Primary Components of Evidence Based Treatments for Addictions

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The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that it is their responsibility to disclose this information.
Educational Objectives

At the conclusion of this activity participants should be able to:

• Describe what “Evidenced Based Treatment” means
• Describe the relationship between (and the principles of) the components of psychotherapies for addictions:
  ▪ Enhancing motivation to change
  ▪ Realigning priorities
  ▪ Improving skills
  ▪ Incorporating peer and family involvement in treatment
• Understand the value of incorporating multiple modalities of treatment from psychotherapies to medications to family support during treatment, tailored to the needs of the patient/client
What does evidence-based treatment mean?

Evidenced-based treatment for addictions

• Psychotherapies/Behavioral interventions
  ▪ Motivational interviewing
  ▪ Cognitive behavioral therapies
  ▪ Contingency management
  ▪ Family/community/group therapies

• Medication assisted treatment(s)

Integration of evidence-based treatments
A Case: John

[Case does not represent an actual patient, but rather is compilation of features from different patients.]

- John is a 22 year-old unmarried man, referred to the clinic by Drug Court case manager. He has a history of bipolar disorder, opioid use disorder (daily intravenous heroin), occasionally smokes cocaine, lives with parents, several legal run-ins for possession of drugs/intoxications, brought to my clinic by parents along with his drug court case manager. His parents state: John is “Out of control. He won’t go into treatment. He’s killing himself!”
John, continued

- John is a disgruntled appearing young man, sitting with his arms crossed and head-down, slouched in chair, sniffling repeatedly, tapping his leg impatiently while his parents regale me with how John is ruining his life, and driving the family apart, and how hard they’ve tried to get him to treatment (multiple emergency room visits with overdoses, bounced in and out of residential programs, and he’s left against medical advice from inpatient medical and psychiatric units)
John, continued

Questions:

- How would I first approach the evaluation of John
  - Evaluation is going to help me determine what treatments I might recommend: When the diagnosis is correct, the treatments tend to work better

- How might I think about enhancing John’s commitment to treatment?

- What factors would I consider in determining which psychotherapy I might recommend?

- If John needs medications, how might I choose which ones I’ll recommend?
Goals

- Assess acuity/risk (medically unstable, psychiatrically unstable)
  - Inpatient vs. outpatient
- Arrive at informed diagnostic impressions:
  - Medical
  - Psychiatric
  - Substance use
- Establish treatment plan
Evaluation

Assessment
- Intoxication/withdrawal
- Biomedical conditions
- Emotional/behavioral/cognitive conditions
- Readiness to change
- Relapse potential
- Recovery/living environment

Continuum of care
- 0.5 → early intervention
- 1 → outpatient services
- 2 → IOP/PHP
- 3 → Residential
- 4 → Medically managed, inpatient
John, continued

- Evaluation complete:
  - In withdrawal from opioids, little motivation to stop currently
  - No SI/HI, and not acutely psychotic = does not need inpatient medical or psychiatric
  - With encouragement, is willing to meet with me again
  - Diagnoses:
    - Opioid use disorder, severe
    - Bipolar disorder, type 1
    - Cocaine use disorder, moderate
Now What?
What is Evidence-Based Treatment?

1. Best available research evidence
2. Clinical expertise
3. Patient preferences/values
Simple Enough…

Google

Treatment for John…
Simple Enough...
Psychotherapies for Addictions

Enhance motivation to change behavior

Improve skills in managing illness

Re-align Priorities

It takes a village

(For overview reference, see Haller & Nunes 2014)
Enhancing Motivation to Change

I want to change X

I DON’T want to change X

I want to change X
Enhancing Motivation to Change

I want to change X

I DON’T want to change X
Enhancing Motivation to Change

Stages of Change

PRECONTEMPLATION  CONTEMPLATION  PREPARATION  ACTION  MAINTENANCE  RELAPSE

(Prochaska J.O., DiClemente C.C. 1983)
Motivational Interviewing:

“a collaborative conversation style for strengthening a person’s own motivation and commitment to change” (Miller & Rollnick 2013, p. 29)
Enhancing Motivation to Change

**Less likely to change**

- Stop It!!
- I Don’t believe you can change
- I don’t expect that you’ll change

**More likely to Change**

- Client decides to change
- Client and therapist believe client can change
- Client *TALKS* about change
- Empathic counseling style

Derived from (Miller & Rollnick 2002, p. 9)
Graphic is product of this author.
Enhancing Motivation to Change

Strategy
Motivational Interviewing: Evidence Base

- Over 1200 publications to date
- 200 Randomized clinical trials
- Studied across a broad range of change goals
- Tested across short interventions of 1–4 sessions, even with sessions 15 minutes or less

- Meta–analyses:
  - Small to medium effect sizes relative to no intervention, brief advice, or when added to other treatment

- Variability in study effects likely due to clinician skill variations

(Miller & Rollnick 2013, p.401)
John reports that he has “no interest” in stopping heroin. It helps him relax, he feels “I can handle it,” and it helps him deal with being anxious especially in social situations. His parents annoy him.

