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Psychiatry and Addictions Case Conference
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01/10/2019

WELCOME!

Today's Topic:

Psychosocial Support in OUD Treatment

Should I require psychosocial treatment and if so, what should I ask them to do?

Speaker: Rick Ries, MD

PANELISTS:

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"COUNSELING" APPROACHES FOR PERSONS WITH OPIOID USE DISORDERS

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GENERAL DISCLOSURES

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.

SPEAKER DISCLOSURES

- ✓ Any conflicts of interest?

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LEARNING OBJECTIVES

1. Review issues of psychotherapy in opioid dependence

2. Case management vs. therapy discussed

3. Look at different strategies which may prove fruitful

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WHAT EVIDENCE BASED COUNSELING APPROACHES EXIST FOR PATIENTS WITH OPIOID USE DISORDERS TREATED IN PRIMARY CARE OR OTHER NON METHADONE SITES.

- Currently no counseling or psychotherapy approach has shown efficacy in enhancing outcomes in Primary Care based opioid dependence treatment
- Several randomized studies (Fiellin 2006, 2013) (Weiss 2011) have shown little to no effect related to type or degree of addictional counseling or psychotherapy (including CBT)
- All studies showed low levels of therapy attendance
- Weiss study showed if over 60% attendance there was a positive effect with less heroin use
- All randomized studies looked at first 3 months of Rx
- What about counseling later- after 3 months stabilization?

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SO NOW WHAT?

- What do we know about outcomes over-all in opioid dep treatments?
  - Better adherence to Opioid Rx **meds** = better outcomes, linearly related
  - Psychosocial instability = worse outcomes

- Thus many have suggested that initial "psychotherapy" or "counseling" in first months might better focus on Care or Case Management
  - Such as:
    - housing, shelter, transportation, funding, decreasing barriers attendance, affording meds etc
    - Facilitating med adherence issues such at knowledge, support, education,
    - Working in a team model

Addict Behav. 2017 Oct;73:129-132. doi: 10.1016/j.addbeh.2017.05.010. Epub 2017 May 10.

Predictors of buprenorphine treatment success of opioid dependence in two Baltimore City grassroots recovery programs.

Damian AJ[1], Mendelson T[2], Agus D[3].

RESULTS:

The odds of being retained in treatment ≥90days increased with age (5% increase with each year of age; p<0.001), adjusting for other sociodemographic factors. **Clients who reported unstable housing had a 41% decreased odds of remaining in treatment for 90 or more days compared to clients who lived independently at intake**. Treatment success did not significantly differ by several other client-level characteristics including gender, race, employment, legal issues and incarceration.

CONCLUSIONS:

In vulnerable populations, the age factor appears sufficiently significant to justify creating models formulated for younger populations. **The data also support attention to housing needs for people in treatment.** Findings from this paper can inform future research and program development.

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SO MAYBE THERE ARE "PHAZES" OF PSYCHOSOCIAL TREATMENTS

- 1. Initial 3 months focus on case management,
  - housing, shelter, transportation, etc
  - medical

- 2. Months 3-6 on problem solving
  - Relationships, vocational, depression, anxiety, PTSD
  - Peer support, 12 step, "getting a life- Walter Ling"

- 3. Recovery phaze
  - Stabilizing housing, income, relationships
  - Vocational
  - More specific therapies (COD) etc
  - More 12 step or other peer support

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J Subst Abuse Treat. 2015 Oct;57:89-95.

Buprenorphine Treatment and 12-step Meeting Attendance: Conflicts, Compatibilities, and Patient Outcomes.

Monico LB

Using quantitative (n = 300) and qualitative (n = 20) data collected during a randomized trial of counseling services in buprenorphine treatment, this mixed-methods analysis of African Americans in BMT finds

The number of NA meetings attended in the prior 6 months was associated with a

1. ^ rate of retention in BMT (p < .001)

2. ^ rate of Heroin/cocaine abstinence at 6 months (p = .005).

Conclusion: Twelve-step meeting attendance is associated with better outcomes for BMT patients over the first 6 months of treatment

Uncontrolled Study

RRies 2018

WHAT ARE SOME EXAMPLES, BOTH POSITIVE AND NEGATIVE THAT YOU HAVE OBSERVED OR EXPERIENCED?

LETS LOOK AT SOME WAYS YOU CAN USE VARIOUS COUNSELING STRATEGIES TO ENHANCE OUTCOMES IN VARIOUS PATIENTS….

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MOTIVATIONAL INTERVIEWING AND OPIOID RX ENHANCEMENT

- "So you thought about stopping your meds last night and using

Instead?

- What do you think you might have gained if you had used?

- What would have been the downside of using ?

- ***Now your TURN…..***

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COGNITIVE/BEHAVIORAL THERAPIES AND AA FACILITATION

- "So you thought about using last night, when you had cravings, but didn't…
- ….lets examine what you said to yourself to convince yourself not to use , then work out a strategy to solidify this
- ***Now your Turn….***

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12 STEP "DISEASE MODEL" FACILITATION

- "So you thought about going to a meeting last night, but didn't quite get there….."
- What was responsible for not getting there... was it you or was it your disease?
- That kind of experience is the illness at work…it's the disease that tells you that you don't have a disease….who could you have called?

INTEGRATED PSYCHIATRIC TREATMENT AND OPIOID TREATMENT

- So you thought about going back to work, now that you are stabilizing,---- but were afraid you would panic if you even applied
- Lets talk to your doctor about this regarding diagnosis and put together a plan

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