CASE TWO

Short case number: 3_15_2
Category: Mental Health and Human Behaviour
Discipline: Psychiatry
Setting: General Practice
Topic: Substance Abuse

Case

Samuel West, 19 years old, presents for review of cellulitis of his arm. He was treated at the local hospital initially and has been discharged on oral antibiotics.
In your assessment of Samuel you record that he has had previous episodes of cellulitis and you note the presence of 'track marks' on both arms.

1. What are the key features of your history and examination of Samuel and why?

Samuel explains that he has been a heroin, tobacco and cannabis user for 4 years, over the last 12 months his heroin habit has been costing >$150.00/day, while cannabis and tobacco are a further $40/day. He wishes he could stop using heroin but feels that life is just "too difficult" to stop using right away. He can see that using heroin has made him sick a few times. When asking about his history you find out Samuel's mother used heroin, and that he left school at 16 because he was getting into trouble and quickly found himself living on the street. He started using cannabis, tobacco and alcohol at age 14, and heroin at 17. Before he started using substances he had a goal to become an electrician like his uncle, who he's always admired.

2. What questions would you ask to assess Samuel's stage of change?

3. Outline how motivational interviewing techniques could help Samuel.

Samuel engages well with motivational interviewing and starts to think using heroin is more trouble than it's worth. He is less resolute about cannabis, tobacco and alcohol. He wants to try seek some help for his problem.

4. Present management options for Samuel using a biopsychosocial approach. Consider community and other services that you would involve in his ongoing management. Consider the use of opioid substitution for Samuel – would you recommend it?

Suggested reading:

1. Management of Mental Disorders (5th edition) World Health Organisation, Collaborating Centre for Evidence in Mental Health Policy. Sydney 2013

2. Dolan KA, Mehrjerdi ZA. Medication-assisted treatment of opioid dependence: a review of the evidence. Australian National Council on Drugs 2015 https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/MATOD%20A%20Review%20of%20the%20Evidence.pdf

3. Wu SS, Schoenfelder E, Ray, C-J (2016) Cognitive Behavioral Therapy and Motivational Enhancement Therapy. Child and Adolescent Psychiatric Clinics of North America 25, 4, 629-643
https://learnit.nd.edu.au/bbcswebdav/xid-7430631_1.

Extra reading:

https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDARC_ANXIETY_FINAL.pdf
and a brief CBT program for cannabis dependence.
https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.064.pdf

ANSWERS

1. What are the key features of your history and examination of Samuel and why?

General principles in history include:

- Establishing and maintaining and empathic relationship based on respect and non-judgemental
- Taking a drug and alcohol history and assessing level of risk associated with the use of each
- Investigating the underlying reasons for substance misuse
- Assessing the patient's motivation to change.

General principles in examination include:

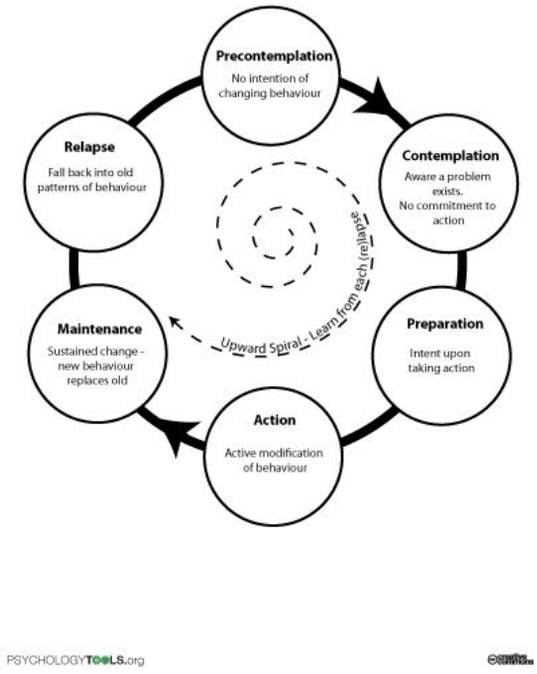
- General appearance, signs of systemic infection – tachycardia, febrile, hypotensive
- Mental state examination may be appropriate
- Examine arm for cellulitis/ lymph node involvement; other possible injury secondary to drug abuse
- Investigations recommended: FBC; UEC; LFT (anaemia, fatty liver); HIV; Hep B,C serology

