PREVENTION, HARM REDUCTION, STAGES OF CHANGE AND TREATMENT OF ADDICTION

PREVENTION

- General prevention strategies target adolescents, focused strategies target specific at risk populations
- Family, school, leisure, media, healthcare, community, legislation and regulations strategies:

Educate and provide information

Target daily routine and boredom – leisure time

Target stress and anxiety management

Skill training - Target relationships, self-esteem, communication skills

Preschool

- High quality early childhood education – reinforcement of cognitive and social skills
- Parental training and education

Elementary school

- Teacher education – class becomes an important factor
- Parent education

Preparing for the Drug (Free) Years (Hawkins et al., 1988)

Middle school

- Period of increased peer influence
- An effort to increase the individual's interactions with prosocial groups of classmates and involve them in prosocial activities
- The School Transitional Environment Program (Felner & Adan, 1988)
- The Midwestern Prevention Project
- **P. A. N . D. A .** American Program „Prevent and Neutralize Drug and Alcohol Abuse“

High school

- Programs focused on individuals:

Responsible behaviour, realistic goals, career planning, self-esteem

- School based programs (significant impact of school):

Free time activities, adjustment of school regulations

Peer programs

- The principle of the peer program is the involvement of pre-prepared peers
- It is one of the most effective forms of prevention
- The advantage of the peer program is that young people between the ages of 13 and 18 turn to their peers for support

training of communication skills and abilities,

exercises of empathy, assertiveness and decision-making,

training in skills and abilities to listen to others,

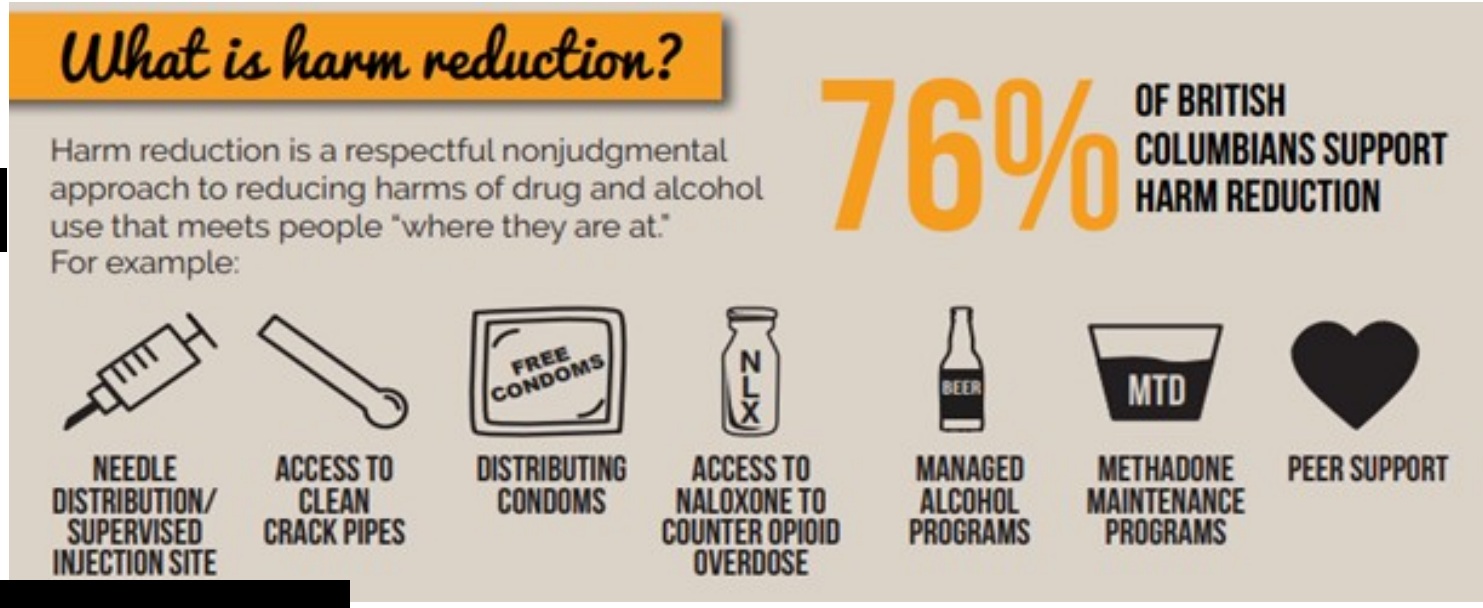
strengthening proper self-assessment, information on drug addiction and their prevention,

