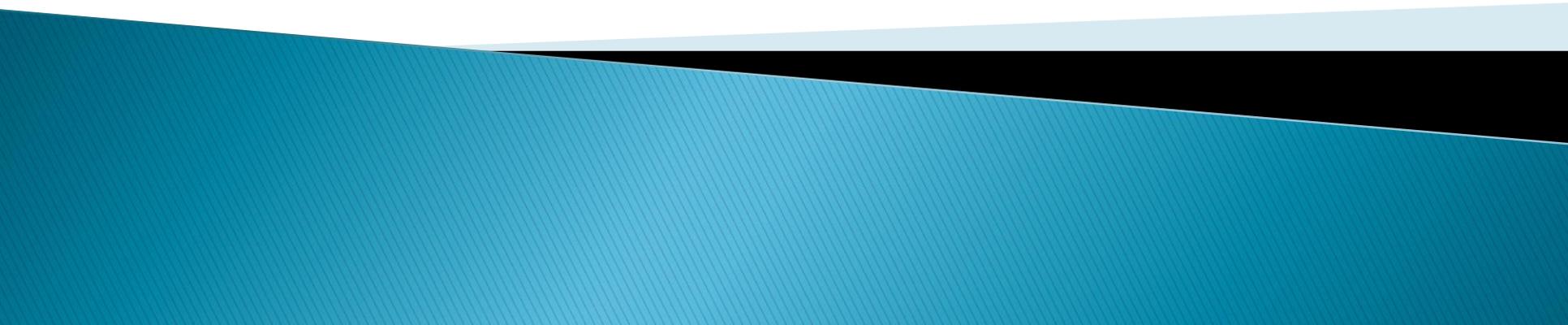


# Introduction to Working with People Who Have Substance Use Disorders

Francine Martin Sambuco, MA CADC

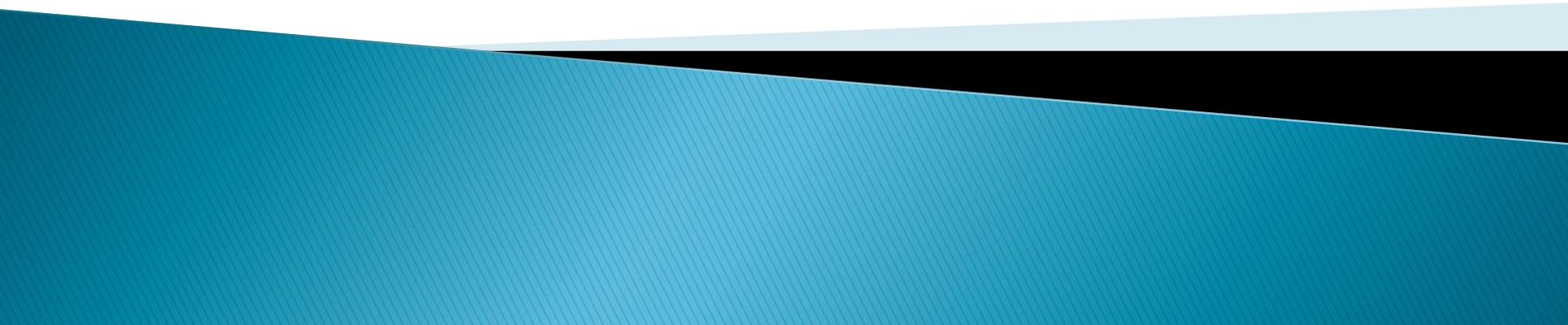
March 28, 2017



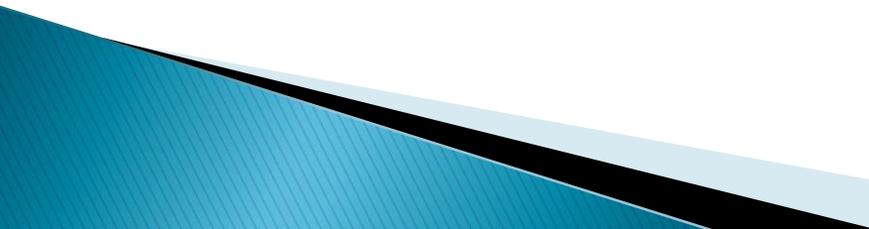
# Outline & Goals

- ▶ Engagement
  - ▶ Assessment
  - ▶ Opioid Agonist Therapy
  - ▶ Comorbid Disorders
  - ▶ Resources
- 

# Engaging Persons with Substance Use Issues



# Engagement Issues: Perceptions

- ▶ Negative stereotypes of substance users
  - ▶ Disturbing behaviors
  - ▶ Dishonesty
  - ▶ Manipulation
  - ▶ Unlike us
  - ▶ Perpetrators, not victims
- 

# The Nature of Addiction

- ▶ Evolution
  - ▶ Obsessive Preoccupation
  - ▶ Compulsion to Use
  - ▶ Loss of Self and Destruction of Life
  - ▶ Loss of Control
  - ▶ Erosion of Values and Integrity
  - ▶ Continued Use Despite Wish to Change
  - ▶ Fear
  - ▶ Stuckness
- 

# Overcoming Obstacles

- ▶ Suspend Judgment
  - ▶ Depersonalize (It's not about you)
  - ▶ Understand Behaviors and Motivations
  - ▶ Find Common Ground
  - ▶ Avoid Power Struggles
  - ▶ Find the “Real” Person
- 

