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How Behavioral Health Providers Are Addressing Substance Misuse

Introduction

Substance misuse, a complex and multifaceted issue, continues to impact individuals, families, and communities worldwide. From alcohol and opioids to synthetic drugs and emerging substances, the spectrum of substances misused continues to evolve, presenting new challenges for prevention, treatment, and harm reduction efforts. The current landscape for addressing substance misuse and trends is complex and evolving, influenced by various factors, including societal attitudes, economic conditions, legislative changes, and advancements in healthcare. Several factors must be considered when addressing these issues, including prevalence and diversity of substance misuse, rising overdose rates, co-occurring mental health disorders, stigma to barriers and treatment, care integration, advancement in treatment modalities, and policy and legislative changes.

Why is it important to address current trends?

Behavioral health providers need to be aware of current trends in substance use as it is a concerning public health issue. There has been an increase in drug potency, an increase in mortality from substances, and the ongoing challenge of new and emerging drugs coming to market regularly.

Drug potency increases are seen in cannabis with higher levels of THC than has been previously available (Stringer, 2024). There is also an increase in the availability of cannabis as more states are legalizing its recreational use. Fentanyl is increasingly being mixed into other drugs without the users' knowledge, increasing the risk of overdose.

In 2022, over 109,000 people in the United States died of drug overdoses, approximately 54% more than in 2019, according to statistical data from the Centers for Disease Control and Prevention (CDC, 2023).

Emerging drugs are hitting the market, sometimes faster than the healthcare system can track them. This leaves gaps in treatment and life-saving interventions, as emergency departments lack the ability to test for the multitude of emerging drugs (NIDA, 2024).

With more awareness, behavioral health professionals can be prepared to evolve screening and treatment to meet the needs of the ever-evolving substance use field.

Overview of Substance Misuse Disorders

According to the current DSM-5, ten substances have been identified as substances that can be misused. They are (APA, 2013):

- Alcohol
- Caffeine
- Cannabis
- Hallucinogens, including Phencyclidine and other hallucinogens
- Inhalants
- Opioids
- Sedatives, including hypnotics and anxiolytics
- Stimulants, including amphetamines, cocaine, and other stimulants
- Tobacco
- Other or unknown substance-related disorder

Emerging Substances of Abuse

Emerging drugs are substances that have become popular in recent years. They are sold in convenience stores, drug markets, and online. These substances are prolific and always changing. This includes designer drugs and new psychoactive substances. They are often created to mimic the effects of other drugs, such as opioids, stimulants, benzodiazepines, or other drugs that are regulated controlled substances (NIDA, 2024).

Individuals seek out these substances for recreational purposes or to self-medicate without medical supervision (NIDA, 2024). They are frequently mixed into other drugs without the buyer knowing, causing increased health dangers and risk of overdose.

Another danger with emerging substances is they are not part of emergency department drug tests; this can delay or prevent treatment for someone who is seeking emergency medical services (NIDA, 2024). These drugs are not typically part of an autopsy toxicology report after a fatal overdose either (NIDA, 2024). This results in a major gap in information and the inability to know how widespread the use of emerging substances is or the negative consequences it is having on those who have used them.

Demographic Patterns

The 2021 National Survey on Drug Use and Health (NSDUH) collects data on health and substance use from numerous sources. The following were some of the racial and ethnic trends reported for specific substances (CBHSQ, 2022):

Tobacco: The prevalence of past month tobacco product use or nicotine vaping was higher among American Indian or Alaska Native people compared with White, African American, Hispanic, or Asian people. African American or Asian people

were less likely than people in most other racial or ethnic groups to have vaped nicotine in the past month.

Alcohol: White people were more likely than other groups to have used alcohol in the past month. Binge drinking trends were similar among most racial groups, with around 20%-25% reporting binge drinking in the past month, the exception being Asian people, with an estimated 10.7% reporting past month binge drinking.

Illicit Drug Use: American Indian or Alaska Native and Multiracial people were more likely to have used illicit drugs in the past year compared with African American, White, Hispanic, or Asian people. Opioid misuse in the past year did not differ among racial or ethnic groups. Percentages ranged from 2.3% among Asian people to 6.3% among Multiracial people.

Substance Use Disorder: American Indian or Alaska Native and Multiracial people were more likely to have a substance use disorder (SUD) in the past year compared with African American, White, Hispanic, or Asian people.

Substance Use Treatment: The percentage of people who needed substance use treatment in the past year was higher among American Indian or Alaska Native and Multiracial people, compared with African American, White, Hispanic, or Asian people.

Impact of Socioeconomic Factors

Research has found there is a link between adolescents with lower socioeconomic status, lower parental education, and substance use. Low socioeconomic status appears to increase the risk of cannabis use, while low parental education seems to increase the risk of cocaine and heroin use (Gerra et al., 2020).