He also reports that he is “a bit” concerned about HIV and Hep C, and that he’s having trouble getting work done which is delaying his goal of being a mechanic and John is feeling pressure from his PO to start testing clean. He’s aware of overdosing and is “a little” concerned about that—a friend, Jimi, died of overdose last year.
John, Continued
Psychotherapies for Addictions

- Enhance motivation to change behavior
- Improve skills in managing illness
- Re-align Priorities
- It takes a village

(For overview reference, see Haller & Nunes 2014)
Premise: substance use is a learning process (Carroll et al 1991)

- As such, it can be un-learned
Improve Skills in Managing Illness

Cognitive Behavioral Therapy: Goals

- Recognize triggers
- Cope with cravings
- Avoid high-risk situations
Cognitive Behavioral Therapy: Skills taught and rehearsed

- Refusal Skills
- Decisional Delay
- Foster healthy sources of reinforcement
- Talk through Cravings
- Recognize, tolerate, counteract painful feelings
Improve Skills in Managing Illness

Cognitive Behavioral Therapy

- Usually 8 to 12 weeks
- Uses role-play, homework, practice, functional analysis
- “Sleeper effect” (Carroll et al 1994)
John reports that he has “strong cravings” for heroin, and that his use is often triggered by being around his friends, who also use. They typically call one another in the early evening, meet up at Bob’s house and use in the garage before going to bars. He has one friend from middle school, who is not using, who he has lost touch with but with whom he’d like to reconnect. When he feels anxious about meeting girls, his urges increase.
Improve Skills in Managing Illness

- Refusal Skills
  - Foster healthy sources of reinforcement
- Decisional Delay
  - Talk through Cravings
  - Recognize, tolerate, counteract painful feelings
Psychotherapies for Addictions

Enhance motivation to change behavior
Improve skills in managing illness
Re-align Priorities
It takes a village

(For overview reference, see Haller & Nunes 2014)
Realign Priorities

- **Contingency management**: Another learning paradigm
  - Establishes well-defined incentives or sanctions based on a well-defined and assessable target behavior
Realign Priorities

Contingency Management:

**Target Behavior**
- Participation in programming
- Negative drug screen

**Target Behavior = YES**
- Incentives
  - Cash voucher
  - Access to work
  - Draw from lottery pool

**Target Behavior = NO**
- Sanctions
  - Loss of methadone take-homes
  - Sentence isn’t commuted
  - Community service
Realign Priorities

- **Contingency Management**: Keys

  - Target behaviors and incentives/sanctions must be concrete and clear (Kellogg et al 2013)
  
  - Reinforcement must occur in close time-proximity to behavior
  
  - When magnitude of reward increases with continued adherence to target behavior, outcome is better (Higgins et al 2007)
  
  - Relative to other interventions, strong and consistent efficacy (Lussier et al 2006)
  
  - Effects tend to wear off after treatment stopped
Realign Priorities

Contingency Management:

Attempting to provide structure and reinforcement that will help tip the motivational balance towards NOT using substances.
Several months into treatment, John is pulled over for a broken taillight and is ultimately arrested for forgery. His case is re-routed to drug court, and he is offered a treatment program in which, in exchange for negative urine drug screens and group participation, his charges will be decreased and he will have access to vocational training programming. As part of his program, a treatment plan is developed with me for ongoing care.
Psychotherapies for Addictions

- Enhance motivation to change behavior
- Improve skills in managing illness
- Re-align Priorities
- It takes a village

(For overview reference, see Haller & Nunes 2014)
It Takes a Village

- Group therapies
- Family Involvement
- Therapeutic Community
- 12 step programs
Group therapies: (NOT 12 Step)

• Many different kinds of groups
  ▪ Milieu groups
  ▪ Psychoeducation groups
  ▪ Coping skills group
  ▪ Problem-solving groups
  ▪ Family psychoeducation groups

• Various levels of structure

• Peer-led vs. clinician-led

• (Weiss et al 2004): additional group therapy can enhance effectiveness of treatment as usual, no single kind of group showed superiority, group vs. individual treatment showed no differences
Family Involvement:

- Principle: all “family members will need to make changes to effect, support, and sustain positive changes in functioning within the unit as a whole” (Haller & Nunes 2014, p.870)

