Conceptual Models of Substance Use

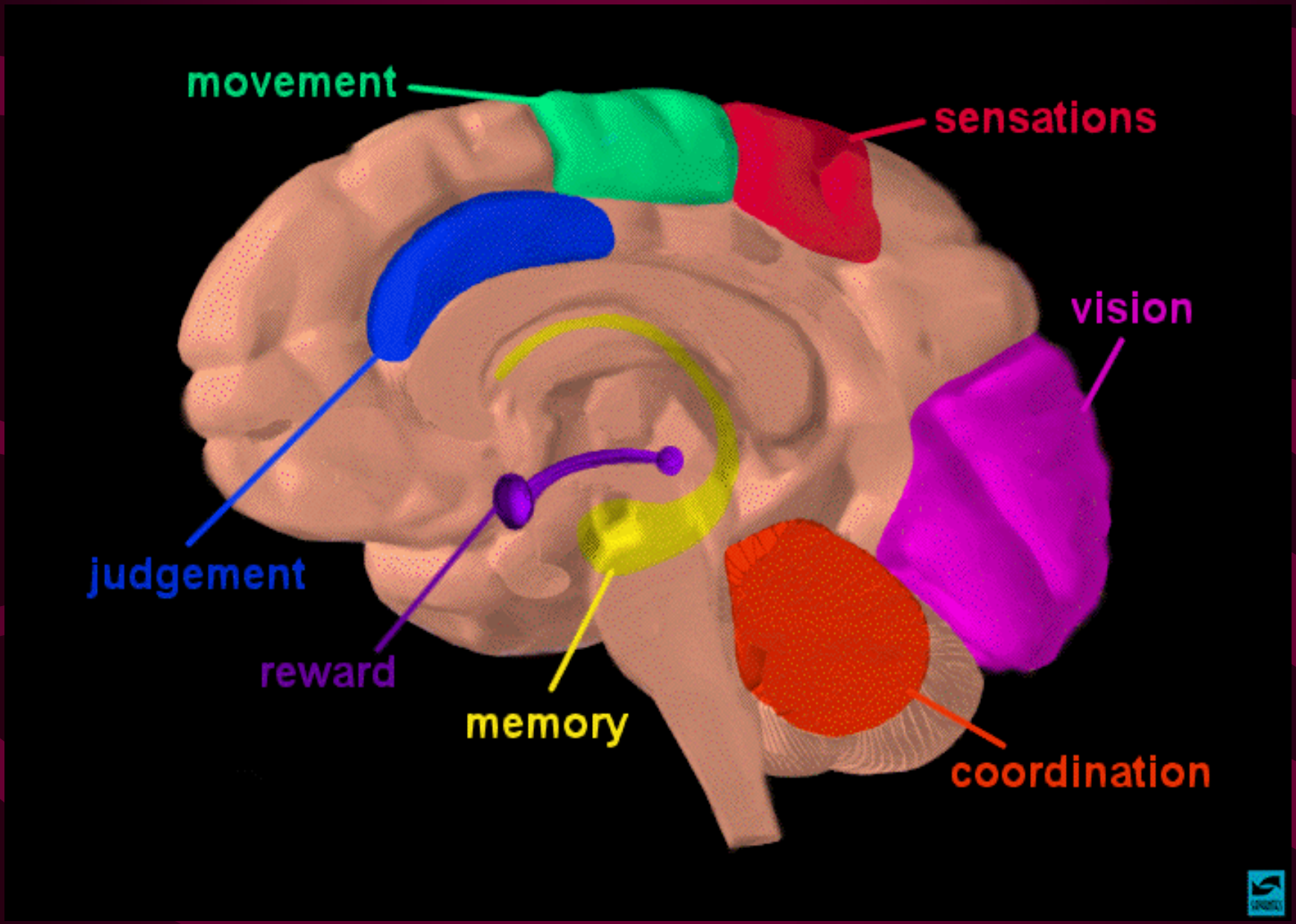
- Different causal factors emphasized
- Different interventions based on conceptual models

