Treatment Planning in Addiction Treatment

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Objectives

- Goals of Treatment
- Harm Reduction
- SMART goals
- Stages of Change
- Treatment Modalities/Levels of Care
- Medication Options (RAAM)

Goals of Addiction Treatment

- Abstinence
- Harm reduction
- Improve physical and/or mental health
- Family, social, occupational, educational, legal…
- Goals change over time
- Goals may be different for each substance

Goals of Addiction Treatment

- No ‘one size fits all’ treatment approach
- Emphasis on patient-centered approaches in SUD
- “Shared Decision-Making (SDM) Model” - patient and clinician go through all phases of decision-making together
- The likelihood of goals being realized is substantially higher when patient and clinician agree on them

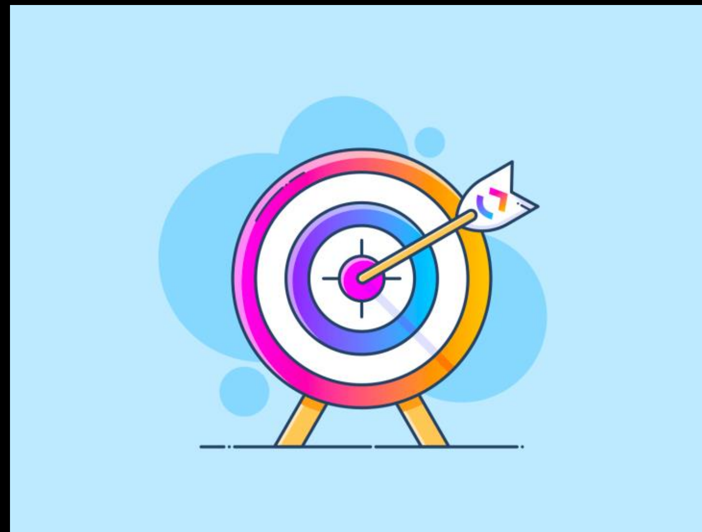
Harm Reduction

- Goal = prevent the negative consequences of substance use and improve health
- Examples: NRT, ORT, water with alcohol, Narcan, needle exchange
- Proven outcomes:
  - more likely to engage in ongoing treatment
  - reduces blood borne illnesses (HIV/AIDS and Hep C)
  - Decreases drug overdose deaths

Safe Consumption Sites

- Provide a hygienic environment for people to consume substances under the supervision of professional staff
- Sterile supplies, education on safer consumption, overdose prevention, medical and counselling services, and referrals to drug treatment, housing, income support and other services
- Shown to:
  - reduce costs for the health care system
  - prevent blood borne illnesses (HIV or Hepatitis C)
  - help individuals access support services
  - prevent overdose deaths
  - decrease public substance consumption
  - NOT lead to increased crime

Setting SMART Goals



SMART Goals

S	• Specific
M	• Measurable
A	• Achievable
R	• Relevant (Realistic)
T	• Time-bound

SMART Goals

- More feasible, less overwhelming
- Helps to prevent feelings of hopelessness or impossibility
- Helps to create a sense of fulfilment when you reach your goals
- Adults who set SMART goals during addiction treatment are 10X more likely to achieve their objectives

Stages of Change

What are "Stages of Change"?

- Transtheoretical Model (TTM)
  – assesses an individual's readiness to change and provides strategies to guide them through the stages
- Change is not an ***event***, but a ***process*** that unfolds over time
- Helps identify where people are along the continuum of change and provides specific approaches for each stage of change to facilitate individuals in moving through the stages

Stages of Change

- = 5 stages along a continuum that are associated with a person's interest and motivation to change current behavior
- Unaware or unwilling to do anything about a problem → considering the possibility of change → preparing to make a change → taking action to make the change → maintenance
- Individuals recycle through the stages or regress to earlier stage from later ones

“Help? Why? What’s the problem?”

