

Volume C, Module 3: Special Populations: Individuals with Co-occurring Disorders, Women, and Young People



Treatnet Training Volume C: Module 3 – Updated 18 October 2007

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



Icebreaker

Who are the people most affected by drug use in your country / region? How does their drug use affect your community?



15 minutes

Training objectives



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 practises 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).

Categories of mental health and substance use disorders

Mental Disorders

- Major Depression
- Antisocial Personality
- Borderline Personality
- Bipolar Illness
- Schizoaffective
- Schizophrenia
- Posttraumatic Stress
- Social Phobia
- Others

Addiction Disorders

- Alcohol Abuse / Dependency
- Cocaine/ Amphetamines
- Opiates
- Volatile Chemicals
- Marijuana
- Polysubstance combinations
- Prescription drugs

Drug-induced psychopathology

Drug States

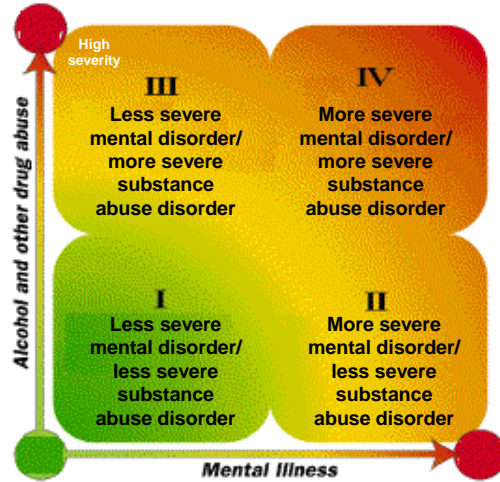
- Withdrawal
 - Acute
 - Protracted
- Intoxication
- Chronic use

Symptom Groups

- Depression
- Anxiety
- Psychosis
- Mania

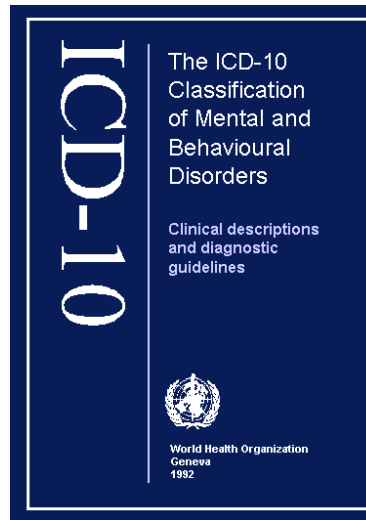
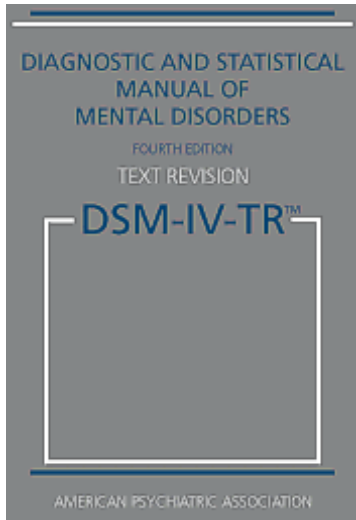
(Source: Rounsaville, 1990)

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”



DSM-III diagnoses (rates per 100 people)

	1 Month	Lifetime
Any Alcohol, Drug or Mental Health Disorder	15.7	32.7
Any Mental Disorder	13.0	22.5
Alcohol Dependence	1.7	7.9
Drug Dependence	0.8	3.5

(Source: Regier et al., 1990)

Lifetime prevalence and odds ratios

	Alcohol	OR	Other Drug	OR
• Any mental	36.6%	2.3	53.1%	4.5
• Schizophrenia	3.8%	3.3	6.8%	6.2
• Any affective	13.4%	1.9	26.4%	4.7
• Anti-social	14.3%	21.0	17.8%	13.4
• Alcohol			47.3%	7.1

Regier, 1990

Likelihood of a suicide attempt

Risk Factor	Increased Odds of Attempting Suicide
Cocaine use	62 times more likely
Major depression	41 times more likely
Alcohol use	8 times more likely
Separation or divorce	11 times more likely

(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....

(Source: Preuss / Schuckit, Am. J. Psych., 2003)

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)
- Higher suicide rates (+8%) in 18- vs 21-year-old legal drinking age states for those 18-21 (Birckmayer, J., Am. J. Pub. Health, 1999)

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

(Source: Preuss / Schuckit, Am. J. Psych., 2003)

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.