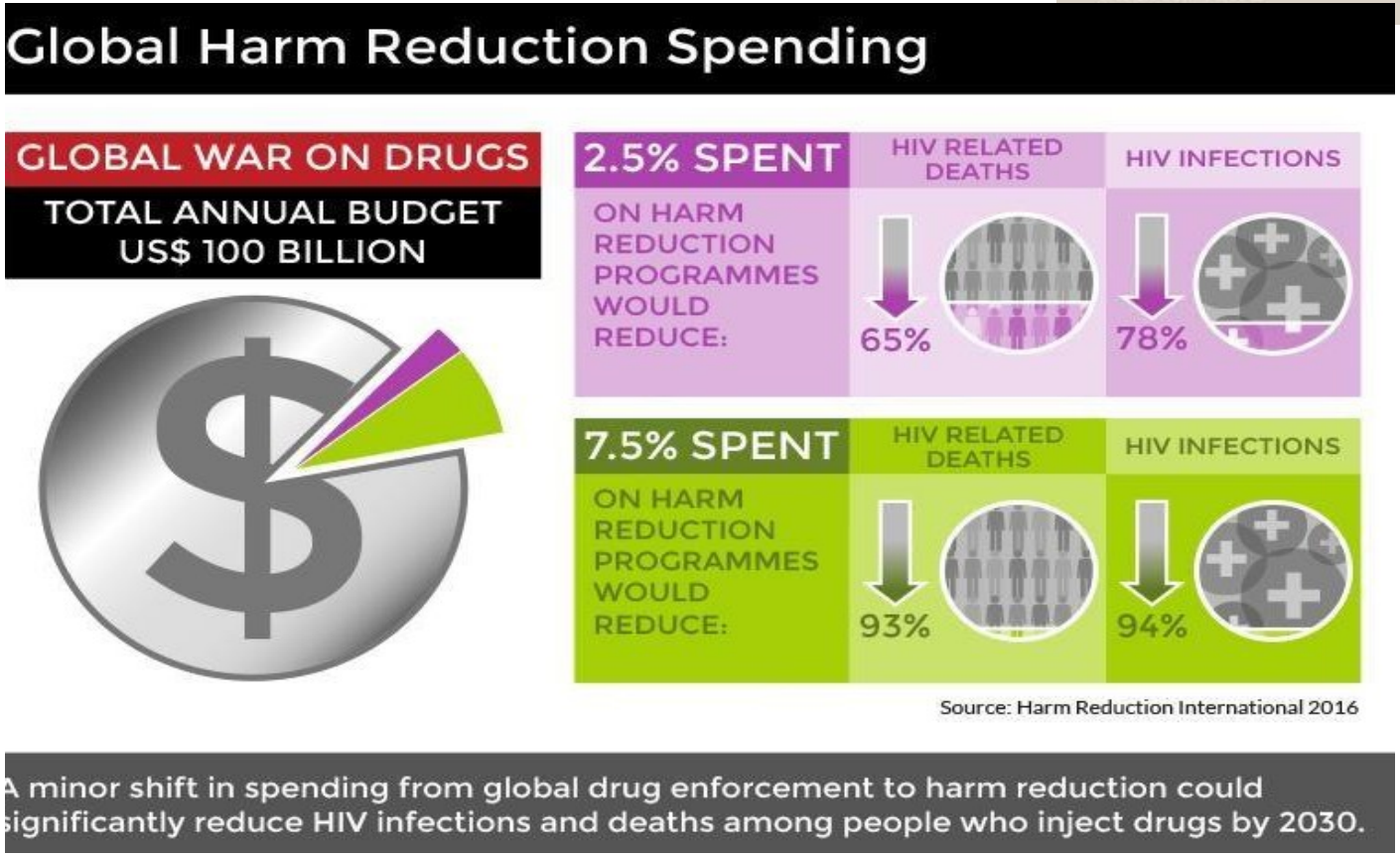
information on crime and prostitution,

information on human sexuality, education for partnerships, marriage and parenthood,

information on the HIV pandemic / AIDS.

