Mistakes Specialized Dockets Make in Drug and Alcohol Treatment and How to Fix Them

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Disclaimer

The views expressed in this presentation are solely those of the presenter and do not represent those of the Veterans Administration or the United States government.

The author has no conflicts of interest to disclose.

WARNING!

You may experience this presentation as provocative....

Some Disturbing Facts

- Alcohol Use Disorders increased by 49.4% from 2001-02 to 12.7% in 2012-13 (Grant et al., 2017)
- There is increasing evidence of heroin as the *first* opioid that is misused (Cicero et al., 2017)
  - In 2005, 8% of opioid initiators started with heroin
  - In 2015, 33.3% started with heroin
- More than 67,000 people died of drug overdoses in 2018, which doubled in a decade (CDC, 2020)
  - Almost 70% of these involved opioids
  - This is a decrease of 4% since 2017
  - This continues even though drug dealers are helping to kill off their clients

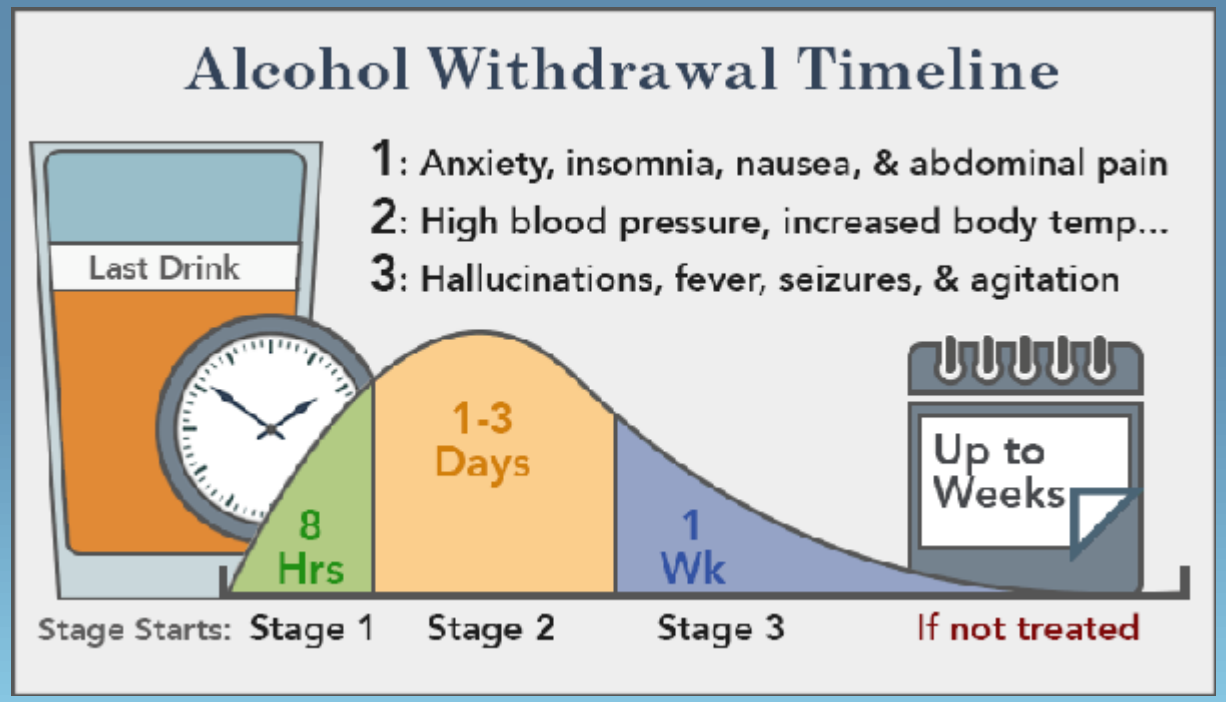
Some Disturbing Facts about Treatment

- 20.7 million people needed SUDs treatment in 2017, but only 4 million (25%) received any treatment (SAMHSA, NSDUH, 2018)
  - Only one million of the rest perceived a need for it
- Less than half of privately-funded SUDs treatment programs offer MAT, and only 1/3 of patients with OUDs actually receive it (ACOG & ASAM, 2012)
- Most people admitted to addiction treatment do not complete it
  - The completion rate was 40.6% in 2002, peaked at 47.5% in 2006, and was 43.7% in 2011 (SAMHSA, TEDS, 2002-2011)
- Only 47% of clients with addictions reach at least 12 months of abstinence within three years of their first treatment episode (Dennis et al., 2005)
  - 42% of clients with lifetime substance dependence do not enter a sustained recovery of over one year

Mistake #1

Demanding immediate abstinence from traumatized people

Immediate Abstinence from Alcohol May Be Dangerous



- Over time, the central nervous system acclimates to having alcohol in it all of the time
- Sudden withdrawal can lead insomnia, anxiety, headaches, nausea, and vomiting
- It can also result in hallucinations and seizures
- First, do no harm

Immediate Abstinence May Not Be Possible for People Who Have Been Traumatized

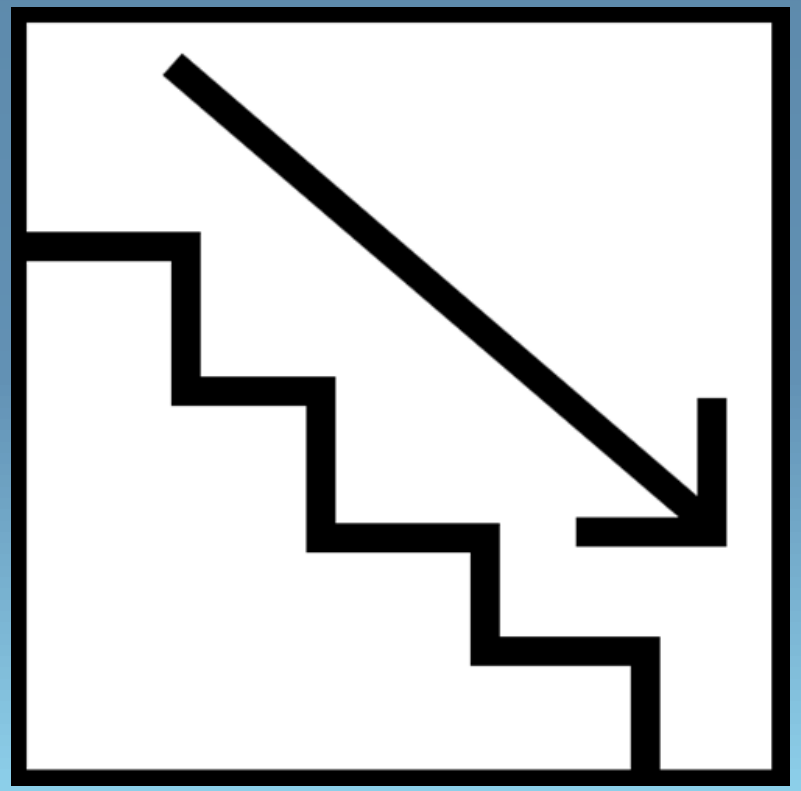
- If they really are using substances to cope with their trauma, immediate abstinence will leave them defenseless
- They will become flooded by all of their trauma-related memories, thoughts, feelings, nightmares, and body experiences
- This will lead to relapse
- This will lead to punishment
  - Punishment can be re-traumatizing
  - It will make them distrust you more

Alternative #1: One at a Time

- When someone misuses multiple substances, it is difficult to give them all up at once
  - Different substances may be used for different purposes
  - Contract to give up the easiest one first
    - This gives them confidence that they can be successful
- This can also be used for safety, such as first stopping driving while using, then stopping going out to use, then stopping use at home

Alternative #2: Warm Turkey

- Contracting to reduce consumption each week until abstinence is achieved
  - e.g., from two cases of beer a day to 18 beers a day, then one case, then 9, 6, 3, 2, 1, and 0
  - Or reducing the number of days per week of usage until there are none



Alternative #3: Try an Experiment

- Contract to try an experiment to go for three days without using
  - Then meet on the fourth day to discuss how it went
  - If successful, renew the experiment
  - If not, try something else

The Goal Is Abstinence

- Methods may be mixed
  - For example, they can cut down one substance at a time, but the last substance (the hardest) may need a warm turkey approach
- Clinicians should monitor the changes
- IMPORTANT: Let them choose the method
  - This empowers them to make the choice, rather than having you make it for them
  - Empowerment is critical for people who have been traumatized
  - It is choice within limits

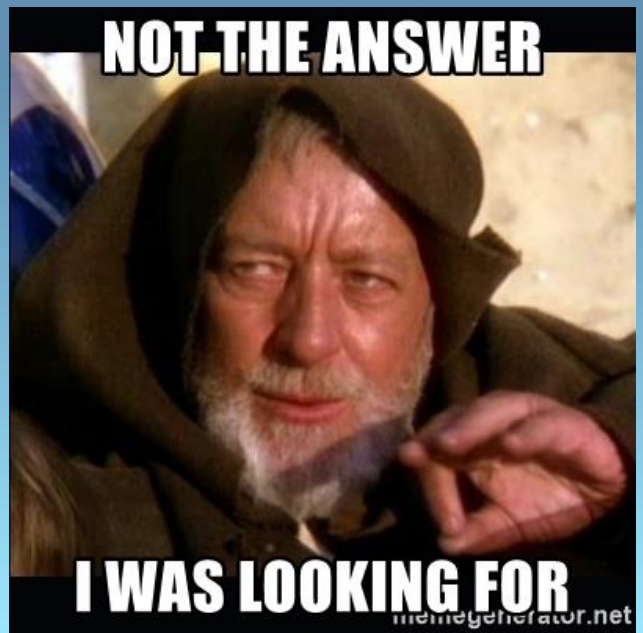
Mistake #2

Referring to residential treatment as the answer to addictions

Residential treatment is a beginning or a middle, not the end, to addiction treatment.

