Medically Assisted Treatment The Counseling Side

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Dominion Diagnostics

Objectives

1. Establish the need for counseling in a Medically Assisted Treatment approach.
2. Discuss the process of a counselor coming to believe in medication.
3. Identify the many tools that counselors have in their "Recovery Tool Box".
4. Present Lessons learned during the intake and assessment process.
5. Present lessons learned and some practical skills to use during the treatment process.

What is Medically Assisted Treatment?

A) A partnership between medical staff and clinical staff to provide multi disciplinary treatment approaches that assist the patient in reaching their personal goals for recovery.

B) When the same old counseling has not been working, medications are needed to save the day.

C) Empirically Evidenced Based practices have been exhausted, so now we can try medications.

D) Now that the patient has a prescription for 30 days, counseling might be a good idea as well.

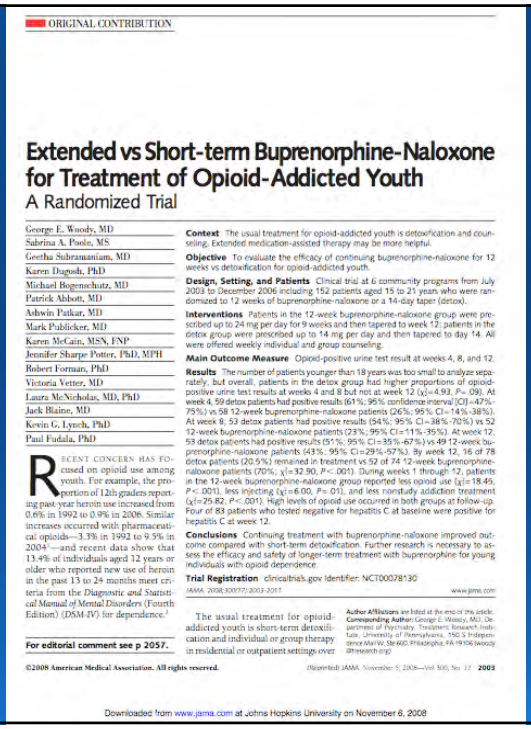
MEDICATION assisted treatment

- The past decade has given us medications that have been groundbreaking in helping us to fight opioid use disorders.
- The past decade has also been overshadowed by the introduction and use of Relapse Prevention Medications.
- The counseling part of the MAT partnership needs attention to keep up with the advances being made by medications.

Coming to Believe in Medications

- (1990's) Using standard group, 1:1 counseling and psychoeducational groups along with 12-Step involvement.
- (2000) Candid discussions with Drs. about the use of Methadone and Buprenorphine for opioid use disorders.
- (2002) Invited to clinically coordinate a National Clinical Trial using Buprenorphine with adolescents and young adults.
- Completing the 2 year study and realizing the benefits of buprenorphine alongside of treatment.
- Assisting in the implementation and facilitation of an Opioid Specific Treatment Program from inpatient to outpatient.

Journal of the American Medical Association, 2008



ORIGINAL CONTRIBUTION

Extended vs Short-term Buprenorphine-Naloxone for Treatment of Opioid-Addicted Youth

A Randomized Trial

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Context The usual treatment for opioid-addicted youth is detoxification and counseling. Extended medication-assisted therapy may be more helpful.

Objective To evaluate the efficacy of continuing buprenorphine-naloxone for 12 weeks vs detoxification for opioid-addicted youth.

Design, Setting, and Patients Clinical trial at 6 community programs from July 2003 to December 2006 including 152 patients aged 15 to 21 years who were randomized to 12 weeks of buprenorphine-naloxone or a 14-day taper (detox).

Interventions Patients in the 12-week buprenorphine-naloxone group were prescribed up to 24 mg per day for 9 weeks and then tapered to week 12; patients in the detox group were prescribed up to 14 mg per day and then tapered to day 14. All were offered weekly individual and group counseling.

Main Outcome Measure Opioid-positive urine test result at weeks 4, 8, and 12.

