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Psychiatry and Addictions Case Conference

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"COUNSELING" APPROACHES FOR PERSONS WITH OPIOID USE DISORDERS

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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.

- No counseling or psychotherapy approaches have shown consistant 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 additional counseling or psychotherapy (including CBT)
  - **However-All studies showed low levels of therapy attendance**

- Weiss study showed if over 60% attendance there was a positive effect with less heroin use

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- All randomized studies looked at first 3 months of Rx-What about counseling later-after 3 months stabilization?

- Weiss (2018) 4 year outcomes showed
  - Better med adherence = better outcome
  - More 12 step = better outcomes
  - No effect of various " therapies"

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

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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**

SO MAYBE THERE ARE "PHASES" OF PSYCHOSOCIAL TREATMENTS

- 1. Initial 3 months focus on
- Med adherence, problems, side effects, etc
- 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 phase
  - Stabilizing housing, income, relationships
  - Vocational
  - More specific therapies (COD) etc
  - More 12 step or other peer support

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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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MED ADHERENCE

- How have your opioid treatment meds been working?
- What have been the pros and cons of taking them?
- Lets review HOW you are taking them.
- Your urine tox screens show _____, does that seem right?
- What do you think about dose?
- How about your other medications?

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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 examples……***

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HARM REDUCTION

- So over-all your heroin use has dropped off, but you are still using once or twice a week.
  - How can you increase your safety if using?
    - Alone vs with a friend, naloxone available
    - Check for fentanyl
    - Other sedatives, Benzos, alcohol others?
    - Clean needles, Meth?
  - How many times have you NOT used, when you were craving?
  - ***Now your examples…..***

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
- ***<u>Now your examples….</u>***

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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?
- ***Now your examples…***

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INTEGRATED PSYCHIATRIC TREATMENT AND OPIOID TREATMENT

- So now that you are stabilizing from opioid addiction, your PTSD seems to be acting up
- Lets talk about this regarding diagnosis and put together a plan

- What resources might be available?

- ***Now your examples….***

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