








Supporting Substance Misusers in a Homeless Setting: Harm Reduction and Motivational Interviewing







Course Objectives


By the end of today, you will be able to:




-  Understand what is meant by harm reduction
-  Identify a range of harm reduction practices
-  Understand the basic principles of Motivational Interviewing
-  Practice using the principles of MI
-  Identify sources of signposting/referral









What Is Harm Reduction?




-  A pragmatic, non-judgemental set of strategies to reduce individual and community harm caused by drug use
-  The focus is on taking incremental steps to reduce harm, rather than on eliminating drug use
-  Abstinence may or may not be the end goal





Core Principles of Harm Reduction: Pragmatism

-  There will always be a percentage of the population who will engage in higher risk behaviour for social, economic, mental health, and/or personal reasons
-  HR recognises that drug use is a complex and multifaceted phenomenon that encompasses a continuum of behaviour from abstinence to chronic dependence
-  HR also recognises that drug use produces varying degrees of personal and social harm


 **Core Principles of Harm Reduction: Focus on Harm**


- Priority for HR = decrease negative consequences of drug use to the user and others, rather than decrease/eliminate drug use itself
- Doesn't rule out the longer-term goal of abstinence, but emphasises changes to safer practices/patterns of use
 - Complementary to the abstinence model of addiction treatment




 **Core Principles of Harm Reduction: Human Rights**

- HR respects the basic human dignity and rights of people who use drugs
- Accepts one's decision to use drugs as fact, without condemnation or support of the use of drugs
- Acknowledges the individual's right to self-determination and supports informed decision-making in the context of active drug use
- Emphasis placed on personal choice, responsibility, and self-management

 **Core Principles of Harm Reduction: Maximising Intervention Options**



- HR recognises that people with drug use problems benefit from a variety of approaches
 - No one prevention or treatment approach that works reliably for everyone
- It is choice and prompt access to a broad range of interventions that help to keep people alive and safe, and promote health

 **Core Principles of Harm Reduction: Priority of Immediate Goals**

- HR recognises readiness to change as key to the process of individuals leading healthier lives
- People may be anywhere along a continuum – from not thinking about change → contemplating it → taking action → maintaining change, and moving forward and back
- HR starts with “where the person is” with their drug use, with the immediate focus on the most pressing needs
- Based on the importance of incremental gains that can be achieved over time

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Core Principles of Harm Reduction: Involvement of People Who Use Drugs

- The active participation of people who use drugs is at the heart of HR
- People who use drugs are seen as the best source of information about their own drug use, and are empowered to join with service providers to determine the best interventions to reduce harm from drug use
- HR recognises the competency of people who use drugs to make choices and change their lives



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Individual Harm Reduction Strategies




- Know your supplier to establish the source, strength, and toxicity of the drug
- Reduce the amount of drugs consumed
- Avoid using alone
- When injecting, use different veins each time

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Individual Harm Reduction Strategies


- Always use new “works” (fresh needle, water, spoon, cotton) – preferably a safer injecting kit that is available from selected pharmacies
- Use needle exchange programmes
- Do not share “works”
- Learn CPR and other first aid strategies
- Carry Naloxone



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Individual Harm Reduction Strategies

- Consider substituting to a less harmful substance
- Get support for physical and mental health concerns, housing, or basic necessities, legal problems, employment concerns, and relationship issues
- Access support groups
- Take part in committees and other activities that are influencing service planning and policy making (e.g. RSUN)



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Individual Benefits of Harm Reduction

- Prevention of infection of bloodborne viruses (e.g. HIV, Hep C)
- Fewer overdoses
- More stability/reduced chaos associated with drug use
- Increased sense of control over drug use (how they use, whether or not they use at all)
- More options
- Increased capacity for self-care
- Opportunity to link with support services

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Community Harm Reduction Strategies

- Needle exchange programmes
 - Available across NI for injecting users
 - Provide clean “works” (safer injecting kits)
- Substitute or maintenance treatments
- Naloxone
- Outreach and other support services
- Clinical/medical care
- Support groups



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Community Benefits of Harm Reduction



- Fewer overdoses
- Decreased transmission of bloodborne viruses (e.g. HIV, Hep C)
- Reduced strain on social, health, and income/employment services
- People who use drugs become less marginalised
- A more comprehensive and collaborative approach to drugs, including HR, prevention, treatment, and enforcement → more effective use of public resources

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Types of Interventions: Engagement


Interventions focused on:

- Building the therapeutic relationship
- Engagement with the care planning process
- Building motivation for change
- Setting initial treatment goals

