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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

LEVERAGING FAMILY IN OUD TREATMENT

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project ECHO

If involving families in treatment of SUDs improves outcomes, then why is it not standard practice?

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including families improves outcomes

The overarching conclusion is that family-based models are not only a viable treatment alternative for the treatment of drug abuse, but are now consistently recognized among the most effective approaches for treating both adults and adolescents with drug problems.

Rowe, C. L. (2012). Family therapy for drug abuse: Review and updates 2003–2010. Journal of marital and family therapy, 38(1), 59-81.

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including families improves outcomes

family members remain on the periphery, overlooked by our current health care system

Evidence-based interventions targeting family members of individuals with SUDs have been shown to improve health outcomes for all family members, result in better addiction treatment outcomes, and prevent adolescent substance use.

Despite continued and mounting empirical support that family members and loved ones play an integral role in the success and wellbeing of individuals' engagement along the SUD care continuum, family members remain on the periphery, overlooked by our current health care system.

Family members have been filling gaps in the SUD care continuum for decades, frequently without recognition from the health care system. Cycles of urgent acute care followed by discharge home with no formal support are common in the US addiction treatment system. Individuals with SUDs often must wait weeks or months to move from one level of care to the next. To fill this gap, untrained family members often have no choice but to provide life-sustaining transitional care at home.

Ventura, A. S., & Bagley, S. M. (2017). To improve substance use disorder prevention, treatment and recovery: Engage the family. Journal of addiction medicine, 11(5), 339-341.

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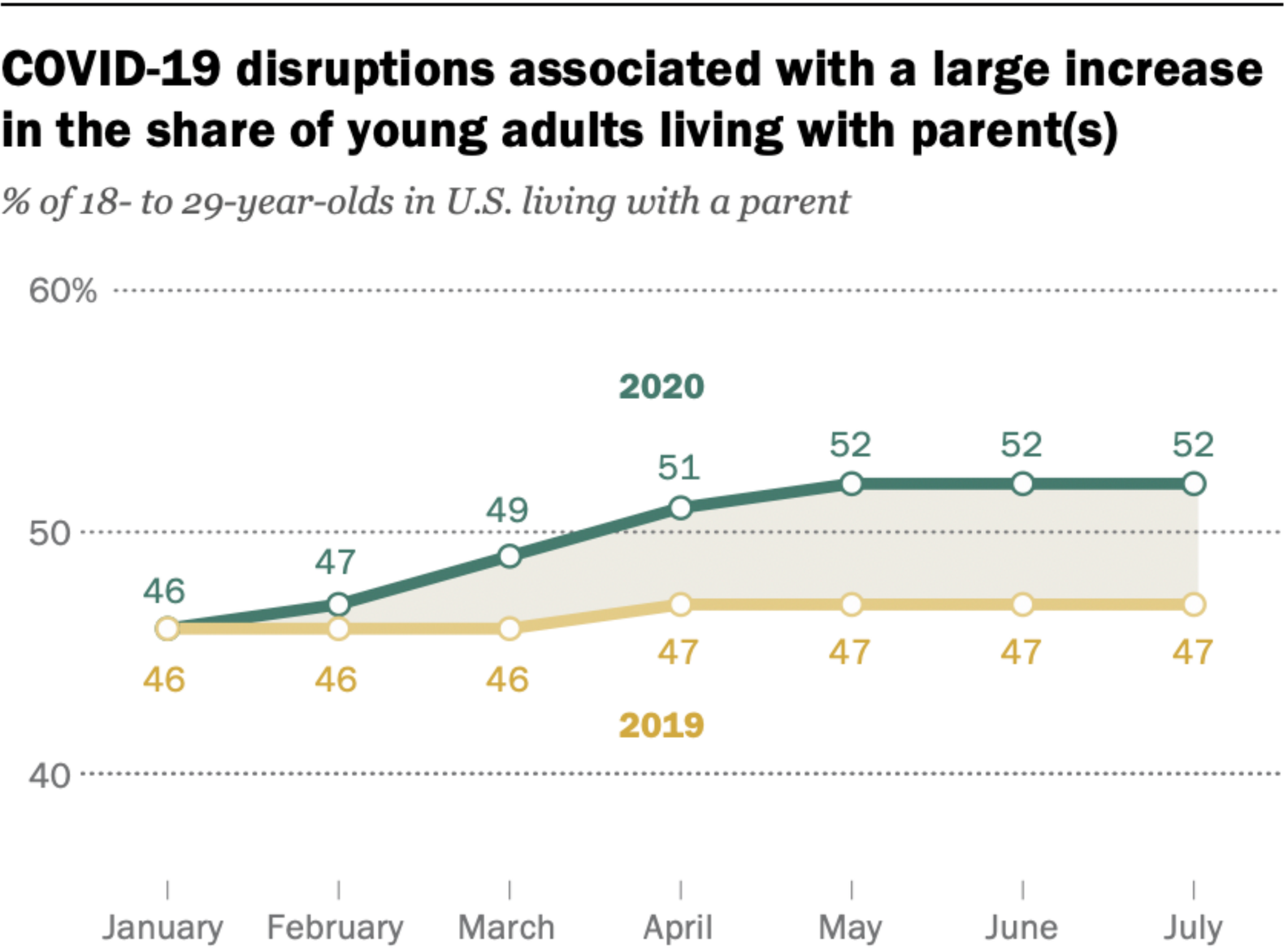