HARM REDUCTI





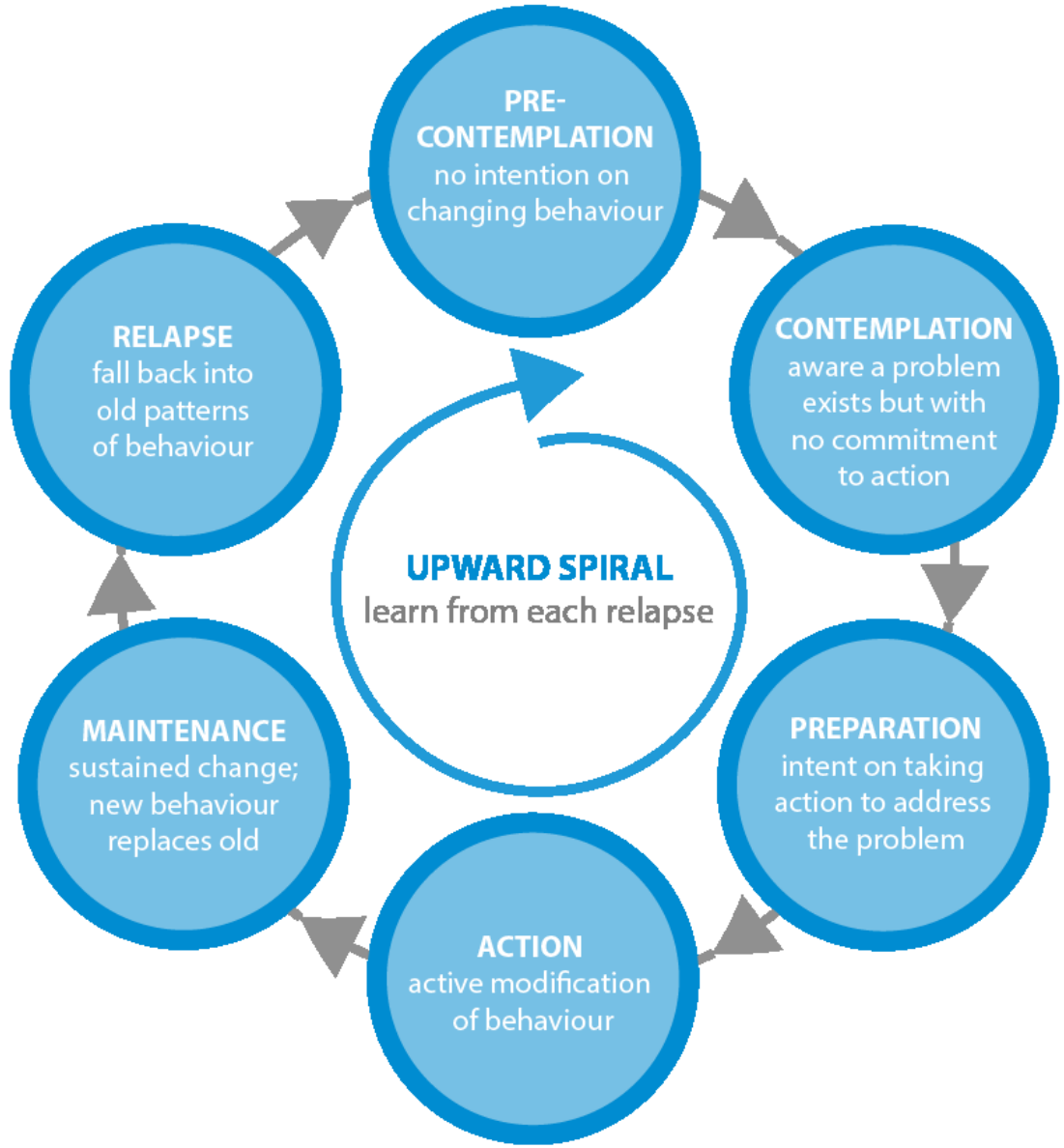
HARM REDUCTION

- Policies and programs which attempt primarily to reduce the adverse health, social, and economic consequences to drug users and their families or communities – it tries to solve the problems caused by addiction but not primarily the addiction itself
- Helping strategies for individuals for whom the abstinence perspective may not be appropriate/expected
- Accepts some drug use
- Harm reduction interventions, if successful, reduce the negative consequences of substance use
- Many of the harmful consequences related to substance use can be reduced without abstinence
- These interventions did not remove the possibility of future abstinence-based interventions and engaged clients by meeting them where they were
- Protective effect to general public (stops spreading of transmitted diseases etc.)
- Examples: providing clear injection tools, providing tests for substance purity, providing substitutes for substances (e.g. methadone and naloxone in heroin addicts), supervised injection sites, shelters for homeless people, controlled drinking training

STAGES OF CHANGE (Prochaska & DiClemente, 1983)

- Also known as Transtheoretical Model (TTM)
- Individual's **readiness to change** certain behaviour (not in addictions only)
- People go through several stages not necessarily in linear fashion, stages may repeat several times before any lasting change occurs
- Treatment doesn't have an impact because patients are not motivated (professionals used to blame the patience for poor motivation). People who seek help are seldom ready for the change itself (only about 10%)
- According to TTM is important to identify the stage the patient is in and adjust the treatment accordingly

STAGES OF CHANGE



Pre-contemplation

- No intention to change in the foreseeable future