Session topics could include:


- Personal strengths/resources
- Costs and benefits of drug use
- Ambivalence
- Risk awareness

May be supported by protocols and mapping tools, and delivered in 1:1 or group settings




Types of Interventions:
Preparation

<p>Interventions focused on:</p> <ul style="list-style-type: none"> ○ Refining treatment goals ○ Preparing for change 	<p>Session topics could include:</p> <ul style="list-style-type: none"> ○ Commitment to change ○ Recovery goals and change plans ○ Triggers for using and management strategies ○ Personal and community resources <p>May be supported by protocols and mapping tools, and delivered in 1:1 or group settings</p>
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Types of Interventions:
Change

<p>Interventions focused on:</p> <ul style="list-style-type: none"> ○ Initiating and maintaining changes in substance use, behaviour, and cognition ○ Building recovery capital 	<p>Session topics could include:</p> <ul style="list-style-type: none"> ○ Cravings ○ Relapse prevention and lapse management ○ Leisure/vocational/educational plans ○ Personal and community resources ○ Skill development (social, personal, vocational) <p>May be supported by protocols and mapping tools, and delivered in 1:1 or group settings</p>
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Types of Interventions:
Completion

<p>Interventions focused on:</p> <ul style="list-style-type: none"> ○ Moving on from/exiting formal treatment ○ Reviewing achievements ○ Planning for reintegration ○ Developing recovery capital 	<p>Session topics could include:</p> <ul style="list-style-type: none"> ○ Recovery checklists ○ Reviewing changes achieved ○ Relapse prevention and lapse management ○ Undertaking leisure/vocational/educational plans ○ Personal and community resources ○ Skill development (social, personal, vocational) <p>May be supported by protocols and mapping tools, and delivered in 1:1 or group settings</p>
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Types of Interventions:
Reintegration


<p>Interventions focused on:</p> <ul style="list-style-type: none"> ○ Strengthening community integration ○ Developing recovery capital ○ Exiting formal treatment 	<p>Session topics could include:</p> <ul style="list-style-type: none"> ○ Future plans and support ○ Structuring time ○ Skill development (social, personal, vocational) ○ Undertaking leisure/vocational/educational plans ○ Personal and community resources <p>May be supported by protocols and mapping tools, and delivered in 1:1 or group settings</p>
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 **What Is Motivational Interviewing?**


- A “directive, client-centered counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence” – Miller & Rollnick (1991)
- An approach designed to help clients build upon commitment and reach a decision to change
 - Useful for clients that are ambivalent or reluctant about changing
- Broadly applicable in the management of behaviour (e.g. alcohol misuse, drug misuse, smoking cessation, weight loss, etc.)

 **Basic Principles of MI: Overview**


- Basic principles underlying Motivational Interviewing:
 - Express empathy
 - Amplify ambivalence
 - Roll with resistance
 - Support self-efficacy




 **Basic Principles of MI: Expressing Empathy**



- Expressing empathy towards a participant shows acceptance and increases the chance of the practitioner and participant developing a rapport
 - Acceptance enhances self-esteem and facilitates change
 - Skilful reflective listening is fundamental
 - Participant ambivalence is normal

 **Basic Principles of MI: Amplifying Ambivalence**

- Amplifying ambivalence enables the participant to see that their present situation doesn't necessarily fit into their values and what they'd like in the future
- A participant (rather than the practitioner) should present the arguments for change
 - Change is motivated by a perceived ambivalence between present behaviour and achieving important personal goals and values



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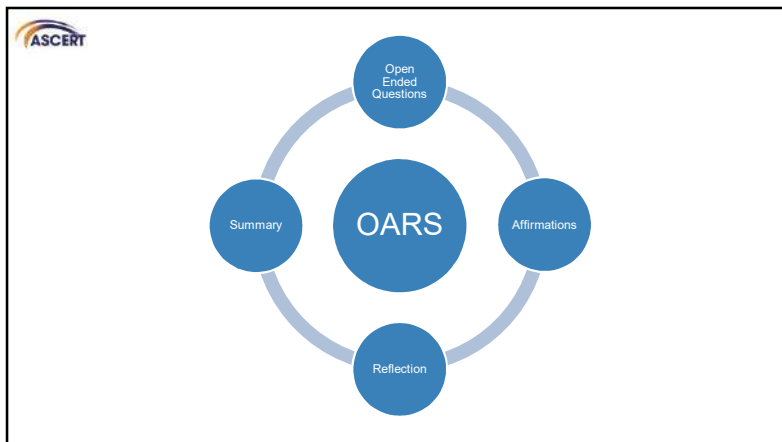
Basic Principles of MI: Rolling With Resistance

