“IS THERE EVIDENCE TO PROVIDE MENTAL HEALTH COUNSELING ALONE (WITHOUT SUD OR CO-OCCURRING TREATMENT) FOR PEOPLE WHO ARE USING DRUGS BUT DECLINE SUD TREATMENT?”

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Speaker Disclosures

- I have no conflicts of interest to declare.
- The views expressed herein are my own and may or may not align with those of the UW or VA Puget Sound.

PLANNER DISCLOSURES

The following series planners have no relevant conflicts of interest to disclose; other disclosures have been mitigated.

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Objectives

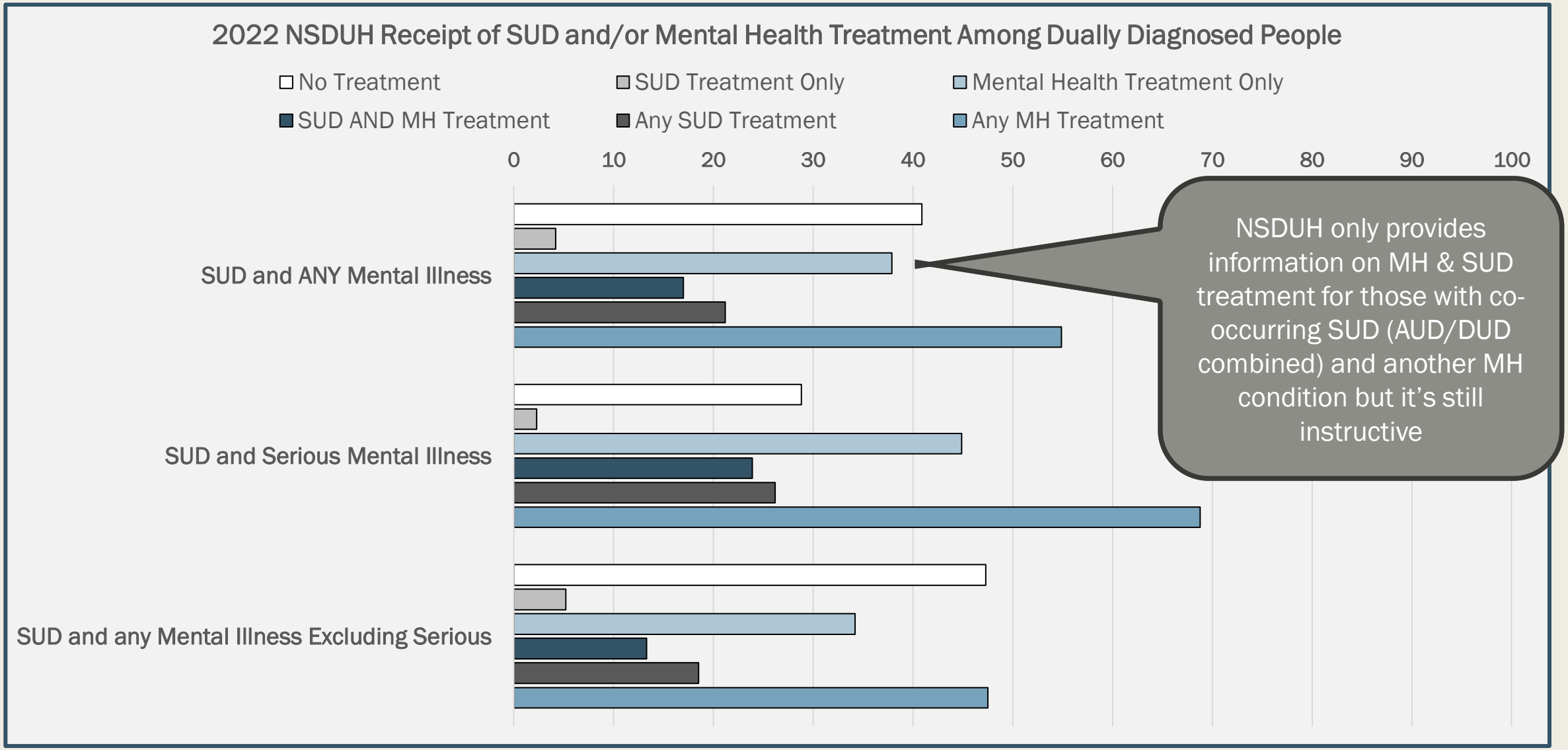
- I plan to address the question *"Is there evidence to provide mental health counseling alone (without SUD or co-occurring treatment) for people who are using drugs* but decline SUD treatment?"* by covering the following:
  - Why this is a great (and very important) question
  - Why there is not a straightforward "Yes" or "No" answer to the question
  - Clinical practices that are likely to be helpful when people with drug use disorders decline SUD treatment

I am assuming that the "people who are using drugs" have a drug use disorder

SUD = Substance Use Disorder

WHY THIS IS A GREAT (AND IMPORTANT) QUESTION…..