Residential Treatment May Not Be the Answer

- Reviews of the outcomes of residential treatment for addictions (and co-occurring disorders) are mixed and not definitive (cf. Brunette et al., 2004)
- For example, one review (Finney et al., 2006) found that, out of 14 studies of inpatient vs. outpatient alcohol treatment:
  - Five found residential treatment to be more effective
  - Two found day treatment to be more effective
  - Seven found no difference



Residential Treatment May Not Be the Answer

- Residential treatment is far more expensive
- Longer programs are not better
  - A study of 28 residential treatment programs for addiction (Harris et al., 2011) found that participants in programs with ALOS 15-30 days and 31-45 days showed significantly *greater* decreases in alcohol use than participants in programs with ALOS > 90 days
  - Moreover, the shorter programs also had participants who started with more severe alcohol addiction
  - There were no differences in drug addiction between longer and shorter programs

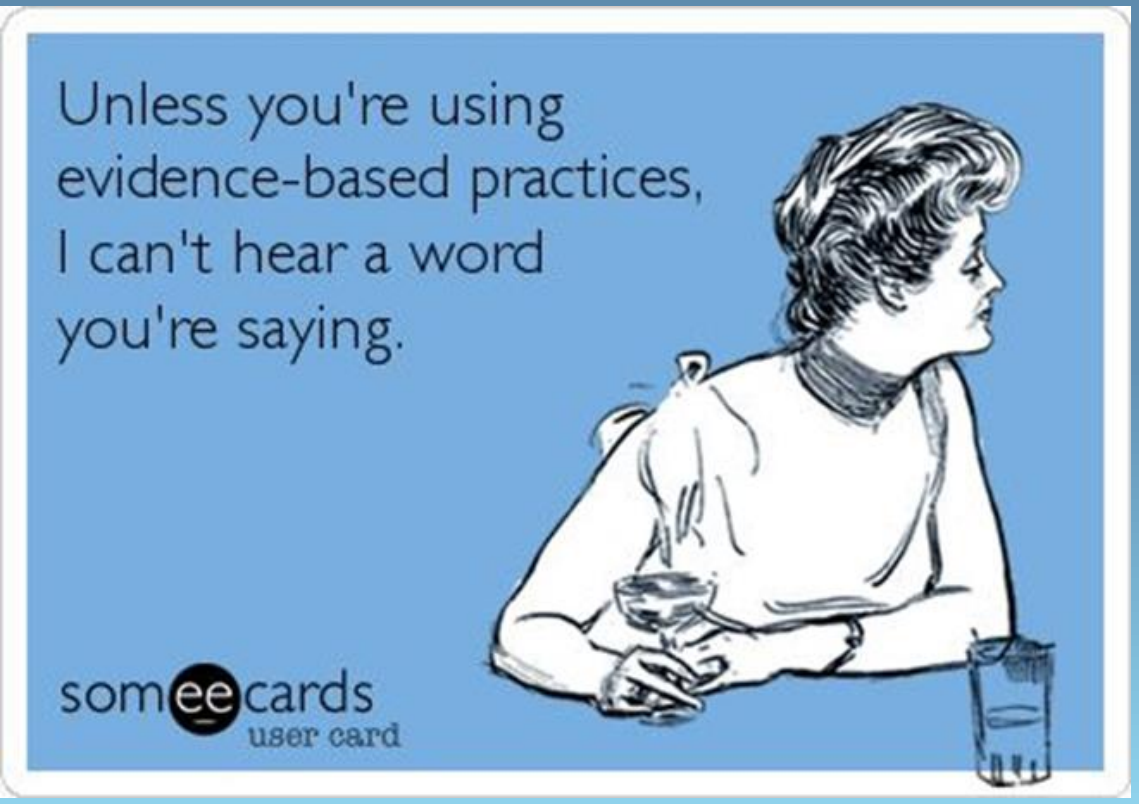
Factors to Consider When Referring to Residential vs. Outpatient Programs

- Has Intensive Outpatient Programming been tried?
  - If not, try IOP first
- Do they have a good reason not to want to be in residential treatment, such as caregiving responsibilities that others cannot do?
  - If not, consider IOP or other alternatives such as:
    A. Housing alternatives
    B. Day reporting programs
    C. Electronically monitored home confinement

Factors to Consider When Referring to Residential vs. Outpatient Programs

- What outcome research proves the effectiveness of the program?
  - The research must include follow-up data
    - Otherwise residential programming will show abstinence at discharge
    - That is not an indication of effectiveness: it's just a result of containment
  - The true measure of effectiveness is whether abstinence lasts continuously *past* discharge
    - Require a minimum of one year of continuous follow-up data
- How intensive is Intensive Outpatient Programming?
  - At least 9 hours per week are needed

Factors to Consider When Referring to Residential vs. Outpatient Programs



- Do they use evidence-based treatments?
  - Find out which ones, and what is the evidence for them?
- Is the client able to quit without being removed from their environment?
  - If not, then consider residential treatment
  - But then the client must move to another environment after discharge
- Does the client have already existing supports in the community?
  - If so, IOP may be more effective

Factors to Consider When Referring to Residential vs. Outpatient Programs

- Does the residential program have community reintegration programming?
  - If not, then success is less likely
- Do they have dual diagnosis programming, and is it evidence-based?
  - If not, that increases the risk of relapse
- Is job skills training part of the program?
  - If not, then success is less likely
- Are homeless services part of the program?
  - If not, then success is less likely

Mistake #3

Referring to organizations using treatments that don’t work

We Often Believe and Practice What We Were Taught in School

- It's what we learned first
- It's easier than learning new things
  - But the older we get, the more out of date that is
- It takes a long time for practice to catch up with research
  - The usual estimate in healthcare is 17 years (Green et al., 2009; Westfall et al., 2007)

What We Were Taught: Confrontation

What We Were Taught: Confrontation

- Confrontational leaders make addicted clients worse (Lieberman et al., 1973)

Four decades of research have failed to yield a single clinical trial showing efficacy of confrontational counseling, whereas a number have documented harmful effects…clinical studies show that more effective substance misuse counselors… practice with an empathic, supportive style…the harsh confrontational practices of the past are ineffective, potentially harmful, and professionally inappropriate.

White & Miller, 2007

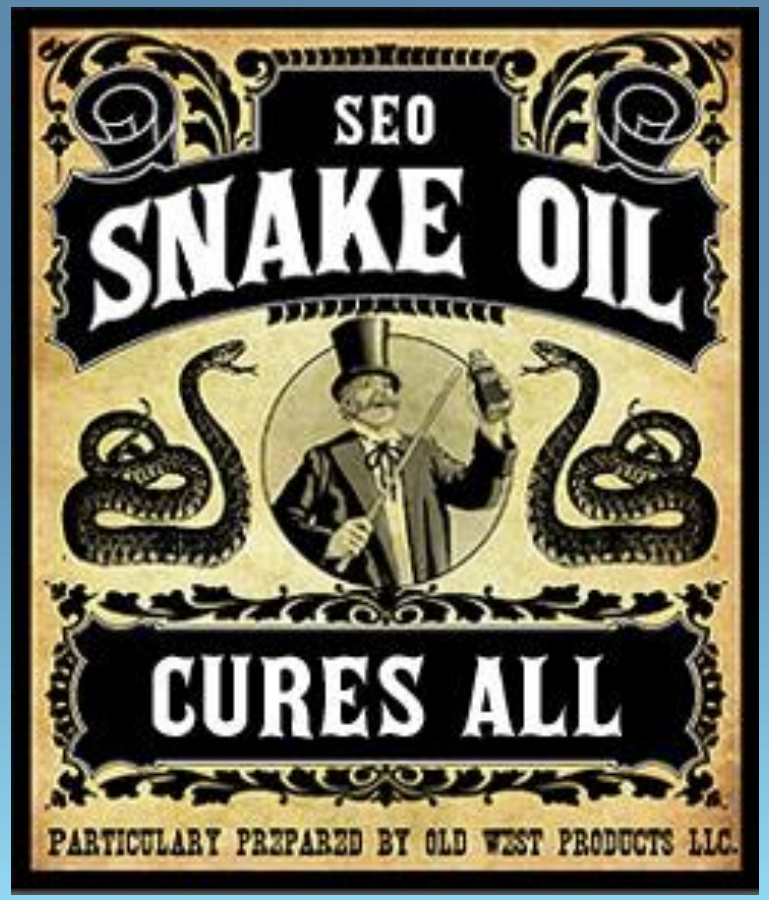
Beware of Using an Uncommon Approach

- Be careful about believing that you know better than what the research literature shows because of your own experience.
- That's ego, not evidence.

Beware of Using an Approach Because It Is Common

- Just because it is common does not mean that there is consistent high-quality evidence for it.

