Module 3: Training goals

1. Increase knowledge of the extent and nature of co-occurring psychiatric and substance use disorders and their treatment methods

2. Increase knowledge of the critical aspects of women’s addiction and treatment

3. Increase knowledge of the critical aspects of young peoples’ addiction and treatment
Module 1: Workshops

Workshop 1:
Individuals with co-occurring psychiatric and substance use disorders: Identification and treatment issues

Workshop 2:
Women: Addiction and treatment issues

Workshop 3:
Young people: Addiction and treatment issues
Workshop 1: Individuals with Co-occurring Psychiatric and Substance Use Disorders: Identification and Treatment Issues
Who are the people most affected by drug use in your country / region? How does their drug use affect your community?
At the end of this training you will:

- Understand how psychiatric and substance use disorders interact
- Understand the key issues in identifying and diagnosing these interacting disorders
- Understand the importance of and the methods for integrating treatment for individuals who have co-occurring disorders
- Know about promising practices for treating individuals with these disorders
What’s the problem?

- Estimates of psychiatric co-morbidity among clinical populations in substance abuse treatment settings range from 20% - 80%
- Estimates of substance use co-morbidity among clinical populations in mental health treatment settings range from 10% - 35%

Differences in incidence due to: nature of population served (e.g., homeless vs. middle class), sophistication of psychiatric diagnostic methods used (psychiatrist or DSM checklist) and severity of diagnoses included (major depression vs. dysthymia).
<table>
<thead>
<tr>
<th>Mental Disorders</th>
<th>Addiction Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depression</td>
<td>Alcohol Abuse / Dependency</td>
</tr>
<tr>
<td>Antisocial Personality</td>
<td>Cocaine/ Amphetamines</td>
</tr>
<tr>
<td>Borderline Personality</td>
<td>Opiates</td>
</tr>
<tr>
<td>Bipolar Illness</td>
<td>Volatile Chemicals</td>
</tr>
<tr>
<td>Schizoaffective</td>
<td>Marijuana</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Polysubstance combinations</td>
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<tr>
<td>Posttraumatic Stress</td>
<td>Prescription drugs</td>
</tr>
<tr>
<td>Social Phobia</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
</tr>
</tbody>
</table>
Drug-induced psychopathology

**Drug States**
- Withdrawal
  - Acute
  - Protracted
- Intoxication
- Chronic use

**Symptom Groups**
- Depression
- Anxiety
- Psychosis
- Mania

(Source: Rounsaville, 1990)
The four quadrant framework for co-occurring disorders

A four-quadrant conceptual framework to guide systems integration and resource allocation in treating individuals with co-occurring disorders.
DSM and ICD: The “Bibles”

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
FOURTH EDITION
TEXT REVISION
DSM-IV-TR™

AMERICAN PSYCHIATRIC ASSOCIATION

ICD-10
The ICD-10
Classification of Mental and
Behavioural Disorders
Clinical descriptions and diagnostic
guidelines

World Health Organization
Geneva
1992
### DSM-III diagnoses
(rates per 100 people)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>1 Month</th>
<th>Lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Alcohol, Drug or Mental Health Disorder</td>
<td>15.7</td>
<td>32.7</td>
</tr>
<tr>
<td>Any Mental Disorder</td>
<td>13.0</td>
<td>22.5</td>
</tr>
<tr>
<td>Alcohol Dependence</td>
<td>1.7</td>
<td>7.9</td>
</tr>
<tr>
<td>Drug Dependence</td>
<td>0.8</td>
<td>3.5</td>
</tr>
</tbody>
</table>

(Source: Regier et al., 1990)
### Lifetime prevalence and odds ratios

<table>
<thead>
<tr>
<th>Condition</th>
<th>Alcohol</th>
<th>OR</th>
<th>Other Drug</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any mental</td>
<td>36.6%</td>
<td>2.3</td>
<td>53.1%</td>
<td>4.5</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>3.8%</td>
<td>3.3</td>
<td>6.8%</td>
<td>6.2</td>
</tr>
<tr>
<td>Any affective</td>
<td>13.4%</td>
<td>1.9</td>
<td>26.4%</td>
<td>4.7</td>
</tr>
<tr>
<td>Anti-social</td>
<td>14.3%</td>
<td>21.0</td>
<td>17.8%</td>
<td>13.4</td>
</tr>
<tr>
<td>Alcohol</td>
<td>47.3%</td>
<td>7.1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regier, 1990
## Likelihood of a suicide attempt

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Increased Odds of Attempting Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine use</td>
<td>62 times more likely</td>
</tr>
<tr>
<td>Major depression</td>
<td>41 times more likely</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>8 times more likely</td>
</tr>
<tr>
<td>Separation or divorce</td>
<td>11 times more likely</td>
</tr>
</tbody>
</table>

(Source: NIMH / NIDA ECA Evaluation)
Suicide: Certain populations are at higher risk

Suicide rates among those with ADDICTION are 5-10 times higher than for those without addiction.