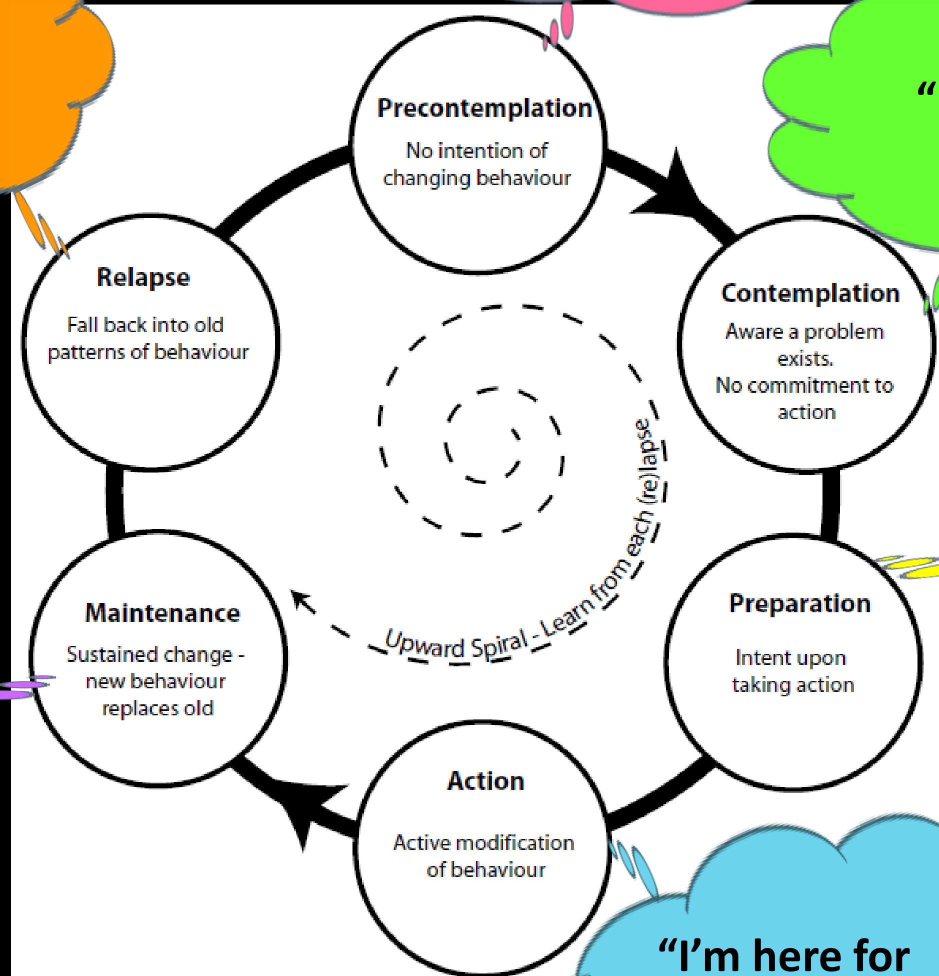
“Maybe I do have a problem…

“It’s time to make a change. I have to do something, but what?

“I’m here for help, let’s create a plan”

“I get the problem, I have a plan, I’m doing this…”

“What went wrong?”



What's the point??

- One of the most important aspects of treatment is assessing the patient's stage of change and ***tailoring*** the intervention to match
- The time a person can stay in each stage is variable, ***but the tasks required to move to the next stage are not***
- Only a minority (<20%) of a population at risk is prepared to take action at any given time – an action-oriented approach will not work for individuals in the early stages

Successful Change

- Successful approaches to the change process adhere to the following principles:
  - Tailor your approach to each stage of change.
  - Move one stage at a time.
  - Be patient and allow time to change.

Precontemplation

"It isn't that we cannot see the solution. It's that we cannot see the problem."

Remember…

- Not considering change
- Aware of few, if any, negative consequences
- Unlikely to take action anytime soon

Strategy…

- Build trust
- Educate and inform
- Raise doubts

Precontemplation

Treatment needs:

- Information and education
  - Educate about negative consequences
  - Link problems to substance use
- Brief intervention
  - Express concern, build trust, remain non-judgmental and “agree to disagree”
  - Raise doubts or concerns about substance use by:
    - Exploring the meaning of events that brought the client to treatment
    - Eliciting the client’s perceptions of the problem
    - Explore the pros and cons of substance use
    - Examining discrepancies between the client’s and other’s perceptions of the problem behavior

Contemplation

Remember…

- Aware of some pros and cons of substance abuse…
- but feel ambivalent about change
- not yet decided to commit to change

Strategy…

- Explore feelings of ambivalence
- Increase awareness of consequences of use vs benefits of quitting

Contemplation

Treatment needs:

- Motivational interviewing
- Explore ambivalence
  - Ambivalence = something is holding them back - comes from having both positive and negative feelings toward a new behavior
    - Help "tip the decisional balance scales" toward change by:
      - Weighing pros and cons of substance use and change
      - Changing extrinsic to intrinsic motivation
      - Examining personal values in relation to change
- Brief intervention
  - benefits of decreasing or stopping use.
  - Recognize when intent is high but desire to work is low
    - SMART goals – sense of achievement and increase commitment

Preparation

Remember…

- The person has decided to change
- Begins to plan steps toward recovery

Strategy…

- Work in strengthening the commitment
- Create a realistic action plan

Preparation

Treatment needs:

- Discuss available options for treatment and help the client choose the best one
- Clarify the client's own goals and strategies for change.
- Break down barriers
- Help enlist social support
- Explore treatment expectations and the client's role
- Elicit what has worked in the past

Action

Remember…

- The first active steps toward change
- Trying new behaviors, but not yet stable.