- Network Therapy (Galanter 1999)
  - Combines different modalities of treatment:
    - CBT for relapse prevention
    - Support of client’s natural social network is employed
    - Orchestration of resources
    - NOT an “INTERVENTION”

- Community reinforcement and family training (CRAFT) (Smith & Meyers 2004)
  - 6 to 8 sessions
  - Teaches family how to use positive and negative reinforcement
    - Positive: pleasant activities, gifts, trips → specifically tied to target behavior of NOT using
    - Negative: ignore patient, withhold reinforcement → specifically tied to target behavior of using

- Provides guidance for how to suggest treatment
Therapeutic Communities:
• Usually 30 to hundreds of clients
• Stay from 9–15 months
• Treatment IS community (peers)
  ▪ Goal = Global change in lifestyle
  ▪ Vocational counseling, work therapy, education/medical/social/family/legal services
• “Community as method” (De Leon 1997)
It Takes a Village

- 12 Step Programs—ubiquitous
  - Alcoholics anonymous
  - Narcotics anonymous
  - Over-eaters anonymous
  - Cocaine anonymous
  - Marijuana anonymous
  - Nicotine anonymous

- Gay, lesbian, women's, men's, young people, certain racial/ethnic groups, etc.

- AA: a “fellowship” not a treatment program, per se
12 Step Programs

- Difficult to study:
  - Heterogeneous, data not collected

- Trends:
  - Those with more severe drinking, those with greater commitment to change, less spousal support, social network supportive of drinking, greater desire to find meaning in life = more likely to affiliate
  - Affiliation = less drinking/substance use

- How to assess if it works
  - “30 million Elvis fans can’t be wrong”
  - RCTs, naturalistic studies
John, Continued

- John consistently indicates that he doesn’t like “that God stuff” in narcotics anonymous. However, after months of encouraging him to go to different meetings (and as part of his legal issues) he finds a young men’s group, sits in the back for a while, then starts making coffee, then finds a sponsor.

- His parents, who initially said “we’re not the problem” and resisted treatment of their own, begin attending support groups, and agree to short course CRAFT with me.
Medication Assisted Treatment

- Approach:

  - Medical conditions
    - Substance use disorders
    - Psychiatric conditions
Medication Assisted Treatment

- Opioid use disorders (FDA Approved)
  - Agonist Treatment
    - Methadone
    - Buprenorphine
  - Antagonist
    - Naltrexone

- Cocaine use disorder (FDA Approved)
  - None

- Overdose prevention (now FDA-approved)
  - Intranasal Narcan rescue kits
When John was arrested, he had not slept in 3 days, had just spent most of his savings and stolen money from his parents, the police described him as talking rapidly and at times not making sense and describing himself as “spiritually enlightened.”
John agreed to try a mood stabilizer for his bipolar disorder, and began to sleep better, his speech returned to normal.

He agreed also to buprenorphine trial, since he felt that he could agree to come to my office for prescriptions, and because he knew that the local methadone clinic was not a place he wanted to go.

Both John and his parents were instructed on the use of narcan rescue and provided with kits.
Combining Treatment Modalities

• Old teaching that still persists: You shouldn’t try to treat someone while they are actively using. We disagree.

• Old teaching that still persists: There is only one path to *true recovery*. We disagree.
Combining Treatment Modalities

- Emerging data:
  - Co-treatment of co-occurring disorders with substance use disorders is most effective (even better if all care is under one roof)
  - Combining treatment modalities for substance use disorders can be more effective than rigid adherence to one modality alone.
Combining Treatment Modalities

Evidence Based Treatment

1. Best available research evidence
2. Clinical expertise
3. Patient preferences/values
Integration: John

- Treatment alliance
  - Goal of each session should be: “Get them to come back for the next session”

- Introduce different strategies/treatment modalities as patient/client needs dictate
  - Continually work to shore-up motivation for change
  - Introduce skills for preventing relapse and remaining abstinent
  - Work to ascertain patient/client goals
  - Introduce reinforcements (positive and negative) to support abstinence
  - Facilitate peer/group involvement

- Support those healthy relationships and behaviors that promote abstinence

- Work with parents/context

- Continually assess for the need and benefit of medications to support abstinence and overall well-being
  - Medical, psychiatric, and for substance use disorders

- Combine treatments
Frequently Asked Questions

- How long should treatment last?
- How do the treatment providers determine when, if ever, a person should be weaned from MAT?
- When should the drug court participant be reassessed for treatment change?
- How is drug testing used in the treatment milieu?
- Post structured treatment – How important are after care programs or a sponsor to continue sobriety?
References


References


About this Project

For More Information:

Website: www.ndcrc.org

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