Substance abuse and trauma

- 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

Continued

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

Continued

Substance abuse and trauma

- 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

Continued

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



(Source: Mueser, K.T., Trumbetta, S.D., Rosenberg, S.D., Vidaver, R., Goodman, L.B., Osher, F.C., Auciello, P., & Foy, D.W. (1998). *Journal of Consulting and Clinical Psychology*, 66(3), 493-499.)

Definition 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
AND
- 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

PTSD

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

PTSD

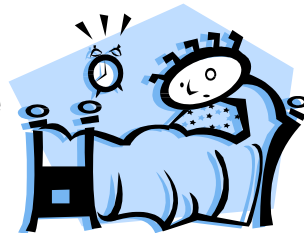
Avoidance of stimuli and numbing of general responsiveness indicated by 3 or more of the following:

- 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

PTSD

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



(Source: McGrath et al., Psych. Clin. N. Am., 2001.)

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

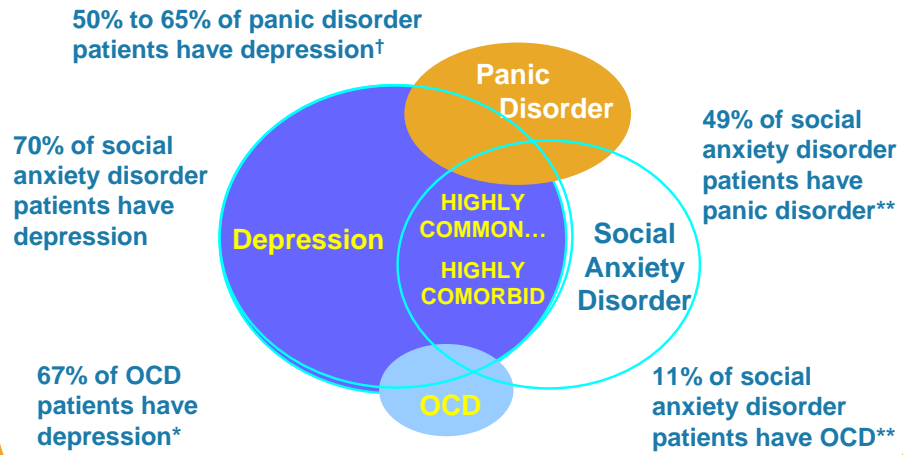
- atypical neuroleptics most commonly used (olanzapine, risperidone, quetiapine, aripiprazole, or clozapine for refractory symptoms), but there is evidence supporting use of typical neuroleptics as well (haloperidol, perphenazine)

Medications for treating individuals with schizophrenia

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



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

Treatment of co-occurring disorders: Areas of promise - Anxiety

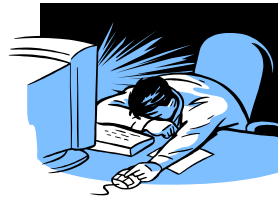
- **Anxiety Disorders**
 - Social anxiety disorders: SSRIs
 - Panic attacks: SSRIs
 - PTSD: Psychotherapies
 - Generalized anxiety disorders
 - Many forms of psychotherapy, relaxation training, biofeedback, exercise, etc. can be useful
 - Concerns about use of benzodiazepines with individuals in SA treatment

Treatment of co-occurring disorders: Areas of promise - Schizophrenia

- 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

Treatment 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

Treatment of co-occurring disorders

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)

Elements of an integrated model: Preliminary assessment



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

Elements of an integrated model: Extended treatment plan

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



Training objectives



At the end of this training you will understand the:

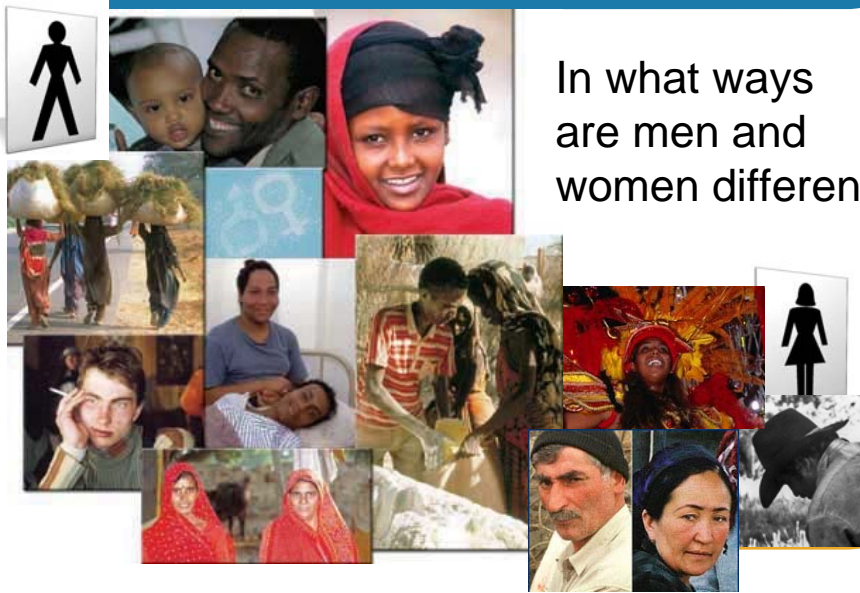
- Impact of alcohol and drug use on women
- Medical and substance abuse treatment issues important to the treatment of women

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.

64

Notes

There may be a range of other factors to which general practitioners (GPs) can contribute; e.g., impact on child care when the mother is the primary caregiver.

Prevalence of AOD use in women (1)

- 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



65

Notes

In Australia, 41% of males and 34% of females reported ever having used illicit drugs (including cannabis and non-medical use of prescription drugs); 20% of males and 14% of females reported having used any illicit drug in the last 12 months (including cannabis) (Australian Institute of Health and Welfare (AIHW), 2002).

Increasingly, there are fewer gender differences in prevalence of AOD use. Women, especially young women, tend to consume different types of alcoholic beverages (such as premixed spirits, wine, and coolers) than young men (beer and spirits). Knowledge about the types of beverage can assist in appropriate discussion about reducing alcohol-related harms

Although males tend to consume more alcohol more frequently than females, given the higher susceptibility of females to alcohol-related harms, similar proportions of males and females are at risk of long-term harm

It is helpful if screening for AOD use (in women as well as men) is a routine enquiry for GPs. Patients expect health professionals including GPs to ask about lifestyle issues, including use of AOD.

Source: AIHW (Australian Institute of Health and Welfare) 2002, *2001 National Drug Strategy Household Survey: Detailed Findings*, Drug Statistics Series No. 11, AIHW cat no. PHE 41, AIHW, Canberra.

Prevalence of AOD use in women (2)

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

67

Notes

Harm minimisation strategies (especially intoxication and regular use) are critically important given the susceptibility of women to AOD-related harms.

Problems relating to intoxication and regular use form the bulk of problems (as for men), dwarfing problems relating to dependent use.

It is important that GPs recognise changing patterns of AOD use such as binge drinking and polydrug use, both of which are increasingly common in women, and implement harm minimisation strategies in response to these.

Regular physical health checkups are important given higher risk of alcohol-related disease and breast cancer. An opportune time for investigating lifestyle issues around AOD patterns of use may occur during routine cervical screening and breast examination.

Case study

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?



68

Instructions

Facilitate discussion about this scenario.

Identifying harms from drug use

Intoxication

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

Dependence

- family and societal censure
- child welfare intervention
- marginalisation
- reluctance to seek help
- overdose potential
- rapid deterioration in health

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

Why can it be difficult to detect AOD problems in female patients?



Notes

Barriers may include:

Greater social stigma for women with AOD problems (than for men) which can result in a reluctance to present, disclose & engage with their GP.

Feelings of guilt regarding their AOD use greater than for most men, particularly if a mother (or pregnant).

Therefore:

Greater vigilance is required on the part of a GP to detect AOD problems in females. Offer emotional support where this is warranted.

As women tend to be more vigilant about their health and visit GPs more frequently than men, there is an opportunity for GPs to engage women in discussing lifestyle issues associated with AOD use or related problems.

General:

Confrontational approaches to drug issues are ineffective. Women have a greater tendency than men towards feeling guilty about AOD-related issues, or to experience low mood or anxiety. Use of motivational interviewing principles may be effective in eliciting their perception of problems related to their drug use.

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.

71

Notes

There is a high prevalence of women who have experienced physical, sexual, or emotional abuse in AOD treatment. They are likely to have a greater severity of psychosocial problems than other women. Such women may require more intensive, longer-term interventions.

It is important that GPs and health services recognise and respond to the specific needs of women, such as need for childcare, privacy, or additional emotional support.

