Practical Difficulties and Challenges in Managing Substance Abuse

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Answer

- Keep it short
- Don’t “lecture” any more (“enough is enough”)
- Rather, listen to *them*!
- Make them feel that you are sincere in whatever you say or do
- Make them feel involved and participating
- Keep the door open (to leave or to come back)!

You won't be able to "eradicate" substance use and abuse from this world!!!

- Substance abuse is NOT small pox or polio
- More like malaria – control programme succeeded, but eradication failed
- Controlling substance use and abuse is even more difficult
- WHY????

The 5 “eed”s

- Breed
- Seed
- Need
- Deed
- Greed!

Many factors at Many levels

- **Macro-level** (world-country-region)
  - Substance use has ALWAYS been part of human **existence**
  - **Law** in every country permits some substance use
  - **Vested interests** at international, national and regional levels (money, mafia, politics)
  - A powerful instrument of global terrorism **('narco-terrorism')**
  - **Technology** has made it easier to manufacture, distribute and sell drugs

- **Micro-level** (society-family-individual)
  - Society has ambivalent **attitude** towards substance ("bad addict, good scotch")
  - **Stigma** makes it more difficult for seeking treatment and for recovery
  - **Genetics** of addiction proneness in some individuals
  - Individuals will seek out ***something other than simply existing*** – *drugs are one of them*
  - **Stress** in drug-exposed people will push them towards heavy use → abuse → dependence

- **Nano-level** (tissue-cell-molecule)
  - Substances, when used repeatedly, **alters the brain**, often for a very long time!
  - At the neuronal network level:
    - Hijacks the natural reward system of the brain
    - Creates long-term imprints, or memories
    - Alters learning profoundly
  - At the neuronal level:
    - Alters synaptic architecture, dendrite density
  - At the sub-cellular level:
    - Alters epigenetic expression of key proteins

“So what the hell are we doing here?”

- Substance USE is not a disorder….
- But substance use DISORDER is!
  - Harmful use, dependence syndrome
- These are psychiatric disorders
- Hence who else will treat, other than us and related health professionals?
- Even if you help ONE person, you have helped many!
  - How?

So what are supposed to do???

- Detect
- Engage and Motivate
- Detoxify
- Diagnose and treat comorbid conditions
  - Physical
  - Mental
- Retain
- Prevent Relapse
- Help them in Recovery

Case vignette 1

- 45-year male, businessman, joint family, Higher SES. Referred from GE, admitted with h/o pain abdomen, nausea, mild fever since last two weeks.
- Irritable, decreased sleep, hand tremors x 2 days after admission.
- “Have come for a health check up, no alcohol problems. What is a psychiatrist doing here?”
- ???

Case vignette 2

- 45-year male, businessman, joint family, Higher SES. Seen in Psychiatry OPD, c/o sadness of mood following loss in business
- Irritable, decreased sleep, looks dishevelled, faintly smells of alcohol
- “Just having a few drinks of late, to help my nerves”

Detection

- In non-psychiatric setting
  - Consultation liaison
    - Medical setting
    - Surgical and ICU setting
- In psychiatric setting
  - Depression
  - Anxiety
  - Psychosis
  - Difficult adjustment or behaviour

DETECTION
Challenges and (Potential) Solutions

Challenges

- Simple forgetfulness
- Active Denial
- Competing interests of medical/surgical care

Solutions

- Remember: it's YOUR job to detect, not theirs to declare! (unlike passing through Customs!)
- Ask!
- Listen!
- May use simple scales like CAGE
- More detailed interview

Case Vignette 3

- 40-year female, insurance agent, started having anxiety while anticipating dealing with clients. Advised tablet alprazolam 0.25 mg BD. Gradually escalated, till reached 8-10 tablets per day. Would feel totally incapable of meeting clients and even going out unless she took 2-3 tablets before that. Started having tremors in the morning and severe anxiety as and when effect of the drug would wear off. Had to stop working.
- She has come to see you “just to get rid of my anxiety, without touching the medication, which actually helps me.”
- ???

ENGAGEMENT AND MOTIVATION
Challenges and (Potential) Solutions

Challenges

- Lack of importance
- Active Denial
- Competing interest with the perceived “positive” aspects of the substances used

Solutions

- Remember: Motivation is as much YOUR problem as your patient’s!!!
- Use the principles of Motivational Interviewing and Motivation Enhancement Therapy

The Spirit of Motivational Interviewing

- There is an overall spirit or guiding set of perspectives that underlie Motivational Interviewing (MI)
- "Motivational Interviewing is a directive, client-centred brief intervention to elicit behaviour change by helping clients explore and resolve **ambivalence**."