Results The number of patients younger than 18 years was too small to analyze separately, but overall, patients in the detox group had higher proportions of opioid-positive urine test results at weeks 4 and 8 but not at week 12 (χ^2=4.93, P=.09). At week 4, 59 detox patients had positive results (61%; 95% confidence interval [CI]=47%-75%) vs 58 12-week buprenorphine-naloxone patients (26%; 95% CI=14%-38%). At week 8, 53 detox patients had positive results (54%; 95% CI=38%-70%) vs 52 12-week buprenorphine-naloxone patients (23%; 95% CI=11%-35%). At week 12, 53 detox patients had positive results (51%; 95% CI=35%-67%) vs 49 12-week buprenorphine-naloxone patients (43%; 95% CI=29%-57%). By week 12, 16 of 78 detox patients (20.5%) remained in treatment vs 52 of 74 12-week buprenorphine-naloxone patients (70%; χ^2=32.90, P<.001). During weeks 1 through 12, patients in the 12-week buprenorphine-naloxone group reported less opioid use (χ^2=18.49, P<.001), less injecting (χ^2=6.00, P=.01), and less nonstudy addiction treatment (χ^2=25.82, P<.001). High levels of opioid use occurred in both groups at follow-up. Four of 83 patients who tested negative for hepatitis C at baseline were positive for hepatitis C at week 12.

Conclusions Continuing treatment with buprenorphine-naloxone improved outcome compared with short-term detoxification. Further research is necessary to assess the efficacy and safety of longer-term treatment with buprenorphine for young individuals with opioid dependence.

Trial Registration clinicaltrials.gov Identifier: NCT00078130

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RECENT CONCERN HAS FOCUSED on opioid use among youth. For example, the proportion of 12th graders reporting past-year heroin use increased from 0.6% in 1992 to 0.9% in 2006. Similar increases occurred with pharmaceutical opioids—3.3% in 1992 to 9.5% in 2004[1]—and recent data show that 13.4% of individuals aged 12 years or older who reported new use of heroin in the past 13 to 24 months meet criteria from the *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition) (*DSM-IV*) for dependence.[2]

For editorial comment see p 2057.

The usual treatment for opioid-addicted youth is short-term detoxification and individual or group therapy in residential or outpatient settings over

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The Clinical Trial

152 Adolescents and Young Adults (Age 15 to 21) randomly assigned to either;

1. 2 weeks of Buprenorphine detox
2. 12 weeks of Buprenorphine maintenance (extended detox)

Both groups received 1 manualized individual session a week and 1 manualized group session a week, for 12 weeks.

Opioid Specific Treatment Groups

12 Manualized Group Sessions

Understanding Addiction
Process of Recovery
People, Places, Things
Refusal Skills Training
Support Systems
Relationships
Self-Help groups
Managing Feelings
Coping with Shame, Guilt
Relapse Warning Signs
Trigger Management
Maintaining Recovery

Group Drug Counseling for Adolescents and Young Adults in Recovery for Opiate Dependence. (Woody, Mercer, Daley)

Engagement is Key

- 16 of the 78 buprenorphine detox patients were still attending the counseling sessions at week 12. (20.5%)
- 52 of the 74, 12 week buprenorphine maintenance patients were still attending the counseling sessions at week 12. (70%)

What's in Your Tool Box?

- 1:1 Counseling
- Group Counseling
- Psycho Educational Groups
- Relapse Prevention Group
- Family Counseling
- Intervention/confrontation
- 12-step fellowships

Upgraded Tool Box

- Medications to help prevent relapse
- Transtheoretical Stages of Change
- Motivational Interviewing
- Motivational Incentives
- MET/CBT recovery skills building
- DBT
- Experiential Activities
- Technology

Motivational Interviewing Basic Skills

O- Open Ended Questions
A- Affirmations
R- Reflections
S- Summaries

Intake and Assessment

- Engagement is key
- Remember the spirit of Motivational Interviewing
  - Express Empathy
  - Non Judgmental
  - Avoid Argumentation
  - Go Alongside the patient
  - Be nice, its hard to come for help…. again

Intake and Assessment

- "Thank you for choosing to come and see me today." (Dr. David Mee-Lee)
- Confidentiality discussion. Tell me what you know about Confidentiality.
- What's been happening in your life lately to get you to make the decision to come for help today?
- I've been doing Heroin again and I just can't take it anymore, everything is a mess.
- You've relapsed on Heroin and sound pretty disappointed about it, how did the relapse happen?

