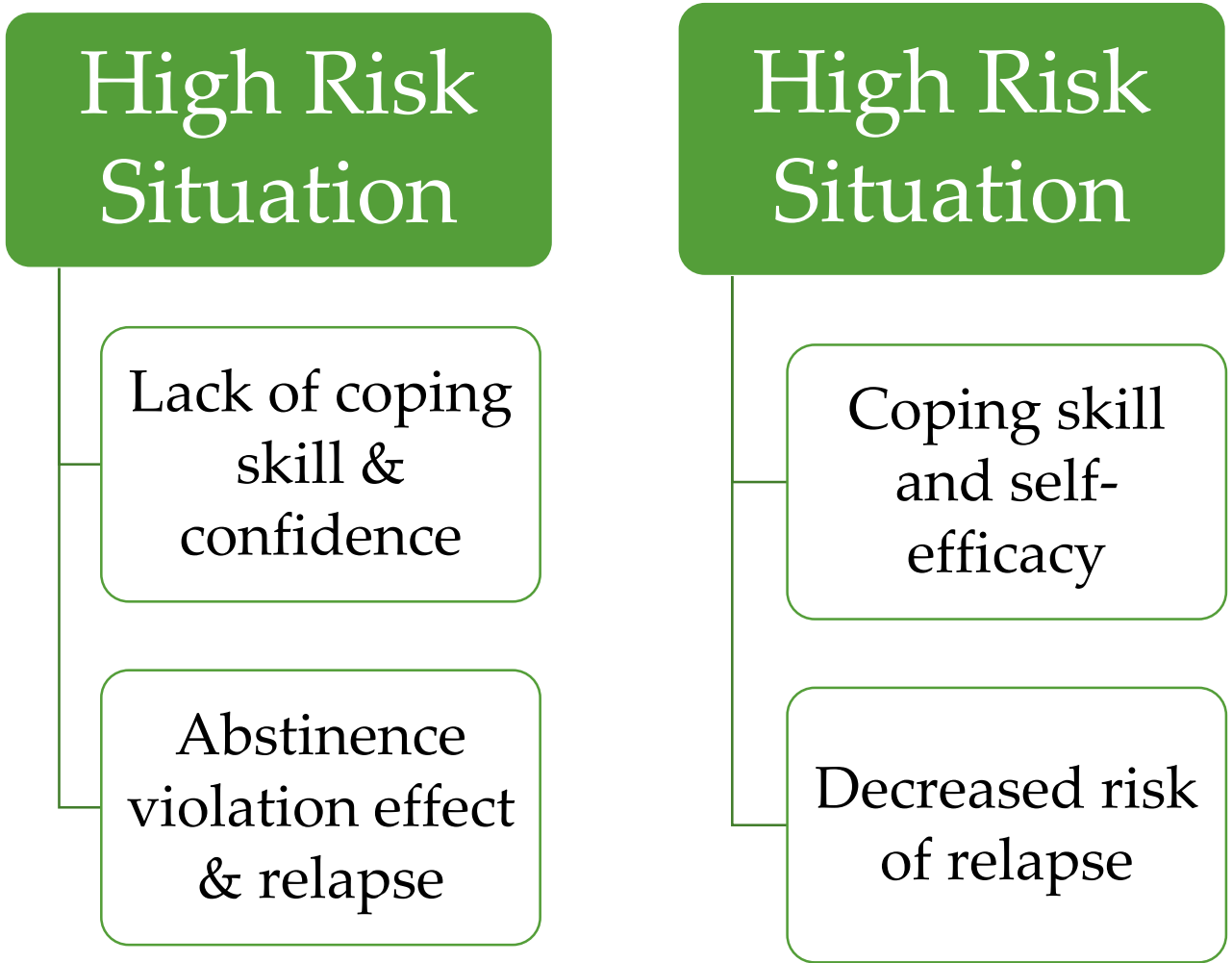
Social pressures to use

Direct & Indirect

Intrapersonal Triggers

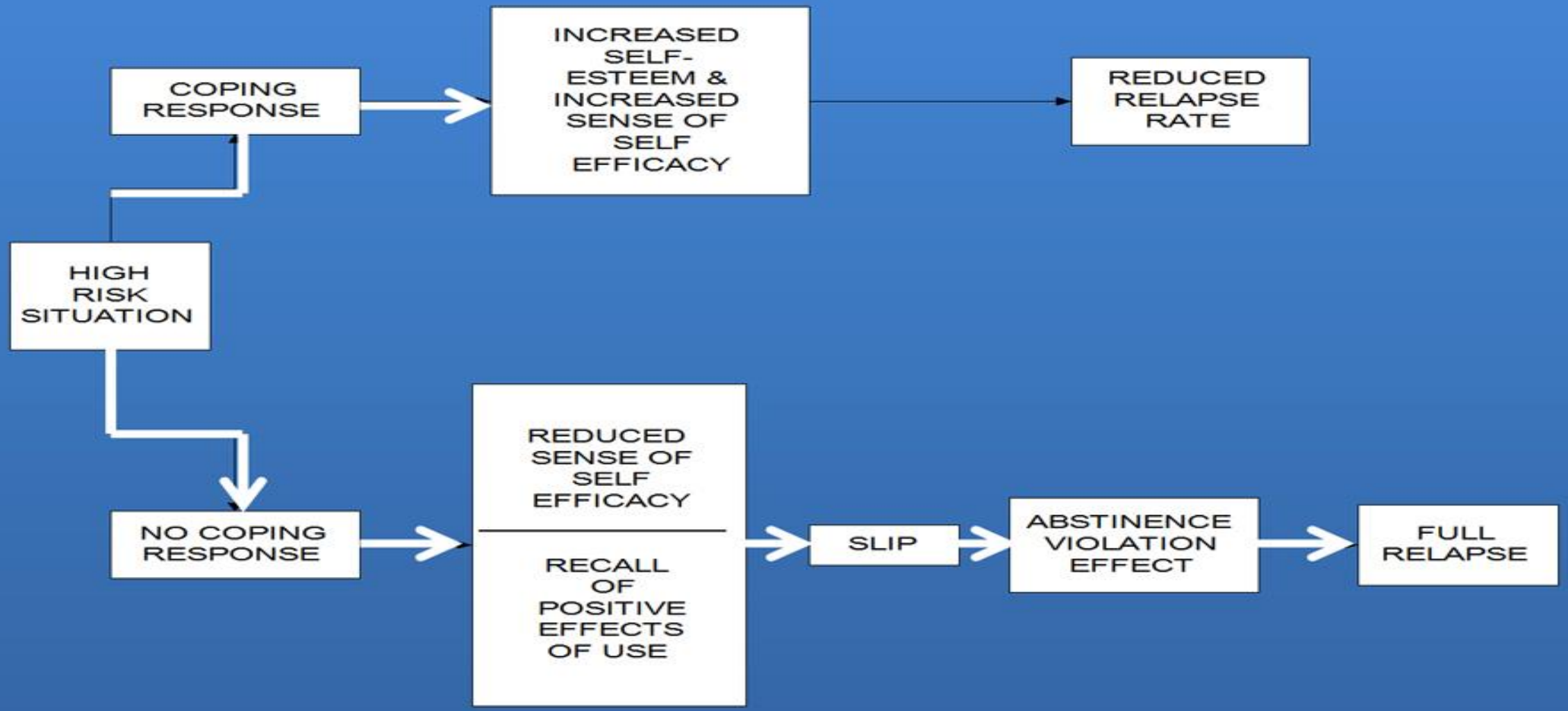
Extreme emotions

Relapse Prevention Model



RELAPSE PREVENTION MODEL

MARLATT & GORDON



Mindfulness Based Approaches

Mindfulness

Shown to be effective for anxiety, eating disorders, depression, reduction in stress and there is a growing body of research supporting its efficacy for SUD treatment.

Mindfulness Compliments Relapse Prevention

Avoidance based goals verses approach based goals

Navigating negative thoughts and emotions

Relapse prevention supports the idea of learning to control the cause of negative feelings and cravings

Experiential Avoidance

Consciously or not, we tend to avoid anything that we think will cause us the slightest uncomfortable feelings thoughts or sensations.

"And everybody expects me to be happy, which only makes things worse!"

Acceptance may be the key to stress coping

"People who habitually accept their negative emotions experience fewer negative emotions, which adds up to better psychological health."

- *Iris Maus*

Purposeful Living

Requires experiencing a certain amount of difficulty and pain.

We must take risks such as being vulnerable, hurt, and rejected, to get what it is that we most want.