Beware of Buying Snake Oil



- There is a large gap between what we know works in addiction treatment and what is practiced in the field (Miller et al., 2006)
- Many commonly used treatments have not been subjected to much research
- Be careful about the power of testimonial

Use What Has Been Proven to Work

In a famous study, Miller and Wilbourne (*Addiction,* 2002) compared the evidence of 361 controlled studies of treatments for Alcohol Use Disorders:

Least Effective

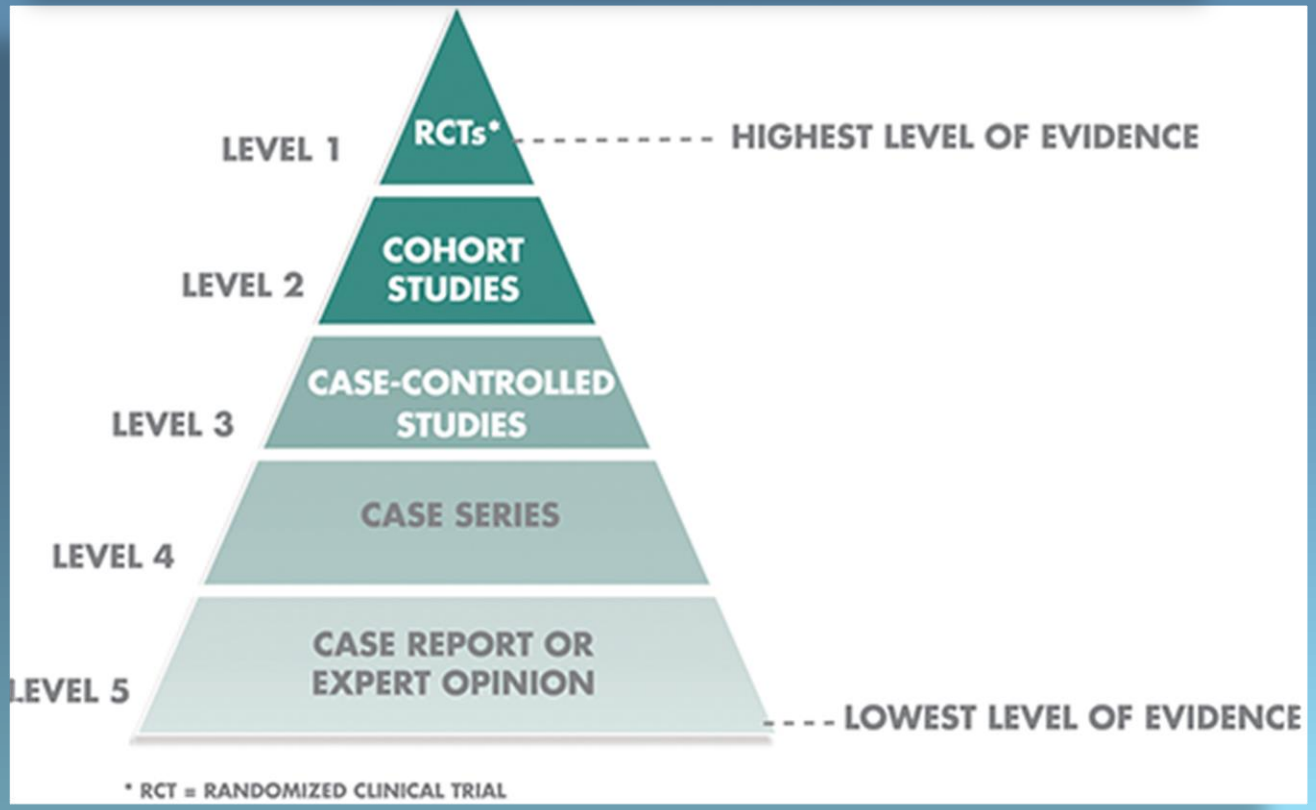
- Educational lectures, films, groups
- General alcohol counseling
- Psychotherapy
- Confrontational counseling
- Relaxation training
- Standard treatment
- Video self-confrontation
- Alcoholics Anonymous
- Milieu therapy
- Antidepressant, non-SSRI
- Metronidazole (anti-bacterial medication)

Most Effective

- Brief intervention
- Motivational Enhancement
- GABA agonist (sedatives, anxiolytics)
- Opiate agonist (Naltrexone, Naloxone)
- Social skills training
- Community reinforcement
- Behavior contracting
- Behavioral marital therapy
- Case management
- Self monitoring
- Cognitive therapy

Other Evidence-Based Treatments for Addictions

Common practices are not always evidence-based.



- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Cognitive-Behavioral Therapy
- The Matrix Model
- Contingency Management
- Medication-Assisted Treatment
- 12 Step Facilitation
- Seeking Safety
- Community Reinforcement Approach
- Family Behavior Therapy

Just Because It Is Evidence-Based Doesn't Mean That We Use It: The Example of Naloxone

- Naloxone reverses overdoses
- Naloxone is safe (Wermeling, 2015)
- Naloxone saves lives
  - From 1996-2014, at least 26,500 opioid overdoses in the U.S. were reversed by laypersons using naloxone (Wheeler et al., 2015)
- Naloxone does not increase opioid use
  - A naloxone distribution program in Massachusetts reduced opioid overdose deaths in communities that implemented it without increasing opioid use in those communities (Walley et al., 2013)

This is true of MAT, too.

What Is Evidence-Based Practice?

- It's more than evidence-based treatment

Mistake #4

Using derogatory language

Problems in Commonly Used Language

- Language can be definitional
  - For example, “addict” means you are defined by your addiction
- Language can create stigma
  - For example, “dirty urine” means you are a dirty person
- Language can create a life sentence
  - For example, “personality disorder” means a permanent condition
- Language can create false causes
  - For example, “You could stop if you wanted to.”
  - This example also makes a brain disease into a moral failing
- Language can be shaming
  - For example, “You are a drunk.”

Changing Your Language

Harmful	Helpful
• "Defendant"	• Use their name
• "Addict"	• Person with an addiction
• "Your urine drug screen was dirty."	• "Your urine showed the presence of drugs."
• "Your urine drug screen was clean."	• "Your urine did not show the presence of drugs."
• "You could stop drinking if you wanted to."	• "We want to help you obtain safety, stability, and support so that you can succeed."

Changing Your Language

Harmful	Helpful
• "You are a drunk."	• "You were intoxicated."
• "Substance abuse"	• "Addiction"
• "You have a Borderline Personality Disorder."	• "You have frequent difficulty regulating your emotions."
• "You should know better."	• "These are our expectations."
• "You violated your contract."	• "You did not meet the terms of your contract."
• "Compliance/noncompliance"	• "Adherence/nonadherence"
• "Treatment failure"	• "Continues to use substances"

Mistake #5

Requiring that all traumatized clients participate in AA/NA

Traumatized Individuals May Not Like AA/NA

- Reason #1: What is the first step?

Some Traumatized Individuals May Not Like AA/NA

- Reason #1: What is the first step?
  1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
  - Most traumatized people need control
    - Yes, it is a contradiction that they use substances that make them lose control
  - Admitting they are powerless violates their identity

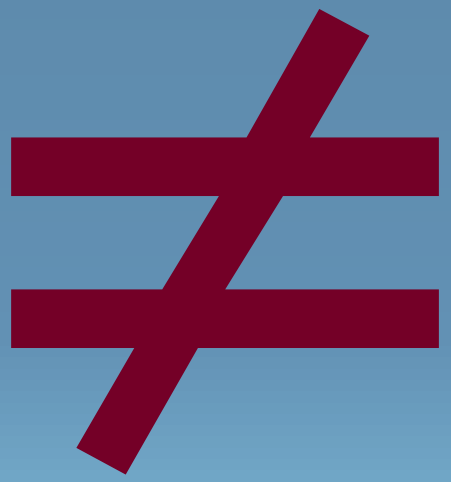
Some Traumatized Individuals May Not Like AA/NA

- Reason #2: What is the third step?

  3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

- Not all traumatized people believe in a higher power
  - They question why God let terrible things happen to them
  - Then they have three choices:
    1. God is good, so I am bad
    2. God is not good
    3. There is no God
- AA and NA depend on faith and trust, which many traumatized people lack

Not All AA or NA Meetings Are Created the Same



- Some are better than others
- It usually depends on the leaders
- Some meetings mostly tell war stories about alcohol or drug use
- Some AA meetings are followed by drinking parties
- Make sure you send them to the *right* meetings

Not All Participants Respond in the Same Way

- More than 40% of participants drop out prematurely from self-help groups (Kelly & Moos, 2003)
- Some people are triggered by hearing stories of others drinking or using drugs
- Make sure your participants are not triggered to drink or use drugs by hearing stories of others drinking and using

Just to Be Clear

- AA and NA have helped millions of people
- This discussion is not meant to stop you from referring to AA and NA
- It is meant to make you think about *which* meetings are helpful to *which* people
  - AA and NA may not be helpful to all traumatized people
- The NADCP Adult Drug Court Best Practice Standards (Volume I, 2013) recommend using Peer Support Groups
  - The Standards do not recommend specific peer support groups