Standard questionaries used to assess substance abuse:

- Alcohol Use Disorders Identification Test AUDIT (see above)
- Opiate Treatment Index: This instrument is a structured interview covering 6 independent outcome areas: drug use, HIV risk taking behaviour, social functioning, criminality, health status and psychological adjustment. It takes between 20 – 30 minutes to administer and is available from the National Drug and Alcohol Research Centre, University of NSW Sydney https://ndarc.med.unsw.edu.au/resource/opiate-treatment-index-oti-manual

2. What questions would you ask to assess Samuel's stage of change?

The 'Stages of Change' model allows the practitioner to fully understand the process where people move through different stages of preparedness to change.



Adapted from Prochaska and DiClemente's Stages of Change Model

Stage of Change	Characteristics	Techniques
Pre-contemplation	Not currently considering change: "Ignorance is bliss"	Validate lack of readiness Clarify: decision is theirs Encourage re-evaluation of current behavior Encourage self-exploration, not action Explain and personalize the risk
Contemplation	Ambivalent about change: "Sitting on the fence" Not considering change within the next month	Validate lack of readiness Clarify: decision is theirs Encourage evaluation of pros and cons of behavior change Identify and promote new, positive outcome expectations
Preparation	Some experience with change and are trying to change: "Testing the waters" Planning to act within 1month	Identify and assist in problem solving re: obstacles Help the client identify social support Verify that the client has underlying skills for behavior change Encourage small initial steps
Action	Practicing new behavior for 3-6 months	Focus on restructuring cues and social support Bolster self-efficacy for dealing with obstacles Combat feelings of loss and reiterate long-term benefits
Maintenance	Continued commitment to sustaining new behavior Post-6 months to 5 years	Plan for follow-up support Reinforce internal rewards Discuss coping with relapse
Relapse	Resumption of old behaviors: "Fall from grace"	Evaluate trigger for relapse Reassess motivation and barriers Plan stronger coping strategies

Stage 1: Pre-contemplation
Here, people are not thinking seriously about changing and not interested in any kind of help. People in this stage say they do not consider it is a problem. They tend to defend their current bad habit(s) and be defensive in the face of other people's efforts to pressure them to quit.

Stage 2: Contemplation
Here, people are more aware of the personal consequences of their bad habit and spend time thinking about their problem. Although they can consider the possibility of change, they tend to be ambivalent (weighing the pros and cons of quitting or modifying their behaviour). Although they think about the negative aspects of their bad habit and the positives associated with giving it up (or reducing), they may doubt that the long-term benefits associated with quitting will outweigh the short-term costs. It might take from a couple weeks to a lifetime to get through the contemplation stage! On the plus side, people are more open to receiving information and to actually use it and to reflect on their own feelings and thoughts concerning their bad habit.

Stage 3: Preparation
Here, people have made a commitment to make a change. Their motivation for changing is reflected by statements such as: "I've got to do something about this - this is serious. Something has to change. What can I do?"

Stage 4: Action
Here, people believe they have the ability to change their behaviour and are actively involved in taking steps to change their bad behaviour by using a variety of different techniques.

This is generally the shortest of all the stages: it generally lasts about 6 months, but it can be as short as one hour! This is the stage when people most depend on their own motivation and willpower as they are making overt efforts to quit or change the behaviour and are at greatest risk of relapse. They will review their commitment to themselves and develop plans to deal with both personal and external pressures that may lead to slips. They may use short-term rewards to sustain their motivation, and analyse their behaviour change efforts in a way that enhances their self-confidence. People in this stage also tend to be open to receiving help and are also likely to seek support from others (a very important element).

Stage 5: Maintenance
Maintenance involves being able to successfully avoid any temptations to return to the bad habit. The goal is to maintain the new status quo. Here, people tend to remind themselves of how much progress they have made. They constantly reformulate the rules of their lives and as they acquire new skills to deal with life and avoid relapse. They are able to anticipate the situations in which a relapse could occur and prepare coping strategies in advance.