Miller & Rollnick, 2002

DARES

- Not just a set of techniques or skills that one does to someone.
- Way of being with people based on belief that people have the capacity to change in a collaborative effort that supports their autonomy and evokes change.
- Some fundamental principles / techniques that highlight this way of being.

Develop Discrepancy
Amplify Ambivalence
Roll With Resistance
Express Empathy
Support Self-Efficacy

SUPPORT SELF -EFFICACY

- Belief in the possibility of change is an important motivator
- The client is responsible for choosing and carrying out personal change
- There is hope in the range of alternative approaches available

Interview Techniques – **OARS-C**

- Open-ended questions
- Reflective listening
- Affirmation
- Summarization
- Elicit self-motivational / CHANGE statements

Case vignette 4

- 25-year male, graduate, unemployed, referred from ART Clinic with HIV infection. Used to inject ‘white’ heroin up to 1 g/day. Admitted for detoxification for the 3rd time (earlier 2 attempts had failed). Started on clonidine 0.1 mg TDS, analgesic, sedative-hypnotic and anti-diarheal.
- On 3rd day of admission, became very agitated, demanded more medicine or immediate discharge. Threatened staff that he would hurt others and break window glass pane to escape.
- ???

DETOXIFICATION
Challenges and (Potential) Solutions

Challenges

- Powerful craving
- Aggressive combative behaviour, problems with staff
- Competing interest with medical/surgical complications arising during detox

Solutions

- Remember: You can hardly over-medicate a patient in acute withdrawal!
  - Mostly, we under-medicate instead
- Most of the problems can be resolved by proper medication within safe limits
- Use buprenorphine for opioid detoxification in challenging cases

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Case vignette 1 continued…

- The 45-year old businessman was diagnosed to have alcohol dependence and transferred to de-addiction ward. He was detoxified with chlordiazepoxide, but he continued to complain of pain abdomen even after detox was complete.
- Considered by staff as ‘protracted withdrawal’ which would take weeks to subside and was reassured.
- Patient demanded discharge.
- ???

PHYSICAL COMORBIDITY
Challenges and (Potential) Solutions

Challenges

- Tendency to explain ALL physical symptoms as Withdrawal (and hence dismiss without further attention)
- Competing interest with our preoccupation with detoxification

Solutions

- Remember: An “alcoholic” ***can ALSO*** develop acute tonsillitis, piles, sinusitis, and certainly tuberculosis!
- Be aware of the host of medical complications of substance use disorder
- Clinical exam A MUST
- Relevant investigations
- Liaison with specialists
- **Diabetes needs special care**

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Case vignette 2 continued….

- The 45-year old was diagnosed to have alcohol dependence and transferred to de-addiction ward. He was detoxified with chlordiazepoxide, but he continued to complain of sadness of mood and occasional suicidal ideations even after detox was complete.
- Considered by staff as ‘protracted withdrawal’ which would take weeks to subside and was reassured.
- Patient demanded discharge.
- ???

MENTAL COMORBIDITY
Challenges and (Potential) Solutions

Challenges

- Tendency to explain ALL mental symptoms as Withdrawal (and hence dismiss without further attention)
- **Actual difficulty in diagnosing psychiatric comorbidity in patients actively using substances or in withdrawal**
- Competing interest with our preoccupation with detoxification

Solutions

- Remember: An “alcoholic” ***can ALSO*** develop phobia, OCD, psychosis and certainly depression!
- Be aware of the host of psychiatric complications of substance use disorder
- Mental State exam A MUST – often to be repeated if needed
- Manage according to diagnosis – seek specialist help from addiction specialists if needed

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Case vignette 3 continued….

- The 40-year old woman eventually understood she had developed benzodizepine dependence and was treated with a slow gradual taper of replacement diazepam over 6 weeks.
- During this time it also became apparent that she had significant problems at work and in her family.
- However, she felt that her treatment was complete and dropped out of follow up.
- ???