Is suicide a mental health or co-occurring disorder issue?

- Alcohol strongest predictor of completed suicide over 5-10 years after attempt, OR = 5.18 (Beck, 1989)

- 40% - 60% of completed suicides across USA/Europe are alcohol / drug affected (Editorial: Dying for a Drink: Brit. Med. J., 2001)

Suicide in alcoholic populations

- 4.5% of alcoholics attempted suicide within 5 years of detoxification
  - (Mean age 40, N = 1,237)

- 0.8% in non-alcoholic comparison group
  - (Mean age 42, N = 2,000)...

- P < .001............7X increased risk

What do substance abuse treatment centers need to do?

- Acknowledge that about half of their patients have been or are suicidal.
- Be aware that these patients are at just as high a risk for suicide than most “mental health” (MH) patients.
- Educate staff on recognising suicidal risk and have clear procedures for intervening.
- Deliver assessment and emergency treatment on site, or have close working relationship with MH agency and emergency service.
- Know that individuals with suicidal risk can be managed in substance abuse treatment. Much of the suicidal ideation and connected feelings will remit as withdrawal symptoms reduce in early treatment.
- Continue monitoring for suicidal risk throughout treatment, knowing that individuals who continue to use drugs while receiving services (e.g., those in harm minimisation services) are at high ongoing risk of suicide.
98% reported exposure to at least one traumatic event in their lifetime

43% of sample received a current diagnosis of Post Traumatic Stress Disorder (PTSD), but only 2% had PTSD diagnosis in their charts.

Sexual abuse in childhood is related to PTSD for both men and women.

Sexual abuse in childhood may increase vulnerability to trauma in adulthood.
Substance abuse and trauma

- 60% to 90% of a treatment-seeking sample of substance abusers also had a history of victimization.
- More than 80% of women seeking treatment for a substance use disorder reported experiencing physical / sexual abuse during their lifetime.
- Between 44% and 56% of women seeking treatment for a substance use disorder had a lifetime history of PTSD.
10.3% of the men and 26.2% of the women with a lifetime diagnosis of alcohol dependence also had a history of PTSD.

Severely mentally ill patients who were exposed to traumatic events tended to have been multiply traumatized, with exposure to an average of 3.5 different types of trauma.
Substance abuse and trauma

- Despite the prevalence of PTSD in patients, it is rarely diagnosed: Only 3 out of 119 identified patients in one study received a chart diagnosis of PTSD

Exposure to a traumatic event in which the person:

- experienced, witnessed, or was confronted by death or serious injury to self or others
- responded with intense fear, helplessness, or horror

(Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders, 4th ed. 1994.)
Symptoms of PTSD

Symptoms:

- appear in 3 symptom clusters: re-experiencing, avoidance / numbing, hyperarousal
- last for > 1 month
- cause clinically significant distress or impairment in functioning
Persistent re-experiencing of ≥ 1 of the following:

- recurrent distressing recollections of event
- recurrent distressing dreams of event
- acting or feeling event was recurring
- psychological distress at cues resembling event
- physiological reactivity to cues resembling event
Avoidance of stimuli and numbing of general responsiveness indicated by 3 or more of the following:

- avoid thoughts, feelings, or conversations
- avoid activities, places, or people
- inability to recall part of trauma
- ↓ interest in activities
- estrangement from others
- restricted range of affect
- sense of foreshortened future
2 or more persistent symptoms of increased arousal:

- difficulty sleeping
- irritability or outbursts of anger
- difficulty concentrating
- hypervigilance
- exaggerated startle response
Guidelines for clinicians (1)

- Take the trauma into account
- Avoid triggering trauma reactions and / or re-traumatizing the individual
- Adjust the behavior of counsellors, other staff, and the organisation to support the individual’s coping capacity
- Allow survivors to manage their trauma symptoms successfully so that they are able to access, retain, and benefit from the services

(Source: Adapted from Maxine Harris, Ph.D.)
Guidelines for clinicians (2)

- Provide services designed specifically to address violence, trauma, and related symptoms and reactions

  - The intent of the activities is to increase skills and strategies that allow survivors to manage their symptoms and reactions with minimal disruption to their daily obligations and to their quality of their life, and eventually to reduce or eliminate debilitating symptoms and to prevent further traumatization and violence

(Source: Adapted from Maxine Harris, Ph.D.)
Is it major depression or “just” substance-induced mood disorder

- Does it matter?
- Comparative lethality
- Can clinicians tell the difference?
- Assessment methods
- Different treatment approaches
Antidepressants and addictions

- Numerous studies of non-depressed clients show little or no benefit on substance use.
- Several studies of mild / moderately depressed clients show little or no benefit on substance use and no or mild effect on mood.
- Studies of severely depressed / hospitalized patients show moderate positive effect on both mood and substance use.

