National American Indian & Alaska Native
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Native Center for Behavioral Health

The University of Iowa

SAMHSA
Substance Abuse and Mental Health Services Administration

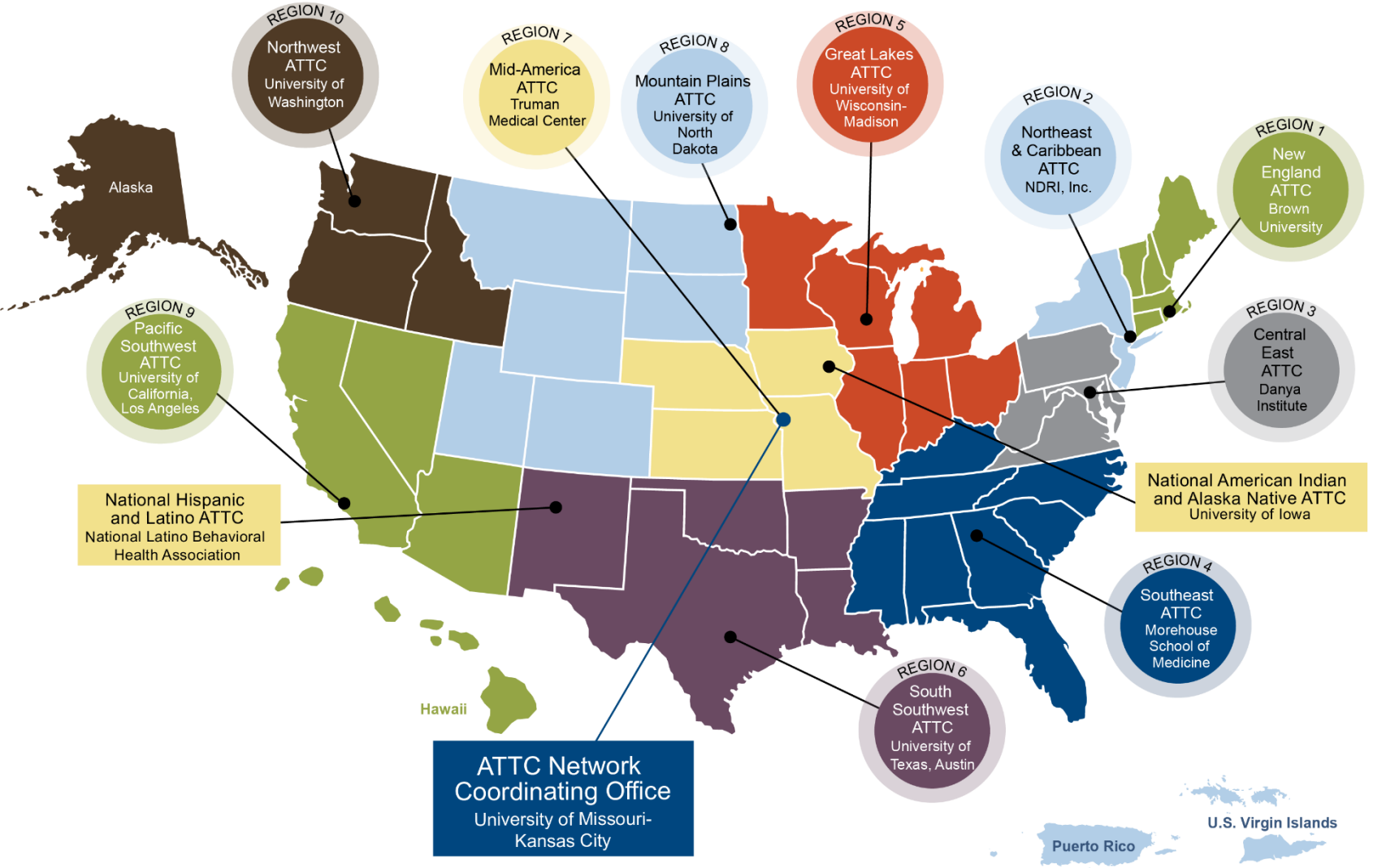
Treatment Knowledge Series

Steve Steine, MA, CADC

ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Essential Substance Abuse Skills webinar series

U.S.-based ATTC Network



This webinar is provided by the National American Indian & Alaska Native ATTC, a program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Webinar follow-up

- CEUs are available upon request. We are currently waiving any fees for CEUs during quarantine.
  - This session has been approved for 1.5 CEU's by:
    - NAADAC: The National American Indian & Alaska Native MHTTC is a NAADAC (The Association for Addiction Professionals) certified educational provider, and this webinar has been pre-approved for 1.5 CEU.
  - Participants are responsible for submitting state specific requests under the guidelines of their individual state.