Strategy…

- Work on skills to maintain sobriety
- Focus on relapse prevention

Action

Treatment needs:

- Skills to maintain sobriety
- Relapse prevention
- Help identify high-risk situations and develop appropriate coping strategies to over come these.
- Assist in finding new reinforcers of positive change.
- Be a source of encouragement and support
- Acknowledge the uncomfortable aspects of treatment, but focus on the experience as an important opportunity or “gift”, rather than a burden or a chore

Maintenance

Remember…

- The person establishes new behaviors on a long term basis.

Strategy…

- Relapse Prevention
- Reassure and redefine long-term recovery plans

Maintenance

Treatment needs:

- Redefine long-term sobriety maintenance plans
- Support lifestyles changes.
- Help the client practice and use new coping strategies to avoid a return to use.
- Maintain supportive contact
- Review long-term goals
- Anticipate difficulties as a means of relapse prevention – **Plan!!**
- Develop a “fire escape” plan if the client resumes substance use.

Relapse

Remember…

- The person has experienced a recurrence of symptoms
- Must now cope with consequences and decide what to do next

Strategy…

- Explore the relapse
- Create alternative strategies
- Reengage!

Relapse

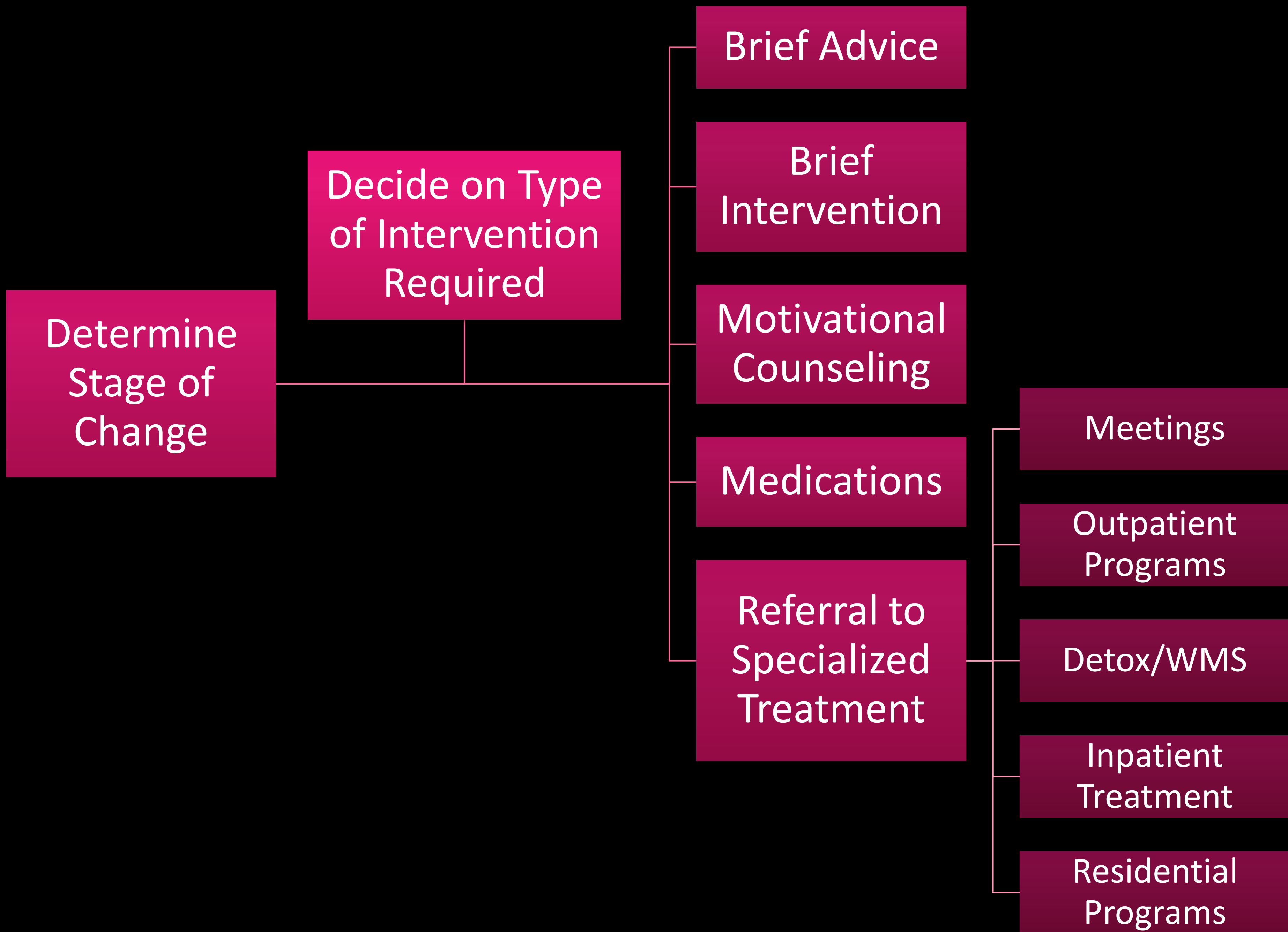
Treatment needs:

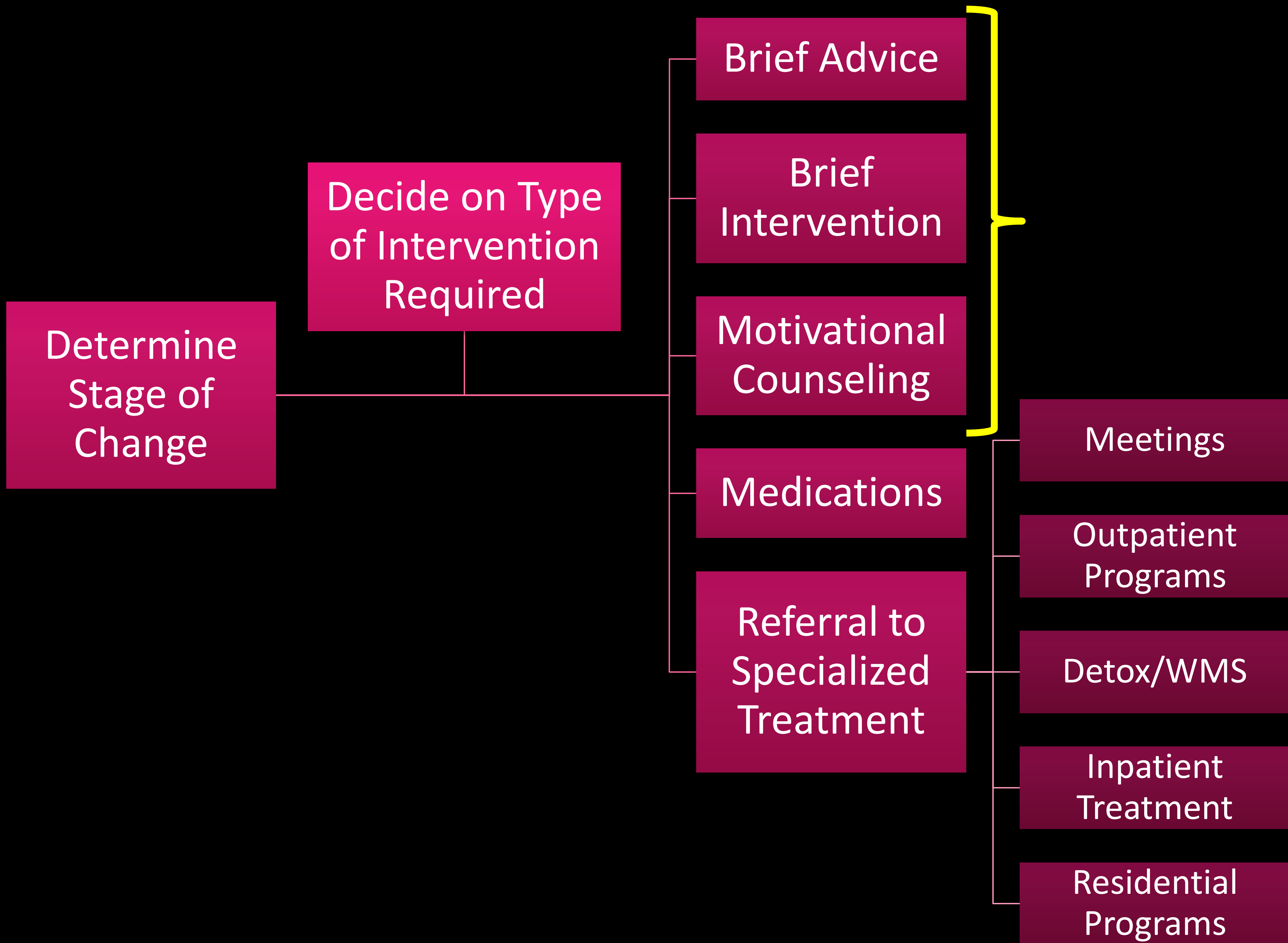
- Help the client reenter the change cycle
- Explore the meaning and reality of the recurrence as a learning opportunity
- Assist the client in finding alternative coping strategies.
- Emphasize positive aspect of the effort to seek care
- Support patient’s self-efficacy so that recovery seems achievable

