



Testimony of  
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to the  
New York State Assembly Standing Committees  
on Codes, Judiciary, Correction, Health,  
Alcoholism and Drug Abuse, and Social  
Services

May 15, 2008

Rochester City Hall

## Attachment One

### DRUG POLICY IN AMERICA

#### PHILOSOPHY

##### **Public health approach:**

Harm reduction

1. Degree of regulations based on the adverse public health effects of each individual substance
2. No early release of offenders for violent behavior associated with substance use (drug business or intoxication)
3. Adherence to the two canons of medical ethics:  
Reduce suffering and preserve patient autonomy

##### **War on Drugs approach:**

- 1, Some drug use is evil and a criminal justice approach will eliminate it

##### **EFFECTS** (some selected examples)

##### **Public health approach:**

1. Reduction of HIV and Hepatitis B/C via syringe availability and health care access
2. Enhancement of fetal and child outcomes via provision of affordable pre/postnatal care and substance use treatment
3. Seven-fold reduction in the costs of dealing with substance use

##### **War on Drugs approach:**

1. Increased number of Americans with serious addiction  
Doubling of deaths from illicit drugs (1979-1998)
2. Increased African-American morbidity and mortality from illicit drugs
3. Increased prison population (over 2 million Americans incarcerated; 60% of Federal inmates and over 25% of state and local inmates are incarcerated for drug law violations)
4. Increased ease of availability of illicit

substances for children and adolescents

5. Decreased prices and increased purity of heroin and cocaine

6. Corruption of the criminal justice system

7. Loss of civil liberties

8. International herbicide and pollution

9. Military and pseudomilitary interventions in foreign nations

**CONCLUSION:**

Our current drugs policy has turned a difficult public health problem, the harms associated with substance use, into an intractable national and international public health disaster

There are no public health benefits in making personal substance use a misdemeanor or a felony

## Attachment Two

### **HARM REDUCTION AND PUBLIC HEALTH**

1. Harm reduction is a public health alternative to the moral/criminal and disease models of drug use and addiction
2. Harm reduction recognizes abstinence as an ideal outcome but accepts alternatives that reduce harm
3. Harm reduction has emerged primarily as a "bottom-up" approach based on addict advocacy, rather than a "top-down" policy promoted by drug policy makers
4. Harm reduction promotes low-threshold access to services as an alternative to traditional, high-threshold approaches
5. Harm reduction is based on the tenets of compassionate pragmatism versus moralistic idealism

**Attachment Three**

**Four Pillars Drug Policy (Vancouver, Canada)**

Prevention

Accurate, reality-based substance use education

Treatment

Rapid detoxification

Ibogaine-assisted therapy

Methadone

Buprenorphine

Co-morbid oriented, integrated treatment of substance use disorders

MDMA assisted trauma treatment

Substance use disorders treatment

Heroin maintenance clinics

Prenatal care and ancillary substance use disorder treatment

Harm Reduction

Law Enforcement

Behaviorally-based, violence-oriented crime priorities

Drug courts for violent offenders with substance use disorders

Prison treatment options

## **A Health-Oriented Substance-Use Interview with Treatment Applications**

Gene Tinelli, MD, PhD

Given the political climate of minimal tolerance toward drug users, obtaining a reliable history and treatment focus can be difficult. The author presents a brief, structured substance use interview, progressively developed over 20 years, that the author has found establishes a tone of choice, health, and therapeutic focus

My background for this type of interview is varied. As a military trained psychiatrist, my professional duties, instilled in residency training, always started with the principles triage; immediacy, proximity, simplicity, and positive expectancy, and always held a person accountable for their actions. My first duty station as a psychiatrist was at the Naval Hospital in Guam, Mariana Islands. There I helped co-found a non-military sexual assault clinic, a process that produced intimate exposure to a wide cross-cultural range of people. I quickly learned to assume a perspective of cross-cultural ignorance and asked people to teach me how to respect their cultural values and biases in a therapeutic context. This cross-cultural perspective eventually led to certification in medical acupuncture, a field where the concepts of context, balance, and a consistent health focus are prominent. This substance use interview is my balance of military efficiency within a respectful context of health.

### **Perspective**

The use of mind-altering agents has been a prominent human behavior throughout recorded history (Nicholson, Duncan & White, 2002). Some have said that the desire to alter one's consciousness is a fundamental human drive (Siegel, 1989, Weil, 1998) yet many societies view the use of psychoactive substances in a moral framework, assigning goodness or evil to particular substances. This reflects our ambivalence toward altering our consciousness and often results in a restrictive framework surrounding both the diagnosis and treatment of substance use disorders. Difficulty in asking questions about positive effects of substance use makes assessment more complicated and less effective.