- Presentation handouts:
  - A handout of this slideshow presentation will also be available by download

Webinar follow-up

Evaluation: SAMHSA's GPRA

This webinar is provided by the National American Indian & Alaska Native MHTTC, a program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA).

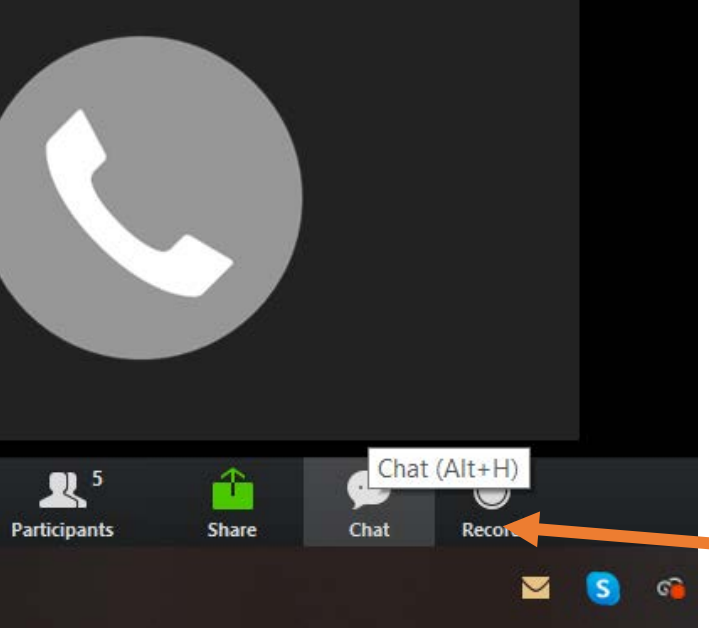
Participation in our evaluation lets SAMHSA know:

- How many people attended our webinar
- How satisfied you are with our webinar
- How useful our webinars are to you

You will find a link to the GPRA survey in the chat box. If you are not able to complete the GPRA directly following the webinar, we will send an email to you with the survey link. Please take a few minutes to give us your feedback on this webinar. You can skip any questions that you do not want to answer, and your participation in this survey is voluntary. Through the use of a coding system, your responses will be kept confidential and it will not be possible to link your responses to you.

We appreciate your response and look forward to hearing from you.

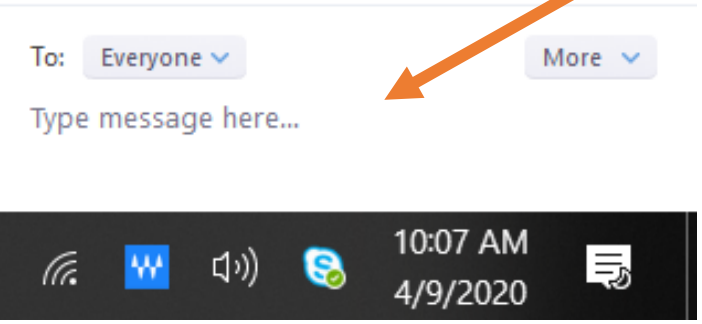
Substance Abuse and Mental Health Services Administration
SAMHSA



Zoom Overview

Participant overview:

- You will need to click on the “Chat” icon to open up the chat on the right side of the screen.
- To ask questions or share comments, please type them into the chat pod and hit “Enter.”



Today’s Speaker

Steven G. Steine, MA, CADC, earned his BA in Communications (1994) and his MA in Substance Abuse Counseling (1997) from the University of Iowa. He has been a certified Alcohol and Drug Counselor with the State of Iowa since 1997. He was born and raised in Iowa and has worked in the Behavioral Health Services and non-profit sector for the past 23 years, providing both direct patient care as a clinician and provided supervision as a clinical manager. He has been in recovery for over 32 years and has committed his life and profession to helping others in the recovery process. “Persons with Substance Use Disorders, can and do recover from the disease of addiction, but recovery goes far beyond simply not drinking or using, it is about healing the spirit...”

Training Objectives

1. Gain a better understanding of Evidence-Based practices, best practices and promising practices
2. Gain a better understanding of the importance of the treatment alliance
3. Become familiar with commonly used evidence-based and best practice approaches
4. Better understand Co-occurring Disorders and integrated care
5. Explore medication-assisted treatment (Naltrexone Buprenorphine, Subutex, etc.)

Evidence-Based & Best Practices

Evidence-Based, Best & Promising Practices

- **Evidence-based practices** are methods or techniques that have documented outcomes, have an ability to replicate key factors, and have been recognized in scientific journals by one or more published articles. Evidence-based practices are often manualized, for instance in SAMHSA's Technical Assistance Publication Series (TAPs).