Sources: Baily, S. 1990, 'Women with Alcohol Problems: a Psychosocial Perspective', *Drug and Alcohol Review*, vol. 9, pp. 125–131.

Kelly, B. & McGregor, D. 1994, 'Models of Alcohol and Other Drugs Service Delivery Among Women', in Copeland, J. & Swift, W. (eds.) proceedings of the *National Women & Drugs Conference: Challenge, Consensus and Change*, NSW Health Department, pp. 65–75.

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

72

Notes

Women are the primary caretakers in many families. Consequently, it may be extremely difficult for some women to enter treatment without child care provision for their children. Non-residential interventions may be more appropriate in the first instance.

Many women request complementary therapies, considered by some health and medical practitioners to lack an evidence-base. However, encouraging personal choice and responsibility for health care and providing accurate information and advice may result in a suitable balance of options.

Providing the opportunity for a female patient to ask about referral to a female health professional may be appropriate.

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.

73

Notes

Retention in treatment is a challenge with AOD clients, so much weight must be put upon service characteristics that are likely to engage women.

Source: Copeland, J. & Hall, W. 1992, 'A Comparison of Predictors of Treatment Drop-out of Women Seeking Drug and Alcohol Treatment in a Specialist Women's and Two Traditional Mixed-sex Treatment Services', *British Journal of Addiction*, vol. 87, pp. 1293–1302.

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

74

Notes

Depression is very common in females who are alcohol-dependent; therefore, the depression may need to be treated in its own right.

When a patient is dependent on AOD, good clinical judgement is needed prior to commencing antidepressant therapy – even when criteria for a diagnosis of depression are met. A time frame of 4–6 weeks to recover from residual symptoms of dependence may be required before an accurate assessment for depression can be obtained. Also consider risk of overdose if medicating for depression during 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.

75

Notes

Specialist treatment is recommended for women with both AOD problems and an eating disorder.

In the instance of polydrug use, negotiate with the patient in deciding which drug will be prioritised initially.

Relapse prevention for women (1)

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).

76

Notes

It should be stressed that these gender differences are a matter of emphasis. There is considerable overlap between the sexes. Any similarities may become more pronounced in time as social and occupational roles of women and men become more alike.

Source: Baily, S. 1990, 'Women with Alcohol Problems: a Psychosocial Perspective', *Drug and Alcohol Review*, vol. 9, pp. 125–131.

Relapse prevention in women (2)

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)

77

Notes

Consider both individual and gender-specific approaches to relapse prevention and management program.

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

78

Notes

Despite the potential and inherent barriers in encouraging women to enter treatment, the rewards may be well worthwhile and significant. Women with dependent children are likely to complete treatment. This relationship has not been investigated among males.

Fertility and AOD 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)
- amenorrhoea (heroin, amphetamines, cocaine)
- increased risk of sexually transmitted disease (which affects fertility)



79

Source: Dore, G. 2002, 'Women and Substance Abuse' in Hulse, G., White, J., & Cape, G. (eds.), *Management of Alcohol and Drug Problems*, Oxford University Press, South Melbourne, pp. 289–309.

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

80

Notes

A broad assessment is required. It remains unclear whether drug use per se causes damage to the fetus (except at exceptionally high doses), or whether the lifestyle associated with chaotic drug dependence is primarily responsible for the damage. In many cases, fetal damage may be a result of the combination of drug use and lifestyle factors.

Assessment of 'mothers-to-be' (2)

- 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)

81

Notes

To protect the fetus, pregnancy is a period in which a thorough drug assessment is vital.

Some debate may ensue around requiring the consent of the patient in obtaining corroborative information. This is a difficult area and divergence of opinion may be expected. If the GP suspects that the patient is giving an inadequate report, this can be discussed with the patient in an attempt to elicit greater accuracy of the report. If concerns persist, and the GP thinks the fetus is at considerable risk, the GP can gently inform the patient that further information must be sought (bearing in mind the prospect that the patient may change GPs). Reporting the case to the relevant health/welfare authorities is also an option.

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)

82

Notes

The purpose of this slide is to discourage practises that may frighten new or intending mothers. Scare tactics may make some mothers feel extremely anxious (and this may impact on the fetus' wellbeing) or may result in disengagement from antenatal care.

'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.

83

Notes

The points above do not represent hard-and-fast diagnostic criteria for high-risk AOD use. Each point serves to raise suspicions of factors that may indicate high-risk use.

