Substance Use Disorder Curriculum Modules

Integrating SUD Treatment Skills into the Behavioral Health Curriculum
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into the Behavioral Health Curriculum

These modules were compiled by Kristin Dempsey, LMFT, LPCC, Senior Associate, California Institute for Behavioral Health Solutions, and Robert Williams, Ph.D., Associate Professor of Counseling in the College of Health and Social Sciences, San Francisco State University.

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Why the Substance Use Disorder (SUD) Curriculum Modules were created

About 7.9 million individuals in the United States reported a co-occurring mental health and substance use disorder in 2014 (SAMHSA, 2017). In a report published in 2012, the National Center on Addiction and Substance Abuse estimated that 40 million Americans can be diagnosed with “the disease of addiction,” and an additional 80.4 million individuals are using substances in a manner that threatens their health and safety. Such statistics indicate that about a third of Americans are significantly impacted by substance use disorders, yet our behavioral health workforce is typically not receiving sufficient training on substances use, addiction, or related disorders.

Depending on the discipline and the regulatory requirements associated with various degree programs, substance use treatment training can range from daylong workshops to fifteen-week courses. The quality of substance abuse treatment curricula can be of high quality, but given the prevalence of the associated disorders, trainees are often left in need of more skills and/or practice with SUD issues when they enter the workforce.

Creation of the SUD Curriculum Modules is an attempt to expand the SUD clinical treatment into other areas of clinical training so future providers can benefit from learning how to address SUD in various contexts. The topics in this manual have been determined by focus group and survey research involving SUD consumers and family members, college and university faculty members, and mental health and substance use treatment providers in the San Francisco Bay Area.

The modules are intended to be used in non-substance use disorder courses, so the SUD treatment components can be more broadly distributed throughout the training curriculum. Each topic area includes student learning objectives, questions for a pre- and post-test, and lecture, discussion and/or teaching exercises ranging from one hour to three hours in duration. The goal is to provide behavioral health faculty with SUD training material that can be used flexibly within the classroom or training setting.
Sample Grid for Determining Where to Use SUDs Modules in Curriculum

Modules can be used in any course. This grid is to help determine some sample matching of modules to curriculum and is to be considered a potential tool for course planning.

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**Key to modules:**

**M1:** Culture of Addiction  
**M2:** Engaging SUD Clients  
**M3:** Intersection of Multiculturalism and SUDs  
**M4:** Case Management  
**M5:** Co-Occurring Mental Health and SUD  
**M6:** Relapse Prevention  
**M7:** Family and Community  
**M8:** Adolescents, Young Adults  
**M9:** SUD and Primary Care
MODULE 1

Culture of Addiction

Substance use as its own culture. Work with stigma as it shows up in addiction.

Where does it belong:

• Cultural competency
• Community mental health
• Macro concepts (social work)
Student Learning Objectives

As a result of this module, students will achieve the following outcomes:

1. Reduction of stigma around addiction and addiction-related disorders that could impact clinician judgment and reduce accuracy of assessment, treatment planning, and intervention.

2. Reduction of stigma around addiction through increased empathy and compassion in order to build therapeutic alliance and allow of more accurate SUD assessment, planning, and intervention.
Module 1, Pre- and Post-Test

Part 1

1. When an issue such as substance use is stigmatized, those who are engaged in the behavior can feel ______________ (disgraced, shame, embarrassed. Other negative emotional responses are accepted).

2. In the field, it is not uncommon to call a positive drug screen “dirty.” T/F (True.)

3. Stigma around substance use treatment is a major reason individuals might avoid seeking help. T/F (True.)

4. The language we use when working with people with substance use disorders has no impact on perceived or actual stigma. T/F (False.)

Part 2

5. People in recovery do not have their own distinct culture. T/F (False.)

6. One belief that increases stigma toward substance users is that substance users are at “fault” for their disorder. T/F (True.)

7. A counselor’s countertransference can contribute to stigma toward substance users. T/F (True.)

8. As substance use issues are an individual’s responsibility, someone with a substance use disorder (SUD) will probably not benefit in any significant way from spending time with other people with SUD. T/F (False.)
Module 1, Part 1

Summarize the reading "Addiction Language" PDF.

Pre-lecture Exercise

1. Draw a line across the board.

2. Left side — Have students word-associate what comes to mind when you bring up the word "heart disease." Write exactly what they say. Edit or change what is said only in response to clarification.

3. Right side — Have students brainstorm what comes to mind when they hear the word "addiction."

Lecture

1. Review differences between primary care test results and SUD results — "Elevated glucose levels" vs. "Dirty" test.
   - Among 23 million Americans who meet criteria for a substance use disorder each year, only 10% access treatment, and stigma is a major barrier to seeking help.

2. Two main factors influence stigma: cause (it is their FAULT) and controllability (can CONTROL addiction).

3. Chronic effects of substances on the central nervous system produce profound changes in brain structure and function that radically impair efforts to control use, despite harmful consequences. Yet, despite evidence of a strong causal role for genetics and impairment in inhibitory control, stigma is alive and well. Research is now revealing that one contributory factor to the perpetuation of stigma may be the type of language we use.

4. Have students review their list and notice the different comparisons between what they created on the lists. How might our immediate reactions impact how we feel about a client? How might it shape our interactions?

Exercise

1. Give half of the group the first vignette on the second page of the addiction language article (see below). Give the other half the second vignette. Have each group discuss their immediate perceptions and concerns about the case and where they might start.

2. Have the groups come together, ask them to read the two vignettes side by side, and compare the thought process of each group. Review their conclusions on how language can impact the case formulation and treatment planning.
Lecture

1. Use of the more medically and scientifically accurate “substance use disorder” terminology is linked to a public health approach that captures the medical malfunction inherent in addiction. Use of this term may decrease stigma and increase help-seeking.

2. In contrast, tough, punitive, language, including the word “war,” as in “war on drugs,” is intended to send an uncompromising message, “You use, you lose,” in the hopes of deterring drug involvement. Accompanying this aggressive rhetoric are terms such as drug “abuse” and drug “abusers,” implying willful misconduct (i.e., “they can help it and it is their fault”). This language increases stigma and reduces help seeking.

Addiction language article: http://www.amjmed.com/article/S0002-9343(14)00770-0/pdf

Reference

Module 1, Part 2

Introduce the students to Faces & Voices of Recovery.

Lecture

Faces & Voices of Recovery is dedicated to organizing and mobilizing the over 23 million Americans in recovery from addiction to alcohol and other drugs, our families, friends, and allies into recovery community organizations and networks. The organization promotes the right and resources to recover through advocacy, education, and demonstrating the power and proof of long-term recovery.

Visit: http://www.facesandvoicesofrecovery.org

Discuss

• Why do people with SUD need to have an advocacy organization?
• How might linking a client to an advocacy organization impact treatment?

DISCUSSION RE: Faces and Voices of Recovery Policy Position Paper #1

Download: Faces & Voices of Recovery Policy Position Paper #1

• In what ways does the Policy Position Paper #1 (PPP 1) positioning paper challenge the cultural norms for addiction?
• How does the PPP 1 positioning paper challenge some of your own thoughts about addiction?
• Given the PPP 1 how do you think you might change how you intervene with someone with a substance use disorder?
• Would your intervention be different for someone who has been "mandated" (ordered) to treatment? Why or why not? Would your intervention be different for a family member? Why or why not?

Exercise

• Have students choose or assign video vignettes from this link:
  http://facesandvoicesofrecovery.org/what-we-do/recovery-stories.html

In a small group, consider how you might approach a person in treatment who is coming to you at the time they are in greatest need:

• What are the main concerns you think this person would want to address?
• How might you start the conversation about their SUD?

• Are there any values or attitudes that would come up for you as a result of hearing their story? How might you manage the counter-transference? If you don't identify any of your own concerns, what concerns might an individual have?

• What might be one intervention you could use to help affirm or empower the client? How would this help the client to engage in his or her own treatment?

References


All links were live at time of publication (March 2017). However, links can become non-functional. If a link for Faces and Voices of Recovery is no longer operable, please search for "Faces and Voices of Recovery" to find current resources with similar content.
Engaging the SUD Client

Engaging substance-using clients into therapy is the most critical stage of treatment. The majority of substance-using clients drop out of treatment before or after the first session. This points to the importance of engaging the client from the very first point of contact. To be successful, clinicians need to understand (a) stages of change and how to quickly assess stages of change, (b) motivational interviewing and how it can be used to engage a client into treatment, and (c) how to use family dynamics in support of engaging the substance-using client into treatment.
Student Learning Objectives

As a result of this module, students will achieve the following outcomes:

1. Recognize the underlying premises of motivational interviewing and how these concepts relate to engaging clients in treatment.

2. State the targeted interaction skills associated with motivational interviewing.

3. Summarize the transtheoretical model on stages of change, and apply this model to current counseling cases.

4. Analyze when a client is in or out of sync with therapy, and guide disengaged clients in restoring synchronization.
Module 2 Pre- and Post-Test

Part 1

1. A counselor can expect that a client with substance use issues will be resistant. T/F (False — our interactions create resistance.)

2. Empathic responses help engage people in treatment, and reduce resistance. T/F (True.)

3. There is nothing a counselor can do to engage a student if he or she was mandated to attend sessions. T/F (False.)

4. What skill does each letter stand for in the AROSE interaction skills module?

   A:
   R:
   O:
   S:
   E:

Part 2

1. What are the six stages of change, according to the transtheoretical model of change? (precontemplation, contemplation, planning, action, maintenance, relapse/recycle)

2. A client who was referred to you by her probation officer says that although she was told to see you, she doesn’t believe she needs help because she “doesn’t have a problem.” What stage of change might you consider for her?

3. You have seen John for six months. He drinks beer and occasionally hard liquor four times a week. He comes to you reporting that he is still using, but he wants to start attending 12 Step meetings because he thinks doing so eventually will help him to stop. Given just this information, what stage of change would you assign to John?

4. Rebecca had chosen quitting smoking as a target behavior. Eight months ago she quit smoking, and she has remained completely smoke-free. She does spend time trying to avoid smoking triggers, such as spending long evenings in bars, and she has started some light exercise to help her manage stress. What stage of change might you consider for Rebecca?
Module 2, Part 1
Lecture 1 and Activities

1 hour

It may be ideal to begin the lecture with an exercise in which the instructor plays the role of a client who needs to be "motivated" to do something (e.g., eat differently, go to the gym, complete homework assignments). Ask students, one at a time, to offer their counseling skills to "help you" change your behavior. While listening to their counseling interventions, work at two levels: (a) respond in a manner that is consistent with the particular intervention, and (b) make internal notes about interventions that seem to be more consistent with engagement. At the end of the exercise, point out which interventions seemed consistent with empathic engagement.

The AROSE skills can be used to engage clients who are new to treatment and/or ambivalent about changing their behavior or behaviors (Miller and Rollnick, 2013):

- A – Affirmation
- R – Reflection
- O – Open-ended questions
- S – Summaries
- E – Elicit needs, provide advice or information, elicit feedback

Lecture on empathic engagement. Individuals with SUD are not resistant. Resistance is created when the clinician pushes an agenda that is not the client’s.

Also consult www.motivationalinterviewing.org

Questions to Consider:

We consider the metaphor of "dancing vs. wrestling" in motivational interviewing. What do you think is the meaning of this metaphor in terms of client engagement? When we are out of sync, it feels as if we are wrestling with a client. When we are moving along in-sync, engaging them where they are in the change process, and using the AROSE skills — with mostly reflection — we tend to "dance" or move the client along.

- What types of responses moved the instructor toward change talk?
- What responses tend be less engaging, and engender more resistance?

Other situations to consider:

- Asking too many questions in a row, especially closed or non-evocative questions
- Unwanted or poorly timed advice
- Too much information (overwhelming the client)
- Insisting on “taking responsibility” for the presenting problem.
Module 2, Part 2
Lecture 2

1.5 hours

Lecture on “stages of change,” emphasizing that change is related to one particular behavior rather than an entire group of behaviors. Using page 70 at the link http://www.motivationalinterviewing.org/sites/default/files/mia-step.pdf, review the stages of change. Help the students consider how the stage of change might influence how, where and when a clinician engages. End this discussion emphasizing that we start where the client is willing to start (the “action stage”), and approach the places of "pre-change" with empathy, curiosity and respect.

Activity

You are someone who has a diagnosis or schizoaffective disorder, bipolar type and alcohol use disorder.

• Moderate. How might you be engaged if you were in ACTION regarding your mental health concern and in pre-action regarding your alcohol use?

• How might the clinician engage differently if someone were in ACTION regarding her substance use and pre-action regarding the mental health issue?

Next step: consider assigning the students to take on one of the above positions. Have students practice engaging each other using AROSE skills. Do this in triads, with one student observing the "counseling." The observer should actively take notes and provide feedback at the end of the session, describing which interventions work and what could be changed.
Family-Level Manifestations of Stages of Change

**Pre-Contemplation**
Aware of a problem, but family members take on the following behaviors to address the problem.

- Covering up for the addicted person.
- Doing the work that the addicted person does not complete.
- Paying bills (bailouts) that the addicted person fails to pay.
- Rescuing the addicted person from various kinds of problems, e.g., legal.
- Generally taking up the responsibilities the addicted person has abandoned.

**Contemplation**
Aware that a problem exists, but not quite sure of the steps toward change.

- Seriously thinking of making personal changes (e.g., leaving the marriage).
- Making little commitment to take action (e.g., complain, blame, shame, but do not act).
- Beginning to explore options to help the addicted person.
- Vacillating between changes family members want in themselves and changes desired in the addicted person.
- Waiting for the addicted person to change or take her or his own first steps.
- Blaming the addicted person for family problems.

**Preparation**
The addicted family member:

- Intends to take action soon (begin action planning).
- May be taking small steps toward behavior changes.
- May have taken actions in the past that were unsuccessful.
Action

The addicted family member:

- Engages in his or her own behavior changes.
- Invests time and energy into changes.
- Either changes or leaves.

Maintenance

The addicted family member.

- Works to prevent himself or herself, as a family member, from relapsing.
- Is committed to maintenance for a long duration.

Reference


Special Populations

Students can role-play the following populations, identifying issues in which engagement might take special effort. Discussion following the role plays should identify areas of motivation inherent in the role play situation.

- Pregnant women
- Transgender persons
- Adolescents/youth
- Coerced treatment for substance abusers
- Special considerations when engaging different ethnic groups

All links were live at time of publication (March 2017). However, links can become non-functional. If a link for Faces and Voices of Recovery is no longer operable, please search for "Faces and Voices of Recovery" to find current resources with similar content.
MODULE 3

The Intersection of Multiculturalism and SUDs
Student Learning Objectives

As a result of this module, students will achieve the following outcomes:

1. Students will know the impact of SUDs on a broad spectrum of multicultural populations.
2. Students will know the contribution of culturally competent SUD therapies above and beyond the contribution of generic, empirically supported therapies.
3. Students will know the common factors across culturally competent SUD therapies.
Module 3, Pre- and Post-Test

1. AI/AN stands for ____________________________. Fill in blank (American Indian / Alaska Native.)

2. AI/AN have the lowest rates of abstinence from alcohol. T/F (False. They have the highest rates of abstinence from alcohol.)