NUMERICALLY AND (PROPORTIONALLY) IT IS EXCEEDINGLY COMMON THAT PEOPLE WHO HAVE DRUG USE DISORDERS (DUD) WILL SEEK MENTAL HEALTH TREATMENT AND WILL NOT SEEK OR WILL ACTIVELY DECLINE SPECIALTY SUD TREATMENT



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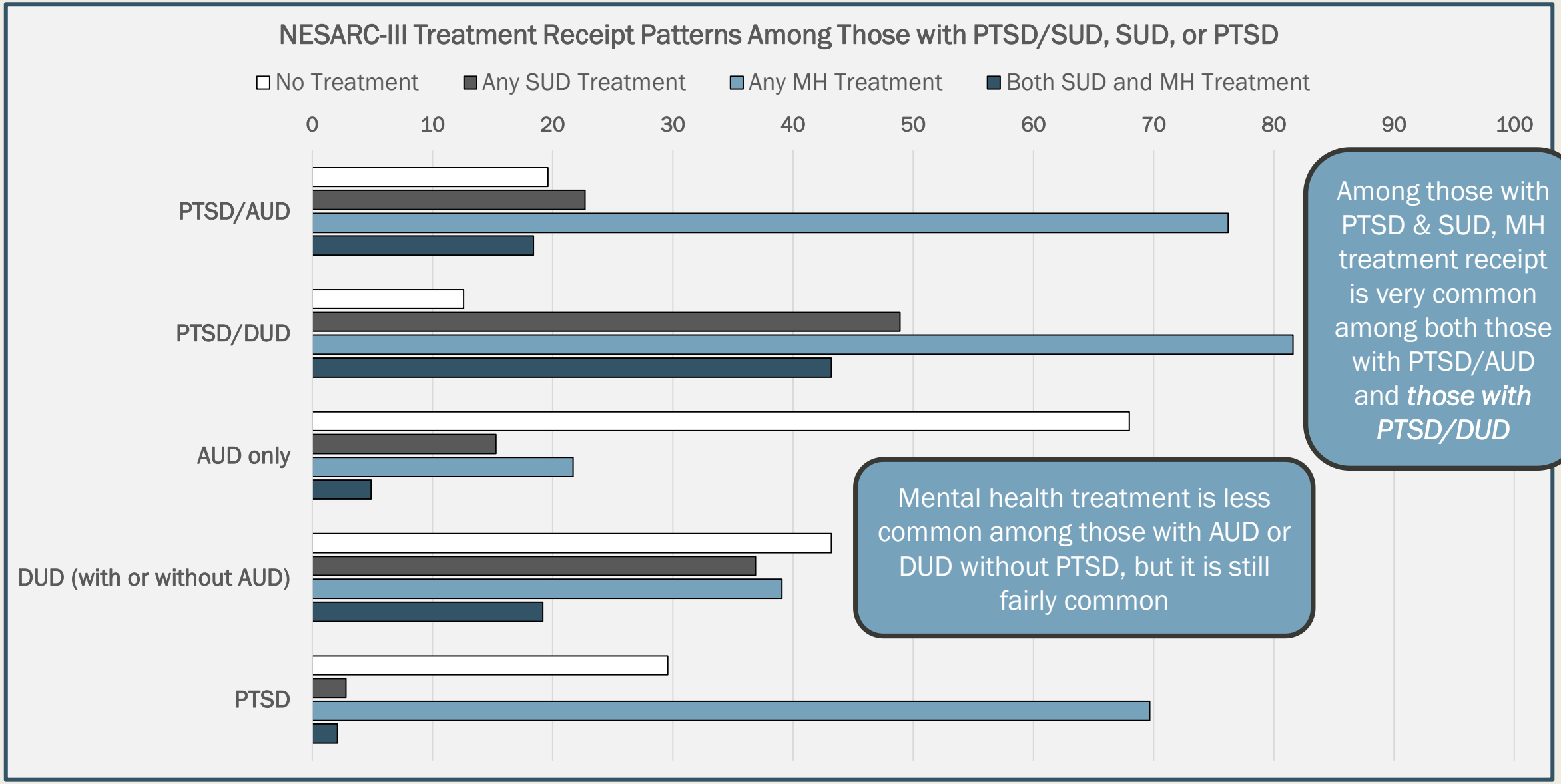
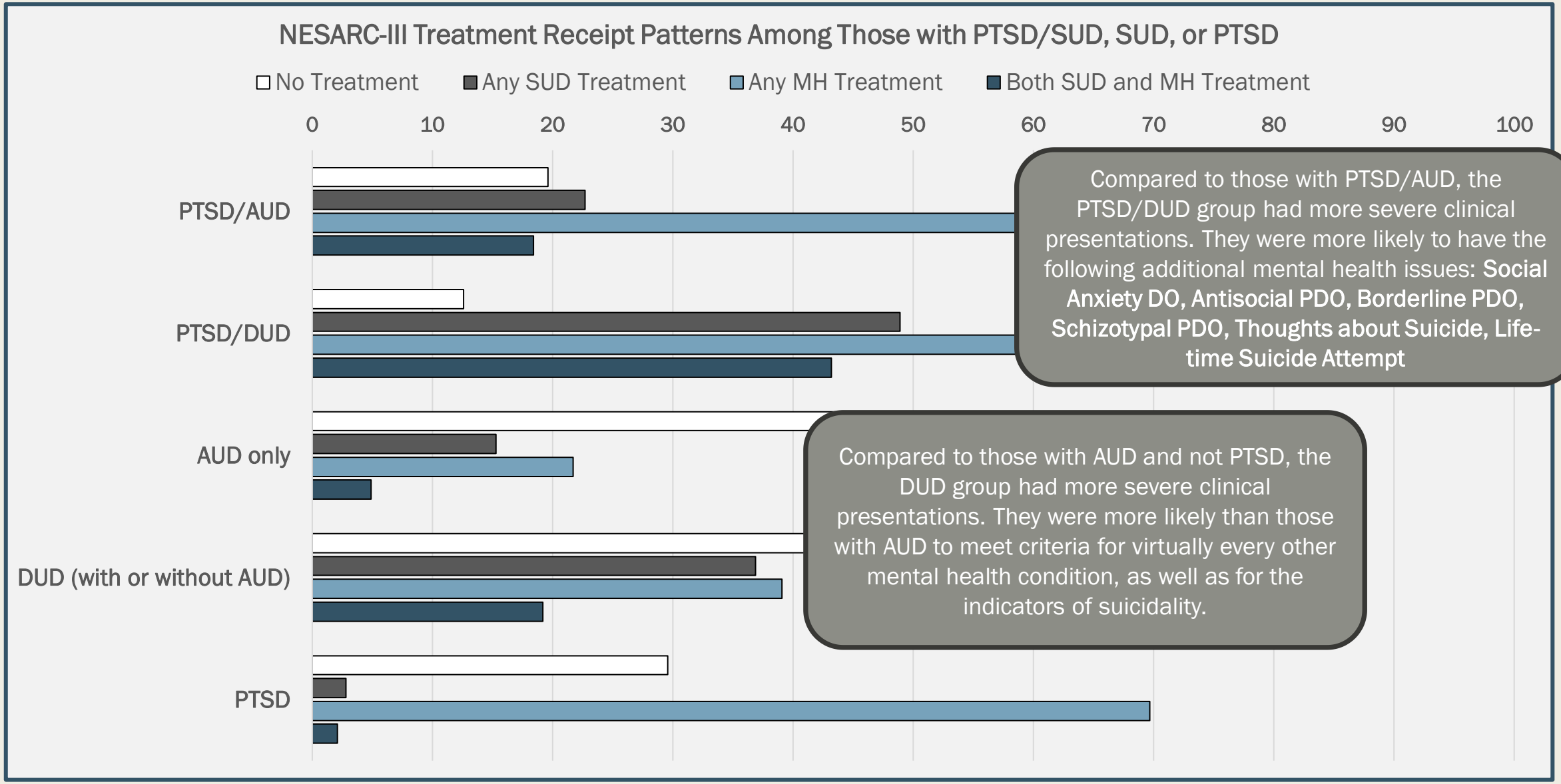