Half of 25 year olds live with their parent

R. Fry, J.S. Passel, D.V. Cohn
A majority of young adults in the U.S. live with their parents for the first time since the great depression
Pew Research Center (2020, September 4)

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“The role of family in treatment-seeking warrants particular attention. **Young adults frequently report seeking treatment primarily for family-related reasons.** These may be externally motivated, such as verbal pressure, loss of privileges or other supports, expulsion from home, or internally-motivated such as coming to terms with the harmful effects of their behavior on family members and experiencing guilt as a consequence.”

Fishman, M., Wenzel, K., Gauthier, P., Borodovsky, J., Murray, O., Subramaniam, G., ... & Marsch, L. A. (2024). Engagement, initiation, and retention in medication treatment for opioid use disorder among young adults: A narrative review of challenges and opportunities. Journal of Substance Use and Addiction Treatment, 209352.

including families improves outcomes

yet most SUD programs don't offer EVP for families

"Numerous SUD treatment models exist that directly include family members in the treatment process, each of which demonstrate improved engagement and SUD reductions compared to typical individual treatment.

Many of these treatments were developed and evaluated in the United States, yet very few community-based substance use treatment programs offer evidence-based therapies for couples and families here."

Dopp, A. R., Manuel, J. K., Breslau, J., Lodge, B., Hurley, B., Kase, C., & Osilla, K. C. (2022). Value of family involvement in substance use disorder treatment: Aligning clinical and financing priorities. Journal of Substance Abuse Treatment, 132, 108652.

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For almost all other health concerns it is considered routine, even obligatory, to help a loved one (especially a family member) who faces challenges.

"For almost all other health concerns it is considered routine, even obligatory, to help a loved one (especially a family member) who faces challenges and may be having difficulty with optimizing utilization of treatment services. But this is not the case in OUD services, for many reasons.

To be sure, prominent barriers against involving CSO exist among both providers (e.g., biases against CSO as causes of OUD problems, lack of skills or motivation to pursue CSO outreach, beliefs that youth with OUD need unilateral individuation from parents, beliefs that only internal insight and motivation can produce behavior change and among CSO themselves (e.g., demoralization about providing support, reticence to engage with substance use services.

To overcome these barriers and successfully engage CSO in routine behavioral services for OUD, clinically pragmatic interventions focused on active CSO involvement in MOUD decision-making and adherence planning are needed."

Hogue, A.,et al(2023). Launching relationship-oriented behavioral services for youth opioid use disorder: Innovations in medication decision-making and adherence planning. Child & family behavior therapy, 45(3), 199-225.

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“[stigmatizing] stereotypes dissuade family members from engaging with SUD treatment providers, and unfortunately disregards the **many ways in which family support is instrumental in SUD recovery —such as being actively involved in a loved one's SUD treatment appointments, positively reinforcing a patient's choices, or listening and validating the patient's struggle to overcome addiction.**

In the absence of formal inclusion in SUD treatment, family members have primarily relied [12 step] models that focus entirely on the family members' coping, and evidence of benefits is mixed for both family members and the person with an SUD. In fact, depending on the group composition and leadership, members may receive stigmatizing messages—e.g., that family members are “powerless” over their loved one's SUD, or that medication treatment for SUD is “trading one drug for another.” These factors illustrate the pitfalls of a disjointed SUD system in which patients and their **families receive separate, sometimes dissonant, sources of information and support during the recovery process.”**

Dopp, A. R., Manuel, J. K., Breslau, J., Lodge, B., Hurley, B., Kase, C., & Osilla, K. C. (2022). Value of family involvement in substance use disorder treatment: Aligning clinical and financing priorities. Journal of Substance Abuse Treatment, 132, 108652.

