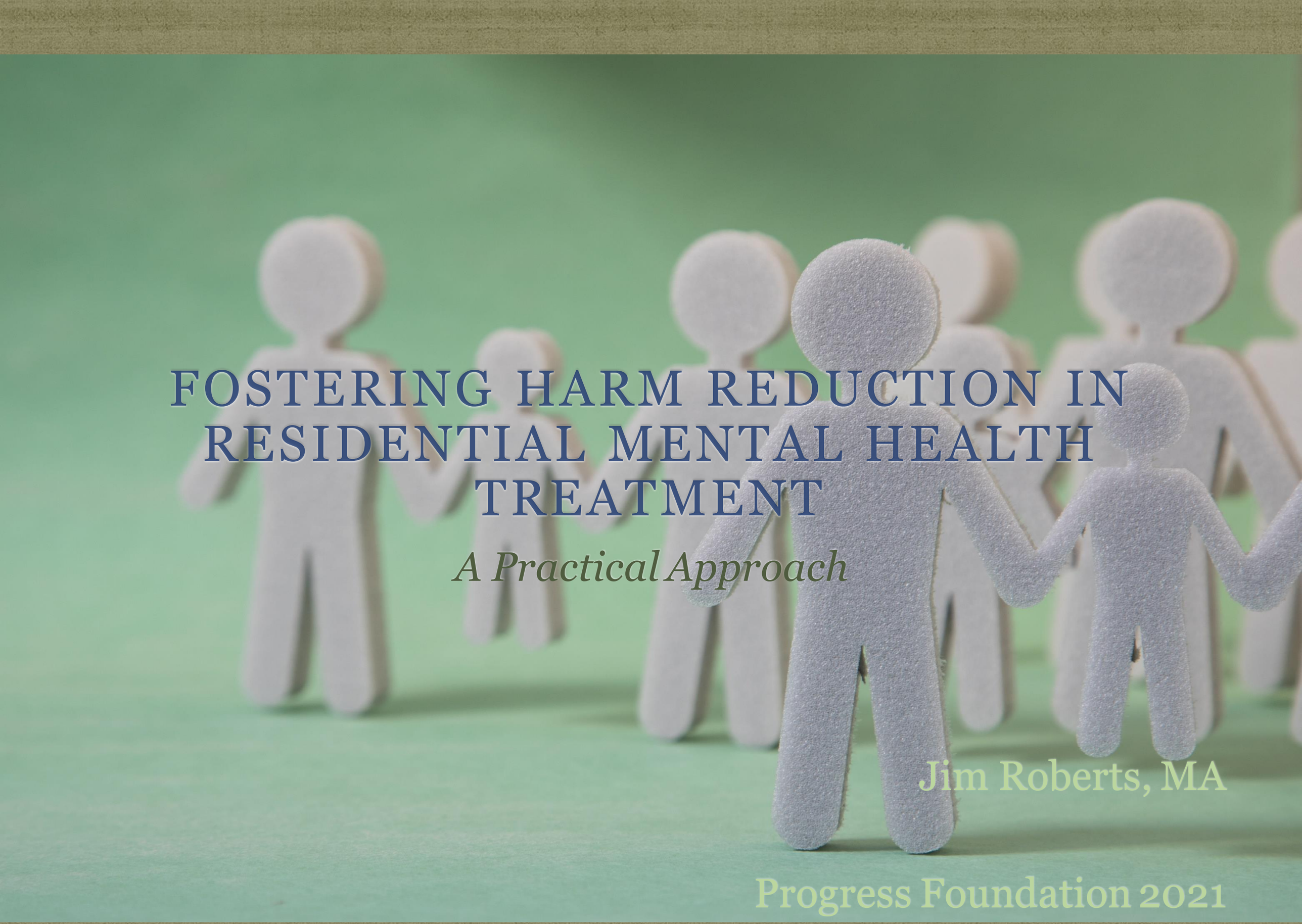

FOSTERING HARM REDUCTION IN RESIDENTIAL MENTAL HEALTH TREATMENT

A Practical Approach

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Progress Foundation 2021


NICE
PEOPLE
TAKE
DRUGS

Our relationship to substances:

They keep you company

They don't let you down

…and they don't argue with you

- “Human beings become addicted when they cannot find anything better to live for and when they desperately need to fill the emptiness that threatens to destroy them. The need to fill an inner void is not limited to people who become drug addicts, but afflicts the vast majority of people to a greater or lesser degree.”
- Bruce Alexander

GOAL

- To understand of where we have been in treating addictions and how it impacts the treatment of dually diagnosed clients today in the context of Residential Mental Health Treatment.