Simpson et al. 2019 *Addiction*



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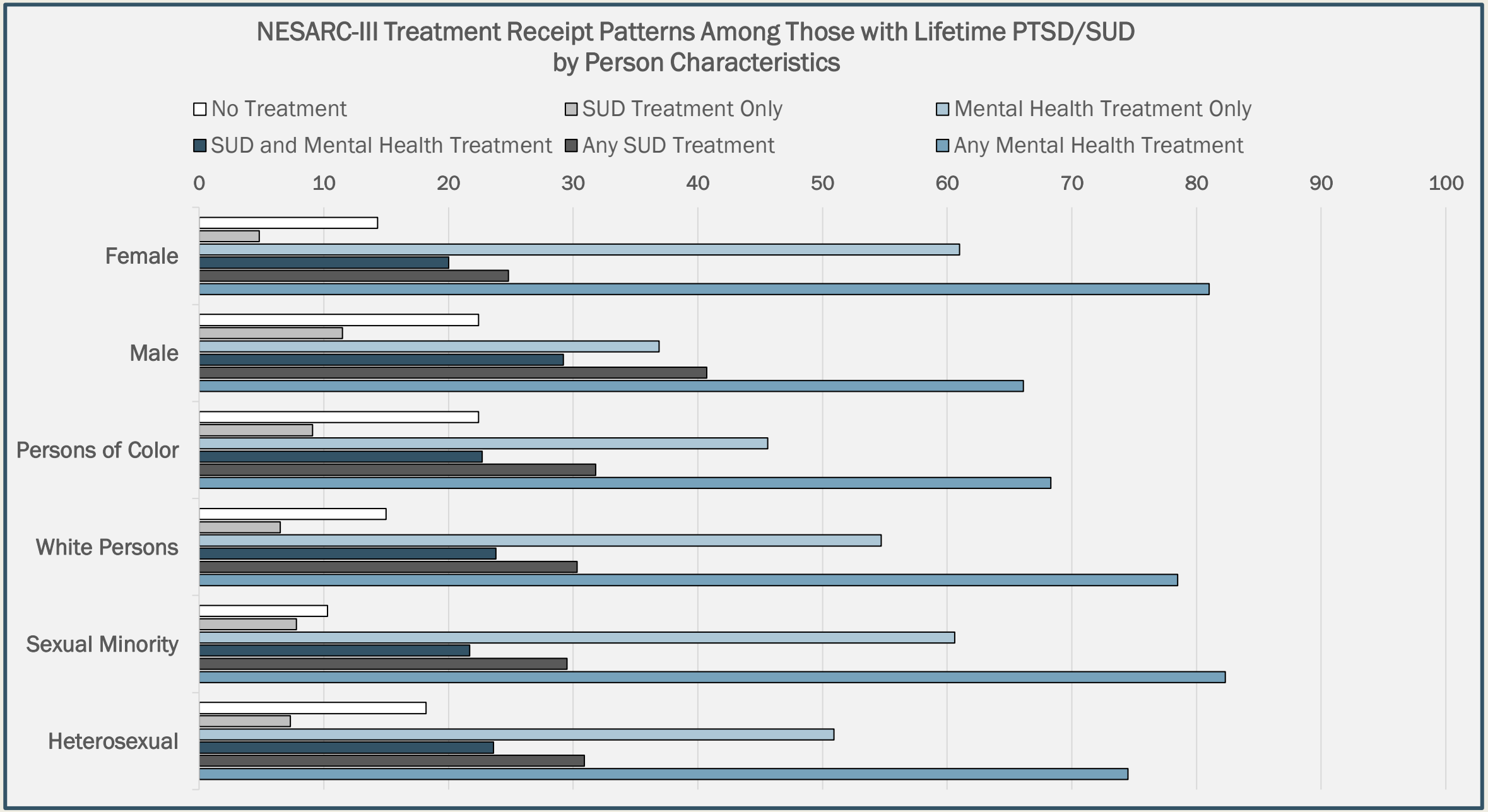


Simpson et al., 2020 *JCCP*

IN SUMMARY:

PEOPLE WITH DUD ARE MORE LIKELY THAN THOSE WITH AUD TO GET SUD TREATMENT, BUT RECEIPT OF MENTAL HEALTH TREATMENT WITHOUT RECEIPT OF SUD TREATMENT IS VERY, VERY COMMON AMONG THOSE WITH DUD

OK, BUT CAN PEOPLE WITH DUD RECOVER WHEN THEY RECEIVE ONLY MENTAL HEALTH TREATMENT?

