Substance Use Counseling Skills: Evidence in Practice
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There are no actual or potential conflicts of interest to disclose; this presentation was created without any commercial support.
### Today’s Schedule

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<td>8:30 - 9:00 am</td>
<td>Registration</td>
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<tr>
<td>9:00 – 10:15 am</td>
<td>Opioid Overdose Prevention Counseling</td>
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<td>10:15 – 10:30 am</td>
<td>Break</td>
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<td>10:30 – 11:30 am</td>
<td>Motivation</td>
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<td>11:30 – 12:45 pm</td>
<td>Lunch</td>
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<td>12:45 – 2:00 pm</td>
<td>Managing Cravings</td>
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<td>2:00 – 2:15 pm</td>
<td>Break</td>
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<td>2:15 - 4:00 pm</td>
<td>Preventing &amp; Responding to Relapse</td>
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### Learning Objectives

1. Conduct opioid overdose risk assessments and create overdose prevention plans as a part of overdose prevention counseling.
2. Identify different aspects of motivation, and practice using Change Rulers to elicit and strengthen motivation for positive change.
3. Learn to incorporate mindfulness and urge surfing interventions in addressing cravings.
4. Practice Behavior Chaining as part of Relapse Prevention Therapy.
Housekeeping

➢ Group Agreements
➢ Bike Rack
➢ Restrooms
➢ Phones, Beepers & Electronic Watches
➢ Introductions

Opioid Overdose Prevention Counseling

Image Source: Harm Reduction Coalition
http://harmreduction.org/miscellaneous/photobooth/
Comparison of Drug Caused Deaths in Florida (2014-2016)

2016 Medical Examiners Commision Drug Report; Florida Dept. of Law Enforcement.
Historical Overview of Heroin Occurrences in Florida Deaths, both present and cause of death (2002-2016)

Historical Overview of Fentanyl Occurrences in Florida Deaths, both present and cause of death (2003-2016)
WE PLAY A CRITICAL ROLE IN PREVENTING FUTURE OPIOID OVERDOSES

We can help prevent and reverse overdoses by:

▪ Encouraging open, person-centered conversations about alcohol and substance use.
▪ Learning about risk factors for overdose.
▪ Learning what an overdose looks like and what to do if someone may be overdosing.

WE PLAY A CRITICAL ROLE IN PREVENTING FUTURE OPIOID OVERDOSES

We can help prevent and reverse overdoses by:

▪ Engaging clients in risk-reduction counseling.
▪ Sharing our knowledge with clients, and their social supports.
▪ Helping clients create an Overdose Prevention Plan & connecting them (and their supports) with **naloxone**.
Opioid Overdose Risk Factors

Social Determinants

- **People experiencing homelessness**
  - A leading cause of death (Baggett et al., 2013)

- **People exiting incarceration**
  - A leading cause of death (Binswanger et al., 2013)

- **People in treatment for an Opioid Use Disorder**
  - Detox riskier than no treatment (Strang et al., 2003)

- **People living with HIV/AIDS**
  - 74% higher incidence of overdose (Green et al., 2012)

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Opioid Overdose Risk Factors

- **Using alone**
  - There is no one to recognize, respond and get help.

- **Prior overdoses**
  - Previous overdoses lower one’s overdose threshold, making it easier to overdose in the future.
Opioid Overdose Risk Factors

● Not having an overdose prevention plan
  ◦ Lack of support and planning for how to prevent an overdose, including access to naloxone, increases risk.

● Physical health vulnerabilities
  ◦ It becomes easier to overdose when our internal systems and organs are already compromised by a health condition.

Opioid Overdose Risk Factors

● Mixing with alcohol and/or other substances
  ◦ Mixing substances can strengthen their effects, so it could take a smaller amount to produce overdose. Some substances may mask the effects of opioids (such as stimulants), which could then lead a person to take more opioids, which could result in overdose.
Opioid Overdose Risk Factors

- **Using opioids with CNS depressants**
  - Using opioids with other “downers” such as alcohol, sleep aids, anxiety medications, and other opioids (such as methadone, or prescription medications), will depress breathing, making overdose more likely.

Opioid Overdose Risk Factors

- **Not ‘testing’ the dose**
  - By using a tiny amount of the substance to “test” it before using their more typical amount, the person can increase their awareness of the strength of the substance as well as their current tolerance.
Opioid Overdose Risk Factors

**Recent period of abstinence**
- Tolerance to opioids can change quickly, so a recent period of abstinence can reduce one’s tolerance, and make overdose more likely. Recent abstinence may not be planned or voluntary, but could be due to exiting an institution (such as jail or a nursing home), or a recent hospitalization.