Source: Kahan, M. & Wilson, L. 2001, '*Managing Alcohol, Tobacco and Other Drug Problems: A Pocket Guide for Physicians and Nurses*' [draft], Canada.

'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)

84

Notes

The points above do not represent hard-and-fast diagnostic criteria for high-risk AOD use. Each point serves to raise suspicions of factors that may indicate high-risk use.

Source: Kahan, M. & Wilson, L. 2001, '*Managing Alcohol, Tobacco and Other Drug Problems: A Pocket Guide for Physicians and Nurses*' [draft], Canada.

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.

85

Notes

This slide aims to reinforce the idea that most women are receptive to developing strategies and interventions that will protect their babies. Most will respond to offers of assistance.

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

86

Notes

An extension of the previous slide

For mothers who are reluctant to engage fully in care, a harm minimisation focus is still worthwhile and may be enough to insure the wellbeing of the fetus.

Antenatal shared care (1)

- 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



87

Notes

It is not expected that the GP manage a drug-dependent mother alone. Shared care is essential to provide comprehensive risk-reduction.

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

88

Notes

It is best that termination counselling is given by those with expertise in this area. Some GPs may have experience and competence to address this issue

Remember, the mother is your patient and until the fetus is born, the baby (fetus) does not have rights.

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)

89

Notes

Although many facts raised in this topic will be familiar to most GPs, it is important to reinforce the role of accurate screening and intervention for women and intending mothers, because of the risk to the developing fetus from high-risk patterns of AOD use.

More detail on drug-specific effects and the Neonatal Abstinence Syndrome is included later in the module.

Risk for the fetus: Alcohol (1)



- 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

90

Notes

Women drinking alcohol or using drugs in high-risk or dependent patterns rarely identify themselves as such and may be unaware of the possible impact on their baby.

Risk for the fetus: Alcohol (2)

- 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).

91

Notes

The distinction between Fetal Alcohol Syndrome and Fetal Alcohol Effects is an important one. The full-blown syndrome of FAS is relatively rare. However, damage to the fetus lies on a continuum from mild to severe harm. Less severe consequences (and therefore harder to diagnose) than those represented by the 'syndrome' are summarised as 'Fetal Alcohol Effects' on the following slide.

Source: Dore, G. 2002, 'Women and Substance Abuse' in Hulse, G., White, J., & Cape, G. (eds.), *Management of Alcohol and Drug Problems*, Oxford University Press, South Melbourne, pp. 289–309.

Kahan, M. & Wilson, L. 2001, '*Managing Alcohol, Tobacco and Other Drug Problems: A Pocket Guide for Physicians and Nurses*' [draft], Canada, pp. 214–215.

Risk for the fetus: Alcohol (3)

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

92

Notes

The estimated occurrence of Fetal Alcohol Effects is 1 in 100 births (Kahan & Wilson, 2001), which is a caution that extreme vigilance is required in relation to drinking and pregnancy. Although it appears prudent to advise intending mothers and pregnant women to abstain, there is little evidence to suggest that consumption of ≤ 1 standard drink a day represents harm to the fetus. On the other hand, there are no established levels of drinking considered safe for the developing fetus

Advise all women of safe drinking levels, and advise pregnant women in particular, to avoid intoxication.

Source: Dore, G. 2002, 'Women and Substance Abuse' in Hulse, G., White, J., & Cape, G. (eds.), *Management of Alcohol and Drug Problems*, Oxford University Press, South Melbourne, pp. 289–309.

Kahan, M. & Wilson, L. 2001, '*Managing Alcohol, Tobacco and Other Drug Problems: A Pocket Guide for Physicians and Nurses*' [draft], Canada, pp. 214–215.

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

93

Notes

While cutting down frequency or changing cigarette content may reduce the risks to the fetus, there are no therapeutic benefits to the mother or baby to continue tobacco use. Encourage abstinence, at least for the period of pregnancy.

“SIDS” is the acronym for Sudden Infant Death Syndrome.

Source: Dore, G. 2002, ‘Women and Substance Abuse’ in Hulse, G., White, J., & Cape, G. (eds.), *Management of Alcohol and Drug Problems*, Oxford University Press, South Melbourne, pp. 289–309.

Risk for the fetus: Smoking (2)

- 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



94

Source: Dore, G. 2002, 'Women and Substance Abuse' in Hulse, G., White, J., & Cape, G. (eds.), *Management of Alcohol and Drug Problems*, Oxford University Press, South Melbourne, pp. 289–309.