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STIGMA

What is it?

How does it function?

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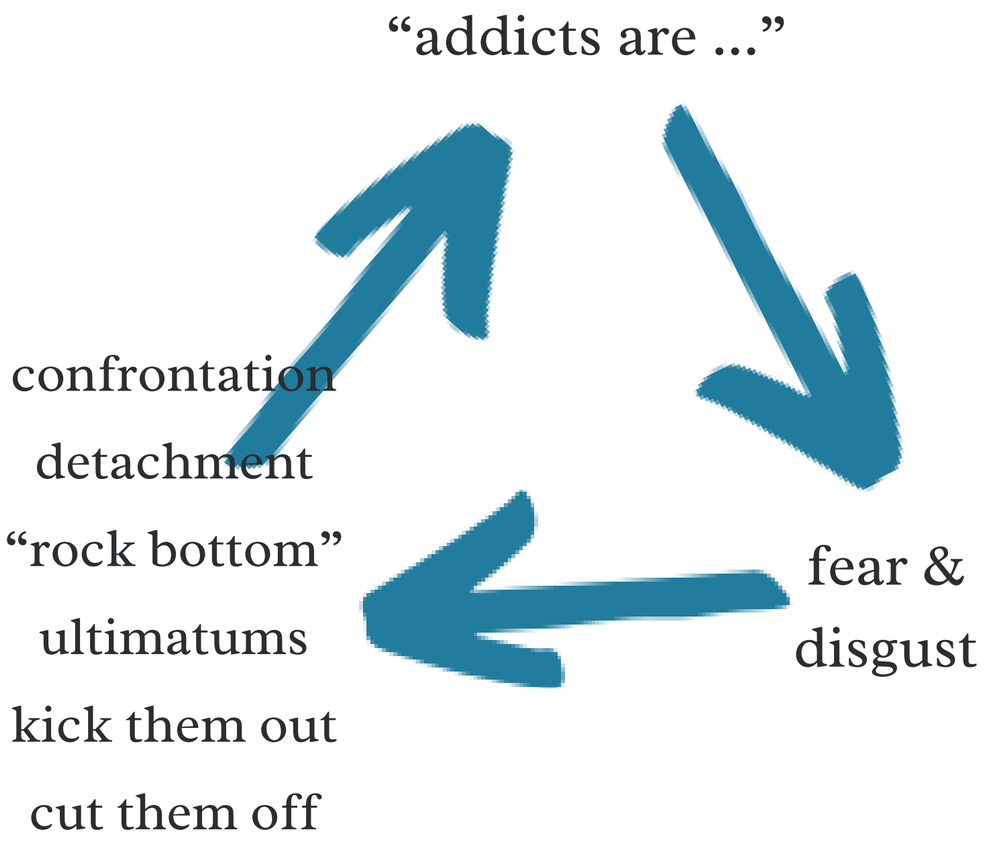

STIGMA IS THE WAY WE COMMUNICATE SOCIAL DISAPPROVAL.

We hold negative beliefs (stereotypes) and attitudes (fear, disgust) towards stigmatized people. Which leads to exclusion and sanctioned discrimination.

Stigma extends to the family and shapes the standard advice given to families of people with SUDs.

I've become less willing to talk about it, as in the beginning when I reached out, people demanded I leave him, demanded this and that. I've been told I'm an idiot…there's a fear of judgment and a lot of shame, even though it's not my fault.
(Participant, female partner)

When I try and get [professional] support, there seems to be an attitude or belief that there is no hope for the person with the addiction, that they are evil or narcissistic and will never change, that I'm co-dependent and a big part of their problem.. . .that's not helpful to me.
(Participant, female partner)

[Clinicians] were telling me, 'You're doing the wrong thing, you shouldn't be paying accommodation', that sort of thing. I mean, during that tough time, you don't need to be told you're doing the wrong thing.
(Participant, father)

(2018) "Stigma experience of families supporting an adult member with substance misuse"

STIGMA

"Studies have shown that secrecy prevents family members from seeking and receiving both informal and formal support and increases the burden of helping their loved one with a mental health issue. In fact, stigma contributes to delays in seeking help more than structural barriers such as lack of funds."

(2019) "Bad Parents," "Codependents," and Other Stigmatizing Myths About Substance Use Disorder in the Family

"People with alcohol use disorder (AUD) who perceive a high degree of public stigma toward those with their condition were about half as likely to seek help as those perceiving a low degree of stigma"

(2021) Choosing appropriate language to reduce the stigma around mental illness and substance use disorders.