Opioid Overdose Risk Factors

**Erratic pattern of use**
- Inconsistent use, or using different forms of opioids (or from different sources), can all lead to dramatic shifts in tolerance, which increases the risk for overdose.
### Opioid Overdose Risk Factors

- **Suicidal or para-suicidal history**
- **History of depression or dysthymia**
- **Pattern of impulsivity**
  - Someone with a history of suicidality/para-suicidal behavior, depression/dysthymia, and/or impulsivity, may be less likely to take measures to prevent an overdose, and/or may use in a more haphazard or impulsive manner, which then increases the risk for overdose.

### Opioid Overdose Risk Factors

- **Route of administration**
  - Routes of administration that are more direct increase the risk of overdose, because a larger and more potent amount of the substance is more quickly absorbed by the body. Using intravenously presents the highest overdose risk, followed by snorting, then smoking, and eating the substance. It is possible to overdose by any route of administration.
Opioid Overdose Risk Factors

● Seeks profound intoxication
  ◦ Someone who enjoys and/or seeks the sensation of profound intoxication is more likely to use a higher amount and/or a more direct route of administration.

Key Steps in Preventing Overdose

● Engagement & Trusting Relationships
  ◦ Develop a relationship with clients that keeps the door open for discussing substances no matter where they are in the change process.
  ◦ Provide nonjudgmental, and non-coercive education around overdose risk and prevention.
  ◦ Engage clients’ friends, family members, neighbors, and using partners (with their informed consent) and provide overdose prevention counseling & support.
Key Steps in Preventing Overdose

● Support clients to…
  ◦ create an overdose prevention plan
  ◦ access naloxone on an ongoing basis
  ◦ know tolerance changes with frequency and amount used
  ◦ start low and go slow especially when their pattern of use has recently changed, or is erratic
  ◦ avoid mixing substances, especially downers
  ◦ use when others are around
  ◦ keep a naloxone kit nearby when using

Intoxication vs Overdose

PROFOUND INTOXICATION

● Pupils pinned (same as OD)
● Can be aroused (responds to stimuli, such as sternal rub)
● Speech is slurred
● Breathing (8+ times/min)

OVERDOSE

● Pupils pinned (same as intox)
● Unresponsive to stimuli
● Can open eyes but not speak
● Breathing slowly or not at all
  ○ Less than 8x/min
  ○ May hear choking, gurgling or snoring sound
  ○ Blue/gray lips and/or fingertips

It can take HOURS for a person to overdose… or seconds (fentanyl)
Responding to Overdose

Naloxone (Narcan) is available as:
- intramuscular injection
- auto-injector
- nasal spray

With and without prescription

Administer additional doses of naloxone every 3 minutes if the person has not responded.

Supporting the Person

Continue to support the person until paramedics arrive, and/or for at least 1-2 hours after the overdose. Naloxone can wear off, and the person can overdose again. Prevent them from using more.
Always Call an Ambulance

- Medical support is needed.
- Naloxone wears off, and they could overdose again.
- There could be other drugs in their system that produce overdose.
- Naloxone only works for opioids.
- Good Samaritan laws exist in many states, including Florida.

What **NOT** to do during an overdose

- DO NOT put the individual in a bath. They could drown.
- DO NOT put ice on them. They could go into shock.
- DO NOT induce vomiting or give them something to eat or drink. They could choke.
- DO NOT give medications, over-the-counter drugs, stimulants, street drugs, caffeine, or vitamins (other than naloxone). They don’t help.
- DO NOT try to walk them around in hopes of waking them up. This doesn’t work and just wastes time.
- DO NOT leave the person to “sleep it off.”
- DO NOT run away – call 911!
In your naloxone kit

**Required items:**
- Naloxone (3 doses),
- Written instructions on recognizing, responding to, and reversing overdose.

**Optional items:**
- Rescue Breathing Mask
- Rubber Gloves
- Alcohol Pads

Learn – Access - Share

In order for opioid overdose prevention counseling to be effective, the person must be ready and able to access overdose reversal materials and share the information with their support networks.

Overdose cannot be reversed by the person experiencing it.