CAN THEY?
YES, BUT IT'S COMPLICATED.

Why isn't there a clear "Yes" or "No" answer to the question?

- Despite there being decades of evidence that people with SUD and mental health comorbidities – to include those with DUD – are apt to seek only mental health care, there is not a literature base addressing how well this care addresses either their SUD or their co-occurring mental health conditions
  - *Most randomized trials of behavioral interventions for non-SUD mental health disorders EXCLUDE people with DUD and/or AUD and even if they are included, they are not analyzed separately*
  - *Very few randomized clinical trials (if any) have evaluated behavioral mental health treatments WITHOUT SUD treatment for those with DUD*
    - Tests of mental health treatments for people with MH/SUD comorbidities have nearly all been add-ons to SUD treatment as usual bases
- This is in marked contrast with the literature base going the other way that focuses on people in SUD treatment with mental health comorbidities
  - *Numerous studies have compared SUD-only behavioral treatments to combined MH+SUD treatments for those with MH/SUD comorbidities to see if the combined treatments confer greater benefit*

Why is there this disconnect across the SUD and MH clinical research arenas?

- Among those with a
  - *MH comorbidities*
    among people wit
    - in 2022 **about**
      have a co-occu
      disorder (in 20
  - *Historically, patie*
    providers) were fr
    MH issues "had t
    could focus on th
    disorder
  - *Over time, it beca*
    issues aren't atten
    changes in alcohol or drug use are unlikely

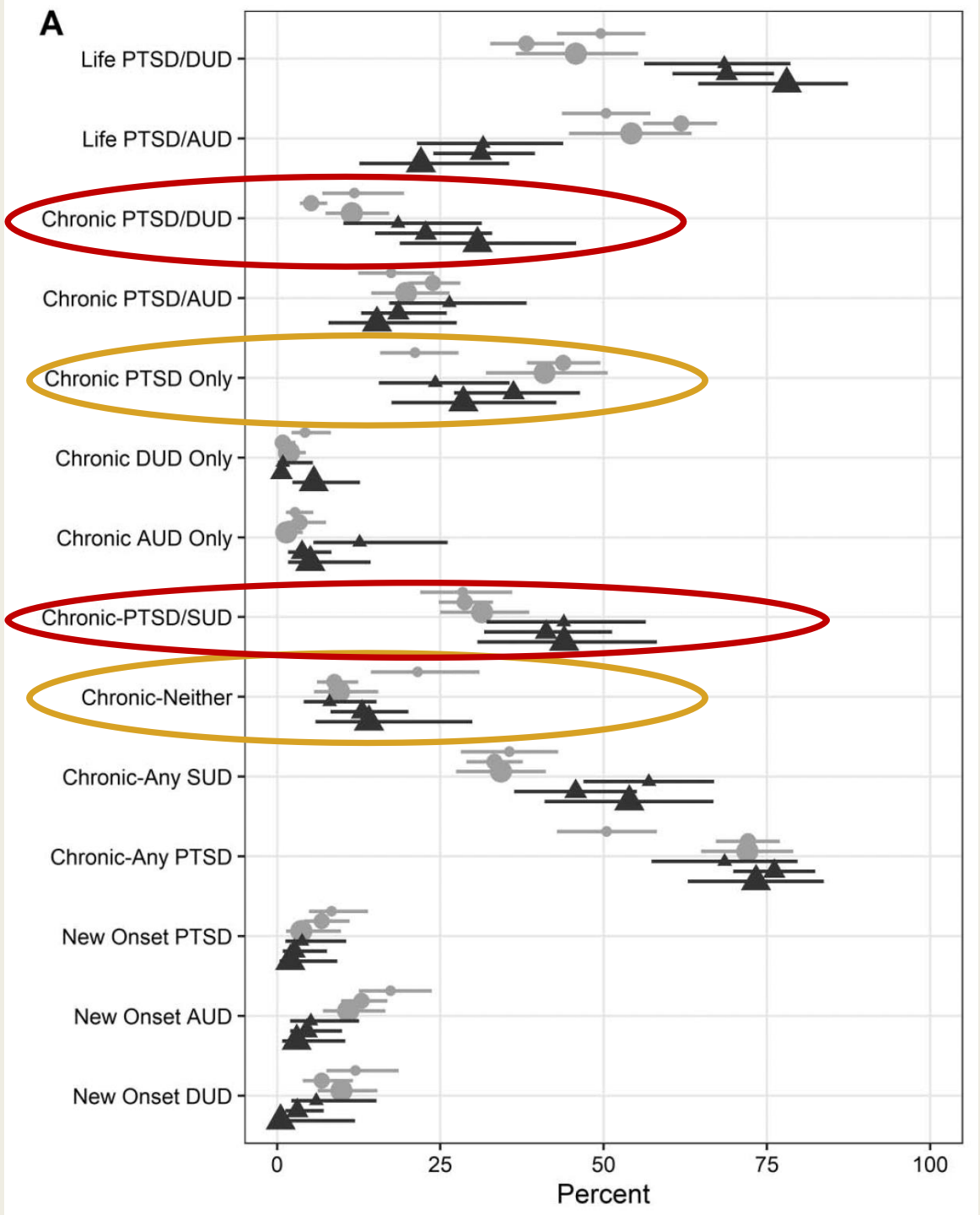
All told, in 2022 about 8.4% of people in the US ages 18 and older had both a current SUD and a current mental health disorder.