What are some other open ended questions that could be asked here?

Intake and Assessment

- Allow them to tell the story of their drug use, encourage them with open ended questions, reflections and affirmations.
- Statements like: "Tell me more, what else, and what would a day of your drug use look like? Paint me a picture.
- "It sounds like you want to stop using Heroin and get clean again, how can I help?"

What kinds of statements have you heard at this point?

Intake and Assessment

- Stages of Change: Pre-Contemplation, Contemplation, Preparation, Action.

Contemplation: The mission is to resolve ambivalence, but first lets get them to agree to continue in treatment.

Gather assessment information with an MI style and skills.

What is their plan?

What are they willing to do?

Will they negotiate ?

Is their a loved one involved who can help or is creating pressure?

How high are they?

Dangerously intoxicated: Can't stand up, falling out of chair, suddenly unresponsive. Call 911 and ready your local Naloxone emergency overdose kit.

High: Nodding out but coming up again, eyes pinned, scratching, slurred speech, disorientation about them. "Dope fiend Lean."

Well: Drooping eyes, maybe a few nods, scratching, eyes pinned, pretty lucid, mannerism and personality shifts can be noticed over time.

Withdrawal: Irritable, sweaty, fidgety, anxious, rubbing muscles, dehydrated, suddenly leaving for the bathroom. (You will know)

Did they bring drugs with them?

- Program rules about bringing drugs to treatment.
- How do they get rid of them safely, if they are honest enough to give them to you at inpatient admission?
- Getting high that last time before going to inpatient… in the bathroom.
- Search the bathroom after use, use caution in trashcans, beware of uncapped needles.
- Withdrawal time line for Suboxone initiation has changed if they used again.

Suboxone Detox Protocol

A patient must be in withdrawal to begin Suboxone detox

Day 1: 4mg am, 2 hours later 4mg, (prn dose)

Day 2: 8mg, 2 hours later 4 mg, (prn dose)

Day 3: 12 mg

Day 4: 12 mg

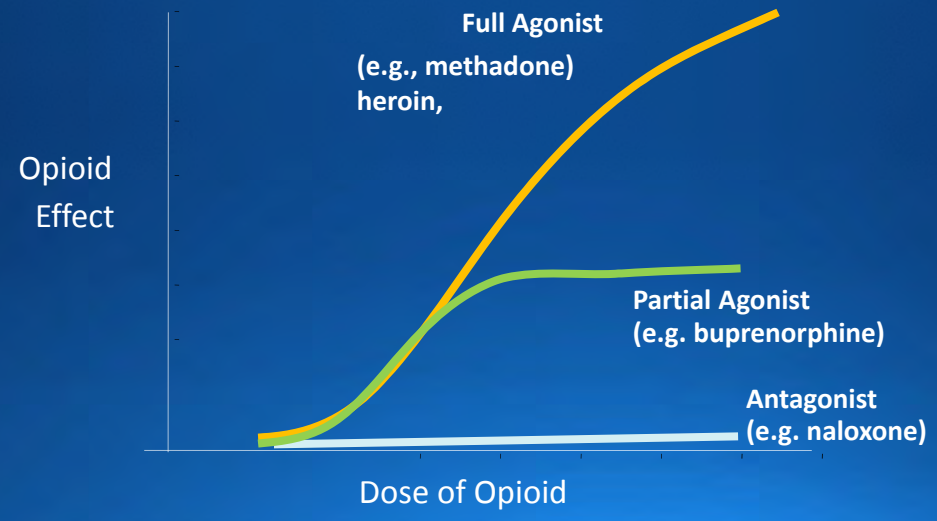
Day 5: 8 mg

Day 6: 4 mg

Day 7: 2 mg

Clonidine .1, Vistaril 50mg, Bentyl 10mg, Aleve

Partial vs. Full Opioid Agonist and Antagonist



Ordering Off The Menu

No Medication
Buprenorphine Detox (Suboxone)
Buprenorphine Maintenance (Suboxone)
Methadone Maintenance
Naltrexone Oral
Naltrexone XR (Vivitrol)
I would just rather get high thank you

Naltrexone Extended Release

- 7 day detox from opiates
- 7 day wash out period
- 4 day Oral Naltrexone challenge
  - Day 1: Naltrexone 6mg
  - Day 2: Naltrexone 12 mg
  - Day 3: Naltrexone 25 mg
  - Day 4: Naltrexone 50 mg
- Vivitrol injection, blocks receptor site for 3 to 4 weeks.
- Repeat injection every 3 to 4 weeks.