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If we are modernizing outdated practices for the patient, let's not leave families behind.

“Encouraging frustrated family members to conceptualize OUD as a chronic remitting/relapsing illness was helpful during chaotic trajectories. By coaching TSOs to play the ‘long game’ and ‘pick your battles’, they were able to stay more focused on re-engagement rather than giving in to their exasperation and giving up”

Fishman, M., Wenzel, K., Vo, H., Wildberger, J., & Burgower, R. (2021). A pilot randomized controlled trial of assertive treatment including family involvement and home delivery of medication for young adults with opioid use disorder. Addiction, 116(3), 548-557.

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Assertive treatment including family involvement and home delivery of medication for young adults with opioid use disorder.

1. Home-delivery of XR-NTX
2. Family coaching of three primary sessions focused on OUD education and behavioral skills relevant to family goals.
3. Contingency management: gift cards with cash value were given according to escalating reinforcement schedule of $25-$50.
4. Assertive outreach: this incorporated frequent outreach to patients and families with treatment reminders, progress check-ins, scheduling for medication and other sessions and case-management regarding insurance and other logistics. Group texts were used as a way to promote open communication with patients and TSOs.

Fishman, M., Wenzel, K., Vo, H., Wildberger, J., & Burgower, R. (2021). A pilot randomized controlled trial of assertive treatment including family involvement and home delivery of medication for young adults with opioid use disorder. Addiction, 116(3), 548-557.

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Family involvement in MOUD

Compared to TAU, participants received significantly more doses of XR-NTX, lower rates of opioid relapse at both 12 and 24 weeks and fewer overall days of opioid use.

Participants received a greater number of XR-NTX does (mean 4.28) compared to those in TAU (mean .7). Participants in the YORS group compared to those in TAU had lower rates of relapse at 24 weeks (61 versus 95%, P ‹ 0.01).

For participants, the assertive outreach approach to engagement was frequently able to re-establish care, prevent a lapse from progressing to a full relapse and prevent disaster.

Fishman, M., Wenzel, K., Vo, H., Wildberger, J., & Burgower, R. (2021). A pilot randomized controlled trial of assertive treatment including family involvement and home delivery of medication for young adults with opioid use disorder. Addiction, 116(3), 548-557.

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Relationship Oriented Behavioral Services for youth with OUD

Despite their exceptional research portfolio, relationship-oriented models for substance use problems have not been widely adopted in mainstream practice.

We now describe three relationship-oriented interventions, operating under a coherent developmentally informed theory of OUD, designed to address barriers to MOUD uptake, enhance MOUD adherence planning, and strengthen OUD recovery among youth.

Relational Orientation, Medication Education and Decision-making Support (MEDS), and Family Leadership and Ownership of Adherence to Treatment (FLOAT).

The Relational Orientation intervention is used to introduce and secure the value of involving CSO in MOUD service delivery, while simultaneously accounting for autonomy-seeking and independence status as overarching developmental themes for transitional aged youth.

Hogue, A., Bobek, M., Porter, N., MacLean, A., Wenzel, K., Fishman, M., ... & Langer, D. A. (2023). Launching relationship-oriented behavioral services for youth opioid use disorder: Innovations in medication decision-making and adherence planning. Child & family behavior therapy, 45(3), 199-225.

Common Elements

- Non-Pathologizing
- Systemic
- Collaborative & Validating
- Behavioral
- Harm Reduction Values

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Common Elements

Non-Pathologizing

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“An abnormal reaction to an abnormal situation is normal behavior.”