# Useful Approaches

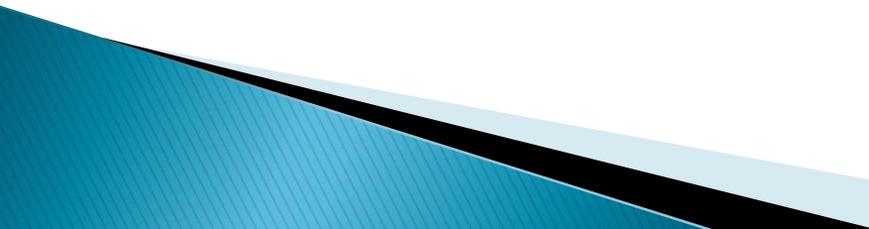
- ▶ Problem Solving
  - ▶ Work with Motivations
  - ▶ Set Limits, Establish Respective Responsibilities
  - ▶ Reduce Harm, Establish Safety
  - ▶ Connect with Significant Others
  - ▶ Communicate with Other Providers
  - ▶ Create Partnerships
- 

# Assessment

# Purpose of Assessment

- ▶ Identify Significant and Urgent Issues
  - Priority Populations
    - Pregnant Women
    - Women with Children
    - IDU
- ▶ Determine Apparent Needs
  - Physical well-being
    - Potential for withdrawal
    - Medication(s) and/or side effects of medication(s)
- ▶ Make Appropriate Referrals
- ▶ Establish Safety
- ▶ Develop Relationship (Caring Curiosity)

# Screening

- ▶ Identify Issues Requiring Immediate Attention
  - ▶ Risk of Harm to Self or Others
    - Medical Issues?
    - Injurious behavior?
    - Awareness and Judgment (Intoxication)
  - ▶ Determine Appropriate Setting for Comprehensive Evaluation
- 

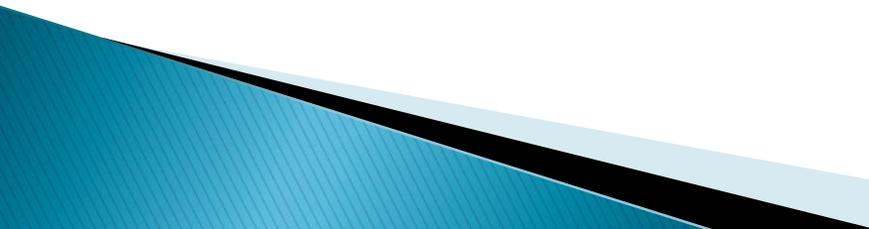
# Identify Substance Use Issues

- ▶ Type of Substance Use and Intensity
  - ▶ Intoxication
  - ▶ Withdrawal or Potential for Withdrawal
  - ▶ Behavioral Manifestations
  - ▶ Self Perception of Use and Level of Distress
  - ▶ Motivation for Change
  - ▶ Environmental Impact
  - ▶ Support Network
  - ▶ Physical Impact
  - ▶ Level of Function
- 

# Pattern of Use

- ▶ What is being used?
  - ▶ What is the route of administration?
  - ▶ How much is being use?
  - ▶ Why is it being used?
  - ▶ What effects does it have?
  - ▶ What happens when substances are not available?
  - ▶ How is it obtained? What is the cost?
  - ▶ Be curious!
- 

# Other Influences and Outcomes

- ▶ How does your living situation affect use?
  - ▶ How do the people in your life affect use?
  - ▶ Does your health affect your use?
  - ▶ How does your use affect your health?
  - ▶ How does your use affect your ability to do things, i.e. work, take care of family, other responsibilities
- 

# Opioid Agonist Therapy

- ▶ Two types of medication used for “maintenance”:
  - Methadone
  - Buprenorphine

# Methadone

- ▶ Long acting opiate displaces or blocks opiates from receptors
  - Blocks euphoric effects of opiates
  - Dependent on dosage
  - Lasts about 24 hours, daily dosing
  - Administered through clinics
  - Somewhat disruptive due to daily dosing
  - Does not block effects of other substances
  - Sometimes difficult withdrawal and discontinuation
  - Few side effects

# Buprenorphine

- ▶ Very long acting opiate/agonist/antagonist also blocks opiate receptors and displaces other opiates
  - Limited euphoric affects
  - Often administered with an antagonist to prevent misuse
  - Administered in an office setting
  - Usually daily dosing, but last up to 60 hours
  - Does not block effects of other drugs
  - Frequent side effects i.e. headaches
  - Relatively easy withdrawal.

# Controversies of Maintenance Therapy

- ▶ Maintenance of Addiction?
  - ▶ Pathway to Recovery?
  - ▶ Misuse and Diversion
  - ▶ Harm Reduction?
  - ▶ Public Health Impact?
  - ▶ Stigma
- 

# Co-Occurring Disorders

- ▶ Relationships between AOD use and psychiatric disorders:
  - AOD can exacerbate psychiatric symptoms
  - AOD can mimic psychiatric symptoms and disorders
  - AOD can mask psychiatric symptoms and disorders
  - AOD withdrawal can cause psychiatric symptoms and mimic psychiatric syndromes
  - Psychiatric behaviors can mimic behaviors associated with AOD problems

**“Comorbidity is an expectation, NOT an exception”**



# Prevalence of Co-Occurring Disorders

- ▶ An estimated 8.9 million people have co-occurring disorders.
- ▶ Only 7.4% receive treatment for both mental illness and substance abuse disorders.
- ▶ 55.8% received no treatment.