- To begin to identify the challenges and move toward a more effective, integrated treatment of dually diagnosed clients in a social rehabilitation framework.

MORNING CHECK – IN GROUP

Is this what treatment looks like???

“BUT WE ARE A MENTAL HEALTH PROGRAM… WE DON’T TREAT SUBSTANCE USE!”

Does that ever sound familiar?

Do we still recommend that our clients get substance use treatment elsewhere

Do we mandate our clients access 12 step programs if they are Dually Diagnosed

Do we focus on one set of rules that expect sobriety in residential treatment even if that is not the clients goal

SUBSTANCE USE & ADDICTION

- Addiction is regarded in the modern world as a specific definable problem
- It has moved on from being seen as a moral deficit or a fall from grace
- The prevailing view is that of a medical model
- There are a variety of often incompatible definitions for addiction in use currently
- there is little consensus on the causes of addiction and therefore there is a debate on the best form of treatment.
- Currently there are three main definitions for substance use and addiction

THE DISEASE MODEL

Categorized as a change in Brain Systems –

Those that process awards – the anticipation, motivation and evaluation of use

Effects the cognitive ability for an individual to evaluate rewards and control delayed gratification

Therefore client struggles to identify predicted outcomes and best choices

Believes that some individuals are more pre-disposed to addictive behaviors because of genetics

The disease is chronic and there is no cure

EVOLUTION OF THE MEDICAL MODEL

- E.M. 'Bunky' Jellinek's book The Disease Concept of Alcoholism, published in 1960, articulated a medical model that traced the progression of addiction through a series of phases leading to loss of control, insanity and death

- The AMA classed alcoholism as an illness in 1967

- The disease model is now the definition used by all 12 step abstinence based treatment worldwide.

- The Drug and alcohol rehab treatment is a multi-billion dollar industry

- The disease model is a useful tool for the insurance industry as it defines and limits the kind of treatment that will and will not be covered

ADDICTION AS A CHOICE MODEL

A cognitive rather than a biological perspective that emphasizes changes in thought process

In the short run it's a rational choice made by the individual until pleasure or relief of the drug use outweighs other possible choices

Addicts are considered to be indulgent and selfish

The individual is deliberately inflicting harm on themselves and others

Choice model however does a better job of explaining long term recovery than Disease Model

SOCIAL DEMOGRAPHIC MODEL

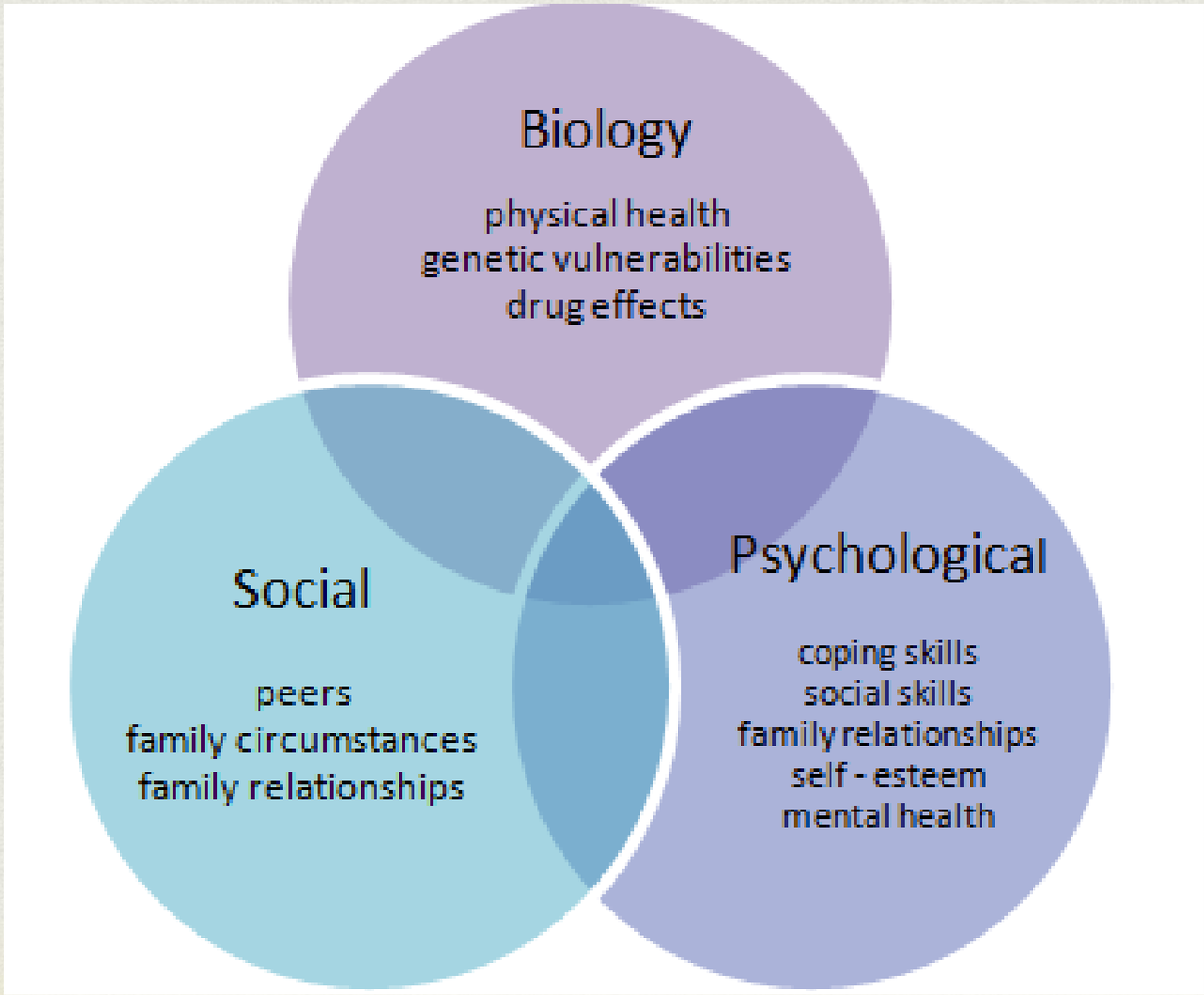
Environmental and economic conditions such as poverty and social isolation are the biggest factors in an individual developing maladaptive behaviors around substance use