- “Happy users” – don’t see a problem, but it is seen by his/her environment
- Reasons for no reflection: denial, resistance, lack of information, resignation
- Help may be ignored or even harmful – the person may become resistant
- The main purpose of intervention in this stage – to make client more likely to motivate to make a commitment to change

Contemplation

- The person acknowledges that “something is wrong”- willing to change, however commitment is rather weak
- Costs/benefits analysis – hesitation may last for extended period even chronic
- Intervention should focus on facilitation of movement to the next stage by strengthening feelings of benefits and by being personally relevant

Preparation

- Brief periods with little behaviour changes
- After that the person either returns to previous stages or continues to “action”
- Important is to be realistic and have realistic plans – people are often unrealistic and when face the first difficulties, they return to previous behaviour

Action

- The person is modifying the behaviour for up to 6 months – he/she has some plan or intention to do and making some moves in that direction
- Common stage when people actually enter treatment - they want external motivator and confirmation, public commitment, seek support in what they already started
- Treatment should focus on removing obstacles so that the action goes smoothly and to strengthen their self-efficacy

Maintenance

- Person continues in the effort for longer than 6 months
- Not a static stage but continuation of change
- Relapse is less and less likely with progressive time, but it is still possible
- Relapse prevention is one of the main focus in treatment
- Each relapse (abstinence violation effect) brings strong negative feelings (shame, hopelessness), lowered self-esteem and self-efficacy so that the person relapses even more

When would harm reduction strategy be appropriate?