We have stage-oriented models of how people change over time (Prochaska, Norcross & DiClemente, 1992) and motivation and skill enhancing techniques to help people move through the stages and processes of change (Baer, Kivlahan & Donovan, 1999, Miller & Rollnick, 2002). Finally, we have harm reduction frameworks that can engage challenging dual diagnosis patients into treatment (Levy, 2002).

Even though these harm reduction approaches explore and empathize with both the positive and negative effects of substance use, simply asking patients directly for this data is not a staple of the substance abuse treatment experience. The following is a four-question health-oriented interview to address this issue.

### **Four questions**

1. Why are you here?

This simple question is not always asked. It provides subjective patient information in addition to any opinion that may have preceded the patient. It can provide data from their perspective about motivation in participating with an interview about potentially socially deviant behavior. Finally, it is helpful clarifying other areas, such as probation, parole, or job performance issues.

2. What is your drug of choice?

This question allows patients to identify the one substance they find useful in their present life. This patient-oriented question about choice avoids making assumptions from previously scanned information and, by the patient choosing their substance of choice, shifts the frame of the interview toward an internal locus of control. It also implies personal responsibility for behavioral choices.

3. How does your drug of choice work for you in a healthy way?

This question separates the interview from most other substance abuse interviews, mainly by its simplicity. It has a paradoxical effect and dramatically shifts the focus of the interview from pathology to health. It assumes that the learned repetitious behavior, i.e., psychoactive substance use, was originally acquired not for pathological reasons but for reasons of perceived health.

4. What are the disadvantages of your drug of choice?

This question is often included in some form in a substance abuse interview as the initial question, thus framing the interview with a negative focus.

### **Patient responses**

Question one can elicit affects such as shame, anger, distress, or fear. Question two replaces those affects with curiosity and interest. The role of choice is maximized in having patients identify a psychoactive substance that functionally works for them.

Question three prompts the most interesting responses. Initially patients are usually startled or surprised as most have no prepared response for this health-oriented question. Often, they recover from their surprise and provide "expected" negative responses that they have been told about their substance use, in effect denying any health effects of the substance in question. General persistence, perhaps with the comment that "people are not fools and tend to repeat what works for them," leads some patients to examine their original and/or current healthy goals in using their drug of choice. At other times, the author comments on the persistence of the behavior despite severe negative physical, social, and occupational effects, indicating to patients the positive role substance use must have or had in their lives. If this proves inadequate, the author reviews the positive outcomes of psychoactive substance use, either generally or more commonly in terms specific to the substance.

There are many desired effects of psychoactive substance use, from attenuation of withdrawal symptoms to numbing of dysphoric and/or poorly regulated affects. Often overlooked, however, are the specific actions individual substances have on particular affects. Tompkins (Nathanson, 1996) postulated an affect theory that has a continuum of nine innate biological mechanisms he described as affects. These are listed in Table 1.

**Table 1. Innate Affects**

- Positive Affects
  - Interest-Excitement
  - Enjoyment-Joy
- Neutral Affect
  - Startle-Surprise
- Negative Affects
  - Fear-Terror
  - Anger-Rage
  - Distress-Anguish
  - Shame-Humiliation
  - Dissmell
  - Disgust

From Nathanson, D.L. (1996). About emotion. In *Knowing feeling: Affect, script and psychotherapy*, Nathanson, D.L. (ed.). New York: Norton

For example, when alcohol is the drug of choice, positive high dose desired outcomes include numbing of physical and psychological pain, attenuation or temporary abolition of terrifying flashbacks, and/or induction of sleep. At lower doses, alcohol is one of the most effective substances to lower shame (Nathanson, 1992). Marijuana and heroin can reduce anger/aggression, anguish, and enhance contentment (Barleywine, 2002). Cocaine can produce a short-term sense of excitement that can overwhelm most negative affects. MDMA (ecstasy) can soften ego defense mechanisms, attenuate neurotically based fear, and enhance emotionally based love and empathy. Though psychoactive substances can sometimes produce the negative outcomes patients want relieved, this area is usually left for question four.