"If you aim at nothing. You will hit every time."

-Unknown

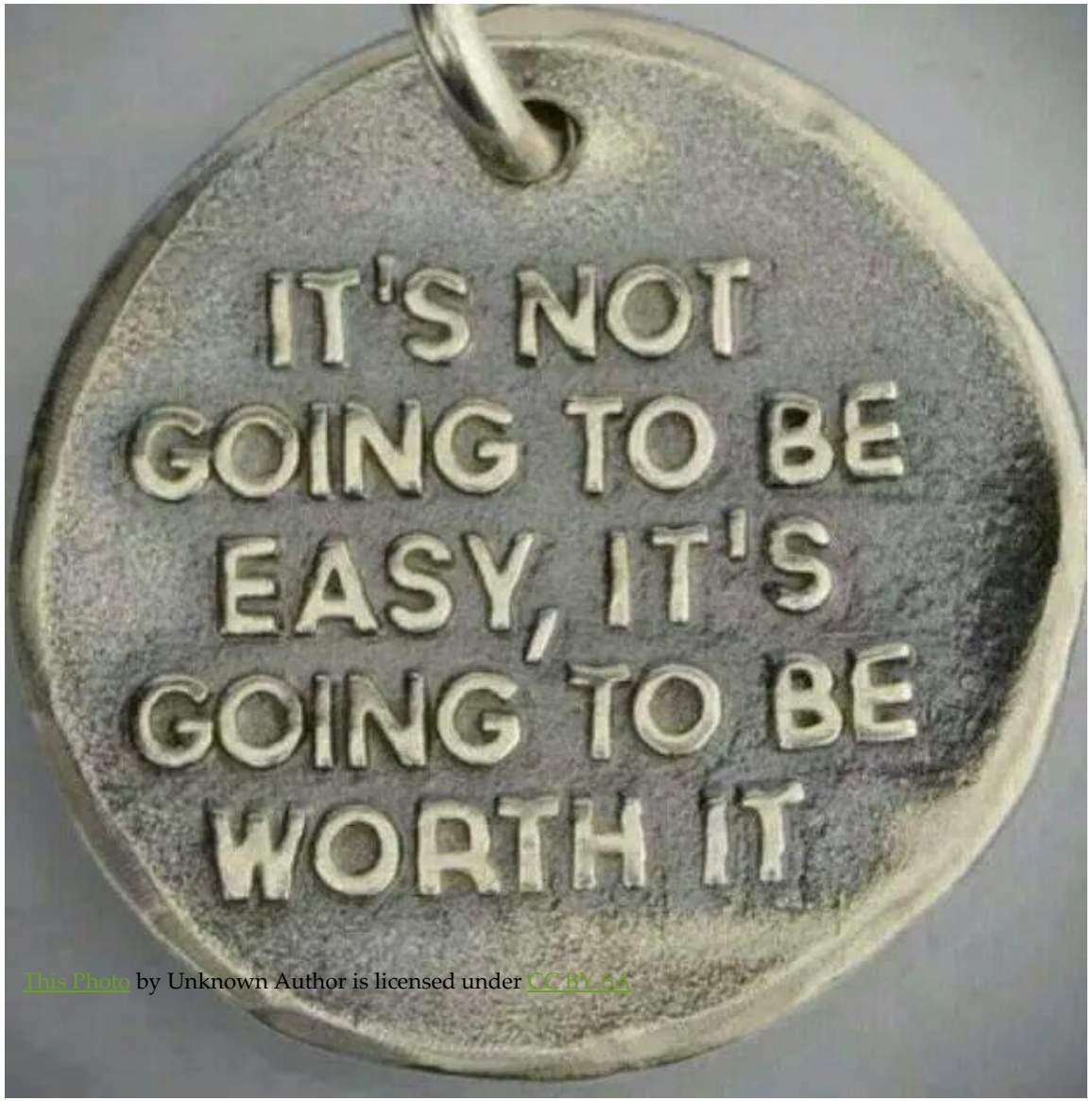
Mindfulness Based Sobriety

- The overall approach is helping individuals with substance use disorders achieve sobriety by enhancing their awareness, accepting experience, and clarifying values.

- When goals and actions align with personal values, people are less like to engage in self-defeating behaviors.

Value Based Living

Sobriety is approached in the service of living life according to one's values.