It is suitable for individuals whose motivation for change is not yet at the action stage in stages of the change model – contemplation, precontemplation

COERCION & CONFRONTATION

- Person is forced to treatment and abstinence. Most typically via legal means (e.g. when person causes car crash under influence), but also family (e.g. in case of teenagers), work (e.g. when drunk at work), medical (e.g. person is hospitalized, needs some operation)
- Lasting effect is questionable – when the pressure is weaker, people tend to return to previous behaviours. Coercion may be contra productive as many addicts react with rebellion. However, these methods do motivate some individuals to change
- Best impact for the contemplator, on the other hand precontemplator will probably be rebellious

- Denial is common in addicts so confrontation is often seen as the only method to comply. Confrontation and directiveness often starts defence mechanisms as is it raises levels anxiety and undermine one's own self-esteem and self-efficacy
- Reflective and motivational approaches have much better results – person must want him/herself to change

MOTIVATIONAL ENHANCEMENT

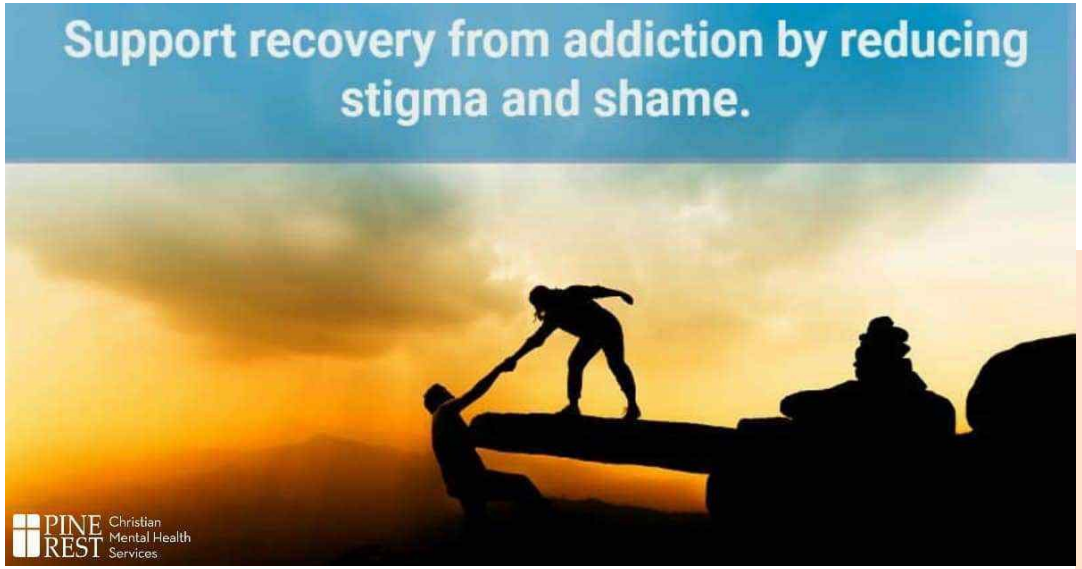
- Miller, Rollnick and colleagues – motivational enhancement therapy for those that are ambivalent
- Counselling approach (rather than treatment itself) – helping addicts to overcome their ambivalence and hesitation. It is not manipulative approach - it works only with “what is already in the client”
- Quite effective technique, but it only works with people who more or less want to change

- Phase 1: with people in “contemplation” stage (unsure whether they want any change) - make them understand their resistance and why it is important to change
- Phase 2: with people who show signs of readiness (they ask for advice what to do etc.) – to make their commitment to change stronger (e.g. development of personal plan)