RETENTION IN TREATMENT
Challenges and (Potential) Solutions

Challenges

- Once detoxified and stabilized, many patients feel their treatment is over
- Chronic craving and relapse tendency
- Personality issues
- Unstable work and relationship make it difficult to attend clinic regularly
- Competing interest with our preoccupation with “what is right for them”

Solutions

- Remember: unless we can retain a patient in follow-up, we **cannot move on** to the next stages
- Listen to patient’s concerns
- Hold **family meetings** (if feasible) to sort out practical problems (work, relationship, critical comments, lifestyle, etc)
- In selected opioid dependent patients, OST provides **the BEST RETENTION**

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Case vignette 4 continued….

- The 25-year old heroin dependent male was finally detoxified successfully with sublingual buprenorphine 8 mg/day. It was tapered after detox over 3 weeks and patient was discharged in healthy asymptomatic state.
- However, he again relapsed (3rd time) within 2 months once he found an empty syringe lying nearby.
- Family was fed up and threatened to disown him. He came back to you but was not sure if you could do anything better this time.
- You felt……
- You said “I can’t treat you if you don’t have will power”
- ???

RETENTION IN TREATMENT
Challenges and (Potential) Solutions

Challenges

- The **MOST CHALLENGING** (AND FRUSTRATING!) part of de-addiction management!
- Repeated relapses break the morale and confidence of both the patient AND the doctor!
- Can evoke negative attitudes and reactions from the family and society
- This can generate a vicious cycle of mistrust, isolation and further relapse!
- Competing interest with our preoccupation with “will power”

Solutions

- Remember: Most of the factors that retain the patient in treatment will also help relapse prevention
- **Relapse Prevention Counseling** (RPC) A MUST in every detoxified patient
- Hold family meetings (if feasible) to sort out practical problems (work, relationship, critical comments, lifestyle, etc)
- In selected opioid dependent patients, **OST** provides the **BEST RELAPSE PREVENTION**

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“Relapse—not dependence—must be seen as the addict's most dangerous enemy.” (George Vaillant, 1988)

- Relapse is an integral, defining feature of substance use disorders, hence no addiction treatment package should be complete without addressing and tackling the issue of relapse.
- Pharmacological
- Non-pharmacological

Pharmacological

- Alcohol
  - Disulfiram
  - Naltrexone
  - Acamprosate
  - Topiramate
  - Baclofen
- Opioids
  - Antagonists: naltrexone
  - Agonists: methadone, buprenorphine

Non-pharmacological

- Behavioral: Aversion therapy (no longer used); covert sensitization; Cue extinction; Contingency Management
- Cognitive Behavioral Approaches, including "**Relapse Prevention**"
- Lifestyle changes and life support approaches, including 12-step facilitation and recovery training
- Others, including mindfulness-based relapse prevention