Medications for treating individuals with bipolar disorders

Treatments for bipolar disorders

- Atypical neuroleptics for acute mania: olanzapine, risperidone, quetiapine, ziprasidone, aripiprazole.
- Atypicals for bipolar depression: quetiapine
- Atypicals for bipolar maintenance treatment: olanzapine, aripiprazole
- Mood stabilizers include: lithium, divalproex, and carbamazepine for acute mania / maintenance, and lamotrigine for bipolar depression and maintenance
Medications for treating individuals with borderline personality disorders

Borderline personality disorder medications are used for the following clinical features / symptom clusters:

1. Affective dysregulation (i.e., mood lability):
   - SSRIs and related antidepressants (e.g., fluoxetine, sertraline, & venlafaxine). Mood stabilizers (e.g., lithium, carbamazepine, & valproate).
   - low-dose neuroleptics (atypicals may be used, e.g., olanzapine & risperidone.
   - SSRIs and related antidepressants (fluoxetine, sertraline, etc.). Mood stabilizers (lithium, carbamazepine, & valproate). Low-dose atypical and typical neuroleptics (olanzapine, quetiapine, haloperidol; clozapine for refractory severe self-mutilation/aggression).

2. Perceptual disturbances / psychotic symptoms
   - atypical neuroleptics most commonly used (olanzapine, risperidone, quetiapine, aripiprazole, or clozapine for refractory symptoms), but there is evidence supporting use of typical neuroleptics as well (haloperidol, perphenazine)
Medications for treating schizophrenia

- **Atypical** (or "second generation") neuroleptics: risperidone, aripiprazole, olanzapine, quetiapine, ziprasidone, clozapine.

- **Typical** (or "first generation") neuroleptics: haloperidol, fluphenazine, chlorpromazine, perphenazine, trifluoperazine, thiothixene, pimozide.
Comorbidity of depression and anxiety disorders

50% to 65% of panic disorder patients have depression†

70% of social anxiety disorder patients have depression

67% of OCD patients have depression*

49% of social anxiety disorder patients have panic disorder**

11% of social anxiety disorder patients have OCD**

Depression

Social Anxiety Disorder

OCD

Panic Disorder

HIGHLY COMMON...

HIGHLY COMORBID
Treatment of co-occurring disorders: Areas of promise - Depression

Integration of substance abuse (SA) treatment and treatment of affective disorders

- Depression
  - Use of tricyclics and SSRIs produces excellent treatment response in SA patients with depression. Can be used with SA populations with minimal controversy.
  - Good evidence of effectiveness with methadone patients, women with alcoholism and depression.
Treatment of co-occurring disorders: Areas of promise - Bipolar disorders

- Bipolar disorder (BPD) and SA disorders
  - Medications for BPD often essential to stabilise patients to allow SA treatment to be effective
  - Challenges often occur in diagnosis
    - Cocaine / methamphetamine use disorders often mimic BPD, medications for these disorders have not yet demonstrated efficacy and these disorders do not respond to medications for bipolar disorders
Anxiety Disorders

- Social anxiety disorders: SSRIs
- Panic attacks: SSRIs
- PTSD: Psychotherapies
- Generalized anxiety disorders
- Many forms of psychotherapy, relaxation training, biofeedback, exercise, etc. can be useful
- Concerns about use of benzodiazepines with individuals in SA treatment
Schizophrenia and SA Disorders

- Differential diagnosis with methamphetamine psychosis can be difficult.
- Medication treatments frequently essential.
- Knowledge about medication side effects and the possibility that these side effects can trigger drug use is important.
Sleep problems in those recovering from alcoholism / addiction

- Abnormal for weeks / months in most
- Is this “normal toxicity” and should it be tolerated?
- Poor sleep associated with relapse, anxiety, depression, PTSD, and protracted withdrawal
Medications for sleep problems

- Treat the comorbid disorder causing the sleep problem....(e.g., depression / anxiety) with an antidepressant

- And / or, for protracted withdrawal, with anticonvulsants for 1 to several months (efficacy not established)

- Prazosin for PTSD nightmares

- Antihistamines, trazedone, remeron as non-specific aids
Summary of co-occurring disorders

- There is a problem
- We have documented it for a long time
- We need more information to figure it out
  - The current state of affairs
  - What we do about it
Treatment of co-occurring disorders

Treatment system paradigms

- Independent, disconnected
- Sequential, disconnected
- Parallel, connected
- Integrated
Treatement of co-occurring disorders

Independent, disconnected “model”

- Result of very different and somewhat antagonistic systems
- Contributed to by different funding streams
- Fragmented, inappropriate, and ineffective care
Treatment of co-occurring disorders

Sequential Model

- Treat SA disorder, then MH disorder
  - Or
- Treat MH disorder, then SA disorder
- Urgency of needs often makes this approach inadequate
- Disorders are not completely independent
- Diagnoses are often unclear and complex
Treatment of co-occurring disorders