Trauma experienced in childhood makes an individual more likely to seek methods to manage and sooth their symptoms anxiety due to PTSD

When life and circumstances improve addictive behavior changes and an individual is less likely to use a substance in a damaging way that impairs life functioning in other areas

BIO-PSYCHO-SOCIAL

If we add these three perspectives together we can see addiction in terms of a bio-psycho-social model



HARM REDUCTION

WHAT IS HARM REDUCTION?

At its core harm reduction is:

Non – judgmental

Supports self- determination

Accessibility of services : Come high, come low, come as you are

WHAT IS HARM REDUCTION?

Accepts, for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.

- Understands drug use as a complex, multifaceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.

- Establishes quality of individual and community life and well-being–not necessarily cessation of all drug use–as the criteria for successful interventions and policies.

- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.

- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.

WHAT ARE THE BARRIERS TO DELIVERING A HARM REDUCTION APPROACH IN RESIDENTIAL TREATMENT?

Which of these are true?

It is dangerous to have our clients using street drugs in our programs

Being high interferes with us treating you for your mental health

Appearing under the influence is triggering to other clients

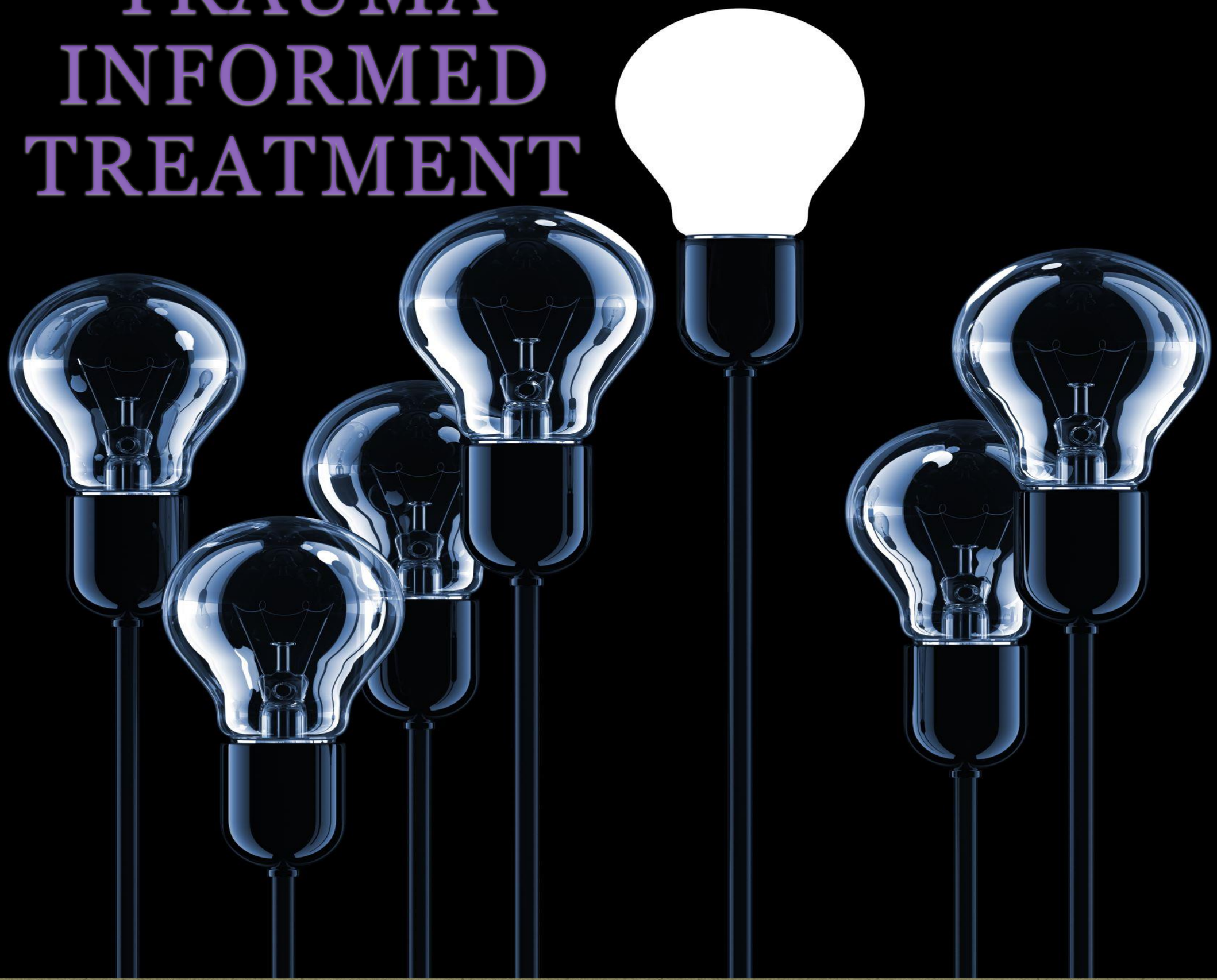
Using drugs in our programs mean you need to receive your services elsewhere

WHAT ARE THE BARRIERS TO DELIVERING A HARM REDUCTION APPROACH IN RESIDENTIAL TREATMENT?