RELAPSE PREVENTION

EDITED BY
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SECOND EDITION

RELAPSE PREVENTION

MAINTENANCE STRATEGIES IN THE TREATMENT OF ADDICTIVE BEHAVIORS

edited by
G. Alan Marlatt and Dennis M. Donovan

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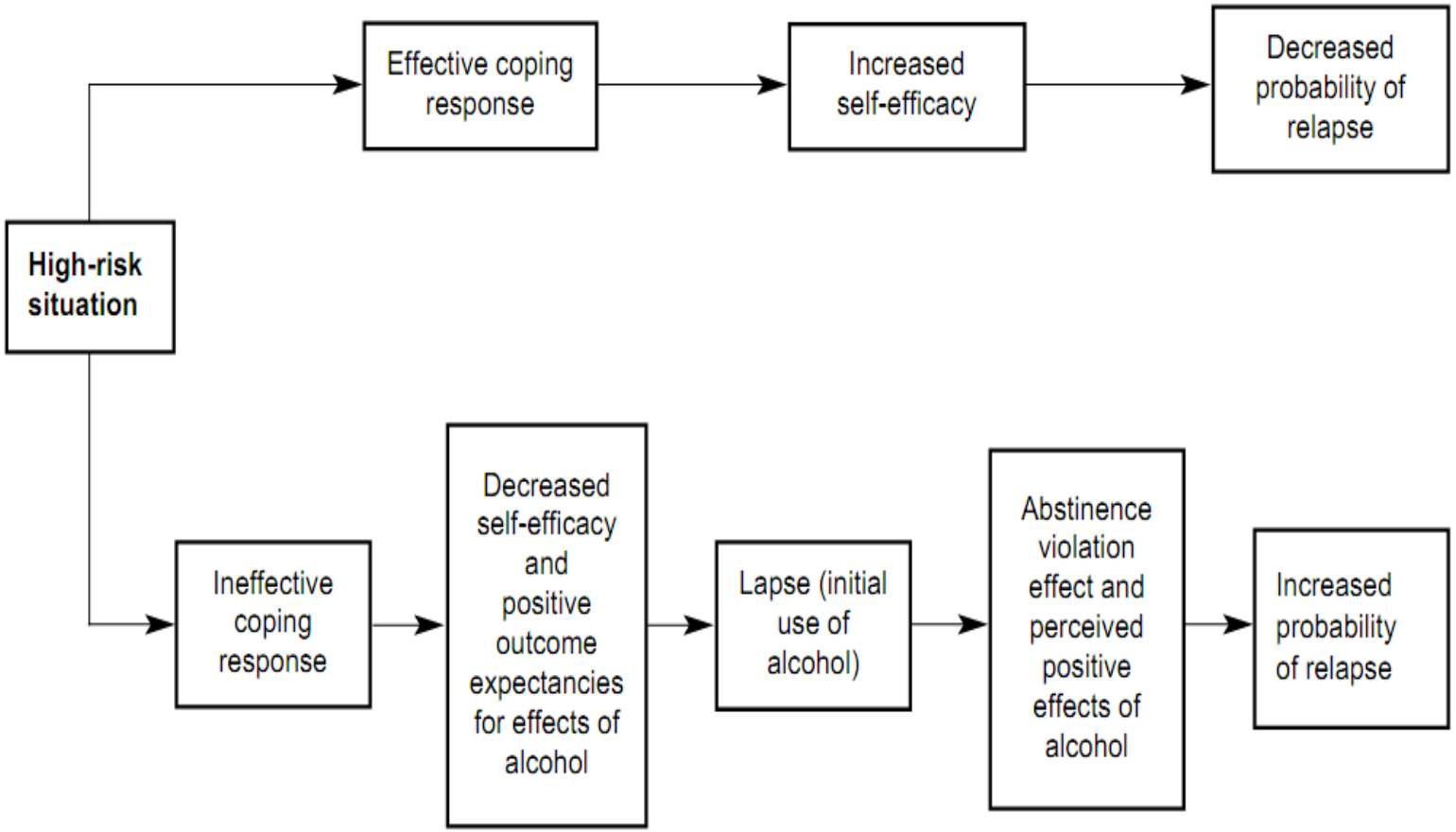
High-risk situation
Effective coping response
Increased self-efficacy
Decreased probability of relapse
Ineffective coping response
Decreased self-efficacy and positive outcome expectancies for effects of alcohol
Lapse (initial use of alcohol)
Abstinence violation effect and perceived positive effects of alcohol
Increased probability of relapse

Basic techniques of Relapse Prevention

- Identifying high-risk situations
  - External
  - Internal
- Stimulus control
- Urge control
- Coping skills
- Lapse management
- Behavioral tasks
- Cognitive restructuring

Case 4 continued….

- With adequate OST with buprenorphine 4 mg/d and psychosocial counseling for relapse prevention, the patient maintained relapse free from heroin for the next 3 years.
- However, he did only odd jobs, was not much close with his family, lost his previous drug-taking group but unable to find a new company. Kept on trying some new drugs, including one named “meow-meow”.
- He still could not identify himself as a member of the traditional society and felt he didn’t belong to it.
- ???

RECOVERY IN ADDICTION
Challenges and (Potential) Solutions

Challenges

- The most protracted process
- Multiple barriers:
  - Social (stigma → lack of social inclusion)
  - Occupational ("I won't employ even a former addict")
  - Self identity ("once an addict, always an addict")
- Competing interest with our preoccupation with "abstinence only" and "medical only" approach

Solutions

- Remember: It's recovery in addiction (a JOURNEY), not recovery from addiction (an endpoint)
- Can be a long, even unending process
- Focus on social, occupational, familial, and especially identity-related issues
- De-focus substance use, but provide help if and when a relapse occurs

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Finally, a word about meow-meow

Substances, and Substance Abuse, are like HYDRA!

- The mythological 9-headed monster
- The moment you cut one head, another two grow in its place!
- Try to stop a drug somewhere
  - It goes elsewhere (“ballooning”)
  - New drugs take its place, often more potent, and often beyond the clutches of the existing law!

