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Substance Misuse Module

Recovery Concepts, Psycho-social Treatments and Service Development

Developing people
for health and
healthcare

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Insert name of the LEP

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Aims and Objectives (from handbook)

- To understand principle of recovery and how this is implemented with drug and alcohol services
- To gain knowledge of some of the basic concepts of motivation interviewing
- To gain knowledge about how services for drug and alcohol are developed
- To understand what ancillary services are frequently used with alcohol and drug services

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To achieve this

- Case Presentation
- Journal Club
- 555 Presentation
- Expert-Led Session
- MCQs

- Please sign the register and complete the feedback

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Expert Led Session

Psychosocial treatments for people with substance misuse problems

Acknowledgement

- Dr Mani Mehdikhani (Principal Clinical Psychologist)
- Dr Jan Moring (Consultant Clinical Psychologist)
  - Greater Manchester West MH Foundation Trust
  - who provided the basis of the presentation

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Expert led session

- Psychological approaches in substance misuse problems
- Review models of dependence
- Review psychosocial treatments for people with substance misuse problems
- Overview of various interventions that are offered in substance misuse: brief interventions, mapping techniques (e.g., ITEP), motivational interviewing overview

Models of addiction: disease model

- Drug misuse can be conceptualised as a ‘Brain disease model’
- A diverse range of substances, including opiates, stimulants, cannabis, alcohol and nicotine, produce euphoric effects in the brain.
- Euphoria resulting from drug use potentiates further use, particularly for those with a genetic vulnerability.
- Chronic drug use produces long-lasting changes in the reward circuits involving dopamine neurons
- Challenge to Theory - Normal process/ Social model a better explanation/ Bioethical concerns

Hall 2015
Heather 2017

‘Alcoholism’ as a disease (Jellinek, 1960)

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- Underlying principles in AA & NA
- **IRREVERSIBLE** (‘you can go from a cucumber to a gherkin but you can’t go back from a gherkin to a cucumber’)
- **PROGRESSIVE**
- **INCURABLE** (always ‘recovering’ never ‘recovered’)
- Characteristics of the model: Inability to control drinking or use
- Goals of treatment: Long term abstinence

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The 12 Steps 1-6

1. We admitted we were powerless over alcohol - that our lives had 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.