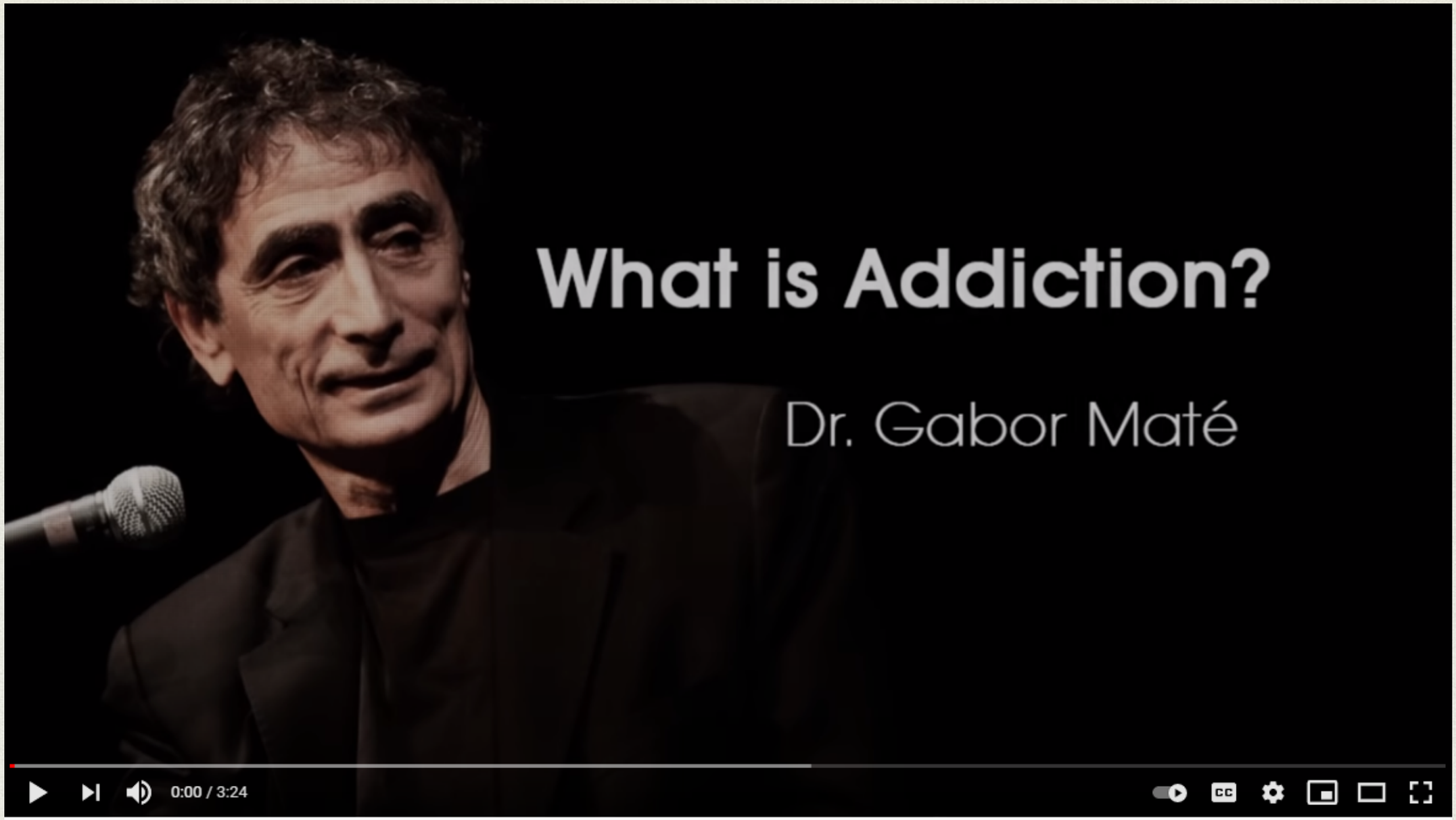
Question?

Is it a requirement that a client should address substance use in or before entering Mental Health Treatment

TRAUMA INFORMED TREATMENT



TRAUMA INFORMED TREATMENT



ADVERSE CHILDHOOD EXPERIENCES(ACE) STUDY

- Method: A questionnaire about adverse childhood experience was mailed to 13,494 adults who completed a standardized medical evaluation at a large HMO. 9,508 (70.5%) responded.

- The study found statistically significant correlations between adverse childhood experiences (defined as psychological, physical or sexual abuse, violence against the mother, living with household members who were substance abusers, mentally ill, suicidal or imprisoned) and risk factors for the leading causes of death in adult life.

TRAUMA INEQUITIES

AS NOTED IN THE ADVERSE CHILDHOOD EXPERIENCES (ACE) STUDY

- Youth living in poverty are more likely to be exposed to traumatic experiences both at home and in the community.

- Poverty is a greater problem for minority ethno-cultural groups that have historically been subjected to political and cultural trauma in the US and in their families' countries of origin.

- Asian-American children and their families who are immigrants from impoverished and violence torn countries are more vulnerable to violence as a result of racism and the scars of historical trauma.

- Other groups at high risk for exposure to violence in childhood include: urban and rural poor, tribal communities, lesbian, gay, bisexual, transgender and questioning youth, children and parents with physical disabilities or mental illness, homeless individuals and families.

SUBSTANCE USE

AS NOTED IN THE ADVERSE CHILDHOOD EXPERIENCES (ACE) STUDY

- Trauma increases the risk of developing substance abuse and substance abuse increases the likelihood that youth will experience trauma

- Up to 59% of youth with Post Traumatic Stress Disorder subsequently develop substance abuse problems.