Motivational enhancement - REDS

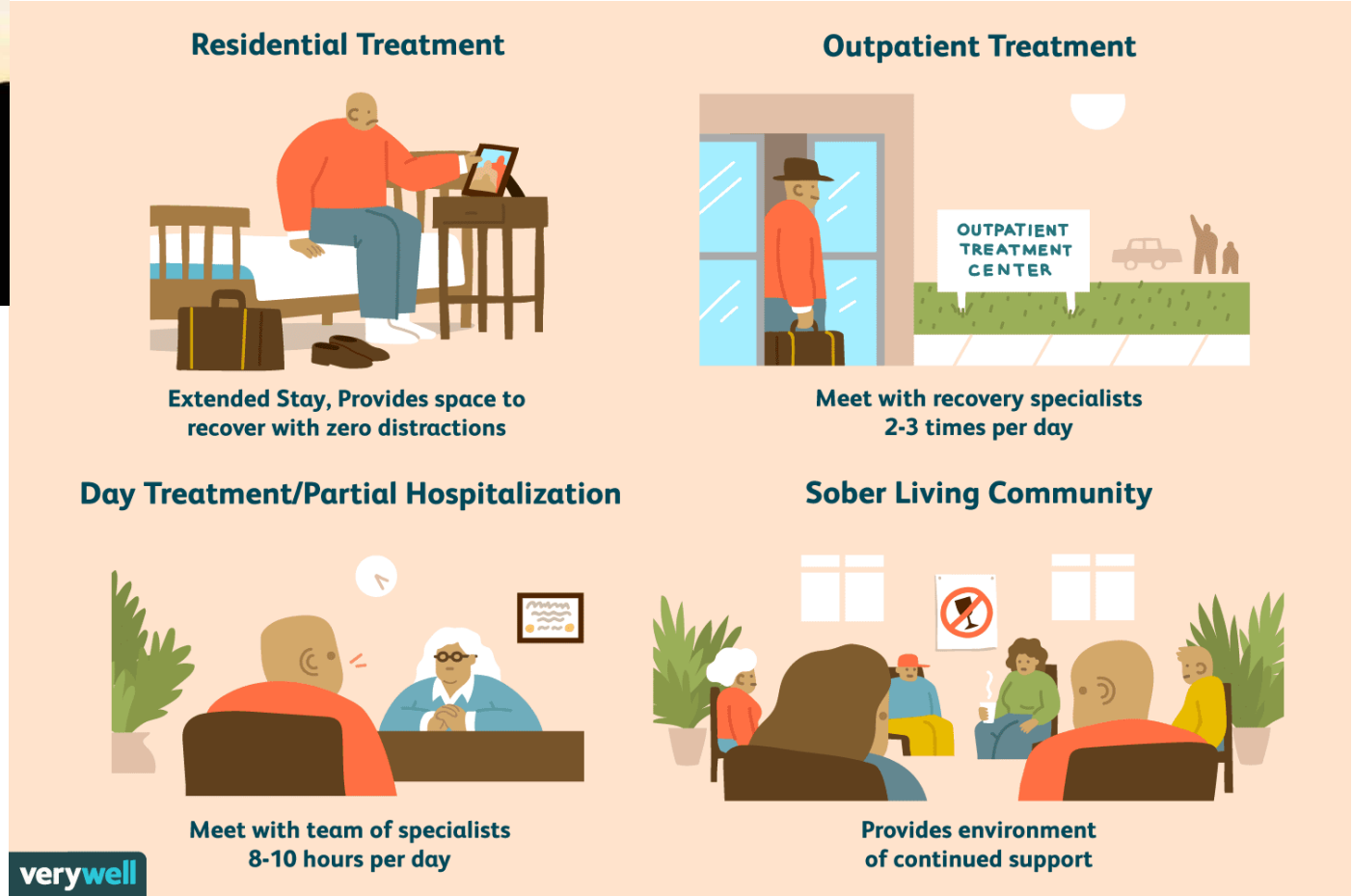
- Roll with resistance – resistance of addicts points to their dilemmas (e.g. “drinking relaxes me”) and thus to the obstacles one is facing. Resistance is not opposed and confronted
- Express empathy – no judgments and criticism. Let people to feel comfortable and able to open.
- Develop discrepancy – addiction is discrepant to one’s own ideal – reflect the discrepancy in addicted person so that he/she has some wish where they want to develop – their life goals
- Avoid argumentation
- Support self-efficacy – people are more motivated when they believe they can do it. Embrace addicts’ confidence (e.g. based on their past experience) that they have the strength, skills and power to be successful in the process

TREATMENT


Support recovery from addiction by reducing stigma and shame.
PINE REST Christian Mental Health Services