The 12 Steps 6-12

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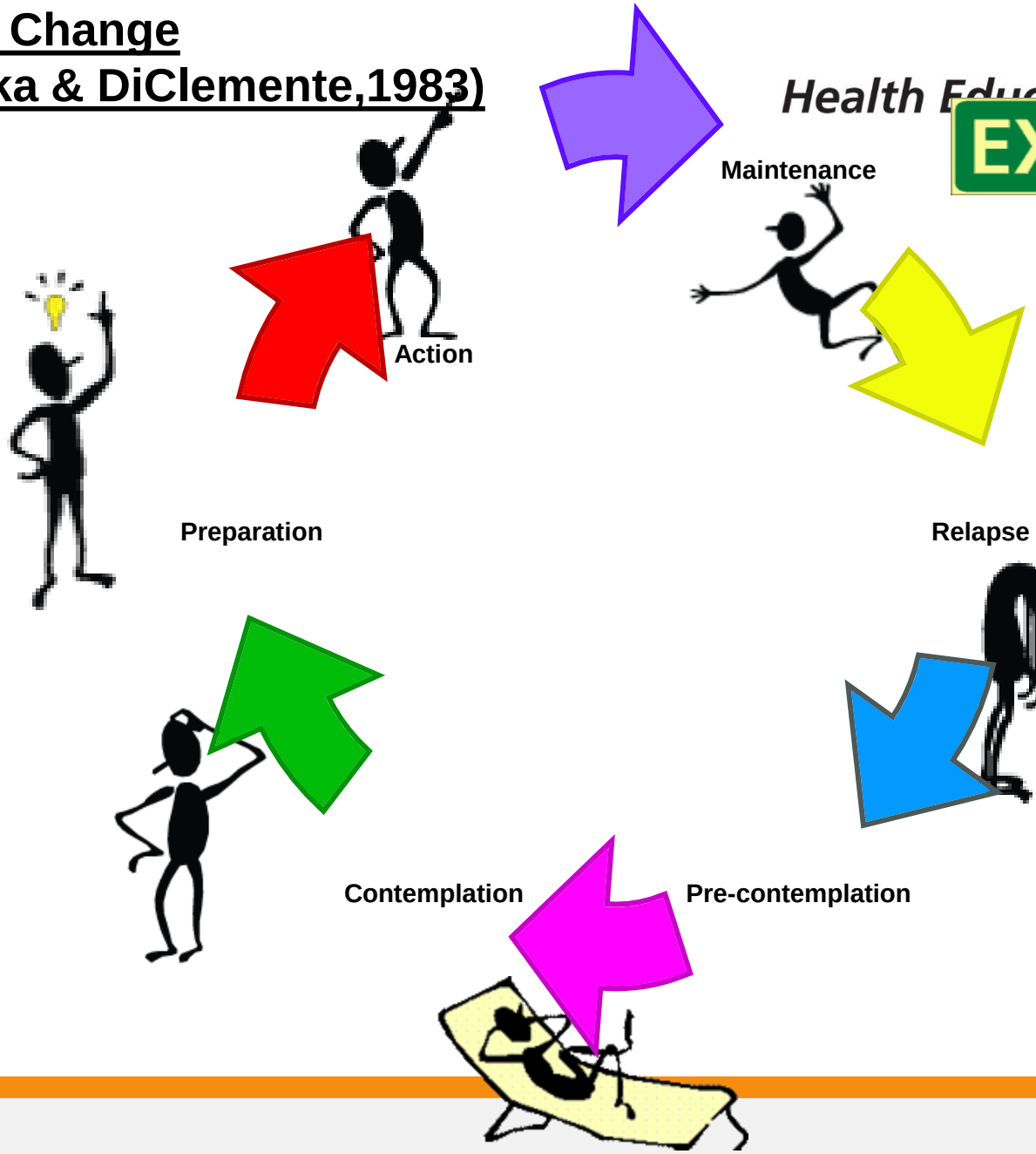
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were 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 tried to carry this message to alcoholics and to practice these principles in all our affairs.

Stages of Change (Prochaska & DiClemente,1983)



Nice guidance CG51* - Brief interventions

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- Can use in a variety of settings for people not in contact with drug services and for people in limited contact with drug services
- Suggest not to provide group psychoeducational interventions about reducing BBV risks / injecting
- Opportunistic brief interventions focused on motivation should be offered to people in limited contact / no contact with drug services
  - 2 sessions each lasting 10–45 minutes.
  - explore ambivalence - drug use and possible treatment

***Nice guidance CG51 Drug misuse in over 16s: psychosocial interventions**

Self-help

- Routinely provide people who misuse drugs with information about self-help groups. These groups should normally be based on 12-step principles; for example, Narcotics Anonymous and Cocaine Anonymous.
- If a person who misuses drugs has expressed an interest in attending a 12-step self-help group, staff should consider facilitating the person's initial contact with the group

Contingency management (CM)

- Offer incentives for abstinence or a reduction in illicit drug use
- Emphasis on reinforcing positive behaviours
- Good evidence that contingency management increases the likelihood of positive behaviours and is cost effective.
- Effective incentives include vouchers (for goods), privileges (e.g., take-home methadone doses) and modest financial incentives.

Other interventions

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- **Behavioural couples therapy (BCT)**
  - Consider for people who are in close contact with a non-drug-misusing partner – focus on
    - the service user's drug misuse
    - consist of at least 12 weekly sessions.
  - Naltrexone concordance - use BCT/CM
- **CBT and psychodynamic therapy**
  - Not to people presenting for treatment of cannabis or stimulant misuse or those receiving opioid maintenance treatment
  - Use for treatment of comorbid depression and anxiety disorders

Residential and inpatient care

- Same range of psychosocial interventions (PSI) for inpatient and residential settings as in community settings.
- Consider Residential treatment for people who are seeking abstinence and comorbid physical, mental health or social problems.
- Should have completed a residential detoxification programme and not benefited from previous community-based psychosocial treatment.