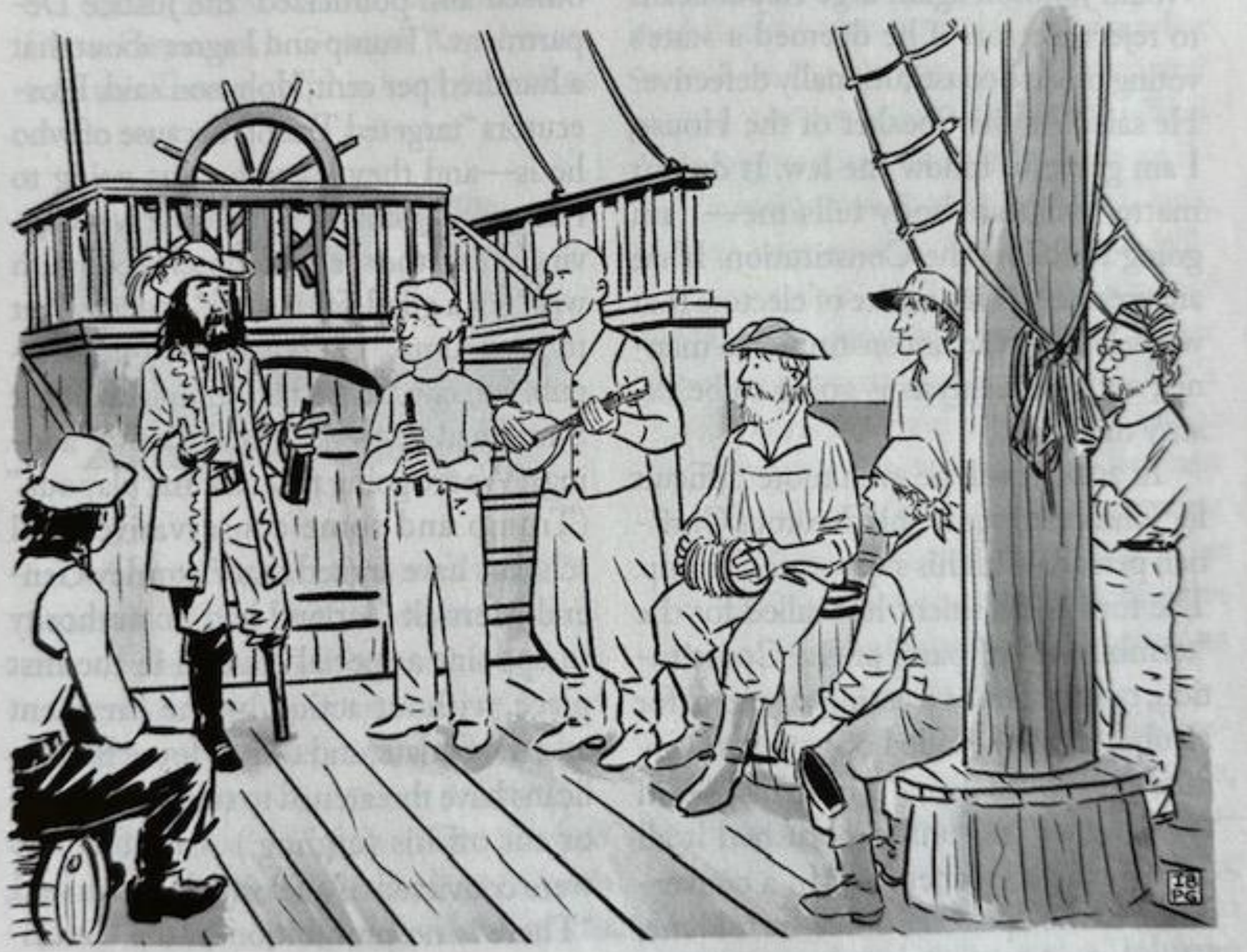
-Viktor Frankl, Austrian psychiatrist and Holocaust survivor

why I don’t talk about “co-dependency”

MORE THAN WATCHING YOUR WORDS

Our behavior must communicate:

- the person with the SUD is a valuable human being, deserving of compassion.
- family connections are valuable and to be respected.



"Tyler makes a good point. Do we have any pillaging and plundering songs that aren't problematic?"

Common Elements

- Systemic
- Collaborative & Validating
- Behavioral

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If one does not see himself as part of a system, his only options are to try to get others to change or to withdraw. If one sees himself as part of a system he has a new option: to stay in contact with others and change self.

-Murray Bowen

- Multidimensional Family Therapy
- Brief Strategic Family Therapy
- Functional Family Therapy
- Multisystemic Therapy
- Community Reinforcement and Family Therapy
- Alcohol Behavioral Couples Therapy

Systemic/Strategic seek to understand the "problem" in the context of the family as a whole, rather than only in the individual.

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Common Elements

Non-Pathologizing

Harm Reduction Values

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Harm Reduction

"Compassionate pragmatism, instead of moralistic idealism"

-Dr. Alan Marlatt

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Common Elements

- Non-Pathologizing
- Systemic
- Collaborative & Validating
- Behavioral
- Harm Reduction Values

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COMMUNITY REINFORCEMENT & FAMILY TRAINING

Developed by Dr Robert J Meyers (University of New Mexico) and colleagues and tested by research for almost 30 years.

a counseling approach for the family and friends of people with substance use disorders

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THE SPIRIT OF CRAFT

Respectful
Hopeful
Relational
Non-Judgmental
Non-Confrontational

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Recovery for the addicted person

(treatment engagement and reduced or eliminated substance use)

Well-being for the family members

(regardless of what the addicted person does or doesn’t do).