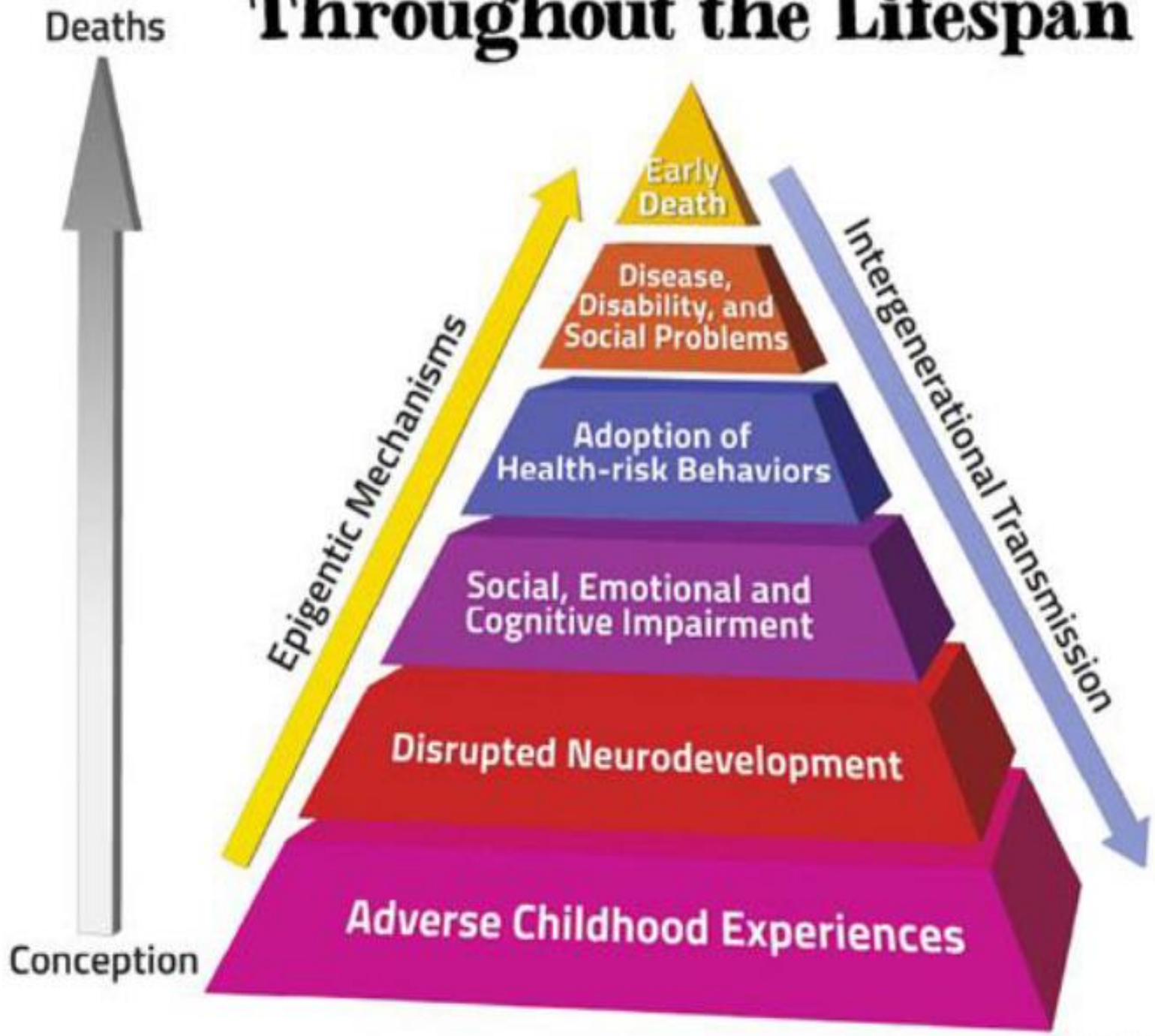
- In surveys of adolescents receiving substance abuse treatment, more than 70% had a history of trauma exposure

- Traumatic stress/PTSD may make it more difficult for adolescents to stop using, as exposure to reminders of traumatic events have been shown to increase drug cravings in people with co-occurring trauma and substance abuse

- Youth with both substance abuse and trauma exposure show more severe and diverse clinical problems than do youth who have been afflicted with only one of those problems.

- When trauma and substance abuse are treated separately, youth are more likely to relapse and revert to previous maladaptive coping strategies.

Mechanisms by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan



SOCIAL REHABILITATION

SOCIAL REHABILITATION

- What is our treatment methodology?
- We normalize our treatment relationship
- It’s a social relationship model
- At its most effective the client is the expert
- And it’s the client’s goals that inform the intervention

SOCIAL REHABILITATION

A TRAUMA INFORMED MODEL

We are not going to treat your substance use but we will see your substance choices as a behavior or symptom of your mental health

SOCIAL REHABILITATION

A TRAUMA INFORMED MODEL

We want the client to set their own goals in regard to substance use and we do not assume that long term sobriety is a one-size-fits-all goal of each person in treatment.