Parallel Model

- Treat SA disorder in SA system, while concurrently treating MH disorder in MH system. Connect treatments with ongoing communication.
- Easier said than done.
- Languages, cultures, training differences between systems.
- Compliance problems with patients.
Integrated Model

- Model with best conceptual rationale
- Treatment coordinated best
- Challenges
  - Funding streams
  - Staff integration
  - Threatens existing system
  - Short-term cost increases (but better long-term cost outcomes)
Elements of an integrated model: Staffing

A true team approach including:

- psychiatrist (trained in addiction medicine / psychiatry)
- nursing support
- psychologist
- social worker
- marriage and family counsellor
- counsellor with familiarity with self-help programs

(Other possibilities: vocational, recreational, educational specialists)
Preliminary assessment of mental health and substance use urgent conditions:

- Suicidality
- Risk to self or others
- Withdrawal potential
- Medical risks associated with alcohol / drug use
Elements of an integrated model: Diagnostic process

Diagnostic process that produces provisional diagnosis of psychiatric and substance use disorders using:

- Urine and breath alcohol tests
- Review of signs and symptoms (psychiatric and substance use)
- Personal history timeline of symptom emergence (What started when?)
- Family history of psychiatric / substance use disorders
- Psychiatric / substance use treatment history
Elements of an integrated model: Initial treatment plan

Initial treatment plan (minimum 1 day; maximum 10 days) that includes:

- Choice of a treatment setting appropriate to initially stabilise medical conditions, psychiatric symptoms, and drug / alcohol withdrawal symptoms
- Initiation of medications to control urgent psychiatric symptoms (psychotic, severe anxiety, etc.)
- Implementation of medication protocol appropriate for treating withdrawal syndrome(s)
- Ongoing assessment and monitoring for safety, stabilization, and withdrawal
Elements of an integrated model: Early stage treatment plan

Early stage treatment plan (minimum 2 days; maximum 10 days) that includes:

- Selection of treatment setting / housing with adequate supervision
- Completion of withdrawal medication
- Review of psychiatric medications
- Completion of assessment in all domains (psychological, family, educational, legal, vocational, recreational)
- Initiation of individual therapy and counselling (extensive use of motivational strategies and other techniques to reduce attrition)
- Introduction to behavioral skills group and educational groups
- Introduction to self-help programs
- Urine testing and breath alcohol testing
Elements of an integrated model: Intermediate treatment plan

Intermediate treatment plan (up to six weeks) that includes:

- Housing plan that addresses psychiatric and substance use needs
- Plan of ongoing medication for psychiatric and substance use treatment with strategies to enhance compliance
- Plan of individual and group therapies and psychoeducation, with attention to both psychiatric and substance use needs
- Skills training for successful community participation and relapse prevention
- Family involvement in treatment processes
- Self-help program participation
- Process of monitoring treatment participation (attendance and goal attainment)
- Urine and breath alcohol testing
Extended treatment plan (up to 6 months) that includes:

- Housing plan
- Ongoing medication for psychiatric and substance use treatment
- Plan of individual and group therapies and psychoeducation, with attention to both psychiatric and substance use needs
- Ongoing participation in relapse prevention groups and appropriate behavioural skills groups and family involvement
- Initiation of new skill groups (e.g., education, vocational, recreational skills)
- Self-help involvement and ongoing testing
- Monitoring attendance and goal attainment
Elements of an integrated model: Ongoing plan

Ongoing plan of visits for review of:
- Medication needs
- Individual therapies
- Support groups for psychiatric and substance use conditions
- Self-help involvement
- Instructions to family on how to recognise psychiatric problems and relapse to substance use

In short, a chronic care model is used to reduce relapse, and if / when relapse (psychiatric or substance use) occurs, treatment intensity can be intensified.
Challenges of building integrated models

- Cost of staffing
- Training of staff
- Resistance from existing system
- Providing comprehensive, integrated care with efficient protocols
- Providing full integration of the treatment team at the same site, which is optimal
Moving towards integration

The most likely strategy for moving towards this system is in increments

- Psychiatrist attends at AOD centers
- Relapse prevention groups introduced to mental health centers
- Staff exchanges, attending case conferences, joint trainings
- Gradual shifting of funding
Thank you for your time!

End of Workshop 1
Questions?

Comments?
Workshop 2
Women: Addiction and Treatment Issues
At the end of this training you will understand the:

- Impact of alcohol and drug use on women
- Medical and substance abuse treatment issues important to the treatment of women
Women-Specific Treatment

- Vulnerabilities
- Treatment Issues
- Pregnancy
Brainstorm: How are we different?

In what ways are men and women different?
Women: Vulnerability to AOD effects

- The same level of consumption of a psychoactive drug will have a greater impact on females than males because of their:
  - lower body weight
  - a higher fat-to-fluid ratio resulting in less dilution of the drug
  - variable responses to drugs because of menstrual hormonal fluctuations

- Result:
  - women become more easily intoxicated
  - women sustain tissue damage at lower doses.
Recently, the traditionally higher prevalence of AOD use among men compared to women has narrowed.