(SAMSHA, 2009)



# Prevalence of Co-Occurring Disorders

- 50% of the estimated 600,000 homeless present with co-occurring disorders
    - 70% of homeless clients identified substance abuse as primary reason for their homelessness (National Institutes on Alcohol Abuse and Alcoholism)
  - 700,000 of the estimated 10 million incarcerated adults have co-occurring disorders
  - More than 50% of adolescents that have a substance abuse diagnosis also have a diagnosable mental illness
  - Compared to their male counterparts, women with substance abuse disorders are more likely to have mental health disorders
- 

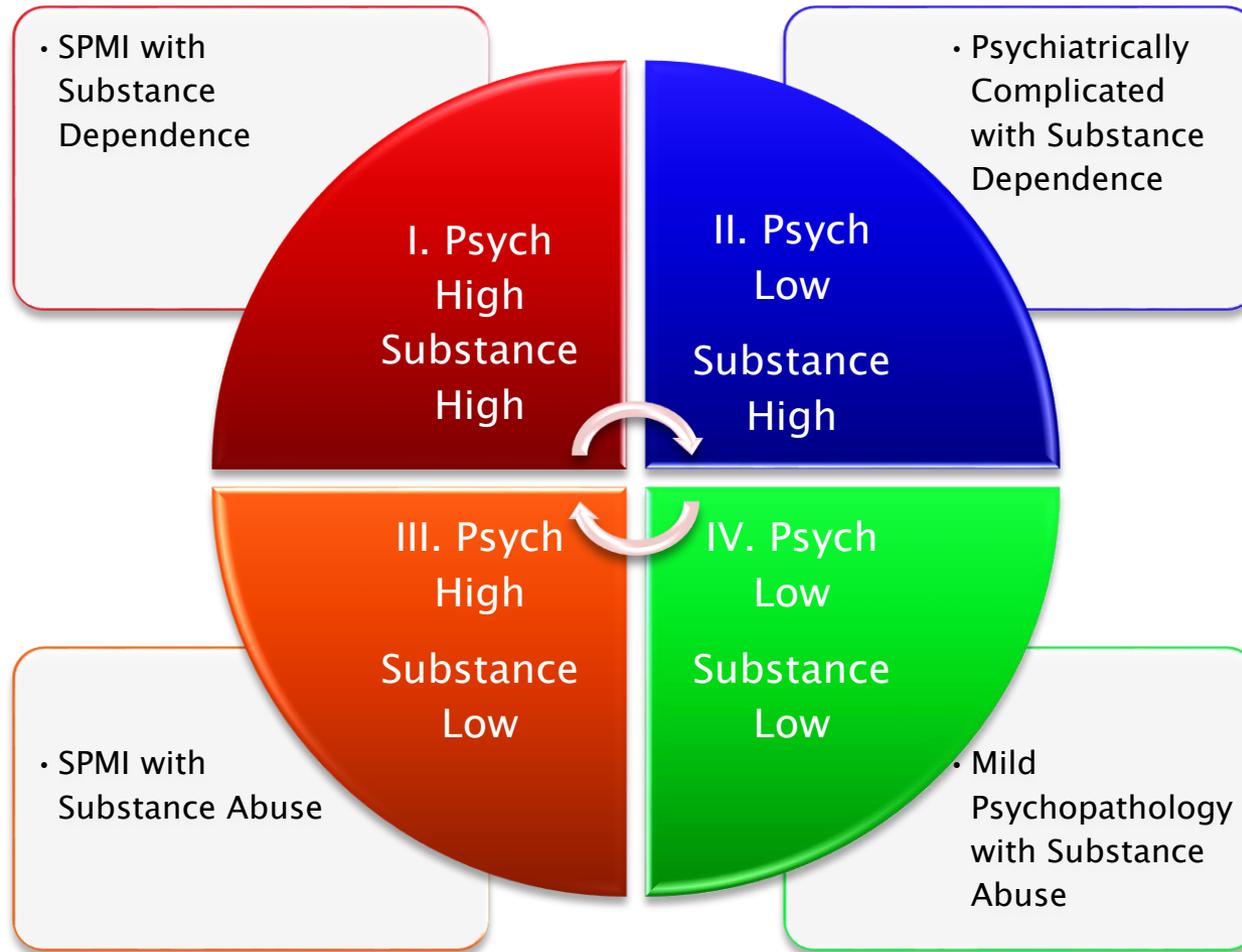
# Principles of Successful Treatment

- ▶ Importance of the therapeutic relationship
  - ▶ Coordination of care....even through multiple treatment episodes
  - ▶ Each disorder should be considered primary
  - ▶ One size does not fit all
  - ▶ Be mindful of delivering culturally-sensitive treatment
- 

# Cultural Competency

- ▶ Minorities are less likely than whites to receive treatment and are more likely to receive poor quality of care.
  - ▶ Minorities are over-represented among the Nations most vulnerable populations (people who are homeless, incarcerated, or institutionalized) with higher rates of mental disorders and more barriers to care.
- 