- Rolling with resistance prevents a breakdown in communication between participant and practitioner, and allows the participant to explore her views
 - Avoid arguing for change
 - Do not directly oppose resistance
 - New perspectives are offered but not imposed
 - The participant is a primary resource in finding answers and solutions
- Resistance is a signal for the practitioner to respond differently

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Basic Principles of MI: Supporting Self-Efficacy


- Self-efficacy is a crucial component to facilitating change
 - If a participant believes they have the ability to change, the likelihood of change occurring is greatly increased
 - Belief in their own ability to change is an important motivator
- The participant (not the practitioner) is responsible for choosing and carrying out change
- The practitioner's own belief in the participant's ability to change becomes a self-fulfilling prophecy



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OARS: Open-Ended Questions

- Questions that do not invite brief answers
 - How?
 - What?
 - Where?
 - When?
 - Who?
 - Why?



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OARS: Open-Ended Questions



- Open-ended questions should be used to elicit information and encourage **elaboration**
 - Rather than asking "Is there anything else that can help you?", consider "What, who, etc. else can help you?"
- When a client's answer is in general terms, use open-ended questions to encourage and support more specifics

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OARS: Open-Ended Questions Example



- Client: If I cut down my relationships will improve.
- Helper: In what ways will relationships improve?
- Client: My partner will see that I am committed, I will be able to contribute to the house.
- Helper: So you will notice several improvements, how will you be able to contribute more?

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OARS: Open-Ended Questions





"I learn who I am as a hear myself speak."
It's what the client says that they remember most.

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OARS: Affirmations


- Recognising the work that the client has done in relation to their problem
 - Should be specific and meaningful to each individual
 - "It seems as though you have been trying everything in order to reduce the amount of alcohol you consume; this shows how dedicated and committed you are to making changes"
- For many of us, having positives noticed is a very unusual experience and one that is normally followed by a request for something






OARS: Affirmations

- To be effective, take your time getting used to this skill – particularly as you'll need to be offering your affirmations in an unconditional manner
- Note the tone of voice, timing, and content when giving affirmations
- Think of values as the source of some affirmations
 - Accomplishment, intimacy, creativity, justice, fun, credibility, dependability, family, fidelity, friendliness, open-mindedness, punctuality
- It's also helpful to explore how to translate familiar criticisms into positive character assets
 - Stubborn – single-mindedness; shy – sensitive and considerate




OARS: Reflection



- Using statements to mirror back the client's own experiences to them
 - Take your time as you learn to develop your use of reflective statements
- Think about
 - What did the client say?
 - What did they client mean?
 - How does the client feel about what they're saying?
- We can also integrate affirmations into the reflective listening
 - "So you are committed to your family and that's why it's important to make these changes"



OARS: Summary



- Listening to the client and reflecting back to them the main points of what they are feeling or thinking every few minutes
- This shows the client that you have been listening and that you genuinely want to support them in making change
- "Taking what you have said into account, what do you want/need/plan to do about your behaviour in the future?"

Thanks!


Any questions?

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0800 2545 123
info@ascert.biz
www.ascert.biz

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Polydrug Use and Alcohol Withdrawal



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What Is Polydrug Use?



- The act of taking 2 or more psychoactive substances together or within a short time frame
- Can also include mixing use of steroids (known as stacking), but steroids are usually not psychoactive

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Polydrug Use: Current Context

- More substances available in NI than ever before
 - Post-conflict 'normal' western European culture
 - NPS/"legal highs"
 - Internet sales of many drugs
 - Travel is more common to producer countries as is migration to and from them, leading to increased links between producer and consumer countries and increased networks for the supply of drugs
 - Travel to countries with more liberal drug laws more common e.g. drug tourists in Amsterdam

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Polydrug Use: Current Context



- Homeless population use more substances, more often than most settled groups, and this use is more likely to be chaotic and/or dependent
 - Coping strategy
 - Reason for homelessness occurring in 1st place
 - Or both

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Polydrug Use: Implications

- PDU is **more of the norm** among people in the homeless population than single drug use
- It is **usually** more risky than single drug use
- We need to ask questions about client's use of a range of substances including alcohol, OTCs, prescription meds, 'legal highs'/NPS and other drugs including on
 - Frequency of use
 - Combinations used

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Reasons for Polydrug Use

- Absence of the primary drug of choice
 - E.g. temazepam for heroin
- Boost effects of primary drug used
 - E.g. ketamine for MDMA
- Relieve comedown effects of primary drug or drugs
 - E.g. codeine for alcohol hangover
- Think of some examples of each of these reasons from your work with people



