Embracing Any Positive Change: Beyond Traditional Addiction Treatment Models

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A case of uncontrolled diabetes

- You are working with a patient with diabetes. Her blood sugars have all been very elevated. She frequently misses her medical appointments. She continues to eat sweets frequently and has not been interested in meeting with a nutritionist. What should you do?

  A. Accept that she will never have good control of her diabetes but continue to work with her.
  B. Tell her that she clearly is not ready to change and you will no longer work with her as a patient.
  C. Spend time exploring what barriers exist for her and try to learn what her goals are when it comes to her health.
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Patient-centered care

• Relationship-based health care orientation toward the whole person

• Respects each patient’s unique needs, culture, values, and preferences

• Supports patients in learning to manage and organize their own care at the level the patient chooses

Agency for Healthcare Research and Quality
http://pcmh.ahrq.gov/page/defining-pcmh
Harm Reduction

- Reduce negative consequences of use
- Provide menu of services
- Non-judgmental, non-coercive
- Focus on quality of life
- Patients engaged in plan
- Celebrate any positive change
Perceptions of harm reduction
WE TREAT ALL OUR PATIENTS...

WITH RESPECT

WE KNOW OUR PATIENTS WHO USE ALCOHOL, DRUGS, AND CIGARETTES VALUE THEIR HEALTH

OUR GOAL IS TO PROVIDE EVERY PATIENT THE BEST MEDICAL CARE WE CAN

WE'RE HERE TO HELP YOU, NOT JUDGE YOU
A false dichotomy

“Harm reduction is often made an unnecessarily controversial issue as if there was a contradiction between prevention and treatment on one hand and reducing the adverse health and social consequences of drug use on the other. This is a false dichotomy. They are complementary.”

UNODC, 2007
Dignity & compassion

“Human rights apply to everyone. People who use drugs do not forfeit their human rights, including the right to the highest attainable standard of health.”

Harm Reduction International
http://www.ihra.net/
Why harm reduction?

- Congruent with general principles of medicine
  - Non-maleficence
  - Patient autonomy
- Addiction is a relapsing disease
- Pathway to recovery can be circuitous
Any positive change

• “If our goal is to promote health and reclaim lives, then we must understand the sometimes circuitous paths through which individuals achieve and sustain such health. We must meet each individual with fresh eyes in every encounter with a belief that each encounter is an opportunity for movement, no matter how small, towards health and wholeness.”

Evidence-based

- Syringe exchange programs (SEP) associated with reductions HIV, HBV, HCV
- SEPs do not increase rates of drug use
- Safer injecting facilities reduce HIV & overdose deaths
- Naloxone distribution is cost effective and saves lives
- Low threshold treatment programs have good retention

Low threshold treatment models

• Flexible, focused on engagement

• Reach marginalized populations with chaotic lives
  – Patients with high risk of blood-borne disease transmission and overdose, lower socioeconomic level, h/o incarceration, and high prevalence of co-occurring psych illness

• Cumulative treatment duration has positive health outcomes, even for patients who cycle in and out of care
Fig 2 Survival: probability of not dying before long term cessation by exposure to opiate substitution to treatment.

Kimber J et al. BMJ 2010;341:bmj.c3172
Risk of death 10x ↑ on waiting list

Poor outcomes without maintenance

Treatment group:
- Highly significant ASI reduction
- 75% negative tox screens
- 75% retained in treatment
  - No deaths

Control group:
- 0% retained in treatment
  - 20% died (N=4)
Interim MMT improves outcomes

Schwartz et al. Arch Gen Psychiatry. 2006;63:102-109

Table 2. Primary Outcomes at Baseline and at 4 Months or Time of Entry Into Comprehensive Methadone Hydrochloride Treatment*  

