Psychosocial Screening Tools & Interventions

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CSAM Review Course in Addiction Medicine

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CONFLICT OF INTEREST DISCLOSURE

Founder, BDH Pharma, LLC

Consistent with our CME standards the disclosed conflict has been resolved to the satisfaction of members of the CSAM RC Planning Committee. This has included a review of this slide set for balance and lack of bias.

I will not be discussing “off label” use of drugs or devices in this presentation.

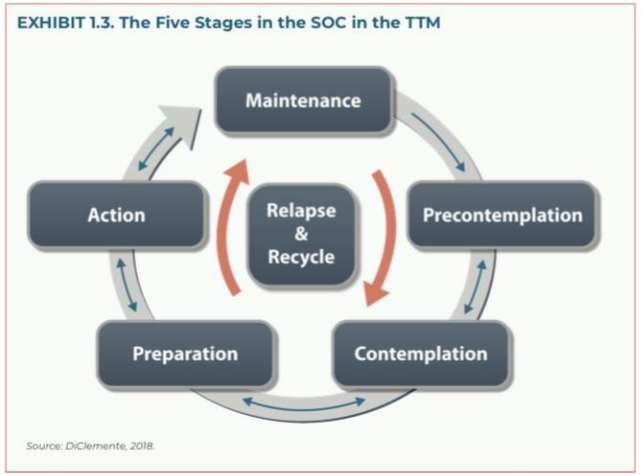
LEARNING OBJECTIVES

1. Utilize appropriate psychosocial treatments when treating patients with substance use disorders
   - Screening, Brief Intervention & Referral to Treatment (SBIRT)
   - Cognitive Behavioral Therapy
   - Motivational Interviewing
   - Contingency Management
2. Describe mutual self-help groups, including AA/NA's Twelve Steps and Twelve Traditions, and how to support a patient's use of them
3. Determine a patient's readiness for change
4. Utilize appropriate Screening/Assessment tools

1. Your 35 year old female patient presents to the clinic informing you that she received a DWI/DUI a month ago (her second DWI/DUI) and wonders about recommendations from you. She feels stopping would be important for her. She has spoken to a friend (who she knows is in AA) and has agreed to go to an AA meeting with him next week. Regarding changing her alcohol use, she is at which stage in the Stages of Change model?

A. Pre-contemplation
B. Contemplation
C. Preparation

C. PREPARATION



Stages of change include:

- *Pre-contemplation* – no intention to take action in the foreseeable future (6 months)
- *Contemplation* – aware that a problem exists/seriously thinking about overcoming it but have not yet made a commitment to take action
- *Preparation* – intends to take action in immediate future (usually defined as under 1 month); generally has plan of action
- *Action* – make specific, overt modifications in lifestyle (within preceding 6 months)
- *Maintenance* – working to prevent relapse (without need to apply change processes as frequently); consolidate progress they have made

Miller et al. The ASAM Principles of Addiction Medicine. 6th Edition. 2019.

2. Which of the following screening tools is not used to assess for alcohol use concerns?

A. AUDIT
B. DAST-10
C. CAGE questions
D. ASSIST

B. DAST-10

DAST-10 (Drug Abuse Screening Test-10) takes approximately 5 minutes to administer and may be given in either a self-report or interview format and may be used in a variety of settings to provide a quick index of drug use problems, but *not* alcohol or tobacco

AUDIT (Alcohol Use Disorders Identification Test) is the most widely validated instrument to assess for unhealthy alcohol use, has 10 items, and takes two to three minutes to complete

Four **CAGE** alcohol screening questions (Cut down; Guilty; Annoyed; Eye Opener) are another widely validated method of screening which are helpful for identifying alcohol use disorders in primary care settings; CAGE-AID has been adapted to screen for both alcohol and other drug use disorders

ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) is a brief screening questionnaire to find out about people's use of all psychoactive substances, developed by WHO, including alcohol and tobacco

Fiellin DA, et al, 2000; Humeniuk R, et al, 2008; Maisto SA, et al, 2003

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3. Which of the following is a commonly used *adolescent* screening tool for substance use disorders?