- CRAFT is a process, not an event
- CRAFT therapist doesn't need to meet the addicted person – the family has their own conversations with their loves one, guided by the skills you will teach them
- The family begins to change their own behavior while seeking to influence their loved one's behavior
- Many paths to recovery are recognized, is not rigid about what treatment the person must do to begin recovery

CRAFT is an alternative to a confrontational "intervention" model

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We can help families improve quality of life and relationships

even when they are experiencing SUDs

"most of the CSO's reflected that participating in CRAFT improved their quality of life and relationship with the IP independently of whether the IP entered treatment or not…It was in switching communication styles and focusing on the positive aspects with the IP that the CSO experiences an enhancement of their relationship with the IP and with life in general."

Hellum, R., Bilberg, R., Bischof, G., & Nielsen, A. S. (2021). How concerned significant others experience Community Reinforcement and Family Training (CRAFT)–a qualitative study. BMC Family Practice, 22(1), 241.

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(2021) How CSO's experience CRAFT

a qualitative study

"They felt they were met without any prejudice or sense of taboo...describing their situation gave them a sense of relief."

"[some CSO's] realized it had become easier to talk about difficulty subjects and problems. Some CSO's mentioned how they found that their IP became more open when the CSO's themselves switched to a more positive communication style."

"Most of the CSO's reflected that participating in CRAFT had improved their quality of life and and relationship with the IP independently of whether he entered treatment or not."

"A better insight into the disorder was associated with improvements in understanding, coping, and stigma reduction for the relatives."