- A **best practice** is a method or technique that has consistently shown results superior to those achieved by other means. In addition, a "best" practice will evolve as empirical research advances.

- A **promising practice** is generally described as having a body of evidence (either evaluation studies or expert consensus) to support efficacy, is likely to raise to the next level when scientific studies can be conducted, and/or has been endorsed by one or more groups whose opinions matter producing specific desired outcomes.

Characteristics of a Substance Use Disorder

- The American Society of Addiction Medicine (ASAM), 3rd Edition, describes the characteristics of a substance use disorder as:

- “An inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response.”

Our Goals for Treating Substance Use and Co-Occurring Disorders

- To properly assess the patient using multi-dimensional tools
- To provide Integrated, coordinated longitudinal care using evidence-based approaches
- To provide an optimum opportunity for healthy behavior change through the therapeutic alliance
- To improve the patient s overall health and wellness
- To measure outcomes
- To provide informed consent

- Individual, family, and community ROSC (***Recovery-Oriented Systems of Care)***

What Does All This Mean?

- We have a responsibility to improve service delivery and monitor patient outcomes
- The field of addictions treatment is evolving and will require a broader understanding of the term “treatment”
- We have a responsibility to stay informed about evidence-based practices, best practices and promising practices
- Those in leadership positions have a responsibility to prepare and mentor the next generation of SUD treatment professionals

Therapeutic Relationship

The more we involve our patient in the decisions about their treatment process, the more meaning and purpose they will likely associate with their treatment experience…

S.Steine

Therapeutic Relationship

- The Therapeutic Alliance
  - Develop:
    - Rapport
    - Common or shared goals
    - Safety & Trust
  - Ethical Responsibilities
  - Power distribution

Therapeutic Relationship: Function

- Positive reinforcement, encouragement, instill hope, build self-efficacy
- Provide the patient with support and accurate, genuine empathy
- In partnership with the patient , develop goals that are realistic, attainable and adaptable
- Model adaptive interpersonal functioning

Therapeutic Relationship: patient Development

- patient feels heard, understood, accepted, respected, and empowered
- Feels the therapist is concerned
- Feels the therapist is working with him or her
- Feels the therapist is realistically optimistic
- Feels (and recognizes) that positive change is possible and/or occurring

Assessment: ASAM, 3rd Edition

- American Society of Addiction Medicine (ASAM) Criteria:
  - Clinically driven, not program driven
  - Criteria do not involve a prescribed length of stay, but promote a flexible continuum of care
  - Involve an interdisciplinary approach to care
  - Include informed consent
  - Are outcomes driven
  - Clarify medical necessity

Dimensions of ASAM

1. Acute intoxication and withdrawal potential
2. Biomedical conditions and complications
3. Emotional, behavioral or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potential
6. Recovery/Living environment

- *Severity in each dimension can be rated as mild, moderate or severe

Whole-Person/patient -Centered Care

- Establishing the therapeutic alliance begins with the patient ’s initial contact with the helping professional/organization
- Proper treatment requires proper assessment: The American Society of Addiction Medicine (ASAM, 3rd Edition) is a commonly used multi-dimensional assessment tool
- Multi-disciplinary team approach, using community support systems (ROSC)
- Selecting a particular theoretical approach that is most likely to result in the patient ’s improved health

Counseling Theories and Practice

Evidence-Based Practices

- Behavioral Theory (Skinner)
- Cognitive/Behavioral Therapy (CBT) (Beck)
- Contingency Management/Incentivizing
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Rational Emotive Behavior Theory (Ellis)
- Motivational Interviewing (Miller)
- Stages of Change/Transtheoretical Model (DiClemente)
- Medication-Assisted Therapy (MAT)

Behavioral Theory

- Some constructs to consider:

- Behavior is learned, therefore it can be unlearned
- New behaviors can replace old ones
- Focus on the observable: How people act, react, and behave
- Less interested in cognitive/emotional states, believe that behavior represents learned habits

Behavioral Theory: Conditioning

- Classical Conditioning refers to the association between a stimulus and an involuntary or automatic behavior (response)
    - Craving can be a conditioned response triggered by stimuli that the patient may or may not be conscious of (Pavlov)

- Operant Conditioning refers to an association between a voluntary behavior and a consequence (Skinner)
    - The nature of the consequence will impact whether the behavior occurs again (legal, health-related consequences, etc.)