# Sub-Groups of People with Co-Occurring Disorders



# Conceptual Framework

- ▶ Need for integrated treatment approach
- ▶ Likely to benefit from additional support services
- ▶ Substance dependence without SPMI
- ▶ Substance-induced/exacerbated psychiatric disorders
  - Anxiety/Panic Disorder
  - Depression/Hypomania
  - Psychosis
  - Suicidality
  - PTSD
  - Personality Disorder/traits

I. Psych High/Substance High

II. Psych Low/Substance High

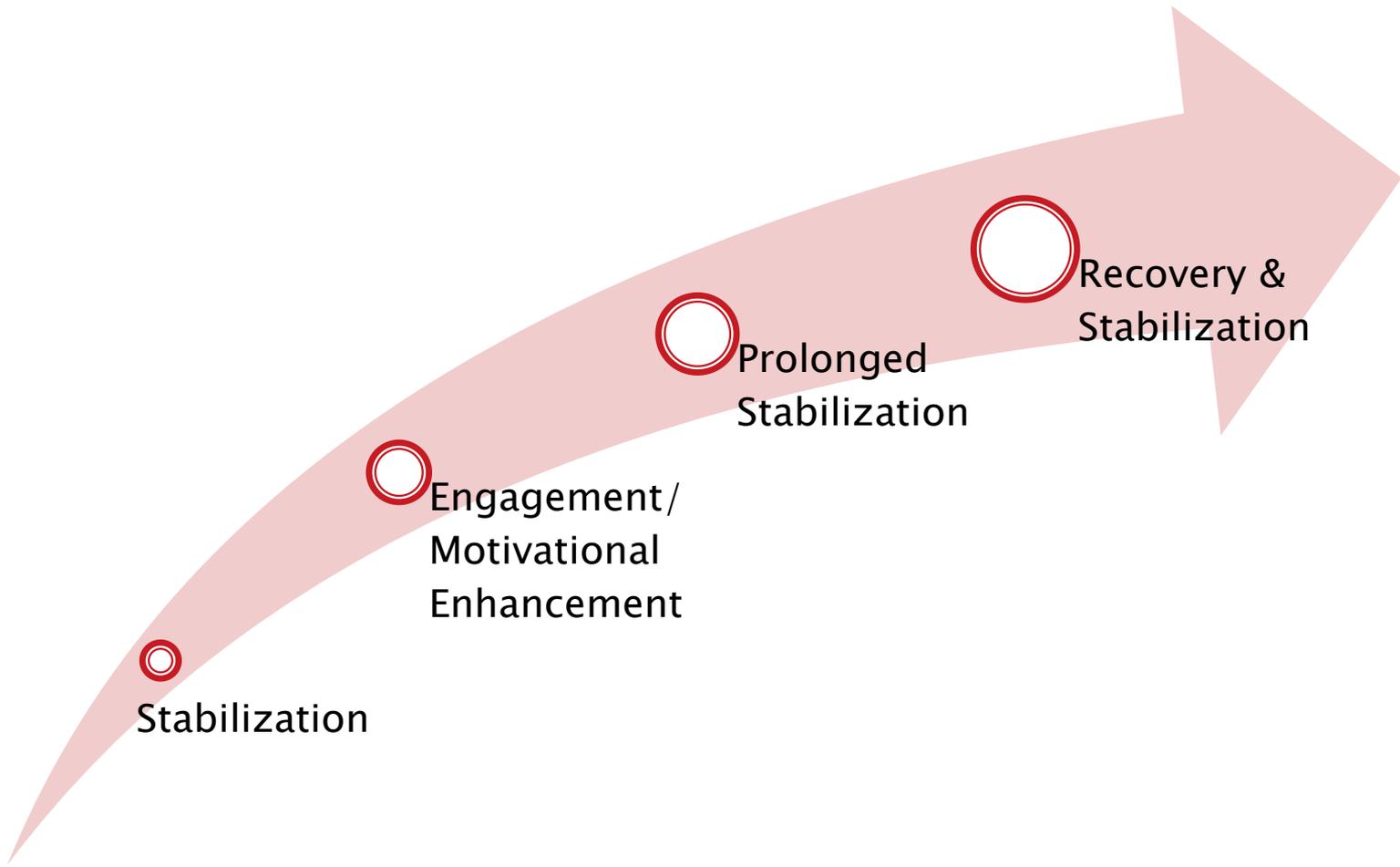
# Cont'd

- ▶ Presents with SPMI (e.g. schizophrenia, Major Affective Disorders with Psychosis, PTSD) complicated by Substance abuse
- ▶ Presents with combinations of psychiatric symptoms (e.g. anxiety, depression) and patterns of substance misuse and abuse

III. Psych High/Substance Low

IV. Psych Low/Substance Low

# Process of Recovery



# Take Home Message for Co-Occurring Disorders

- ▶ Identify the issues
  - ▶ Help people to talk about their experience
  - ▶ Help them to identify the impact that substance use has on their lives
  - ▶ Help them to determine what they would like from their lives (motivations)
  - ▶ Help them identify what they would like to change and how they can begin that process
  - ▶ Refer them to additional sources of help.
- 

# How People Change: The Transtheoretical Model

The transtheoretical model (TTM) shows how people successfully make changes in their lives. It is based on the research of Prochaska and DiClemente (1984), who found a number of characteristics common to all types of successful change in all types of circumstances. They found that change takes place over time in *five distinct stages of change*:

- Precontemplation: not seeing a problem
  - Contemplation: seeing a problem and considering whether to act
  - Preparation: making concrete plans to act soon
  - Action: doing something to change
  - Maintenance: working to maintain the change
- Prochaska and DiClemente also identified 10 specific *processes of change*.
- Two groups
- Experimental Processes – focuses on internal thought processes and how a person views his/her situation
  - Behavioral Processes – focuses on actions and behavior

# Experimental Process

1. *Consciousness raising* – Clients gain knowledge about themselves and the nature of the behavior
2. *Dramatic Relief* – A significant, often emotional experience related to the problem
3. *Self reevaluation* – The recognition of how a current behavior conflicts with personal values and life goals
4. *Environmental reevaluation* – Clients are often motivated by the realization that their substance abuse has not only negatively affected themselves but also other, external areas (such as the people in their lives and the environments in which they function)
5. *Social liberation* – Recognition and creation of alternatives in the social environment that encouraged behavior change

# Behavioral Process

1. *Stimulus control* – Avoidance or alteration of cues, so that the likelihood of engaging in the problem behavior is lessened. Clients who associate alcohol or drug use with specific environments are less likely to engage in substance use if they avoid those “trigger” situations
2. *Counterconditioning* – Substitution of healthy behaviors for unhealthy ones. This often involves healthy alternatives
3. *Reinforcement management* – Rewarding of positive behavior changes
4. *Self-liberation* – Belief in one’s ability to change, and acting on that belief by making a commitment to alter behavior
5. *Helping relationships* – Relationships that provide support, caring, and acceptance to someone who is attempting to make a change

# Precontemplation

- ▶ Earliest stage of change
  - ▶ Individuals are unaware of problem behavior or they are unwilling, or discouraged, when it comes to changing it
  - ▶ Engage in little activity that could shift their view of problem behavior
  - ▶ Can be defensive about the targeted problem behavior
- 

# Objectives or Goals in Engagement Stage of Treatment

- ▶ Agreement to engage in services.
  - ▶ Identification of why really there.
  - ▶ Identification of how recovery might help.
  - ▶ Willing to discuss or explore treatment as a means of change.
- 

# ENGAGEMENT STAGE (CONT)

- ▶ The Clinical focus is Outreach
  - ▶ Developing the Treatment Relationship
  - ▶ Ask the consumer what is important to them
  - ▶ Listen and respect their priorities, don't judge
- 

# ENGAGEMENT STAGE (CONT.)

- ▶ GET TO KNOW WHO THEY ARE
  - ▶ PRACTICAL SUPPORT FOR DAILY LIVING, FOOD, SHELTER ,MEDICINE, SAFETY, CRISIS INTERVENTION
  - ▶ ASSESSMENT IS IMPORTANT IN THIS STAGE
- 

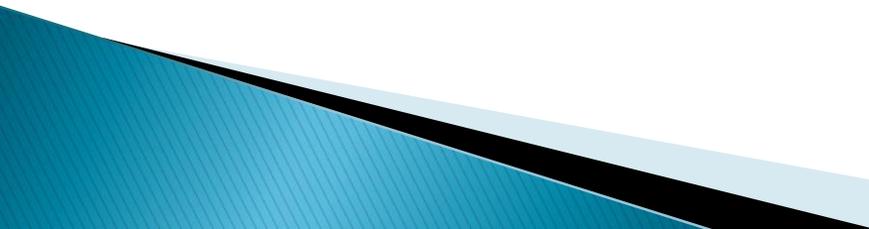
# Contemplation Stage of Change

- ▶ Person acknowledges that he or she has a problem
  - ▶ Begins to think seriously about solving it
  - ▶ Struggles to understand their problem, to see its causes, and think about possible solutions
  - ▶ They may be far from actually making a commitment to action
- 

# Objectives or Goals in Persuasion Stage of Treatment

- ▶ Becoming self-motivated
  - ▶ identification of benefits of treatment and risks of no treatment
  - ▶ Rehab Readiness
  - ▶ Ready to risk treatment
  - ▶ visualization of recovery.
  - ▶ Encouragement and support
- 

# PERSUASION STAGE OF TX (CONT)

- ▶ MOTIVATIONAL INTERVIEWING
  - ▶ --COMMIT YOURSELF TO UNDERSTANDING THE CONSUMER'S GOALS
  - ▶ HELP CONSUMERS ESTABLISH THE DISCREPANCY BETWEEN GOALS AND LIFESTYLES (THOUGHTS, FEELING ACTIONS)
- 

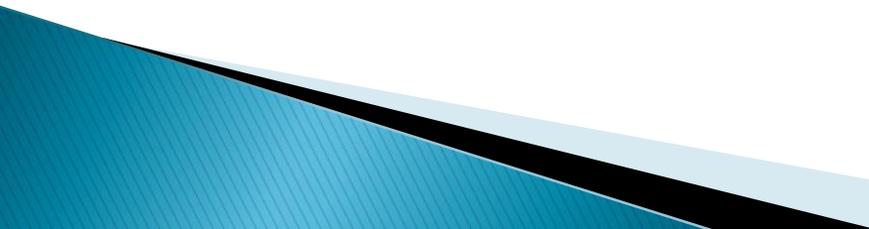
# PERSUASION STAGE (CONT)