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

95

Notes

A range of physical, psychological, and social factors may contribute to increased risks of obstetrical complications associated with illicit drug use, including infection, lack of prenatal care, poor nutritional status and risks associated with intoxication or withdrawal.

Although neonatal risk of HCV transmission is < 5%, the mother needs to be advised of possible risk.

Withdrawal is associated with increased risk of miscarriage in early pregnancy or premature labour.

Source: Dore, G. 2002, 'Women and Substance Abuse' in Hulse, G., White, J., & Cape, G. (eds.), *Management of Alcohol and Drug Problems*, Oxford University Press, South Melbourne, pp. 289–309.

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).

96

Notes

If the mother’s lifestyle can be stabilised and the risk of unplanned sharing of equipment eliminated, then the disadvantages of methadone for the fetus are far outweighed by the risks associated with abrupt cessation of heroin use.

Australian studies are in progress with buprenorphine in pregnancy. It has been used successfully overseas.

Source: Dore, G. 2002, ‘Women and Substance Abuse’ in Hulse, G., White, J., & Cape, G. (eds.), *Management of Alcohol and Drug Problems*, Oxford University Press, South Melbourne, pp. 289–309.

Risk for the fetus: Amphetamines and cocaine

- 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

97

Notes

The risks from the use of psychostimulants are in addition to the general effects already described as presenting risks to the fetus.

Not a great deal is known regarding specific dose-related risks from using psychostimulants. However, use of these drugs has been found to cause vasoconstriction and hypertension, which may result in fetal hypoxia.

Cocaine may cause increased risk of miscarriage, pre-term labour, low birthweight, abruptio placentae, or still birth. It is possible that the effects from amphetamines resemble those of cocaine.

A range of physical, psychological, and social factors may contribute to increased risks of obstetrical complications associated with illicit drug use, including infection, lack of prenatal care, poor nutritional status, and risks associated with intoxication or withdrawal.

Source: Dore, G. 2002, 'Women and Substance Abuse' in Hulse, G., White, J., & Cape, G. (eds.), *Management of Alcohol and Drug Problems*, Oxford University Press, South Melbourne, pp. 289–309.

Risk for the fetus: Benzodiazepines

- 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

98

Notes

These effects are noted at levels well in excess of standard therapeutic dosage of benzodiazepines.

Source: Dore, G. 2002, 'Women and Substance Abuse' in Hulse, G., White, J., & Cape, G. (eds.), *Management of Alcohol and Drug Problems*, Oxford University Press, South Melbourne, pp. 289–309.

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

99

Notes

Thresholds of risk are not known, but use is associated with poor nutrition and poor self-care in disadvantaged women. Lifestyle factors compound the risks to the fetus.

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



100

Notes

The relatively low levels of caffeine consumption associated with low birthweight may surprise some GPs. This is consistent with reported mild toxicity of 5–6 cups of coffee in users generally.

Most cups of tea have less caffeine than coffee (especially brewed coffee). Caffeine levels associated with Neonatal Abstinence Syndrome are in excess of that contained in 5–6 cups of coffee/tea.

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

101

Notes

The precise details of NAS are relevant to GPs informing their patients of the dangers, and advising the relevant medical personnel of the possibility of NAS.

Many GPs will be aware of these details.

60% of babies born to methadone-dependent mothers will experience NAS.

Source: Dore, G. 2002, 'Women and Substance Abuse' in Hulse, G., White, J., & Cape, G. (eds.), *Management of Alcohol and Drug Problems*, Oxford University Press, South Melbourne, pp. 289–309.

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

102

Notes

Emphasise a holistic approach to NAS for the wellbeing of the mother and infant.

Source: Dore, G. 2002, 'Women and Substance Abuse' in Hulse, G., White, J., & Cape, G. (eds.), *Management of Alcohol and Drug Problems*, Oxford University Press, South Melbourne, pp. 289–309.

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)



104

Notes

This is harm reduction information that is highly relevant to the GP's ongoing relationship with the mother.

An opportunity presents itself to promote breast feeding per se when dealing with the issues of AOD use and breast feeding.

Source: NHMRC (National Health and Medical Research Council). 2001, *Australian Alcohol Guidelines: Health Risks and Benefits*, Commonwealth of Australia, Canberra.