New Goals
Old Habits


STOP


Residential Treatment
Extended Stay, Provides space to recover with zero distractions
Outpatient Treatment
OUTPATIENT TREATMENT CENTER
Meet with recovery specialists 2-3 times per day
Day Treatment/Partial Hospitalization
Meet with team of specialists 8-10 hours per day
Sober Living Community
Provides environment of continued support
verywell

TREATMENT

- Treatment/Addiction centers – Inpatient/outpatient

Covers the biological, psychological, and social aspects of addiction

- Psychotherapy
- Occupational therapy
- Biofeedback therapy

Cognitive behavioral therapy

- Based on general principles of human behaviour and as such is very suitable for treating addictions - the roots are in classic behavioural theory so it understands and targets conditioning, cues, craving etc.
- 2 basic components:

Functional analysis – understanding the addiction

Skills training – cognitive skills

- Highly structured and shorter than other therapies – 12-24 weeks with a meeting every week

Psychodynamic therapies

- They are usually lasting longer, for years, patients come regularly several times a month
- Understands addiction as compensation of some unpleasant experience, affective states, inner conflicts, traumas, etc.
- Uncovers those experience and feelings (interpretation)
- Helps to build positive self-esteem, better coping skills
- In general, the purpose is to change one’s own personality
- Ideal solution would be CBT first, followed by psychodynamic therapy

Family therapies

- Work with people whose family member is addicted (family support; education about addiction; *pressure to change* – how to get a family member to treatment; family support for relapse prevention)
- Family/systemic therapy – works with family system and communication patterns. Addiction is not understood as a problem in an individual (no individual to be blamed) but as a result of not working family system (family is the cause and thus must work on the problem together). Often used in case of children and teenagers – all family members participate in treatment sessions

Support groups

- After finishing an addiction treatment program, it is highly recommended that a patient join a support group.
- Essential part of staying on the right path once out of treatment.
- 12-Step Programs

Alcoholics/Narcotis/etc. Anonymus

Map of addiction care in Europe

Reitox network | **Reitox Map of Addiction Care in Europe**

The **Reitox Map of Addiction Care in Europe** was established as an initiative of the Reitox network, the network of national centres in Reitox countries collecting and reporting the data on drug situation at the national level. The network is coordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), an EU decentralised agency located in Lisbon.

This Reitox Map of Addiction Care in Europe (Reitox Facility Locator) is European "gateway" to national sources and contacts, aimed to provide information **for professionals and clients in situations where addictology services clients are travelling or moving abroad and are looking for (continuity of) addiction care.**

Further information from other resources:

- Information for Travelling Internationally with Medicines Containing Controlled Substances:
- General Information for Travellers Carrying Medicines Containing Controlled Substances
- Regulations by Country.

- Methadone Worldwide Travel Guide
- Coordinating and Information Resource Center for International Travel .

Note: For consequences of illegal consumption of drugs, see Penalties for drug law offences in European countries.

- Austria
- Belgium
- Bulgaria
- Croatia
- Cyprus
- Czech Republic

Is there a simple solution?