3. African Americans shift from having some of the lowest rates of substance use (compared to White Americans and Latinos/as) to high rates of substance use in young adulthood. This pattern is known as the ______________________? Fill in blank (crossover effect.)

4. Some keys to treatment success with African Americans are building rapport and overcoming mistrust of the dominant majority group in the U.S. T/F (True.)

5. Research has found that Latinas who were either U.S.-born, or lived in the U.S. before the age of 18, and held U.S. cultural values were more likely to drink and more likely to drink heavily than Latinas who were foreign-born, spoke Spanish, visited their country of origin regularly, and maintained Latin American values. T/F (True. Refer to Alvarez article.)

6. Research indicates that Mexican Americans and Puerto Ricans may be at lower risk of substance abuse and dependence than other Latinas/os, and European and African Americans. T/F (False. Refer to Alvarez article.)

7. Rates of substance use are lower for heterosexuals than LGBT persons because heterosexuals have better coping strategies. T/F (False.)

8. People who are LGBT experience pressures that contribute to their increased rates of substance use disorders. What are those unique pressures?
Module 3, Part 1
Activity 1


Lecture 1

1-hour and 3-hour modules

Lecture on Prevalence of Substance Use and SUDs

Rates of substance use intersect with ethnicity, gender, sexual orientation, and disability status. Because rates vary from year to year, refer to the SAMHSA (Substance Use and Mental Health Services Administration) website (http://www.samhsa.gov/) for updated information. Look for “data” links, then go to the NSDUH link (annual household survey link). From this link, national, state, and metropolitan level data are available. Choose the Behavioral Health Barometer PDF link. Search for “ethnic” or “male” or “female” to find data related to ethnicity and gender. Past year and lifetime use rates are the best metrics to use. Students can be assigned different parts of the report to deepen their understanding of the epidemiology of substance use in the United States. What were students’ impressions of substance abuse rates prior to being presented with the statistics? What are their reactions now?

SAMHSA has brief reports published on substance use rates among persons with disabilities.

SAMHSA has a whole section committed to LGBT youth in particular.

Note the "crossover" trend with respect to African Americans and White Americans. That is, why do African Americans shift from the lower rates of substance use as adolescents to much higher rates as adults, compared to White Americans and Latinos/as? What are the economic and sociocultural reasons that explain the different trends over time (e.g., pot legalization, cultural prohibitions against drug use, cultural tendencies to be permissive with respect to teen cigarette smoking, influence of media, keeping secrets as a person who is GLB or T, impact of disability)?
Module 3, Part 2
4-Part Lecture and Activities

In this section, the instructor can choose to focus on one population or all four ethnic groups. Allow at least 30 minutes of lecture and discussion per group. To avoid rushing through all four groups, consider dividing students into four groups. Instruct each group to go beyond knowledge (i.e., reporting facts), but to delve into a deeper understanding and application of the treatment of each ethnic group. Be sure to walk around as they discuss each group. Instructors must not implicitly or explicitly invite a student who is from a particular ethnic group to voice any expertise about that group. Instead, allow small groups to emerge naturally. Randomly assign topics to each small group. Ensure that members are talking about the topic. You may want to consider assigning points to each member for participating, then additional points to the spokesperson for the group.

1. Regionally, clinicians may have few encounters with American Indians and Alaska Natives. However, the lack of contact does not mean that these populations should be ignored. SAMHSA has provided a helpful fact sheet that can be the basis of lecture and discussion. The document addresses myths and facts about American Indians and Alaska Natives. Instructors and students alike can explore their preconceptions, stereotypes, and new learnings about American Indians and Alaska Natives. Visit: http://store.samhsa.gov/shin/content//SMA08-4354/SMA08-4354.pdf

2. Although Asian Americans have the lowest rates of substance use in the United States, some Asian populations have more difficulty with substance use than others. Also, Asian Americans encounter significant barriers to accessing treatment. This lecture and discussion can and should incorporate PowerPoint documents offered by the Institute for Research, Education, and Training in Addictions (www.ireta.org)→ Download: http://my.ireta.org/sites/ireta.sitesquad.net/files/BarriersChallengesSubstanceAbuseRecoveryAmongAsianAmericans.ppt and: http://ireta.org/2015/08/28/barriers-to-substance-use-disorder-treatment-in-asian-americans-pacific-islanders/

3. African American teens may have lower rates of substance use, but adult African Americans emerge as having significant substance use problems. Ronald Williams published a helpful set of guidelines called “Cultural Considerations in AOD Treatment of African Americans.” Another solid resource is provided by the Association for Addiction Professionals, which has a set of PowerPoint slides on...
the treatment needs of African Americans.


4. Latinos/as have rates of substance use that are higher than African Americans and White Americans, especially in adulthood. Acculturation stress, intergenerational stress, economic stress, and other structural barriers play roles in rates of use and responsiveness to treatment. Josefina Alvarez and colleagues provide a solid overview of the problem and offer treatment guidelines to address Latinos/as and their diversity in the United States.


5. People who are lesbian, gay, bisexual, or transgender (LGBT) are often a neglected population in any context, but especially with respect to multicultural issues. SAMHSA has a great set of PowerPoint slides and lecture content on substance abuse and LGBT persons. It provides a good education on terminology of sexuality, too.

Refer to: http://store.samhsa.gov/shin/content//SMA12-4104/SMA12-4104.pdf
and https://www.nalgap.org/PDF/Resources/Substance_Abuse.pdf
Bibliography (From PubMed 8/19/15)


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MODULE 4

Case Management

Individuals in recovery are concerned regarding the need for housing, employment, and re-integration into society. Case management skills can be useful in the practice of LINKAGE and WARM HANDOFF.

Characteristics of strength-oriented case management skills:

• Culturally informed
• Strengths-based
• Person-driven
• Need to be about skills
• Re-frame case management to consider case management as a clinical skill
• Documentation skills
• Assisting with ADLs, and integration/re-integration into community (through, for example, record expungement, tattoo removal)

Courses to include:

• Community mental health
• Crisis
• Practicum
Student Learning Objectives

As a result of completing this module, students will achieve the following outcomes:

1. By the end of the module, students will view case management of SUD clients as a clinical skill (skill-based SLO, not simply a knowledge-based SLO). Students will need to be able to state how case management of SUD clients can or should be integrated with psychotherapy.

2. By the end of the module, students will take a strengths-based, cultural humility approach to case management of clients with SUD.

3. By the end of the module, students will understand recovery-oriented systems of care, and students will be able to apply recovery-oriented care to case management and clinical practice.
Module 4, Pre- and Post-Test

Part 1

1. _____________ is the term used when a professional conducting therapeutic services speaks out on behalf of a client so she can get her needs met. (Advocacy)

2. Therapy facilitates intra- and interpersonal change, whereas case management focuses on _______________ ________________. (Resource acquisition)

3. When considering case management, only certain behavioral health professionals with “case management” designations in their job descriptions or titles can do the work. T/F (False)

4. Lack of coordinated care services is one reason only 10% of the people who need substance use disorder (SUD) treatment access SUD treatment services. T/F (True)

Part 2

1. Case management is community-based. T/F (True)

2. Case management is anticipatory in that it requires an ability to understand the natural course of addiction and recovery, to foresee a problem, to understand the options available to manage it, and to take appropriate action. T/F (True)

3. It is important to set goals for people in recovery because they will not have a good sense of what they need. T/F (False)

4. Flexibility is not as important as a firm structure when providing case management. T/F (False)
Module 4, Part 1

1-hour module (this module can take more time if you let the discussion go longer)

Pre-lecture Discussion

Engage students in a discussion about why substance abusers would need case management.

1. What are the typical life domain areas — vocational, housing, recreational, spiritual, family, health, or finances — in which someone in recovery might need additional support, and how would these be different from the needs of people who have only mental health issues or physical issues?

2. What are some potential issues that could come up as the result of stigma or judgment? (You might expect some people to assert that substance users do not "deserve" treatment in the belief that they created their own problems.) Discussion topics can include asking how much is society expected to provide in terms of free services for someone with addiction, as well as other responses. A second conversation about our own beliefs around substance users can be helpful here.

Lecture, Part 1

From TIP 27 (see references) — Why is case management for substance abuse needed? Case management is needed because, in most jurisdictions, services are fragmented and inadequate to meet the needs of the substance-abusing population. This lack of coordinated services results from a variety of factors, including the determination that of the 23 million Americans who meet criteria for a substance use disorder each year, only 10% access treatment, and stigma is a major barrier to seeking help.

Inconsistencies among SUD case management programs occur due to:

• Different funding streams. Substance abuse treatment is funded from a variety of sources, including block grants, competitive grants, state and local funding, criminal justice funding, and others. The different requirements or goals of these sources can result in a piecemeal approach to programming.

• A focus on program funding rather than system funding.

• Funding focused on single modalities rather than a continuum of care.

• Inadequate funding created by missing pieces in the continuum.

• Waiting lists caused by inadequate funding.

• Barriers between systems (e.g., mental health vs. substance abuse, criminal justice vs. mental health and substance abuse).

• Lack of incentives geared to client outcome; programs rewarded for process measures, not outcome measures.

• Eligibility/admission criteria that exclude certain clients.

• Lack of agreement on priority for admission/treatment.

• Lack of incentives for programs to work together.

Because of this fragmentation, those in recovery might not get what they need despite their best
efforts. That is, there can be administrative or functional barriers, and case management encompasses the set of skills needed to help clients get past these barriers. Case management is especially relevant for people with SUD because they can become overwhelmed, frustrated, or demoralized, and relapse is not uncommon in such situations.

**Definitions of Case Management**

TIP 27 explains why helping students understand the distinction between case management and therapy is important:

1. Case management encompasses a set of social service functions that help clients access the resources they need to recover from a substance abuse problem. The functions that comprise case management — assessment, planning, linkage, monitoring, and advocacy — must always be adapted to fit the particular needs of a treatment or agency setting. The resources an individual seeks may be external in nature (e.g., housing and education) or internal (e.g., identifying and developing skills).

2. Advocacy is one of case management's hallmarks. While a professional who is conducting therapy may speak out on behalf of a client, case management is dedicated to making services fit clients, rather than making clients fit services.

3. Case management may be implemented by an individual dedicated solely to helping the client access needed resources — a case manager — or by a professional who has this responsibility along with therapeutic or counseling functions. It is important to stress the intervention rather than the intervener's profession.

4. The primary difference between case management and therapy is that the former stresses resource acquisition, while the latter focuses on facilitating intra- and interpersonal change. However, case management and therapy are not incompatible. Indeed, both are generally needed in addressing the needs of a majority of SUD clients.

5. When implemented to its fullest, case management challenges the addiction treatment continuum of pretreatment, primary treatment, and aftercare (discussed further in Chapter 2 of TIP 27 — see references). This occurs because of the advocacy function of case management; the need for case managers to be flexible, community-based, and community-oriented; and the need for case managers to be the primary figures in planning work with the client.
Lecture, Part 2

Models of case management: Use this table (Figure 1-2) to review in lecture the different components of the case management model:

Small groups can also be used in this exercise. Students break into groups of 4–5. Each group is assigned one of the types of case management. Using the vignette provided, each group considers how they would apply their assigned form of case management. Have them state specific case management interventions they would use.

Exercise

Ronald is a 35-year-old Caucasian male who is seeing you after leaving a residential program following two weeks of attendance. Individuals are typically enrolled in the program for 90 days. Ronald tells you he left early because he “has to get back to work and take care of my kids.” From a prior relationship, he has two children, ages 5 and 7, who are in foster care. They were placed there after police arrested Ronald for sales of methamphetamine eight months ago. He was in jail for six months and is currently on probation. He attended the program at the encouragement of his probation officer. His drugs of choice are alcohol, methamphetamine, and marijuana, in that order. He is sleeping on his brother’s couch, and tells you he needs to work ASAP so he can pay his brother and then find a new place to live, because they are not getting along very well. He presents as somewhat agitated, looks tired, and has low frustration tolerance.

• List what you see as potential case management needs.
• What else would you want to know? What would you do with this information?
• Given your assigned case management approach, what would be 2–3 possible interventions (things you would do to help him overcome barriers to his goals)?
• Why would or wouldn’t this particular case management approach work with this client?
Module 4, Part 2

3-hour module

Principles of Case Management and How they Apply to SUD

For more detail, refer to Chapter 2 in TIP 27 (see references).

Case management offers the client a single point of contact with the health and social services systems. The strongest rationale for case management may be that it consolidates to a single point responsibility for clients who receive services from multiple agencies.

Case management is client-driven and driven by client need. Throughout models of case management, in the substance abuse field and elsewhere, there is an overriding belief that clients must take the lead in identifying needed resources.

Case management involves advocacy. The paramount goal when dealing with substance abuse clients and diverse services with frequently contradictory requirements is the need to promote the client's best interests.

Case management is community-based. All case management approaches can be considered community-based because they help the client negotiate with community agencies and seek to integrate formalized services with informal care resources such as family, friends, self-help groups, and church.

Case management is pragmatic. Case management begins "where the client is," by responding to such tangible needs as food, shelter, clothing, transportation, or child care.

Case management is anticipatory. Case management requires an ability to understand the natural course of addiction and recovery, to foresee a problem, to understand the options available to manage it, and to take appropriate action.

Case management must be flexible. Case management with substance abusers must be adaptable to variations occasioned by a wide range of factors, including co-occurring problems such as AIDS or mental health issues, agency structure, availability or lack of particular resources, degree of autonomy and power granted to the case manager, and many others.

Case management is culturally sensitive. Accommodation for diversity, race, gender, ethnicity, disability, sexual orientation, and life stage (for example, adolescence or old age), should be built into the case management process.

Exercise

Using the Ronald vignette, have groups of 4–5 students determine how each principle might come into play with a client. Each group is assigned a different principle. At the end of ~ 10–15
minutes, each group takes a turn sharing what they believe would be their way of applying the principle to the case.

A similar exercise can be done using the Case Management Practice – Knowledge, Skills, and Attitudes in Chapter 2 of TIP 27. Instead of the principles, the groups are assigned individual case management skills to apply to the vignette. Each group takes turns sharing how they applied the skill to the case.

The skills include:

Referral

- Establish and maintain relations with civic groups, agencies, other professionals, governmental entities, and the community at large to ensure appropriate referrals, identify service gaps, expand community resources, and help to address unmet needs

Service coordination

- Implement the treatment plan
- Consulting

References

MODULE 5

Co-Occurring Mental Health and Substance Use Disorders

Beyond the existence of COD, but how to work with it.

- Use a stage-of-change approach to assess readiness to change for each issue.
- Develop ability to understand a case and assess for each issue (MH and AOD need to exist separate from each other).
- Practice use of alcohol and drug use screening.
- Determine how to assess biopsychosocial needs and create treatment plans for individuals with COD.