ALL RISE NADCP National Association of Drug Court Professionals

Alternatives to AA/NA: SMART Recovery

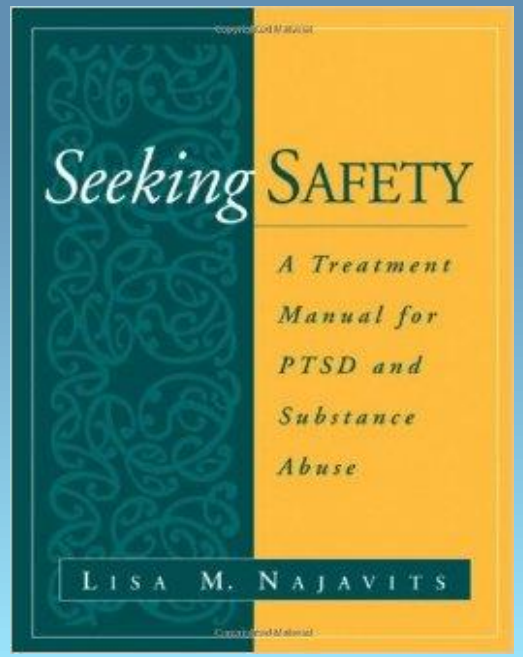
- Self Management and Recovery Training Groups
- Four Point Program
  1. Building and Maintaining Motivation
  2. Coping with Urges
  3. Managing Thoughts, Feelings and Behaviors
  4. Living a Balanced Life
- Allows the use of psychiatric medication
- Does not require belief in God
- Does not require belief that addiction is a disease

SMART Recovery

- A cognitive-behavioral approach to addiction
- Focuses on empowerment and self-reliance
- Uses empirically-supported treatment strategies
- Research shows it is effective (e.g., Hester et al., 2013)
- Provides tools and techniques
- Worksheets
- Web courses
- In person and online meetings
- Online resources

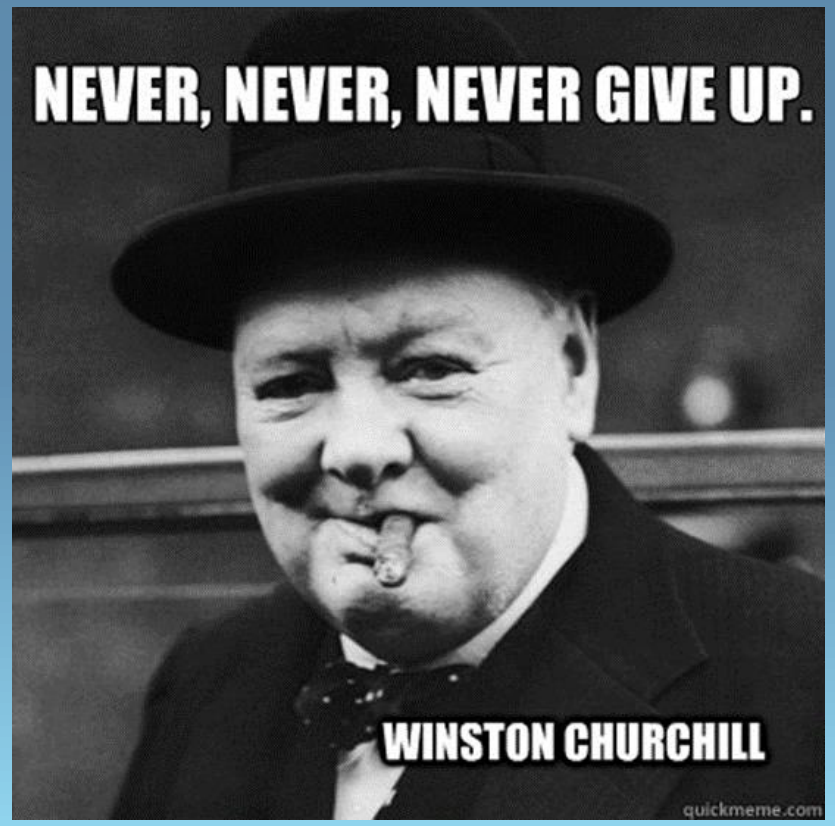
Alternatives to AA/NA: Seeking Safety

- An integrated treatment for PTSD and addiction
- Combines psychoeducational and psychodynamic treatment
- 25 lessons on topics that overlap between PTSD and addiction
  - Safety Skills
  - Grounding
  - Anger
  - Boundaries
  - Self-care
  - Honesty
  - Compassion



Seeking Safety

- Can be provided by professionals or paraprofessionals
- 6 randomized controlled trials and 3 controlled studies
- Seeking Safety has shown positive results across all studies (Najavits & Hien, 2013)
- Seeking Safety is the only evidence-based treatment for PTSD and addiction



Mistake #6

Referring to organizations that kick people out of addiction treatment

Addiction Treatment Programs Kick People Out of Treatment

- 7.3% of participants were administratively discharged from addiction treatment programs in 2013 (SAMHSA, 2014)
- This is more than 126,000 clients
- These figures are underestimates (Williams, 2015)

Official Reasons Why Addiction Treatment Programs Kick People Out of Treatment

- Continued use of substances: >50%, (White, 2014)
- Rule infractions
- Curfew violations
- Possessing contraband, including substances
- Refusal to comply with treatment recommendations
- Non-compliance
- Fraternization

Problematic Reasons Why People are Kicked Out

- As a method of punishment to encourage cooperation
- To protect the treatment milieu
- For “therapeutic reasons”
- The client has complex problems
- As a message to the client
- Insurance has run out
- To protect the reputation of the treatment program

White et al., 2005; Williams & Taleff, 2015; Williams & White, 2015

The Only Good Reasons for Administrative Discharges

- Severe violence
- Supplying drugs or alcohol to other participants?

THAT'S ALL!

“It’s Time to Stop Kicking People Out of Addiction Treatment”

1. It is hypocritical to kick people out for the disease they came into treatment for

> We know of no other major health problem for which one is admitted for treatment and then thrown out for becoming symptomatic in the service setting.

White, Scott, Dennis, & Boyle, 2005

It's Time to Stop Kicking People Out

2. It blames the client for the disease
3. It disproportionately affects African-American, Hispanic, and low SES clients (Illinois Office of Alcoholism and Substance misuse, 2002)
4. It disproportionately affects clients with high severity, complexity, and chronicity

White et al., 2005; Williams & White, 2015

It's Time to Stop Kicking People Out

7. It doesn't account for the progressive erosion of willpower in addiction
8. It's often the result of countertransference
9. It masks treatment programs from their own deficiencies and prevents them from evaluating and refining their clinical practices
10. It violates professional ethics

White et al., 2005

Negative Consequences of Kicking People Out

1. It contributes to clinical deterioration when they most need help (Williams & White, 2015)
   a. Escalation of drug misuse
   b. Criminal offending
   c. Incarceration
   d. Increased mortality (anecdotal)
2. Patients administratively discharged from MAT had negative outcomes (Svensson & Andersson, 2012)
   a. They could not maintain sobriety
   b. They had a high risk of mortality
   c. They returned to prostitution, crime, and heroin misuse

Negative Consequences of Kicking People Out

3. It destroys pro-recovery social networks
4. Patients kicked out of six methadone treatment programs experienced a mixture of arbitrariness, unfairness, unnecessary policy, and stringent procedures
(Reisinger et al., 2009)

What Programs Can Do to Keep Clients in Treatment

1. Develop clear policies and procedures related to administrative discharges
2. Increase the percentage of staff with Masters degrees
3. Train staff to be aware of their countertransferences
4. Set up weekly clinical supervision to increase staff monitoring
5. Train all staff in Motivational Interviewing to enhance client motivation

White et al., 2005; Williams & White, 2015

What Programs Can Do to Keep Clients in Treatment

6. Develop a feedback loop between failure to complete discharges and admission assessments and placement decisions
   A. Consider factors in failed placements, such as clients' legitimate needs to remain in their homes like caretaking responsibilities
7. Develop alternatives to residential treatment
   A. Housing alternatives
   B. Day reporting programs
   C. Electronically monitored home confinement

8. Assign a patient advocate at the start of treatment to meet with the client regularly

White et al., 2005

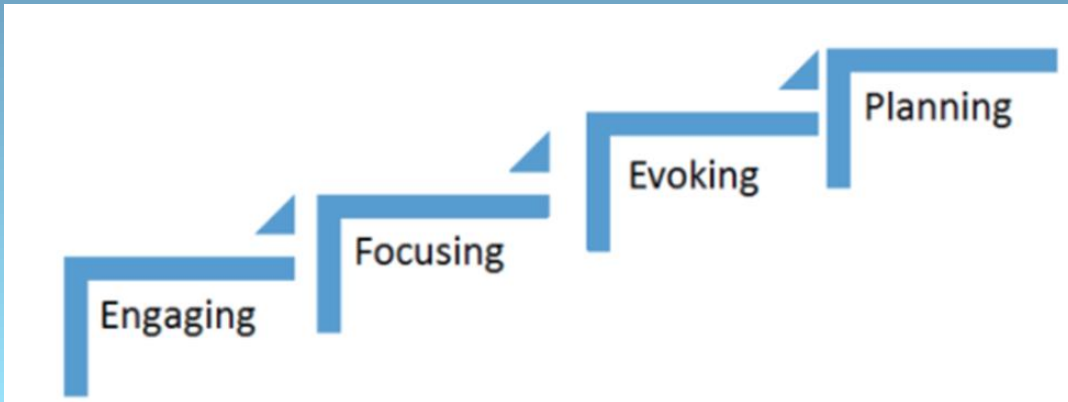
What Programs Can Do to Keep Clients in Treatment

9. Ensure adequate detox services and adequate dosing in MAT
10. Attend to racial and class conflicts in the program
11. Establish continuity of care in recovery relationships
    A. Use the same therapists and peers on the treatment team over multiple episodes of treatment when possible
12. Evaluate problematic behaviors clinically before considering administrative discharges
13. Use transfers between levels of care, service modalities, or service settings instead of administrative discharges
14. Leave the door open for returns

White et al., 2005

What Program Staff Can Do to Keep Clients in Treatment

- Increase your assessments of:
  - Motivation for change
    - Use the URICA (DiClemente and Hughes, 1990)
  - Therapeutic alliance
    - Use the Session Rating Scale (Duncan et al., 2003)
    - Use the Working Alliance Inventory – Short Revised (Horvath, 1992; Munder, 2010)
- Practice Motivational Interviewing
- Be aware of your countertransferences
  - Talk about them in team meetings



What Clinicians Can Do to Keep Clients in Treatment

- Recognize each client's historical pattern of resisting change
  - Anticipate that it is likely to be replicated in treatment and address it
- When feeling frustrated or angry, separate the person from the disorder. Focus on getting through to the person.
- Use peer or clinical supervision
- Make extra efforts to engage and counsel people with multiple prior episodes of treatment. Remind yourself that:
  - The majority of clients with severe and persistent addiction do get better;
  - What you do could shorten or lengthen a person's addiction career;
  - This may be a window of opportunity.