Image Source: Harm Reduction Coalition
http://harmreduction.org/miscellaneous/photobooth/
NALOXONE

- Naloxone availability decreases fatal overdoses and does not increase rates of use.
- Prescribers can prescribe naloxone without any additional waiver.
- Clinics and organizations can dispense naloxone, creating immediate access.
- Also available at many local pharmacies.
- Advocate for your in-house pharmacy to stock.

Naloxone Info & Resources

For prescribers and pharmacists: Prescribetoprevent.org

SAMHSA 2016 toolkit:
http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2016/SMA16-4742

Harm Reduction Coalition Overdose Prevention & Naloxone Manual
Providing Information and Feedback

**ELICIT - PROVIDE - ELICIT**

● **ELICIT**
  ○ *Would it be alright if I shared some information about _____ with you?*
  ○ *I have information on _____ that you might find relevant. May I share it with you?*
  ○ *Tell me your thoughts on ______.*
  ○ *Tell me what you know about ______.*
  ○ *What has been your experience with ______.*

Providing Information and Feedback

**ELICIT - PROVIDE - ELICIT**

● **PROVIDE**
In a compassionate, non-stigmatizing, and person-centered manner, we can provide information and/or feedback, such as:
  ○ Results of test, screening, assessment, etc.
  ○ Information on associated risks/harms, etc.
  ○ Concerns related to risks, substance use, etc.
  ○ Relevant data and statistics
Providing Information and Feedback

**ELICIT - PROVIDE - ELICIT**

- **ELICIT**
  - *What do you think about that?*
  - *How might this influence your next steps?*
  - *What might you try differently now?*
  - *What do you think you’ll do?*
  - *How would you like to move forward?*

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Case Scenario: Kevin

Kevin is a 22yo veteran presenting with opioid and alcohol use, PTSD-related symptoms, and depressive symptoms. Kevin currently lives with his parents, plans to enroll in college, and has a large social support network. Kevin misuses his rx. opioids, and sometimes snorts heroin when he runs out of rx.

In groups of 3-4:
- Identify overdose risk factors.
- Identify areas of further assessment to better understand overdose risk.
Demonstration: Initial Opioid Overdose Risk Assessment

Kevin is a 22yo veteran presenting with opioid and alcohol use, PTSD-related symptoms, and depressive symptoms. Kevin currently lives with his parents, plans to enroll in college, and has a large social support network. Kevin misuses his rx. opioids, and sometimes snorts heroin when he runs out of rx.

- Did we touch on any of the areas that you marked for further assessment?
- What risk reduction strategies did you identify?

Role Play: Initial Opioid Overdose Risk Assessment

In pairs,
- Role play based on your own client, or Kevin’s case scenario.
- Switch roles, repeat
Case Scenario: Victoria

Victoria is a 47 year old woman, diagnosed with PTSD, and alcohol use d/o (severe). Her rx. include a sleep aid and a benzodiazepine for panic attacks. She has a hx. of suicide attempts, self-injury, and driving while intoxicated. She recently had oral surgery and was rx a 30-day supply of an opioid analgesic.

In groups of 3-4:
- Identify overdose risk factors.
- Identify relevant risk reduction strategies to prevent potential opioid overdose.
Demonstration:  
Opioid Overdose Prevention Counseling & Plan

Victoria is a 47 year old woman, diagnosed with PTSD, and alcohol use d/o (severe). Her rx. include a sleep aid and a benzodiazepine for panic attacks. She has a hx. of suicide attempts, self-injury, and driving while intoxicated. She recently had oral surgery and was rx a 30-day supply of an opioid analgesic.

- What risk reduction strategies did we identify?  
- What was missing from the prevention plan?

Role Play:  
Opioid Overdose Prevention Counseling & Plan

Victoria is a 47 year old woman, diagnosed with PTSD, and alcohol use d/o (severe). Her rx. include a sleep aid and a benzodiazepine for panic attacks. She has a hx. of suicide attempts, self-injury, and driving while intoxicated. She recently had oral surgery and was rx a 30-day supply of an opioid analgesic.

In pairs,  
- Role play based on your own client, or Kevin’s or Victoria’s case scenario.  
- Switch roles, repeat.
Motivation

- The “why” of change;
- Substance-specific goals must be connected to greater life goals;
- Life goals must be rooted within values;
- Treatment is not an end unto itself, it is a means to an end.
What Matters Most to Me?

Values Identification

Circle your top ten values from list (feel free to add your own).

Number them 1-10 with #1 being the top.