<table>
<thead>
<tr>
<th>Variable</th>
<th>Interim Group</th>
<th>Control Group</th>
<th>F_{0.05} Value</th>
<th>P Value</th>
<th>R^2 Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time of heroin use in the past 30 d, d</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>29.5 (2.2)</td>
<td>29.8 (1.0)</td>
<td>421.2</td>
<td>&lt;.001</td>
<td>0.60</td>
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<tr>
<td>4 mo</td>
<td>4.2 (8.6)</td>
<td>26.4 (8.8)</td>
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<tr>
<td>Time of cocaine use in the past 30 d, d</td>
<td></td>
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<td></td>
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<tr>
<td>Baseline</td>
<td>7.2 (10.6)</td>
<td>6.1 (9.7)</td>
<td>12.3</td>
<td>&lt;.001</td>
<td>0.04</td>
</tr>
<tr>
<td>4 mo</td>
<td>2.4 (5.5)</td>
<td>5.8 (8.8)</td>
<td></td>
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<tr>
<td>Time of alcohol intoxication in the past 30 d, d</td>
<td></td>
<td></td>
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<tr>
<td>Baseline</td>
<td>7.5 (11.4)</td>
<td>7.2 (10.9)</td>
<td>11.5</td>
<td>&lt;.001</td>
<td>0.04</td>
</tr>
<tr>
<td>4 mo</td>
<td>4.0 (8.3)</td>
<td>8.5 (11.9)</td>
<td></td>
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<tr>
<td>Money spent on drugs in the past 30 d, $</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Baseline</td>
<td>883 (818)</td>
<td>813 (814)</td>
<td>20.1</td>
<td>&lt;.001</td>
<td>0.07</td>
</tr>
<tr>
<td>4 mo</td>
<td>76 (206)</td>
<td>560 (981)</td>
<td></td>
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<tr>
<td>Illegal income in the past 30 d, $</td>
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<tr>
<td>Baseline</td>
<td>459 (1046)</td>
<td>485 (1022)</td>
<td>5.5</td>
<td>&lt;.02</td>
<td>0.02</td>
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<tr>
<td>4 mo</td>
<td>36 (160)</td>
<td>412 (1391)</td>
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<tr>
<td>Opiate-positive drug test result†</td>
<td></td>
<td></td>
<td></td>
<td>.28</td>
<td></td>
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<tr>
<td>Baseline†</td>
<td>192 (99.5)</td>
<td>111 (98.2)</td>
<td></td>
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<tr>
<td>4 mo§</td>
<td>99 (56.6)</td>
<td>80 (79.2)</td>
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<tr>
<td>Cocaine-positive drug test result†</td>
<td></td>
<td></td>
<td></td>
<td>.87</td>
<td></td>
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<tr>
<td>Baseline†</td>
<td>122 (62.9)</td>
<td>70 (61.9)</td>
<td></td>
<td>.85</td>
<td></td>
</tr>
<tr>
<td>4 mo‖</td>
<td>107 (61.5)</td>
<td>62 (62.6)</td>
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Low threshold treatment models

Relais Methadone

• Structure:
  – Methadone dispensed at specified pharmacies
  – Hours and location flexible
  – Clients can refuse services including psychosocial support
  – Protective measures (syringes, condoms) available

• Clients:
  – 60% use cocaine in addition to opioids
  – >90% previously been to treatment; 40% 3+ programs
  – 6 months prior to treatment, 50% homeless and one-third incarcerated

Low threshold treatment models

Harm Reduction Coalition Pilot:

• Structure:
  – Initial visit at syringe exchange or at the HRC
  – Patients told they would not be penalized for continued drug use
  – No toxicology done initially or at follow-up; focus on engagement
  – Home induction w phone contact at 24-48 hours, visit in 1 week
  – Initial prescription #14 Suboxone (8mg/2mg)
  – Subsequent visits q1-2 weeks during stabilization, then monthly
  – Referrals for counseling made for all, attendance not required
  – If missed appt, patient called to reschedule

• Clients:
  – Syringe exchange clients
  – Out of care patients welcomed back to start a new induction

Outcomes

- Low threshold methadone
  - 88% retention at 30 days, 64% at 1 year
  - Significant reduction in heroin & cocaine
  - Increased stable living conditions

- Buprenorphine harm reduction pilot
  - Patients retention similar to “standard” bup
  - 68%, 63%, 56%, 42% retained at 3, 6, 9, 12 mo

Cocaine users had:

• Reduced self-reported opioid use from 94% to 27%
• 6-month treatment retention of 59%
• No significant difference from non-users
Engagement & Hope

• “Hope and growing aspirations for a better life can be a catalyst to recovery as much as a desire to escape addiction-related pain. Our intent is to affirm the recovery option in every encounter and to provide the support that makes this movement toward health possible—either as a sudden dramatic leap or a process involving incremental steps over time.”

Making a Difference: Effective Intervention with Substance Using Patients
Is there any real hope of change?

With such a high rate of relapse, how can we claim that “Treatment works!”?

Does anyone ever really “recover”? 
Diagnosis

• Old concepts:
  – Substance abuse
  – Substance dependence
  – False dichotomy

• Recognition of chronic disease
  – Severity continuum – mild, moderate, severe
  – Symptom based – severity measured by number of symptoms present
  – Mild (2-3), Moderate (4-5), Severe (6+)
Recovery Happens!