- ▶ AMBIVALENCE IS NORMAL
  - ▶ --ASSURE CONSUMERS THAT AMBIVALENCE TO CHANGE IS NORMAL (CHANGE MAY OCCUR SLOWLY OVER TIME)
  - ▶ Payoff-matrix—use a payoff matrix to tip their decisions away from ambivalence toward positive action
- 

# Persuasion Stage of TX (cont)

- ▶ Education
  - ▶ --teach consumers about mental illness & activities that promote health and awareness
  - ▶ --offer skills training opportunities
  - ▶ --reach out and provide support to families
- 

# Preparation Stage of Change

- ▶ Persons are ready to change in the near future
  - ▶ On the verge of taking action
  - ▶ People may have tried and failed to change before, yet they have learned valuable lessons from the past attempts
  - ▶ Need to develop a concrete plan that will work for them
- 

# Objectives / Goals of Treatment in Early Action Stage of TX

- ▶ Skills and resource assessments
  - ▶ Recovery planning
  - ▶ New coping strategies explored.
- 

# Action Stage of Change

- ▶ People overtly modify their behavior
  - ▶ Stop smoking, remove all the desserts from the house, pour the last beer down the drain, or enter a treatment program
  - ▶ Busiest period and requires the greatest commitment of time and energy
  - ▶ Changes made during this stage are more visible to others and receive more recognition
- 

# Objectives / Goals in Active Stage of TREATMENT

- ▶ Skill development
  - ▶ Resource development
  - ▶ Development of positive routines
  - ▶ Promotion of independence
- 

# ACTIVE STAGE OF TREATMENT (CONT)

- ▶ Skills Building

- teach illness management skills on both disorders

Social Support—encourage positive peer supports (self-help groups)

Cognitive Behavioral Intervention

- assist consumers with transforming negative thoughts and behaviors in coping skills on both disorders.

# Maintenance Stage of Change

- ▶ Final stage and difficult
  - ▶ Individual works to consolidate the gains attained during the action stage
  - ▶ Struggles to prevent relapse from 6 months to a lifetime
  - ▶ Without a strong commitment to maintenance, there will be a relapse
- 

# Maintenance Stage of Change

- ▶ Planning—developing relapse prevention plan
  - support consumers as they maintain life style changes.
  - RECOVERY LIFE STYLE—help consumers set new goals for enhancing their quality of life
  - SOCIAL SUPPORT—reduce frequency intensity and duration of relapses and improve relationships.

# Objectives /Goals of Treatment Relapse Prevention Stage of TX

- ▶ Continuation of support
  - ▶ lifestyle management
  - ▶ reinforcement of learning and use of skills
  - ▶ Use of natural supports
- 

# Staging Process

- ▶ All consumers with a dual diagnosis must be staged every six months 1 month prior to treatment plan due date (best practice)
- ▶ Develop new monthly list based on when treatment plan is due and commit to staging
- ▶ Who is facilitating the staging process?
  - Co-occurring Therapist/Clinical Lead
  - Observer/Note taker
- ▶ Quality of the staging process
  - Staging process involves all areas of expertise from the ACT team
  - Staging form should be completed during the staging process, not prior
  - Staging should be done first in the morning meeting process to ensure increased participation and lack of distraction
  - The information from staging should be used at the ITT meeting and incorporated into the consumers treatment plan goals

# WHAT HAPPENS AFTER STAGING ???

- ▶ THE ITT IS SCHEDULED
  - ▶ THE ITT MEETS AND REVIEWS THE RESULTS OF THE STAGING DURING ITT MEETING
  - ▶ THE TREATMENT PLAN GOALS AND OBJECTIVES ARE DEVELOPED BASED ON THE RESULTS/RECOMMENDATIONS OF THE STAGING PROCESS AND THE GOAL PLANNING SHEET COMPLETED WITH THE CONSUMER.
- 

# Strategies for Facilitating Change

- ▶ A Motivational Approach:
  - Motivation plays an important role in decisions to change during substance use
  - Motivation is viewed as something that can be influenced rather than a specific personality characteristic or trait
  - Miller and Rollnick (1991) have developed a style of intervention called “motivational interviewing” (MI) which complement the stages of change model

