Treatment of Substance Use Disorders in the Real World

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Objectives

• identify the core components of the most common substance use disorder treatment modalities

• compare substance use disorder treatment options to make realistic and informed recommendations for patients/clients

• describe common addiction-related behaviors that patients/clients display and how to address them
Take home points

1. You are already treating people with substance use disorders
2. You know more than you think you do
Definitions

• Drug = all licit and illicit drugs, alcohol; NOT tobacco
• Patients vs. clients
Figure 49. Past Year Substance Use Disorder among Adults Aged 18 or Older with Any Mental Illness in the Past Year, by Age Group: Percentages, 2008-2014

+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.
Figure 15. Receipt of Specialty Treatment in the Past Year among People Aged 12 or Older Who Needed Substance Use Treatment: 2014

- 2.6 Million Received Treatment at a Specialty Facility for a Substance Use Problem (11.6%)
- 19.9 Million Did Not Receive Treatment at a Specialty Facility (88.4%)

Total: 22.5 Million Needed Substance Use Treatment
Figure 21. Perceived Need for Substance Use Treatment among People Aged 12 or Older Who Needed Substance Use Treatment But Did Not Receive Substance Use Treatment in the Past Year: 2014

- 231,000 Felt They Needed Treatment and Did Make an Effort to Get Treatment (1.2%)
- 567,000 Felt They Needed Treatment and Did Not Make an Effort to Get Treatment (2.9%)
- 19.1 Million Did Not Feel They Needed Treatment (96.0%)

19.9 Million People Needing But Not Receiving Treatment for Substance Use

NSDUH, 2014
History of SUD treatment

- Developed parallel to other psychiatric treatment
- Group-based and paraprofessionals
  - *Standards for training vary widely*
- Evidence-based treatment is not uniformly offered
- Conceptualization and treatment for SUD may not reflect the highest current standards
Treatment modalities

• Adjunctive Care: NOT treatment
• Inpatient treatment
  • Short-term; Long-term
• Psychosocial outpatient & intensive outpatient
• Medication-assisted treatment
  • Buprenorphine; methadone
  • Disulfiram (Antabuse); naltrexone (Vivitrol)
Adjunctive care

• Detoxification
• ~3 days in hospital
• Purpose is to medically manage withdrawal
• *Benzodiazepines and alcohol* most common
Adjunctive care

• 12-step (and other) fellowships: AA, NA, Smart Recovery
• Typically regular meeting times
• Format varies, but no leader and no expectation of specific training for helpers
• Purpose is to offer social support for recovery
• Sponsor, home group
Adjunctive care

- Recovery housing
  - Typically a group home for people with SUD
  - Most are privately managed, but some are affiliated with SUD treatment
- Minimal training or regulations
- Purpose is to offer a drug-free living environment
LUXURY REHAB CENTER IN ORLANDO
# Short-term inpatient treatment

<table>
<thead>
<tr>
<th><strong>Length</strong></th>
<th>7-30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indication</strong></td>
<td>Any SUD</td>
</tr>
</tbody>
</table>
| **Purpose**   | Controlled environment  
                   Establish motivation |
| **Advantages** | Removes triggers and daily stressors |
| **Disadvantages** | Can be expensive  
                           Difficult to accommodate  
                           Doesn’t allow skills practice |
| **Best for** | Beginning of extended treatment |
# Long-term inpatient treatment

<table>
<thead>
<tr>
<th>Length</th>
<th>3-6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indication</td>
<td>Any SUD</td>
</tr>
</tbody>
</table>
| Purpose | Controlled environment  
Establish new habits and skills |
| Advantages | Removes triggers and daily stressors |
| Disadvantages | Very few available  
Expensive  
Difficult to accommodate  
 Doesn’t allow skills practice |
| Best for | Beginning of extended treatment |
## Psychosocial outpatient/Intensive outpatient

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Length</strong></td>
<td>Varies (1-3 months typical)</td>
</tr>
<tr>
<td><strong>Indication</strong></td>
<td>Any SUD</td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td>Learn and practice skills</td>
</tr>
<tr>
<td><strong>Advantages</strong></td>
<td>Allows skills practice</td>
</tr>
<tr>
<td><strong>Disadvantages</strong></td>
<td>High dropout, Quality varies widely, Medication not usually offered, Drug screens not universal</td>
</tr>
<tr>
<td><strong>Best for</strong></td>
<td>Extended treatment</td>
</tr>
</tbody>
</table>
Drug-Induced Deaths Second Only to Motor Vehicle Fatalities, 1999–2007

Motor vehicle fatalities

Suicides

Gunshot deaths

Homicides

# Medication-assisted treatment

<table>
<thead>
<tr>
<th>Length</th>
<th>Long-term ( &gt; 1 year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indication</td>
<td>Opioid use disorder (+- other SUD)</td>
</tr>
<tr>
<td>Purpose</td>
<td>Reduce/eliminate opioid use</td>
</tr>
<tr>
<td>Advantages</td>
<td>Drug screens common</td>
</tr>
<tr>
<td></td>
<td>Highly effective</td>
</tr>
<tr>
<td>Disadvantages</td>
<td>May not address related problems</td>
</tr>
<tr>
<td></td>
<td>Very long term</td>
</tr>
<tr>
<td></td>
<td>Requires more frequent visits</td>
</tr>
<tr>
<td>Best for</td>
<td>Extended treatment</td>
</tr>
</tbody>
</table>
# Medication-assisted treatment