A. ASSIST
B. DAST-10
C. TAPS
D. CRAFFT 2.1

D. CRAFFT 2.1

CRAFFT instrument is the best validated tool to screen for substance use disorders in adolescents; however, the NIAAA recommends a two question screening for youth aged 12 to 21. CRAFFT is an acronym for Car, Relax, Alone, Forget, Friends, Trouble

ASSIST screens for all levels of problem or risky substance use in adults

DAST-10 focuses on drug use disorders and is only used for adults

TAPS (Tobacco, Alcohol, Prescription medication, and other Substance use) Tool is intended for adults which consists of a combined screening component (TAPS-1) followed by a brief assessment (TAPS-2) for those who screen positive

- TAPS-1 is a 4-item screen for tobacco, alcohol, illicit drugs, and non-medical use of prescription drugs

Gryczynski, J et al, 2017; Knight JR, et al, 2002; McNeely J et al, 2016

4. A 55 year-old male (KH) presents to your clinic with epigastric abdominal pain. After acknowledging his alcohol use has increased, (with his permission) you share some information about how alcohol use can lead to gastritis/gastric ulcers. He isn't sure what to do about his use. You inquire about his previous experiences cutting back on alcohol use. He tells you that he was able to abstain from alcohol use for a few months last year, which you respond to with encouragement. You acknowledge that while he enjoys relaxation effects of alcohol, he is also aware alcohol may be causing him health problems. When you ask what he wants to do regarding alcohol use, he voices desire to cut back and follow-up with you in 2 weeks.

4. This strategy is known as which of the following?

A. Multidimensional Family Therapy
B. Contingency Management
C. Motivational Interviewing
D. Cognitive Behavioral Therapy

C. MOTIVATIONAL INTERVIEWING

Motivational Interviewing (MI) is a directive, patient-centered counseling approach that has shown evidence of significantly reducing substance use.

It was developed in part by clinical psychologists William R. Miller and Stephen Rollnick. It focuses on helping patients explore and resolve ambivalence around their substance use. Each patient may be in differing stages of readiness and providers need to act according to the patient's current stage, culture, type of problems, treatment setting, and current needs.

C. MOTIVATIONAL INTERVIEWING

Research suggests that motivational interventions are associated with successful outcomes including adherence to and retention in SUD treatment; reduction in or abstinence from alcohol, cannabis, certain illicit drugs, and nicotine/tobacco use; and reductions in substance misuse consequences and related problems (*DiClemente et al., 2017*)

Motivational interventions have demonstrated efficacy across ages (i.e., adolescents, young adults, and older adults), genders, and racial and ethnic groups (*Lenz et al., 2016*)

One study found that MI was one of two evidence-based treatments endorsed as culturally appropriate by a majority of surveyed SUD treatment programs serving American Indian and Alaska Native (AI/AN) clients (*Novins, Croy, Moore, & Rieckmann, 2016*)

MI's core elements, including its emphasis on collaboration, evoking clients' perspectives, and honoring clients' autonomy, align well culturally with African Americans (*Montgomery, Robinson, Seaman, & Haeny, 2017*)

C. MOTIVATIONAL INTERVIEWING

Multidimensional Family Therapy is manualized, family-centered treatment for adolescents with drug use disorders and problem behaviors, focusing on a range of influences on drug use patterns, designed to improve overall family functioning

Contingency Management is based on operant conditioning principles, providing tangible reinforcers for evidence of behavior change (*discussed further in a future question*)

CBT is structured, multi-session behavioral treatment to help patients understand their current ways of thinking and behaving and creating tools to change their maladaptive cognitive and behavioural patterns (*discussed further in a future question*)

5. This is the transcript of the interaction from the prior case:

KH: I am worried about recent abdominal pain and my wife seems to think I am drinking too much.

MD: You are concerned about your health and I am glad you came in to speak today. Tell me about your diet and drinking habits.

KH: Being at home, it seems like I am constantly snacking on something and after a full day of Zoom meetings, I need a few beers to unwind, which I didn't think was an issue. However, now I am worried about my stomach.