There is a strong connection between socioeconomic factors and overdose. Research shows receiving state-funded health insurance is associated with an

increased risk of overdose, the assumption being it is linked to low income. Overdose is higher among people who have recently been released from prison and among people with a history of incarceration. Experiencing hardships across multiple areas, such as social and economic, increases overdose risk. Overall, overdose rates are higher in low-income communities and in areas where people are living in poverty, and there is a racialized population (VanDraanen et al., 2020). Finding ways to decrease socioeconomic disadvantage may be a key component to addressing the opioid epidemic and other substance use disorders.

Challenges in Addressing Substance Misuse

Stigma and Barriers to Treatment

Stigmatizing attitudes towards people who use drugs exist throughout our society, including in health care. Studies show that people who use drugs are reluctant to access medical care because they do not trust healthcare providers to maintain their privacy from law enforcement. Individuals with SUD are viewed more negatively than people with physical or other mental disorders. Even language choices can play a huge role in how people are treated. One study looked at how mental health and substance use treatment providers reacted to individuals if they were labeled a "substance abuser" rather than as a "person having a substance use disorder" and found that the providers were more likely to blame the individual and believe that they should be subjected to punitive, rather than therapeutic measures (The White House, 2022).

Providing harm reduction services to people who use drugs allows them to have a non-judgmental environment where they can talk freely about their needs and concerns, build supportive and trusting relationships, and reinforce feelings of self-worth, control, and empowerment. When people have relief from the shame

and judgment carried by the stigma associated with their drug use, they have the freedom to objectively consider the risks their drug use may pose to themselves and others and explore steps they can take to reduce those risks. For individuals who are socially marginalized and have internalized stigma about their drug use, these services can substantially benefit their safety and chances of survival (CDC, 2018).

Stigma is often experienced on three different levels. Institutional stigma exists at a systems level and is experienced through rules, policies, and practices that limit the opportunities and resources for the stigmatized group. Public stigma is stereotypes and negative attitudes that are experienced as prejudice and discrimination. Self-stigma is the negative thoughts and emotions that an individual experiences from being part of a stigmatized group and the negative impact it has on the person's mental health, physical well-being, and behavior. Each level of stigma reinforces the other. It is possible to identify sources at each level of opioid use stigma, how they impact access to treatment, and possible strategies at each level to reduce stigma (Cheetham et al., 2022).

Co-occurring Mental Health Disorders

When a person experiences two disorders or illnesses at the same time, either simultaneously or sequentially, they are described as comorbid or co-occurring disorders. Comorbidity implies that the illnesses interact, affecting the course and prognosis of both disorders. Research shows significant comorbidity with substance use disorders and anxiety disorders. Substance use disorders also have a high rate of co-occurrence with other mental health disorders, including depression, bipolar, attention-deficit hyperactivity disorder, psychotic illnesses, borderline personality disorder, and antisocial personality disorder. Individuals diagnosed with schizophrenia have higher rates of alcohol, tobacco, and drug use

in comparison to the general population. This is a similar theme seen among adults diagnosed with a serious mental illness (SMI). SMI is defined as a diagnosed mental, behavioral, or emotional disorder causing serious functional impairment that interferes with life activities over the past year. Major depressive disorder, schizophrenia, bipolar, and other mental disorders that cause severe impairment all fall under the SMI category. Approximately 1 in 4 people with an SMI diagnosis also have a SUD diagnosis. Those with a co-occurring mental health and substance use disorder are at a higher risk of nonmedical use of prescription opioids, with research showing 43% of those in SUD treatment for prescription painkiller misuse also have a mental health diagnosis (most frequently, it is depression or anxiety) (NIDA, 2021).

Accessibility and Equity Issues

Racial and ethnic minority populations who use substances experience distinct use patterns, disparate rates of long-term health consequences, criminalization, and limited treatment access compared to their White counterparts (McCuistian et al., 2021).

Some of the contributing factors to the disparities in treatment faced by racial and ethnic minority populations include less access to treatment programs, less likely to have insurance, and less likely to have employment that allows them to take time for treatment when compared to White people who have substance use disorders (McCuistian et al., 2021).

Some key barriers to addressing the demand for treatment include workforce shortages in the mental health and substance abuse treatment field, low insurance reimbursement rates, and payment models, federal and state laws and program requirements, and the stigma of drug abuse (GOA.gov, 2021).

Legal and Policy Challenges

One example of legal issues that cause challenges is that of cannabis use. On the federal level, cannabis use is illegal. However, numerous states have made medical marijuana legal, while other states have gone a step further and allowed for its recreational use (Smart & Pacula, 2019). This can cause confusion not only to the person who uses cannabis but also to law enforcement. There is the added issue that there are racial disparities in the enforcement of substance use laws that need ongoing attention and advocacy.