This works out to about 21.4 million people.

- a MH disorder....
  - *mmon among those*
    er, but not as common
  - **36%** of people with a
    disorder have a co-
    (in 2014 it was about
  - *MH treatment only are*
    evere SUDs than those
  - *eatment with a SUD*
    us primarily, if not solely,
    es
  - *Patients and providers can often get by without directly focusing on substance use issues*

WITHOUT A LITERATURE BASE, IS THERE ANYTHING TO GUIDE CLINICAL DECISION-MAKING?

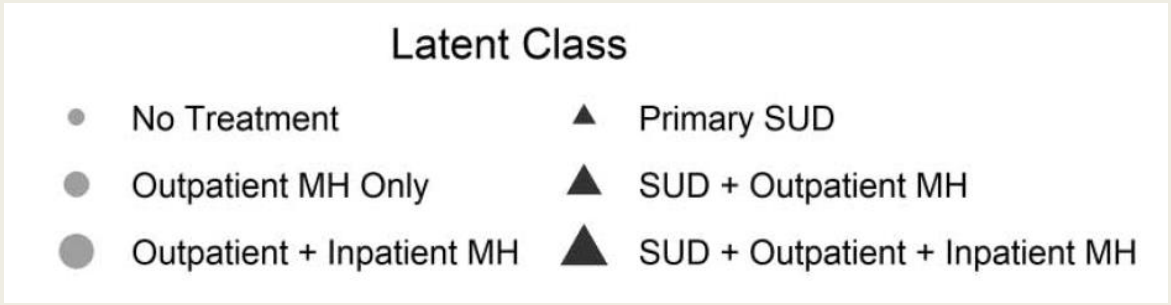
It’s not great, but there is some indirect evidence that may be useful



Among those with lifetime PTSD/SUD, those with only past year PTSD (i.e., no current SUD) were somewhat more likely to have received only outpatient mental health treatment than any SUD treatment.

Those with neither past year PTSD nor SUD were somewhat more likely to be in the no-treatment group than in any of the other groups.

Notes: the error bars are largely overlapping, and we cannot disaggregate the AUD from the DUD people



Simpson et al., 2020; *JCCP*

RCT comparing un-adapted Cognitive Processing Therapy and Relapse Prevention for people with PTSD/AUD*

Importantly and unfortunately, during the post-treatment period, there were numerous serious adverse events ~
mostly among those assigned to CPT.

8 psychiatric admissions – 7 CPT
5 substance-related hospital admissions – 3 CPT

	Post-Treatment		3-month Follow-up		12-month Follow-up	
	CPT n=38	RP n=33	CPT n=34	RP n=34	CPT n=27	RP n=28
Past month alcohol abstinence						
Both PTSD remission and abstin						
Low-risk drinking						
Both PTSD remission and low-risk dri						

...erall, the percent reduction in both PTSD and drinking ...omes from baseline to posttreatment for both active ...nditions tested in the present study was comparable to those found among individuals assigned to the integrated intervention COPE in trials addressing comorbid PTSD/SUD, which for PTSD range from 26% to 40% (current study: CPT 40%; RP: 37%) and for primary substance use outcomes range from 36% to 65% (current study: CPT 59%; RP: 77%)"

*57% of the sample reported past month cannabis use and 22% reported past month other drug use at baseline

Simpson & Kaysen et al. 2022; *PLOS ONE*

FOR WHOM MIGHT SUD TREATMENT BE CRITICAL?

And is there a specific type of SUD treatment that is needed?

Treatment Receipt Among Commercially Insured and People on Medicaid with OUD (N = 30,332; 2015-2017)

	No Treatment	Inpatient Detox or Residential	Behavioral Intensive Outpatient	MOUD (Buprenorphine or Methadone)	Naltrexone	Other Behavioral Health
Female	4%	13%	4%	11%	2%	66%
Male	6%	18%	6%	14%	3%	53%
White	5%	16%	5%	13%	3%	58%
Hispanic	6%	15%	5%	10%	1%	63%
Black	6%	13%	3%	9%	1%	67%
Other/Unknown	6%	16%	5%	13%	3%	59%

Wakeman et al., 2020; *JAMA Open*

Only MOUD was associated with DECREASED risk of opioid overdose and with DECREASED risk of needing intensive acute care for OUD at 3- and 12-months

but critically, it was not received at the same rates across key demographic groups

nd People on Medicaid with OUD (N = 30,332)

			ral ve ent	MOUD (Buprenorphine or Methadone)	Naltrexone	Other Behavioral Health
				11%	2%	66%
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Other/Unknown	6%	16%	5%	13%	3%	59%