Mindfulness Based Sobriety

Curriculum focuses on planning, building skills, & enhancing motivation with the goal of preparing the for the next level of care.

There are 12 group topics. Each group session is three hours long with 5 to 10 minute breaks.

"Dreamt I joined a twelve-step program."

12-Step Facilitation (TSF)

- Based on the principles of Alcoholics Anonymous (AA) and the "Disease Model" of addiction

- Assumes that substance use disorders are chronic diseases that require lifelong commitment to abstinence

12-Step Facilitation

- Manualized approach designed to enhance ongoing involvement in 12 step meetings
- Can be used as a stand-alone treatment or used in conjunction with another model

12-Step Facilitation

- Introduces patients to the principles of the 12-step model, learn about options for meetings in their area, and begin to set goals for getting involved in NA/ AA.

- The long term goal of TSF may be abstinence, but the short-term objective is to encourage commitment to and participation in 12-step groups.

Two Primary TSF Goals

Acceptance

Willpower alone is not enough

Chronic & progressive disease

Life has become unmanageable

Only alternative is complete abstinence

Surrender

Reach out beyond oneself and follow the 12- steps

Acknowledge hope for recovery

Faith that a high power can help when willpower cannot

Organization & Structure TSF

- Includes a core program, an elective program, and a conjoint or family program

- 12 to 15 individual sessions, plus 2 to 3 conjoint sessions if needed

Organization & Structure TSF

- Core Program
  - 4 Core Topics
    - Assessment, Acceptance, Surrender, and Getting active in AA or NA

Organization & Structure TSF

- Elective Program
  - 6 Elective Topics
    - Genograms, Enabling, People-places-routines, Emotions, Moral inventories, and Relationships

Organization & Structure TSF

- The conjoint program
  - Purpose is to educate the patient's partner about addiction and to introduce them to the 12-step model
    - introduce to the concept of enabling and encouraged to make a commitment to attend six Al-Anon or Nar-Anon meetings.

Review (10 minutes)

- Review of Journal
- Note what AA/NA meetings the patient attended since the last session
- Discuss patients reactions to those meetings
- Review of slips
- What if anything did the patient do to try to stay abstinent after the slip?
- What NA/NA resources could the patient use in the event of a future slip?
- Review of urges to drink or use
- Review of sober days

New Material (30 minutes)

- Introduction of new concepts for discussion
- Questions and reactions to material discussed

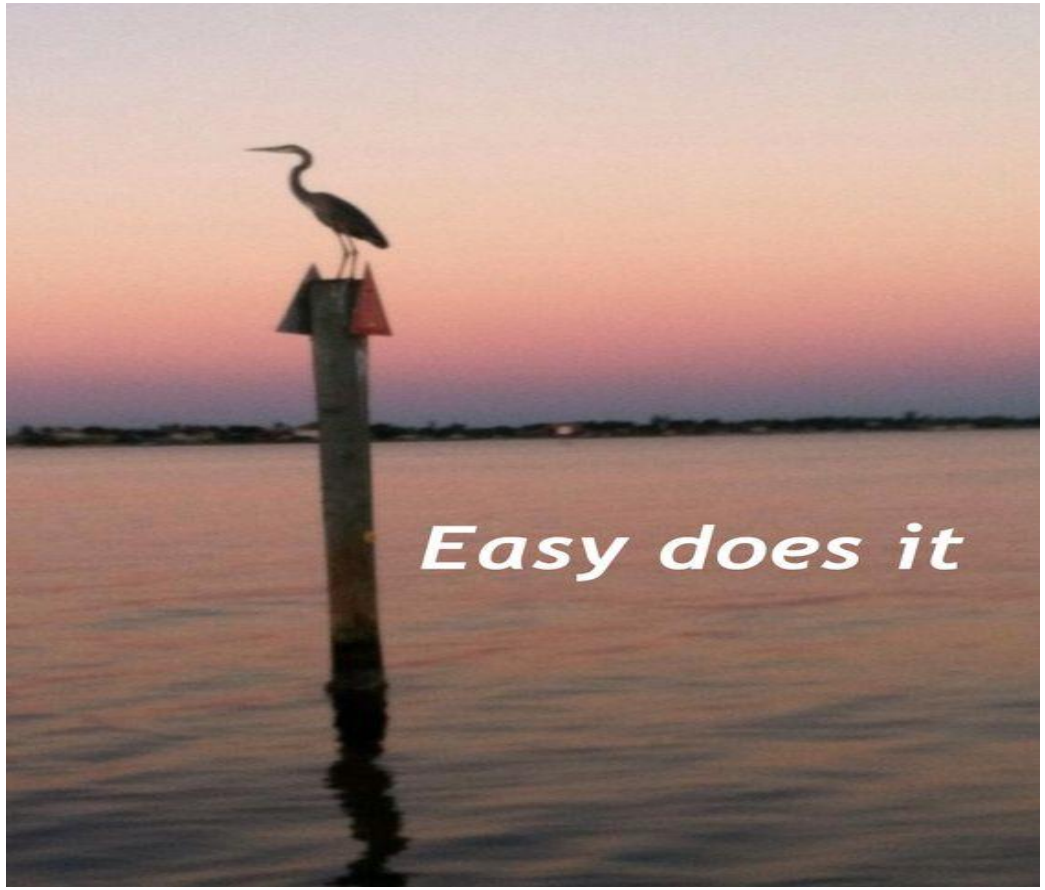
Recovery Tasks (10 minutes)