There is an increased need for substance use treatment and resources for those with co-occurring disorders. The need continues to grow, but there is a shortage of available resources in many communities. Find (Barney et al., 2020)

Promising Practices and Interventions and Advancements in Treatment Modalities

Screening and Assessment Tools

The Tobacco, Alcohol, Prescription Medication, and Other Substance Use (TAPS) Tool is a combination screening tool (TAPS-1) followed by a brief assessment tool (TAPS-2) for those who screen positive. See Appendix A for the TAPS-1 and TAPS-2 screening and brief assessment.

The TAPS Tool (NIDA, 2024):

- provides a screening and brief assessment of the most frequently used substance, eliminating the need for multiple screening tools and lengthy assessments.
- can be self-administered by the client reading and answering the questions or administered as an interview by a behavioral health provider.

- can be administered by pen/paper or electronic format, which is available on the NIDA website.
- uses screening questions to address the frequency of use over the past 12 months.
- uses brief assessment questions to determine the client's level of problem over the past 3 months.

Evidence-Based Treatment Approaches

Evidence-based treatment approaches for substance use disorders that are most successful use a combination of medication-assisted treatment and behavioral therapy (VA, 2024). Below, some of the most common evidence-based treatment approaches will be explored.

Pharmacotherapy

Medication-assisted treatment is a pharmacological intervention for alcohol and opioid use disorders. Depending on the medication, it can help alleviate cravings, which helps the person overcome their physical dependence, while others can help minimize withdrawal symptoms. Through stabilization, the person can build healthy psychological, social, and lifestyle changes. Research shows that medication-assisted therapy reduces opioid use, overdoses, criminal activity, and other risky behaviors.

Alcohol

There are three FDA-approved medications to treat alcohol use disorder they are (Cleveland Clinic, 2022):

Naltrexone: Once a person stops drinking, taking naltrexone helps them to maintain their sobriety. Naltrexone binds to the endorphin receptors in the body,

blocking the feelings and effects of alcohol. Naltrexone reduces alcohol cravings and the amount of alcohol consumed.

Acamprosate: Acamprosate helps by decreasing cravings to use alcohol. This allows people who take the medication to control their urges to drink and maintain sobriety. Acamprosate does not help with symptoms of alcohol withdrawal.

Disulfiram: Disulfiram causes unpleasant effects when alcohol is consumed. While it is not a cure for alcohol misuse, the unpleasant effects do discourage drinking. The effects begin within ten minutes of consuming alcohol and last for at least an hour. The effects include flushing of the face, headache, nausea, vomiting, chest pain, weakness, blurred vision, mental confusion, sweating, choking, breathing difficulty, and anxiety.

Opioids

Medication for opioid use disorders interacts with the same opioid receptors in the brain as the opioid drug. Medications include (NIDA, 2021 & NIDA, 2022):

Methadone is an opioid receptor full agonist, which means it attaches to and activates opioid receptors to reduce withdrawal symptoms and cravings. It is taken as a daily liquid or tablet. Brand names are Dolophine and Methadose; generic is available.

Buprenorphine is an opioid receptor partial agonist, which means it attaches to and partly activates opioid receptors to reduce withdrawal symptoms and cravings. It is taken as a daily tablet or monthly injection. The brand name is Sublocade, and generic is available.

Naltrexone is an opioid receptor antagonist, which means it prevents opioids from attaching to the opioid receptors, blocking their potential effects. It is taken as a monthly injection. The brand name is Vivitrol; there is no generic at this time.

Buprenorphine/Naloxone is a partial agonist and antagonist combination that partly activates the opioid receptor while at the same time preventing opioids from attaching to the opioid receptors. It is taken as a daily tablet or film dissolved under the tongue. Brand names are Zubsolv and Suboxone; generic is available.

Lofexidine is an adrenergic receptor agonist that attaches to and activates adrenergic receptors to help reduce withdrawal symptoms. It is taken as needed as a tablet. The brand name is Lucemyra; no generic option is available at this time.

Naloxone is the drug used to reverse overdoses and is available as a nasal spray for emergencies and as an injection for medical personnel. Brand names are Kloxxado, Narcan, and Simhi; generic is available.

Behavioral Therapies

Substance use treatment often consists of a combination of group and individual therapy sessions focused on teaching skills to become sober, maintain abstinence from substance use, and navigate situations and triggers without relapsing to drugs or alcohol. Individual therapy is guided by a therapist in one-on-one sessions. Group therapy is usually led by a therapist with a group of peers in a safe and supportive environment. Family therapy is led by a therapist and includes the person in treatment and their significant other, family members, or other significant people in the person's life.