Wakeman et al., 2020; *JAMA Open*

Interim summary

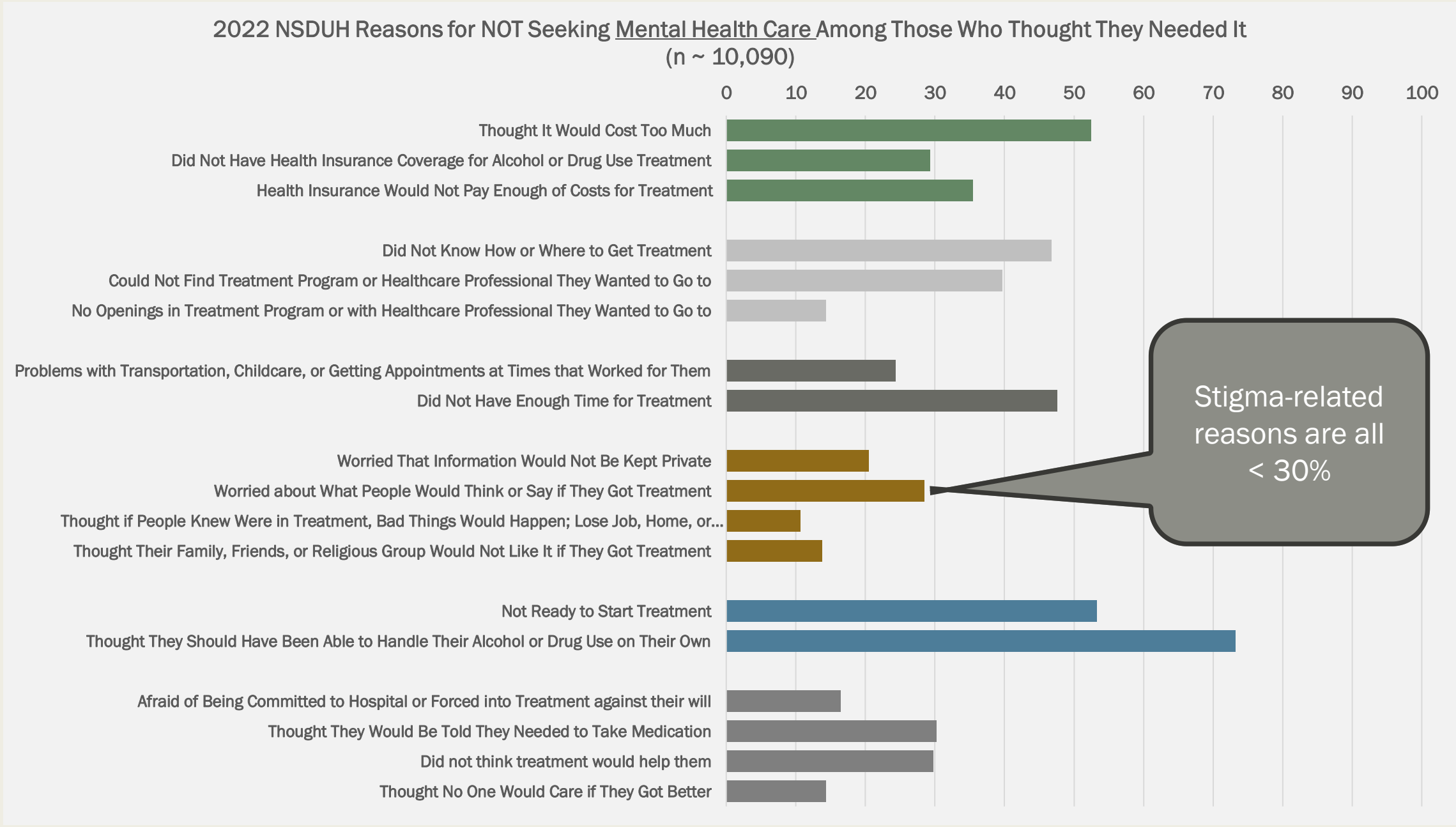
- A lot of people with drug use disorders seek and receive only mental health treatment
- There is some, albeit very limited and indirect, evidence that those with DUDs who receive only mental health treatment are less likely to have chronic DUDs than are those who receive SUD treatment
- There are two (known) major caveats to this
  - *Receipt of un-adapted trauma focused treatment for those with PTSD and SUD likely needs to be tapered slowly and with quite a lot of support*
  - *The ONLY treatment modality that is associated with decreased overdose risk among those with OUD is medication for the OUD*

The logical upshot of all this is

- There will almost certainly continue to be a steady stream of patients with DUD who present in mental health treatment settings and decline specialty substance use treatment
- It will continue to be important that these patients be served as well as possible where they present, namely in mental health settings
  - *From public health and humanitarian perspectives, this "no wrong door" approach is preferable to turning people away*
- And it may be helpful to recognize that the people with DUD who will accept only mental health treatment are likely to have at least somewhat less severe clinical presentations than those who do go for specialty SUD treatment

BEFORE EXPLORING TREATMENT AUGMENTATIONS APPROPRIATE TO MENTAL HEALTH SETTINGS, AN IMPORTANT DETOUR:

Why might people not get treatment?