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Routes of Administration





- Most common, and generally least risky, is oral (swallowing)
- Least common, and often risky, is injecting
- PDU does not require the same administration route e.g. snorting mephedrone and swallowing alcohol
 - This can lead to overdose as the different drugs become available in the bloodstream at different times

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Common Polydrug Use Combinations


- Stimulants → depressants, cannabis, benzos
- Opiates → other opiates, alcohol, benzos, stimulants
- Dissociatives → benzos, cannabis
- Alcohol → some stimulants, codeine
- Benzos → alcohol, antipsychotics, antiepileptics, opiates







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4 Types of Users



4 Types of Users: The **Novice**

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- Cautious use of substances in combination
- Usually stays in a group for safety reasons
- Usually remains relatively safe, depending on the peer group



4 Types of Users: The **R Plate**

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- Risk-taker
- Not enough experience to understand and reduce risks
- Impulsive
- Prone to harm




4 Types of Users: The **Expert**



- Knows quite a lot or a lot about the drugs they use, and importantly, their combined and cumulative effects
- Has enough experience to source the drugs they want effectively and moderate many/most of the risks
- Will be able to educate you, more than you educate them
- Has preferred routes of administration

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4 Types of Users: The Kamikaze



- Wants 'out of it'
- May not be selective about the drugs used
- High doses of each drug used, frequent redosing
- Seeking maximum drug effect
- May understand some/many of the risks they are taking
- Ambivalent about life
- Prone to death or serious harm


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Polydrug Use: Risks

- Very difficult to predict effects accurately
- Dosing is critical, potentiation sometimes occurs
- Increased levels of intoxication likely to lead to more harms:
 - Physical e.g. accidents
 - Psychological e.g. MH deterioration or psychotic episode
- More severe comedowns in certain cases, especially binge use
 - However for some, the reason for PDU is to float down rather than crash
- Behavioural: aggression, sexual risk-taking or vulnerability

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Polydrug Use: Overdose




- This is the main concern with PDU
 - Users should apply caution with their dosing and consider different duration of effect of different substances
- Often hard to establish at PM which drug(s) caused the fatality, but higher number of substances used together = higher risk of OD (both fatal and non-fatal)

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Polydrug Use: Overdose



- The point of **maximum risk** is the point of **maximum pleasure** (or relief) for some
- Alcohol and cocaine produces cocaethylene, more toxic than either on it's own
- Overdose prevention and intervention practices are essential


 **Early Overdose Signs**

- Erratic/unusual behaviours or movements
- Vomiting
- Overheating
- Confusion
- Very slurred speech
- Paranoia and suspicion
- Speechless; jaw is 'locked'
- Chest pains
- Pale faced
- Cramps
- Profuse sweating with flushed/appearance
- Hyperventilation

 **Late Overdose Signs**

- Seizure
- Stroke
- Cardiac arrest
- Unresponsive/unconscious
- Respiratory sedation & failure
- Coma
- Profuse sweating with flushed/appearance
- Stopping sweating but still flushed/hot appearance
- Blue colour around extremities

Warning: the time between early and late overdose signs can be small, especially when opiates, crack or methamphetamine are used by injection or are smoked

 **Managing Risks - Users**

- Know what substances have been taken, when and quantities used.
 - This can be difficult to know with accuracy but get into the habit of trying
- If agitated; understand that most of the time the drug effects will wear off naturally without any long-term harms but remaining calm is essential to reduce cardiovascular strain (which can be very risky)
- The basics; eat, drink, sleep, sort practical things out like bills, appointments etc.


 **Managing Risks - Workers**



- Create and maintain a calm, low-stimulus environment
- Awareness of own safety
- If person is agitated or distressed → remain calm and confidently reassure them
- Look for signs of drug-induced psychosis
 - Delusions: false, fixed beliefs (often persecutory)
 - Hallucinations: seeing, hearing, feeling, tasting, or smelling things that aren't there

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Managing Risks - Workers



- Number of drugs used is a factor but it's also the
 - Effect they have on the individual (and others)
 - Patterns of use; binge, recreational, dependent
 - Way they're used; oral, IV, snorted etc.
 - Where they are used; alone, outdoors, club, bedroom
- Looking at these 4 present more creative opportunities to intervene
- Treat the **presenting symptoms** and issues e.g. if unsteady on feet prevent falls, if distressed give calm reassurance etc.