There is a trend for older women, i.e., those > 40, towards increasing levels of alcohol consumption.
Increased prevalence of binge drinking in young women (i.e., ≥ 4 drinks in a session) increases the risk of:

- Overdose in conjunction with other drugs
- Drunk driving
- Vulnerability to physical / sexual abuse
- Unsafe sex
- Babies with fetal alcohol syndrome
- Other intoxication-related harms (e.g., accidents and injury)
Harm minimisation is a priority

Look for opportunities to:

- Educate women about their greater susceptibility to AOD-related harms
- Provide information regarding drug interactions
- Engage patients in discussions about strategies to reduce AOD intake and frequency of use
- Routinely undertake physical assessment
- Provide regular health check-ups and discuss lifestyle issues
Janis is a 17-year-old apprentice hairdresser. She presents requesting testing for hepatitis C. In a discussion of risk factors she admits to occasionally using heroin.

How would you respond?
Identifying harms from drug use

Intoxication
- lower tolerance
- severe physical reactions
- overdose
- victimisation
- falls
- drunk driving
- unsafe sex
- accidents and injury

Regular/Excessive Use
- organ damage at lower dose
- organ damage at lessor duration
- conception difficulties
- pregnancy – risk to the fetus
- work
- relationships
- finances
- child-rearing

Dependence
- family and societal censure
- child welfare intervention
- marginalisation
- reluctance to seek help
- overdose potential
- rapid deterioration in health
Why can it be difficult to detect AOD problems in female patients?
Treatment issues (1)

- Women perceive that the costs associated with treatment are greater, compared to men
  - social / family censure, financial, separation from children

- Many women who present to AOD treatment have been physically, sexually, or emotionally abused at some time

- Women have reported feeling vulnerable, or have experienced sexual harassment in mixed-sex programs. This may lead to premature ending of treatment.
Treatment issues (2)

- Women-only treatment services may be of value with some populations of women, especially where abuse and violence are common.
- Mixed-sex programs may be appropriate where policies & protocols supporting the specific needs of women have been adopted.
- Child-care arrangements may be required before some women will agree to enter treatment.
- Holistic treatments offering conventional and/or complementary therapies may be preferred.
- Female health professionals may be preferred.
Female-oriented treatment

- Interventions oriented towards women are associated with:
  - greater progress towards goals during treatment
  - higher rates of abstinence during treatment than for women in conventional mixed-sex treatment
- Women are more likely to present to female-only treatments and to complete treatment if:
  - they have dependent children
  - they are lesbian
  - their mothers experienced an AOD-related problem
  - they have suffered sexual abuse.
Comorbidity in women (1)

- Women with AOD problems commonly experience anxiety and / or depression
  - more likely than males with AOD problems to experience a combination of anxiety and depression

- Concurrent benzodiazepine and alcohol dependence presents additional treatment challenges, e.g., consider:
  - pharmacotherapy options
  - risk of substitution of dependence
  - graduated reduction / withdrawal
Comorbidity in women (2)

- Younger women who are drug-dependent are increasingly likely to be polydrug users
- Association between eating disorders (particularly bulimia) and high-risk alcohol use
  - the eating disorder usually predates the alcohol problem
  - drinking temporarily suppresses stress, shame, & anxiety associated with the eating disorder
  - cognitive-behavioural treatment for eating disorders and AOD problems is similar, so there is an opportunity for dual intervention.
Women with alcohol dependence:

- tend to drink at home and / or alone more often than men (Males are more likely to engage in dependent patterns of drinking in social settings)
- tend to report feelings of powerlessness and distress about life events prior to drinking episodes, and to a greater extent than their male counterparts
- are more likely to live with a male who is alcohol-dependent (than the converse).
Social supports are a vital factor in preventing relapse. Relapse prevention may need to address issues such as:

- loneliness
- low self-esteem or perceptions of self-efficacy
- guilt
- depression
- difficulties in social and family relationships (including children)
Mothers

- Pregnant women and women with dependent children tend to engage in treatment longer than other women.
- Women who are dependent on AOD may experience difficulty conceiving.
- Lower fertility can occur for those women with dependent patterns of psychoactive drug use.
High-risk or dependent patterns of psychoactive drug use can affect female fertility causing:

- disruption of hypothalamic-pituitary-gonadal axis (alcohol and heroin)
- menstrual irregularities, ovulatory failure, early menopause (alcohol)
- amennorhoea (heroin, amphetamines, cocaine)
- increased risk of sexually transmitted disease (which affects fertility)
Assessment of ‘mothers-to-be’ (1)

Assess for factors that may be associated with high-risk patterns of AOD use:

- pharmacotherapy options
- poor nutrition
- inadequate / poor / unsafe accommodations or environment
- presence of blood-borne viruses (BBV)
- high-risk sex
- risk or likelihood of sharing injection equipment
- social isolation & mental health issues
- relationship stress / violence
Access possible sources of information on the patient’s drug use and lifestyle to determine her risks (be aware of confidentiality)

Determine:
- quantities and types of AODs used
- frequency / patterns of use
- route(s) of administration
- concurrent drug use (including over-the-counter and “herbal” preparations)
Alerting the ‘mother-to-be’

- Take care not to over- or understate potential for AOD-related fetal damage
  - because of the high prevalence of binge drinking among women, many fear the occurrence of possible fetal damage during first trimester
  - if the patient has high-risk or dependent patterns of use, she may fear her children will be removed from her care
- Provide accurate information
- The precise “dose-damage threshold” by stage of pregnancy for many drugs is unknown (most information relates to alcohol & tobacco)
‘Red Flags’ suggestive of high-risk AOD use (2)

- Family history of high-risk drug use
- Chaotic lifestyle
- Repeated injuries, emergency department visits
- Partner who is abusive and/or uses drugs in a high-risk manner
- Lack of antenatal care, missed appointments, non-compliance.
‘Red Flags’ suggestive of high-risk AOD use (2)

- Intoxication or drowsiness during visit
- Requests for opioids or benzodiazepines, STDs, HIV, HBV, HCV
- Mental health issues
- Previous pre-term delivery, fetal demise, or placental abruption
- Previous child with Fetal Alcohol Syndrome (FAS) or Neonatal Abstinence Syndrome (NAS)
A good time for change...

- Pregnancy is a strong motivator for women to change their SA behaviors. Many pregnant women will wish to cease risky levels of drug use to protect their baby.

- Most pregnant women will respond to offers of treatment.

- If the patient is dependent, advise ongoing care or drug titration / maintenance, as rapid drug cessation (and the resulting withdrawal) may pose a significant risk to the fetus.
Opportunistic engagement

When contact with pregnant women who engage in high-risk AOD use is limited or inconsistent:

- Be flexible
- Derive maximum benefit from each contact
- Do not judge or make the mother feel (more) guilty
- Be clear about the dangers, but express hope (use examples of success for similar patients)
- Be patient! Most pregnant women do eventually engage in treatment
Dependent drug use in the mother requires coordinated shared care, ideally with specialist involvement:
- obstetrician
- neonatologist
- addiction medical specialist with expertise in pregnancy

Antenatal care is essential
Antenatal shared care (2)

- Involve relevant support organisations
- Consider counselling to terminate the pregnancy when the woman is concerned about damage having already occurred and/or is HIV-positive
- Consider benefits of withdrawal treatment or pharmacotherapy maintenance regimes if she is dependent
  - involve specialist AOD centres
The ‘drug vulnerable’ fetus

Almost all drugs used in a high-risk manner by the mother may result in:

- increased risk of miscarriage, premature labour, still birth
- fetal distress
- reduced birth size / weight and associated slow growth
- developmental delays

Dependent drug use in a mother may result in Neonatal Abstinence Syndrome (NAS) (withdrawal shortly after birth)
The first few weeks after conception present the greatest risk to the fetus, as alcohol enters the fetus’ bloodstream.

High peak blood alcohol levels (i.e., drinking to intoxication) are particularly dangerous for the fetus.

Fetal death has been associated with high intake (> 42 standard drinks per week) throughout pregnancy.

Abstinence is preferred during pregnancy. While there is no evidence that consumption of ≤1 standard drink per day results in harm to the fetus, there is no established safe consumption limit.
Fetal Alcohol Syndrome (FAS)
- occurs in 1/1,000 live births

Features
- characteristic facial malformations (e.g., flat midface, small head, thin upper lip, small eyes, short upturned nose, prominent epicanthic folds, low-set ears etc.)
- prenatal and postnatal growth retardation (e.g., underweight, small body length, lack catch-up growth)
- central nervous system dysfunction (e.g., mental retardation, short attention span, developmental delays, long-term learning difficulties, behavioural problems).
Fetal Alcohol Effects (FAE)

- Occurs in 1 in 100, when some but not all features of FAS are described. Symptoms include:
  - low birth weight
  - behavioural difficulties
  - learning difficulties

- High-risk patterns of drinking during pregnancy may result in:
  - spontaneous abortion, cardiac malformation, stillbirth, intrauterine growth retardation
Risk for the fetus: Smoking (1)

- **Nicotine**
  - Crosses placenta and is found in breast milk
  - Restricts placental blood flow with reduced oxygenation
  - Higher quantities of cigarettes smoked are associated with lower birth weight

- **Smoking**
  - Inhibits fetal breathing, leading to increased risk of SIDS, stillbirth, perinatal death
  - Higher incidence of respiratory infections, asthma, middle ear infections in babies
Impact of cannabis is similar to tobacco
- there are concerns about the cumulative effects of THC (stored in the fatty tissues of the brain) on the child both before and after birth