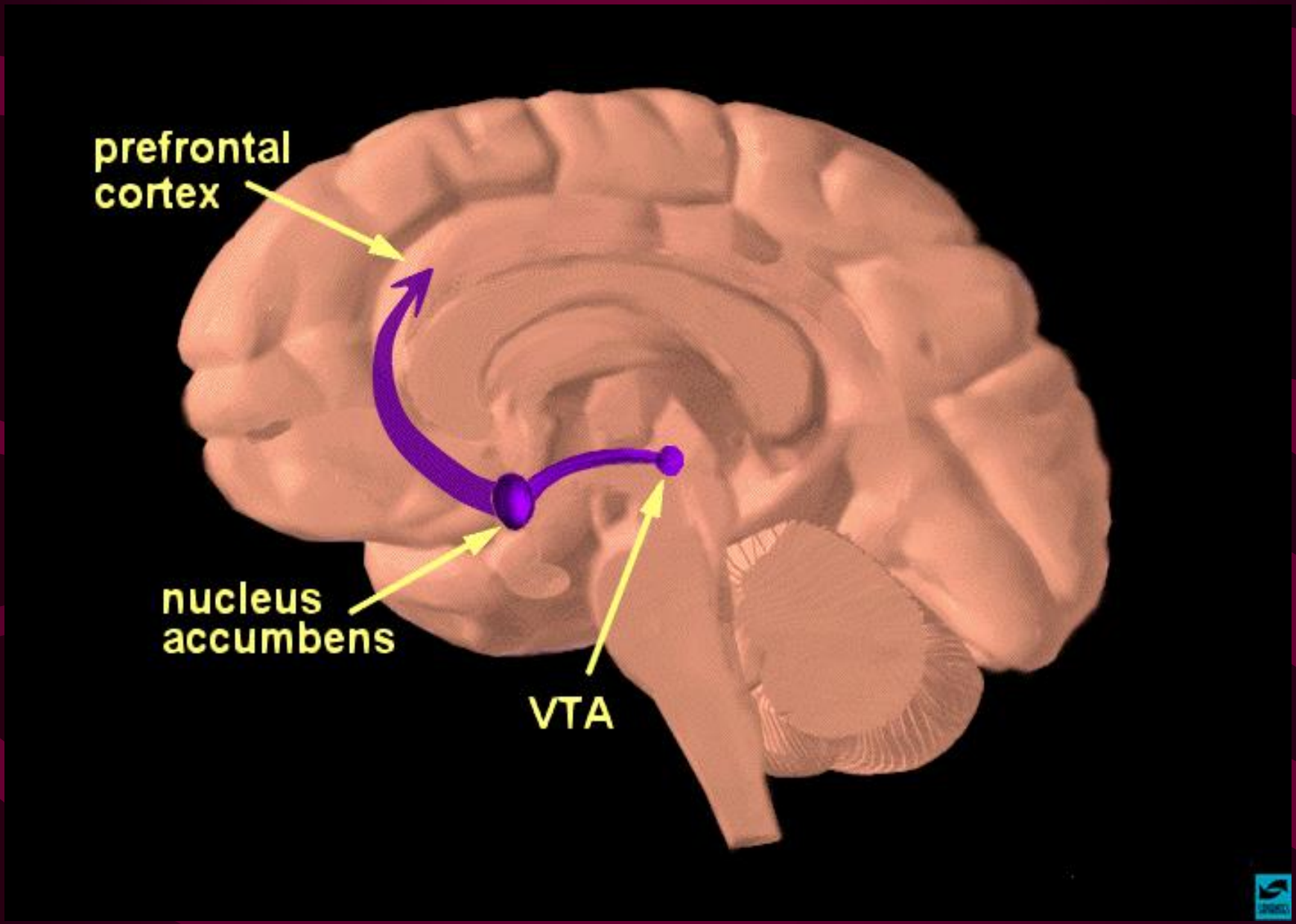
Developing a Conceptual Model

- What is the nature of the disorder?
- Why causes it?
- Is it permanent/irreversible?
- How much responsibility does the individual bear?
- How much responsibility lies outside the individual?
- What is the solution or best approach to the problem?

Brain disease model

- Addiction is a brain disease
- Repeated use of drugs has changed the brain so that normal survival and lifestyle choices have been undermined
- Abstinence and brain healing are the first steps in addiction treatment


movement
sensations
vision
judgement
reward
memory
coordination


prefrontal
cortex
nucleus
accumbens
VTA

Trauma Model

- Addiction is caused by unresolved trauma, often based or beginning in childhood
- Multiple psychiatric problems
- PTSD is a common outcome
- When trauma is addressed, the process or recovery is accelerated.

Traumgenic factors for childhood sexual abuse (White)

- Perpetrator is trusted individual
- Abuse begins early
- Abuse is on-going
- Victim is not believed or is blamed
- Invasive abuse
- Physical threat to victim, family members or cherished object

Emotional Intelligence Model

- Self awareness (Understanding yourself and your emotions)
- Self-regulation (Managing emotions)
- Self-motivation (Moving ahead)
- Empathy (Understanding how other people feel without being told in words)
- Social skills (The art of social relationships)
- Conversation

Emotional intelligence Model

- Addiction occurs as the result of deficits in emotional intelligence
- Closely tied to personality disorders model
- Treatment consists of teaching emotional intelligence skills and skills training

Learning disorder model

- Addiction has a cultural basis
- Addiction results from observing and emulating poor role models.
- Addiction reinforced by using AOD to cope with life stressors.
- Treatment consists of:
  - Skills training
  - Changing cultural influences
  - Substitution of appropriate role models (successful, sober persons)

Moral Model

- ATOD users are hedonistic
- Their pursuit of pleasure is immoral
- Individual is personally responsible for addiction
- Behavior related to addiction is associated with a "bad person"
- The person has complete self-control, and can choose to do the "right" thing (abstinence/control control over substance use)