MD: Your current work situation keeps you at home and having a few beers helps you relax after a stressful day. However, it also seems that you are concerned about recent weight gain and want to make some positive changes for your health. What areas do you think you can change?

KH: I know alcohol isn't the best and I need to cut back. I did stop for a few months last year.

(Continued on next slide)

5. Previous Scenario: *(continued)*

MD: You're clearly aware that alcohol isn’t helping, and you think you should reduce. You have already shown the ability to stop.

KH: I think I can cut down on my use. I don’t need to drink every night.

MD: You're making a commitment to get healthy, and now you have thought of ways to make that happen. You have recognized some concerns about your health, which alcohol may be contributing to, and you plan to reduce your amount.

5. What Motivational Interviewing technique(s) were used in the previous scenario?

A. Open-ended questions
B. Affirmations
C. Reflections
D. All of the above

D. ALL OF THE ABOVE

OARS is a basic communication style that is used throughout consultation or counseling sessions.

O: open-ended questions

A: affirmations

R: reflective statements

S: summarizations

These techniques are used to elicit “change talk” from patients. Using these tools, a clinician expresses empathy, develops discrepancy, dances with discord, and supports self-efficacy, which are key principles of MI.

Miller WR, Rollnick S., 2013

E. ALL OF THE ABOVE

KH: I am worried about recent abdominal pain and my wife seems to think I am drinking too much.

MD: You are concerned about your health (***reflection***) and I am glad you came in to speak today. (***affirmation***) Tell me about your diet and drinking habits. (***open-ended question***)

KH: Being at home, it seems like I am constantly snacking on something and after a full day of Zoom meetings, I need a few beers to unwind, which I didn't think was an issue. However, now I am worried about my stomach.

MD: Your current work situation keeps you at home (***reflection***) and having a few beers helps you relax after a stressful day. (***reflection***) However, it also seems that you are concerned about recent weight gain (***reflection***) and want to make some positive changes for your health. (***affirmation***) What areas do you think you can change? (***open-ended question***)

KH: I know alcohol isn't the best and I need to cut back. I did stop for a few months last year.

E. ALL OF THE ABOVE

MD: You're clearly aware that alcohol isn't helping, and you think you should reduce. (***reflection***) You have already shown the ability to stop. (***affirmation***)

KH: I think I can cut down on my use. I don't need to drink every night.

MD: You're making a commitment to get healthy (***affirmation***), and now you have thought of ways to make that happen. (***reflection***) You have recognized some concerns about your health, which alcohol may be contributing to and you plan to reduce your amount. (***summarization***)

6. Screening, Brief Intervention, and Referral to Treatment (SBIRT) has shown the most efficacy for what substance?

A. Alcohol
B. Heroin
C. Methamphetamine
D. Cocaine

A. ALCOHOL

Several systematic reviews and meta-analyses confirm the efficacy of SBIRT for unhealthy alcohol use in primary care patients; however, this effect was not been consistently replicated in other settings (EDs), with more severe alcohol use, or with other substances (although findings showing the effectiveness of SBIRT for tobacco use and drug misuse are accumulating.)

Saitz R, 2010; Saitz R, et al, 2014; Roy-Byrne P, et al, 2014; Babor TF, et al, 2017

7. You are seeing a 52 year old female patient of yours for follow-up 6 months after she completed an intervention strategy for treating her alcohol use disorder. She notes further reductions in her substance use which she attributes to her prior treatment. What intervention strategy most likely accounts for this “sleeper effect”?

A. Brief advice
B. Contingency management
C. Motivational interviewing
D. Cognitive-behavioral relapse prevention

D. COGNITIVE-BEHAVIORAL RELAPSE PREVENTION

This is a time limited (8 – 12 sessions usually), structured, goal-oriented treatment that can be adapted to a variety of substances and settings. Skills taught (and rehearsed) include recognizing triggers for substance use, avoiding high-risk situations, and coping with cravings.

Extensive evidence exists to support benefit for multiple substance use disorders.

Data from multiple studies has shown a “sleeper effect, ” where individuals show greater improvement over time after formal treatment ends.