Next, think of an important decision you recently made.

How did your values inform your decision?

Share what you’d like in groups of 2-3.

(Miller et al., 2001)
Linking Values with Goals

In your same small groups (2-3):

- Share your top three values.
- As a group, develop one potential goal for each member’s #1 value.

Example:

- Value: Family
- Goal: Be fully present and engaged when at home (and leave work at work!).

Linking Values with Goals

In your same small groups (2-3) discuss:

What does it look like to link RECOVERY GOALS to VALUES?

What difference might that make?

How are some ways you root goals within deeply held values?
Ambivalence

• Feeling two ways about a situation.
• Often seen as a barrier to motivation… when it is actually a necessary ingredient for change.
• If someone is bringing up a behavior or situation in their treatment services, it is likely they are at least thinking about change.

(Miller & Rollnick, 2013)

Motivational Interviewing

MI aims to engage person in change process through

➢ Resolving their ambivalence
➢ Enhancing their self-efficacy
➢ Eliciting and strengthening their commitment to change
Elements of Motivation

• Importance
  • “How important is it to make this change?”

• Confidence
  • “How confident do you feel that you can do it?”

• Readiness
  • “How ready do you feel to make this change?”

(Miller & Rollnick, 2013)

Using Change Rulers

On a scale of 0-10, 0 meaning not at all, and 10 meaning as much as possible, where would you place yourself?

• You’re at a [# given], so this change is somewhat/fairly important for you. How come you are at a [# given] and not a [lower #]?

• What would need to happen for you to move towards a [next higher #]?

(Miller & Rollnick, 2013)
### Responding to Importance and Confidence Measures

<table>
<thead>
<tr>
<th>Importance</th>
<th>Confidence</th>
<th>Strategy</th>
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<tbody>
<tr>
<td>High</td>
<td>Low</td>
<td>Explore “hows” of change</td>
</tr>
<tr>
<td>Low</td>
<td>High</td>
<td>Explore “whys” of change</td>
</tr>
<tr>
<td>High</td>
<td>High</td>
<td>Start with “hows” of change</td>
</tr>
<tr>
<td>Low</td>
<td>Low</td>
<td>Explore “whys” OR… This may not be the right time to address making a change. Check with the client and ask if there is anything else they would like to work on.</td>
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(Miller & Rollnick, 2013)

### Change Rulers: Demonstration

**Volunteer for real play demonstration?**

- Speaker (volunteer) gives a brief (30 second) summary of situation
- Listener asks a scaling question using **readiness**, **importance**, and/or **confidence** ruler.
  - What puts you at a [# given] and not a [lower #]?
  - What would help you move towards a [next higher #]?
Change Rulers: Practice

Real-play (in pairs)

• Speaker gives a brief (30 second) summary of situation
• Listener asks a scaling question using readiness, importance, and/or confidence ruler.
  • What puts you at a [# given] and not a [lower #]?
  • What would help you move towards a [next higher #]?

Lunch
Skill: Managing Cravings

- The “how” of change;
- Skills support people to reach their goals;
- Skills must be clearly linked to goals;
- Meaningless without the “why”.

Defusion

The ability to experience our thoughts and feelings as what they are (thoughts and feelings), rather than what they say they are.

Allows us to ACT rather than REACT
Mindfulness

Managing Cravings

● *Identify & defuse* from the craving experience (both physiological and psychological).

● Cravings tend to peak and then diminish within 5-10 minutes.

● Cravings WILL subside regardless of use.

● Use reinforces cravings.

(Mueser et al., 2003)
Urge Surfing

Three basic steps:

1. **Mindfulness**: turn your attention inward, notice how and where in your body you sense the craving.

2. **Focus** on an area within your body where you are experiencing the urge. Nonjudgmentally describe the sensations to yourself as you notice them. Shift your focus to different areas of your body, one at a time, describing the sensations where you experience the craving.

3. **Ride** out the craving, releasing tension with each breath. Continue to practice mindfulness, observing the craving until it subsides.

(Bowen, Chawla, & Marlatt, 2011; NIAAA, 2013)
Craving Management Planning

Develop a plan for managing cravings

- Ask the person to make a list of soothing behaviors that they believe they can and will do in multiple situations.
  - Carry the list at all times.
  - Role play consulting the list, and selecting and practicing in the soothing behavior.
  - Some activities may work well and others may not. Help the person re-evaluate and revise regularly.