Question three, when framed around health, frequently elicits trauma histories, data that patients have often been too ashamed to disclose to other physicians and allied health care providers. Having a trauma treatment framework when exploring ways in which people can chemically reduce their suffering can dramatically humanize the substance use interview. As patients become aware that the author's focus is on health, roadblocks to communication tend to dissolve and the interview fills four of the five early strategies of motivational interviewing - asking open-ended questions, listening reflectively, affirming, and eliciting change talk (Miller & Rollnick, 2002). The fifth strategy, summarizing, can be used to calibrate and reinforce material that has been elicited. This allows patients to be enticed, rather than commanded or coerced, into therapy. This type of interview also follows all four principles of motivation interviewing (Table 2).

**Table 2. Principles of Motivational Interviewing**

Express Empathy

Develop Discrepancy  
Roll with Resistance  
Support Self-Efficacy

From Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change, 2<sup>nd</sup> ed.*, pp. 33-42. New York: Guilford Press.

Coming at the end, question four is often much more useful and revealing as the patient is more focused on health. For example, even though the patient's goal in using high dose alcohol may be to lower terrifying flashbacks, the exact opposite can occur. Asking about choice and health first builds the rapport necessary for more accurate self-reporting of negative consequences of substance use.

This makes the construction of the decisional balance sheet or payoff matrix considerably easier because patients can more safely look at their ambivalence surrounding the benefits and costs of their substance use and changing their behavior (Mueser, et al, 2003). In effect, this is a method of having the patient perform an informed consent on their own substance use (Table 3).

**Table 3. Decisional Balance Sheet / Payoff Matrix**

|                                   |                                       |
|-----------------------------------|---------------------------------------|
| Advantages of using substances    | Advantages of not using substances    |
| Disadvantages of using substances | Disadvantages of not using substances |

Adapted from Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L (2003). *Integrated treatment for dual disorders: A guide to effective practice.*, pp. 65-83. New York: Guilford Press.

### Attitude

A judgmental or confrontational attitude toward psychoactive substances and/or the substance user can lower self-report accuracy. The author has found the most effective nonjudgmental style is one of curiosity which, when combined with the inherently paradoxical nature of question three, tends to shift the patient out of self-denial and into reflection.

Often a substance use interview focuses only on two variables, the substance and the substance user. The third variable is the relationship between the person and his/her substance of choice. Weil (1993) has identified four characteristics that can distinguish good or bad relationship with substances (Table 4) and his relationship criteria tend to summarize and reframe the patient's perspective on substance use.

**Table 4. Drug Relationship Questions**

Do you recognize that the substance you are using is a drug and do you have an awareness of what it does to your body?  
Do you experience a useful effect of the drug over time?  
Can you easily separate from use of the drug?  
Do you have freedom from adverse effects on health or behavior?

Adapted from Weil, A. & Rosen W. (1993). *Chocolate to morphine: Everything you wanted to know about mind-active drugs.*, pp. 22-27. Boston:Houghton Mifflin.

The author's substance use interview is a derivative of Weil's original drug relationship concept.

### Treatment goals and planning

The first treatment goal is derived from a stage of change format, either via the original five-step model (Table 5) or the co-occurring disorder/MICA modification, the Substance Abuse Treatment Scale (Table 6).

|   |  |
|---|--|
| <p><b>Table 5. Stages of Change</b><br/>Precontemplation<br/>Contemplation<br/>Preparation<br/>Action<br/>Maintenance (Relapse Prevention)</p> <p>From Prochaska, J.O., Norcross, J.C., &amp; DiClemente, C.C. (1992). In search of how people change: Applications to addictive behaviors. <i>American Psychologist</i>, 47(9), 1102-1114.</p> | <p><b>Table 6. Substance Abuse Treatment Scale (SATS)</b><br/>Preengagement<br/>Engagement<br/>Early Persuasion<br/>Late Persuasion<br/>Early Active Treatment<br/>Late Active Treatment<br/>Relapse Prevention<br/>Remission/Recovery</p> <p>From McHugo, G.J., Drake, R.E., Burton, H.L., &amp; Ackerson, T.H. (1995). A scale for assessing the stage of substance abuse treatment in persons with severe mental illness, <i>Journal of Nervous and Mental Disease</i>, 183, 762-767.</p> |
|---|--|

Questions about the course of substance use and the patient's subjective impression generate the first treatment goal, the next stage of change. The individual processes of change between each stage define the objectives of the first treatment goal, allowing more focused treatment matching (Prochaska et al, 1992).

Question three elicits the positive desired outcomes of the patient's substance use and these define the second treatment goal. Physician-patient collaboration can then construct specific skill enhancement techniques to achieve outcomes previously obtainable only through substance use. Behaviorally, it becomes considerably easier to help patients explore different tools for getting some, if not all, of the positive outcomes of their substance of choice because it accepts them where they are and assumes that the positive outcomes derived from their drug of choice are important and desired goals. It is also a strong impetus for patients to begin focusing on the next stage of change and counters assumptions that the substance of choice is evil, their behavior a vice, or that they are bad or weak-willed.