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is one of the most frequently used approaches for substance use recovery; it is also used to treat co-occurring disorders. This approach encourages people to explore how their thoughts and behaviors have perpetuated their substance use. CBT helps people learn coping skills, identify risky situations and what to do about them, and relapse prevention (Miller, 2023).

Contingency Management

Contingency Management (CM) is effective in treating several substance use disorders and is used to encourage and reinforce sobriety. This treatment method provides rewards when the person maintains their recovery goals, usually with proof such as a negative urine screen (Guenzel & McChargue, 2023). It is an effective intervention to motivate desirable behaviors. A benefit of CM is it reduces two of the biggest treatment barriers: dropping out and relapse.

Motivational Interviewing

Motivational interviewing (MI) is an approach to address the ambivalence some people experience in recovery, allowing them to embrace their treatment efforts in a way that works best for them to address their substance use. The goal is to strengthen the person's motivation for and commitment to change in a way that is consistent with their values (Miller, 2023). MI is effective in that it encourages the person to identify their needs and develop a plan for their treatment, which gives them a sense of control, while the therapist’s focus is on building and maintaining motivation.

Dialectal Behavioral Therapy

Dialectal Behavioral Therapy (DBT) teaches people how to regulate their emotions to reduce their self-destructive behaviors driven by extreme, intense emotions.

DBT focuses on four skill sets: distress tolerance, emotion regulation, mindfulness, and interpersonal effectiveness (Miller, 2023). DBT works to reduce cravings, help people avoid situations or triggers to relapse, support them in giving up behaviors that reinforce substance use, and help them learn healthy coping skills.

Eye Movement Desensitization and Reprocessing

Eye Movement Desensitization and Reprocessing (EMDR) is extremely effective in treating people who are recovering from traumatic experiences that result in ongoing distress. EMDR uses "dual stimulation" exercises to explore past trauma while at the same time engaging other parts of the brain through bilateral eye movements, tones, or taps. EMDR helps heal the brain's information-processing system and promotes emotional stability and symptom reduction (Miller, 2023).

12-Step Facilitation

The 12-step facilitation goal is to promote abstinence through involvement with 12-step peer support groups. Meetings are hosted by different fellowships, such as Alcoholics Anonymous and Narcotics Anonymous (Miller, 2023). The peer support aspect of these groups can be a powerful support system for those in recovery.

Integrative Care Models

Collaborative Care

Collaborative Care is an evidence-based integrative treatment that includes primary care, mental healthcare, and substance use treatment. A case manager coordinates care with a team of providers to meet the individual's needs. The case manager works as a liaison between providers and an advocate for the client.

Research shows collaborative care improves outcomes for all areas of the person's health (Stein et al., 2019).

The 4C model of care involves (Stein et al., 2019):

- Collaborative
- Coordinated
- Continuing
- Centered

The collaborative care model emphasizes good communication, shared decision-making, proactive monitoring, multidisciplinary guidelines, and integrated electronic health records. Using this model for substance use treatment improves access to care, reduces fragmented services, and delivers services in response to the individual's needs (Stein et al., 2019).

Trauma-Informed Approaches

Research shows a strong connection between trauma exposure and substance use disorders (NIDA, 2024). Many people who have experienced child abuse, natural disasters, criminal attacks, war, or other traumatic events begin using alcohol or drugs to help them cope with bad memories, emotional pain, difficulties sleeping, guilt and shame, nervousness, and fear. Traumatic stress can change how a person's brain functions, increasing the likelihood that their substance use will morph into a substance use disorder (NIDA, 2024).

People who struggle with substance use problems are more likely to experience traumatic events than those without substance use problems. As a result, people find themselves in a vicious cycle of exposure to traumatic events that lead to increased substance use, which leads to new traumatic exposures, which leads to even worse substance use, and so forth (ISSTS, 2024). With such a strong

connection between trauma and substance abuse, behavioral health professionals should assess for trauma when working with substance-using clients and vice-versa. Providing trauma-informed care is necessary to provide ethical care.

Trauma-informed care incorporates knowledge of trauma even though the treatment may focus on other areas such as substance use, mental health disorders, or physical health needs. In contrast, trauma-specific treatment is specifically designed to address trauma.

The experience of trauma and untreated symptoms related to full or partial Post Traumatic Stress Disorder (PTSD) can increase the risk for comorbid health and behavioral health issues and hinder recovery from these conditions. Trauma-informed organizations prioritize clients' safety and promote trust, collaboration, healing, empowerment, and recovery from the effects of trauma. Behavioral health providers who operate from a trauma-informed care lens (Mancini, 2021):

- Recognize the impact of trauma on health and behavioral health and integrate trauma awareness into all practices, policies, and procedures.
- Understand the strategies that lead to recovery.
- Routinely screen and assess for the signs and symptoms of trauma.
- Eliminate practices that have the potential to be re-traumatizing to clients.
- Deploy practices that are responsive to those who may have experienced trauma and that create a practice environment that promotes safety, empowerment, and healing.