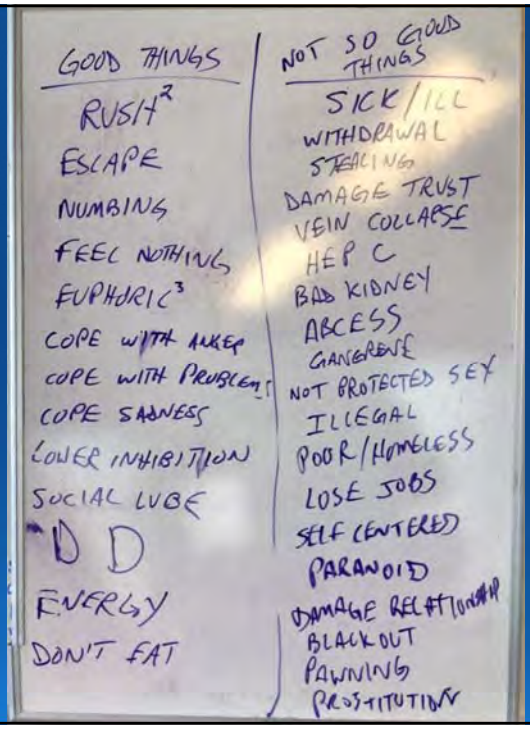
Specialty Opioid Treatment

- Inpatient detox, intervention, medication induction, opioid group, discharge planning and orientation to outpatient.
- PHP 5 days weekly stabilization in OP.
- Opioid treatment groups X4 weekly.
- Individual counseling sessions MET/CBT.
- Medication management weekly.
- Weekly urine drug testing.
- Weekly Opioid treatment specific rounds.

Resolving Ambivalence
Pro's and Con's

Some of the good things	Some of the not so good things

Opiate Pros and Cons for Group or 1:1



Readiness Ruler

1 ——— 10

1 means you are not ready at all, 10 means you are completely ready.

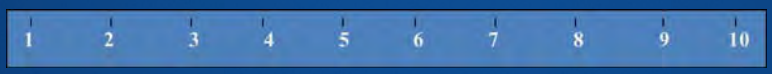
How ready are you to make changes with your heroin use?
I would say a 5.
Reflect – you say you are a 5, it sounds like you are right in the middle.
Open ended - Tell me what makes you a 5.
Part of me wants to stop and part of me doesn't
So it sounds like you are right in the middle and not really sure what you want to do.
What would need to happen in your life to get you from a 5 to a 6 or 7?

Importance Ruler

- "On a scale of 1-10 with 10 being the most important and 1 being the least, how important is it for you to make some changes?"
- If the client chooses a 4, a follow-up question may be- "You chose a 4, tell me why you chose a 4 and not a 3 or a 2?" Asking the question in this way encourages "change" rather than "sustain" talk.
- "I guess it's a 4 because my girlfriend tells me she will move out if I don't stop pawning her stuff." Of course it would be easier to use if she did.
- What would need to happen to make the importance of this change a 5 or a 6?

"Maybe if I lost my job for being high at work."

Confidence Ruler



- "On a scale of 1-10 with 10 being the most confident and 1 being the least, how confident are you that you can make changes with your heroin use?"
- You chose a 6, what makes it a 6?
- "Well, I have had some clean time before, but I keep relapsing and I'm afraid I will just relapse again."
- What would need to happen to make that 6 a 7 or an 8 in confidence?
- "If I had a better discharge plan this time. Last time I went home instead of to a recovery house. Do you still have those Vivitrol shots? Maybe I should do that this time"

Goals for Change

- What would you like to do about your opioid use?
- They may want to come inpatient
- They may want just outpatient
- They may want to use socially
- They may want to stop opioids and just smoke weed and drink
- They may want Suboxone only
- They may want Vivitrol
- They may want Suboxone and Xanax
- They may want no medications
- They may want to come back tomorrow for change

Supports (friend or foe)

What are the available Supports?