# Nasal Naloxone

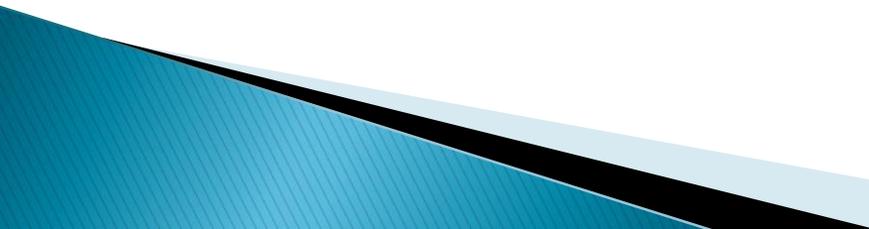
# Nasal Naloxone/Introduction

## **Purpose:**

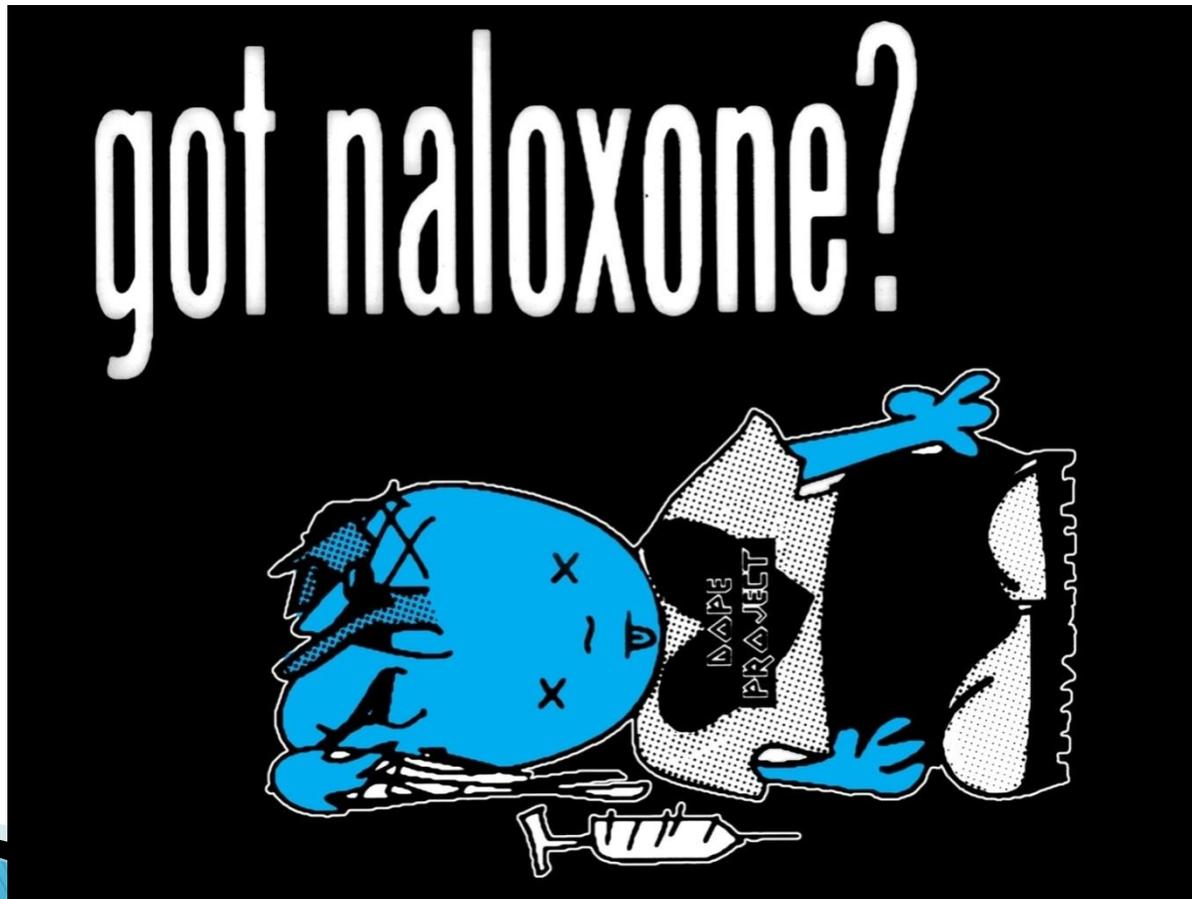
- ▶ Early intervention can help reduce fatalities
  - ▶ The First Responder Narcan Program is designed to educate first responders in recognizing signs and symptoms of opiate overdose
- 

# OBJECTIVES

At the conclusion of this training participants will be able to:

- ▶ Recognize signs and symptoms of opiate overdose
  - ▶ Initiate appropriate treatments and interventions
  - ▶ Assemble the nasal narcan delivery device
  - ▶ Successfully administer appropriate dosing of Nasal Narcan
- 

# Naloxone



**Generic Name :**

**Naloxone Hydrochloride**

# Brand Name : Narcan®



- Endo Pharmaceuticals brought Narcan<sup>®</sup> to the market in the 1960's
  - Narcan<sup>®</sup> is currently available generically under the name Naloxone
- 

# Naloxone is..

- ▶ An opiate antagonist which reverses opiate overdoses
- ▶ Some commonly abused opiates are:
  - Heroin
  - Oxycontin
  - Percocet
  - Vicodin
  - Methadone
  - Morphine

Narcan<sup>®</sup> /Naloxone has been used in emergency rooms and EMS for more than forty years as an antidote for opiate overdoses.

# Pharmacology

- Opiates produce their effects as an agonist on the mu receptors in the central nervous system
- Mu<sup>1</sup> receptors are responsible for a large portion of analgesic (pain management) effects
- Mu<sup>2</sup> receptors are responsible for respiratory distress

- Naloxone kicks opiates out of the brain by blocking certain receptor sites.
  - Naloxone occupies the receptor sites and prevents opiates from binding to the brain.
  - Naloxone in conjunction with rescue breathing has life saving potential.
- 

# An opiate overdose is..

- ▶ When opiates settle in the part of the brain that regulates breathing.
  - ▶ The immediate concern during an opiate overdose respiratory depression.
- 

- The effects of Naloxone wears off between 30–60 minutes after administration
- Heroin lasts 6–8 hours
- Methadone lasts 24 hours
- Opiates outlast Naloxone
- **BE PREPARED FOR THE PATIENT TO RELAPSE**