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Managing Risks - Workers




- Don't get caught up too much in what exactly the person has used. If they tell you or recall easily, great; but don't keep asking or guessing
- Look for signs of severe intoxication including:
 - Decreasing response level
 - Slurred speech getting worse
 - BP rise or fall (red or pale face)
 - Vomiting
- Look for signs of overdose

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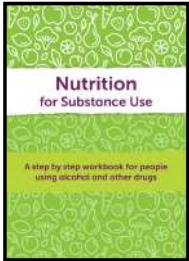
Issues for Staff

- Implications of PDU can affect the ability of PDUs to engage with services effectively
- Medications and the self-administration dilemma
- Managing behavioural implications in a group living context



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Interventions for Polydrug Use



- Raise awareness of risks of PDU
- Harm reduction information in useful formats e.g.
 - Nutrition for Substance Use Workbook, CHNI/Extern
 - Overdose awareness session
 - Less harmful routes of administration
- Use screening tools to gather assessment information

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Interventions for Polydrug Use




- Work with people to separate out which drug(s) they want to work on reducing or stopping first
- Referral to specialist services e.g. CAT, Addiction NI, Extern HST etc.
- Counselling approaches like CBT and MI have proven effective for many

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Alcohol Withdrawal


- What is withdrawal?
 - Alcohol is a depressant drug - which means that your nervous system has to work at an increased level to counteract the presence of alcohol to maintain its correct level of functioning
 - When the alcohol is removed, your body continues to function at this increased level, and thus withdrawal symptoms are experienced
 - This is why it is sometimes necessary to prescribe a drug to help the body adjust to normal.



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Alcohol Withdrawal

- Withdrawal symptoms can vary in severity depending on how much and how long you have been drinking alcohol and also on how high your tolerance is
- Tolerance can be described as the way your body gets used to the effects of alcohol and usually over time people need to drink or more to get the same effects




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Alcohol Withdrawal

The signs and symptoms of AWD may appear anywhere from six hours to a few days after your last drink. These usually include at least two of the following:


- Tremors
- Nausea
- Headache
- Sweating
- Confusion
- Nightmares
- Anxiety
- Vomiting
- Increased heart rate
- Irritability
- Insomnia
- High blood pressure

 **Alcohol Withdrawal**



- The symptoms may worsen over two to three days and persist for weeks. They may be more noticeable when you wake up with less alcohol in your blood
 - Severe symptoms = medical emergency
- The most severe type of withdrawal syndrome is known as **delirium tremens (DT)**. Its signs and symptoms include:
 - Extreme confusion and agitation
 - Fever
 - Seizures
 - Hallucinations
 - Tactile: sense of itching, burning, or numbness not actually occurring
 - Auditory: hearing sounds that don't exist
 - Visual: seeing images that don't exist

 **Alcohol Withdrawal: Causes**

- Excessive drinking excites the nervous system
- If you drink daily, your body becomes dependent on alcohol over time
- When this happens, your central nervous system can no longer adapt easily to the lack of alcohol
- If you suddenly stop drinking or significantly reduce the amount of alcohol you drink, it can cause AWD

 **Alcohol Withdrawal: Interventions**

- In severe case seek medical advice immediately
- Home care, support by friend or family member who can support with ensuring recommended practices are followed
- Medication
- Clinical Detox
- Prevention
- Harm reduction measures

  **Thanks!**


Any questions?

ASCERT
0800 2545 123
info@ascert.biz
www.ascert.biz

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Understanding Substance Misuse: The Effects of Drugs and Alcohol



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What Is a Drug?



- A drug is a substance which, when taken into the body, may modify one or more of its functions
- Ingestion routes vary depending on the drug, the desired effect, user's knowledge, how "inducted" by others
- Dose critical
 - Too little > "just right" > too much

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What Is Harmful Use?

- The harmful use of any substance such as alcohol and street drugs or the unauthorised use/overuse of a prescribed or over-the-counter drug
- Intoxication by – or regular excessive consumption of and/or dependence on – psychoactive substances, leading to social, psychological, physical, or legal problems



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What Is Harmful Use?

- From MI, the 4 Ls: Liver, Lover, Livelihood, and Law
- 3 categories (Nutt et al., 2007)
 - Physical harm
 - Tendency to induce dependence
 - Effect of use on families, communities, and society



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➔ **Most Commonly Used Substances in NI**



- Alcohol
- Tobacco/e-cigarettes
- Sedatives/tranquilisers
- Opioids
- Cannabis
- Stimulants
- NPS/"legal highs"

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What Can You See?