If a window of
opportunity
appears, don't pull
down the shade.
~Tom Peters

Mistake #7

Believing the self-medication hypothesis

Many Reasons Why People Use Substances

- To numb their painful feelings (self-medication).
- To try to relax.
- To forget the past.
- To go to sleep.
- To prevent nightmares.
- To cope with physical pain.
- To stop dissociation and flashbacks.
- To feel some pleasure in life.
- To let out their anger.

Many Reasons Why People Use Substances

- Peer pressure.
- To socialize with other people and feel accepted.
- Family members drank or used drugs when they were growing up.
- It was common in the military.
- Boredom.
- To get through the day.
- To show people how bad they feel.
- To commit “slow suicide.”

The Truth about Self-Medication

- Only about 1/3 of people start abusing substances after their traumatic experience
- About 1/3 experience trauma and start abusing substances simultaneously
- About 1/3 misuse substances before they experience trauma

Investigate

- Find out when they started using substances and when they first experienced trauma
- Find out what their experience was when they first used substances and in what context
- Ask why they used substances then
- Ask if the reason they use substances now is the same
- Find out for each substance, both those used in the past and those used now

Treating Everyone with an Addiction Like They Self-Medicate Is Like....

Don't Get Fooled Again

PTSD ≠

addiction

- Even when someone begins using substances to cope with traumatic experiences, that does not mean that is why they are using substances now
- People can become substance dependent over time
- Even if treatment significantly decreases their PTSD symptoms, they may not stop abusing substances (Mills et al., 2012)

Mistake #8

Not assessing for and treating trauma

Co-Occurrence of PTSD and Addiction

Co-occurring disorders are the rule rather than the exception.

SAMHSA, 2002

Co-Occurrence of PTSD and Addiction

- PTSD and addiction co-occur at a high rate
  - 20-40% of people with PTSD also have SUDs (SAMHSA, 2007)
  - 40-60% of people with SUDs have PTSD
- Substance use disorders are 3-4 times more prevalent in people with PTSD than those without PTSD (Khantzian & Albanese, 2008)
- The presence of either disorder alone increases the risk for the development of the other
- PTSD increases the risk of substance relapse (Norman et al., 2007)
- The combination results in poorer treatment outcomes (Ouimette et al., 2003; Sonne et al., 2003)

National Comorbidity Survey

Among people with PTSD:

	Male	Female
Alcohol misuse/ Dependence	51.9%	27.9%
Drug misuse/ Dependence	34.5%	26.9%

Kessler et al., 1995

PTSD Assessment: The Life Events Checklist 5

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war-zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (for example, homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

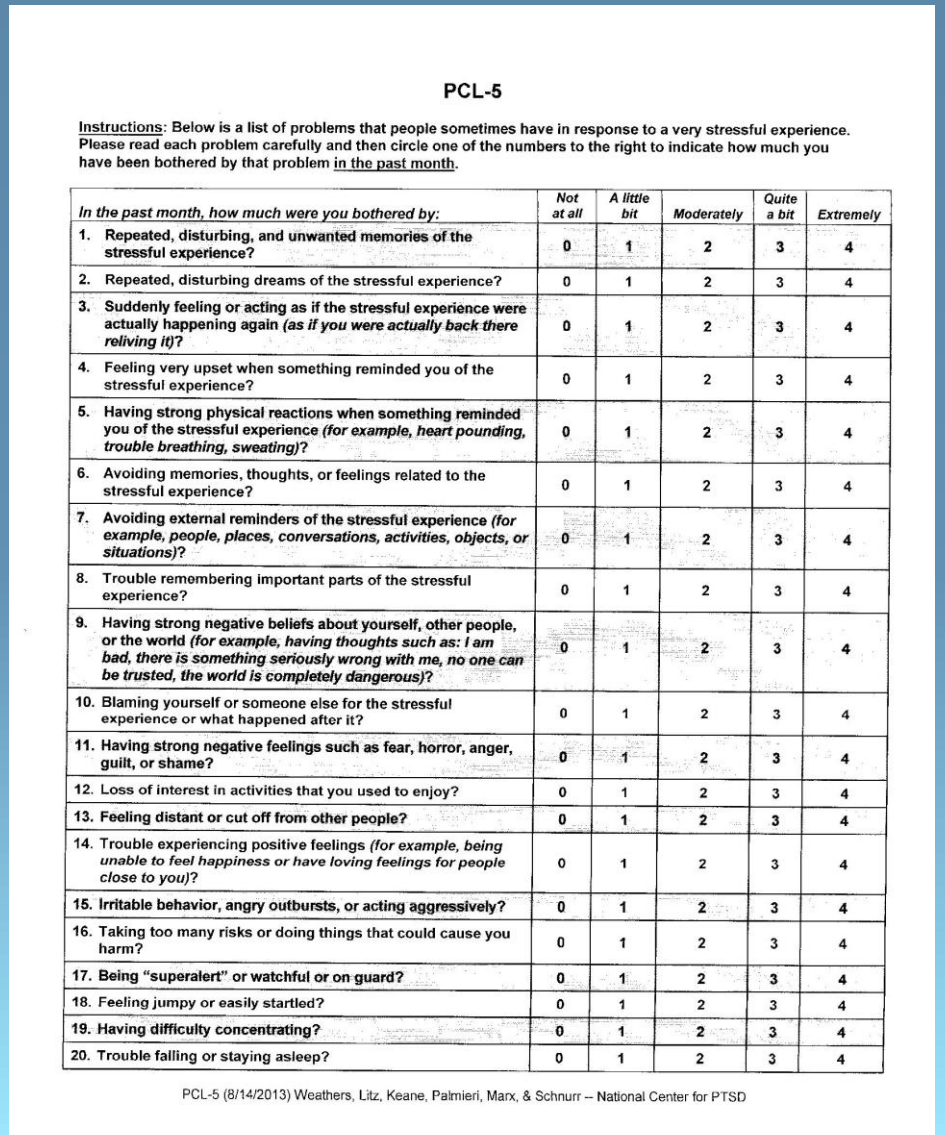
- Self-report measure
- 17 categories of traumatic events
  - Happened to me
  - Witnessed it
  - Learned about it
  - Part of my job
  - Not sure
  - Doesn't apply

PTSD Assessment: The LEC 5

- The LEC 5 measures trauma load
  - How many different kinds of trauma have they experienced?

- It does not compare impact of different traumas (e.g., physical assault vs. captivity)

PTSD Assessment: The PTSD Checklist 5



PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

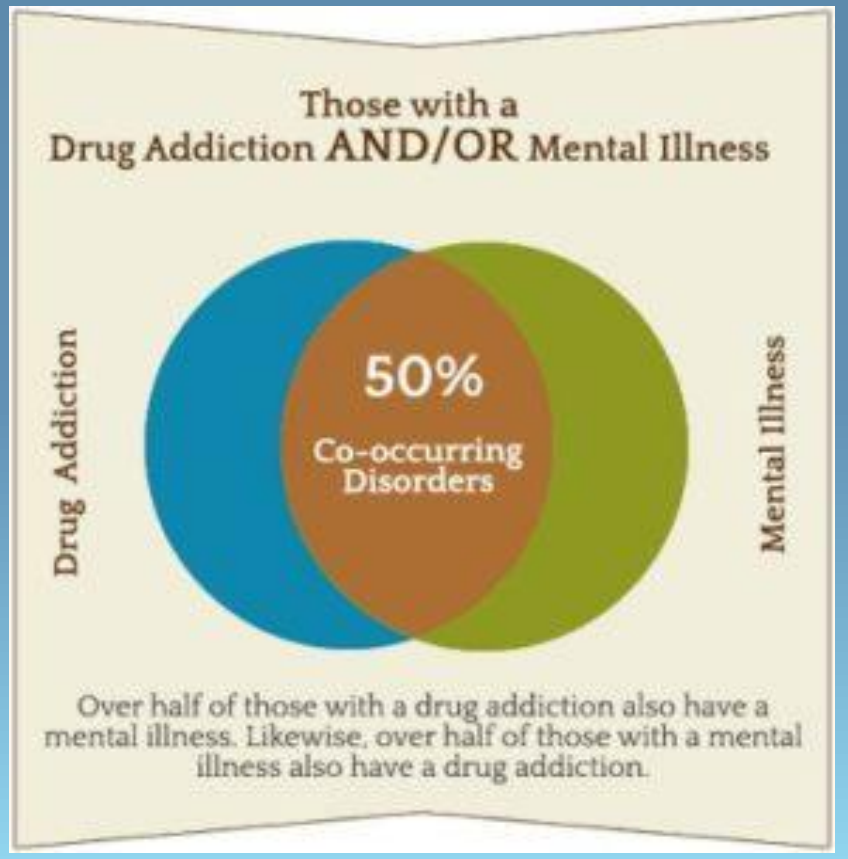
- 20 item self-report questionnaire, 1 per symptom
- Rates how much a person has been bothered by a symptom in the past month
- Scored 0-4
- Takes 10 minutes