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

105

Shared care: Child protection

- 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

106

Notes

This is a sober note on which to end this topic, but a necessary one as there is a high risk to children of mothers who continue to use drugs.

GPs may wonder how realistic it is that they be closely involved in shared care. Reassure them that if they make the necessary referrals, aid the patient in making contact, and then follow-up to ascertain the outcome, they will have done as much as can be reasonably expected.

Workshop 3

Young People: Addiction and Treatment Issues



Training objectives



At the end of this training you will understand the:

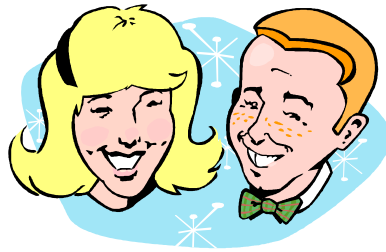
- Impact of alcohol and drug use on young people
- Medical and substance abuse treatment issues important to the treatment of young people

Young People



Who is young?

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



110

Notes

Sometimes the distinction between a “young person,” a “youth,” or “young adult” may appear arbitrary and serve no functional purpose when dealing with AOD problems.

Surveys and health studies arbitrarily usually define people as “young” if they are between 14 and 25 years old. However, agencies may define their target group of young people as comprising people up to 30 years of age. Socially, people under 30 are often defined as “young.”

Legal implications – be aware of your region’s laws regarding the age over which a young person can be treated as an adult without the need for parental consent/involvement. Treatment of people under a certain age may require consent and parental involvement. There is a need to consider legal implications of any interventions offered in a general practice setting.

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?

111

Notes

A number of issues are likely to be raised from this brief vignette, which can then be linked to specific slides from this set.

Why do young people use drugs?



Notes

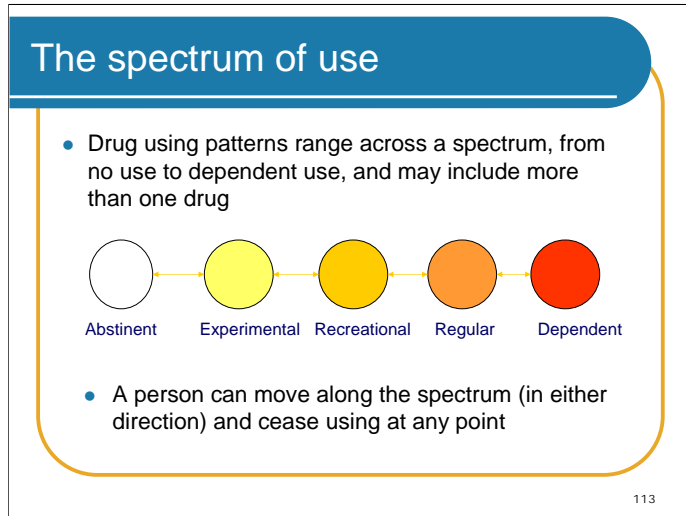
There may be numerous reasons, but they are similar to those for adults, i.e.:

- many positive rewards, or to serve a particular purpose
- fun, relief of boredom, a sense of daring, satisfies curiosity, achieves group membership or provides “time out” from life’s issues
- for many, drug use provides a bonding experience, a rite-of-passage, or may boost confidence
- life may appear inconsistent and confusing
- some young people perceive life difficult as they define their identity and role in the world, while having to deal with a myriad of pressures

Some GPs may find the “drugs are fun” thesis unpalatable. They may need to consider the reasons for using their own drugs of choice, e.g., alcohol, cigarettes.

Experimental drug use tends to have greater perceived benefits for young people and these usually tend to outweigh any costs. The costs tend to mount up after some time of regular use. Young people are at most risk of intoxication-related harms. Thus there is an understandable emphasis among many young people that encourages use in high-risk ways (e.g., binge drinking, drinking/using to intoxication, getting stoned etc.), and stresses enjoying the moment rather than being concerned about possible future consequences.

Most young people experiment with some drugs. It is important not to view this use as deviant or pathological, but rather to keep a focus on reducing the likelihood of harm. Experimental use is addressed on a later slide.



Notes

The categories described above are not mutually exclusive (with the exception of non-use or abstinence) but reflect an emphasis on pattern of use at any given point in time. Experimental and recreational use, in particular, overlap.