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NICE CG115* - Harmful drinking and mild alcohol dependence

- Offer PSI - cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies - focused specifically on alcohol-related cognitions, behaviour, problems and social networks.
- People with a partner - behavioural couples therapy.

NICE CG115 -Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence

Nature of intervention

- Cognitive behavioural therapies
  - one 60-minute session per week for 12 weeks.
- Behavioural therapies
  - one 60-minute session per week for 12 weeks.
- Social network and environment-based therapies
  - eight 50-minute sessions over 12 weeks.
- Behavioural couples therapy
  - One 60-minute session per week for 12 weeks

Behavioural approaches

- Behavioural therapies
  - Cue exposure /Behavioural self control training / contingency management / aversion therapy
- Social behaviour and network therapy (SBNT**)**
  - Range of strategies to help build social networks supportive of change involving patient and patient's networks (friends / families)
  - Aim of the integration is to build a 'positive social support for a change in drinking'

NICE CG115

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Interventions for moderate and severe alcohol dependence after successful withdrawal

- Consider offering acamprosate or oral naltrexone in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies

NICE CG115

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Comorbid disorders

- For people who misuse alcohol and have comorbid depression or anxiety disorders,
  - Treat the alcohol misuse
- If depression / anxiety continues after 3 to 4 weeks of abstinence from alcohol use appropriate NICE guidelines
- People who misuse alcohol and comorbid mental health disorder/ high risk of suicide
  - Refer to a psychiatrist

Motivational Interviewing

- Developed by psychologists Bill Miller & Steve Rollnick
- Motivation interviewing is a collaborative conversational style for strengthening a persons own motivation and commitment to change
- Can be effectively integrated into other interventions (e.g. brief interventions, results feedback, managing resistance, etc).

Motivational Interviewing

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- Uses one of the forms of “helping conversational” style
  - Styles include directing / guiding/ following style
  - MI is guiding style
- Righting reflex – element within a “helping conversational style”
- Ambivalence – key focus of MI
  - Change talk – person’s own statements that favour change
  - Sustain talk – person’s own statements that favour status quo
- MI uses righting reflex to develop change talk compared to sustain talk

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Motivational Interviewing

- Spirit – 4 elements
  - Partnership
  - Acceptance
    - Absolute Worth/ Accurate empathy/Autonomy/ Affirmation
  - Compassion
  - Evocation

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Motivational Interviewing - process

- Engaging
- Focusing
  - client has an agenda and the therapist has an agenda
- Evoking
- Planning
  - threshold of readiness - when and how to change rather than whether or why
- “Planning is the clutch that engages the engine of change talk”

Aspects of motivational interviewing -OARS

- Open ended questions
- Affirmations
  - Therapist could say “Well done”
- Reflections
  - Simple - repeat what is said
  - Complex
    - Client: “I want to stop eating so much junk food ; I must eat more fruit and veg”
    - Therapist: “It sounds like you are worried about your health”
- Summarize

Aspects of motivational interviewing - REDS

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- Roll with resistance - discussed later
- Express empathy – can be tricky
  - Therapist : “I know”
  - Client: “You don’t know”
- Develop discrepancy
  - Therapist could highlight how a person may value appearance yet still inject
- Self efficacy

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Motivational Interviewing

- Resistance - Responding to sustain talk and discord
  - Sustain talk - as previously - discussed part of ambivalence
  - Discord - “Not being on the same wavelength”
- Manage sustain talk using
  - Reflection/ Amplified reflection /Double sided reflection /Emphasize autonomy/ Reframing/Agreement with a twist/ Running head start

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Motivational Interviewing -Discord

- Client – “Smoke alarms”
    - “Defending” /“Squaring off”/ “Interrupting” /“Disengagement”- “Distracted”
- Interviewer Factors
  - Tired/ distracted/very worried about the client/impatient
- Tools
  - Reflection / Affirming /Shifting focus /Apologizing

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Various videos on motivational interviewing on internet

http://www.youtube.com/watch?v=dm-rJJPCuTE&list=PL0C3D4CCB642157AE

Wrong way and Right way

http://www.youtube.com/watch?v=80XyNE89eCs

http://www.youtube.com/watch?v=URiKA7CKtfc

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Motivational Interviewing

- Lundahl et al (2010) evaluated 132 implementations of motivational interviewing, most with substance use outcomes.