PTSD Assessment: The PCL 5

- Self-report measures are vulnerable to both minimization and inflation
- Suggested cutoff is 33
- It should *not* be used to make a diagnosis
  - Only a clinician can make a diagnosis
  - Both score information and clinical interview are needed to make a diagnosis
- It may be useful for initial intake as a screen
- It can be helpful to quickly measure change over time

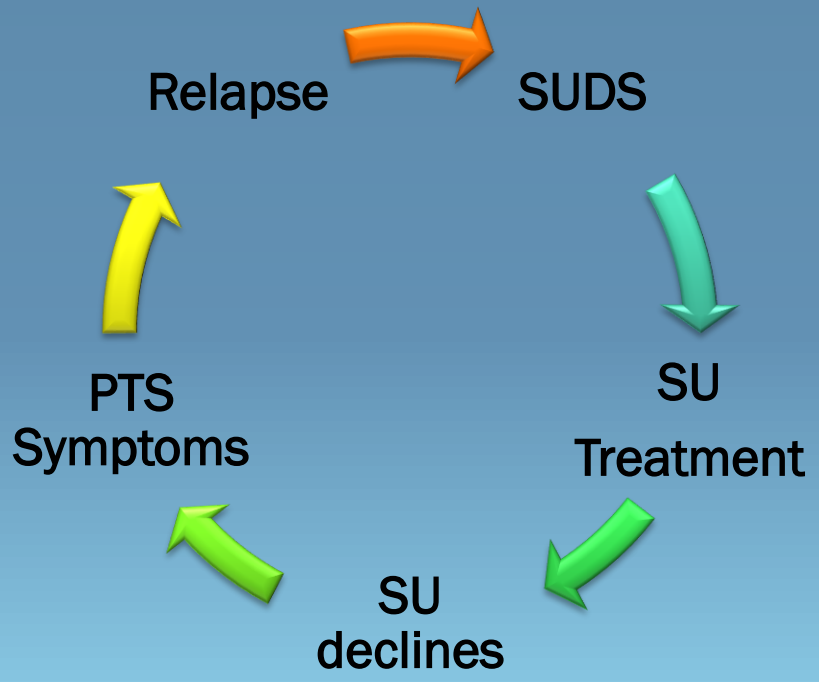
Co-Occurring PTSD and SUDs Make Each Other Worse

- Addiction exacerbates PTSD symptoms, including sleep disturbance, nightmares, rage, depression, avoidance, numbing of feelings, social isolation, irritability, hypervigilance, paranoia, and suicidal ideation
- People who drink or use drugs are at risk for being retraumatized through accidents, injuries, and sexual trauma

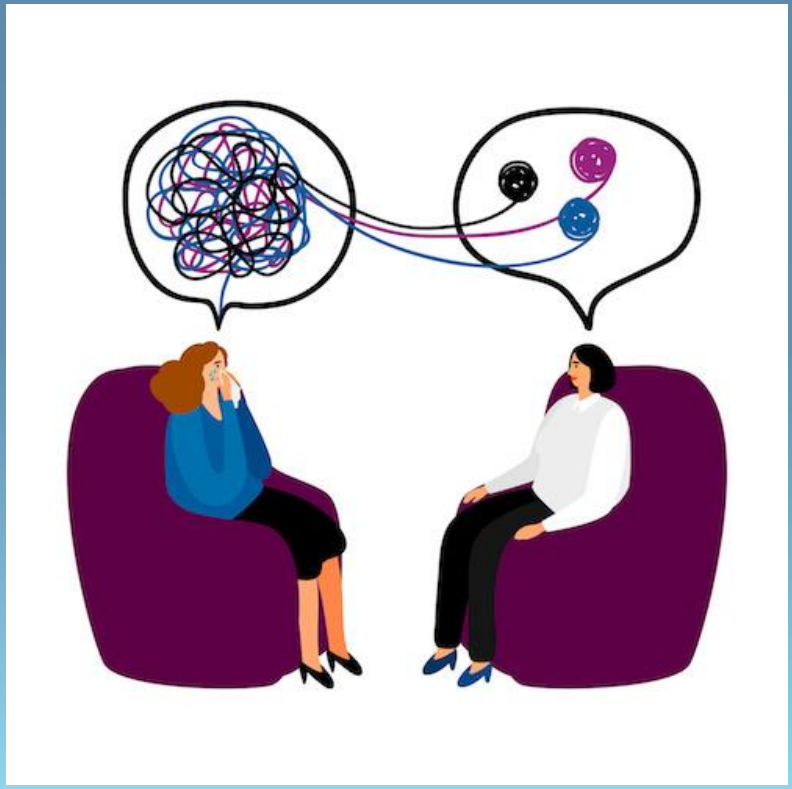


Addiction Treatment Often Does Not Work When There Is Trauma

- Substances are often used to deal with the effects of trauma
- If the addiction is treated successfully, then substance use declines
  - But when the substances are not ameliorating or blocking the effects of trauma, the person is flooded by post-traumatic stress symptoms
  - This may lead to relapse
- Integrated SUDS-PTSD treatment is necessary
  - Only *Seeking Safety* has been shown to work



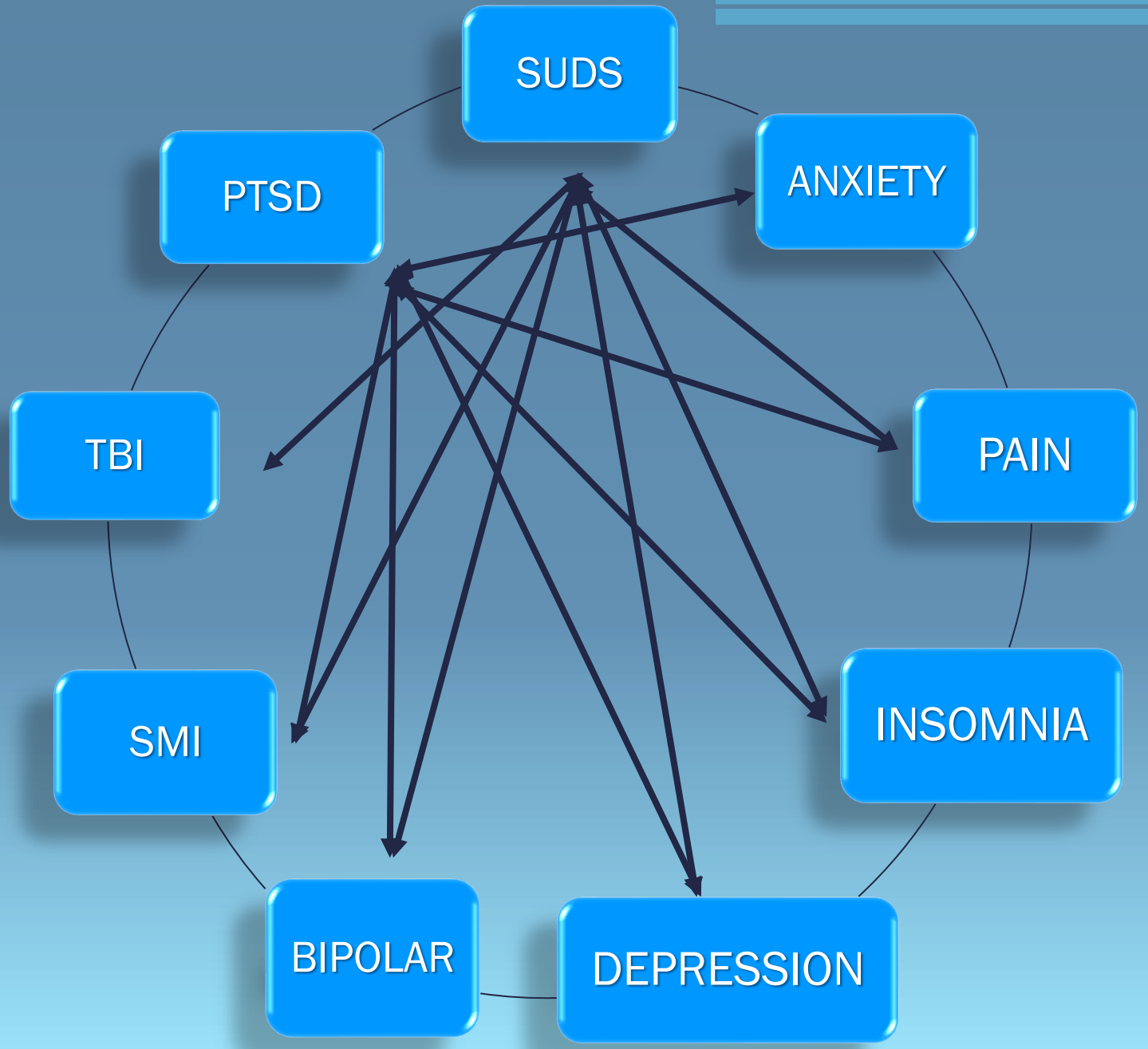
Trauma-Informed Treatment ≠ Trauma-Specific Treatment



- Trauma-informed treatment means that there is awareness of a history of trauma when treating addiction
  - *Beyond Trauma: A Healing Journey for Women* by Stephanie Covington
- Trauma-focused means that traumas are directly treated
  - *Seeking Safety* by Lisa Najavits
  - Trauma-focused treatment is better
- Evidence-based, trauma focused treatment is best

Why Should We Treat Co-Occurring Disorders Integratively?