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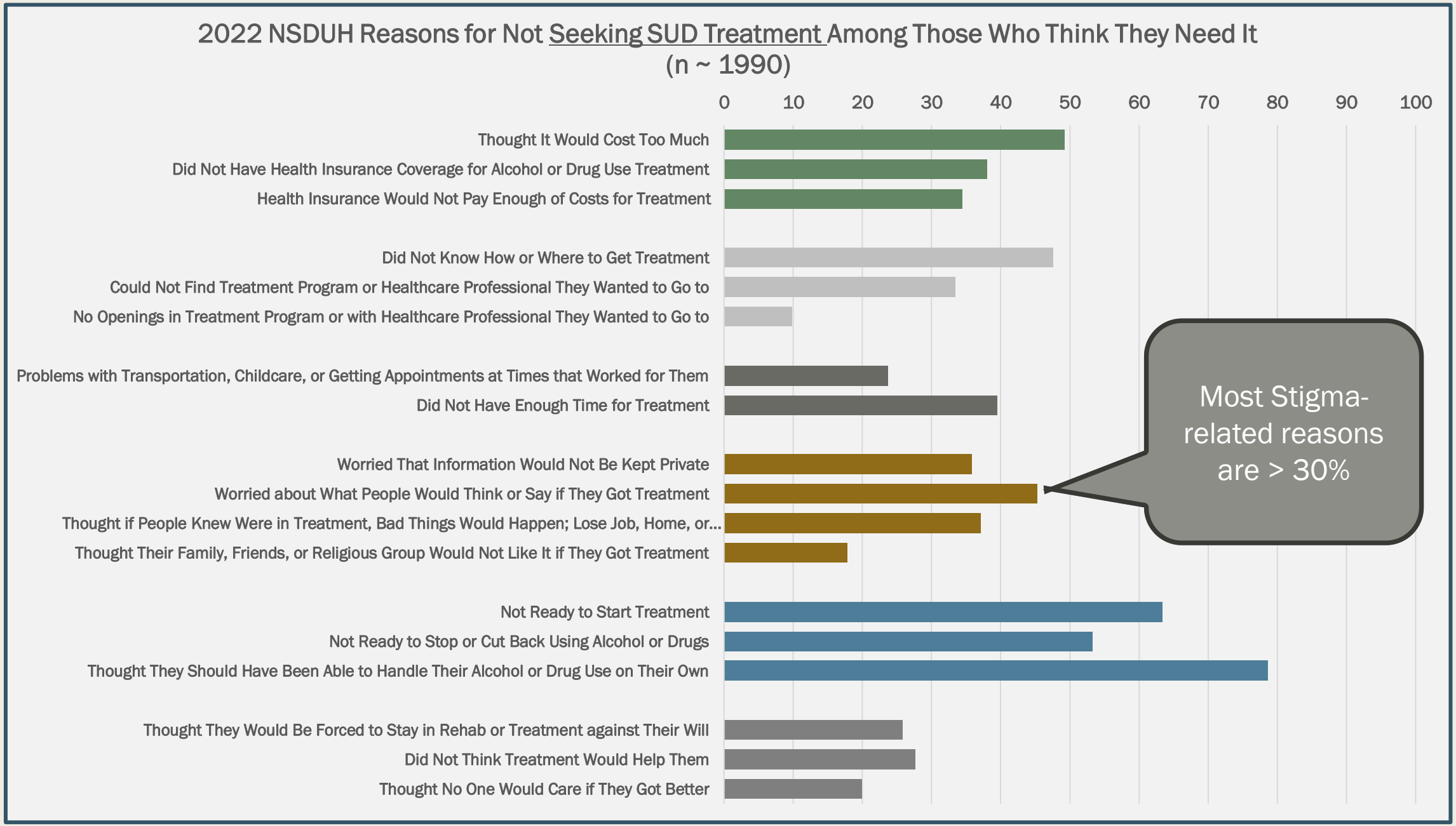

NSDUH Detailed Table 5.36B 2022

Why do people get SUD treatment?

- Serious health issues related to substance use
- Repeatedly unable to get work because of urine screenings positive for drugs
- Major losses associated with substance use
- Threats of major losses if don't change alcohol or drug use
- Being unhoused
- Legally mandated

Aside from being legally mandated….

People usually will have had to try repeatedly and discover that they cannot maintain reduced use or abstinence on their own or with just informal support

….or only with mental health treatment

before they are willing to get SUD treatment

CLINICAL PRACTICES THAT ARE LIKELY TO BE HELPFUL WHEN PEOPLE WITH DRUG USE DISORDERS DECLINE SUD TREATMENT

Overarching clinical framing

- It is obvious, but it can be helpful to remember that substance use is behavior and that the same learning (and unlearning) principles apply to substance use as to any other type of behavior
  - *This is true even though heavy and prolonged alcohol and drug use can cause physical dependence and/or tolerance*
- People can develop compulsive relationships to many, many things – gambling, eating, exercise, porn, social media, etc.
- Often these sorts of behavioral patterns are “designed” to avoid something or some things, including mental health symptoms or challenges

Clinical frame of reference ~ SUD Clinicians

- Clinicians in SUD specialty care are adept at working with clients who have various mental health conditions
  - *Often by helping them learn to recognize when their mental health symptoms and stressors are triggering alcohol or drug cravings or use*
  - *Helping them learn and practice alternative coping strategies that can be applied to both mental health and substance use*
  - *Helping them address any underlying issues that are driving either, or both, the substance use or the mental health symptoms*
  - *Often all of this is predicated on having helped clients identify their "whys" or their motivations for making changes and then helping them keep those top of mind*
- And it is important to recognize that clients in SUD care usually really want to focus on their mental health challenges

Clinical frame of reference ~ MH clinicians

- All the information shared about how SUD clinicians work with their clients around mental health issues is easily adapted to clients in mental health settings with SUDs IF there is openness to work on their substance use
  - *It is probably fair to say that many clients are likely willing to have their substance use be part of the clinical picture if they don't have to go to SUD specialty care*
  - *And it is also fair to say that for many clients, discussion of alcohol or drug use is off the table*
    - Because this latter group of clients is likely more challenging for MH clinicians, they will be the focus for the rest of our time today

Understanding *this* person

- What lines in the sand have your client drawn around their substance use and why have they drawn those lines?
- Gaining a clear understanding of your client's reluctance to engage around substance use can help build empathy and may provide an opportunity for correcting mistaken assumptions
  - *Is it that SUD treatment is an absolute "no" but addressing it in MH treatment in service of treating their depression, anxiety, PTSD, etc. might, maybe be ok?*
  - *Is it that they've felt shamed or embarrassed around their alcohol or drug use by previous clinicians?*
  - *Are they worried that their kids might be taken away?*
  - *Do they think they'll be told they have to abstain (forever)?*
  - *Do they think they can (or should) handle their substance use on their own?*