A computer-based CBT system has also been shown to be effective in helping reduce drug use following standard drug abuse treatment.

Carroll KM, Kiluk BD, 2017; Carroll, KM et al, 2008

8. A 35 year-old male presents to his primary care doctor stating that he is currently participating in an outpatient treatment program where he receives vouchers for attendance and increasing amounts of vouchers for negative urine drug screens. What substance has the best evidence to support efficacy for this treatment intervention?

A. Alcohol
B. Cocaine
C. Nicotine
D. Cannabis

B. COCAINE

The best evidence for contingency management (CM) is for stimulant use disorders, especially cocaine, and opioid use disorders, especially heroin. There are some data to suggest CM may be helpful for cannabis, nicotine, and benzodiazepines, with evidence most limited for alcohol (although there is some.)

CM reinforces a target behavior through rewards (usually involving something of monetary value but typically not actual cash). The most common target behavior for CM is substance use, typically reinforcing substance abstinence as demonstrated by negative point of care test results for a specific substance or substance type. CM is also effective in reinforcing other target behaviors that could be relevant to addiction treatment (e.g., medication adherence, treatment attendance, etc). Various reinforcement schedules and rewards have been used.

McPherson SM, et al, 2018; Prendergast M, et al, 2006; Higgins ST et al. 2000; Lussier JP, et al, 2006; Chudzynski J, et al, 2015

9. Based on data from Project MATCH, which of the three behavioral treatments (Twelve-Step Facilitation Therapy, Cognitive Behavioral Coping Skills Therapy, and Motivational Enhancement Therapy) would be the most effective for the previous patient?

A. Twelve-Step Facilitation Therapy
B. Cognitive Behavioral Coping Skills Therapy
C. Motivational Enhancement Therapy
D. All are equally effective

D. ALL ARE EQUALLY EFFECTIVE

Project MATCH was a multi-site clinical trial which focused on three common forms of behavioral therapy for alcohol use disorder: Motivational Enhancement Therapy, Cognitive Behavioral Therapy, & Twelve Step Facilitation Therapy and attempted to determine if varying subgroups of persons with alcohol use disorder respond differently to the three treatments.

The eight-year, multisite trial confirmed one "match“ (between patients with low psychiatric severity and 12-step facilitation therapy) and did not confirm the other ten, leading researchers to conclude that patient-treatment matching does not substantially alter outcomes.

Overall, Project MATCH participants showed significant and sustained improvement in increased percentage of abstinent days and decreased number of drinks per drinking days, with few clinically significant outcome differences among the three treatments in either treatment arm.

Matching Alcoholism Treatments to Client Heterogeneity: Project MATCH posttreatment drinking outcomes. 1997

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10. Which of the following statements regarding AA and gender/ethnicity is true?

A. Women attend AA meetings less frequently and are less involved in AA than men

B. AA has no cultural adaptation for American Indian / Alaskan Native (AI/AN) men, women, or adolescents

C. Latinx individuals are less likely to attend 12-step meetings than European Americans but other indicators of 12-step involvement are similar

D. Gay and bisexual men are more likely than lesbian and bisexual women to attend AA

C. LATINX INDIVIDUALS ARE LESS LIKELY TO ATTEND 12-STEP MEETINGS THAN EUROPEAN AMERICANS BUT OTHER INDICATORS OF 12-STEP INVOLVEMENT WERE SIMILAR

Studies have found that women become as, or more, involved, as their male counterparts, and also benefit as much or more than men *(Kelly JF, Hoeppner BB, 2013).*

Medicine Wheel and Twelve Steps Program (MWTSP) is a culturally appropriate version of the twelve steps of AA/NA for AI/AN men, women, and adolescents *(Legha RK, Novins D, 2012*).