(Mueser et al., 2003)

Recovery Oriented Care & Language Surrounding “Relapse”
<table>
<thead>
<tr>
<th>Common Language</th>
<th>Issue</th>
<th>Language Alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>John <em>relapsed</em> after his discharge from addiction treatment.</td>
<td><strong>Implies moral failure</strong></td>
<td>John <em>resumed</em> drinking following his discharge from addiction treatment. John experienced a <em>recurrence</em> of his alcohol use problem four months after his discharge from addiction treatment.</td>
</tr>
</tbody>
</table>

(White and Ali, 2010)

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<tr>
<td>John is a chronic relapser.</td>
<td>John ceases to be a person through such objectifying language. He becomes instead a “thing” – a category</td>
<td>John is a person who has experienced recurring episodes of alcohol-related problems. John continues to experience intermittent episodes of substance use. John has not yet achieved stable recovery in the community.</td>
</tr>
</tbody>
</table>

(White and Ali, 2010)
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| John has not *relapsed* since his last treatment. | **Focus is on what John has not done rather than what he has achieved.** | John *has maintained stable recovery.*  
John’s alcohol dependence is currently in full *remission.*  
John is a *person in long-term recovery:* he has not used alcohol or other substances since ____ (date) – or for ____ years. |

*(White and Ali, 2010)*

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<th>Language Alternative</th>
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<td>Relapse is part of recovery.</td>
<td><strong>Normalizes the presence of pathology as a dimension of recovery. For persons with severe substance use disorders, AOD use is part of the disorder. NOT part of the healing process.</strong></td>
<td>Addiction is often characterized by cycles of excessive AOD use/issues interspersed with voluntary or coerced periods of abstinence. Recovery is the replacement of these cycles with stable and sustained health. While this process may be marked by diminished frequency and severity of AOD use, depicting such use as a dimension of the recovery experience is a misnomer.</td>
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*(White and Ali, 2010)*
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<th>Issue</th>
<th>Language Alternative</th>
</tr>
</thead>
<tbody>
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<td>John has <em>relapsed</em>, but things are not as bad as they used to be.</td>
<td><strong>Language conveys degrees of John’s “badness.”</strong></td>
<td>John is <em>in partial remission</em> from alcohol use disorder. John continues to experience some alcohol-related issues, but he’s experiencing less negative events as a result of his alcohol use.</td>
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(White and Ali, 2010)

Pause
Preventing & Responding to Setbacks

Image: ‘Bangkok Excessway’ Found on Flickr net
http://www.flickr.com/photos/80854685@N08/7454743336

Cognitive-Behavioral Model of Relapse

(Marlatt & Witkiewitz, 2004)
Common Factors in Lapse

- Decreased self-efficacy
- Distressful internal states
- Isolation
- Lack of social support
- Interpersonal conflict
- Traumatic distress
- Moments for recreation / celebration
- Exposure to AOD-use situations
- … and more

(White & Ali, 2010)

Anticipating Risks for Lapse

Make space to grieve losses associated with progress.

- Loneliness, social disconnection, feeling “different” or stigmatized.
- Feeling distress with negative feelings, symptoms of depression, anxiety, etc.
- Trauma material may increase.
- Changes in sleeping, eating, well being, etc.
- Grief over loss of substance use relationships.
- Guilt over past actions
- Others ….
Abstinence Violation Effect (AVE)

What is the Abstinence Violation Effect?

Abstinence Violation Effect (AVE) contributes to lapses turning into relapses.

Factors that strengthen AVE:

- All-or-nothing thinking: the person believes factors contributing to relapse are beyond their control.
- Self-attribution effect: individual attributes cause of the relapse to internal weakness and personal failure.
- Negative affect and low self-efficacy may strengthen AVE.

(Hendershot, et al., 2011)
Preventing AVE

- A lapse doesn’t have to become a relapse.
- Often negative reactions about the lapse leads to relapse.
- Have an emergency plan ready for when lapse occurs, to keep it from progressing.

(Marlatt & Gordon, 1985)

Leading Up to the Lapse

Seemingly Irrelevant Decisions
A series of mini-decisions begin a chain of behaviors which set stage for lapse.

(NIAAA, 2013)
Seemingly Irrelevant Decisions

Explore the seemingly irrelevant thoughts, behaviors, and decisions that may lead to a high-risk situation.

My brother left a few beers in the fridge, I need to keep them in case he wants them back.

I keep a lighter in my bag in case someone asks me for a light.