- Homeless
- Supports that use
- Supports that are easily manipulated
- Supports that have been a part of the admission process and seem invested in the treatment process.
- 12- step supports like a sponsor
- OP Counselor, coach, clergy

Support Systems

Do the supports know the patients drug history?

- Involve patient in a discussion about helping them get honest with supports so that they can be best prepared to offer support.

Emergency relapse prevention plan that includes a conversation about involving supports in case of relapse or AMA from treatment.

- "I would like permission to contact some supports that you identify at times when you may need extra support in treatment. Let's list some times that you think you will need additional support."

Communication with Doctors and Nurses

- They are very busy and often times do not have the time to communicate at the level that we would like.
- Clinicians need to be aware of medication changes.
- Doctors need to be made aware of relapses.
- Doctors need to be made aware of missed sessions.
- Doctors need to be made aware of side effects and benefits.
- Teach your patients how to talk to the Doctors and ask for help. (I'm craving at 12mg, but she thinks I'm drug seeking)
- Communicate urine drug test results.
- Treatment Teams work best for communication.

Preparation and Action

- Continue to use a foundation of MI skills and principles, but now that some type of change has been decided its time for skills building.
- Addicts use drugs for many reasons, but the drugs become coping mechanisms for life stressors.
- We have helped them make the decision to remove the coping mechanisms that they know best.
- If we do not teach them new coping mechanisms they are sure to return to the old ones in times of stress.

Skills Building

- Make use of the tools in your tool box.
- 12-step meetings, help them have discussions about medications.
- CBT and DBT to develop coping for life's stressors.
- Relapse Prevention Skills
- Motivational Incentives to increase the likelihood of recovery oriented behaviors. Clean urine drug tests, attending group, attending NA meetings, participating in groups.
- Experiential Activities to engage in some clean fun in treatment.
- Groups to teach them how to talk about themselves.

CBT Sessions

- Goal Setting
- Craving Management
- Trigger Management
- Refusal Skills
- Communication Skills
- Stress Management
- Problem Solving Skills
- Anger Management
- Health Awareness
- Family Communication
- Educational and Vocational
- Managing Emotions and Feelings
- Mood Regulation

Relapse Happens

- We do not encourage relapse, we work together developing skills to prevent relapse.
- Do not SHAME RELAPSE.
- Make use of Relapse Behavior Chains to determine what happened and use problem solving skills to make a change that will disrupt the relapse process.
- Teach supports to use affirmations for getting honest about a relapse, encourage prompting a discussion about how the relapse occurred and how they can better be of support in the future to help prevent another relapse.
- Open lines of communication are imperative.

Vision of Quality Opioid Treatment

- Early engagement session with patient and family day 1.
- AMA contingency plan, emergency aftercare plan.
- Medication early education for patient and family.
- Inpatient Opioid Group attendance.
- Hand off session with Outpatient counselor and or therapist.
- Communication of discharge plan.
- Follow up.

Vision of Quality Opioid Treatment

- Participation in hand off session prior to discharge from inpatient.
- Scheduled sessions for the first week.
  - Individual, Group, Family and Doctor.
- Ongoing weekly individual sessions.
- Opioid Treatment Group tapering down from 4x weekly.
- Ongoing family sessions.
- Ongoing Doctor medication management, weekly to taper.
- Missed session contingency plan.

FOUR VERY GOOD REASONS

Danielle was 18 when she relapsed the last time on Heroin, turning to prostitution she was found murdered and raped. Discarded on the side of the road.

Michael was 23 when he overdosed on Heroin and stopped breathing, he was at home with his 3 year old son.

Damien was 19 when he overdosed on Heroin and the police found his parked car, his body was found close by propped up by a tree.

Haudi was 21 when he discontinued his medically assisted treatment with Suboxone. 3 months later he overdosed on an opioid analgesic. He was to take over the family business.

Thank you for the work that you do.

Recovery is more than just not using drugs. Lets show them how to really live.