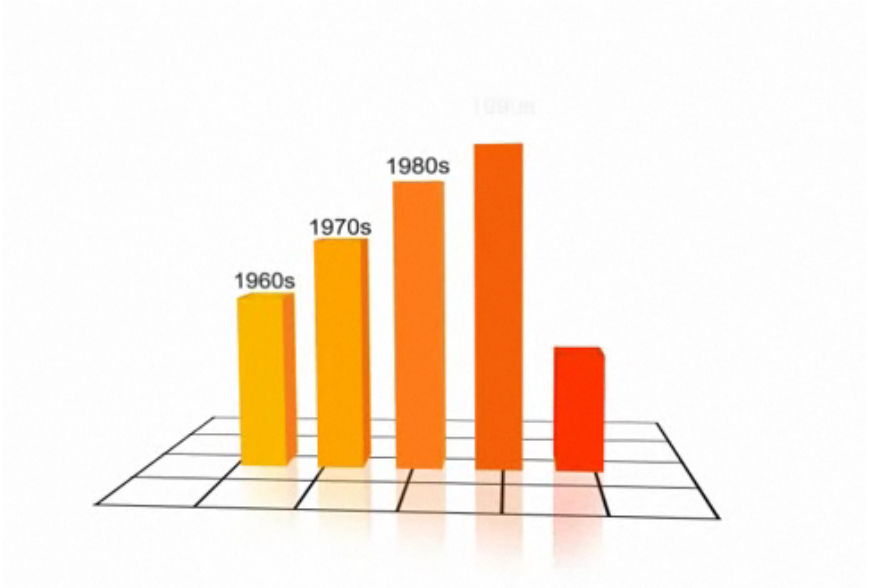
MOTIVATIONAL INCENTIVES SUITE

blending initiative
NIDA+SAMHSA

A Proven Approach to Treatment

Welcome to **Motivational Incentives-A Proven Approach to Treatment**, a collection of products which offer tools needed to learn about and use Motivational Incentives. Also, referred to as Contingency Management, Motivational Incentives has been subject to decades of research in the addiction treatment field; beginning in the 1960s. This collection of products assists organizations along a continuum from raising awareness about Motivational Incentives through dissemination and implementation activities.

Promoting Awareness of Motivational Incentives (PAMI) is an introductory training that exposes organizations to the principles of Motivational Incentives and demonstrates evidence of clinical effectiveness. Behavioral healthcare practitioners can then deepen their knowledge about Motivational Incentives through participating in the ***free***, self-guided, interactive on-line course, Motivational Incentives: Positive Reinforcers to Enhance Successful Treatment Outcomes (MI:PRESTO). Treatment organizations can also access additional implementation support through the Motivational Incentives Implementation Software (MIIS), developed by the National Institute on Drug Abuse and available at no cost. This desktop software provides mechanisms for maintaining patient information and Motivational Incentive activities.



PAMI - Promoting Awareness of Motivational Incentives

MI:PRESTO - Motivational Incentives: Positive Reinforcers to Enhance Successful Treatment Outcomes

MIIS - Motivational Incentives Implementation Software

Motivational Incentives = Contingency Management

Motivational Incentives = Contingency Management

- Providing reinforcement for healthy behavior

- Promoting Awareness of Motivational Incentives (PAMI) is based on the positive research outcomes and lessons learned from the National Institute on Drug Abuse (NIDA) Clinical Trials Network (CTN) study, titled Motivational Incentives for Enhanced Drug Abuse Recovery (MIEDAR).

- For more information: http://www.bettertxoutcomes.org/bettertxoutcomes/

Cognitive Behavioral Theory

- Cognitive behavior therapy (CBT) combines
    - **Behavior therapy** helps to weaken the connections between troublesome situations and your reactions to them
    - **Cognitive therapy** teaches you how certain thinking patterns/feelings impact behavior
- Very simply put, CBT attempts to help patients recognize, avoid, and cope