<table>
<thead>
<tr>
<th></th>
<th>Buprenorphine (Suboxone, Zubsolv)</th>
<th>Methadone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Setting</strong></td>
<td>Office or clinic</td>
<td>Clinic</td>
</tr>
<tr>
<td><strong>Visits</strong></td>
<td>Weekly to quarterly</td>
<td>Daily to 2x/mo</td>
</tr>
<tr>
<td><strong>Counseling</strong></td>
<td>Minimal</td>
<td>Varies</td>
</tr>
<tr>
<td><strong>Subjective effect</strong></td>
<td>Less acute effect</td>
<td>More acute effect*</td>
</tr>
<tr>
<td></td>
<td>Less withdrawal</td>
<td>Greater withdrawal</td>
</tr>
<tr>
<td><strong>Overdose potential</strong></td>
<td>Less risk</td>
<td>More risk</td>
</tr>
</tbody>
</table>
Other pharmacotherapy

• Opioids
  • naltrexone (Vivitrol, Revia)

• Alcohol
  • disulfiram (Antabuse): careful monitoring
  • acamprosate (Campral)
  • naltrexone
Evidence-based treatment: Strong

Cognitive behavioral therapy
Relapse Prevention: Marlatt; Witkiewitz
Coping with Craving: Carroll
Contingency Management: Higgins; Stitzer; Petry
Community Reinforcement (CRA/CRAFT): Meyers; Azrin
Behavioral Couples Therapy: O’Farrell
Evidence-based treatment: Moderate

12-step Facilitation Therapy: Baker

Dialectical Behavior Therapy: Linehan
Acceptance and Commitment Therapy: Hayes
Evidence-based treatment components

• Skills training and practice
• Objective and subjective monitoring of symptoms (e.g., drug use)
• Strengthen support for recovery
• Monitor treatment adherence, including medication
Elements of evidence-based treatment
Joseph video #14
Treatment elements not recommended

• Confrontation and punishment
• Focus on “graduation”
• Reliance on self-report alone
• Discharge from treatment for drug use
But...what should I do?
What you can do

• Be aware of your own assumptions
• Conceptualize the problem accurately
• SBIRT
• Encourage harm reduction
• Use CBT principles/skills
• Consider and monitor medication
• Encourage recovery-oriented social support
• Recognize and address problems
Stigma

the *shame* or disgrace attached to something regarded as socially unacceptable

a mark of disgrace associated with a *particular circumstance*, quality, or person

a set of negative and often unfair beliefs that a *society* or group of people have about something

*Remember: WE are members of society!*
Life with addiction
Joseph video #13
Stigma

MORAL FAILING

Drug users are weak, lazy, sinful, immoral
Drug users are inherently flawed or broken
Drug users should be ashamed
Drug users have an addictive personality
Only the “right” treatment is appropriate
### Stigma

**COMPLEX DISORDER**

- Drug users have a psychiatric disorder
- Some people have a chronic disorder
- Drug users may do bad things, but are not bad people
- Treatment should be targeted to the patient and patient needs

**TREATMENT**

- Psychosocial and medical intervention
- Need for repeated/longer treatments and continued monitoring
- Take responsibility for actions, not disorder
- Different or combined treatments may be necessary
Conceptualization

Mood disorder // Substance use disorder
## Conceptualization

<table>
<thead>
<tr>
<th>Mood disorder</th>
<th>Substance use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hiding evidence of self-harm</td>
<td>Lying about/hiding drug use and consequences</td>
</tr>
<tr>
<td>Refusal to participate in treatment/take medications</td>
<td>Refusal to participate in treatment/take medications</td>
</tr>
<tr>
<td>Belief that manic symptoms are helpful and should not be stopped</td>
<td>Belief that drug use is harmless or beneficial</td>
</tr>
</tbody>
</table>
Conceptualization

• As severity increases, treatment intensity increases
• Relapse is possible and more likely as severity increases
• Relapse is not failure of patient or treatment
• More severe and chronic disorders may need very long-term monitoring and treatment
• Medication is a tool to be used – neither the sum total of treatment nor to be discarded without consideration
SBIRT

- Screening: include a screening measure in your assessment—for everyone
- Brief Intervention: review your assessment, commenting on drug use
  - Place drug use in context, like any other behavior
  - Could end here if problem is mild
Referral to treatment