Treatments and Interventions

Treatment Options/Interventions

- Addiction counseling —community-based clinics
- Mutual help groups/12-step programs
- Contingency management
  - offers incentives to encourage abstinence
- Internet-based Programs
- Pharmacotherapy
- Psychotherapy – MI, CBT, DBT, groups


Determine Stage of Change
Decide on Type of Intervention Required
Brief Advice
Brief Intervention
Motivational Counseling
Medications
Referral to Specialized Treatment
Meetings
Outpatient Programs
Detox/WMS
Inpatient Treatment
Residential Programs



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- Brief Advice
- Brief Intervention
- Motivational Counseling

- Least intensive options
- Range from unstructured to more formal therapy
- May be sufficient to address the problem
- May be required as "pretreatment" strategies
    - (Contemplative and Pre-contemplative stages of change)

Brief Advice

- Education, prevention messages
- Improve knowledge, awareness and understanding of behaviour and associated problems

Brief Interventions

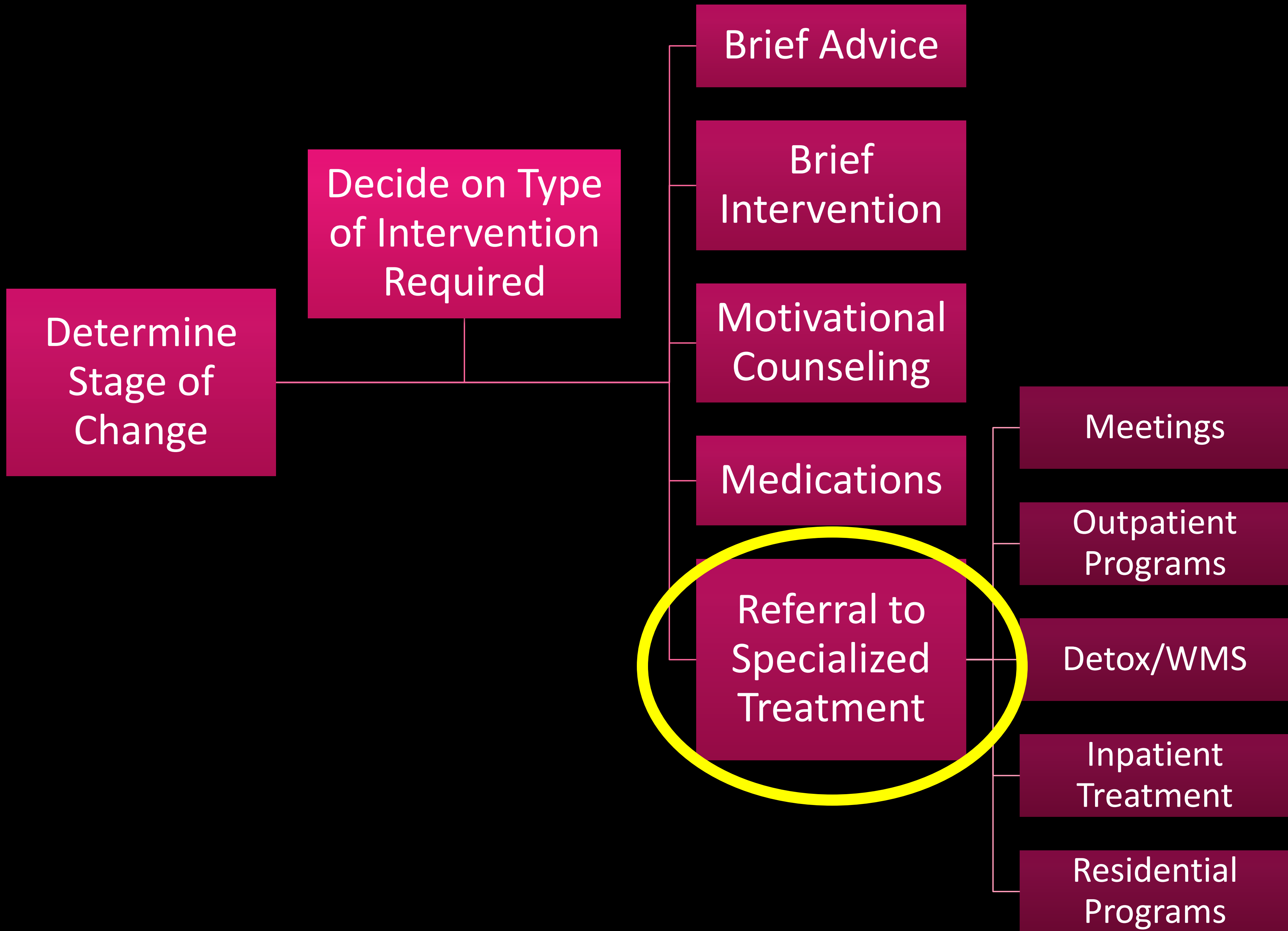
- FRAMES model
  - Feedback (personal risk/impairment)
  - Responsibility (to change)
  - Advice (for changing behaviour)
  - Menu (of options for changing)
  - Empathic (motivational style)
  - Self-efficacy (promote empowerment)