- Motivational Interventions significantly outperformed when compared with treatment as usual, being handed written materials, being placed on a waiting list, or offered no treatment at all.

Is MI as effective as other structured interventions?

- YES. Motivational interventions are roughly equivalent when compared with specific interventions such as CBT
- But MI takes about 100 fewer minutes to have same effect.

Are the effects durable?

- YES. Benefits of MI showed no signs of fading up to two years or more after intervention.

Does MI work in group formats?

- NO. Limited data on group-delivered MI, but researchers interpretation is that “relying solely on group-delivered MI would be a mistake”

International Treatment Effectiveness Project (2007)

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- Provided principles of mapping currently used in GMW substance misuse services
- Collaboration btw National Treatment Agency, Texas Christian University and UK Providers
- Aim was to improve treatment effectiveness
  - Make the delivery of psychosocial interventions both easier and clearer
  - Promote organisational improvements.
- Built around a manual to make the intervention work

NTA 2009 ; Simpson 2004

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ITEP promoted ‘node-link mapping’

- A cognitive approach for discussing issues with clients
- Visualised issues in a series of ‘maps’
- Used the same cognitive behavioural principles as motivational interviewing and relapse prevention
- Reduced sessions to a record of decisions and progress

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ITEP – ‘node-link mapping’

- Formed a model for ‘cause-and-effect’ thinking + problem-solving which clients could use
- Interventions used aimed at changing thinking patterns
- E.g., address thought-processes that could hamper behavioural change
- Maps were used as a way of creating a visual ‘hook’ for the discussion

Example of a Map used

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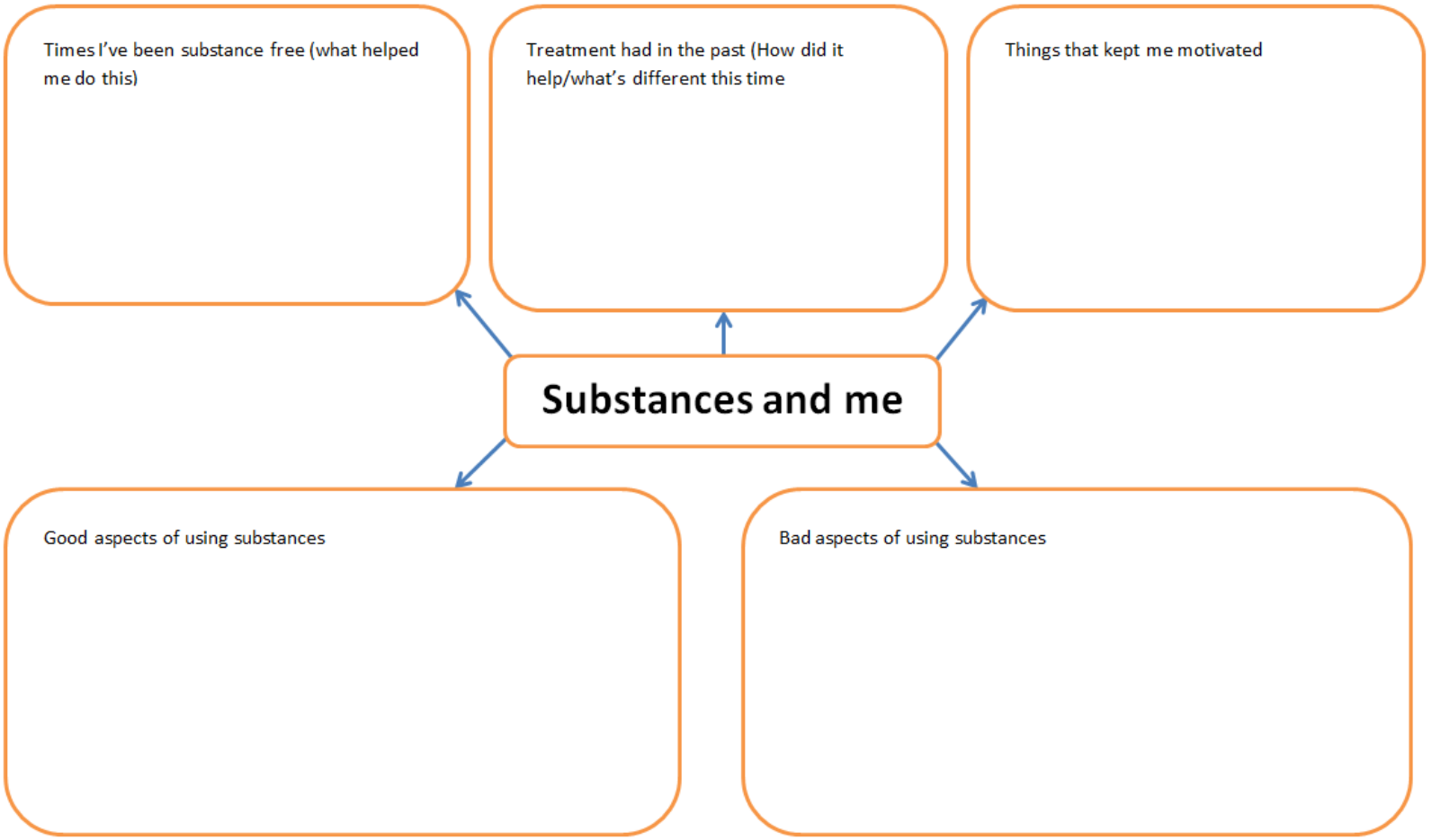
UNITY