Harm Reduction Strategies

Harm reduction is an approach to care that meets people where they are and knows that not everyone is able to or desires to stop their substance use. Instead of judging a person's health and behavior who is struggling with addiction, harm

reduction focuses on promoting evidence-based methods for reducing use-associated health risks at this moment in time. Harm reduction is not a set of rules or regulations but a generalized approach that meets each individual where they are and their specific need to improve their quality of life. Harm reduction understands that drug use, abuse, and dependence is a multi-faceted and complex experience with a spectrum of behaviors ranging from severe abuse to complete abstinence and accepts that some ways of using drugs are safer than others. The defining feature of harm reduction is its focus on preventing harm rather than on preventing substance use. Harm reduction initiatives span a broad spectrum, from disease prevention and medical care to education and linkage to addiction treatment (Recovery Research Institute, 2023).

Evidence-based harm reduction strategies for addressing substance use disorder and overdoses include:

Naloxone Distribution

Naloxone is a medication that quickly reverses an opioid overdose. Naloxone's biggest impact is that it can quickly restore normal breathing to a person experiencing an opioid overdose if their breathing has slowed or stopped. Naloxone is not a treatment for opioid use disorder outside of its emergency response to an opioid overdose. Targeted distribution programs train and equip people who are most likely to interact with someone experiencing an overdose with naloxone kits. Effective strategies include community distribution programs, co-prescribing Naloxone, and equipping first responders. Naloxone is also known as Narcan, a pre-packaged nasal spray (NIDA, 2022).

Syringe Service Programs

Syringe services programs, also known as needle exchange programs, are community-based prevention programs that provide access to clean and sterile

equipment used for the preparation and consumption of drugs. Research has found syringe services programs to be a safe, effective, and cost-saving resource to prevent the spread of HIV and other infectious diseases and reduce high-risk injection behaviors among people who use injection drugs. Syringe services programs do not increase substance use. Research shows program participants were more likely to access substance use treatment and reduce or even stop drug use (NIDA, 2021).

Overdose Prevention Sites

Overdose prevention sites, also known as supervised consumption centers or supervised injection centers, are legally sanctioned spaces for people can use pre-obtained drugs with medical supervision and intervention available in the event of an overdose. The centers do not provide drugs, and medical staff do not inject users. The sale or purchase of drugs is prohibited on the premises, and many programs have admission criteria such as local residency or require identification cards. Models range from peer-run facilities to mobile units to medical models colocated with addiction treatment programs (Recovery Research Institute, 2023).

Drug Test Strips

Currently, there are two test strips available; one is fentanyl test strips, and the other is amphetamine test strips. They are a low-cost method to help prevent drug overdoses and reduce harm. Test strips are small paper strips that can detect the presence of fentanyl or amphetamine in all different kinds of drugs and drug forms (pills, powder, and injectables). Test strips provide people who use drugs and communities with important information about fentanyl and amphetamines in the illicit drug supply so they can take necessary measures to reduce their risk of overdose (CDC, 2022).

Good Samaritan Laws

Many states have enacted Good Samaritan Laws to encourage calls for emergency help for an overdose. These laws protect the person who calls for medical assistance for an overdose from legal action against them for being in possession of a controlled or illegal substance. These laws also protect bystanders from overdose, even those who may also have been using but did not have an emergency event. Bystanders are protected against criminal charges, parole violations, and warrant searches. Good Samaritan laws aim to increase calls for overdose emergency assistance while providing immunity to those involved. Naloxone Access laws protect the person who administered the opioid reversal drug. Forty-seven states and Washington D.C. have Good Samaritan laws and Naloxone Access laws. Kansas, Texas, and Wyoming do not have Good Samaritan laws but do have Naloxone Access laws (GOA, 2021).

Prevention and Long-term Recovery

Stages of Relapse

Relapses are almost an inevitable part of the substance use recovery process. However, it can have serious, life-threatening consequences, and therefore, relapse prevention must receive more attention as part of recovery treatment.

Guenzel & McChargue (2023) discuss the stages of relapse and how early recognition of each stage can allow for interventions to be implemented and prevent a relapse from happening. The stages are as follows:

Emotional Relapse

In this stage, the person is not planning to relapse however, their emotions and behaviors are setting them up for a potential relapse. The person is frequently in

denial that they are at risk for relapse as they have no plan to use. Signs include isolation, skipping peer support meetings, focusing on others' problems instead of their own, and poor habits in sleeping and eating.