Motivational Counseling

- Reactions to counseling depend on an individual's readiness to change
- Acknowledge differences in readiness and "meet people where they are"
- Focus on reasons to change ("change talk")
  - desire to maintain independence, optimal health and mental capacity

Principles of Motivational Counseling

1. Express Empathy
   – Accept ambivalence, build rapport
2. Develop Discrepancy
   – between clients' goals/values and their current behavior
3. Roll with Resistance
   – Avoid argument and direct confrontation
4. Support Self Efficacy and Optimism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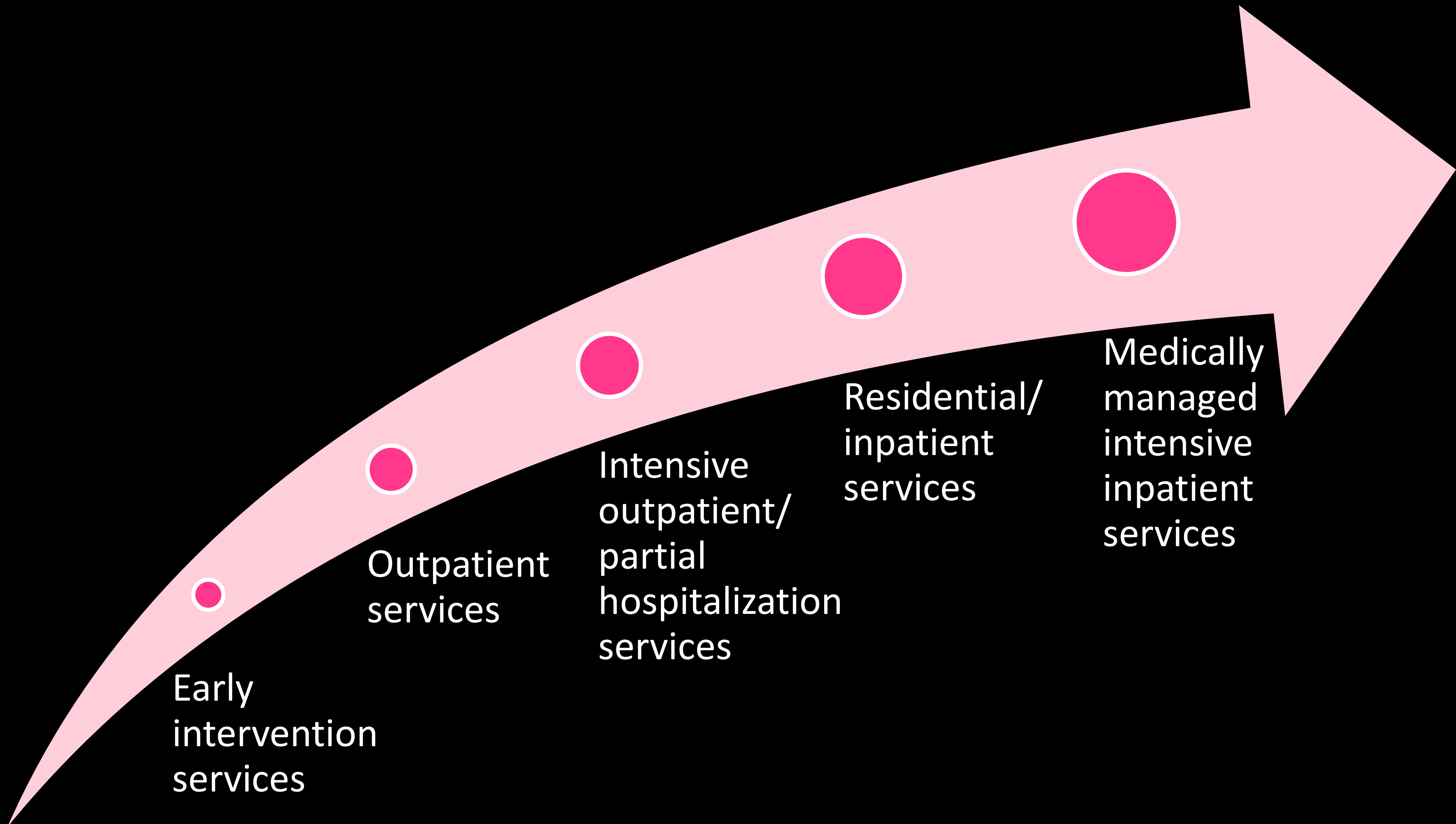
Specialized Treatment (Action Stage)