Courses:

- Psychopathology
- Developmental
- Assessment
Student Learning Objectives

As a result of this module, students will achieve the following outcomes:

1. Students will be able to identify and use tools to assess for COD.
2. Students will be able to engage with clients with both co-occurring mental health and substance use needs, depending on where the individuals are in their stage of change for each issue.
3. Students will be able to accurately identify appropriate placement options for clients with COD.
4. Students will practice basic strategies to engage and focus individuals with COD.
Module 5, Pre- and Post-Test

Part 1

1. Self-help groups and family are examples of __________ systems a client with co-occurring mental and substance use services can use to stabilize and/or maintain recovery. (support)

2. Regarding the treatment of co-occurring issues, treatment should address __________ and long-term needs for housing, work, health care, and a support network. (immediate)

3. Assisting clients in solving practical problems, such as obtaining housing or food, is often an important first step toward achieving client engagement in continuing treatment. T/F (True)

4. Clients with COD often display cognitive and other functional impairments that affect their ability to comprehend information or complete tasks. T/F (True)

Part 2

1. The first step in working with a client with co-occurring conditions is ____________. (engagement)

2. Determining risk of harm as well as functionality are two important components of determining __________ of care. (level)

3. In regard to co-occurring conditions, screening and assessment are the same thing. T/F (False)

4. A __________ -centered approach to co-occurring conditions addresses the client’s perception of the problem, what the client wants to change, and how the client thinks that change will occur. (client)
Module 5, Part 1

1.5-hour module

Lecture

Clinician Attitudes and Basics of COD Assessment

SAMHSA’s TIP 42 can be downloaded and used as required reading for students. The following six principles are recommended for use in working with clients with COD.

1. **Employ a recovery perspective.** The recovery perspective acknowledges that recovery is a long-term process of internal change and that these changes proceed through various stages. This perspective generates at least two main principles for practice:
   - Develop a treatment plan that provides for continuity of care over time.
   - Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the co-occurring disorder recovery process.

2. **Adopt a multi-problem viewpoint.** Because people with COD generally have an array of psychiatric, medical, substance abuse, family, and social problems, most are in need of substantial rehabilitation and habilitations. Treatment should address immediate and long-term needs for housing, work, health care, and a support network.

3. **Develop a phased approach to treatment.** Many clinicians view clients as progressing through phases. Generally, three to five phases are identified: engagement, stabilization, treatment, and aftercare or continuing care. These phases are consistent with, and parallel to, stages identified in the recovery perspective.

4. **Address specific real-life problems early in treatment.** Approaches that address specific life problems early in treatment may incorporate case management and intensive case management to help clients find housing or handle legal and family matters. It also may be helpful to use specialized interventions that target important areas of client need, such as money management and housing-related support services.

Psycho-social rehabilitation, which helps clients develop the specific skills and approaches they need to perform their chosen roles, is also a useful strategy for addressing these specific problems. Solving such problems is often an important first step toward achieving client engagement in continuing treatment, which is a critical part of substance abuse treatment generally and of treatment for COD specifically.
5. **Plan for the client’s cognitive and functional impairments.** Clients with COD often display cognitive and other functional impairments that affect their ability to comprehend information or complete tasks. Such impairments frequently call for relatively short, highly structured treatment sessions that are focused on practical life problems. Gradual pacing, visual aids, and repetition are often helpful. Even subtle impairments may have a significant impact on treatment success; therefore, careful assessment and treatment planning consistent with the assessment are essential.

6. **Use support systems to maintain and extend treatment effectiveness.** The mutual self-help movement, family, and other resources that exist within the client’s community can play an invaluable role in recovery. The clinician should help to ensure that the client is aware of available support systems and is motivated to use them effectively.

For more information, see chapter 3 of TIP 42.

**Exercise**

*45 minutes*

Using the following vignette (or another vignette), and break the group into six groups. Each group is assigned one of the above principles. Each group’s participants discuss for about 20 minutes how they might imagine the principle would be applied to this case. At the end of the time, each group is to debrief with the class, and the instructor can write the ideas on the board as the students participate.

Have the students consider:

- For your principle, what specific interventions or approaches did you select?
- Why?
- What else would you want to know in order to serve the client better?
- In what way is your intervention culturally responsive? Trauma-informed?

**Vignette:**

*R. is a 36-year-old Chinese-American male who lives with friends in a small San Francisco apartment. He tells you he is grateful to his friends for allowing him to stay for a few months, otherwise he’d have no other place to stay. He is presenting due to symptoms of anxiety, and says he has a hard time focusing during the day. He hates leaving the house, and this is creating some stress between himself and his friends. He has worked as a mechanic, but has not worked in the past year due to his anxiety. He says he’s been anxious “even as a kid,” and he reports that his anxiety has kept him from continuing after 10th grade in school. He says he learns “hands on” and has had some challenges with focusing, reading, and*
comprehension. He has little contact with his family members; he says they will not talk to him any longer, although he has a female cousin with whom he talks occasionally.

When he first came to the office, he said he had “no other issues,” but an AUDIT and an ASSIST screen indicate that he has potentially problematic cannabis use, and some occasional alcohol use. When you provide feedback on his results, he tells you that he does smoke marijuana about six times a day, which he says helps him feel at ease. He adds that when he runs out of marijuana, he is even more anxious and miserable.

R. is hoping for some medication to help him feel better, and he has heard from a friend that alprazolam is very helpful and he hopes you will be able to help him get a prescription for the medication.
Module 5, Part 2 — Assessment

Lecture

The following "12 Steps of Assessment" narrative is taken from TIP 42 (samhsa.gov). This outline can be used as a lecture to review the basic concepts associated with assessing for co-occurring disorders. It includes two exercises: one for completing a COD screening (to determine if someone has COD), and the other for making an assessment (of the COD issues and supports for this specific person). Each of the exercises could take 45 minutes, following a 45-minute lecture on assessment using the outline below.

The screening process for COD seeks to answer a “yes” or “no” question (e.g., Does the substance abuse treatment client have any significant indication of a possible mental health disorder?), and indicates only whether the possibility of a co-occurring mental health problem warrants further attention at the current time.

Basic assessment, on the other hand, enables the counselor to understand the client’s COD, diagnoses, readiness for change, problem areas, disabilities, and strengths. Intake information consists of:

- Background: Family; trauma history; marital status; legal involvement; financial situation; health; education; housing status; strengths and resources; employment.
- Substance use: Age of first use; primary drugs used; patterns of drug use; treatment episodes.
- Psychiatric problems: Family history of psychiatric problems; client history of psychiatric problems, including diagnosis, hospitalization, and other treatment; current symptoms and mental status; medication and medication adherence.

If the screening and assessment process establishes a substance abuse or psychiatric disturbance beyond the capacity and resources of the agency, referral should be made to a suitable residential or mental health facility or other community resource. Mechanisms for ongoing consultation and collaboration are needed to ensure that the referral is suitable to the treatment needs of people with COD.

The Assessment Process

The following steps are recommended for assessment of each individual.

Step 1: Engage the client.

Five key concepts that promote the engagement of the client include:
• **Universal access (no wrong door):** Recognize that individuals with COD may enter a range of community service sites and that proactive efforts are necessary to welcome them into treatment.

• **Empathic detachment:** Acknowledge that you and the client are working together to make decisions to support the client’s best interests and maintain empathic connection even if the client does not fit your expectations, treatment categories, or preferred methods of working.

• **Person-centered assessment:** Focus on the client’s perception of the problem, what the client wants to change, and how the client thinks that change will occur.

• **Sensitivity to culture, gender, and sexual orientation:** Recognize your own cultural perspective and inquire how cultural factors influence the client’s request for help.

• **Trauma sensitivity:** Consider the possibility of a trauma history before the assessment begins, and try to promote safety in the interview by providing more support and gentleness.

**Step 2: Identify and contact collaterals (family, friends, other providers) to gather additional information.**

Information from collaterals is particularly valuable in evaluating the nature and severity of psychiatric symptoms when the client may be so impaired that he or she is unable to provide that information accurately. Note, however, that the process of seeking such information must be carried out strictly in accordance with applicable guidelines and laws regarding confidentiality and with the client’s permission.

**Step 3: Screen and detect co-occurring disorders.**

All individuals in need of substance abuse treatment should be screened for co-occurring mental disorders, and all individuals in need of mental health treatment should be screened for the presence of a substance use disorder. In addition, all clients should be screened for past and present victimization and trauma.

**Safety screening:** Safety screening requires the clinician early in the interview to specifically ask the client if he or she has any immediate impulse to engage in violent or self-injurious behavior, or if the client is in any immediate danger from others. A variety of tools are available for use in safety screening (see appendices G and H of TIP 42).

**Mental health screening:** A summary of the Mental Health Screening Form-III (MHSF-III) is provided on the following pages. The full form is reprinted in appendix H of TIP 42, and can be obtained at [www.projectreturn.org](http://www.projectreturn.org) or [http://ecdc.syr.edu/wp-content/uploads/2013/06/mental_health_screening_form_iii.pdf](http://ecdc.syr.edu/wp-content/uploads/2013/06/mental_health_screening_form_iii.pdf).

Use of the form is best undertaken after the client and the screener have developed a
strong rapport, because some of the questions deal with sensitive matters. Also, screeners must be appropriately trained to administer these items and record the clients’ responses. The MHSF-III is just one of a number of mental health and substance abuse screening instruments available. For more information on other screening and assessment instruments and how to obtain them, see appendices G and H of TIP 42.

The Mental Health Screening Form-III (MHSF-III): The preferred mode of administration is for staff members to read each item to respondents and get their “yes” and “no” responses. After completing all 18 questions (question 6 has two parts), the staff member should inquire about any “yes” response by asking:

- “When did this problem first develop?”
- “How long did it last?”
- “Did the problem develop before, during, or after you started using substances?”
- “What was happening in your life at that time?”

The form provides space for this information and for staff member comments. The MHSF-III also can be given directly to clients to complete, providing they have sufficient reading skills. If there is any doubt about someone’s reading ability, have the client read the MHSF-III instructions and question number one to the staff member monitoring this process. If the client cannot read and/or comprehend the questions, the questions must be read and/or explained to him or her. It is strongly recommended that a qualified mental health specialist be consulted about any “yes” response to questions 3 through 17. The mental health specialist will determine if a follow up, face-to-face interview is needed for a diagnosis and/or treatment recommendation.

Step 4: Determine the severity of symptoms.

To determine the severity of symptoms and disability, consider consulting the American Association of Community Psychiatrists’ Level of Care Utilization System (LOCUS, see Step 5 immediately below or go to www.wpic.pitt.edu/aacp/finds/locus.html for more information) or the Dimension 3 subscales in the American Society of Addiction Medicine’s Patient Placement Criteria (ASAM PPC-2R) — see Step 5. Some clients may be eligible for certain mental health programs or benefits. Counselors may need to be aware of how these determinations are made in the state where the client resides.

Step 5: Determine the level of care.

LOCUS may help to determine appropriate placement in “level of care” for individuals presenting for substance use disorder treatment. LOCUS is simple to use and involves consideration of multiple dimensions of assessment:
• Risk of harm (to self or others)
• Functionality (ability to fulfill social responsibilities, interact with others, etc.)
• Comorbidity (level of severity and/or acuity)
• Recovery support and stress (availability of family, social, and community support systems)
• Treatment attitude and engagement (positive about or resistant to change)
• Treatment history (previous periods of sobriety, etc.)

The ASAM PPC-2R is also used for determining level of care and employs six dimensions of assessment:

1: Acute Intoxication and/or Withdrawal Potential Dimension
2: Biomedical Conditions and Complications Dimension
3: Emotional, Behavioral, or Cognitive Conditions and Complications Dimension
4: Readiness to Change Dimension
5: Relapse, Continued Use, or Continued Problem Potential Dimension
6: Recovery/Living Environment Dimension

3 is particularly useful in evaluating level of care requirements for individuals with COD, and encompasses five areas of risk to be considered:

• Suicide potential
• Interference with addiction recovery efforts
• Social functioning
• Ability for self-care
• Course of illnesses

Step 6: Determine the diagnosis.

Addiction counselors who want to improve their competencies to address COD are urged to become conversant with the basic resource used to diagnose mental disorders: the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR). Also consider the following three principles:

• Principle 1: Diagnosis is established more by history than by current symptom presentation (applies to both mental health and substance use disorders).
• Principle 2: Document prior diagnoses and gather information related to current diagnoses, even though you may not be licensed to make a mental health diagnosis.
• Principle 3: For diagnostic purposes, it is almost always necessary to tie mental health symptoms to particular periods of time in the client’s history, especially times when active substance use disorder was not present.

**Step 7: Determine the disability and functional impairment.**

Current level of impairment is determined by assessing functional capabilities and deficits in each of the following areas:

• Is the client capable of living independently (in terms of independent living skills, not in terms of maintaining abstinence)? If not, what types of support are needed?

• Is the client capable of supporting himself financially? If so, through what means? If not, is the client disabled, or dependent on others for financial support?

• Can the client engage in reasonable social relationships? Are there good social supports? If not, what interferes with this ability, and what supports would the client need?

• What is the client’s level of intelligence? Is there a developmental or learning disability?

• Are there cognitive or memory impairments that impede learning?

• Is the client limited in ability to read, write, or understand?

• Are there difficulties with focusing, concentrating, and completing tasks?

The Addiction Severity Index (ASI) and the Global Appraisal of Individual Needs (GAIN) provide some information about level of functioning for individuals with substance use disorders. (The ASI also exists in an expanded version specifically for women: ASI-F.) The counselor also should inquire about any current or past difficulties the client has had in learning or using relapse prevention skills, participating in self-help recovery programs, or obtaining medication or following medication regimens. In the same vein, the clinician may inquire about the use of transportation, budgeting, self-care, and other related skills.

**Step 8: Identify strengths and supports.**

All assessments must include some specific attention to the individual’s current strengths, skills, and supports, both in relation to general life functioning and in relation to his or her ability to manage either mental or substance use disorders. This often provides a more positive approach to treatment engagement than focusing exclusively on deficits.

Questions might focus on:

• Talents and interests.

• Areas of educational interest and literacy; vocational skill, interest, and ability, such as social skills or capacity for creative self-expression.
• Areas connected with high levels of motivation to change, for either disorder or both.
• Existing supportive relationships, treatment, peer, or family, particularly ongoing integrated treatment relationships.
• Previous mental health and addiction treatment successes, and exploration of what worked.
• Identification of current successes: What has the client done right recently, for either disorder?

The counselor can build treatment plans and interventions that reinforce strengths and extend what has worked previously. The Individualized Placement and Support model of psychiatric rehabilitation has been demonstrated to promote better vocational outcomes and (consequently) better substance abuse outcomes. In this model, clients with disabilities who want to work may be placed in sheltered work activities based on strengths and preferences, even when actively using substances and inconsistently complying with medication regimens. In unsheltered work activities, it is critical to remember that many employers have alcohol- and drug-free workplace policies.

Step 9: Identify cultural and linguistic needs and supports.
• Will the client fit into the treatment culture (either substance abuse or mental health)? Will there be conflicts in treatment (e.g., the client is attached to certain cultural healing practices)?
• Are there cultural or linguistic service barriers (e.g., the client reads or speaks only Spanish, or does not read any language)?