Motivation

- Motivation for change waxes and wanes ~ it is not a trait that some people have and other people don't have
- Motivation can absolutely be helped to wax (increase, flourish…)
  - *If clinical interactions are focused on what clients want for themselves and why they want those things*
  - *If clinical interactions are grounded in the clients' values and what brings them a sense of meaning and purpose (and joy!)*
- Motivation can also absolutely wane (decrease, tank….)
  - *If clinical interactions are focused on what clinicians think clients should want for themselves*
  - *If clinicians take a "my way or the highway" stance*
- Basic training in Motivational Interviewing can come in handy for reluctant clients with SUD and clients with any number of behavior profiles that are incompatible with their values
- The Values & Priority List (Linehan, 2014) can be a helpful tool

Case example ~ backdoor motivation building

- Your client, Melony, is a Hispanic women who is 34 years old. She has been with her woman partner for 5 years and they have two children. Melony works full time and does most of the household and child coordination for the family. She has been struggling with depression and generalized anxiety for most of her adult life. Melony is using increasing amounts of cocaine on the weekends and tends to alternate between several beers and a bowl of cannabis during the week to relax and take the edge off. She has stated that she is motivated to work on her depression and anxiety but does not want to address the substance use.
  - *How might we go about helping Melony connect the dots between her mental health challenges and her substance use and how both are likely keeping her from living the life she wants to live?*
  - *Importantly, how likely is that dot-connecting to happen in the first few sessions?*

Negotiating measurement-based care

- Often it is helpful to have clients monitor a few things day-to-day
  - *Mood and other symptoms*
  - *Stress levels and stressors*
  - *What doing and who doing it with*
  - *Alcohol and other drug use*
  - *If applicable, medication adherence*

  This may need to start out very basic with things added as clients start to see the benefits of monitoring

- Initially, the goal isn't to change anything but rather to see what patterns might be there and to start doing that crucial dot connecting
- People are often more motivated to make changes once they see better what is happening
  - *Careful behavioral functional analysis can also be helpful in clarifying patterns and what is driving or contributing to what*

CBT

- There is a good chance that whatever cognitive and behavioral treatment is used to address the agreed upon target symptoms (mood, anxiety, PTSD, etc.) will help the person be less reactive and avoidant
  - *Cognitive skills can help people not catastrophize, consider different options, not believe everything they happen to think, etc.*
  - *Behavioral skills can help people set boundaries with themselves and others, activate when they don't feel like doing things they know would be good for them, communicate more effectively, etc.*
- Thus, there is a good chance that CBT will help clients manage symptoms and stress more effectively such that they don't need to rely on substances to cope

If target symptoms are improving

- Find out what your client thinks is helping
- Find out whether they are noticing changes in other areas, like in their relationships, how they feel about themselves, their substance use…
  - *Help them identify how it is that these other things have improved too (if they have improved)*
    - If other areas are not improving, explore together why this might be and what could be done about it
  - *If things are going well, help client identify what they likely need to do going forward to stay on track*

If target symptoms are not improving…

- Gently explore what might be getting in the person's way
  - *Is there a challenging or toxic relationship that needs to be addressed?*
  - *Are they trying to be super-human and not giving themselves breaks or grace?*
  - *Are they physiologically or psychologically dependent on a drug and/or on alcohol or is their use otherwise interfering and keeping symptoms elevated?*
    - If so, might they now be willing to consider cutting back or quitting use?

Strategies for keeping lines of communication open

- Ideas for when someone does not want to talk about their substance use but it is clearly part of the clinical picture
  - *Refer to drug or alcohol use matter-of-factly; it is behavior like any other behavior*
  - *Notice and be curious when client seems to be shifting from their baseline mood or functioning – What is helping? What is making things worse?*
  - *Appreciate openness when it's there and practice acceptance when it's not*
  - *Remind yourself that trust can take a long time to build*
  - *Consistently use person-centered, non-stigmatizing language regarding substance use even if the person themselves uses stigmatizing language*

Examples of stigmatizing and non-stigmatizing language

About the Person

Stigmatizing: “addict” / “junkie” / “drug abuse” /”mentally ill”

Helpful: “person with cannabis use disorder” / “person who sometimes has difficulties with opioids” / “person in long-term recovery” / “addiction survivor” / “experiencing depressed mood”

About substance use behaviors

Stigmatizing: “dirty UA” / “clean UA” / “substance abuse” / “disengaged”

Helpful: “negative or positive UA” / “harmful substance use” / “substance use disorder” / “chronic brain disease” / “psychiatric or emotional challenges”

Other concepts/issues

Stigmatizing: “wasted” / “strung out” / “high” / “relapse” / “stuck” / “treatment resistant”

Helpful: “intoxicated” / “return to use” / “unsure how to proceed” / “ambivalent about change”

Taking care of yourself

- Often working with people who have drug or alcohol use disorders is hard, especially when that isn't what you feel like you signed up for
- Often the stakes can feel very high with these clients since harmful substance use can be scary for all involved
- Finding ways to take care of yourself is key
  - *Accept that you will sometimes feel frustrated and unsure what to do and give yourself grace/compassion*
  - *Find or establish a consultation group or find a trusted mentor or colleague to talk with about challenging clinical situations*
  - *Read and learn about the ways that substance use and mental health often coexist and exacerbate one another*
  - *Regularly re-center and remember that while your clinical ways of being are important, your clients lives and choices are their own*

QUESTIONS? COMMENTS?

Thank you

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