Moral Model

- "Treatment":
  - Individual needs to be persuaded that s/he is making wrong choices.
  - Social, religious, and legal sanctions are threatened or applied

Temperance Model

- Often confused with moral approaches.
- Belief system predominated late 19th century- repeal of Prohibition in 1933.
- Historic pressure on congress to prohibit the manufacture, sale, transportation, and importation of alcoholic beverages.
- 1919: 18th amendment to the Constitution (Volstead Act) ratified
- Belief = Not possible for anyone to drink in moderation
- Abstinence only viable alternative

Temperance Model

- Alcohol's addictive and destructive power strong
- The problem is substance, not person.
- Take away the substance and the problem will disappear
- "Treatment" = consists of "just say no", and control of the supply
- Prohibition unpopular and impossible to enforce
- Repealed in 1933 by the 21st amendment
- Implications for other drugs?

American Disease Model

- After prohibition repealed, new way of looking at alcohol problems needed
- Model emerged in 1935, same year Alcoholics Anonymous began
- Primary assertion is that addiction is a unique, progressive condition, or disease.
- Addiction caused by irreversible, constitutional abnormality of an individual
- Problem is within the individual, not the substance

American Disease Model

- Users are not responsible for their condition, and are deserving of humane treatment
- Chemically dependent individual is incapable of using a mood altering substance in moderation.
- Treatment is effective and necessary
- Treatment consists of
  - Identifying the disease
  - Confronting the person
  - Lifelong abstinence from the substance.
  - Following the steps of AA

Spiritual Model

- Problem results from a lack of spiritual connection.
- The treatment consists of replacing the spiritual deficit through:
  - Participation in faith-based activities
  - Prayer
  - Spiritual education
  - Support
  - Program of personal growth and development.

Family Systems Model

- Addiction results from dysfunctional family dynamics
- Treatment consists of family therapy.

Public Health Model

Public Health Model

- Agent
- Host
- Environment
- Host = the person or population in which symptoms are visible
- Agent = the substance that enters the host, producing symptoms

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Public Health Model

- Environment:
  - Factors present in the immediate physical, emotional, social and spiritual environment that contribute to the problem.
- Treatment consists of interdisciplinary, multiple levels of simultaneous intervention (including primary prevention and *harm reduction).*

Psychiatric Model

- Substance use disorders are caused by underlying psychological problems
  - Depression
  - Bi-polar disorder
  - Anxiety
  - PTSD
  - Trauma (often in childhood)

Psychiatric Model

- Treat the psychological condition and the substance use disorder will go away
- Often involves the use of medication
- If addiction treatment is necessary, it should be offered after the psychological problem is resolved (sequential treatment)

Other Models of Treating Dual Diagnosis (Co-Occurring disorders)

- **Parallel**: Psychiatric treatment and addiction treatment are provided at the same time, but by different providers who may not coordinate the case
- **Integrated**: Psychiatric treatment and addiction treatment are provided at the same time, by the same provider, or at least in a coordinated manner

Biopsychosocial Model

- Addiction involves multiple areas of the client's life
- All aspects of the client's life should be investigated and assessed
  - Incidence (Did it happen)
  - Severity/breadth (How serious was the problem or disorder)
  - Recency (When was the last time the problem occurred)
  - Service utilization (Has the problem been treated? When? By Who?)

Biopsychosocial Model

- Assessment follows ASAM criteria
  - **Acute Intoxication and Withdrawal**
  - **Bio-Medical Conditions and Complications**
  - **Cognitive, Behavioral, and Emotional Conditions**
  - **Readiness to change**
  - **Relapse, continued use or continued problem potential**
  - **Recovery/Living Environment**

Analysis of ASAM Criteria Information

- Leads to treatment plan, including level of care (LOC)
  - 0.5 Early intervention
  - I: Low intensity outpatient
  - II: Intensive outpatient (IOP)/Patial hospitalization
  - III: Residential/inpatient
  - V: Medically-managed/intensive inpatient

Recovery Management

- 90 days of engagement with a qualified professional or program is gold standard for good outcomes (continued sobriety and recovery)
- Continuing care (1-4 times a week) can extend treatment to the 90 day timeline
- AA: 90 meetings in 90 days
- What happens after treatment?

Recovery Management

- Acute illness/condition: Broken leg
  - Examination
  - Diagnosis
  - Treatment
  - Physical therapy
  - Professional care ended
- Chronic condition: Coronary artery disease (CAD)
  - Examination
  - Diagnosis
  - Treatment
  - Check-ups
  - Individual takes significant personal responsibility for recovery and health maintenance

Continuing Care Services Approach: Post-Treatment Check Ups

- Follow-up visits focus on incremental behavioral changes & addressing recovery issues
- Once acute treatment issues have been stabilized, client moves to continuous care services with instructions for recovery management
- Client responsible for monitoring and maintaining sobriety and recovery
- client always welcome to return