Relapse
Most people experience relapses along the way to permanent cessation or stable reduction of a bad habit. In fact, it is much more common to have at least one relapse than not. Relapse is often accompanied by feelings of discouragement and seeing oneself as a failure. While relapse can be discouraging, the majority of successful quitters do not follow a straight path to a life time free of self-destructive bad habits. Rather, they cycle through the five stages several times before achieving a stable life style change (see diagram). Consequently, the Model considers relapse to be normal.

The following is a list of strategies clinicians can use in motivational interviewing (see Table). Practitioners select their approach for a given consultation depending upon the patient's readiness to change. More than one strategy may be employed in an interview. The practitioner moves down the list of strategies as the patient's readiness to change increases.

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The overall shape of the sessions includes:
1. Opening strategy – lifestyle, stresses, substance abuse
2. Looking at what is involved in a typical day/session
3. Evaluating the good things/the less good things
4. Providing information
5. Discussing the future and the present
6. Exploring concerns
7. Assisting with decision making.

3. **Outline how motivational interviewing (MI) techniques could help Samuel.**
   The MI approach is non-confrontational and person-centred. By its nature it is transparent and puts the onus back onto the person to decide where on the change cycle they feel comfortable. The key to management is to engage the patient in articulating for themselves the positive and negatives about their drug use. This can lessen defensiveness and lead to more open conversation.

   As there are things that can be done at each stage (see Table), the clinician can feel useful rather than helpless. MI is about patients finding their own motivation rather than being told by their doctor what is good for them. It may be useful to work with the patient to develop a motivational matrix to help them move from the pre-contemplative to the contemplative and subsequent stages

   Doctors need to walk a fine line between drawing out what a person knows about their drug use and informing the patient about the medical consequences of their drug use.

4. **Present management options for Samuel using a biopsychosocial approach. Consider community and other services that you would involve in his ongoing management. Consider the use of opioid substitution for Samuel – would you recommend it?**

   Ongoing pharmacological and psychological management strategies that may be useful
   There are a wide range of treatment options for patients with heroin dependence.

   The following information is amended from Dolan and Mehrjerdi: Medication-assisted treatment of opioid dependence: a review of the evidence, 2015.
   https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/MATOD%20A%20Review%20of%20the%20Evidence.pdf
   Good local handout at https://www.betterhealth.vic.gov.au/health/healthyliving/heroin-dependence-medication-treatments?viewAsPdf=true

   To become drug-free, dependent users have to overcome the compulsion of drug use, ongoing cravings and the physical adaptation to chronic drug use. They also have to address psychological and social issues that may be underlying reasons for using drugs or the consequences of a drug-using lifestyle. This often requires a radical rethink of how they spend their time and who they associate with.

   Recovery from severe and long-standing dependence is likely to require substantial physical, psychological and lifestyle readjustments, which can take years.
   Patients may require several different types of treatments in order to overcome their dependency.
   While detoxification is not considered a treatment, it is often the first step in overcoming drug dependence.

   Stage 1: Detoxification
   Detoxification refers to the elimination of heroin or other drugs from the body and takes about one week. People may detoxify in hospital, specialist drug and alcohol units, outpatient clinics or at home. Two distinct medication approaches to manage heroin withdrawal are (i) the abrupt cessation of heroin use and symptom relief using non-opioid drugs like benzodiazepines, anti-emetics, NSAIDs and clonidine; and (ii) a short course of reducing doses

of buprenorphine to manage withdrawal. This approach enables the transfer to naltrexone for relapse prevention treatment or to substitution treatment.

The provision of detoxification services entails: assessment; treatment matching; planning for withdrawal; supportive care, and linkages with services for further treatment and support. Detoxification in opioid dependence should always be considered as part of a structured treatment approach.

