CBT=Cognitive Behavioral Therapy from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2897895/
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- Cognitive behavioral therapy (CBT) for substance use disorders has demonstrated efficacy as both a monotherapy and as part of combination treatment strategies.
- Examining irrational thoughts and beliefs and how feelings; and how thoughts can influence feelings
- Emphasis is on distinguishing thoughts from facts

Motivational Interviewing from http://www.motivationalinterview.org/quick_links/about_mi.html

- Started by William R. Miller in 1983 in working with "problem drinkers."
- 2009 Definition, "a collaborative, person-centered form of guiding to illicit change." Goal is to elicit "change talk."
- 1. MI is a particular kind of conversation about change (counseling, therapy, consultation, method of communication)
- 2. MI is collaborative (person---centered, partnership, honors autonomy, not expert—recipient)
- 3. MI is evocative (seeks to call forth the person's own motivation and commitment)
- **OARS** Open Ended Questions, Affirmations, Reflections, and Summaries
- **DARN-CAT** (see MI Handout)

Motivational Enhancement Therapy from http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-2
NIH-NIDA

- Motivational Enhancement Therapy (MET) is a counseling approach that helps individuals resolve their ambivalence about engaging in treatment and stopping their drug use.
- **This approach aims to evoke rapid and internally motivated change, rather than guide the patient stepwise through the recovery process**.
- This therapy consists of an initial assessment battery session, followed by two to four individual treatment sessions with a therapist. In the first treatment session, the therapist provides feedback to the initial assessment, stimulating discussion about personal substance use and eliciting self-motivational statements.
- Motivational interviewing principles are used to strengthen motivation and build a plan for change. Coping strategies for high-risk situations are suggested and discussed with the patient. In subsequent sessions, the therapist monitors change, reviews cessation strategies being used, and continues to encourage commitment to change or sustained abstinence. Patients sometimes are encouraged to bring a significant other to sessions.
- In general, MET seems to be more effective for engaging drug abusers in treatment than for producing changes in drug use.

Harm Reduction from http://www.ihra.net/what-is-harm-reduction and http://harmreduction.org/

- Harm reduction refers to policies, programs and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs.
- Harm reduction began to be discussed frequently after the threat of HIV spreading among and from injecting drug users was first recognized. However, similar approaches have long been used in many other contexts for a wide range of drugs.
- Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.
- Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users "where they're at," addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

- **However, HRC considers the following principles central to harm reduction practice.**

1) Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
2) Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
3) Establishes quality of individual and community life and well-being–not necessarily cessation of all drug use–as the criteria for successful interventions and policies.
4) Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
5) Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
6) Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
7) Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
8) Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

Trauma Informed Care/Treatment TIP 57 from http://store.samhsa.gov/shin/content/SMA14-4816/SMA14-4816.pdf

- Trauma-informed care: TIC is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p.82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services.

Psychodynamic Model in SUD Treatment from http://www.cphjournal.com/archive_journals/v4_walsh_26-36.pdf
Drug and Alcohol Counselling from a Psychodynamic Perspective Paper Presented on 11-July-2008 Damian Walsh

- In psychodynamic therapy awareness of the relationship is an indispensable tool.
- Key concepts for the therapist to be aware of and to be continually self-monitoring are the need to be genuine and transparent; non-defensive and to be open to learn from the client; to be oneself and allow spontaneity; always view the client with utmost respect.
- Psychodynamically, we learn the most about clients by allowing ourselves to feel what they are feeling, to enter their world as if it were our own. The therapist normally takes an attitude of unconditional acceptance.
- This basically means that the therapist holds the person in high regard because the client is seen first and foremost as a person, no matter what your problem is. Careful exploration of the client's experience without judgment produces a lowering of defenses.
- As the person feels listened to, understood and responded to by the therapist, s/he begins to feel safe enough to allow unacknowledged needs, fears and vulnerabilities to emerge.
- Basic premises of psychodynamic work:
    - Client can work with an interpersonal therapy for problems stemming from interpersonal relationships
    - Dysfunctional styles are learned in the past
    - Dysfunctional styles are maintained in the present
    - The client re-enacts interpersonal difficulties with the therapist
    - Therapist as a participant observer
    - There is one identifiable, problematic relationship pattern

12-Step Facilitation Therapy from http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-4
NIH-NIDA 12-Step Facilitation Therapy (Alcohol, Stimulants, Opiates)

- Twelve-step facilitation therapy is an active engagement strategy designed to increase the likelihood of a substance abuser becoming affiliated with and actively involved in 12-step self-help groups, thereby promoting abstinence.
- Three key ideas predominate:
    - (1) ***acceptance***, which includes the realization that drug addiction is a chronic, progressive disease over which one has no control, that life has become unmanageable because of drugs, that willpower alone is insufficient to overcome the problem, and that abstinence is the only alternative;
    - (2) ***surrender***, which involves giving oneself over to a higher power, accepting the fellowship and support structure of other recovering addicted individuals, and following the recovery activities laid out by the 12-step program; and
    - (3) ***active involvement in 12-step meetings and related activities.***
    - While the efficacy of 12-step programs (and 12-step facilitation) in treating alcohol dependence has been established, the research on its usefulness for other forms of substance abuse is more preliminary, but the treatment appears promising for helping drug abusers sustain recovery.