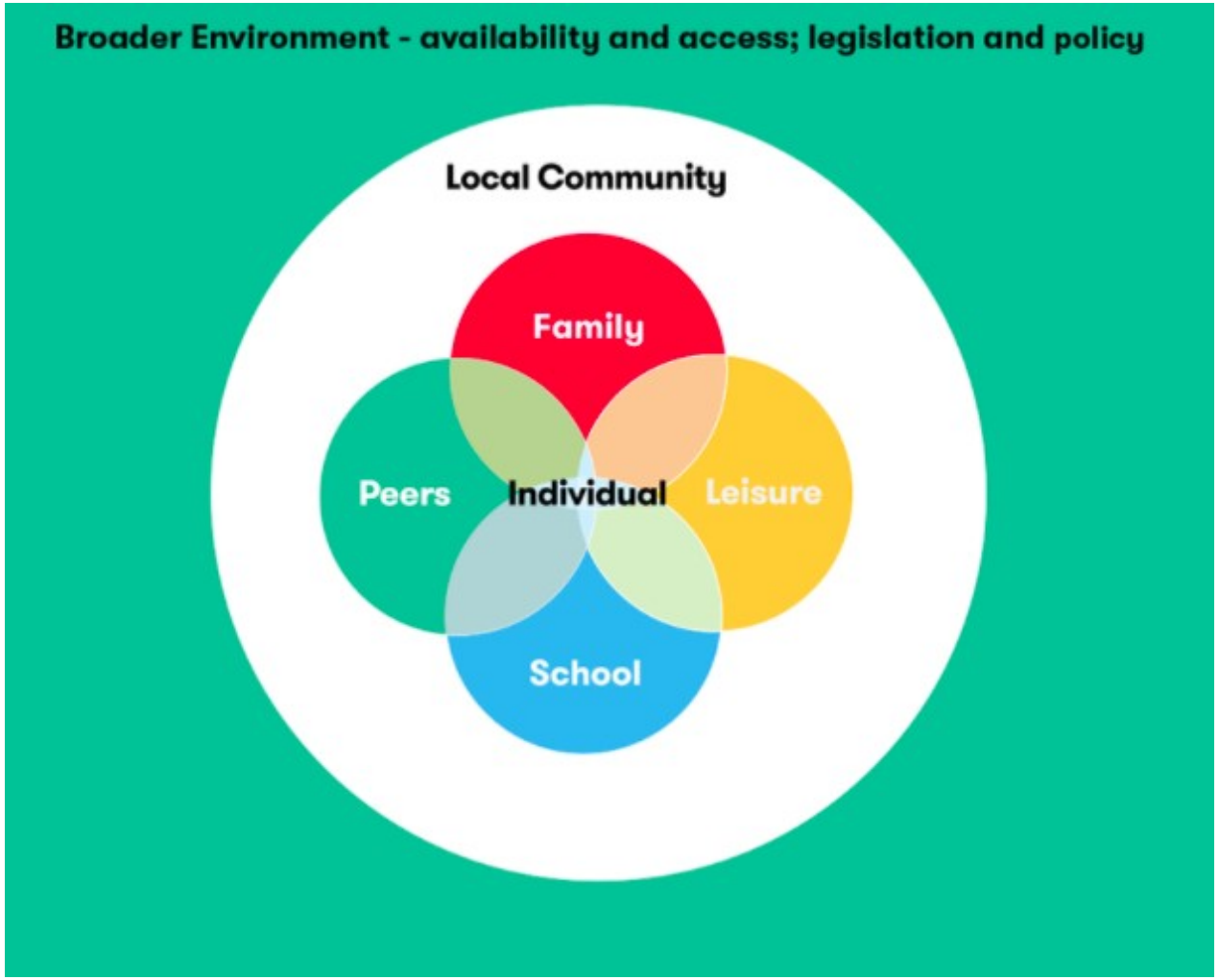
Prevention?

Treatment?

Decriminalisation?

Icelandic Model for Preventing Adolescent Substance Use

- Environmental approach
- The model is centered around the domains of family, school, peers and leisure time



Switzerland – Harm Reduction

- Public health crisis in 1980s related to heroin use
- Drug policy based on four pillars: prevention, therapy, harm reduction and sanction
- Opened free heroin maintenance centers
- It resulted in decrease of HIV, heroin overdose deaths, drug related crime, less new users etc.
- Currently considering decriminalisation of drugs

Portugal

- 1960s- large amount of heroin addicts, huge HIV rates…
- Solution?
- Decriminalisation of personal drug use
- Instead of judging individuals they seen them as patients – addicts were individually judged by committee
- Before 2001 - 90% of finances spend on figting with drugs were used on enforcement and only 10% on healthcare, after 2001 that was reversed
- Consequently, there was a slight rise of drug use (due to drug trafficking), however it led to an increasement of rehab involvement, decrease of heroin users and drug related deaths