- Which meetings will the patient attend between now and the next session?
- What should the patient read before the next session?

Summary (5 minutes)

- What was the overview of today's discussion?
- Does the patient understand the recovery tasks that have been suggested?

Are Slogans Just Bumper Sticker Psychology?



There is practical wisdom captured in these slogans and they are valuable to those who participate in the model.

Behavioral Couples & Family Therapy

- Active involvement of the patient's spouse or partner

- 12 to 20 couples sessions over 3 to 6 months

What makes a good candidate?

- Married or living with a partner
- Willing to accept at least temporary abstinence
- Both people are willing to work on the issues
- No high risk for violence
- Generally treatment recommended following detox, residential or IOP

Objectives

- Engage the couple
- Support abstinence with recovery contracts (daily rituals that support abstinence)
- Improving relationship by building positive activities and improving communication
- Continuation of care and relapse prevention

BCT Recovery Contract

- Rebuild trust
- Reduce conflict about substance use
- Reward abstinence

BCT Recovery Contract

- Daily Trust Discussion
  - Patient states intention to stay abstinent that day
  - Spouse thanks patient for efforts to stay abstinent

BCT Recovery Contract

- Daily Trust Discussion
- Focus on present, & future, not past
- Self-help involvement
- Weekly UDS
- Calendar to record progress