Step 10: Identify problem domains. Identify problem areas in the client’s life (e.g., medical, legal, vocational, family, social).

The ASI is helpful in detecting these issues (see appendix G of TIP 42). Clarify how both the mental health and substance use disorder interact with these problem areas, and use this knowledge to identify how a client might better engage in treatment. Gather information about the client’s family, social, and provider networks, and, when appropriate, work out confidentiality issues so communication can occur.

Step 11: Determine the stage of change.

Questionnaires such as SOCRATES and URICA (both reproduced in appendix B in TIP 35, Enhancing Motivation for Change in Substance Abuse Treatment, pages 220–229) can facilitate the stage of change assessment, or it can be clinically determined by interviewing the client and evaluating the client’s responses in terms of stages of change:
• No problem and/or no interest in change (Precontemplation)
• Might be a problem; might consider change (Contemplation)
• Definitely a problem; getting ready to change (Preparation)
• Actively working on changing, even if slowly (Action)
• Has achieved and is trying to maintain stability (Maintenance)

Step 12: Plan treatment. In integrated treatment settings, staff clinicians provide interventions for mental health and substance use disorders.

In nonintegrated treatment settings, staff clinicians must develop relationships with mental health providers to coordinate client treatment planning. Integrated treatment planning involves helping the client to make the best possible choices of treatment for each disorder and adhere to that treatment consistently. At the same time, the counselor needs to help the client adjust the recommended treatment strategies for each disorder as needed in order to take into account issues related to the other disorder. For more information on assessment issues, see chapter 4 of TIP 42.

Post-Lecture

Students can practice administering screening tools to each other. They can take turns administering tests, and can designate an observer to note the more subtle aspects of the interaction.

Ask students to respond to the following:

• For the "client": What was it like to be asked the questions? Did you engage? Why or why not? If you did engage, what persuaded you to do so? If you didn't engage, what got in your way?
• For the "counselor": Speak to the questions you found easiest and hardest to ask. What got in your way of asking the questions? What would you have done differently?
• For the observer: Speak to what you noticed in regard to the interaction between the client and counselor. What recommendations would you make to increase the engagement and comfort? In what ways would you consider the training trauma-informed (supports client safety, predictability, trustworthiness, collaboration, and control)?

Mental Health Screening Form-III instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside
person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note that each item refers to your entire life history, not just your current situation; this is why each question begins “Have you ever....”

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>YES / NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>2</td>
<td>Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>3</td>
<td>Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>4</td>
<td>Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>5</td>
<td>Have you ever heard voices no one else could hear or seen objects or things which others could not see?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>6</td>
<td>Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>7</td>
<td>Have you ever attempted to kill yourself?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>8</td>
<td>Have you ever had nightmares or flashbacks as a result of being involved in some traumatic or terrible event — for example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>9</td>
<td>Have you ever experienced any strong fears — for example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>10</td>
<td>Have you ever given in to an aggressive urge or impulse on more than one occasion that resulted in serious harm to others or led to the destruction of property?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>11</td>
<td>Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>12</td>
<td>Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>13</td>
<td>Have you ever experienced a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating — for example, by repeatedly dieting or fasting, engaging in too much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>14</td>
<td>Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly nonstop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?</td>
<td>YES / NO</td>
</tr>
</tbody>
</table>
15. Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, or you felt dizzy or unsteady, as if you would faint? YES / NO

16. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. YES / NO

17. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling? YES / NO

18. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem? YES / NO

Print client's name: _____________________________________________

Program to which client will be assigned: __________________________

Name of admissions counselor: ________________________________

Date: _______________________________________________________

Reviewer’s comments: _________________________________________

Total score: (each "yes" = 1 point) ________________________________

Note: Summing the number of "yes" responses cannot be taken to be indicative of more or less of any “trait” or “dimension.” Even the use of a “total score” for research and program evaluation purposes requires careful understanding of and attention to the fact that fundamentally each item is an independent and separate screening device/question on its own.


Reference

MODULE 6

Relapse Prevention
Student Learning Objectives

As a result of this module, students will achieve the following outcomes:

1. They will be able to identify triggers to use and assist clients in identifying and changing behavior chains
2. They will be able to determine function of use behavior and adopt alternative behaviors.
3. They can assist in developing practices for emotional regulation for people with SUD.
Courses: Practicum
Module 6 Pre- and Post-Test

Part 1

1. A “trigger” is an antecedent to a behavior. T/F (True)
2. Put these words in correct order: behavior, antecedent, consequence. (antecedent, behavior, consequence)
3. There is no way to manage triggers to a behavior. T/F (False)
4. Environmental factors can make a person more vulnerable to triggers. (T/F) True

Part 2

1. If an individual slips, there is no point in quitting early. T/F (False)
2. Regarding high-risk situations, it is important to both learn how to avoid AND escape high-risk situations T/F (True)
3. When someone justifies getting high, that is known as the abstinence violation effect. T/F (False)
4. It is important to help people in recovery identify and practice pleasurable activities in order to reduce the chance of relapsing on drugs or alcohol. T/F (True)
Part 1 — Lecture

1-hour module

Teach the nature of triggers and relapse:

A - antecedents (triggers)
B - behaviors
C - consequences

Review the concept of internal vs. external triggers. You can ask students to brainstorm, use an app like Poll Everywhere (from https://www.polleverywhere.com/app), or have them fill up the white board with a list of internal and external triggers.

Give concrete examples of triggers, the use behavior that might follow and the potential consequences.

Connect to the AA concepts of "playing the tapes" (anticipating triggers and relapses) and definition of insanity as "doing the same thing over and over while expecting different results" (same behavior leading to similar consequences).

Using the behavioral chain handout, ask the students to identify common triggers they experience. Have them list the behaviors and the consequences.
https://app.box.com/s/685529ff4391b692b579

In the large or small group, they can answer the following:

- What makes you more vulnerable to triggers?
- How might the context impact how someone responds to triggers?
- How is it useful to know of one's triggers?

Following this exercise, offer students an opportunity to share their answers with the larger group. Follow this discussion by explaining how we can be conditioned to respond differently to the triggers we recognize as problematic. Example: When I pass a bar, I will cross the street and take deep breaths while listing all of my friends' pets. Behavior: I reach the end of the block without going into the bar — success! The more we do behavioral chaining, the more we can anticipate the potential triggers and avoid them in the first place — such as walking down a different street instead of walking by a bar.

Activity

Behavior chaining: https://app.box.com/s/685529ff4391b692b579
Lecture 2

1.5 hours

Consider the concept of addressing what happened to someone vs. what is wrong with someone?

**Overview of SAMM Concepts and Skills**

**How to Avoid Drugs (Made Simple)**

The concepts and skills taught in this module are designed to help clients follow these four recommendations:

- If you slip, quit early.
- When someone offers drugs, say no.
- Don’t get into situations where you can’t say no.
- Do things that are fun and healthy.

**Overview of Module Concepts and Skills**

Clients learn how to follow these recommendations by learning key concepts and the skills. Here are four recommendations restated in terms of the module’s key concepts:

<table>
<thead>
<tr>
<th>Plain English</th>
<th>Module Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you slip, quit early.</td>
<td>Practice damage control.</td>
</tr>
<tr>
<td>When someone offers drugs, say no.</td>
<td>Escape high-risk situations.</td>
</tr>
<tr>
<td>Don’t get into situations where you can’t say no.</td>
<td>Avoid high-risk situations.</td>
</tr>
<tr>
<td>Do things that are fun and healthy.</td>
<td>Seek healthy pleasures.</td>
</tr>
</tbody>
</table>

**Concepts and Skills Associated With Each Recommendation**

**Practice damage control**

Main point: If you slip and use drugs or alcohol again, stop early and get right back into treatment. This will reduce damage to your health, relationships, and finances.

Concepts: Maintain recovery, slip versus full-blown relapse, risk reduction, abstinence violation effect, bouncing back into treatment. Skills: Leaving a drug-using situation despite some use; reporting a slip to a support person.

**Escape high-risk situations**

Main point: Some situations make it very hard to avoid using drugs. Be prepared to escape from these situations without using drugs. Realize that it would be much better to avoid these situations in the first place.


**Avoid high-risk situations**

Main point: Avoid high-risk situations by learning to recognize the warning signs that you might be headed toward drug use.

Concepts: Drug habit chain (trigger, craving, planning, getting, using), warning signs, U-turns,
<table>
<thead>
<tr>
<th><strong>Avoid high-risk situations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main point:</strong> Avoid high-risk situations by learning to recognize the warning signs that you might be headed toward drug use.</td>
</tr>
<tr>
<td><strong>Concepts:</strong> Drug habit chain (trigger, craving, planning, getting, using), warning signs, U-turns, removing triggers, riding the wave, money management, representative payee.</td>
</tr>
<tr>
<td><strong>Skills:</strong> Getting an appointment with a busy person; reporting symptoms and side effects; getting a support person.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Seek healthy pleasures</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main point:</strong> You can avoid drugs by focusing on the things that are most important and enjoyable to you. Do things that are fun and healthy.</td>
</tr>
<tr>
<td><strong>Concepts:</strong> Healthy pleasures, healthy habits, activities schedule.</td>
</tr>
<tr>
<td><strong>Skills:</strong> Getting someone to join you in a healthy pleasure; negotiating with a representative payee.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Additional Recommendations and Concepts</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Understand how you learned to use drugs.</strong></td>
</tr>
<tr>
<td><strong>Main point:</strong> Drug abuse is learned and can be unlearned.</td>
</tr>
<tr>
<td><strong>Concepts:</strong> Habits, reinforcement, craving, conditioning, extinction, riding the wave.</td>
</tr>
<tr>
<td><strong>Know why you decided to quit.</strong></td>
</tr>
<tr>
<td><strong>Main point:</strong> Make sure you can always remember why you decided to quit using drugs.</td>
</tr>
<tr>
<td><strong>Concepts:</strong> Advantages and disadvantages of using drugs and of not using drugs.</td>
</tr>
<tr>
<td><strong>Carry an emergency card.</strong></td>
</tr>
<tr>
<td><strong>Main point:</strong> Make an emergency card that contains vital information and reminders about how and why to avoid drugs. Carry it with you at all times.</td>
</tr>
</tbody>
</table>

Engage students in a conversation about what comes up for them when they A) consider what is wrong with a person (list on one half of the board) vs. B) when they consider what happened to someone?

How might these different perspectives change how we work on treatment with an individual or family?

- How might these perspectives create different GOALS?
- How might these perspectives impact our own feelings (counter-transference) about issues?
- How might you choose different interventions based on this different perspective?

**Discuss**

Consider SUD as one of many ways we might cope with what has happened to us.

Brainstorm (in small or large groups):

- List 1–3 stressors. What are ways you COPE or MANAGE these stressors? List them all — good things and not such good things you use to cope.
• Consider then how substances can be a way of coping for clients. How can we help them consider other ways of coping?

**Lecture**

Teach impulse control and alternative behavior techniques by reviewing the concept and skills below:

The Substance Abuse Management Module (SAMM) is based on Alan Marlatt’s Relapse Prevention Therapy (for details, please refer to SAMHSA’s TIP 42. The following table, from TIP 42, addresses common dimensions around relapse and relapse prevention and ways to manage such relapses using cognitive behavioral therapy skills.

**Strategies for Working with Clients with Co-Occurring Disorders**

**Additional Teaching Points**

- Have people come up with alternative activities well before relapse occurs.
- Encourage individuals to participate in activities even when not actively craving. We are more likely to do an alternative behavior when we’ve been practicing our skills during non-stressful times.
- It can take longer than 20 minutes for a craving to subside. A person might have to do an activity several times before the cravings start to subside.
- Also, having a list of alternative, pleasurable, helpful coping activities will be useful in case one coping skill doesn’t work and you have to use another. Not every skill works all the time for everyone!
- When creating a list, consider activities that build MASTERY and/or are PLEASURABLE.

**Activities**

- Role-play creating a plan to manage triggers. Students can take turns being a client or counselor. They can decide if they are going to use a “real” play (use a real triggering situation for themselves) or a “role” play of a SUD client. Both have merit and drawbacks — “real” play scenarios have more accurate feeling and content; “role” play gets to topical issues around SUD and can help in developing empathy toward a client.
- Have students in small groups come up with their own positive activity lists. They can brainstorm on butcher paper and share with the large group. It is often helpful for the students to do this activity as they get the message that infinite numbers of activities can
promote wellness and that options are available for essentially everyone.

- Consider asking students to research and share resources for building positive activities, or to create games or interactive exercises that can be used in group. This might be an activity that is done as a project outside of class.

Reference

MODULE 7

Family and Community

Defining family role and ability for family members to support.
Teach effective motivational strategies, NOT all about co-dependency (e.g., CRAFT model)
How to be part of a community. Reintegration into a community.

Courses:
• Marriage and family course
• Developmental
Student Learning Objectives

As a result of this module, students will achieve the following outcomes:

• By the end of the module, students will understand the CRAFT (Community Reinforcement and Family Training) model that trains affected individuals to motivate a substance user to enter treatment.

• By the end of the module, students will know the impact and importance of Al-Anon and an "intervention" on motivating a substance user to enter treatment and on the affected individual's well-being.

• By the end of the module, students will have the basic skills and knowledge to assist a substance user, who completed residential treatment, to reintegrate into the community.
Module 1 Pre- and Post-Test

Can be used for the 1.5- or 3-hour modules as the longer module builds on the first module.

1. When someone is drinking or using drugs, the best approach is usually “tough love”. T/F (False)

2. Family members are not able to develop their own interests and have fun if another family member is using alcohol or other drugs. T/F (False)

3. What are three alcohol or drug use behaviors that a family member can map for their loved one? (triggers, signs, and consequences)

4. A loved one needs to always be aware of potential safety issues when living with someone who is using alcohol or other drugs? T/F (True)

5. What does the acronym “PIUS” stand for in regard to communication skills and addiction? (Positively state the issue, use “I” messages, show understanding, share responsibility for the situation)

6. Before recovery tools can be used, concerned significant others (CSOs) need to become aware of the opportunities in which they can use such tools. T/F (True)

7. In the CRAFT model, when we look at the behavior chains and create alternative responses in order to break the negative interaction cycle, we call it _________________. (remapping)

8. Family members can learn strategies to control their own behavior in ways that can make drinking less rewarding and less motivating for the drinker. T/F (True)
Module 7, Part 1
1.5-hour module

Activity

• With the Poll Everywhere app (from https://www.polleverywhere.com/app), or by writing on a board, collect the spontaneous responses to the statement, "What comes to mind when you think of co-dependent?"

• Discuss with students the challenges of being in a relationship with a substance user, as well as any secondary gains or other reinforcing aspects of the role.

• Briefly review CRAFT as a way to address substances that is an alternative to current framing around co-dependents and punishing users.

Lecture

Essential points:
From the book Get Your Loved One Sober: Alternatives to Nagging, Pleading and Threatening, by Robert J. Meyers, Ph.D., and Brenda L. Wolfe, Ph.D.; Hazelden, 2004

Why CRAFT:
• It can improve the quality of a family’s life.
• It is applicable regardless of whether the loved one gives up drinking.
• CRAFT can help move a loved one toward sobriety.
• The chances of her moving toward sobriety is helped by improving the quality of your life independent of his behavior.