Intervention goals include educating the individual on the importance of self-care and helping the individual recognize their denial so they can address their needs at this stage and not progress to the next stage of relapse.

Mental Relapse

In this stage, the person is having an internal struggle with their desire to use and their desire to remain sober. Signs include craving their substance of choice, thinking about people, places, and things associated with their past use, ruminating on positive aspects of their past use, minimizing the negative aspects of past use, bargaining, lying, creating plans to use that might still allow them to maintain control, planning ways to use. Individuals in this stage may be at an increased risk of relapse at events such as holidays, trips, or other special occasions.

Intervention goals include recognizing and avoiding situations that increase the risk of a physical relapse. Treatment providers can highlight that occasional thoughts or cravings are a normal part of recovery so clients can be prepared when they experience these challenges.

Physical Relapse

In this stage, the person uses the substance and experiences a full physical relapse.

Intervention for this stage happens beforehand. For example, people are at a higher risk of physical relapse when they are in situations where they believe they may get away with using. Treatment providers can educate clients on this so they

can recognize when they are in high-risk situations and take steps to avoid using drugs or alcohol.

Stages of Recovery

Recovery happens over multiple stages as the person progresses through their recovery. These recovery stages are (Guenzel & McChargue, 2023):

Abstinence Stage

This stage begins as soon as the person stops using and can last for one to two years. The main concerns of a person in this stage are coping with cravings and avoiding relapse.

Repair Stage

This stage lasts for two to three years. During this time, the person is working to repair the damage that their substance use caused. People are beginning to feel better in this stage, and many begin to address past trauma and adverse life events that contributed to their use. They may experience times when they feel worse as they work through the consequences of their substance use.

Growth Stage

This stage only begins once the person has, as much as possible, repaired the damage caused by their substance use. This stage usually happens three to five years after the person has stopped using and will be maintained for the rest of their life. The person's growth often involves experiencing and developing skills they missed out on due to their use, especially if their substance use disorder began when they were young.

Ethical Considerations

The following are some current ethical considerations when working in the substance use field and with clients with substance use disorders.

Code of Ethics

Behavioral health providers are required to know and follow their professional licensure code of ethics. It is recommended to review one's professional code of ethics annually and reference it as needed. May professional associations have monthly ethics consultations and provide phone ethics consultations as part of membership.

Confidentiality

Clients with substance use disorders may fear that seeking treatment may lead to them being prosecuted for their illegal substance use. The Confidentiality of Substances Use Disorer Patient Records regulations provide protection through privacy and confidentiality to those seeking treatment for substance use. The regulation protects "records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States." (HHS, 2024).

Technology-Assisted Treatment

Technology-assisted treatment is the use of digital tools to provide substance use treatment. Technology can be implemented as part of treatment at any stage, including prevention, treatment, and aftercare. The goal of using any piece of

technology in treatment is to improve accessibility and enhance individual treatment interventions.

Technology can be leveraged in prevention to educate and increase awareness among at-risk groups. During treatment, it can provide telehealth therapy and online treatment programs using wearable devices that allow for real-time remote monitoring, personalized support, and interactive therapy features. During aftercare, technology can provide remote support systems to offer relapse prevention support and virtual peer groups (Editor, 2023). As technology continues to evolve, more and more technology-assisted treatment programs are offered.

Recent media outlets have highlighted the possibility for AI therapists to provide treatment to clients, and while protecting confidentiality can be a challenge, some therapists are already providing virtual reality treatment.

While websites, apps, smartphones, and VR are all useful technologies that make access to services easy, maintaining clients' confidentiality is part of most professional codes of ethics. When choosing to use technology, providers must ensure that they meet HIPAA standards for confidentiality and protected health information. Part of the ethical use of technology is that the provider is knowledgeable about the technology they are using. One should not provide services to clients on a platform they are not familiar with how to use.

Conclusion

To fully address the complex issue of substance misuse, there needs to be multifaceted interventions. Removing stigma and increasing access to care is imperative. Providing evidence-based treatment through a combination of behavioral therapy and medication-assisted treatment is very effective in treating

numerous substance use disorders. As technology capacities grow, this may be a positive, non-threatening way to engage people in treatment and provide aftercare support services. To allow this to happen policies and funding must be in place to support substance use treatment providers and programs.