SOCIAL REHABILITATION

A TRAUMA INFORMED MODEL

However, should we have the expectation that all clients refrain from using substances or consuming alcohol during their time in treatment?

This expectation could exist because:

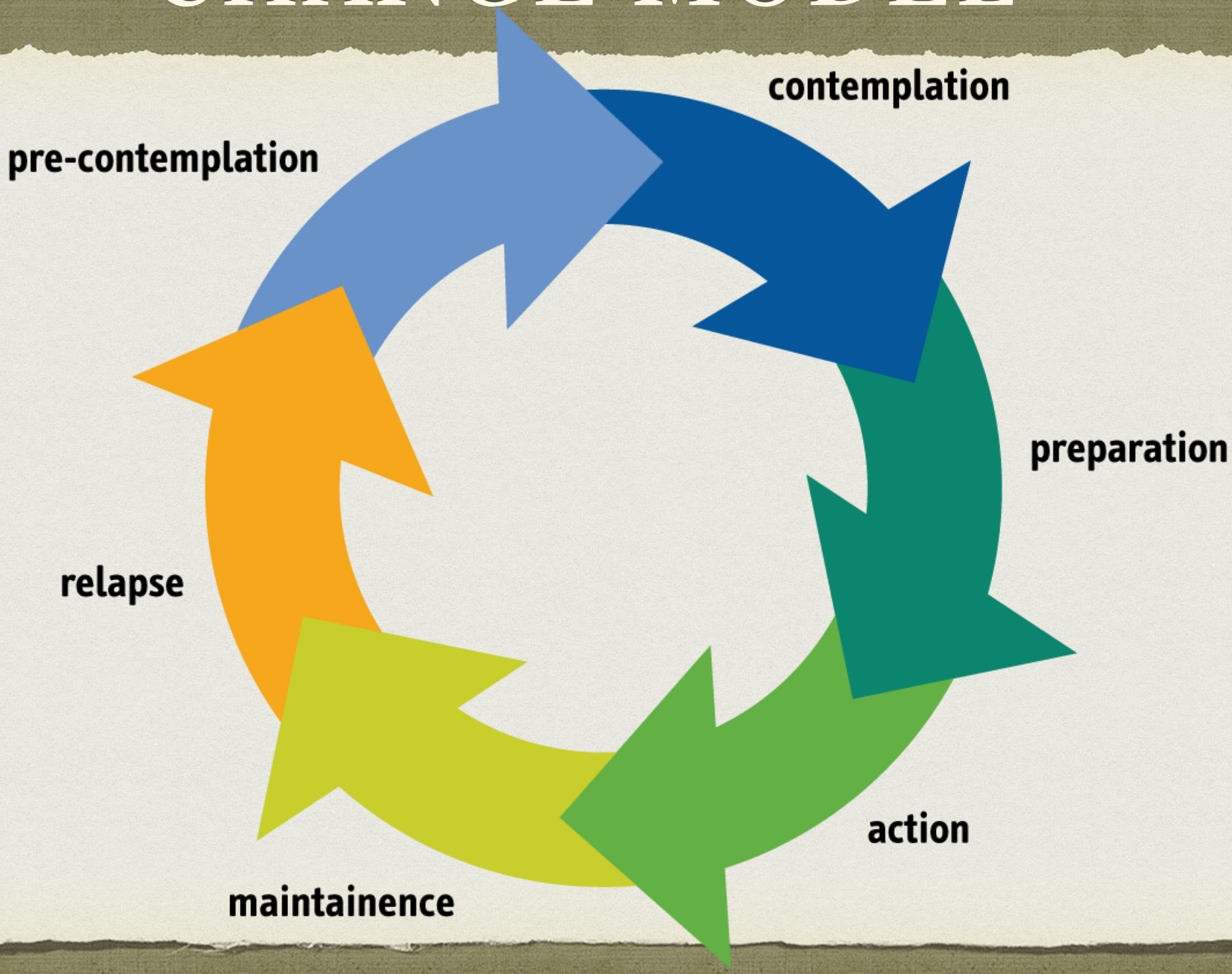
- 1) The need to create a safe place for those whose mental health treatment/recovery requires a sober living environment ?

- 2) Substance use can exacerbate symptoms and interfere with one's treatment ?

SOCIAL REHABILITATION

- We understand that the expectation of sobriety in mental health treatment may not be achievable for every client. Because if we take a harm reduction approach to substance use, a client's use is not automatic means for an immediate discharge from the program. However, if the client uses substances in a way that interferes with their own safety & treatment or the treatment or safety of others, we will need a methodology to base our intervention.