• Overall drug and alcohol treatment is generally effective
  – Recovery rates between 60-70% over the lifespan

• Relapse part of the process –
  – Average for adults is 5-7 relapses before stable sobriety achieved.

• Recovery oriented systems of care more effective than acute, episodic treatment
Recovery from Substance Use and Mental Health Disorders is defined as

“A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential”

(Substance Abuse & Mental Health Services Administration, 2011)
Guiding Principles of Recovery
(SAMHSA, 2011)

• Recovery:
  – Emerges because the patients have hope
  – Is person driven, supported by social networks of peers and allies
  – Is highly variable, driven by an individual’s needs and preferences
  – Is holistic
Guiding Principles of Recovery
(SAMHSA, 2011)

• Recovery is:
  – Grounded in respect for self and other
  – Culturally-based and influenced, rooted in
    • Individual strengths
    • Family ties
    • Community responsibilities
  – Supported by addressing trauma, mental health disorders
Optimizing Recovery through Effective Treatment

Addiction is a complex but treatable condition that affects brain function and behavior.

No single treatment is appropriate for everyone
➤ Comprehensive assessment is necessary
➤ Range of treatment options to address variety of needs
➤ Effectiveness must be monitored and treatment plans modified as needed
➤ Treatment does not need to be voluntary to be effective
    ➤ Sanctions and contingencies often helpful
    ➤ Family, legal, employer
Optimizing Recovery through Effective Treatment

Treatment should be readily available on demand
  ➢ Strike while the iron is hot

Effective treatment attends to multiple needs of the individual
  ➢ Associated medical, social, vocational, legal issues
  ➢ Co-occurring disorders frequent, particularly mood disorders, anxiety disorders, cognitive issues
  ➢ Integrated treatment needed, combining evidence based therapies
Optimizing Recovery through Effective Treatment

Evidence based behavioral therapies:

- Improving problem solving and communication skills, relapse prevention and intervention skills
- Increase in pro-social behaviors, including work, recreation
- Improved social support and interpersonal interactions

Mutual Aid groups also very effective
- AA, NA, Smart Recovery
Optimizing Recovery through Effective Treatment

Effective medication treatment important element
- Particularly in combination with evidence based therapy

Detoxification is limited to medical stabilization
- Step 1
  - Manage the acute symptoms of withdrawal
  - Rarely sufficient for long term recovery
- Integrated treatment systems helpful in providing various levels of care seamlessly
Recovery Oriented Systems of Care
(White and Kelly, 2011; SAMHSA, 2011)

Guiding Principles...

- Rooted in hope and respect
- Person centered, patient determined; vast number of different roads to recovery
- Long term focus rather than acute care treatment models
- Sustained, assertive monitoring and support
- Recovery must be conceptualized over much longer time frames – years to decades
Recovery Oriented Systems of Care
(White and Kelly, 2011; SAMHSA, 2011)

Guiding Principles...

- Chronic health model and holistic approaches
- Mental health and trauma concerns must be addressed
- Recovery is culturally sensitive, linked to “indigenous recovery supports in the community”
- Recovery is a long term process rooted in
  - individual and family strengths
  - community linkages and responsibilities
So Where to Begin?

Enhance motivation to change

(Motivational Interventions have demonstrated efficacy in medical settings for both SUD only and SUD +MH patients)
Stages of Change
(Prochaska and DiClemente)

- Precontemplation
  - “I don’t have a problem…"

- Contemplation
  - “Maybe, but I’m not doing anything about it”
  - “I need to do something..what?”

- Preparation
  - “Give me a meeting list, I’ll make the call”

- Action
  - “I got my 6 month chip!”

- Maintenance
When working with motivation:

• Direct persuasion is not very useful

• Motivation is generated by the patient, not by others

• Ambivalence and uncertainty are expected

• Patient values and autonomy respected

• “Change talk” recognized & responded to
• The Spirit of Motivational Interviewing vs. Its Mirror Image

  – COLLABORATION VS. CONFRONTATION
  – EVOCATION VS. EDUCATING
  – AUTONOMY VS. AUTHORITY
Some Final Thoughts…

• Remember…

  When it comes to substance use disorders…
  - You didn’t cause it
  - You can’t control it
  - You can’t change it alone
  - Even small changes in the right direction can accrue to significant improvement