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Example of a Map used

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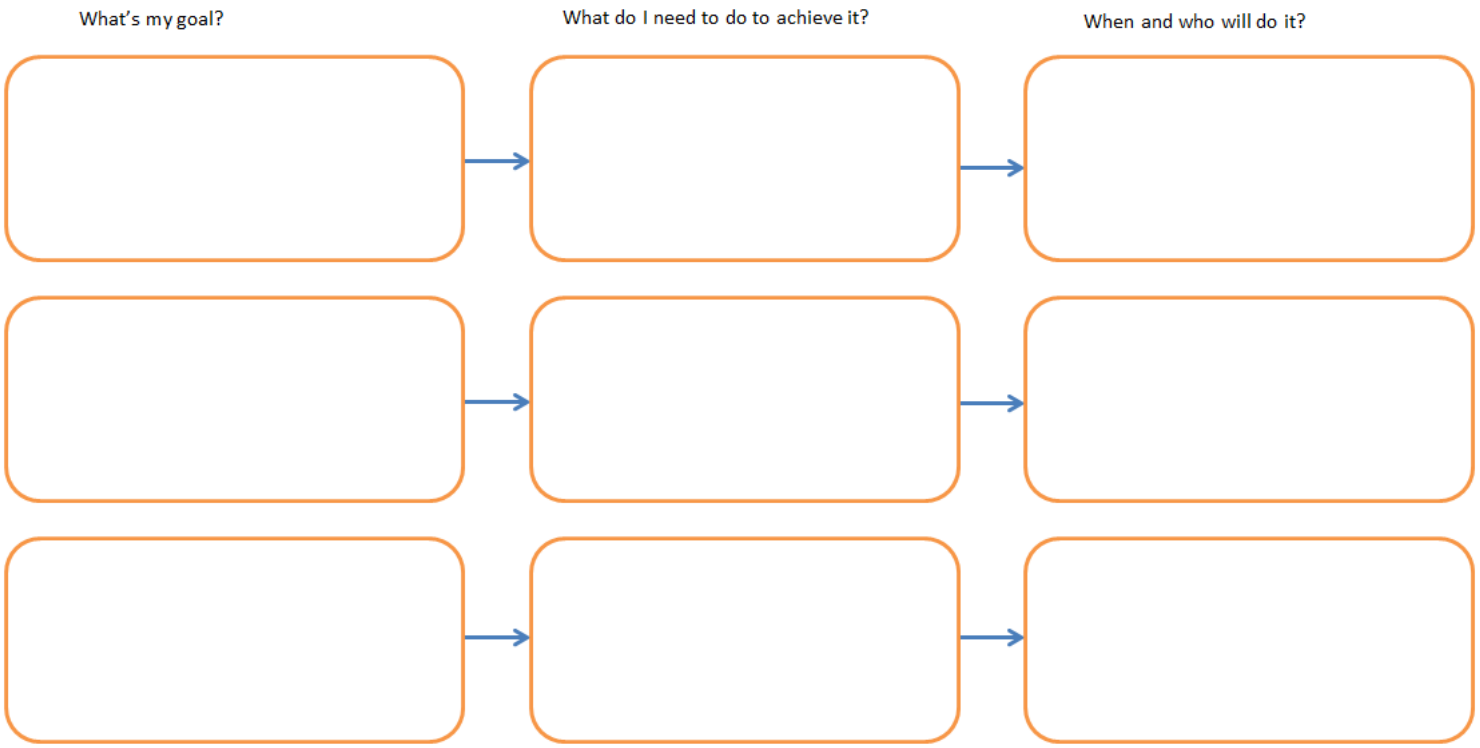
First Steps To Recovery