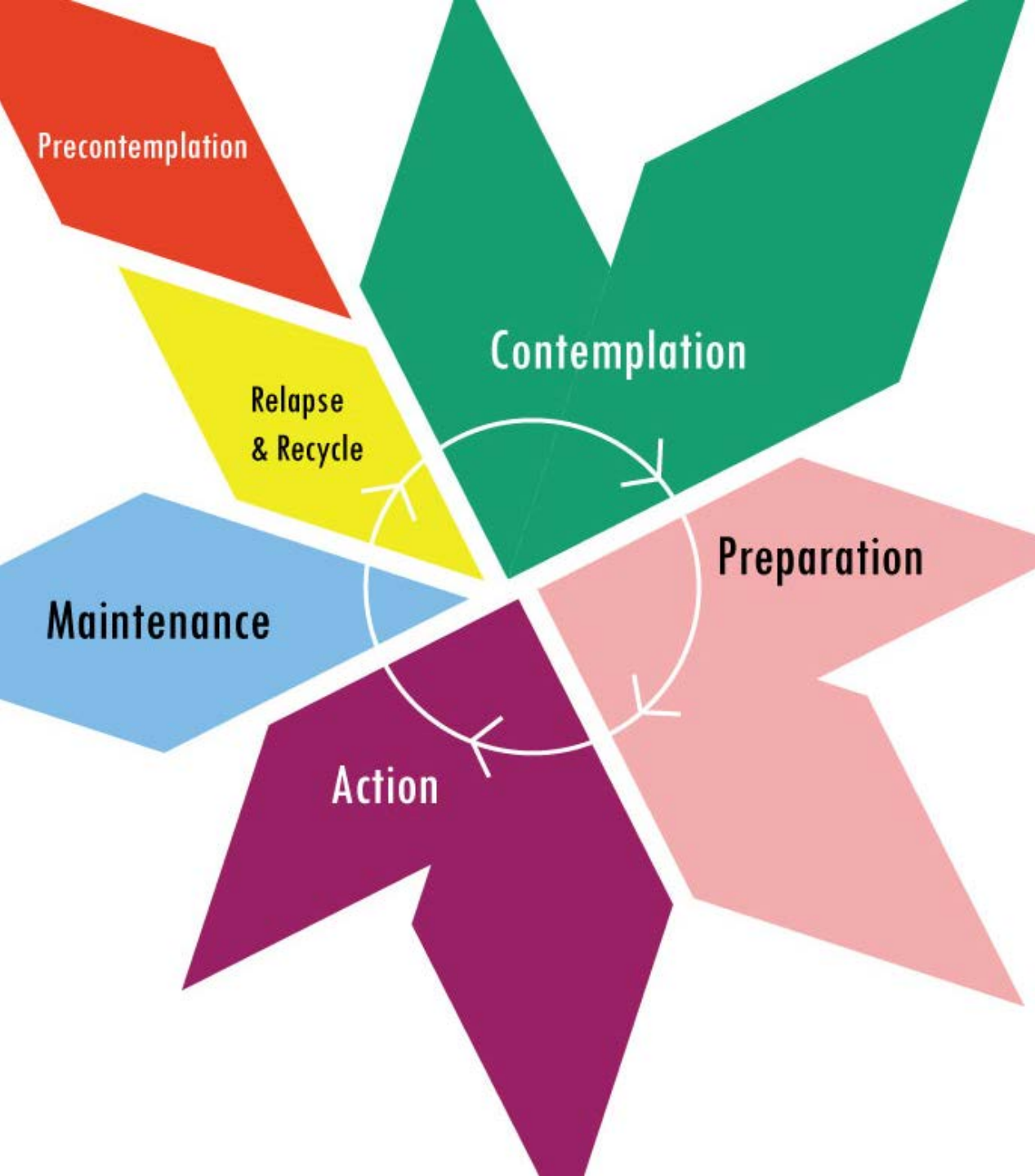
Relapse Prevention (CBT)

- ✓ Identify High Risk Situations
- ✓ Coping Skills Training
- ✓ Enhance Self-Efficacy
- ✓ Relapse Reframed as “teachable moment”
- ✓ Challenge Positive Alcohol Expectancies
- ✓ Lifestyle Balance

Rational Emotive Behavioral Theory (REBT)