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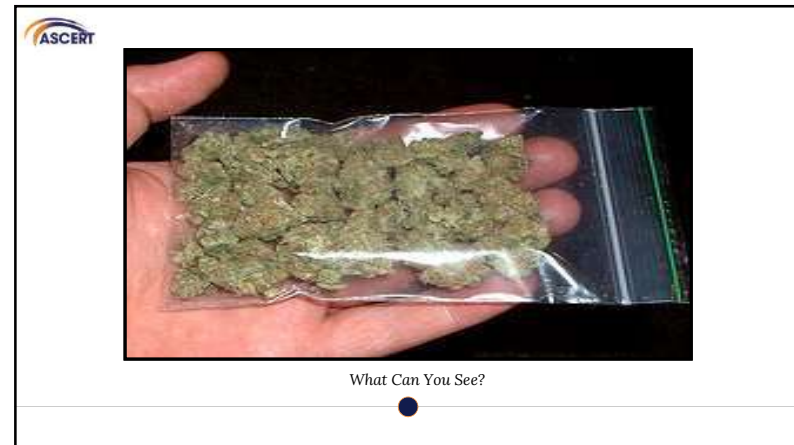


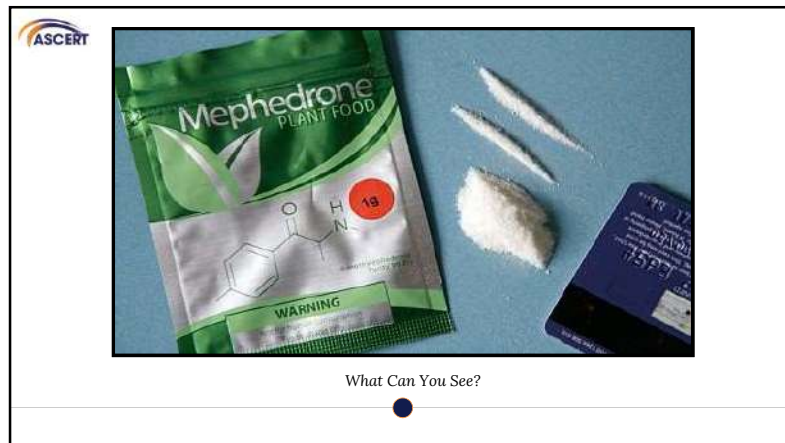
What Can You See?

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What Can You See?





What Can You See?




What Can You See?

Depressants

<p>Definition Any agent that suppresses, inhibits, or decreases some aspect of the Central Nervous System</p>	<p>Possible Effects</p> <ul style="list-style-type: none"> ● Decreased heart rate and blood pressure ● Blurred vision ● Feeling relaxed ● Loss of inhibition/ impaired judgement ● Slurred speech/ loss of coordination ● Drowsiness and memory loss 	<p>Examples of Substances</p> <ul style="list-style-type: none"> ● Alcohol ● Cannabis ● Solvents ● Tranquilisers
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Stimulants

<p>Definition Any agent that activates, enhances, or increases neural activity in the Central Nervous System</p>	<p>Possible Effects</p> <ul style="list-style-type: none"> ● Abnormally rapid heart rate (tachycardia) ● Elevated blood pressure ● Sweating and chills ● Nausea/vomiting ● Abnormal behaviour including agitation, grandiosity, and impulsivity 	<p>Examples of Substances</p> <ul style="list-style-type: none"> ● Cocaine ● Amphetamines ● Caffeine ● Nicotine
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 **Hallucinogens**


Definition
A chemical agent that induces alterations in perception, thinking, and feeling

Possible Effects

- Dilated pupils
- Elevated BP
- Tachycardia
- Tremors
- Overly responsive reflexes (hyperreflexia)
- Psychedelic phase (euphoria or mixed moods, visual illusions, altered perceptions)

Examples of Substances

- LSD
- DMT
- Mescaline
- Magic mushrooms

 **Opioids/Opiates**


Definition
Agents that interact with the Central Nervous System to relieve pain and produce a sense of wellbeing


Possible Effects

- Pain relief
- Feelings of wellbeing
- Respiratory depression
- Impaired concentration
- Drowsiness
- Impaired judgement

Examples of Substances

- Opium
- Heroin
- Codeine
- Methadone
- Fentanyl
- Dihydrocodeine
- Buprenorphine


 **Misuse of Drugs Act 1971**




○ Came fully into effect in 1973

○ Aims to prevent the misuse of controlled drugs → complete ban on the **possession, supply, manufacture, import, and export** of controlled drugs