Control
• Family members can learn strategies to control their own behavior in ways that can make drinking less rewarding and less motivating for the drinker.
• Family members cannot control the drinker.

Teach loved ones to map users’ behavior
• What are drinking triggers?
• What are drinking signs?
• What are drinking consequences?
• How much does he/she use?
• How much is too much? Does it cause problems?
• Remapping – look at the behavior chains and create alternative responses. Break the negative interaction cycle.
 Teach being aware of safety issues

- If there is a potential for violence:
  - Have escape bags packed and be ready to go.
  - Script safe responses to red flags for violence.
  - Make arrangements for a safe house in case you should need it.

 Setting goals

- Set specific, meaningful goals for your relationship.
- Make sure the goals chosen are motivating enough to get the CSO (concerned significant other) through the difficult episodes and times of slow change.

 Empower family members to change their behavior

- CSOs need to be reminded to not take responsibility for anyone else’s behavior. They are not the problem.
- Encourage family members to look for instances in which they can change their reaction to the substance user’s behavior. Before tools can be used, CSOs need to become aware of the opportunities in which they can use such tools.

 Encourage family members to have fun themselves

- Encourage family members to find simple and more involved rewards for themselves.
- CSOs can create action plans to involve other people in their lives.

 Disable the enabling

- If it hasn’t worked in the past, it probably won’t work in the future. Teach problem-solving and new solutions to ongoing problems.

  - Define the problem.
  - Brainstorm solutions.
  - Select a solution and try to make a commitment to follow through on trying the solution.
  - Evaluate the results and, if necessary, make adjustments.

 Communication

- Apply the PIUS model of communication.
- Positively state the issue.
- Use “I” messages.
- Show understanding (empathy).
- State your willingness to share responsibility for the situation.
Treatment for the substance abuser

- Assist CSOs in setting up effective treatment with good outcomes for the user.
- Have treatment lined up for the substance user so it is available ASAP when he/she is ready for treatment.

Relapse prevention

- Lapses are natural part of change, and they are to be anticipated.
- High-risk situations are those circumstances in which lapses are most likely to occur.
- By analyzing the circumstances in which lapses occur and problem-solving new means of handling these circumstances, you can actually build strength and actually facilitate moving toward your goal.

Video

Show this 4-minute video on Robert Meyers, Ph.D., briefly explaining the CRAFT approach.

https://vimeo.com/152609272

To encourage discussion, have the students refer to the 12 Steps of Al-Anon: http://www.al-anon.alateen.org/the-twelve-steps

Discussion 20 minutes – can be longer:

- In what ways is the CRAFT approach different from Al-Anon?
- Do you see any similarities?
- When might you use either approach?
- Can an individual or family use both? Why or why not?
- How might each approach be culturally more relevant for some groups than for others?
- Do you have any concerns about either approach? How might you address such concerns?
- What thoughts or concerns come up for you when reviewing either approach? How could you manage such concerns?
Module 7, Part 2

1–2 hours — depending on number of exercises completed

Exercise

Do Part 1 above without the video and instead start with the video here as you kick off the second part of the practice.

Exercise

South Central (Rural) MIRECC Clinical Education Product

Community Reinforcement and Family Training – Support and Prevention (CRAFT-SP) is an excellent guide for learning how to practice the CRAFT model. http://www.mirecc.va.gov/visn16/docs/CRAFT-SP_Final.pdf

This guide was intended to teach providers how to run family CRAFT support groups. The session exercises provide excellent opportunities for practicing how the model reframes family interactions and allows students to be in the role of practicing teaching or experiencing the work (as potential “clients”).

To reinforce the learning, review the content and decide which exercises you would like the students to practice. As each chapter explains the exercise and related worksheet, the instructions should be clear for the students. Instructors should review the first eight pages of the curriculum with the students to deepen understanding of the CRAFT approach and to understand the group structure.

The same group structure can be used for the training group. The students can take on roles, with one or two being the facilitator and the others taking the roles of concerned significant others (CSOs).

Following the exercises, discussion of the process, including how they worked through barriers or managed their own triggers and countertransference, can be reviewed.

Recommended exercises:

References


The Twenty Minute Guide at http://the20minuteguide.com

HBO Addiction film series at https://www.hbo.com/addiction/thefilm

Center for Motivation and Change: http://motivationandchange.com
MODULE 8

Adolescents, Young Adults

ASAM criteria specific to youth. Kids with problematic use start substance use at ages 10–11.

Courses:

• Developmental
• Adolescents
Student Learning Objectives

As a result of this module, students will achieve the following outcomes:

1. Students will know the differential rates of substance use among adolescents in relation to ethnicity and sexual orientation.
2. Students will be able to state the different developmental paths to substance use disorders.
3. Students will be able to summarize the research-based interventions for substance use disorders.
4. Students will be able to describe treatments and case management strategies for co-occurring disorders.
Module 8
Pre- and Post-Test

1. Common wisdom is that due to lack of financial resources, African Americans have lower rates of substance use compared to White Americans and Latinos/as. (T/F) False

2. The earlier the initiation of illicit drug use, the more difficult it is to treat substance use disorders. (T/F) True

3. Rates of substance use are lower for heterosexuals than LGBT persons because heterosexuals have better coping strategies. (T/F) False

4. What are unique pressures that people who are LGBT experience which contribute to their increased rates of substance use disorders? (Homophobia — including internalized homophobia — lack of support, and cultural pressures within certain LGBT communities that support increased substance use)

5. Name one of the four top family-based, empirically supported models for substance use disorders. (Brief Strategic Family Therapy [BSFT], Multidimensional Family Therapy [MDFT], Multisystemic Family Therapy [MST], and Functional Family Therapy [FFT])

6. The “gateway model” to substance use disorders suggests that there is a logical order of drug use initiation from licit to illicit drugs. (T/F) True

7. The CRAFT (Community Reinforcement and Family Training) model is designed to confront the substance users by getting family members to force the person in to treatment. (T/F) False

8. The CRAFT model emphasizes the family’s wellness in the service of the substance user’s sobriety. (T/F) True
Module 8, Part 1

1.5-hour module

Present prevalence data and lecture. Follow up with 20-minute discussion on assessment and 20 minutes on treatment.

Module 8, Part 2

2-hour module

Present prevalence, assessment, treatment and the Drinking Apart video with discussion.

Module 8, Part 3

3-hour module

Present prevalence (with the initial activity), assessment, a thorough review of CRAFT, Drinking Apart, as well as any one of the additional activities described below.

Activity

Prevalence (20–30 minutes)

- List different ethnicities (African American, Asian American, Latino [Hispanic], White [Caucasian]) in alphabetical order on the board. Alternatively, distribute a handout that lists different ethnicities in alphabetical order. Ask students to rank the ethnicities based on their rates of teen substance use, irrespective of the drug. It is okay to have differences of opinion. No single ranking is needed.

- Have students speculate about the rates of adult substance use per ethnicity. Rank them in order too.


- As part of the discussion, students should speculate about why the crossover effect occurs. What are some cultural, generational, immigration-related reasons for the rates of drug use among different ethnic groups?

Present data on the rate of substance use among gay, lesbian and transgender teens.
• Encourage discussion and speculation about the rates.

Pathways to Substance Use (20–30 minutes)
Discuss different paths to substance use disorders. Emphasize the old “gateway model” and encourage discussion about its relevance today, especially in light of cultural changes about the acceptance of marijuana.


Assessment (30–45 minutes)
Present a mini-lecture on how to detect and assess substance use in teens.

• Begin with OARS (open-ended questions; affirmations; reflections; and summaries), followed by some formal assessment process that may include a clinical interview. End with more OARS, summarization, and goal-setting.

• Present assessments such as the ASI and CAGE (cut down, annoyed, guilty, eye-opener).


• Refer to the CAGE Assessment: http://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/CAGE%20Substance%20Screening%20Tool.pdf

Treatment (30–45 minutes)
Present lecture on top research-based interventions for adolescent substance abuse. They are Brief Strategic Family Therapy (BSFT), Multidimensional Family Therapy (MDFT), Multisystemic Family Therapy (MST), and Functional Family Therapy (FFT). Note that it is extremely difficult to successfully treat an adolescent out of his or her social/familial context, which pulls for homeostasis. (In this context, “homeostasis” means that the family tries to pull a family member back in to the roles he or she occupied prior to treatment. The family might seriously complain about the client, yet it can also be hard for the family to embrace change and allow the loved one to take on a more functional role in recovery.) Here are brief summaries of decades of clinical research.
• BSFT: http://bsft.org/implementing-the-bsft-program/program-summary
• MST: http://www.blueprintsprograms.com/factsheet/multisystemic-therapy-mst

Present lecture on CRAFT, which is an engagement process that involves family members. Refer to Module 2 (the Engagement Module) for additional details. For example, present the 20 Minute Guide video on CRAFT (linked below). Break into small groups to learn about various aspects of the model, which each group will then present to the larger class.

• 20 Minute Guide to CRAFT: http://the20minuteguide.com/

Each group to share:

• Identify which of the four chapters the group worked on.
• Tell what makes CRAFT different from other approaches.
• Provide an example of how you might use the skills learned in your session with a family member dealing with substance use.

If time permits, you can watch this video. It can be helpful to watch at the end of the session.

• Video for CRAFT: http://motivationandchange.com/online-and-in-print-resources/

Additional information:


Activities

30 minutes with discussion, per activity

1. As an alternative to lecturing on rates of substance use, ask a student to volunteer to read aloud a paragraph or two that addresses rates of substance use.

2. Present a list of stimulus questions for students to answer prior to class beginning. Students should bring their responses and turn them in at the beginning of class. Then the instructor can engage students around the questions and their responses.

3. Present the video Drinking Apart, depicting a family therapy session presented by the Ackerman Institute in New York. Students should be asked to evaluate the extent to
which the teen is engaged (and how that happened), the extent to which the parents are encouraged to or blocked from lecturing the teen, and the extent of and manner of involvement of the team behind the one-way mirror. After the clip, discuss their responses, as well as their overall reaction to the intervention. Tie this intervention to the family therapy lecture. In addition, if the link to the video remains live and the contact information for Patria (the mother) is available, it is okay to contact Patria and Erica (the daughter, the identified patient, who now is at least 20 years older) for a Skype or telephone interview. We suggest a small honorarium. This is in support of including consumers in your presentations.

4. Role play a motivational interview with a student in order to (a) evaluate Erica’s readiness (as portrayed in the video) to change and treatment, and (b) address Erica’s going to Job Corps or refraining from drinking alcohol any longer.

References


MODULE 9

Co-Occurring Substance Use and Primary Care

Medical care for primary care conditions sometimes can interfere with treatment approaches for SUDs. This module has two distinct objectives regarding substance use and co-occurring physical conditions. The first is for students to learn how to screen in a non-behavioral health setting, such as primary care, using the SBIRT. The second objective is to learn about serious substance use (alcohol)-induced physical disorders. The intention is to help students become aware of how physical issues might develop as the result of serious substance use.

- Include in consultation courses
- Case management courses
- Second-year practicum
- Child treatment

TOPICS:

- Hepatitis C and HIV
- SBIRT training and demonstration
Student Learning Objectives
As a result of this module, students will achieve the following outcomes:

1. Students will understand common connections between primary care and SUD/mental health, and will be able to address assessment and treatment interventions toward whole-health approaches.

2. Students will be able to learn the basics of screening, brief intervention, and referral to treatment (SBIRT).

3. Students will be able to identify common physical disorders and practice basic interventions to engage patients in discussion of physical health issues.

4. Students will practice providing psycho-education regarding physical health concerns using “ask-provide-ask” model of interaction.
Module 2 Pre- and Post-Test

Part 1

1. What does SBIRT stand for? (screening, brief intervention, and referral to treatment)

2. SBIRT is an example of harm reduction. T/F (True)

3. A risky drinker is someone who is not __________ on alcohol, but who has a drinking pattern that can lead to a variety of health consequences, alcohol-related traffic collisions and other accidents, and alcohol-involved violence. (dependent)

4. Even if they are not dependent on alcohol, people who drink above the U.S. Department of Health and Human Services recommended dietary guidelines — up to one drink per day for women and up to two drinks per day for men — face a number of ________ ________. (health risks)

Part 2

1. Patients undergoing detoxification frequently present with __________ and __________ conditions that can greatly affect their overall well-being and the process of detoxification. (medical and psychological)

2. People who abuse substances often present with medical conditions in advanced stages or in a medical crisis. T/F (True)

3. At least 76 percent of patients who have used injection drugs for less than 7 years are positive for hepatitis C, while 25 percent of patients with alcohol use disorders and those who do not inject drugs show serologic evidence of infection. T/F (True)

4. Researchers have found that the majority (75 percent) of people with an alcohol use disorder have some degree of ______________ impairment (Goldstein, 1987). (cognitive)
Module 9, Part 1
Lecture
3 hours


Screening, brief intervention, and referral to treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.

- **Screening** — a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting.
- **Brief intervention** — in a short conversation, a healthcare professional engages a patient who shows risky substance use behaviors, providing feedback and advice.
- **Referral to treatment** — a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.

The primary goal of SBIRT is not to identify alcohol- or other drug-dependent individuals. SBIRT is intended to meet the public health goal of reducing the harms and societal costs associated with risky use.


While most of the attention given to alcohol and drug issues has been focused on alcohol and illicit drug users who meet the clinical criteria for substance dependence, risky users incur more adverse consequences and costs at the population level.

Even if they are not dependent on alcohol, people who drink above the recommended guidelines — that is, women who consume more than one drink per day and men who consume more than two drinks per day — face a number of health risks.

A risky drinker is someone who is not dependent on alcohol, but who has a drinking pattern that can lead to a variety of health consequences, alcohol-related traffic collisions and other accidents, and alcohol-involved violence.

Risky drinkers, though individually less likely to experience alcohol-related problems than those who are alcohol-dependent, make up the greater portion of the general population; thus, more harm is caused by the population of risky drinkers.
SBIRT provides the opportunity to intervene with this group to prevent serious consequences.

SBIRT has emerged as a critical strategy for targeting the large but often overlooked population that exceeds low-risk use.

Research demonstrates that intervening early with individuals at moderate risk is effective in reducing substance use, in preventing health and other related consequences, and in saving healthcare costs.

SBIRT places risky substance use where it belongs — in the realm of healthcare. It focuses on identifying risky substance use to help prevent the onset of the costlier disease of addiction.

Similar to preventive screenings for chronic diseases such as cancer, diabetes, and hypertension, SBIRT is an effective tool for identifying risk levels related to substance use and for providing the appropriate intervention.

**In-class Exercise:**

The Substance Use in Adults and Adolescents: Screening, Brief Intervention and Referral to Treatment (SBIRT) course through Medscape aims to address the basic principles of SBIRT as well as coding and reimbursement for the implementation of SBIRT in practice.

* A free membership to Medscape is required to view the training.