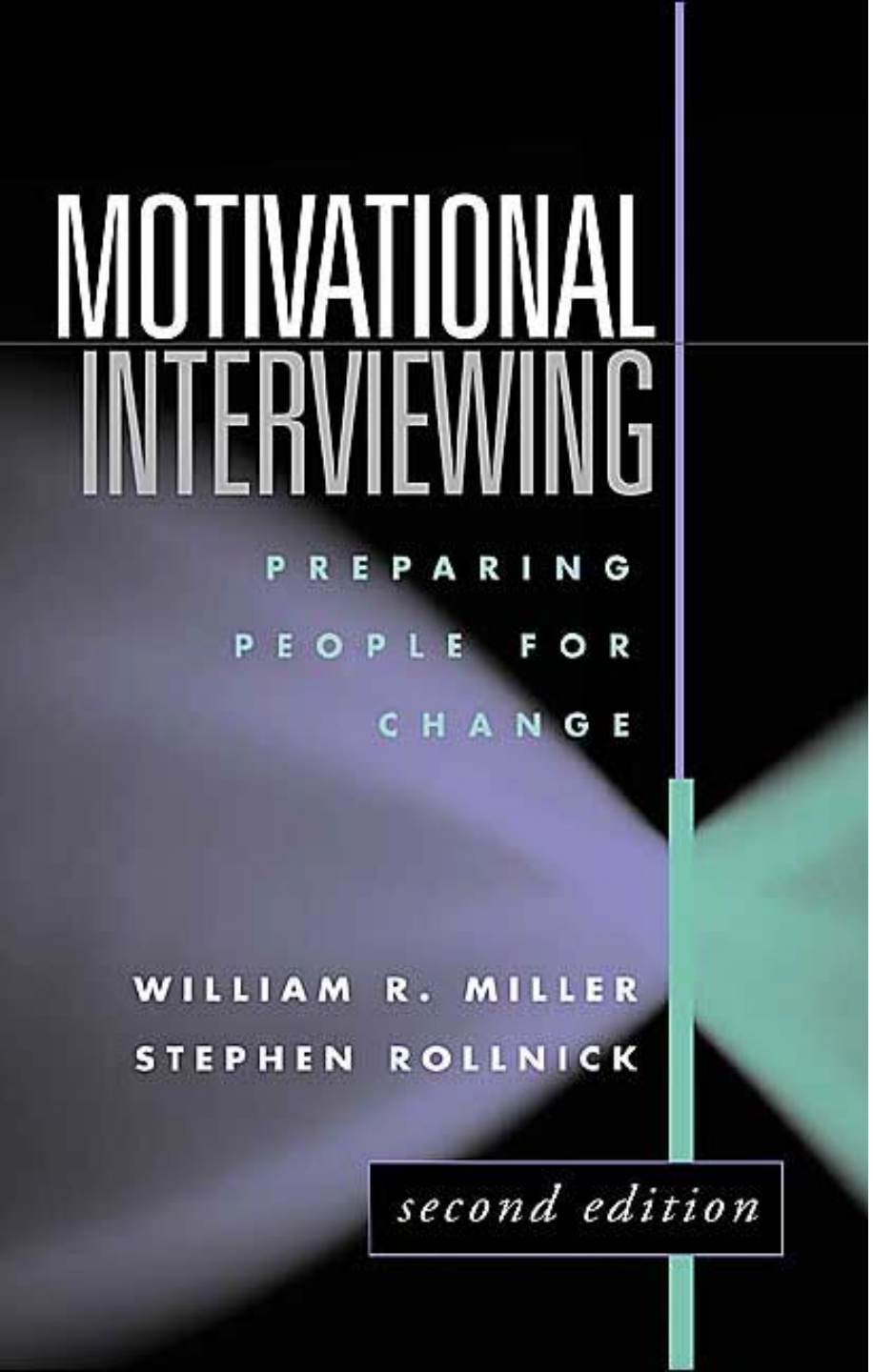
- In a nutshell…
-
- Something happens (to the patient)
- patient has an irrational belief about the situation
- patient has an emotional reaction to the belief
- Therapist helps the patient recognize errors in thinking that led to the irrational belief and find alternative ways of thinking about the event

- Example: “I was only arrested for drunk driving because that cop has it out for me”



Stages of Change Model

- Prochaska & DiClemente
  - Pre-Contemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance
  - Relapse & Recycle



Motivational Interviewing (MI)

- “If motivational interviewing is a way of being with people, then its underlying spirit lies in understanding and experiencing the human nature that gives rise to that way of being. How one thinks about and understands the interview process is vitally important in shaping the interview”.
  - *Miller and Rollnick, Motivational Interviewing, pg. 34*
- Motivational Interviewing was originally developed in an effort to increase the motivation of patients with alcohol problems to change behavior
- As part of that process, Miller found that approaching patients with a modified patient -Centered approach increased the impact of the interview
- What has evolved is a communication style and focus that increases patients’ motivation to work on their problems

Motivational Interviewing

- Fundamental Approach
  - Collaboration
  - Evocation/suggestion
  - Autonomy/self rule

- Four Principles
  - ➢ Express empathy (not sympathy)
  - ➢ Develop discrepancy
  - ➢ Roll with resistance
  - ➢Support self-efficacy

MI Continued

- Clinicians commonly think they already practice Motivational Interviewing…though that's often not the case
- What makes Motivational Interviewing a unique communication approach is how its constructs are employed by the clinician
- Motivational Interviewing requires attention to timing issues, specific strategies, application methods, and maximizing the effectiveness of these skills

SBIRT

- S- Screening tool is used to assess patient ’s risk of having an SUD.
- B,I- Brief intervention consists of a 3-5 minute, motivational discussion with patient concerning the screening results
- R- Referral to a specific resource for additional assessment and/or treatment service
- T-Treatment provider: process should allow for a “warm hand-off” from referral source to treatment provider.