Stage 2: Immediate treatment to initiate and maintain abstinence

Group programs providing education and supporting public, NGO and private settings
It is recommended that patients participate in self-help groups, as participation opposed to just attendance is related to effectiveness. See https://smartrecoveryaustralia.com.au/

- **Self-help groups Narcotics Anonymous (NA)** is a self-help group for individuals who work through 12 steps in order to maintain a drug-free lifestyle (Groh et al., 2008). One study of NA attenders in London found that, after six months, 50 per cent were still attending on average 2.2 meetings per week and 46 per cent were abstinent (Christo & Franey, 1995).
- **SMART Recovery (Self-Management and Recovery Training)** is a cognitive group approach that promotes, but does not require, abstinence. This approach is particularly useful for patients in substitution treatment programs who might benefit from mutual support and networking with other recovering drug users but who may feel excluded by the drug-free emphasis of NA. See https://smartrecoveryaustralia.com.au/
- **Therapeutic communities (TCs)** are residential programs where drug users live and usually work in a community of ex-users and professional staff. Programs last between 1-18 months. TCs aim to build the skills and attitudes required to make positive, long-term changes towards a drug-free lifestyle and include relapse prevention training, group work, employment training, education, life skills training and counselling, then assist individuals to return to their community. The We Help Ourselves (WHOS) program runs for 3-6 six months, after which clients can move into supported accommodation.
- **Medication-assisted treatment of opioid dependence (MATOD)** seeks to reduce or eliminate heroin/unsanctioned opioid use to improve the health and wellbeing of patients.
  Methadone substitution treatment reduces the harms from using heroin, such as HIV and hepatitis C infections, involvement in drug-related crime, or death associated with opioid use. Heroin use can lead to poor physical and mental health: MATOD can help patients reduce their frequency of heroin use, alleviate withdrawal symptoms and improve overall health, quality of life and social functioning among heroin users.
  Buprenorphine treatment: Two buprenorphine products are registered in Australia: Subutex (buprenorphine hydrochloride) and Suboxone (buprenorphine hydrochloride and naloxone hydrochloride), both taken sublingually. Suboxone minimises potential misuse and diversion of buprenorphine, as buprenorphine-naloxone combination preparations are less likely to be injected than mono preparations containing only buprenorphine. This makes Suboxone the preferred option for 'takeaway' doses.
  Naltrexone is used in patients who have ceased opioid use with the aim of preventing relapse to drug use. Psychosocial support is an integral component of naltrexone maintenance treatment. Naltrexone treatment for dependence is a long-term undertaking, as relapse to heroin dependence can occur even after two or three years of treatment.

Stage 3: Changing patterns of thoughts and behaviours/Staying well
Substance use disorders (SUDs) are heterogeneous conditions characterised by recurrent maladaptive use of a psychoactive substance associated with significant distress and disability. Our understanding of the nature of substance use patterns has improved, leading to greater specificity of psychosocial and pharmacologic treatments, with evidence for the efficacy and cost-effectiveness of these approaches.

Cognitive Behaviour Therapy, Motivational Enhancement Therapy (MET)[1] (see Wu SS, Schoenfelder E, Ray, C-J (2016)) have been useful for younger people while Interpersonal Therapy, Dialectical Behaviour Therapy (DBT), Family Therapy are some treatments that may be of use. All of these can be personalised to the individual, according to style, motivation, duration and severity of addiction. In younger people, especially if living at home, involving the family can be very helpful.

NDARC has some resources for addicts who have anxiety disorders which have potential use for Samuel if anxiety is driving his addiction and dealing with his cannabis problem. These would be applied after the heroin issues are dealt with.
https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDARC_ANXIETY_FINAL.pdf
Also, a brief CBT program for cannabis dependence,
https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.064.pdf

[1] Motivational enhancement therapy (MET) begins with the assumption that the responsibility and capacity for change lie within the patient. The therapist begins by providing individualized feedback about the effects of the patient's drinking. Working closely together, therapist and patient explore the benefits of abstinence, review treatment options, and design a plan to implement treatment goals. MET may be one of the most cost-effective treatments. The motivational interviewing technique - a key component of MET - was shown to overcome patients' reluctance to enter treatment more effectively than did other conventional approaches.