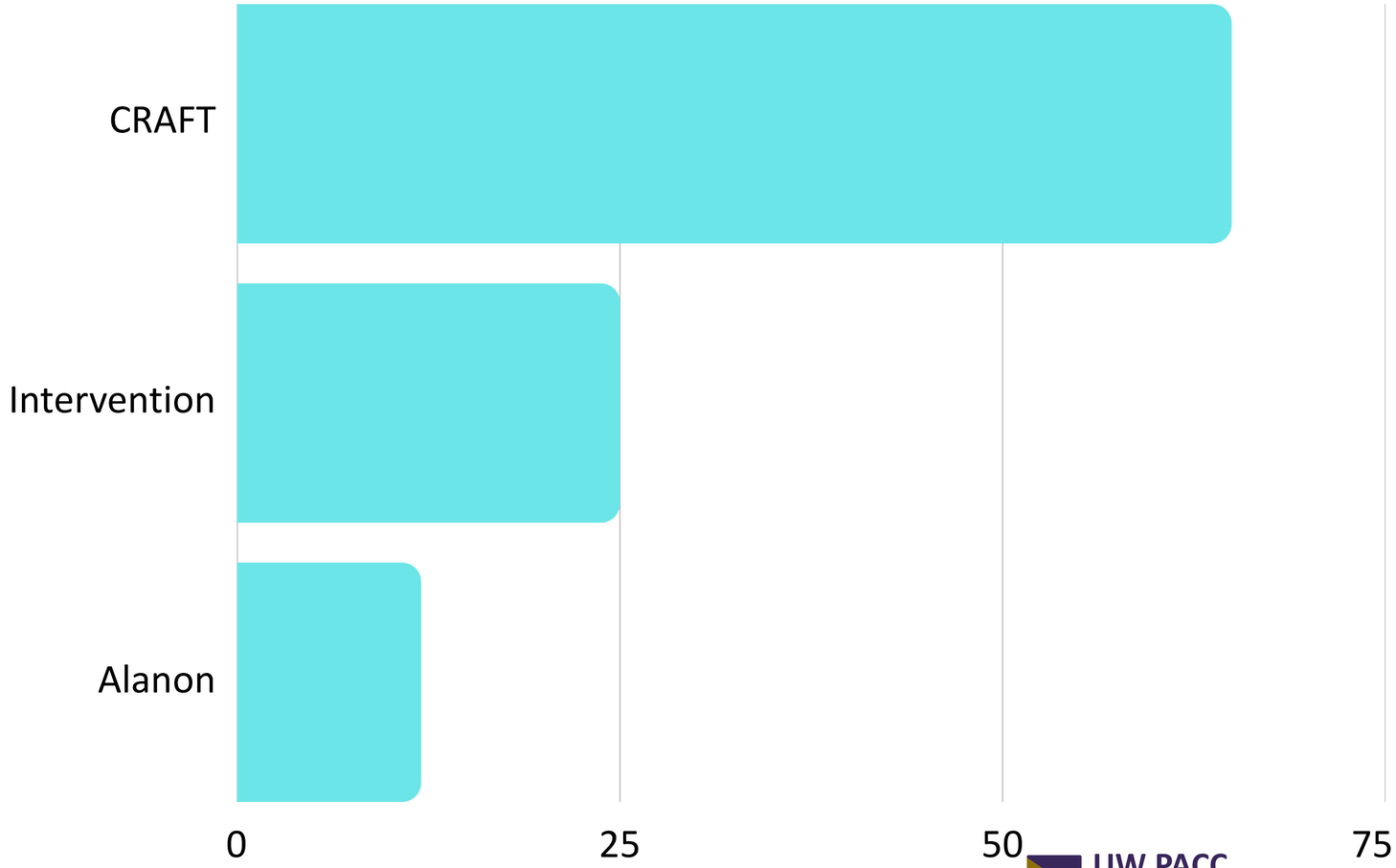
2 OF 3

2 out of 3 participants engaged their loved one into treatment

6

It took an average of 6 sessions to see treatment engagement

ENGAGED DRINKER INTO TREATMENT



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THE PARTICIPANTS BECAME LESS DEPRESSED

CSO's became less depressed, even after counseling was over, and even if their loved one was not sober.

THE EVIDENCE ABOUT CRAFT SAYS:

CRAFT works across a variety of CSO-IP relationships (spouses/partners, parents, siblings, friends)

Mothers are particularly good at CRAFT

CRAFT works for drug use as well as alcohol use and gambling

The CSO can feel better, even if their loved one doesn't enter treatment

CRAFT works in groups, as well as 1:1 counseling

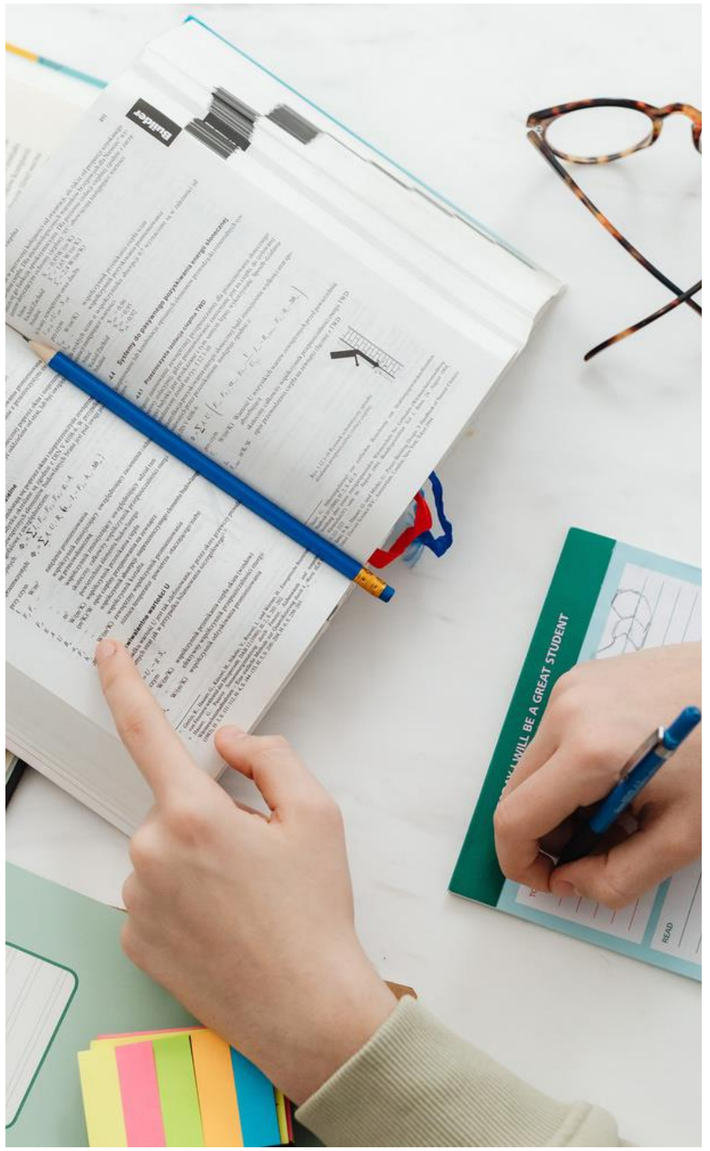

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Table 1 Participant/sample characteristics and IP treatment entry.