Other theories worth mentioning…

- **Social Cognitive Theory:** Personal factors, environmental influences and behavior continually interact. People learn from their own experiences and from observing the actions of others
- **Health Belief Model:** Helps to explain why people do or do not use preventive services. Has to do with perception of reward/risk
- **Social Ecological Model:** Considers multiple influences on behavior and states that behaviors both shape and are shaped by the social environment

Behavioral Health Care Substance Use and Mental Health

Behavioral Health Integrated Care

- A patient’s substance use is not the problem, but rather a sign or symptom of other underlying issues driving the substance use.

Co-Occurring Disorder: What does this mean?

- In medicine, **comorbidity** is either the presence of one or more disorders (or diseases) in addition to a primary disease or disorder, or the effect of such additional disorders or diseases.
- The term **dual diagnosis** is used to describe the co-morbid condition of a person considered to be experiencing difficulties related to a mental illness **and** a substance abuse problem.
- Other ideas?

What are “Co-occurring Disorders”?

- The presence of at least two disorders:
- One being substance use disorders
- The other being a DSM-5 mental health disorder, such as:
  - Major Depression
  - Bipolar Disorder
  - Schizophrenia
  - PTSD/Anxiety

Characteristics of Co-occurring Disorders (General)

- Repeatedly cycle through treatment, emergency departments, detox and jail.
    - More likely to re-offend or to receive sanctions when: Not taking medication, not in treatment, experiencing mental health symptoms, using substances
    - Use of even small amounts of substances may trigger recurrence of mental health symptoms

General Assessment Approach for Co-occurring Disorders

1. ASAM dimensions can also be used as a multi-dimensional assessment tool for co-occurring disorders

2. Assess the significance of the substance use disorder

- Obtain longitudinal history of Mental Health and substance use symptom onset
- Analyze whether Mental Health symptoms occur only in the context of Substance use (substance-induced)
- Determine whether sustained abstinence leads to rapid and full remission of Mental Health symptoms

Characteristics of Co-occurring Disorders

- More rapid progression from initial substance use to higher levels of severity
- Poor adherence to medication
- Decreased likelihood of treatment retention/completion
- Greater rates of hospitalization
- More frequent suicidal behavior
- Difficulties in social functioning
- Shorter time in remission of symptoms

Characteristics of Co-occurring Disorders (cont.)

- Difficulty comprehending or remembering important information (e.g., verbal memory)
- Does not recognize consequences of behavior
- Exhibits Poor judgment
- Disorganization
- Limited attention span
- Respond better to patient -centered approaches

Co-Occurring Conditions in Adolescence

- Ninety percent with lifetime co-occurring disorder had one MH disorder prior to onset of substance use
- Median onset MH disorder at age 11 years
- Onset substance use between 16 and 21 years

- A patient’s substance use is not the problem, but rather a sign or symptom of other underlying issues driving the substance use.

Evidence-Based Best Practices
(continued)
Pharmacotherapy
Medication Assisted Therapy

Pharmacotherapy

- Detoxification/Withdrawal Management
- Cravings for Alcohol
- Replacement
- Aversive
- Antagonist
- Mixed (Agonist-antagonist)

Medicated Assisted Therapy

- Medicated-Assisted Treatment (MAT) is the use of **FDA- approved medications**, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders.

Medications for Alcohol Use Disorders

- Naltrexone
- Vivitrol (injectable form of Naltrexone), longer lasting)
- Disulfiram (Antabuse)
- Acamprosate (Campral)

Medications for Opioid Use Disorders

- Methadone (oral liquid)
- Naltrexone (oral)
- Vivitrol (injectable form of Naltrexone), longer lasting)
- Sublocade (injectable form of Buprenorphine)
- Suboxone/Zubzolv (Buprenorphine/Naloxone)
- Probuphine (Buprenorphine/ implant)

Opiate/Opioid : What's the Difference?