I’m afraid the dope man will take advantage of her, so I go out and get her drugs so I know she’s safe.

Seemingly Irrelevant Decisions

- Encourage reflection and a thoughtful approach to these decisions, no matter how small.
- Explore apparent rationalizations and the overlooking of potentially risky decisions.
- Plan for how to mitigate risks, and for potential lapse (so that it doesn’t become a relapse).

(NIAAA, 2013)
Assessing High-Risk Situations

Returning to substance use tends not to be random. It is important to know:

- The time periods when use occurs.
- The places where substances are obtained/used.
- From/With whom substances are obtained/used.
- The external cues and internal emotional states that typically precede and accompany use.
- The anticipated/perceived benefits/function/effects of the substance(s).

(UN, 2007)

Managing Lapses

- **Overdose prevention.**
- Prevent *Abstinence Violation Effect.*
- Ask about what brought on prior lapses, and incorporate ways to plan ahead should these situations occur.
Managing Lapses

- Enhance/expand skills to avoid lapse.
- Plan ahead: Ask the person what would be helpful if a lapse occurs. How might you support them through that situation?
- Teach Value-Based Avoidance.

Value-Based Avoidance

<table>
<thead>
<tr>
<th>Value</th>
<th>Risk</th>
<th>Action Plan</th>
</tr>
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<tbody>
<tr>
<td>High</td>
<td>Low</td>
<td>Go for it</td>
</tr>
<tr>
<td>Low</td>
<td>High</td>
<td>Avoid long-term</td>
</tr>
<tr>
<td>High</td>
<td>High</td>
<td>Avoid short-term</td>
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(Turner, Welches, & Conti, 2013)
Turning a Setback into a Comeback
Set the stage for open discussion of lapses

Introduce idea of “prolapse”:

when new insights are discovered during lapse, and used to strengthen recovery & recovery plan.

We can assist in reframing a lapse as a prolapse, through the practice of Behavior Chaining.

(Marlatt & Gordon, 1985)

Behavior Chaining
Behavior Chaining

Goals:
- Identify high risk situations.
- Identify opportunities to use coping skills.
- Increase awareness of and decision-making capacity when faced with situations which can/have led to use.
- Refine & individualize treatment services/plan.

Behavior Chaining

- Start with most recent use and work backwards.
- What interactions did the person have with others?
- What was going on around them?
- What were their internal states?

Image: ‘domino effect (cc)’ Found on flickrcc.net
http://www.flickr.com/photos/45409431@N00/12741087104
Behavior Chaining

What sorts of coping strategies were used and how well did they work?
What changes in the client’s treatment plan occurred in response to this incident?
  - Will the current plan be modified? Will it be discontinued and another plan developed?
  - If there are no changes, state that the current plan is adequate and will be continued.
  - Confidence rulers can be useful here.
**Behavior Chaining: Example**

**What Preceded**

- Up late – poor sleep, overslept
- Drank beer to fall asleep, while watching TV in bed

**Events Leading up to the sub use event**

- Running late for work - stressed, got call from friend
- Go to bed. Worried about job
- Bored, watching TV

**Substance Use**

- Got high with friend. Intended to call in sick.
- Asked ex for a cig when he arrived.
- Didn’t put nicotine patch on in the AM figured would put it on later

**What Followed**

- Forgot to call work, was terminated.
- Felt less nervous. Bought a pack, and had 5 more that evening.
- Woke up anxious about meeting ex to return items.

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**What was going on earlier that day (with person, with others, in environment):**

- School reading in library 3hrs. A little antsy.
- Left house without patch. Had nic loz.

**What happened the night/day before (with person, with others, in environment):**

- Waiting in car – 30+ min. Tried counting cars. Anxious & bored

**How was the person feeling (physically, emotionally):**

- Worried about job
- Bored, watching TV

**Was anything bothering the person:**

- Didn’t put nicotine patch on in the AM figured would put it on later
- Didn’t put nicotine patch on in the AM figured would put it on later

**Changes in treatment plan:**
Make Your Own Behavior Chain

Think about the most recent time you made a less than healthy decision.

- Start with the event & what followed.
- Work your way back through the behavior chain.
- What was the starting point (exposure to a cue, certain thoughts and feelings)?
- Can you recognize the choice points where you made decisions?