Recent studies indicate that Latinx individuals in Project MATCH'S 12-step facilitation condition were less likely to attend 12-step meetings than "European Americans"(term used in article; non-Latinx whites may be more accurate); however, no ethnic differences were found for other indicators of 12-step involvement, such has having a sponsor, reading program materials, and working the steps *(Alvarez J, et al, 2007)*

Lesbian and bisexual women, not gay and bisexual men, had greater odds of attending AA *(McGeough, B, et al, 2021)*

11. Which of the following accurately describes assertions of Alcoholics Anonymous?

A. AA has no dogma, theory or creed for members to learn

B. AA is the only path to recovery

C. Moderate drinking is impossible for people with unhealthy use of alcohol

D. People with alcohol use disorders are not responsible for their condition and actions because an alcohol use disorder is a disease

A. AA HAS NO DOGMA, THEORY OR CREED FOR MEMBERS TO LEARN

AA is not a religion; rather it is a spiritual program or way of life. There are no dogmas or creeds. Despite common misconceptions, AA does not assert that no one can learn to drink moderately after developing unhealthy alcohol use, nor does AA philosophy claim that it is the only path to recovery. Nothing in AA literature advocates either absolving personal responsibility or coercing the person into membership.

Alcoholics Anonymous. (2001). Alcoholics anonymous. New York: Alcoholics Anonymous World Services, Inc.

"Twelve Steps and Twelve Traditions," Alcoholics Anonymous World Services, Inc., Ninth Printing (2003).

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12. Which of the following mutual-help groups is an evidence-based (uses CBT and non-confrontational motivation methods) secular alternative to AA meetings?

A. LifeRing
B. Women for Sobriety
C. Secular Organizations for Sobriety
D. SMART Recovery

D. SMART RECOVERY

SMART Recovery is an abstinence-based, secular approach that emphasizes self-empowerment and uses cognitive behavioral therapy (CBT) and non-confrontational motivation methods to develop skills in four areas: Enhancing Motivation, Coping with Urges, Problem Solving, and Lifestyle Balance. SMART holds in-person and online meetings (*https://www.smartrecovery.org/)*

Studies have shown that SMART Recovery methods can help to decrease problems related to drinking and increase the amount of days a person remains abstinent.

Campbell W, et al, 2016

D. SMART RECOVERY

LifeRing – secular, abstinence-oriented self-help group with meetings and doctrine, which encourage members to maintain abstinence from drugs and alcohol and strive toward enhancing each person's "sober self" while weakening their "addict self." (*https://lifering.org/)*

Women for Sobriety (WFS) - is a program that is specifically engineered to focus on women's treatment needs and what will best support their recovery. Face-to-face groups meet throughout the United States. The groups are led by moderators, and serve to promote emotional and spiritual growth free from the bounds of unhealthy alcohol use and use disorders. *(https://womenforsobriety.org/)*

Secular Organizations for Sobriety - is not one specific program, but rather a collection of programs that are autonomous from each other. SOS provides individuals with alternatives to spirituality based recovery programs. SOS hosts both online and physical face-to-face meetings to help people overcoming any form of addiction *(http://www.sossobriety.org/)*

Other Mutual Support Groups:

Moderation Management

Refuge Recovery

NEED TO KNOW

1. Screening, Brief Intervention, & Referral to Treatment (SBIRT)
2. Stages of Change
3. Substance use Screening Tools
4. Motivational Interviewing
5. Contingency Management
6. Cognitive Behavioral Therapy
7. Alcoholics Anonymous & Narcotics Anonymous
    a. *Twelve Steps*
    b. *Twelve Traditions*
8. SMART Recovery/other mutual-help groups

TWELVE STEPS OF AA

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

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TWELVE TRADITIONS OF NA

1. Our common welfare should come first; personal recovery depends on NA unity.
2. For our group purpose there is but one ultimate authority— a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for membership is a desire to stop using.
4. Each group should be autonomous except in matters affecting other groups or NA as a whole.
5. Each group has but one primary purpose—to carry the message to the addict who still suffers.
6. An NA group ought never endorse, finance, or lend the NA name to any related facility or outside enterprise, lest problems of money, property, or prestige divert us from our primary purpose.
7. Every NA group ought to be fully self-supporting, declining outside contributions.
8. Narcotics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9. NA, as such, ought never be organized, but we may create service boards or committees directly responsible to those they serve.
10. NA has no opinion on outside issues; hence the NA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.

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