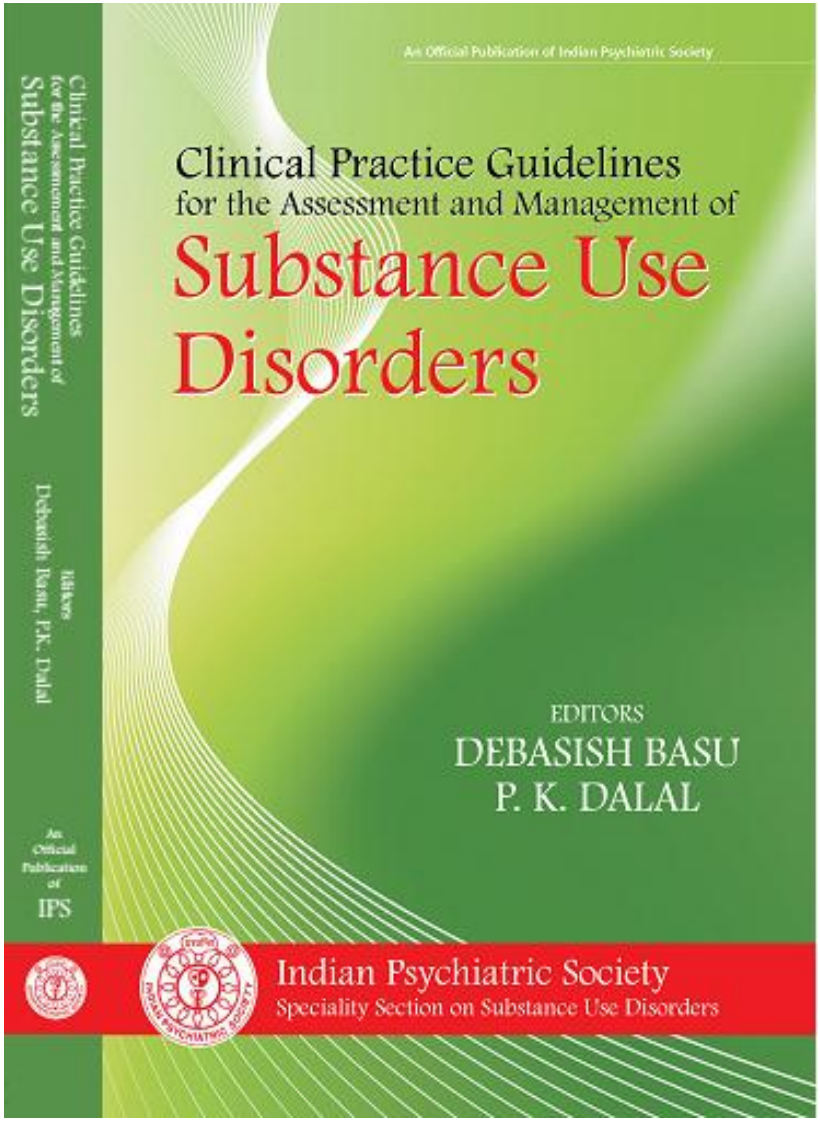
151 Kilos of Meow Meow Seized in Mumbai

New Psychoactive Substances (NPS)

- Synthetic cathinones (mephedrone, also known as M-CAT or “meow meow”)
- Synthetic cannabinoids (“Spice”, K2)
- Ketamine
- And many others…….
- ….It’s a never-ending battle…….

What WE need:
WATCH, WATCH, WATCH!

- Watch the **world** – for new drugs emerging
- Watch the **patients** – detect, engage, motivate…..
- Watch the **families** - utilize their assets, minimize their liabilities
- Watch the **science** – keep abreast of latest advancements and evidence-based clinical practice guidelines



What WE need:
WATCH, WATCH, WATCH!

- And, last but the MOST IMPORTANT perhaps….
- …..Watch ***YOURSELF!!!***
  - Your own reactions
  - Increase your frustration tolerance
  - Decrease your unrealistic expectations
  - Try your best, but also learn to let it go

The Serenity Prayer

- God, grant me….
- The ***calmness*** to accept the things I <u>cannot</u> change
- The ***courage*** to change the things I <u>can</u>
- And the ***wisdom*** to know the <u>difference</u>

Practical Difficulties and Challenges in Managing A tired, hackneyed, bombarded audience desperately looking for the next fix (a ‘substantive’ dinner)

Debasish Basu
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Answer

- Keep it short
- Don’t “lecture” any more (“enough is enough”)
- Rather, listen to *them*!
- Make them feel that you care
- Make them feel involved and participating
- Keep the door open (to leave or to come back)!

CHEER
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