Interventions
- advise cessation of use of tobacco or cannabis before or as soon as becoming pregnant
- although nicotine patches or gum are generally contraindicated when pregnant, these may present the safest option for the fetus
Risk for the fetus: Heroin

- Unclear whether general effects to the fetus are a result of heroin use per se or poor nutrition / health / lifestyle factors
- Opiate use may contribute to many obstetrical complications, e.g.:
  - placental abruption / spontaneous abortion
  - intrauterine growth retardation or death (with low birthweight)
  - premature labour
- Risk of transmission of HIV / HCV through unsafe using or sexual practices
Methadone and pregnancy

- Pregnant women should **not** be advised to quit heroin (i.e., go “cold turkey”). Methadone is treatment of choice.
- Slow reductions in dose during 2nd trimester.
- Little methadone is present in breast milk, but slow weaning of feeding is advised when methadone dose > 80 mg.
- Hepatitis-C-positive mothers should stop feeding if nipples begin to bleed.
- Use methadone in conjunction with coordinated treatment (psychosocial, obstetric, paediatric, and AOD services).
Psychostimulants increase the risk of:

- maternal hypertension
- placental abruption and haemorrhage

Effects will vary considerably depending on:

- gestational period in which use occurs
- frequency, amount, concurrent drug use
- individual differences in metabolism

Risk for the fetus: Amphetamines and cocaine
Use in pregnancy may result in:
- congenital facial (e.g., cleft lip / palate), urinary tract, or neurological malformations
- Neonatal Abstinence Syndrome (particularly if used in conjunction with other drugs)

High doses before delivery may cause:
- respiratory depression, sedation
- hypotonia (floppy baby syndrome)
- hyperthermia
- poor feeding
Risk for the fetus: Solvents and other volatile substances

- Reduced oxygen levels to the fetal brain
- Effects can be similar to Fetal Alcohol Syndrome
- Neonatal renal problems
- Decreased body weight
- Damage to reproductive cells reducing future conception & pregnancy
- Possibly fatal to mother and baby at high doses
Risk for the fetus: Caffeine

- May be an association between low birth weight and > 5–6 cups of coffee / tea, > 6 cans of cola per day
- Irregular fetal heart rate late in pregnancy
- Neonatal Abstinence Syndrome (NAS) has been observed in relation to high caffeine levels in the mother
Neonatal Abstinence Syndrome (NAS) (1)

- High incidence of NAS from prenatal exposure to heroin or methadone, but also results from dependent patterns of alcohol and benzodiazepine use

- NAS characterised by:
  - CNS hyper-irritability (e.g., wakefulness, tremor, hyperactivity, seizures, irritability)
  - gastrointestinal dysfunction, failure to gain weight
  - respiratory distress or alkalosis, apnoeic attacks
  - autonomic symptoms – yawning, sneezing, mottling, fever
  - lacrimation, light sensitivity
Neonatal Abstinence Syndrome (NAS) (2)

- Symptoms appear within 72 hours, more likely in full-term infants
- Rule out hypoglycaemia, infections, hypocalcaemia (which mimic NAS)
- NAS has potential to disrupt bonding with mother if treatment is too intrusive, though neonatal ICU may be appropriate
- Mothercraft (nurses specialised in young children and their families) provides calming effect / relief
- Pharmacological treatment if NAS poses serious risks, e.g., aqueous solution of morphine administered orally
- Refer to specialist outpatient treatment once infant is stabilised
Risks to a baby from continued drug use

- Increased risk of SIDS
- Increased risk of child neglect and abuse
- NAS (Neonatal Abstinence Syndrome) may be pronounced if opioid-dependent

Clinicians should assess environment and social factors and encourage development of parenting skills through appropriate parenting networks.
Breast feeding

- The level of alcohol in breast milk is the same as in the mother’s bloodstream. Feeding after consuming alcohol may result in:
  - irritability
  - poor feeding
  - sleep disturbances

- Smoking / alcohol use reduces milk supply

- Smoking exposes the baby to the effects of passive smoke (an identified risk factor for SIDS)
Recommendations for breast feeding and AOD Use

- Discourage breast feeding if mother continues to use illicit drugs, or is on maintenance pharmacotherapies.

- If the mother wishes to consume alcohol, advise:
  - Abstinence is preferred while breastfeeding.
  - However, if she wants to consume alcohol, recommend doing so immediately after feeding, or at times other than when about to breast feed (not within 2–4 hours of needing to feed).
  - Drink no more than 1 standard drink between feeds.

NHMRC (2001)
Drug-dependent parents may have experienced psychological, sexual, or emotional abuse as children. They may in turn inflict similar treatment on their children.