**Behavior Chaining**

What Preceded → Sub Use → What Followed

Events leading up to the substance use event:

What was going on earlier that day (with person, with others, in environment):

What happened the night/day before (with person, with others, in environment):

How was the person feeling (physically, emotionally):

Was anything bothering the person:

Changes in treatment plan:
Role Play: Behavior Chain

In Pairs:
Role play introducing the behavior chain and completing it, (based on a client you have served).
When done, switch roles and repeat.

**Behavior Chaining**

What Preceded

What Followed

Events leading up to the substance use event

What was going on earlier that day (with person, with others, in environment):

What happened the night/day before (with person, with others, in environment):

How was the person feeling (physically, emotionally):

Was anything bothering the person:

Changes in treatment plan:
Responding to lapse: Demonstration

1. Remain neutral (verbal & non-verbal).
2. Express gratitude for open communication.
3. Affirm courage for disclosure and commitment to recovery.
4. Attend to any negative emotions / minimize shame.
5. Frame as opportunity to learn more about self, recovery needs, and refine plan.
6. With permission, explore circumstances / behavior chain.
7. Refine continuing recovery plan and/or treatment plan.
8. Consolidate commitment.

Reframing a Lapse

- Involves learning not to view lapses as a “failure” or lack of “willpower.”
- Attribute lapse to predictable and potentially controllable events rather than personal failures and character flaws.
- Involves education about the relapse process – navigate through the terrain of ongoing efforts to sustain change.

(Marlatt et al., 2002)
Activity: Reframing a Lapse …

In small groups (4-6 people):

- Start with the person who has the most years of experience, and move clockwise.
- Each person offers a **REFRAME** of the relapse in the case scenario.

Reframing a Lapse …

Your 40 year-old client has had a severe opioid use disorder for 14 years. He has maintained his sobriety since starting treatment 30 days ago. Yesterday he ran into some old associates on his way to the clinic and they offered him heroin, which he used. He sees you today and says, “I am a hopeless addict.”

**REFRAME:**
Reframing a Lapse …
Your 23 year-old client has had a severe cocaine use disorder for 2 years. After 3 months sober, she went to a friend’s BBQ, had a few beers, and ended up smoking cocaine. She comes in Monday morning and says, “I blew it, I’m back to square one.”

REFRAME:

Reframing a Lapse …
Your 65 year-old client has had a severe alcohol use disorder for 30 years. He attended his granddaughter’s wedding this weekend, where he drank alcohol to the point of blacking out and falling down, after 9 months of managed alcohol use. He comes in Wednesday morning and says, “I’ve been a fool thinking I was anything but a drunk.”

REFRAME:
Ideas for Group Sessions

- Elicit group members’ experiences and strategies they have used to prevent a lapse and avoid high risk situations.
- Engage group members in planning out schedule (including leisure), reducing time that is unstructured.
- Help group members consider how they might respond to a lapse in order to prevent escalation of lapse.
- Brainstorm coping skills and risk reduction strategies.
- Use role play to practice specific skills.
- Share continuing recovery plan with social supports.

Sample Continuing Recovery Materials
Sample: Emergency Plan for High-Risk Situation

If I encounter a high-risk situation:

- I will leave the situation and/or environment.
- I will put off the decision to use for 15 minutes. I will remember that most cravings are time-limited and I can ride it out.
- I will recognize my thoughts as thoughts, not absolute facts. Do I really need to use? Not likely. I will remind myself that my only true needs are for air, water, food, and shelter.
- I will think of something unrelated to using.
- I will remind myself of my successes to this point.
- I will call my list of emergency numbers.

(NIAAA, 2013)

Sample: Emergency Plan for after a Lapse (pt.1)

1. Get rid of the substance(s).
2. Get away from the place where I lapsed.
3. Read this out loud: One use or even one day of use does not have to result in a relapse. I will not give in to feelings of guilt or shame because I know these feelings will pass in time. I can get through this without making matters worse.
4. Call a recovery support for help.

(NIAAA, 2013)
Sample: Emergency Plan for after a Lapse (pt.2)

- At my next session, I will examine this lapse with my counselor, discuss the events prior to my lapse, and identify cues and my reaction to them. I will explore with my counselors what I expected substances to change or provide. I will work with my counselor to set up a plan so that I will be able to cope with a similar situation in the future.

- **REMEMBER: A LAPSE IS ONLY A TEMPORARY DETOUR ON THE ROAD TO RECOVERY**

(NIAAA, 2013)

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**Question & Answer**
Thank you!
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Resources & References

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