This educational on-line exercise, which requires about 1.75 hours to complete, will expose students to thinking through which screening tool to use and will help them consider the SBIRT needs of individuals as presented in vignettes. Following the practice, it can be useful to help the students debrief their experience:

- What aspects of the SBIRT experience seemed the most challenging and why? How might you address such challenges in your clinical practice?
- What is one way you might engage someone who doesn't want to take the test?
- What would you say to someone who does not want a referral to treatment?
- How would you anticipate that the SBIRT could be of use to medical practitioners? How about for therapists?

**Video to View**

*1-hour module – Viewing good and not-so-good SBIRT in primary care practice*

1. Anti-SBIRT Interview: https://youtu.be/ZGETDcFcAbI
2. Using SBIRT Effectively: https://youtu.be/ul8QyJF2wVw
Discussion

• What was happening in the first conversation that shut down the discussion? What was missing? What could have been done instead?
• What was happening in the second conversation? What did you notice occurring between the doctor and the patient?
• What was the most effective technique used?
• Would you have done anything differently in the second video?

Practice

Have the students break into groups of three: one to be the audit user, one to be the "client," and one to be an observer.

Prepare the students to do role play by reviewing the way any of us would want to be questioned. Focus on the importance of the following:

• eye contact
• friendliness — personalismo
• reflection between questions
• reassurance
• conversational approach
• encouragement
• gratitude for engaging in process
• education — why are we doing this?

What else? Ask the students to contribute to the list.


Participants can role play someone they know or have heard of to enhance realism.

Debrief

1. What was helpful and challenging as the interviewer?
2. What was the experience like as a client? When did they notice they engaged? When did they resist?
3. Observers: What did you notice in the process; what worked well and not so well?
Module 9, Part 2
Lecture

3 hours with activity

All below content is taken from SAMHSA’s Treatment Improvement Protocol (TIP) 45. There is minimal formatting that has been done on this information, and all or most of the statements below, along with reference citations, can be found at the following link: http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA15-4131

Emphasize that the behavioral health student is not expected to make medical diagnoses. Their role is to consider the following in a "whole health" approach:

- How might the medical issue affect the physical issue and vice versa? How could such co-occurrence impact the treatment?
- How can the medical issue be used to engage the client?
- In what ways can behavioral health professionals speak to the behavioral, cognitive, and affective issues associated with significant medical issues?
- In what ways can the behavioral health professional interact with the primary care provider to ensure proper treatment for the client?

✓ Regarding communication between primary care and behavioral health providers, make sure students are aware of 42-CFR and ensure that confidentiality agreements are signed between providers. It is always best to be clear regarding boundaries and ensure that all confidentiality agreements are in place. A PDF describing the 42-CFR is included in this module as an attachment.

Note news article: “New rule improves the exchange of medical information in ways that protect the privacy of people receiving substance use treatment” (https://www.samhsa.gov/newsroom/press-announcements/201701131200).

The medical conditions listed below are primarily seen in individuals with a significant history of substance use. The below points discuss the medical issues as they might show up for an individual in detox, but consider that any of these issues might be co-occurring for someone with a significant long-term substance use history.

Patients undergoing detoxification frequently present with medical and psychological conditions that can greatly affect their overall well-being and the process of detoxification.
• These may simply be pre-existing medical conditions not related to substance use or the direct outcome of the substance abuse. In either case, the detoxification process can negatively affect the co-occurring disorder or vice versa.
• Furthermore, people who abuse substances often present with medical conditions in advanced stages or in a medical crisis. Co-occurring mental disorders also are likely to be exacerbated by substance abuse. For more on treating patients with co-occurring psychiatric disorders, refer to TIP 42, Substance Abuse Treatment for Persons With Co-Occurring Disorders (Center for Substance Abuse Treatment [CSAT] 2005c).

This lecture is not meant to take the place of authoritative sources from internal medicine. Rather, it presents a cursory overview of special conditions, modifications in protocols, and the use of detoxification medications in patients with co-occurring conditions or disorders. Overall treatment of specific conditions is not addressed unless modification of such treatment is needed.

For further information on each of the conditions below, the lecturer can consult this SAMHSA/CSAT resource: http://www.ncbi.nlm.nih.gov/books/NBK64105/

OVERVIEW

General Principles of Care for Patients With Co-Occurring Medical Conditions
• Gastrointestinal disorders
• Cardiovascular disorders
• Hematologic disorders
• Pulmonary disorders (other than infectious)
• Neurologic system
• Infectious diseases
• Other conditions

Treatment of Co-Occurring Psychiatric Conditions
• Treatment for co-occurring conditions

Standard of Care for Co-Occurring Psychiatric Conditions
• Psychotropics for co-occurring psychiatric conditions
• Anxiety disorders
• Depressive disorders
• Bipolar disorders
• Psychotic disorders
• Adverse effects
• Cognitive state in recovery
• Dosing
GENERAL PRINCIPLES OF CARE FOR PATIENTS WITH CO-OCCURRING MEDICAL CONDITIONS

Patients who use substances can present with any of the conditions or combinations of conditions that can be found in the general population. In most cases, the management of the medical condition in the patient with a substance use disorder diagnosis does not differ from that of any other patient. However, the medication used for detoxification and the actual detoxification protocol may need to be modified to minimize potentially harmful effects relevant to the co-occurring condition.

Staff providing support should be familiar with the signs and symptoms of common co-occurring medical disorders. Likewise, personnel at medical facilities (i.e., emergency rooms, physicians' offices) should be aware of the signs of withdrawal and how it affects the treatment of the presenting medical conditions.

The setting in which detoxification is carried out should be appropriate for the medical conditions present and should be adequate to provide the degree of monitoring needed to ensure safety (e.g., oximetry [a measurement of the amount of oxygen present in the blood], greater frequency of taking vital signs, etc.). Acute, life-threatening conditions need to be addressed concurrently with the withdrawal process, and intensive care unit monitoring may be indicated.

Clinicians should keep in mind that consultation with specialists in infectious diseases, cardiology, pulmonary medicine, hematology, neurology, and surgery may be warranted. Whenever possible, consent should be sought to involve the patient's primary healthcare provider in the coordination of care. Attending medical staff should be aware that co-occurring medical conditions present an opportunity to engage patients.

By focusing on the adverse effects of the substance abuse on the overall health of patients, staff members are in a position to help patients see the importance of engaging in treatment for their substance use disorders. Patients should have appointments for follow-up care made prior to detoxification discharge for all chronic medical conditions, conditions needing further evaluation, and substance abuse treatment.

This section highlights the conditions most frequently seen in individuals who abuse substances, though it is not inclusive. Disorders of the following systems will be covered: gastrointestinal (including the gastrointestinal [GI] tract, liver, and pancreas), cardiovascular system, hematologic (blood) abnormalities, pulmonary (lung) diseases, diseases of the central and peripheral nervous system, infectious diseases, and special miscellaneous disorders. Where special considerations are needed for a patient presenting with a given disorder in a detoxification setting, they are listed following the heading “Special considerations.”
Gastrointestinal Disorders

Frequently, the use of substances can present a range of gastrointestinal problems. Cocaine use, for example, can result in various gastrointestinal complications, including gastric ulcerations, retroperitoneal fibrosis, visceral infarction, intestinal ischemia, and gastrointestinal tract perforations (Linder et al., 2000). Gastrointestinal disorders may affect many different organs and organ systems (e.g., liver, pancreas), making diagnosis difficult. Since symptoms can be vague and patients are not always able to articulate the specific problem, diagnosis can be difficult. For a simple rule of thumb, urgent attention is needed if the patient is diagnosed with any of the following:

- Appendicitis
- Abdominal aortic aneurysm
- Perforated peptic ulcer
- Boerhaave's syndrome (spontaneous esophageal rupture)
- Obstructed or strangulated bowel
- Ischemic bowel disease (a condition that results from inadequate blood supply to the intestines)
- Abscess of the pancreas or liver
- Ruptured spleen or other trauma to the abdominal area

Other possible diagnoses of abdominal pain include:

- Hepatitis
- Peptic ulcer (nonperforating)
- Peritonitis
- Acute pancreatitis
- Pelvic inflammatory disease
- Endometriosis
- Nephrolithiasis (kidney stones)
- Inflammatory bowel disease
- Ovarian cysts

Clinicians should also be aware of some deceptive causes of abdominal pain:

- Myocardial infarction
- Pulmonary emboli
- Herpes zoster (shingles)
- Acute pyelonephritis (kidney infection)

Specific co-occurring gastrointestinal disorders requiring special attention in patients undergoing detoxification are discussed below.

Reflux esophagitis

Reflux esophagitis can be a result of alcohol's effect on the lower esophageal sphincter (i.e., relaxation) and a decrease in peristalsis of the distal esophagus, allowing gastric contents to come into contact with the lower esophagus.
Typical symptoms include burning in the epigastric or retrosternal area (commonly called “heartburn” or “indigestion”). Esophageal bleeding can result from reflux esophagitis and esophageal varices (resulting from portal hypertension).

Special considerations

Several drugs used in typical protocols, such as beta blockers and calcium channel blockers, may decrease lower esophageal sphincter pressure and aggravate reflux (Dell’Italia, 1994).

Mallory-Weiss syndrome

Mallory-Weiss syndrome is caused by torn mucosa of the esophagus at the gastroesophageal junction due to protracted or violent vomiting. Mallory-Weiss syndrome is the etiology of 5 to 15 percent of all upper GI bleeds (Schuyler-Delrieu and Summers, 1994).

Boerhaave's syndrome

Boerhaave's syndrome is manifested by rupture of the esophagus. Patients presenting with this condition complain of acute epigastric pain (83 percent of patients), vomiting (79 percent), and shortness of breath (39 percent) as the predominant, nonspecific symptoms. This lack of specificity can delay making the correct diagnosis (Brauer et al., 1997). Tachycardia, cyanosis, and subcutaneous emphysema also can be seen. If this condition is left untreated, the prognosis is severe.

Gastritis

Gastritis is described as the disruption of the gastric mucus lining that allows gastric acid to contact the mucosa, with resultant inflammation and possible bleeding. The patient presents with nausea, vomiting, and abdominal pain (Ivey, 1981). Alcohol increases gastric acid secretion and reduces the mucosal cell barrier, allowing back-diffusion of the gastric acid into the mucosa. This frequently causes an occurrence of erosive gastritis in the individual with an alcohol use disorder (Fenster, 1982).

Special considerations

Aspirin and nonsteroidal medications should be avoided in the withdrawal protocols.

Pancreatitis

Pancreatitis can be caused by many factors, although studies suggest that alcohol may be a factor in anywhere from 5 to 90 percent of all cases (Apte et al., 1997), with some experts suggesting about 60 percent of all cases result from excessive alcohol consumption (Yakshe, 2004). The acute condition presents with abdominal pain, which is described as sharp, burning, and
constant and is located in the epigastric area of the abdomen with radiation to the back. Presenting symptoms and signs can include abdominal tenderness, decreased bowel sounds, low-grade fever, tachycardia, nausea, and vomiting. Pancreatitis can advance to a chronic condition in which pancreatic calcification, diabetes mellitus, malabsorption, and chronic abdominal pain occur.

**Special considerations**

There may be a need to forbid oral intake of food and medications, necessitating a change of route of administration of both food and medications to intravenous forms. In alcohol withdrawal protocols, Ativan might be considered as an appropriate agent, as it can be administered intravenously or intramuscularly. Opioids may have to be used to control pain.

**Liver disorders**

Liver disease can range from fairly benign fatty liver, which presents usually as an asymptomatic enlargement of the liver associated with mild elevation of the serum liver enzymes, to a broad spectrum of viral infections and the toxic consequences of alcohol and other drug use. The end point of liver disease is liver necrosis or failure. Midway in the progression of liver disease is acute alcoholic hepatitis. The presentation is one of liver tenderness, jaundice, fever, ascites, and an enlarged liver. The patient is quite sick and frequently has nausea and vomiting.

**Special considerations**

Alcoholic hepatitis usually needs acute medical treatment to prevent electrolyte imbalance and dehydration. Protocols may have to be adapted if the patient cannot take oral agents.

**Portal hypertension**

Portal hypertension is a frequent consequence of liver disease. If elevation of the portal pressure goes untreated, esophageal varices develop and hemorrhage can ensue. Treatment of acute hemorrhage includes endoscopic sclerotherapy or ligation. Initial therapy should include prompt and adequate intravascular volume replacement, correction of severe anemia and coagulopathies, and adequate airway management.

**Special considerations**

Propranolol or isosorbide therapy is effective in the prophylaxis of variceal bleeding (Trevillyan and Carroll, 1997), though beta blockers can interfere with measuring the true heart rate that determines the content of many detoxification protocols. If bleeding is present, changeover to intravenous medication protocols is recommended, as the patient will not be able to take
oral medications.

Cirrhosis

Cirrhosis, or the formation of fibrous tissue in the liver, leads to a state of increased resistance in the hepatic venous circulation. The inability of blood to flow freely gives rise to portal hypertension with ensuing esophageal varices, splenomegaly, ascites, dilatation of superficial veins, peripheral edema, and hemorrhoids.

Liver necrosis can be seen in patients who use inhalants, particularly chronic use of benzene and carbon tetrachloride. African Americans and Hispanics/Latinos have higher mortality rates from cirrhosis of the liver resulting from alcohol abuse than do Caucasians and Asians and Pacific Islanders (Sutocky et al., 1993). Liver function test abnormality and jaundice can occur in individuals who use anabolic steroids, but this usually resolves on cessation of the drugs. Studies in the elderly show that 1-year mortality was 50 percent among patients over age 60 with cirrhosis, versus 7 percent for those under age 60 (Potter and James, 1987). Great care needs to be used when giving diuretics to elderly patients with cirrhosis, since their total body water may already be decreased, making them more susceptible to fluid and electrolyte depletion (Scott, 1989).

Alcohol-related hepatic injury is seen in a higher proportion of women due to a possible potentiation (strengthening) of this effect by estrogen (Brady and Randall, 1999).

Special considerations

For the treatment of alcohol withdrawal, lorazepam (Ativan) is well tolerated in patients with severe liver disease (D’Onofrio et al., 1999) as is oxazepam (Serax), with its short half-life of 6 to 8 hours and simple metabolism with no metabolites.

Cardiovascular Disorders

The presentation of chest pain or discomfort remains one of the most difficult differential diagnoses to sort through, as disorders of several systems can cause this single complaint. Difficulty in correctly diagnosing this symptom can be brought about by the patient's inability to be interviewed and describe succinct symptoms (the intoxicated or severely withdrawing patient), a sociocultural or educational level that does not allow for the verbal nuances necessary to making a diagnosis, or fabrication of symptoms by a patient seeking to obtain pain medications or other drugs.

A normal resting electrocardiogram does not rule out the presence of organic heart disease, and the presence of nonspecific changes does not necessarily mean that heart disease is present. Final diagnoses can range from reflux to myocardial infarction brought about by underlying ischemic heart disease or the use of cocaine.
Frequently, lung diseases can have as their presenting symptom chest discomfort. The consensus panel believes that this condition should never be overlooked or minimized, and it is imperative that an especially prompt diagnosis be made and treatment be undertaken to ensure patient safety.