○ Except as allowed by regulations/license from the Secretary of State

 **Misuse of Drugs Act 1971**



○ Possession of a controlled drug unlawfully

○ Possession of a controlled drug with intent to supply

○ Supplying or offering to supply a controlled drug (even without a charge for the drug)

○ Manufacturing

Misuse of Drugs Act 1971:
Classes

<p>Class A</p> <ul style="list-style-type: none"> ○ Cocaine and crack cocaine ○ Ecstasy ○ Heroin ○ LSD ○ Methadone (non-Rx) ○ Crystal meth ○ Magic mushrooms ○ Any Class B drug prepared for injection 	<p>Class B</p> <ul style="list-style-type: none"> ○ Amphetamine ○ Barbituates ○ Codeine ○ Mephedrone ○ Ketamine ○ Cannabis 	<p>Class C</p> <ul style="list-style-type: none"> ○ Anabolic steroids ○ Minor tranquilisers (e.g. Rohypnol) ○ GHB/GBL* ○ Mephedrone/Khat
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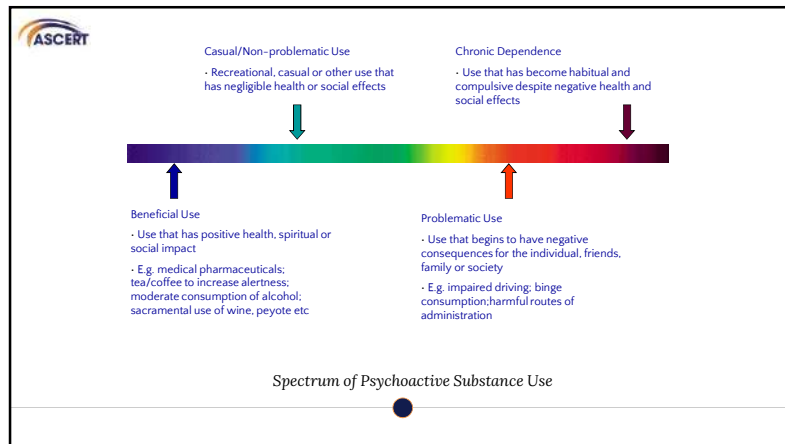
Drug Class	Maximum for Possession	Maximum for Supply
Class A	7 years + fine	Life + fine
Class B	5 years + fine	14 years + fine
Class C	2 years + fine	14 years + fine

Penalties Under the Misuse of Drugs Act



Why do people use substances?
Think of some reasons why people might use drugs or alcohol.

- Why Do People Use Substances?**
- | | |
|--|--|
| <ul style="list-style-type: none"> ○ Predisposition ○ Personality (addictive) ○ Hedonism ○ Age ○ Gender ○ Curiosity ○ Risk-taking (personal fable) ○ Peer pressure | <ul style="list-style-type: none"> ○ Peer preference ○ Locus of control ○ Availability ○ Alienation & lawlessness ○ Educational disturbance ○ Family disruption ○ Self medication ○ Functional use |
|--|--|



Potential Signs of Substance Use


<p>Behavioural</p> <ul style="list-style-type: none"> ● Giddy/excited ● Slurred speech ● Dopey/gouching ● Passive ● Aggressive ● Incoherent ● Itching/scratching ● Changes in appetite 	<p>Appearance/Physical:</p> <ul style="list-style-type: none"> ● Impaired motor skills ● Pale ● Flushed skin ● Smell ● Eyes ● Twitching ● Needle marks ● Changes in breathing
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Potential Signs of Substance Use

<p>Equipment and Paraphernalia</p> <ul style="list-style-type: none"> ● Pipes/bongs ● Burnt spoons, foil ● Plastic/paper wraps ● Vit. C powder ● Swabs ● Filters ● Syringes 	<p>Other</p> <ul style="list-style-type: none"> ● Associates/peers ● Health problems ● Debt problems ● Previous history ● Anxiety, paranoia, irritability between using episodes ● Withdrawal symptoms upon stopping
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Potential Signs of Substance Use

- There are 2 important factors to remember when looking for potential signs of substance use
 - Many of these signs may be nothing to do with substance use; service users have been “diagnosed” wrongly before
 - Only a blood test provides absolute proof
 - The examples shown are best thought of as **indicators**
 - Knowledge of individual’s normal behaviour, appearance, and actions is very useful



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Prescription Medication

- Types of prescribed meds which can be misused
 - Anti-psychotics for schizophrenia (e.g. haloperidol, chlorpromazine, aripiprazole, risperidone)
 - Anti-epileptics/mood stabilisers (e.g. carbamazepine, sodium valproate)
 - Benzodiazepines for anxiety/sleep disorders (e.g. diazepam, temazepam, nitrazepam)
 - 3 Zs (Zopiclone, Zolpidem, Zaleplon)
 - Lithium for bipolar disorder
 - Opiates/opioids (e.g. tramadol, DF118s, subutex)