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Benefits of Maps

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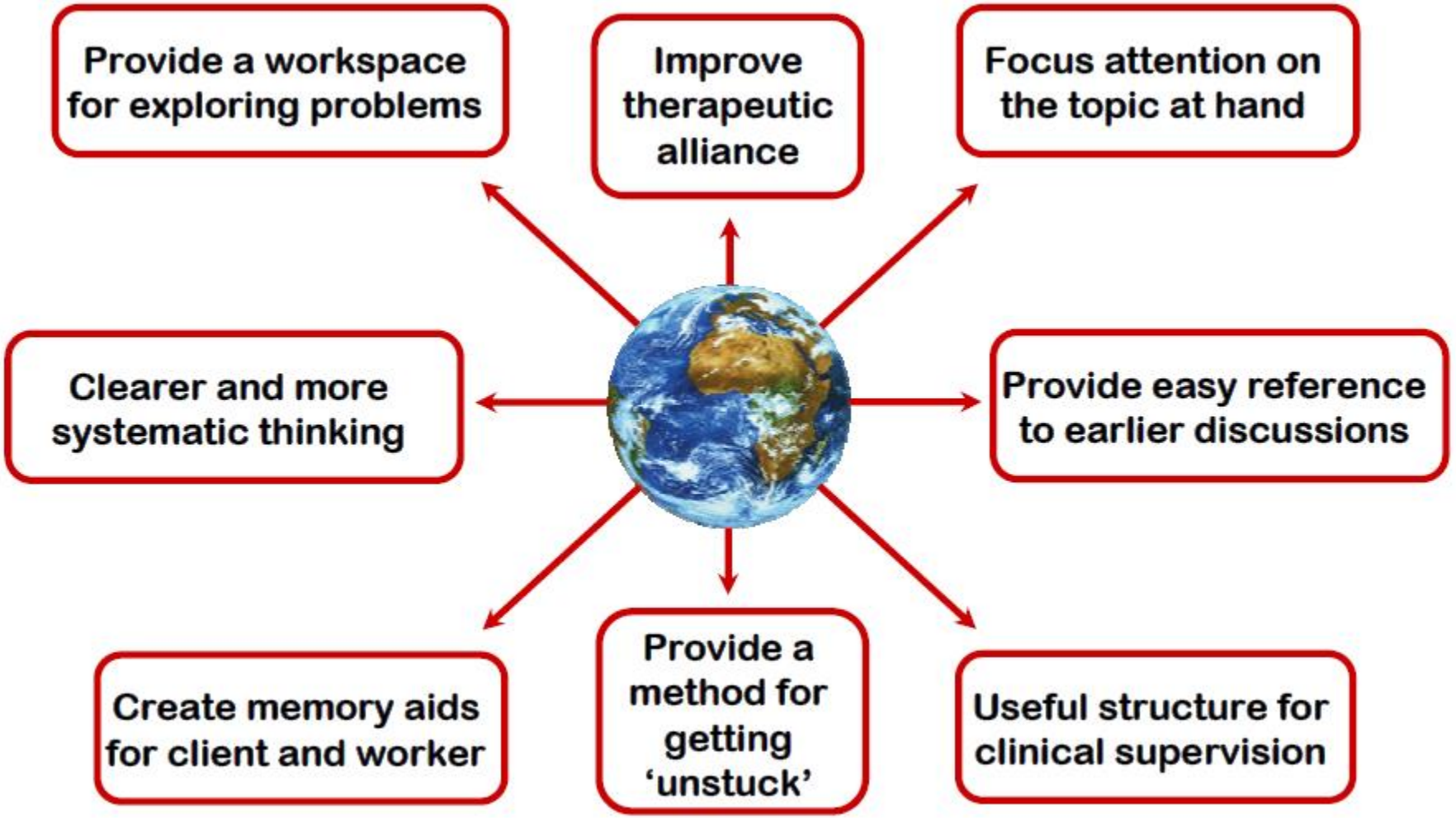