Underlying cardiac illness could be worsened by the presence of autonomic arousal (elevated blood pressure, increased pulse and sweating) as seen in alcohol, sedative, and opioid withdrawal. Thus prompt attention to these findings and aggressive withdrawal treatment are indicated. Special considerations for the treatment of specific cardiac conditions are outlined below.

**Hypertension**

Hypertension frequently is seen in the detoxification patient. Evaluation should include a complete history to determine if the elevated blood pressure predated the present withdrawal status. Consideration should be given to include serum electrolytes, urinalysis, BUN/creatinine, and an EKG in the detoxification unit's initial workup. More elaborate workup can be carried out after completion of detoxification.

Propranolol (Inderal), labetalol (Trandate) and metoprolol (Lopressor) are the beta blockers of choice for treating hypertension during pregnancy (McElhatton, 2001); however, the impact of using them for alcohol detoxification during pregnancy is unclear. If treating African Americans with beta blockers, clinicians should be aware that propranolol is less effective in this population than it is in Caucasians (Pi and Gray, 1999). Asians require much lower doses of beta blockers than Caucasians, inasmuch as they tend to be very sensitive to the blood pressure and heart rate effects (Pi and Gray, 1999).

**Special considerations**

The presence of a hypertensive history and poorly controlled blood pressures may have an effect on the proper evaluation of withdrawal, as the examiner would have difficulty determining whether the elevated blood pressure was due to withdrawal or to the underlying hypertensive history. Thus modifications of the usual parameters and scheduling of detoxification medications should be considered. In any event, severe elevation of blood pressure should be treated concurrently with, at minimum, salt restriction and rest. If the blood pressure is still elevated in several days despite a reduction in other withdrawal parameters and symptoms, then medication is warranted.

Beta blockers and clonidine have been used in the treatment of alcohol withdrawal, and clonidine also has been used in opioid protocols. These medications can help control blood pressure and also work well in the protocol. Calcium channel antagonists have also been used to ameliorate some of the
symptoms of alcohol withdrawal and can be used concurrently for blood pressure control.

**Ischemic heart disease**

Ischemic heart disease presents as chest pain or pressure, palpitations, dizziness, and/or shortness of breath and requires immediate attention, which will dictate what setting is appropriate for the detoxification.

Cocaine use is associated with various cardiovascular complications including angina pectoris, myocardial infarction, and sudden death. It is estimated that over half of the 64,000 patients evaluated annually for cocaine-associated chest pain will be admitted to hospitals for evaluation of myocardial ischemia. Only about 6 percent of patients will demonstrate biochemical evidence of myocardial infarction (Hoffman and Hollander, 1997). The typical patient with cocaine-related myocardial infarction is a male in his mid-30s with a history of chronic tobacco and repetitive cocaine use (Hollander, 1995). This effect of cocaine appears to be increased because the drug causes an increase in myocardial oxygen demand and thus a decrease in oxygen supply. These two factors, which are caused by vasospasm and vasoconstriction of the coronary arteries, may lead to cardiovascular disorders.

Patients with recent cocaine use can experience persistent cardiac complications such as prolonged QT interval and vulnerability for arrhythmia and myocardial infarction (Chakko and Myerburg, 1995). (QT is the Q to T interval measured on EKGs. If the interval is prolonged, it can lead to cardiac rhythm disturbances.) Amphetamines are rarely reported as the cause of myocardial infarction, though a case report shows that a patient subsequently experienced a non-Q-wave anterior wall infarction associated with amphetamine use (Waksman et al., 2001). Cocaine use and HIV infection have been associated with an increased incidence of cardiac dysfunction, but concomitant exposure may cause a synergistic effect (Soodini and Morgan, 2001).

**Special considerations**

Beta-adrenergic blocking agents may exacerbate cocaine-induced coronary arterial vasoconstriction and thereby increase the myocardial ischemia. Nitroglycerin and verapamil reverse cocaine-induced hypertension and coronary arterial vasoconstriction, and are the medications of choice in the patient who uses cocaine and presents with chest pain (Pitts et al., 1999). Cocaine may cause platelet activation leading to acute coronary events — thus more aggressive antiplatelet therapy may be indicated (Callahan et al., 2001).

**Cardiomyopathy**

Cardiomyopathy is caused by degenerative changes of the cardiac muscle with
enlargement of the heart (cardiomegaly) and left ventricular failure. Alcoholic cardiomyopathy presents with a similar picture as cardiac failure from other etiologies, with shortness of breath on exertion, shortness of breath when the patient is lying flat, and edema of the lower extremities.

Besides alcohol as the etiology, a dilated cardiomyopathy can be seen with use of the inhalant trichlorethylene. Cardiomyopathy in the elderly patient with an already underlying ischemic or atherosclerotic heart disease can be quite debilitating. Women have shown alcohol metabolism different from that of men and distinct pathophysiologic mechanisms, which frequently lead to a higher sensitivity to alcohol-induced heart damage. The prevalence of cardiomyopathy in women is equal to that in men, despite cases in which women have consumed far less ethanol (Fernandez-Sola and Nicolas-Arfelis, 2002).

**Special considerations**

Alcoholic cardiomyopathy may respond poorly to digitalis with increased likelihood of digitalis toxicity (Zakhari, 1991).

**Arrhythmias**

Arrhythmias (irregular heartbeats) can be seen in the presence of ischemia and cardiomyopathy. Two specific cases of arrhythmogenic disorders are “holiday heart,” a condition in which a patient who has ingested alcohol presents with supraventricular arrhythmia (Greenspon and Schaal, 1983), and the individual who uses cocaine with the stimulant leading to significant atrial and ventricular arrhythmias. Consumption of anabolic steroids also has been associated with hypertension, ischemic heart disease, cardiomyopathy, and arrhythmia (Sullivan et al., 1999).

**Special considerations**

Treatment of arrhythmia in the person who abuses substances is similar to that for the patient who does not abuse substances, though the setting of detoxification may have to be altered to allow for cardiac monitoring (telemetry).

**Hematologic Disorders**

Hematologic (blood) disorders can be seen due to several factors, such as a direct toxic effect of the drug on the bone marrow, as seen in alcohol and benzene use, or as a result of malabsorption of essential nutrients (B12, folate), or as a general poor state of nutrition.

**Anemia**

Anemia can be seen due to folate deficiency, iron deficiency, B12 deficiency, acute blood loss, or more frequently as a combination of factors. Folate deficiency can cause a megaloblastic anemia, which is diagnosed by
macroovalocytes and hypersegmented neutrophils seen on a peripheral blood smear. Iron deficiency anemia results from blood loss and thus subsequent iron loss. This can be seen in low-level gastrointestinal bleeding, after childbirth, and as a result of menstrual blood loss. The presentation of anemia usually is nondescript, with generalized fatigue and weakness. Severe anemia, shortness of breath on exertion, and an elevated heart rate can be seen. Specific to the megaloblastic anemias (B12 and folate deficiency), one can see neurologic complications such as peripheral neuropathy.

White blood cell disorders
White blood cell disorders can occur due to malnutrition and liver disease. Lymphopenia may be present in the patient with HIV disease.

Platelet disorders
Platelet disorders frequently are attributable to the direct effect on the bone marrow by the substance being abused or, as seen in alcohol-related thrombocytopenia, are due to bone marrow suppression. Splenomegaly caused by portal hypertension also can cause a low platelet count (thrombocytopenia), which is due to enlargement of the spleen and abnormally high platelet storage. Thrombocytopenia also can be seen in cases of vitamin B12 and folate deficiency.

The African-American patient with sickle cell disease or trait can be severely affected (inasmuch as the patient already has an impaired oxygen delivery system) if other harm threatens the bone marrow.

Special considerations
Elevated heart rates can hinder the use of the heart rate as a parameter in various detoxification protocols.

Pulmonary Disorders (Other Than Infectious)
Pulmonary disorders are common in people who abuse substances, in part because of the high rate of nicotine use in this population (Graham et al. 2003).

Aspiration pneumonia
Alcohol or other drug ingestion may reduce a patient's gag reflex, leading to the blockage of the airways. Aspiration pneumonia occurs when oro-pharyngeal secretions and/or gastric contents enter into the lower airways. This serious condition may require prolonged hospitalization.

Asthma
Asthma, a chronic condition characterized by exacerbations of bronchial spasm manifested by wheezing, should be differentiated from bronchospasm, which is related to inhaled drugs and usually is self-limited. Treatment is similar to that provided to patients who do not use substances, with the addition of cessation
of the substance use.

The health of a patient with underlying chronic asthma can be severely compromised if the use of a smokeable drug causes exacerbation of an already impaired system.

*Special considerations*

Asthma medications can cause a significant increase in heart rate, which can affect the evaluation of withdrawal protocols that use heart rate as one of the parameters.

**Chronic Obstructive Pulmonary Disease**

Chronic obstructive pulmonary disease (COPD) — the two main subtypes of which are emphysema and chronic bronchitis — frequently is due to cigarette use and the resulting alterations of the pulmonary immune system, inflammation, and destruction of lung parenchyma. Presentation includes shortness of breath on exertion, a cough-producing mucus, and wheezing.

African Americans who smoke cigarettes take in more nicotine, and therefore more tobacco smoke toxins per cigarette, than Caucasians (Perez-Stable et al., 1998).

Daily marijuana smoking has been shown to have adverse effects on lung function, including a productive cough, wheezing, and excessive sputum production. However, the habitual marijuana-only smoker, in the absence of alpha-1 antitrypsin deficiency, would have to smoke four to five marijuana cigarettes per day for a span of at least 30 years to develop overt manifestations of COPD (Van Hoozen and Cross, 1997).

*Special considerations*

During nicotine withdrawal and cessation treatment, different levels of nicotine absorption, as seen in some groups, will affect dosing for nicotine replacement therapies (Perez-Stable et al., 1998). The patient with COPD, especially if elderly, would be sensitive to the sedating effects of many of the detoxification protocol medications, especially the benzodiazepines, which may have to be reduced in dosage to avoid respiratory depression and worsening hypoxemia and hypercarbia (decrease in oxygen and increase in carbon dioxide). For smokers, always consider the use of the nicotine replacement agents, particularly in hospitalized patients. Evaluation for infections and the use of oxygen, steroids, and inhalers is dictated by the clinical picture. During detoxification, if nicotine use is not allowed, there can be significant effects on drug levels (see SAMHSA’s TIP 45).

**Neurologic System**

The neurologic system of patients with substance use disorders is affected directly in
the toxic effects on cell membranes, effects on neurotransmitters, associated metabolic changes from other underlying disorders, and changes in blood flow. Researchers have found that the majority (75 percent) of those with an alcohol use disorder have some degree of cognitive impairment (Goldstein, 1987). Specific disorders found in patients with substance use disorders can affect the central nervous system and the peripheral system. For example, a broad array of neuropathologic changes are seen in the brains of people who use heroin. The main findings are due to infections as a result of endocarditis or HIV infection. Other complications include hypoxic-ischemic changes with cerebral edema, ischemic neuronal damage thought to be due to heroin-induced respiratory depression, stroke due to thromboembolism, vasculitis, septic emboli, and hypotension. Myelopathy occurs as a result of possible isolated vascular accident in the spinal cord, and a distinct condition, leukoencephalopathy, has been described after the inhalation of pre-heated heroin (Buttner et al., 2000).

As a final note, traumatic brain injury (TBI) should always be considered in patients presenting with neurological impairment. People who abuse substances are at high risk of falls, motor vehicle accidents, gang violence, domestic violence, etc., which may result in head injury (Graham et al., 2003). Unrecognized TBI can affect the treatment outcome.

**Wernicke-Korsakoff syndrome**

Wernicke-Korsakoff syndrome is composed of Wernicke's encephalopathy and Korsakoff's psychosis. Wernicke's encephalopathy is an acute neurological disorder with a triad of

- Oculomotor dysfunction (bilateral abducens nerve palsy — eye muscle paralysis)
- Ataxia (loss of muscle coordination)
- Confusion

Weakness and nystagmus are also seen in this syndrome on examination of the eyes. Wernicke's encephalopathy is clearly related to thiamine deficiency. Korsakoff's psychosis is a chronic neurological condition resulting from thiamine deficiency that includes retrograde and antegrade amnesia (profound deficit in new learning and remote memory) with confabulation (patients make up stories to cover memory gaps).

**Special considerations**

Thiamine initially is given parenterally and then oral administration is the treatment of choice. Always give thiamine prior to glucose administration.

**Alcohol and sedative withdrawal seizures**

Alcohol and sedative withdrawal seizures represent a significant medical
challenge (Ahmed et al., 2000), since no large clinical studies have been conducted to firmly establish the best treatment practices. Up to 90 percent of alcohol withdrawal seizures occur in the first 48 hours, and usually are single and nonfocal. Repeated episodes of drinking and withdrawal are thought to predispose people to seizures due to a kindling phenomenon (Post et al., 1987). Patients with a history of withdrawal seizures are at greatest risk and should receive prophylactic doses of a long-acting benzodiazepine (e.g., chlordiazepoxide 50mg every 6 hours for 24 hours) when detoxifying from alcohol.

Individuals with an alcohol use disorder show an increase in seizures due to withdrawal, metabolic insults such as hypoglycemia or electrolyte imbalance, or head trauma. In one study, researchers found that of 195 cases of seizures in those with an alcohol use disorder, 59 percent were due to alcohol withdrawal, 20 percent to head trauma, and 5 percent to vascular disorders (Earnest et al., 1988).

Special considerations
Evaluation of a first seizure should include a neurological evaluation and evaluation for head trauma. Metabolic etiologies, such as low magnesium levels, should be considered.

Mayo-Smith (1997) has shown that benzodiazepines confer protection against alcohol withdrawal seizures, and thus patients with previous seizures should be treated early with this class of medications. The consensus panel suggests that anti-epileptic drug therapy should be considered in alcohol withdrawal patients with multiple past seizures (of any cause), a history of recent head injury, past meningitis, encephalitis, or a family history of seizures.

Clinicians should be aware that treatment of the first seizure with benzodiazepines does not prevent the likelihood of a second seizure (D’Onofrio et al., 1999). Slower medication tapers should be considered when this condition co-occurs with detoxification. Lorazepam, which can be used in patients with liver disease, has been suggested as appropriate, but it and other short-acting benzodiazepines may not prevent late-occurring withdrawal seizures (Shaw, 1995). Dosages of anticonvulsant medications should be stabilized before sedative-hypnotic withdrawal begins. Adequate treatment with a long-acting benzodiazepine is effective in preventing withdrawal seizures (Mayo-Smith and Bernard, 1995). D’Onofrio and colleagues (1999) found that a one-time dose of the relatively shorter acting agent lorazepam also reduced the risk of a subsequent seizure compared to placebo. However, in D’Onofrio’s study doses were small and the results were limited somewhat by use in an emergency room setting.
Older, first-generation anticonvulsants have limitations in that they have only been studied in mild to moderate withdrawal; on rare occasions they can cause serious hepatic and bone marrow toxicities; and they can interact with other classes of medication. Newer drugs, such as gabapentin (Neurontin) and oxcarbazepine (Trileptal), do not appear to have these liabilities, but sufficient studies to show this have not yet been done. There is little evidence that long-term use of phenytoin is helpful in the patient who does not have an underlying seizure disorder (Kasser et al., 2000). Medications that may lower the seizure threshold, including phenothiazines, such as prochlorperazine (Compazine), and several antidepressants, such as bupropion, should be used with great caution in the patient with a seizure history.