Discharge planning meeting should involve health / welfare personnel & the family

Management plans should be agreed upon and documented

Where specific risk factors are identified, statutory child protection agencies must be notified
  - inform the patient of your statutory obligations
Workshop 3
Young People: Addiction and Treatment Issues
Training objectives

At the end of this training you will understand the:

- Impact of alcohol and drug use on young people
- Medical and substance abuse treatment issues important to the treatment of young people
Who is young?

A “young person” is internationally accepted as someone who is between 10- and 24-years-old.
Case vignette

Your patient, Sue, confides in you about her son:

“I was putting Jason’s clothes away in his drawer a few days ago, and I found a bong.”

She asks you, “How concerned should I be? What do I say to him?”

What may be Sue’s main concerns?
What are your main concerns?
What would you advise?
Why do young people use drugs?
Drug using patterns range across a spectrum, from no use to dependent use, and may include more than one drug. A person can move along the spectrum (in either direction) and cease using at any point.
**Types of problems**

**Intoxication**
- accidents
- misadventure
- poisoning
- hangovers
- truancy / absenteeism
- high-risk behaviour
- pregnancy
- overdose
- BBV

**Regular Use**
- health
- finances
- relationships

**Dependence**
- impaired control
- drug-centred behaviour
- severe problems
- withdrawal
Intoxication-related harm

- A non-judgemental approach towards young people and their intoxication is recommended

- Potential harms resulting from alcohol intoxication are immense. In Australia, alcohol is linked to:
  - 30% of all road, falls, and fire injuries, and 30% of drownings
  - 50% of assaults, 12% of suicides (probably an underestimate for young people, and particularly indigenous youth)
  - overdose, drug-related rape and violence
Indicators of regular drug use in young people

- Family & friends remark on a “personality change”
- Extreme mood swings may be evident
- Possible change in physical appearance or wellbeing
- Change in school / job performance
- Increase in secretive communication
- Change in social group
- Seeking money, or increase in money supply if dealing
- Unexplained accidents
Assessment: The basic approach (1)

- Often young people are not very forthcoming with information until you win their trust.
- If the young person is likely to suffer harm, and/or harm others, then strenuous attempts must be made to gain relevant information from any source.
- However, if a crisis does not exist, then it is not justifiable to intervene without the consent of the young person, or to engage in any deceptive practices, which can permanently damage the young person's trust in health professionals.
Assessment: The basic approach (2)

- Must be conducted sensitively
- Use open-ended questions
- Take particular note of:
  - which drug/s (think polydrug use) have been used immediately before their presentation (i.e., responsible for intoxication)
  - quantity and the route of administration (to assess potential harms)
  - past history of drug use (indicators of long-term harm)
  - the “function” drug use serves for them
  - environment in which drug use occurs (e.g., whether safe, supported)
What does the young person want?

- Determine why the young person is presenting now
- What does he or she perceive immediate needs to be?
- Try and meet his or her requests whenever possible as a starting point (even if far short of clinically ideal)
- Often young people are pre-contemplators in regard to their AOD use
Parental involvement can be extremely important to success of treatment with adolescents and is generally a desired part of treatment.

However, some parents view treatment as a method of punishment and want to control all aspects of treatment and have total access to communications between the youth and clinical staff. It is inappropriate for parents to dictate the terms of treatment.

Remember, the young person, not the parent, is the patient.

Respect and acknowledge the parent’s concerns about the child’s drug use, but insure treatment is designed to meet the needs of the youth.
Reassure parents/caregivers that a harm minimisation approach is effective:
- reducing the risks is the priority until the young person decides he or she wishes to moderate AOD use

Reduce the parents’ sense of guilt
- seldom are parents responsible for their child’s drug use
- drug use is far from unusual in young people

Offer information, support, counselling and referral
‘Treatment’ (1)

- Harm minimisation approaches and support have greater effect. Discuss:
  - keeping safe when intoxicated
  - first-aid knowledge, hydration
  - being aware of potential drug interactions
  - safe drug-using practises
  - using in safe places, with known and trusted people
  - planning drug use and activities while intoxicated
  - monitoring consumption and thinking about unwanted consequences of use
Encourage involvement with youth services (with specialist AOD workers) & school programs, particularly when peer-support programs are offered

- peer-led delivery of harm minimisation AOD packages for homeless youth had better outcomes than adult delivery
- peers speak the same language, are realistic, non-judgemental, humourous, creative and “to-the-point”
‘Treatment’ (3)

- **Non-drug-focused, stimulating youth activities**
  - e.g., drug-free concerts, exhibitions, sporting events, youth zones for skateboarding, etc.

- **Influence family interactions whenever possible**
  - potential to alter communication patterns
  - focus on behaviour
  - negotiate compromise
  - encourage healthy interdependence
A number of family therapy approaches have been found to be very useful in treating youthful substance users.

Approaches include:
- Family systems therapy
- Multidimensional family therapy
- Brief strategic family therapy
- Network therapy
Questions?

Comments?
Post-assessment

Please respond to the post-assessment questions in your workbook.

(Your responses are strictly confidential.)
Thank you for your time!