Study (treatment)/country	*CSO age (years) range/mean*	*CSO % Female*	*IP age (years) range/mean*	*IP % female*	*IP is CSOs: (relationship)*	*IP addiction*	*n*	*IP % Tx entry since CSO intake*[a]
Sisson & Azrin, 1986 [16]/USA	28–62	100%	Not provided	0%	Spouse/partner 75%; sibling 17%; parent 8%	Alcohol	7	86% average 2 months
Miller *et al.*, 1999 [13]/USA	21–81/47	91%	Not provided	Not provided	Spouse/partner 67%; adult child 30%; parent 5%; adult grandchild 5%	Alcohol	45	64% within 6 months
Kirby *et al.*, 1999 [14]/USA	20–70	94%	31.2/16–41	23%	Spouse/partner 57%; adult child 36%; sibling 7%	Drug	14	64% within 2.5 months
Meyers *et al.*, 2002 (individual) [17]/USA	19–76[b]	88%[b]	Not provided	Not provided	Adult child 53%; Spouse/partner 30%; friend, relative 17%[b]	Drug	29	59 within 6 months
Meyers *et al.*, 2002 (individual plus aftercare) [17]/USA	As above[b]	As	As above	As	As above[b]	As above	30	77% within 6 months
Bischof *et al.*, 2016 (immediate intervention) [27]/Germany	49						42	52% within 12 months
Bischof *et al.*, 2016 (wait list) [27]/ Germany	49						36	47% within 12 months
Kirby *et al.*, 2017 (CRAFT) [21]/USA	51						39	62% within 9 months (average 4.3 months)
Kirby *et al.*, 2017 (TeNT) [21]/USA	50					drug e	38	63% within 9 months (average 2.8 months)
Manuel *et al.*, 2012 (group) [18]/USA	26–76[a] /51						20	60% within 6 months
Manuel *et al.*, 2012 (workbook) [18]/USA	As above[a]					drug e[b]	20	40% within 6 months
Meyers *et al.*, 1998 [21]/USA	18–73/45						62	74% within 6 months (average 1.5 months)
Waldron *et al.*, 2007 [19]/USA	46						42	71% average 1.5 months
Study (treatment)/country	CSO Age (yrs range/mean					ction	n	IP % Tx entry since CSO intake[a]
Dutcher *et al.*, 2009 [28]/USA	51						99	55% within 6 months
Bisetto *et al.*, 2016 [29]/Spain	52	76%	Not provided	Not provided	Adolescent/young adult child 100%	drug Drug	25	60% within 2.5 months
Makarchuk *et al.*, 2002 [23] Canada	29–78/50	93%	Not provided	13%	Spouse/partner 73%; adult child 20%; parent 7%	Gambling	13	23% within 3 months
Hodgins *et al.*, 2007 (workbook) [20]/ Canada	45[b]	82%[b]	Not provided	31%[b]	Spouse/partner 62%; parent 18%; sibling 7%; adult child 6%; friend 5%; extended family 3%[b]	Gambling	48	14% within 3 months
	As above[b]		As above		As above[a]	As above[b]	51	17% within 3 months

(*Continues*)

‘The more effective CRAFT interventions tended to include several ‘key’ treatment characteristics: individual therapy modality, thorough training and supervision for therapists and integrated addiction treatments for IPs.”

One small step

Encouraging helpful-helping (enable recovery)

Affirming family involvement

Countering stigmatizing and shaming messaging

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Examples of positive family involvement

Think of an example of helpful-helping or positive-enabling you have witnessed from patient families.

Share it in the chat.

For example: my client drove her daughter to her weekly Suboxone appointments and brought her to the pharmacy to fill prescriptions.

For example: my client called a list of therapists to find someone with an opening who took their son's insurance.

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AFFIRM AND ENCOURAGE

When you see helpful-helping or positive-enabling, being affirming can help counter the shaming comments many families receive from their own social networks as well as professionals in our field.

Think back to your example you added to our virtual feed. What could you say to a family member to encourage and affirm their positive involvement?

For example:
“Its so great that you are able to drive your daughter to these appointments. You are removing obstacles and being helpful to her recovery. Keep looking for ways to enable recovery behaviors, if you are willing. If you want to, we can also talk about how to avoid accidently enabling unhealthy behaviors. Your daughter is lucky to have your support.”

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WANT MORE?

Helping Families Help

SMART Recovery®

Life beyond addiction

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