Recovery Contract Calendar

✓ = Trust Discussion Done

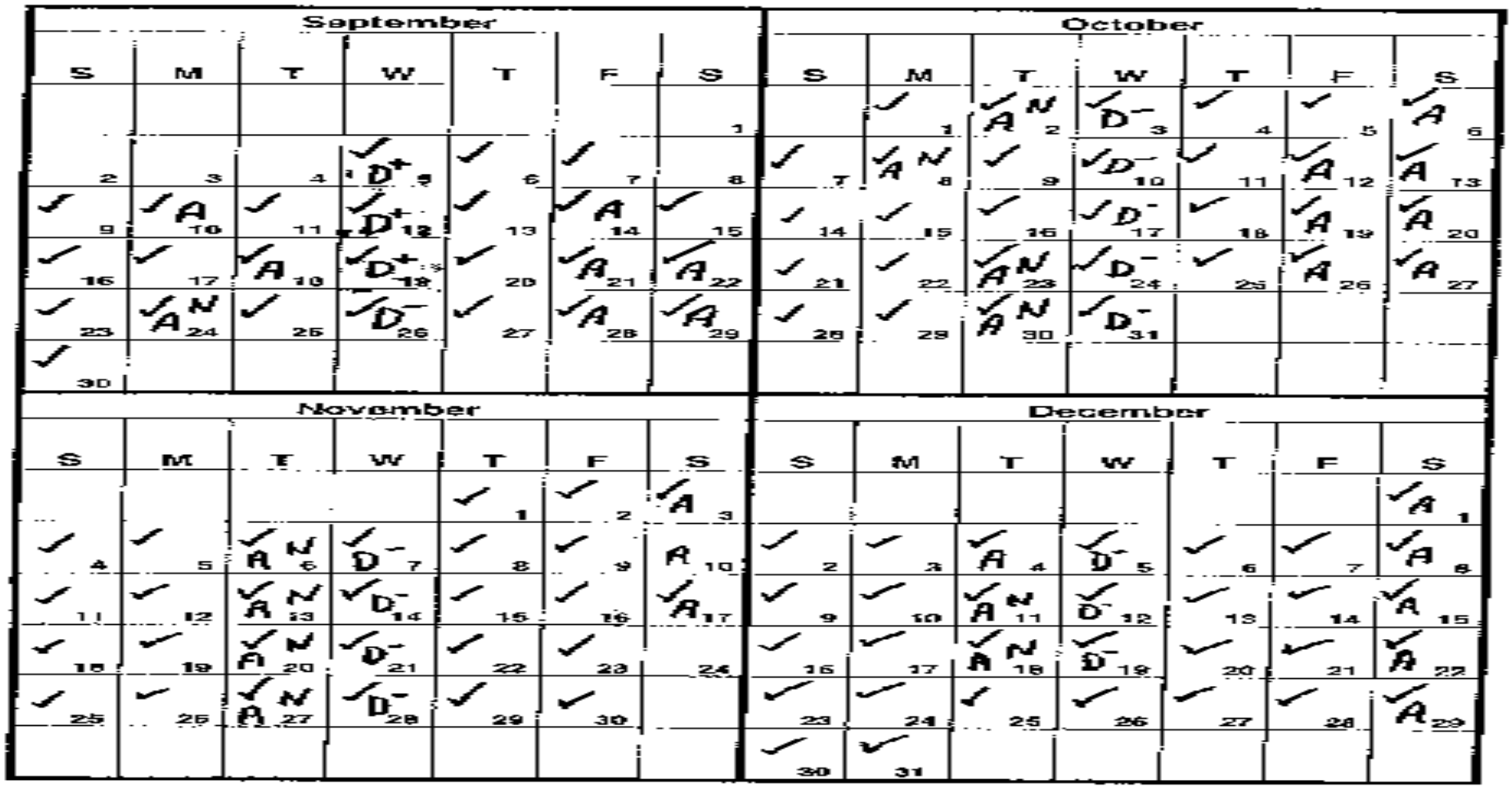
✓ = Trust Discussion with Medication (_____)

A = AA or NA meeting

N = Alanon or Naranon

D = Drug Urine + or —

O = Other (_____)



RECOVERY CONTRACT

In order to help (patient) Mary with his/her recovery and to bring peace of mind to (partner) Jack, we commit to the following:

Patient's Responsibilities	Partner's Responsibilities
X DAILY TRUST DISCUSSION (with medication N.A. if taking it)	
• States his/her intention to stay substance free that day (and takes medication if applicable). • Thanks partner for supporting his/her recovery.	• Records that the intention was shared (and medication taken if applicable) on calendar. • Thanks patient for his/her recovery efforts.
X FOCUS ON PRESENT AND FUTURE, NOT PAST	
• If necessary, requests that partner not mention past or possible future substance abuse outside of counseling sessions.	• Agrees not to mention past substance abuse or fears of future substance abuse outside of counseling sessions.
X WEEKLY SELF-HELP MEETINGS	
• Commitment to 12-Step mtgs: AA mtgs 7pm Tues at church 10am Sat at hospital	• Commitment to 12-Step mtgs: Al-Anon mtg 7pm Tues at church
X URINE DRUG SCREENS	
• Urine Drug Screens: weekly at counseling sessions	
☐ OTHER RECOVERY SUPPORT	
•	•

EARLY WARNING SYSTEM
If, at any time the trust discussion (with medication if taking it) does not take place for two days in a row, we will contact (therapist/phone #: Dr. Tim O'Farrell 123-456-7899) immediately.

LENGTH OF CONTRACT
This agreement covers the time from today until the end of weekly therapy sessions, when it can be renewed. It cannot be changed unless all of those signing below discuss the changes together.

Mary Smith
Patient

Jack Smith
Partner

Tim O'Farrell Ph.D.
Therapist

9 / 12 / xx
Date

Increasing Positive Activities & Communication

- Catch your partner doing something nice
- Shared rewarding activities
- Caring day assignment
- Listening skills
- Expressing feelings directly
- Communication sessions
- Negotiating for requests

Ongoing and Later Stage Recovery

Address psychological issues that go beyond the patient's substance use to explore other areas of their psychological life

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