References

Barney, A., Buckelew, S., Mesheriakova, V., & Raymond-Flesch, M. (2020). The COVID-19 Pandemic and Rapid Implementation of Adolescent and Young Adult Telemedicine: Challenges and Opportunities for Innovation. *The Journal of Adolescent Health*, *67*(2), 164-171. https://doi.org/10.1016/j.jadohealth.2020.05.006

Center for Behavioral Health Statistics and Quality. (2022). 2021 National Survey on Drug Use and Health: Methodological summary and definitions. https://www.samhsa.gov/data/report/2021-methodologicalsummary-and-definitions

CDC (2023). Products - Vital Statistics Rapid release - Provisional drug overdose data. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

CDC (2022). Fentanyl Test Strips: A Harm Reduction Strategy. Centers for Disease Control and Prevention.https://www.cdc.gov/stopoverdose/fentanyl/fentanyl-test-strips.html

Cleveland Clinic (2022). Substance Use Disorder (SUD). https://my.clevelandclinic.org/health/diseases/16652-drug-addiction-substance-use-disorder-sud#management-and-treatment

Editor. (2023). *Technology-Assisted Interventions for Substance Abuse | Harmony Ridge Recovery Center WV*. Harmony Ridge Recovery Center. https://www.harmonyridgerecovery.com/technology-assisted-interventions-for-substance-abuse/

Gerra, G., Benedetti, E., Resce, G., Potente, R., Cutilli, A., & Molinaro, S. (2020). Socioeconomic Status, Parental Education, School Connectedness and Individual Socio-Cultural Resources in Vulnerability for Drug Use among

Students. *International Journal of Environmental Research and Public Health*, *17*(4). https://doi.org/10.3390/ijerph17041306

GAO (2021). Drug Misuse: Most States Have Good Samaritan Laws and Research Indicates They May Have Positive Effects. U.S. Government Accountability Office. https://www.gao.gov/products/gao-21-248

GOA.gov (2021). The Crisis of Drug Misuse and Federal Efforts to Address It. https://www.gao.gov/blog/crisis-drug-misuse-and-federal-efforts-address-it#:~:text=Some%20key%20barriers%20in%20addressing,to%20treatment%20for%20substance%20misuse.

Guenzel, N., McChargue, D. (2023) Addiction Relapse Prevention. [Updated 2023 Jul 21]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan. https://www.ncbi.nlm.nih.gov/books/NBK551500/

HHS.gov (2024).. *HIPAA and Part 2*. https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-part-2/index.html

ISTSS (2024). Traumatic Stress and Substance Abuse Problems. International Society for Traumatic Stress Studies. https://istss.org/wp-content/uploads/2024/05/ISTSS_TraumaStressandSubstanceAbuseProb_English_FNL.pdf

McCuistian, C., Burlew, K., Espinosa, A., Ruglass, L. M., & Sorrell, T. (2021). Advancing Health Equity through Substance Use Research. *Journal of Psychoactive Drugs*, *53*(5), 379. https://doi.org/10.1080/02791072.2021.1994673

Mancini, M. A., & Mancini, M. A. (2021). Trauma-Informed Behavioral Health Practice. *Integrated Behavioral Health Practice*, 191-236.

NIDA (2021). Syringe Services Programs. National Institute on Drug Abuse. https://nida.nih.gov/research-topics/syringe-services-programs

NIDA (2021). Prescription Opioids DrugFacts. National Institute on Drug Abuse. https://nida.nih.gov/publications/drugfacts/prescription-opioids

NIDA (2022). Medications for Opioid Overdose, Withdrawal, & Addiction. National Institute on Drug Abuse.https://nida.nih.gov/research-topics/opioids/medications-opioid-overd

NIDA (2022). What is Naloxone. National Institute on Drug Abuse. https://nida.nih.gov/publications/drugfacts/naloxone

NIDA (2024). Trauma and Stress. 4. https://nida.nih.gov/research-topics/trauma-and-stress

NIDA (2024). Emerging Drug Trends. https://nida.nih.gov/research-topics/emerging-drug-trends

NIDA (2024). Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS) Tool. https://nida.nih.gov/taps2/

Recovery Research Institute (2023). Harm Reduction. https://www.recoveryanswers.org/resource/drug-and-alcohol-harm-reduction/

Smart, R., & Pacula, R. L. (2019). Early evidence of the impact of cannabis legalization on cannabis use, cannabis use disorder, and the use of other substances: Findings from state policy evaluations. *The American Journal of Drug and Alcohol Abuse*, *45*(6), 644. https://doi.org/10.1080/00952990.2019.1669626

Stein, D. J., Benjet, C., Gureje, O., Lund, C., Scott, K. M., Poznyak, V., & Van Ommeren, M. (2019). Integrating mental health with other non-communicable diseases. *BMJ. British Medical Journal*, l295. https://doi.org/10.1136/bmj.l295

Stringer, H. (2024.). *Psychologists are innovating to tackle substance use by building new alliances in treatment efforts*. https://www.apa.org/monitor/2024/01/trends-psychologists-tackling-substance-use

VA.gov (2024). Substance Use Treatment. https://www.mentalhealth.va.gov/substance-use/treatment.asp

Van Draanen, J., Tsang, C., Mitra, S., Karamouzian, M., & Richardson, L. (2020). Socioeconomic marginalization and opioid-related overdose: a systematic review. *Drug and alcohol dependence*, *214*, 108127.