TRANSTHEORETICAL CHANGE MODEL



STAGES OF CHANGE

- Precontemplation: The individual is not thinking seriously about change, is not interested in any kind of help, don't feel as if the behavior is a problem, has no focus on changing the behavior, and has a tendency not to discuss the behavior with others.

- Contemplation: Increased awareness of the consequences of the behavior, able to consider the possibility of change, but ambivalent about it, have not made a commitment to changing the behavior

- Preparation: The decision has been made to change a behavior, and the individual is taking steps to change the behavior. Ambivalence is still present, but does not feel insurmountable.

STAGES OF CHANGE

- Action: Often this stage involves the person making a public commitment to changing her/his behavior, and is making the desired changes. As the individual has success in changing the behavior, her/his confidence that the change is sustainable increases.

- Maintenance: People in this stage of change feel comfortable with the steps they have taken to change their behavior. They continue to express commitment to continued change and growth.

- Relapse: Because a behavior has evolved as a solution to a problem, there is the possibility of the person reverting to old behaviors. This stage is recognized as a normal but not inevitable part of the change process.

PRECONTEMPLATION

- Establish rapport, ask permission, build trust.

- Explore how the client understands what brought him/her to treatment.

- Explore the pros and cons of the behavior.

CONTEMPLATION

- NORMALIZE AMBIVILENCE!!!!!!!!
- Continue to explore the pros and cons of the behavior
- Emphasize the client's choice/agency/self-efficacy for change.
- Help the client make explicit the discrepancies between personal values and actions.

PREPARATION

- Work with the client to clarify their goals and strategies toward change.

- Talk about what has worked in the past, and what hasn't.

- Help the client identify positive social supports.

- Role play potentially difficult situations with clients.

- Help identify barriers to change, and brainstorm ways to manage those barriers.

ACTION

- Support a realistic view of change by working with client to identify small, manageable steps.

- Help the client identify and celebrate small successes.

- Continue to help the client identify potentially difficult situations.

- Encourage and support aspects of change.

MAINTENANCE

- Help the client identify sources of pleasure that are in line with new behaviors.
- Support the client's self-efficacy in the change.
- Review long-term goals.
- Normalize setbacks.

RELAPSE

- Normalize relapse.
- Help the client understand the relapse as a learning opportunity.
- Work with the client to identify further sources of support.
- Remember a Relapse can only be considered as such if the client considers themselves in recovery

USING A RELAPSE TO INFORM TREATMENT

- Behavior chain analysis
- Consequences
- Additional support

WHEN HARM REDUCTION MEANS ABSTINENCE

- **Contextualizing Harm Reduction**

- It is important to note that although harm reduction might be the policy of your Agency, it is not a universal policy among other programs or living environments. Practicing sobriety skills while in treatment may benefit the client greatly when transitioning to environments that require absolute sobriety. Making the choice to use substances may negatively impact a clients ability to find further housing or treatment and this should be carefully considered.

WHAT WOULD YOU DO?

- Client comes back to the program under the influences of a substance.

- You suspect the client is using in the program.

- Client UA comes back positive for substances.

- During a room search, you find paraphernalia and drugs in the program.

QUESTIONS FOR THE CLIENT

- Is your use compromising the safety of your peers and/or staff?

- Do you have an alternative place to live, or another option or place to receive treatment, or access to a shelter?

- Have you brought drugs or alcohol into the program?

- What drives you to recovery at this time?

CONSEQUENCES

- Should we ever say that, at this time mental health residential treatment is not appropriate for the client's presentation?
- What factors go into determining that?
- Has your thinking change given this conversation?
- How do we include harm reduction in this decision?

TO RECAP

- A client does not need to change who they are to access our services

- It should not be a requirement to address substance use in mental Health Treatment

- Addictive behaviors are a symptom of a Mental Health disorder

THOUGHTS , REFLECTIONS & QUESTIONS

RECOMMENDED READINGS

- *Hooked: Five Addicts Challenge Our Misguided Drug Rehab System, Lonnie Shavelson*
- *In the Realm of Hungry Ghosts: Close Encounters with Addiction, Gabor Mate*
- *Chasing the Scream: Johan Hari*
- *Over the Influence : Pat Denning & Jeannie Little*
- *Coming to Harm reduction Kicking and Screaming : Dee Dee Stout*
- *Biology of Desire, Why Addiction is not a disease : Marc Lewis PHD*
- *High Price : Dr Carl Hart*