- Levels of Treatment
  - Detox
  - Inpatient Rehabilitation
  - Residential Rehabilitation
  - Outpatient Services
  - Meetings

Levels of Care



Inpatient Rehab

- Frail, suicidal, or medically unstable patients
- Very little availability of this level of care
- May have to arrange on a medical/psychiatric unit of an acute care hospital

Residential Rehab

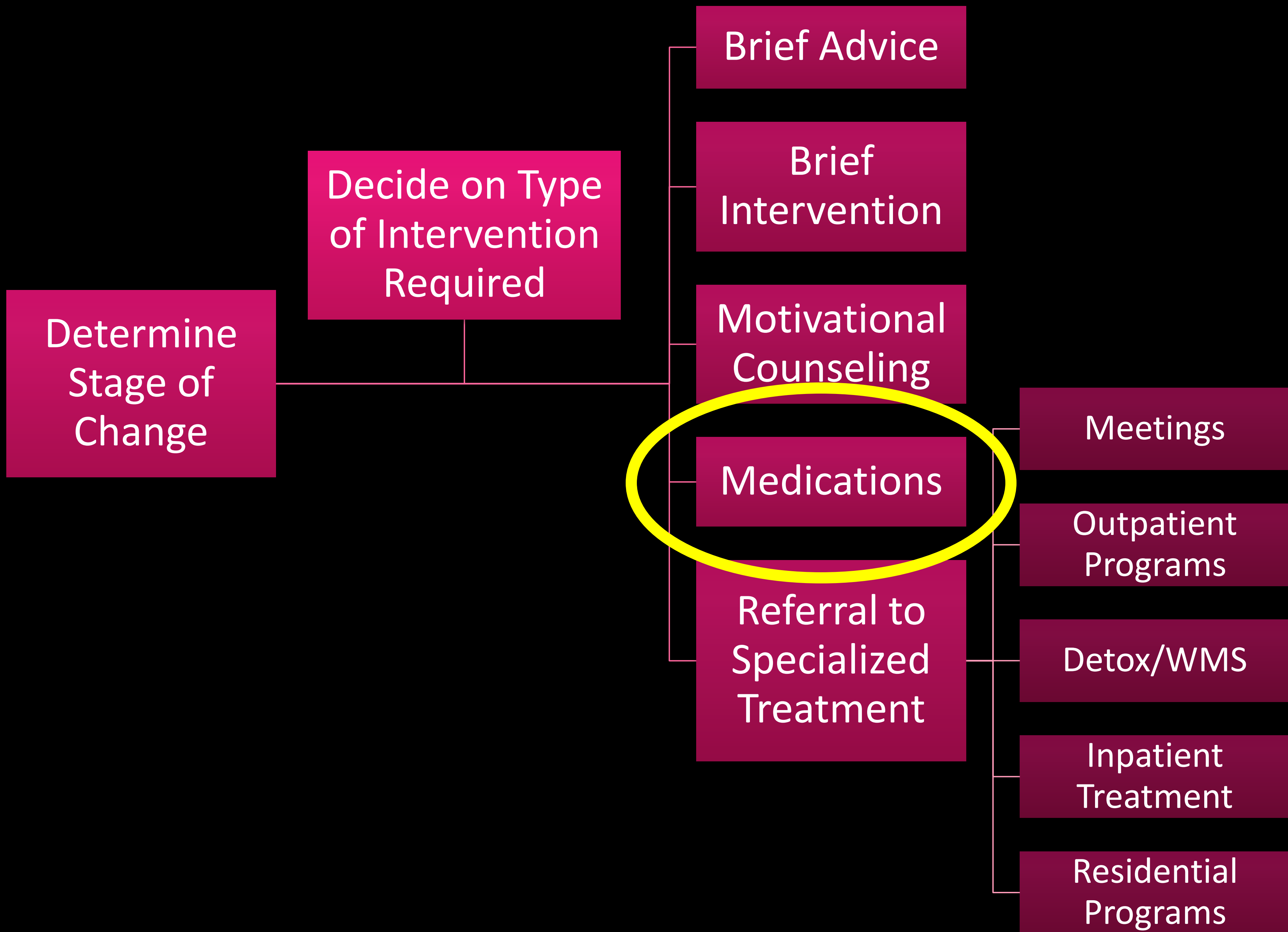
- Avoid continuous access to substances
- Patients who lack resources or have no social network

Outpatient Services

- Ranges from day programs to weekly/monthly sessions
- Generally includes psychiatric consultation and individualized or group psychotherapy

Meetings

- Self help groups, 12 step/AA
- Increased social network and spirituality shown to improve treatment outcomes