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Homelessness and Substance Use



- Substance use as a cause of homelessness
- Substance use as a consequence of homelessness (a coping strategy)
- Both as interrelated factors causing and caused by ongoing instability in a person's life (the snowball effect)

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Homelessness and Substance Use




- Substance misuse is a significant issue among homeless people
- There are barriers to substance misuse services and accommodation services – what might they be?
- Homeless people prioritise accessing accommodation over addressing substance misuse problems – why?

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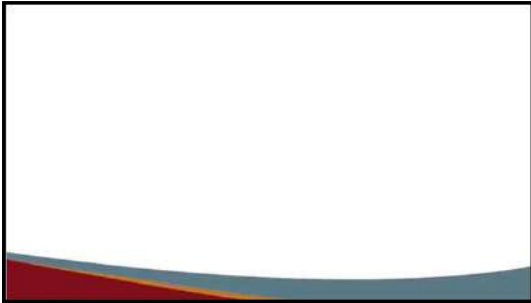
[Harm reduction refers to] policies, programmes, services, and actions which work to reduce the health, social, and economic harms to individuals, communities, and society that are associated with the use of drugs.

“

Newcombe, R (1992)


 **What Is Harm Reduction?**

- A set of practical public health strategies/interventions designed to reduce the negative consequences of drug use and promote healthy individuals and communities
- Understands drug use as a complex, multi-faceted issue that encompasses behaviours from very chaotic use to total abstinence
- Meets people where they're at in the course of their drug use


 

The Rationale Behind Harm Reduction


●

 **Examples of Harm Reduction Strategies**

○ Designated drivers	○ Needle exchange
○ Designated person to watch over drinks	○ Information services
○ Safer sex practices	○ On-site first aid
○ Safer injecting practices	○ Safer dancing
○ Safer routes of administration	○ Vitamins/diet e.g. ARBD
○ Controlled drinking	○ Legislation re. drugs and prostitution
○ Access to testing for BBVs	○ Access to primary health care services
○ Vaccination Hep A & B	○ Overdose training
○ Substitute prescribing	

 **Harm Reduction**


- Individual
 - Own behaviours re: substances
 - Upbringing
 - Experiences
 - Confidence in abilities
- Structure
 - Management views
 - Organisational culture



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Harm Reduction

- Community
 - Expectations
 - Norms
- Social
 - History
 - Government policy
 - Media
 - Legality



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Alcohol Use Disorder Treatment



- Alcohol detox always carries risks but these can often be managed safely
- Community or "home" detox vs. inpatient
 - No difference between numbers sober 6 months later
 - Cost difference substantial

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Alcohol Use Disorder Treatment




- Should be GP led
- Librium (a benzo) for 7 days max to manage withdrawal symptoms
- Daily blood pressure checks recommended
- Daily GP contact allows clinical decisions to be made e.g. dosage adjustments, breathalyser


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Alcohol Use Disorder Treatment





- Other professional involvement could include CPN, pharmacist, primary care nurses
- Many prefer 'home' detox
- Safe for mild and moderate dependence




 **Alcohol Use Disorder Treatment**


- Severe confusion or hallucinations
- History of complicated withdrawal
- Epilepsy or history of fits
- Undernourished
- Severe vomiting or diarrhoea
- Suicide risk
- Severe dependence and unwilling to see GP daily
- Previous home assisted withdrawal has failed
- Multiple substances used (especially benzos)
- Home environment unsupportive of abstinence
- Wernicke-Korsakov syndrome (ARBD)
- DTs (Delirium Tremens): disorientation, hallucinations or delusions. Fits due to autonomic overactivity can be fatal.
- Acute physical (e.g. liver) or psychiatric problems



 **Provision of Services: The 4 Tier System**

- Tier 1: Non substance use specific services requiring interface with drug and alcohol treatment
 - e.g. GP's, A&E, Health Promotion, hostels and housing provision
- Tier 2: Open access drug treatment services
 - e.g. drop-in, outreach services, needle exchange
- Tier 3: Structured community-based drug treatment services
 - e.g. structured counselling or substitute prescribing.
- Tier 4: Residential services
 - e.g. inpatient detox or residential rehabilitation.



 **Thanks!**

Any questions?

ASCERT
0800 2545 123
info@ascert.biz
www.ascert.biz