- Integrated treatment results in better attendance and retention (Amaro et al., 2007; Boden et al., 2011)
- Integrated treatment leads to better outcomes (Najavits, 2006)


SUDS
ANXIETY
PAIN
INSOMNIA
DEPRESSION
BIPOLAR
SMI
TBI
PTSD

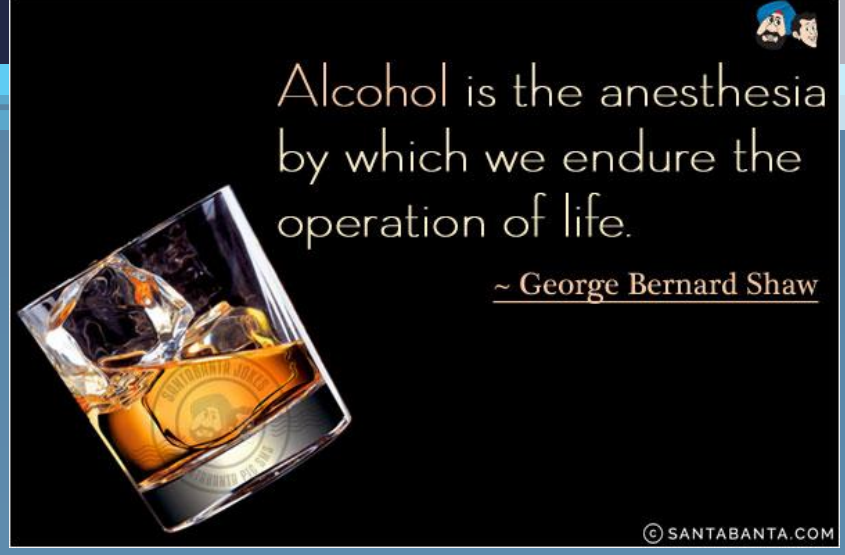
Mistake #9

Not assessing for pain and referring for pain treatment

Chronic Pain and Addiction

- Pain is often used as a justification for substance misuse (Jarcho et al., 2012; Joy et al., 1999)
- Patients in addiction treatment show higher levels of pain than the general population (Sheu et al., 2008; Mertens et al., 2003)
- Patients in pain treatment have higher levels of substance misuse than the general population (Atkinson et al, 1991)
- Among methadone maintenance patients, 61-80% have moderate to severe pain (Barry et al., 2009; Jamison, 2000; Rosenblum et al., 2003)

Alcohol and Pain

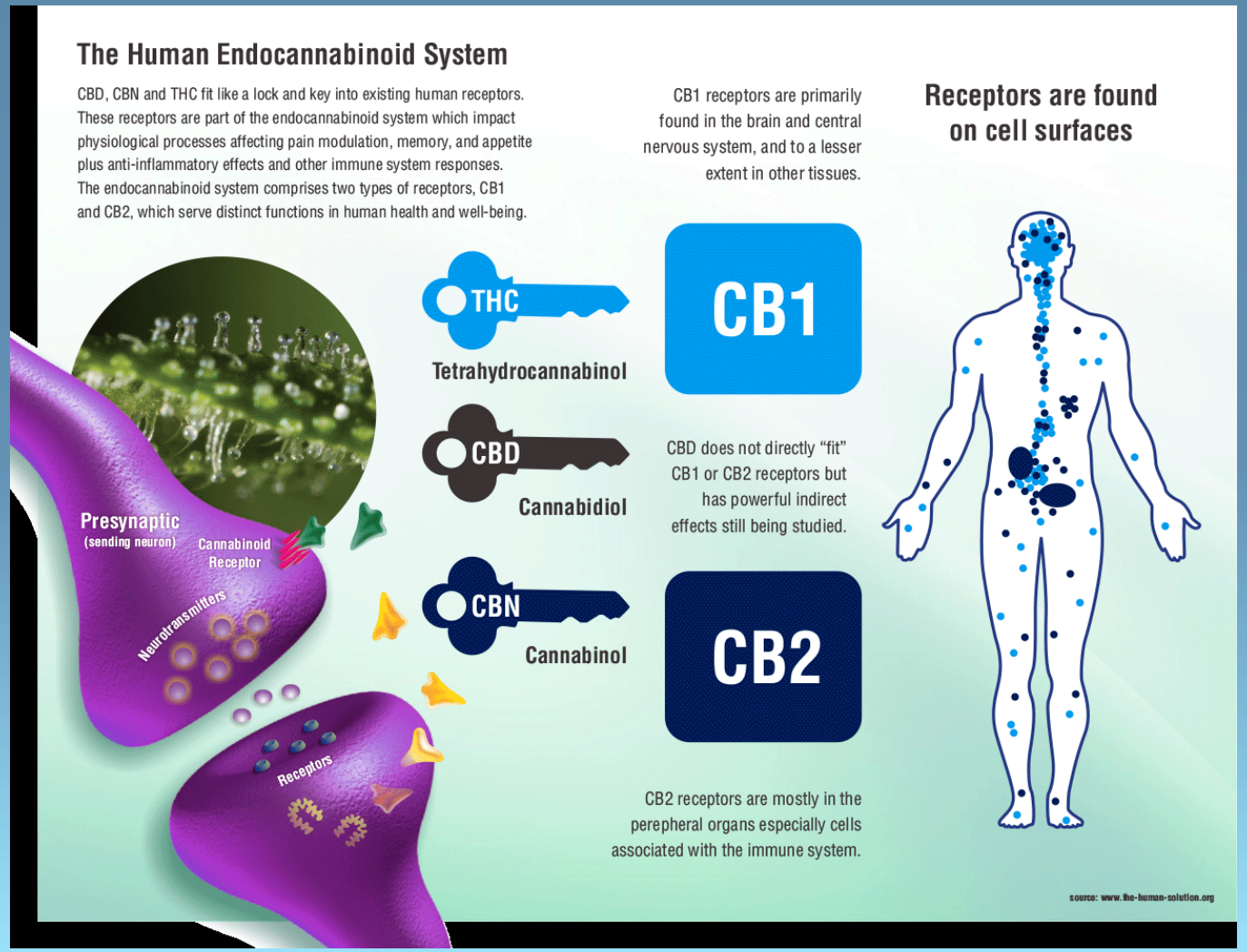


- 73% of patients seeking addiction treatment who identify alcohol as their drug of choice report moderate to severe pain (Larson et al., 2007)
- 43% of older problem drinkers report moderate to severe pain in the past month, compared to 30% of non-problem drinkers (Brennan et al., 2005)
- 25% of treatment-seeking pain patients report heavy drinking (Kim et al., 2013; Lawton & Simpson, 2009)
- Men endorse drinking to cope with pain (Brennan et al., 2005: Riley et al., 2002)
- Excessive drinking predicts chronic pain severity (Castillo et al., 2006)

Chronic Pain and Opioid Addiction

- From 1999-2011, consumption of hydrocodone more that doubled and consumption of oxycodone increased nearly 500% (Jones et al., 2014)
- By 2010, enough opioid pain relievers were sold to medicate every adult in the US with the equivalent of 5 mg. of Hydrocodone every 4 hours for a month
- 4/5 of current heroin users report that their addiction began with opioid pain relievers (Muhuri et al, 2013)

Chronic Pain and Cannabis



- The endocannabinoid system modulates pain in the body (Guindon & Hohman, 2009)
- Therefore, cannabis use may decrease pain
- That is because CBD decreases pain
  - THC has no analgesic effects

What Can Treatment Programs Do?

- Assess pain during clinical intakes
  - Type, location, intensity, frequency, chronicity, functional impact
- Refer to non-drug pain treatment
  - **Medical options** (surgery, TENS units, blocking or burning nerves, etc.)
  - **Topical medications** (Lidocaine, analgesic creams, Capsaicin, etc.)
  - **Physical therapies** (PT, OT, hydrotherapy, heat, cold, massage, etc.)
  - **Integrative health approaches** (acupuncture, yoga, Mindfulness Meditation, etc.)
  - **Psychological therapies** (CBT for Pain, Mindfulness-Based Stress Reduction, etc.)