Non-use/abstinence

- never used (very rare) or currently not using any psychoactive drugs

Experimental use

- trying or experimenting with different drugs to see what they are like and discovering their effects and consequences. This pattern is so common (particularly with alcohol, tobacco, cannabis) it is considered 'the norm'

Recreational use

- deliberate use of a drug tends to enhance ability to socialise
- generally not associated with dependent use but has risks relating to intoxication

Regular Use

- frequent use extends beyond recreational settings
- some describe their use as to assist to respond to life's pressures
- some people may experience some distress if their regular pattern of use is interrupted, however, this pattern is not generally marked by drug seeking behaviours

Dependent use

- life tends to revolve around drug use/drug seeking behaviours
- tends to compromise normal functioning in every aspect
- pronounced withdrawal occurs on cessation of use

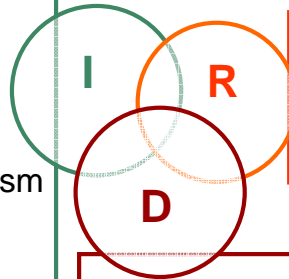
Young people may present anywhere on the spectrum at any point in time. However, dependence is generally unusual, as dependent patterns of use take some time to develop.

Source: ADTRU (Alcohol and Drug Training and Research Unit), 2002, *Training Package for Medical Practitioners in the Effective Identification and Treatment of Pharmaceutical and Illicit Drug Problems*, module 11, ADTRU, Queensland Divisions of General Practice and Department of Psychiatry, University of Queensland, Brisbane, pp. 2–4.

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

114

Notes

Young people are most likely to experience intoxication-related harms.

A sole emphasis on **dependence** may result in the proportionally greater number of non-dependent users with problems related to **intoxication** (particularly among young people) and **regular use** going undetected.

“BBV” stands for blood-borne viruses.

Source: Thorley, A. 1980, ‘Medical Responses to Problem Drinking’, *The British Medicine Journal*, pp. 2474–2482.

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

115

Notes

It is important that GPs seek information from young people about harms associated with high-risk patterns of alcohol use in the first instance.

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

116

Notes

Differential diagnosis is warranted when assessing young people’s AOD use. GPs need to be aware that many AOD indicators can also be indicators of other behaviours and of adolescence in general, e.g., the patient may be unwell, experiencing relationship difficulties, or have mental health issues.

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 practises, which can permanently damage the young person's trust in health professionals

117

Notes

Engage the patient with an initial discussion around something he or she is currently doing, e.g., sport, music, job. Discuss how this is going. Once rapport is established, discuss the concerns a young person may have. The fundamental approach is to be non-judgemental and open-minded.

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)

118

Notes

Assessment must be conducted sensitively. Many young people find assessments very intrusive.

Use open-ended questions, as closed questions will usually elicit closed responses.

Closed questions can be useful to gain specific information, e.g., age, year at school/university, how long the issue has been a concern.

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

119

Notes

Motivational interviewing is a useful technique for engaging the patient in behaviours to reduce AOD-related harms.

Parental involvement (1)



- 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.

120

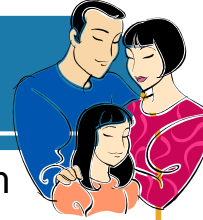
Notes

Parents often look to the GP to provide a solution, to tell their children what they must do.

Young people often resent this parental stance and they are very sensitive to a doctor–parent alliance.

Be aware of your region's laws regarding the young person's privacy & confidentiality rights (unless the GP believes there is risk of harm).

Parental involvement (2)



- 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

121

Notes

Refer parents to parenting classes, couple counselling, and other supports where appropriate.

'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

122

Notes

Reducing intoxication-related harms is especially important with young people, who often push boundaries even when not under the influence of psychoactive drugs. Encourage them to keep safe when intoxicated (no high risk activities such as driving, operating machinery, swimming/diving, fighting, unprotected sex) and assist them to seek skills that may help their friends in times of need (e.g., for overdose or injury).

'Treatment' (2)

- 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, humorous, creative, and "to-the-point"



123

'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

124

Notes

Few young AOD users and their families will undergo family therapy. However, GPs may be in a position to alter communication patterns by working with any member(s) of the family (a flow-on systems effect).

Focus on behaviours rather than the "personality" of the young person, their parents/carers, or siblings.

Stress the value of negotiating compromise in behaviour/lifestyles that all can accommodate.

Encourage healthy interdependence (falls between total independence and total dependence/obedience).

Open communication (acknowledgement of needs and concerns of both the young person and the parent/caregiver).

Family therapy

- 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.)



10 minutes





Thank you for your time!