Appendix A: The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

Retrieved from: NIDA Clinical Trials Network. (2017). The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool. In *TAPS Tool Part 1* [Report]. https://cde.nida.nih.gov/sites/nida_cde/files/TAPS%20Tool%20Parts%20I%20and%20II%20V2.pdf

TAPS Tool Part 1

General Instructions: The TAPS Tool Part 1 is a 4-item screening for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the past year. Each of the four multiple-choice items has five possible responses to choose from. Check the box to select your answer.

1. In the PAST 12 MONTHS, how often have you used tobacco or any other nicotine delivery product (i.e., e-cigarette, vaping or chewing tobacco)?
    - Daily or Almost Daily
    - Weekly
    - Monthly
    - Less Than Monthly
    - Never
2. In the PAST 12 MONTHS, how often have you had 5 or more drinks (men)/4 or more drinks (women) containing alcohol in one day?
    - Daily or Almost Daily
    - Weekly
    - Monthly

- Less Than Monthly
- Never

3. In the PAST 12 MONTHS, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you?
    - Daily or Almost Daily
    - Weekly
    - Monthly
    - Less Than Monthly
    - Never
4. In the PAST 12 MONTHS, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?
    - Daily or Almost Daily
    - Weekly
    - Monthly
    - Less Than Monthly
    - Never

TAPS Tool Part 2

The TAPS Tool Part 2 is a brief assessment for tobacco, alcohol, and illicit substance use and prescription medication misuse in the PAST 3 MONTHS ONLY. Each of the following questions and subquestions has two possible answer choices- either yes or no. Check the box to select your answer.

1. In the PAST 3 MONTHS, did you smoke a cigarette containing tobacco?
    - Yes
    - No

If “Yes”, answer the following questions:

a. In the PAST 3 MONTHS, did you usually smoke more than 10 cigarettes each day?
    - Yes
    - No

b. In the PAST 3 MONTHS, did you usually smoke within 30 minutes after waking?
    - Yes
    - No

2. In the PAST 3 MONTHS, did you have a drink containing alcohol?
    - Yes
    - No

If “Yes”, answer the following questions:

a. In the PAST 3 MONTHS, did you have 5 or more drinks (men)/4 or more drinks (women) containing alcohol in a day?

- Yes
- No

b. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop drinking?

- Yes
- No

c. In the PAST 3 MONTHS, has anyone expressed concern about your drinking?

- Yes
- No

3. In the PAST 3 MONTHS, did you use marijuana (hash, weed)?

- Yes
- No

If “Yes”, answer the following questions:

a. In the PAST 3 MONTHS, have you had a strong desire or urge to use marijuana at least once a week or more often?

- Yes
- No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of marijuana?

- Yes
- No

4. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth)?

- Yes
- No

If “Yes”, answer the following questions:

a. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth) at least once a week or more often?

- Yes
- No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of cocaine, crack, or methamphetamine (crystal meth)?

- Yes
- No

5. In the PAST 3 MONTHS, did you use heroin?

- Yes
- No

If “Yes”, answer the following questions:

a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using heroin?

- Yes
- No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of heroin?

- Yes
- No

6. In the PAST 3 MONTHS, did you use a prescription opiate pain reliever (for example, Percocet, Vicodin) not as prescribed or that was not prescribed for you?

- Yes
- No

If “Yes”, answer the following questions:

a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using an opiate pain reliever?

- Yes
- No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of an opiate pain reliever?

- Yes
- No

7. In the PAST 3 MONTHS, did you use a medication for anxiety or sleep (for example, Xanax, Ativan, or Klonopin) not as prescribed or that was not prescribed for you?

- Yes
- No

If “Yes”, answer the following questions:

a. In the PAST 3 MONTHS, have you had a strong desire or urge to use medications for anxiety or sleep at least once a week or more often?

- Yes
- No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of medication for anxiety or sleep?

- Yes
- No

8. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) not as prescribed or that was not prescribed for you?

- Yes
- No

If “Yes”, answer the following questions:

a. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) at least once a week or more often?

- Yes

- No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of a medication for ADHD (for example, Adderall or Ritalin)?

- Yes
- No

9. In the PAST 3 MONTHS, did you use any other illegal or recreational drug (for example, ecstasy/molly, GHB, poppers, LSD, mushrooms, special K, bath salts, synthetic marijuana ('spice'), whip-its, etc.)?

- Yes
- No

If “Yes”, answer the following questions:

In the PAST 3 MONTHS, what were the other drug(s) you used?

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