The use of anticonvulsants, such as valproic acid and barbiturates, has been studied in pregnant women. Valproic acid is associated with several malformations in the fetus. The use of any anticonvulsant medication should be discussed with the pregnant patient and risks and benefits explained (Robert et al., 2001).

**Cerebrovascular accidents**

Cerebrovascular accident (stroke) can be seen in alcohol and cocaine use, coagulation impairment, and severe uncontrolled hypertension.

Patients with recent cocaine or amphetamine use may present with headaches, which could represent subarachnoid and/or intracerebral bleeding, and therefore should be appropriately evaluated (Buxton and McConachie, 2000). Heavy alcohol consumption increases the risk for all major types of stroke by a variety of mechanisms (Hillbom and Numminen, 1998). There is a higher than normal incidence of hemorrhagic stroke and other intracranial bleeding among patients with heavy alcohol use, and a particular association of strokes within 24 hours of a drinking binge (Altura, 1986).

**Special considerations**

Nifedipine and verapamil have been shown to prevent alcohol-induced vasospasm, which suggests a possible therapeutic approach to hypertension and stroke in the patient with heavy alcohol use (Altura, 1986).

**Polyneuropathy**

Polyneuropathy frequently is seen in nutritional deficiencies that occur in the patient with chronic alcohol use. Presenting signs and symptoms include lower extremity pain, distal motor loss, numbness or tingling, and loss of reflexes. Polyneuropathy can be seen in the inhalation of h-hexane, methyl-n-butyl ketone, and toluene (Geller, 1998).

**Hepatic encephalopathy**
Hepatic encephalopathy is a toxic brain syndrome that results from the accumulation of unmetabolized nitrogenous waste products in a patient with severe liver dysfunction. Presenting signs and symptoms include an alteration in consciousness and behavior, fluctuating neurologic signs such as a flapping tremor (asterixis), and an elevated serum ammonia level. Clinicians should evaluate patients for precipitating causes, which include the following:

- GI hemorrhage
- Electrolyte imbalance (metabolic alkalosis)
- Infections
- Excessive diuresis (dehydration)
- Use of sedatives
- Increase of dietary protein intake

Those patients who are infected with Helicobacter pylori may be more prone to hepatic encephalopathy (Duseja et al., 2003).

**Special considerations**

Clinicians should avoid the use of diuretics, and should identify and treat factors that may have precipitated the encephalopathy, decrease dietary protein intake, and use lactulose to decrease nitrogenous waste products via the GI tract. Protocols that use the benzodiazepines should be adjusted to use those specific medications that are hepatically metabolized minimally or not at all.

**Infectious Diseases**

The viral causes of hepatitis are multiple, though the hepatitis B and C viruses are the predominant causative agents. Hepatitis C virus infection appears to be the most common form of infectious hepatitis in patients with substance use disorders. At least 76 percent of patients who have used injection drugs for less than 7 years are positive for hepatitis C, while 25 percent of patients with alcohol use disorders and those who do not inject drugs show serologic evidence of infection (Fingerhood et al., 1993; National Institute on Drug Abuse, 2000). Hepatitis B infections are likely to present more often as a chronic infection than as an acute-stage phenomenon. Testing for chronic hepatitis B and C infection is appropriate during the detoxification period.

**Special considerations**

Follow-up for hepatitis B and C should be arranged after discharge from the detoxification setting. Vaccination is recommended for hepatitis A and B in the patient with hepatitis C. The vaccination schedule is over a 6-month period, so it needs to be done after the detoxification program. If significant liver disease is present, use of shorter-acting medication with less liver metabolism should be considered. For more on infectious disease and substance abuse, see TIP 6, Screening for Infectious Diseases Among Substance Abusers (CSAT 1993c).
**Endocarditis**

Endocarditis is caused by the introduction of various bacterial species into the vascular system when the protective defense mechanisms of the skin are bypassed through injection. The patient frequently will present with fever, cardiac murmur, anemia, enlargement of the spleen, petechiae, and peripheral embolic disease. The course can be subtle and indolent to fulminant, and if untreated can lead to a poor prognosis. In the patient who uses drugs intravenously, the tricuspid valve is affected in 70 percent of cases, followed by effects on the aortic valve and the mitral valve. Seventy-five percent of all cases are caused by Staphylococcus aureus and up to 15 percent are caused by gram negative aerobic bacilli (Aragon and Sande, 1994).

Endocarditis always should be suspected in the febrile patient who uses intravenous drugs. Patients who use drugs intravenously are 300 times more likely to die suddenly from infectious endocarditis than patients who use drugs nonintravenously (Burke et al., 1997). Patients who use cocaine intravenously may have a higher rate of endocarditis as a result of more frequent injections and the reduced need to solubilize cocaine solutions with heat (Chambers et al., 1987).

**Bacterial pneumonia**

Bacterial pneumonia can result from immune system dysfunction, interference with normal respiratory defense mechanisms (from alcohol or smoked drugs), direct toxicity, or aspiration.

The treating physician should be aware that the usual pathogens found in community-acquired pneumonia (i.e., Streptococcus pneumoniae) may not be the causative agent in pneumonias seen in patients dependent on alcohol. Haemophilus influenzae, Klebsiella pneumoniae, and other gram-negative microorganisms must be suspected and treatment given until definitive culture results are reported. Among patients who use parenteral drugs, pneumonia is the most common reason for admission to the hospital, accounting for 38 percent of all hospitalizations in this population (Marantz et al., 1987).

**Special considerations**

Careful use of respiratory depressants is recommended. Indications for hospitalization of the patient with pneumonia (Neu, 1994) include the following:

- Old age
- Dehydration
- Vomiting and inability to take in oral fluids and medications
- Multilobular disease
- Low white blood cell count
- Respiratory acidosis
• pO\textsubscript{2} less than 55 mm Hg
• Significant concomitant diseases
• HIV

**Tuberculosis**

Tuberculosis (TB) is caused by acid-fast rod (Mycobacterium tuberculosis). Transmission is by droplets spread through the air. The infected patient presents with complaints of cough (the most common finding), bloody sputum, chest pain, fever, and weight loss. Recent immigrants from countries where TB is prevalent, socioeconomically disadvantaged populations, homeless persons, people who use illicit drugs, incarcerated people, and people who live in areas where infection with HIV is prevalent, are at increased risk for this disease and should be tested. Furthermore, new strains of multidrug-resistant TB are appearing, especially among the homeless population (Borgdorff et al., 2000; Moss et al., 2000).

TB is endemic in many areas of the world, including Asia, Africa, and South and Central America (Gupta et al., 2004). As a public health concern, testing all patients is of the utmost importance, even more so for patients from regions where TB is endemic. It is important to remember that immunocompromised patients may not react to the skin tests (anergy). Diagnosis is made with tuberculin skin testing, sputum smears and cultures, and radiographic findings. For more information on dealing with tuberculosis in detoxification and treatment settings see TIP 18, The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers (CSAT 1995i).

**Skin infections**

Skin infections frequently are seen as a result of the intravenous administration of drugs. Staphylococcus aureus and Streptococcus pyogenes are frequently the infectious agents. The patient presents with tenderness, swelling, pain, erythema, and warmth in the injection area. The type and route of antibiotic is determined by the infecting organism and the extent and severity of the infection. Clinicians should remember that injection sites can be found virtually any place on the body where there is access to the venous system.

Patients who use drugs intravenously, patients with peripheral vascular disease, and patients with diabetes (particularly with infections of the feet) should all be evaluated carefully for skin disease.

**Sexually transmitted diseases**

Sexually transmitted diseases can be seen in the form of urethritis, vaginitis, cervicitis, and genital lesions. These disorders are caused by a variety of microorganisms, and a complete history and physical that includes examination of the genitalia is indicated in all patients. The clinical picture and cultures
frequently can guide the treatment protocols. Patients who use drugs intravenously occasionally display a false-positive serologic test for syphilis, possibly due to a nonspecific reaction to repeated exposure of injected antigens (Hook, 1992).

**HIV/AIDS**

HIV/AIDS is a serious and prevalent medical condition among persons with substance use disorders, especially those who inject drugs and may share needles with other users. Patients with AIDS can present with a spectrum of complaints and illnesses ranging from an asymptomatic history to complaints of fever, enlargement of the lymph nodes, difficulty swallowing, diarrhea, weight loss, skin lesions, shortness of breath (due to Pneumocystis carinii pneumonia), headaches (due to Toxoplasma gondii), seizures, and dementia. As a rule of thumb, no complaint in the patient infected with HIV should be dismissed as irrelevant.

Gay men and patients who use drugs intravenously may be at higher risk for HIV/AIDS than other groups; thus, testing or referral for testing should be done and appropriate counseling offered. All such patients should be tested for HIV/AIDS or referred for testing. Some states, including Colorado, require that a risk assessment be administered to all clients and that clients be advised of their risk and referred for testing if they are at risk for HIV/AIDS. Patients who decline HIV testing still should be educated about the risk and prevention.

Due to increased virulence of syphilis in patients who are HIV-positive, as well as increased resistance to the treatments indicated in the usual treatment protocols, all such patients should be tested for syphilis and all patients who test positive for syphilis should be sent for HIV testing (McNeil et al. 2004).

**Special considerations**

If methadone is being used in withdrawal protocols, or maintenance is being continued, the clinician should be aware that certain HIV medications can cause an increased metabolism of methadone. They include:

- Efavirenz (Sustiva)
- Nevirapine (Viramune)
- Lopinavir / ritonavir (Kaletra)
- Rifampin (a drug to prevent mycobacterium avium complex, a serious bacterial infection, in HIV-positive clients)
- Amprenavir (Agenerase)
- Abacavir
- Ritonavir

TIP 37, Substance Abuse Treatment for Persons With HIV/AIDS (CSAT 2000e) provides further information about substance abuse treatment for patients with
Other Conditions

Cancer

Cancer occurrence is increased in people with substance use disorders due to the carcinogenicity of the drugs used. Cigarette smoking is linked to lung, larynx, oral cavity, esophagus, stomach, bladder, and pancreatic cancer. Heavy alcohol consumption is associated with an increased incidence of oral, pharyngeal, esophageal, laryngeal, respiratory tract, and breast cancer (Polednak, 2005). Synergism is seen with alcohol and smoking being associated with even higher risks of cancer (Fagerstrom, 2002). A history of weight loss could suggest many chronic diseases, though cancer should be considered in the differential. There may be an increase in head and neck cancers in persons with heavy cannabis use (Donald, 1991). Liver cancer may be seen in patients with hepatitis C and those using anabolic steroids (Socas et al., 2005). There is a particular interrelationship among alcohol intake, hepatitis C, and hepatocellular carcinoma (Yoshihara et al., 1998).

Diabetes

Patients who use drugs intravenously may experience infections that affect diabetic control, though any infection in any detoxification patient needs to be addressed both from an infectious disease and diabetic viewpoint.

Special considerations

Several medications can lead to impaired glucose tolerance and elevated serum glucose (Garber, 1994). Some examples include:

- Thiazide diuretics
- Clonidine
- Glucocorticoids
- Haloperidol
- Lithium carbonate
- Phenothiazines
- Tricyclic antidepressants
- Indomethacin
- Olanzapine
- Risperdal

Antidiabetic agents in concert with alcohol may produce hypoglycemia and lactic acidosis. Diabetes mellitus also is seen in patients who present with new-onset hyperglycemia (elevated glucose) or with a history of diabetes and poor control.

Acute trauma or fractures
Acute trauma or fractures can be seen in any patient with a substance use disorder due to an altered level of consciousness or impaired gait when intoxicated. Patients with substance use disorders appear to be particularly prone to accidents of all kinds, with a spectrum of complications from head trauma to falls with fractures. Chronic pain frequently is seen in patients as a result of trauma (treated or untreated), poor health maintenance, or an inability to deal with pain without drug use. Chronic pain treatment and the issues of opioid use have to be considered for each patient on an individual basis.

The surgeon should consider drug withdrawal in the differential diagnosis of any physical or neurologic symptoms or signs that emerge during the perioperative period. There is a two- to threefold increase in postoperative morbidity in patients with alcohol use disorders, the most frequent complications being infections, bleeding, cardiopulmonary insufficiency, and withdrawal complications (Tonnesen and Kehlet, 1999).

Special considerations

Opioids may be used to control pain in the initial period of trauma. Detoxification protocols should be started prior to anticipated surgery and continued throughout the perioperative period. Pain that causes an increased heart rate, as well as postoperative temperature elevation, may impact the detoxification parameters.

Due to tolerance to opioids, the daily methadone dose in a methadone-maintained individual will not serve as an analgesic for pain relief from surgical or other illnesses. Full therapeutic doses of analgesic drugs should be given to methadone-maintained patients who have co-occurring painful conditions (CSAT, 2005d; Ho and Dole, 1979).

Since most medications for pain management are drugs with a high abuse potential, programs may need to alter their policies regarding the use of such drugs.

Pain patients do not require detoxification from prescribed medications unless they meet the criteria for opioid abuse or dependence described in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Treatments for pain include physical therapy, transcutaneous electrical nerve stimulation, and therapeutic heat and cold. Trials of nonsteroidal anti-inflammatory agents or nerve block should be considered prior to the use of highly addictive and abusable medications.

The use of acetaminophen in the patient with an alcohol use disorder always has been questioned, especially if there is evidence of liver disease. However, a review article of the medical literature showed that repeated ingestion of a therapeutic dose of acetaminophen over 48 hours by patients with severe
alcoholism did not produce an increase in hepatic aminotransferase enzyme levels or any clinical manifestations as compared to a placebo group (Dart et al., 2000).

Activity
Reverse vignette: The instructor can have students randomly select one or more of the above medical conditions. Working in groups, have the students brainstorm how the "typical" client with the condition might present in their offices. After creating a bio-sketch of the client/patient, have the students answer the following questions regarding how they might use their knowledge of medical concerns that impact substance users to answer the following questions:

- How might the medical issue affect the behavioral issue and vice versa? How could such co-occurrence impact the treatment?
- How can the medical issue be used to engage the client?
- In what ways can behavioral health professionals speak to the behavioral, cognitive and affective issues associated with significant medical issues?
- In what ways can the behavioral health professional interact with the primary care provider to ensure proper treatment for the client?
- Practice engagement strategies via role play of client with one of the above disorders.
  - Practice AROSE skills to engage the “client” in discussing his or her issue.
  - Using the informational material above, practice providing psycho-education to the client with the physical issue. Use this model:
    - **Ask permission** – “I have some information about [medical issue]. Would it be useful to you for me to share it with you?”
    - **Provide one small aspect of information** – be careful to not overwhelm with material.
    - **Ask for feedback** – Was this helpful for you? What else might you need?
      (Miller & Rollnick, 2013)

References