- Opiate
  - A term that refers to drugs or medications that are derived from the opium poppy, such as heroin, morphine, and codeine

- Opioid
  - A more general term that includes opiates as well as the synthetic drugs or medications, such as Buprenorphine, methadone, Meperidine (Demerol®), Fentanyl—that produce analgesia and other effects like morphine

Basic Opioid Facts

- Description: Opium-derived, or synthetics which relieve pain, produce euphoria and morphine-like addiction, and relieve withdrawal from opioids
- Medical Uses: Pain management, cough suppression
- Methods of Use: Intravenously injected, smoked, snorted, or orally administered
- Withdrawal: Prolonged and very unpleasant, but not life threatening

A Brief History of Opioid Treatment

- The Drug Abuse Treatment Act of 2000 and the approval of Buprenorphine by the U.S. Food and Drug Administration, in 2002, for the treatment of OUDs (Opioid Use Disorders) both allow for the expansion of traditional opioid treatment programs beyond the current structure to include treatment in office-based settings. With this expansion, more patients may be willing to access treatment, and the stigma associated with substance use disorders may be reduced by broadening the definition and location of treatment
-

A Brief History of Opioid Treatment

- Opioid use disorders continue to be a significant public health problem across the country. In 2007, approximately 12.5 million Americans ages 12 and older used prescription pain medications for non-medical purposes, according to the National Survey on Drug Use and Health administered by SAMHSA

- By 2019 full scale efforts to systemically decrease the access to prescribed opioids medications, over the previous decade, have created a continual surge in OD deaths, and the ongoing use of heroin and Fentanyl (acquired illicitly in order to manage the dependence to these opiate based-medications). Thus, creating the epidemic we see cycling through our healthcare/SUD treatment systems of care today.

A Brief History of Opioid Treatment
(continued)

- 1964: Methadone is approved
- 1974: Narcotic Treatment Act limits methadone treatment to specifically licensed Opioid Treatment Programs (OTPs)
- 1984: Naltrexone is approved, but has continued to be rarely used (approved in 1994 for alcohol addiction)

A Brief History of Opioid Treatment
(continued)

- 2000: Drug Addiction Treatment Act of 2000 (DATA 2000) expands the clinical context of medication-assisted opioid treatment
- 2002: Tablet formulations of Buprenorphine (Subutex®) and Buprenorphine/Naloxone (Suboxone®) were approved by the Food and Drug Administration (FDA)

Approval of Buprenorphine and Buprenorphine/Naloxone

- U.S. FDA approved Buprenorphine (marketed as Subutex®) and Buprenorphine/Naloxone (marketed as Suboxone®) for opioid use disorder treatment on October 8, 2002
- Product launched in U.S. in March 2003
- Interim rule changes to federal regulation (42 CFR Part 8) on May 22, 2003 enabled OTP's (specialist clinics) to offer Buprenorphine

A Brief History of Opioid Treatment
(continued)

- 2016 The First-Ever FDA-Approved Buprenorphine Implant For Opioid Dependence (Probuphine)
- 2017 FDA approves first once-monthly buprenorphine injection, a medication-assisted treatment option for opioid use disorder (Sublocade)

Buprenorphine Treatment: The Myths and The Facts

MYTH #1: Patients are still addicted

- **FACT:** SUD is pathologic use of a substance and may or may not include physical dependence

  - ✓ Physical dependence on a medication for treatment of a medical problem does not mean the person is engaging in pathologic use

MYTH #2: Buprenorphine is simply a substitute for heroin or other opioids

- **FACT**: Buprenorphine is a replacement medication; it is not simply a substitute

  - ✓ Buprenorphine is a legally prescribed medication, not illegally obtained
  - ✓ Buprenorphine is a medication taken sublingually (under the tongue), a very safe route of administration
  - ✓ Buprenorphine allows the person to function normally

MYTH #3: Providing medication alone is sufficient treatment for opioid addiction

- **FACT**:

  - ✓ Buprenorphine is an important treatment option. However, the **complete** treatment package should include other elements as well (talk therapy, community support, etc.)

  - ✓ Combining pharmacotherapy with counseling and other ancillary services may increase the likelihood of success

MYTH #4: Patients are still getting high

- **FACT**:

  - ✓ When taken sublingually, Buprenorphine is slower acting and does not provide the same “rush” as heroin

  - ✓ Buprenorphine has a ceiling effect resulting in lowered experience of the euphoria felt at higher doses

-

Advantages of Buprenorphine in the Treatment of Opioid Addiction

1. Patient can participate fully in treatment activities and other activities of daily living easing their transition into the treatment environment
2. Limited potential for overdose *(Johnson et.al, 2003)*
3. Minimal subjective effects (e.g., sedation) following a dose
4. Available for use in an office setting
5. Lower level of physical dependence

Advantages of Buprenorphine/ Naloxone

- Discourages IV use
- Can prevent overdose deaths (Naloxone)

Training Summary

1. Evidence Based – Best Practice
2. Therapeutic Relationship and Treatment Alliance
3. Best Practices
4. Co-occurring Disorders
5. (some)Pharmacological Treatment options

- A patient’s substance use is not the problem, but rather a sign or symptom of other underlying issues driving the substance use.

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