Mistake #10

Not paying attention to insomnia

Addiction and Insomnia

- Substance misuse can create sleep disorders
  - Every stimulant misuse worsens insomnia: cocaine, caffeine, nicotine, ADHD medications, etc.
  - 28% of people with insomnia use alcohol to sleep
    - Drinking results in waking up 2½ - 3 hours later to urinate
    - Alcohol disrupts the sequence and duration of sleep states
    - Alcohol consumed within 1-6 hours of bedtime disrupts the 2nd half of sleep (NIH, 1998)
    - Drinking results in a decrease in total sleep time

Substance Misuse and Insomnia

- Opioids cause both sedation and wakefulness (De Andres & Caballero, 1989)
  - Veterans with chronic pain who were prescribed opioids are more likely to report sleep disruption than those who did not take opioids (Morasco et al., 2014)
  - Heroin causes alternation between oversleeping due to sedation and severe sleeplessness
    - It also results in poor sleep quality
- Marijuana decreases slow wave sleep and REM sleep
  - It also decreases sleep quality

High Co-Morbidity of Insomnia

- Insomnia is one of 20 characteristics of PTSD
  - It frequently continues even after PTSD is successfully treated
- Insomnia has a bidirectional relationship with depression
  - 85% of depressed people have insomnia
- Pain is the #1 medical cause of insomnia
  - Of those with chronic pain, 65% have insomnia
  - People with insomnia have higher pain sensitivity (Sivertsen et al., 2015)

What Can Clinicians Do?

- Assess insomnia during clinical intakes
  - Type, onset, duration, functional impact
    - Use the Insomnia Severity Index (ISI) (Bastien et al., 2001)
  - Check for sleep apnea
    - Many people with PTSD also have sleep apnea
    - Many people with chronic pain who take opioids also have sleep apnea
- Refer to insomnia treatment
  - Avoid sedative and hypnotic medications, as they are addictive
  - Use non-addictive medications like Trazodone and Remeron
  - Refer to Cognitive Behavioral Therapy for Insomnia

CBT-I for Insomnia

- Cognitive-Behavioral Therapy for Insomnia (Perlis et al., 2008)
  - 6 session treatment
  - Psychoeducation about sleep and what interferes with it
  - Sleep restriction
  - Stress management
  - Cognitive restructuring
  - Relapse prevention

Resources

Assessments

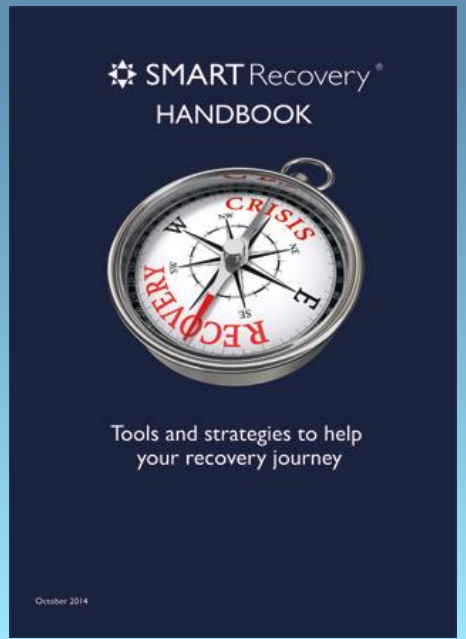
- The URICA is available at http://www.umbc.edu/psyc/habits/content/ttm_measures/index.html
- The Session Rating Scale is available at https://scottdmiller.com/wp-content/uploads/documents/SessionRatingScale-JBTv3n1.pdf
- The Working Alliance Inventory is available at http://wai.profhorvath.com/sites/default/files/upload/WAI-SR%20Client%20Version.pdf
- The Insomnia Severity Index is available at https://www.ons.org/sites/default/files/InsomniaSeverityIndex_ISI.pdf
- The Life Events Checklist 5 and PTSD Checklist are available at https://www.ptsd.va.gov/professional/assessment/documents/PCL-5_LEC_criterionA.pdf

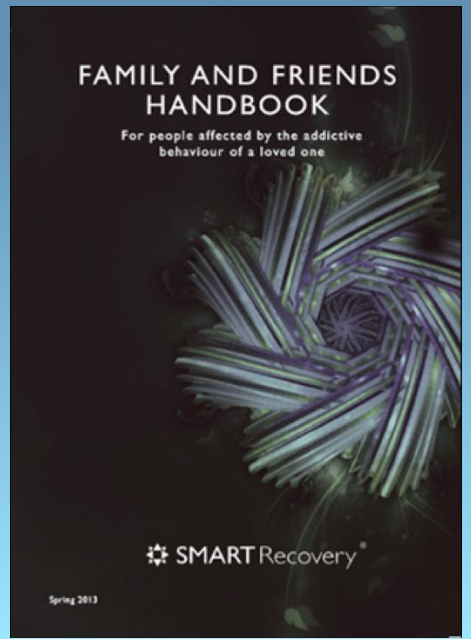
Motivational Interviewing

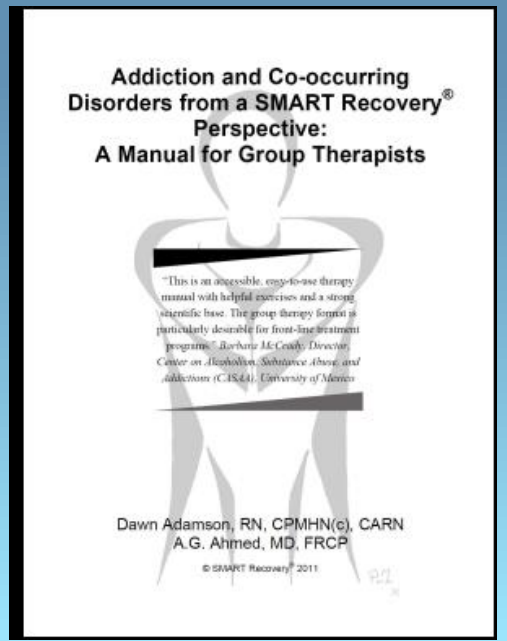
- Motivational Interviewing, 3rd ed. (2012), William Miller and Sam Rollnick
- Motivational Interviewing in the Treatment of Psychological Problems (2007), Hal Arkowitz and Henny Westra, eds.
- Finding Your Way to Change (2015), Allan Zuckoff and Bonnie Gorscak
- The URICA is available at http://www.umbc.edu/psyc/habits/content/ttm_measures/index.html
- http://www.motivationalinterviewing.org/
- http://www.motivationalinterviewing.org/sites/default/files/MATCH.pdf
- http://mid-attc.org/accessed/mi.htm

SMART Recovery

- www.smartrecovery.org
- http://smartrecoverytraining.org/moodle/
- http://www.smartrecovery.org/community/#.Vims8GtRI2Y

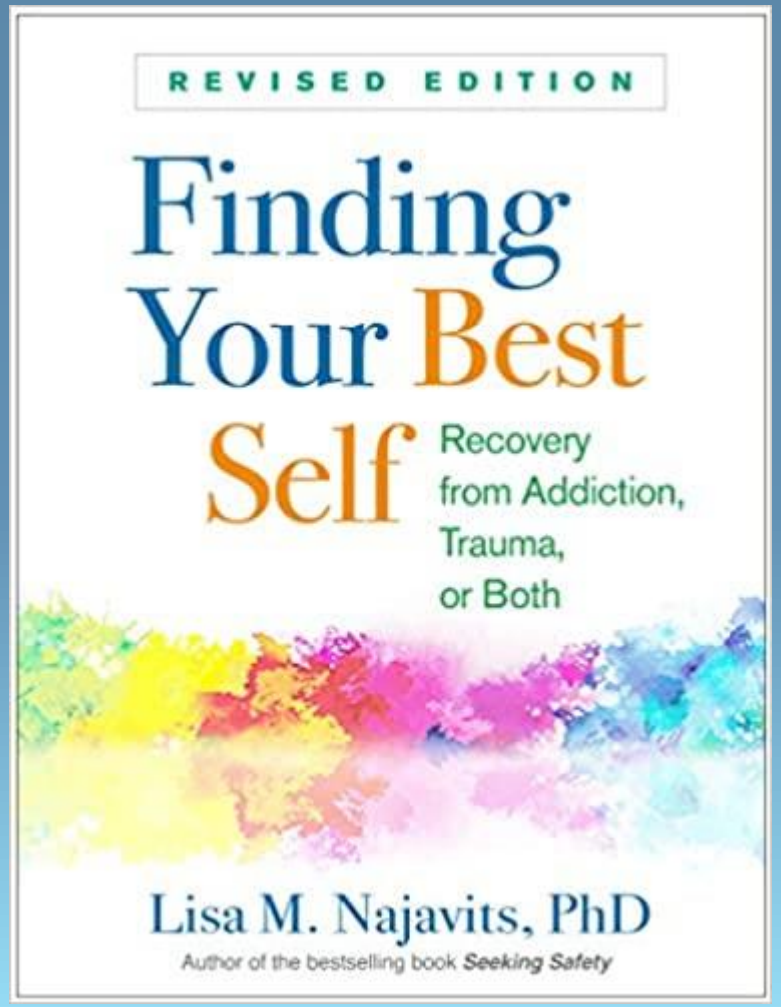






SMART Recovery App

Seeking Safety



- *Seeking Safety* (2002), Lisa Najavits
- *Finding Your Best Self* (2019), Lisa Najavits
- http://www.treatment-innovations.org/seeking-safety.html

Cognitive-Behavioral Therapy for Pain

- *Managing Chronic Pain: A Cognitive-Behavioral Therapy Approach Therapist Guide* by John Otis
- *Managing Chronic Pain: A Cognitive-Behavioral Therapy Approach Workbook* by John Otis

Cognitive-Behavioral Therapy for Insomnia

- *Cognitive Behavioral Treatment of Insomnia: A Session-by-Session Guide* (2008), by Michael L. Perlis, Carla Jungquist, Michael Smith, and Donn Posner
- *Overcoming Insomnia: A Cognitive-Behavioral Therapy Approach Workbook* (2008), by Jack Edinger and Colleen Carney

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