Node mapping evaluated in a number of trials

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- Comparison of clients assigned to "node-link mapping" or "standard"
  - Mapping clients had significantly fewer opiate-positive urine samples during months 2-6 of treatment[+]
  - Greater Coverage of collateral issues by counsellors*
  - Clients reported less criminal activity after 12 months^

[+] Dees 1997 *Pitre 1997 ^ Joe 1997

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Expert led session

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Substance Misuse

MCQs

1. Which of the following is not an example of change talk:

   A. Desire: I would like to stop using alcohol

   B. Ability: I could stop alcohol use

   C. Reason: Alcohol worsens my psoriasis

   D. Accomplishment: I finally stopped alcohol

   E. Need: I have got to stop alcohol

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Substance Misuse

MCQs

2. Prochaska and DiClemente‟s stages of change include the following except:

A. Contemplation

B. Preparation

C. Maintenance

D. Relapse

E. Persistence

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Substance Misuse

MCQs

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Substance Misuse

MCQs

3. Who of the following is most closely linked with Motivational Interviewing:

A. Carl Jung

B. Carl Rogers

C. David Winnicott

D. Aaron Beck

E. Melanie Klein

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Substance Misuse

MCQs

3. Who of the following is most closely linked with Motivational Interviewing:

A. Carl Jung

B. Carl Rogers

C. David Winnicott

D. Aaron Beck

E. Melanie Klein

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Substance Misuse

MCQs

4. All of the following are key principles of Motivational Interviewing except:

A. Roll with resistance

B. Express empathy

C. Develop discrepancy

D. Support self efficacy

E. Strengthen safety behaviour

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Substance Misuse

MCQs

4. All of the following are key principles of Motivational Interviewing except:

A. Roll with resistance

B. Express empathy

C. Develop discrepancy

D. Support self efficacy

E. Strengthen safety behaviour

Substance Misuse MCQs

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5. Which of the following is true of needle exchange programmes in the UK

A. Pharmacies are unable to provide this service

B. It is only available to people prescribed opioid substitute medications

C. It is only available in urban centres with populations greater than 50000

D. Only qualified nursing staff can dispense equipment

E. It reduces injection risk behaviours among people who inject drugs, in particular self- reported sharing of needles and syringes, and frequency of injection

Substance Misuse MCQs

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5. Which of the following is true of needle exchange programmes in the UK

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Substance Misuse EMIs

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Potential mechanisms to manage resistance:

A. Simple reflection

B. Amplified reflection

C. Double sided reflection

D. Shifting focus

E. Reframing

F. Agreement with a twist

G. Emphasising personal control

H. Coming alongside

I. Reaction

J. Summarizing

1a. This approach enables the validity of the client's raw observation to be regarded but tries to interpret the observation in a new way.

1b. This may be considered when someone says "I am my own man, I do not need you to tell me what to do"

1c. The following exchange highlights this approach:

Client:" I have been able to use more heroin than other people in my town"

Therapist: "Perhaps you are simply immune to the effects of heroin".