Things to consider:
• Type, frequency, amount of drugs used
• Need for medical withdrawal
• Motivation
• Social support for recovery
• Barriers to participation
• Comorbid problems
Sue, a 43 year old African-American woman, seeks help with anxious and depressive symptoms she relates to her troubled relationship. She and her husband argue several times a week; sometimes the argument gets physical. The arguments center on Sue’s husband’s complaints about finances and her behavior, including her drinking. Sue believes she is a social drinker, because “everyone” drinks like she does. They both drink several days a week, but more on Friday and Saturday nights when they go out with friends. Those nights, Sue has 4-5 mixed drinks. Weeknights, she will have as much as a bottle of wine.
Sue, a 43 year old African-American woman, seeks help with anxious and depressive symptoms she relates to her troubled relationship. She and her husband argue several times a week; sometimes the argument gets physical. The arguments center on Sue’s husband’s complaints about finances and her behavior, including her drinking. Sue believes she is a social drinker, because “everyone” drinks like she does. They both drink several days a week, but more on Friday and Saturday nights when they go out with friends. Those nights, Sue has 4-5 mixed drinks. Weeknights, she will have as much as a bottle of wine.
Referral to treatment: Sue

Things to consider:
• Type, frequency, amount of drugs used
• Need for medical withdrawal
• Motivation
• Social support for recovery
• Barriers to participation
• Comorbid problems
John, a 29 year old Caucasian man, seeks help for depressive symptoms related to losing his job. He had a work-related back injury ~9 months ago and hasn’t been able to work since then. John has increased his daily Oxycontin dose, but he’s running out before the end of the month and the doctor is threatening to discharge him. He spends his days watching TV, smoking pot, and sleeping. John thinks he might be taking too many pills, but he also reports excruciating pain that “no one cares about.” His girlfriend is fed up with his complaining and not helping around the house.
John, a 29 year old Caucasian man, seeks help for depressive symptoms related to losing his job. He had a work-related back injury ~9 months ago and hasn’t been able to work since then. John has increased his daily Oxycontin dose, but he’s running out before the end of the month and the doctor is threatening to discharge him. He spends his days watching TV, smoking pot, and sleeping. John thinks he might be taking too many pills, but he also reports excruciating pain that “no one cares about.” His girlfriend is fed up with his complaining and not helping around the house.
Referral to treatment: John

Things to consider:
• Type, frequency, amount of drugs used
• Need for medical withdrawal
• Motivation
• Social support for recovery
• Barriers to participation
• Comorbid problems
Referral to treatment

Check SAMHSA treatment locator
Look into your local treatment centers
  Ask to visit
  Talk to providers
  Ask about referral requirements/availability
Ask patients about their experiences*
## Availability

<table>
<thead>
<tr>
<th>State</th>
<th>Methadone providers</th>
<th>Buprenorphine providers*</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Virginia</td>
<td>9</td>
<td>250</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>8</td>
<td>123</td>
</tr>
<tr>
<td>Kentucky</td>
<td>12</td>
<td>500</td>
</tr>
</tbody>
</table>

* 2/3 or more of physicians with a buprenorphine waiver do not write any prescriptions
Within your treatment

- Harm reduction
- Reducing use
- Safety measures: Narcan, informing others of use
- CBT principles/skills training
- Motivational approaches (MI/MET)
- Triggers: “people, places, and things”
- Coping strategies
Within your treatment

• Medications
  • Addiction medications
  • Consider SUD when thinking about other medications
• State PDMP
• Social support for recovery
  • Establish contact with family/other treatment providers
• Social skills and practice
The role of supports in recovery
Joseph video #19
But...what if *they*...?
Problem situations

Active drug use interfering with recovery goals
  Denial of drug use
  Acute drug use
  Ongoing drug use

Nonadherence to treatment goals
  Refusal to attend treatment
  Inadequate treatment

Concern about relapse
Active drug use

Acute vs. chronic drug use
Consider alcohol, prescription and illicit drugs
Use non-stigmatizing language
“Drug-affected” instead of “high”

Describe concerning objective behaviors
“Your eyes are closing while I’m talking, and I’m worried you’re not able to fully focus on this meeting.”
“You haven’t attended the medical appointments that you said you would.”
Active drug use

Ask!
“What do you think the problem is?”
“The benzodiazepines you’re taking could be affecting your memory. How many have you taken?”
“Have you taken anything that could be affecting you in that way?”

Join together to solve the problem
“If taking those medications makes you so tired, what do you think you could do differently?”
Active drug use

Don’t engage with severely drug-affected people
Be very directive; focus on safety
Postpone discussion about concerns until they are alert and aware

Potential for overdose if
Not arousable
Acute medical problem: vomiting, seizures
Get immediate help

Acute drug use is similar to acute suicidality!
Nonadherence to treatment

Motivational approach to explore ideas
Encourage SUD treatment if needed
Support SUD treatment goals
  Attendance for counseling, medication
  Self-help groups
Offer to coordinate care
  Special release of information
Concern about relapse

Lapses and relapses are common and *don’t* indicate failure

**Ask!**
- Cravings, triggers, any lapses

**Provide support**
- Engagement/reengagement with treatment

**Shorter is better** – help to shorten relapses!
What you can do

• Be aware of your own assumptions
• Conceptualize the problem accurately
• SBIRT
• Encourage harm reduction
• Use CBT principles/skills
• Consider and monitor medication
• Encourage recovery-oriented social support
• Recognize and address problems
Take home points

1. You are already treating people with substance use disorders
2. You know more than you think you do
Thank you

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