# When am I supposed to give Narcan<sup>©</sup>???????



# Signs and symptoms of Opiate Overdose



# Signs and Symptoms

- ▶ In addition to a known history of opiate abuse, responders should look for:
  - Weak/Thready pulse
  - Slow or Absent Respirations
  - Constricted Pupils
  - Weakness/Unresponsiveness

# Administration

- ▶ First Responder administration of Narcan<sup>©</sup> will be Intra-Nasally.
- ▶ A preloaded syringe will be affixed with a mucosal atomization device (MAD)

# Administration

- ▶ Pre loaded syringes contain 2mg in 2ml.
- ▶ Per statewide treatment protocols for EMTs and Paramedics the dose for Naloxone is 0.4–2.0 mg and may be repeated if necessary

# Storage of Narcan<sup>®</sup>



# Common Misconceptions



- Administering Naloxone does not require extreme force

# Schedule

- Naloxone is not in the DEA schedule of drug classes, yet requires a prescription
- Naloxone has no potential for abuse

- ▶ Naloxone has no other purpose besides reversing an opiate related overdose.
  - ▶ Naloxone has no mind altering effects
- 

- ▶ Naloxone is the only treatment in medicine that literally cannot hurt anyone.
  - ▶ The only possible effect is the individual may become dope sick (withdrawal).
  - ▶ Naloxone is specific, safe, and effective
- 

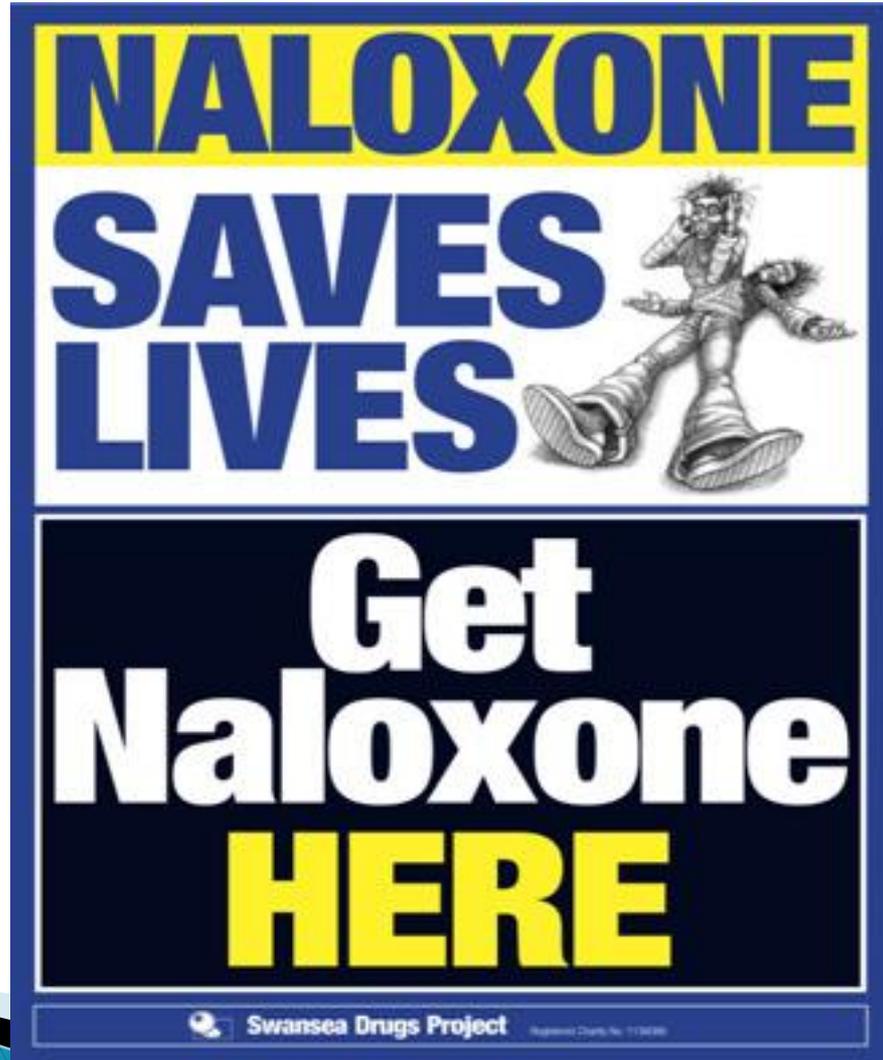
# Epidemiology

- ▶ People coming out of jail or treatment have highest risk of overdose.
- ▶ Most deaths are among opiate users who are in their late twenties to early thirties and have been actively using for the past five to ten years.
- ▶ Only 17 % of opiate related deaths are among new users.

# Bottom Line

- ▶ **Nobody needs to die from an opiate overdose**

# Questions??????



**NALOXONE**

**SAVES LIVES**



**Get  
Naloxone  
HERE**

 Swansea Drugs Project Registered Charity No. 113409

The poster is a vertical rectangular sign with a blue border. It is divided into three main sections. The top section has a yellow background with the word 'NALOXONE' in bold blue capital letters. The middle section has a white background with the words 'SAVES LIVES' in bold blue capital letters on the left, and a black and white illustration of a person in a dynamic, athletic pose on the right. The bottom section has a dark blue background with the text 'Get Naloxone HERE' in white and yellow capital letters. At the very bottom, there is a small logo for the Swansea Drugs Project and the text 'Swansea Drugs Project' followed by 'Registered Charity No. 113409' in a smaller font.