Substance Misuse EMIs

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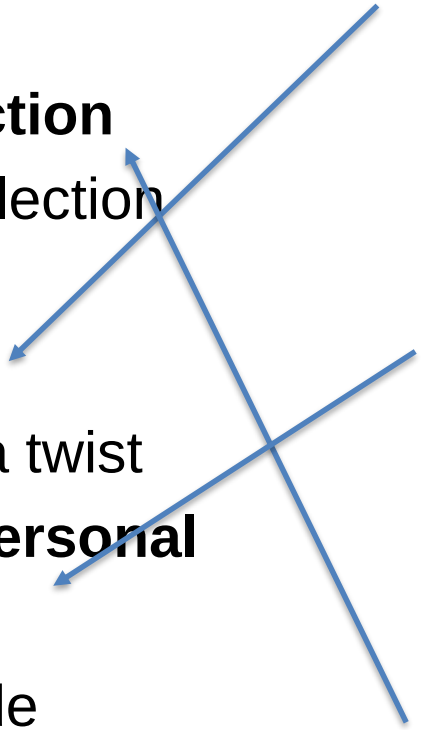

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Substance Misuse EMIs

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Mutual aid groups:

A. Alcoholics Anonymous (AA)

B. SMART Recovery

C. GamCare

D. Frank

E. Teen Challenge UK

F. British Doctors‟ and Dentists' Group

G. Narcotics Anonymous (NA)

H. Breaking free

I. Kaleidoscope

J. Discover

2a. This is a global, community-based organization with a multi-lingual and multicultural membership. It was founded in 1953

2b. This is a science-based programme to help people manage their recovery from any type of addictive behaviour. It began in 1994.

2c. This is a free drug advice service that is aimed at parents and children in particular. It is available 24 hours a day and online and by text message

Substance Misuse EMIs

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The following optional additional slides outline more addiction models.

Psychodynamic model

THE DEFENSIVE MOTIVE

- **Defence against intense affect (anxiety, anger, depression)**

1. Problems in affect tolerance

2. Failure of internalization

- Drugs - as the externalized “good mother”, source of comfort and security

Operant Conditioning – types of contingencies

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	Appetitive	Aversive
Positive (an event produced)	**Positive reinforcement** ('buzz', rewarding aspects of drugs): *increase in behaviour*	**Positive punishment** (hangover, ill-health, etc): *decrease in behaviour*
Negative (an event is prevented)	**Negative reinforcement** (blocks out painful emotions, anxiety etc): *increase in behaviour*	**Negative punishment** (loss of jobs, relationship break ups etc): *decrease in behaviour*

Models of addiction: cognitive – behavioural – sociocultural models

- Orford (2001) - Substance misuse conceptualised as an ‘excessive appetite’ belonging to the same class of disorders as gambling, eating disorders and sex addiction.

- Orford argued that the emotional regulation of appetitive behaviours in their respective social contexts follows principles of operant conditioning.

- Secondary factors, such as internal conflict, may impact on the extent of continued use or recovery.

Attachment

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- From Bowlby's work with children and care givers
- Combines biological component and learned styles of care giving
- Attachment is dependant on a match between the needs of the infant and the care giver - **pathology = mismatch**
- Defined as healthy and unhealthy attachment (anxious-avoidant ; ambivalent; disorganized)
- Linked to developmental psychology, mentalisation (theory of mind) and interactional psychologies i.e. **as adults we replicate early relationships**

Attachment Model of Addiction (Flores, 2004)

- Addictus (Latin)---attached or enslaved to something

- As long as the person continues to use substances it will be difficult to establish good therapeutic relationships

- Model is consistent with 12 Steps and Psychoanalytic approaches

Recovery as reversing ‘narcissistic’ defences (Flores, 2004)

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Conditions that promote addiction (West, 2007)

- A culture in which the activity is commonplace and regarded as normal
- Peer groups in which the activity forms a part of social Identity
- An environment with greater opportunities to engage in the activity
- An environment with reduced opportunities for other sources of reward
- Adverse social, economic or environmental circumstances
- Possibly an environment in which there is lower propensity for the activity to lead to immediate adverse consequences