### Co-occurring disorders

Collaborative, motivational, and harm reduction approaches are especially useful for those with co-occurring disorders. Carey (1996) proposed a five stage treatment model

for this population, including evaluating the cost-benefit ratio of continued substance use and individualizing the goals for change. For those with serious and persistent mental illnesses, such as schizophrenia and bipolar disorder, a health focus provides new information (Warner et al, 1994) and facilitates movement from sequential or parallel treatment for individual disorders into an integrated form of treatment. With an integrated approach, the substance use disorder and the mental illness are treated the same time by the same treatment team whose members have complementary goals and objectives. Treatment of the whole person becomes easier because of the health orientation focus on both adherence to prescribed medications for beneficial effects and non-adherence to psychoactive substances that increase harm.

A health-oriented substance use interview for those with trauma in their history often reveals that their drug of choice is being used to attenuate strong negative affects of shame, anger, despair, or fear. Eliciting the relationship between their drug of choice and its associated target affect facilitates both substance abuse and trauma treatment. The health orientation also facilitates the shift from victim to survivor and allows patients to become aware of their courage and resiliency in surviving.

For example, the author has found many Vietnam combat veterans not only carry the traumas incurred from war, which contains all known human traumas, but also from being blamed for the war when they returned home. Alcohol and marijuana were the most common drugs of choice on return from combat as attenuating flashbacks, numbing hyperarousal, or reducing shame were often the desired effects of alcohol and anger/aggression reduction often the desired effect of marijuana. When these veterans were asked what they would have done if they did not have access to alcohol or marijuana when they came home, many veterans stated that they would have committed suicide many years ago. With a health-oriented approach, they can see that these substances had temporary survival value and this strongly facilitates rapport, abstinence or non-problematic use, and trauma treatment.

## **Conclusion**

The health oriented substance use interview is meant to facilitate the five steps of substance use assessment: detection, classification, functional assessment, functional analysis, and treatment planning. It specifically focuses on the functional analysis part of the assessment. Though this approach empowers and motivates those most in need of hope, it is not a panacea as substance use over time can alter neurochemistry, fueling further substance use and addictive behaviors.

The health-oriented interview is not meant to substitute for a comprehensive, stage oriented treatment plan, especially with co-occurring disorders. It is also not a substitute for other assessment instruments (e.g., MAST, ASI, AUDIT) but neither does it interfere with their use. It can, however, be easily incorporated into most assessments and therapeutic treatment plans and can be generalized to simple benefit/risk assessments of prescribed medications and many habitual behaviors.

Given these limitations, the simple health-oriented substance use interview is an effective and compassionate harm reduction tool for assessing possible substance use disorders. It is effective in that it increases the probability of obtaining a relevant history of clinically useful data in a short period of time; data that is often unexplored or well defended. It is compassionate in that it fits three of the principles of harm reduction substance use disorder treatment; accepting psychoactive substance use as part of human behavior, insuring that users have a real voice in their treatment, and not minimizing or ignoring the many real and tragic harm associated with substance use (Marlatt, 1998). This approach also fits modern harm reduction psychotherapy approaches (Denning, 2000).

By focusing on the most important substance of choice and probing for health-oriented desires fueling the behavior, this type of interview is an excellent vehicle for integrating treatment, enhancing motivation, allowing individuals to perform an informed consent on their own behavior. Finally, it counters many of the negative effects of America's " War on Drugs " that often poison the climate of a substance use interview.

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Health-oriented substance use interviewing – 2007

1. Why are you here?
2. What is your drug of choice?
3. How does your drug of choice work for you in a healthy way?
  - a. go over possible health effects
4. What are the downsides to use of your drug of choice?
5. Frequency of use
  - a. Last use
  - b. Route of administration
6. Dosage
  - a. Range
7. Course of use over the years
  - a. Start with earliest use first
8. How did you learn how to use?
9. How many ways other than your drug of choice do you have to get your health goal(s)?
  - a. Have you been able to obtain your goals, at least in part, recently?
10. How are your tools, other than substance use, in obtaining your goals (skill enhancement)
  - a. Are they rusty?
  - b. Would you like additional tools?
11. If you relapse, how efficient are your tools in handling the downsides to your substance use?
12. Change
  - a. Readiness and/or motivation for change
  - b. Stage of change
  - c. Process of change
13. What would you like to do now?
14. How can I/we help?