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Medications

- MAT = "Medication-Assisted Treatment”
  = medications + counseling/behavioral therapies
  = proven more successful than either alone
- Medications are useful in:
  - Detox/Withdrawal
  - Maintenance/Relapse Prevention
  - PAWS: Anxiety and psychological withdrawal symptoms may continue for several months or even years
  - Treating Co-occurring Disorders (anxiety, depression, psychosis)

Alcohol

- Withdrawal
  - Benzodiazepines
  - Gabapentin
- Maintenance
  - Disulfiram (Antabuse)
  - Naltrexone
  - Acamprosate (Campral)
  - GABA-ergic Drugs (Gabapentin, Topiramate)

Alcohol Withdrawal Treatment

- Benzodiazepines: Diazepam (Valium), lorazepam (Ativan), and chlordiazepoxide (Librium) are used most
- Long-acting benzodiazepines are preferred
- Symptom triggered (CIWA) vs. Scheduled taper

Benzo-Sparing Protocols GABAPENTIN

- A safe and effective alternative to benzos for the treatment of mild-moderate alcohol withdrawal
- Recent studies have found lower CIWA scores
- Better tolerated, less delirium, fewer drug-drug interactions and safe in impaired liver function
- Improves sleep, anxiety and cravings
- Does *not* prevent seizures (add valproate)

Alcohol – Maintenance

- Disulfiram, Naltrexone, Acamprosate and Gabapentin can help patients with alcohol use disorder
  - achieve abstinence
  - reduce heavy drinking days
  - prevent relapse and maintain sobriety

Disulfiram (Antabuse)

- Aversion Therapy
- Blocks alcohol metabolism → ↑acetaldehyde
- sweating, headache, SOB, flushing, palpitations, N/V
- Goal: alcohol avoidance due to fear of experiencing these unpleasant effects
- Cannot be given to anyone with a history of severe heart disease or any unstable medical condition
- Average maintenance dose of 250 mg/day

Naltrexone

- Opioid-receptor antagonist
- Reduces cravings, decreases reinforcement from drinking
- Increased time to relapse and lower intake on drinking days
- (25mg daily x 4 days) then 50mg PO daily
- 380mg IM monthly (Vivitrol)
- Usually taken for 6 months to 1 year
- Monitor LFTs, avoid in acute liver disease

Acamprosate

- NMDA receptor inhibitor
- Increased time to relapse, decreased the number of drinks per drinking day
- Can be used separately or in combination with Naltrexone
- 3 times daily dosing leads to poor compliance (666mg TID)
- Useful if liver disease or patients on opioids, but avoid in renal insufficiency

GABA-ergic Drugs (off-label)

- Gabapentin
  - Improves insomnia, anxiety and cravings
  - Initial dose 300 mg TID, studies used up to 1800 mg/day
  - thought to balance the GABA/glutamate dysregulation found in early alcohol abstinence and reduce risk for alcohol relapse.
- Baclofen and Topiramate
  - Maintain abstinence and decrease heavy drinking days

Opioids

- Withdrawal:
  - Methadone, Suboxone
  - Clonidine, symptomatic relief
- Maintenance
  - Methadone
  - Suboxone
  - Naltrexone

Opioid Withdrawal

- Opioid Agonists
  - based on the principle of cross-tolerance in which one opioid is replaced with another and then slowly withdrawn
  - Methadone, Suboxone
- Non-Opiates – symptomatic relief
  - Clonidine - help reduce anxiety, agitation, muscle aches, sweating, runny nose, and cramping.
    - It does not help reduce cravings.
  - Meds for diarrhea, aches, insomnia (Loperamide, Ibuprofen, Trazodone)

Opioid - Maintenance

- **Methadone**
  - Long acting, full μ-opioid receptor agonist
  - Daily visits to a pharmacy to receive a single dose
  - Can relieve the symptoms of withdrawal and cravings without the high
  - Clients also receive psychosocial support services
  - The idea is the client is not forced to engage in illegal or undesirable behaviors to secure the drug.

Opioid - Maintenance

- **Suboxone**
  - Combination of Buprenorphine and Naloxone (4:1)
  - Buprenorphine = ***partial*** μ-opioid receptor agonist
    - activates opioid receptors, reducing drug craving and preventing withdrawal.
    - very safe drug, with minimal risk of overdose
  - Naloxone = opioid antagonist
    - helps prevent misuse of the medication.
  - client does <u>not</u> need to visit daily, increasing access and convenience.

Stimulants

- No medications have been shown to be reliably useful
- Research:
  - Modafinil - mild stimulant used to treat narcolepsy
  - Propranolol
  - Topiramate
  - Tiagabine
  - Disulfiram (Antabuse)- blocks enzymatic degradation of cocaine and dopamine leading to extremely high cocaine and dopamine levels when cocaine is ingested - Cocaine high is not increased, but instead there is increased anxiety which is unpleasant

Stimulants

- **Methamphetamine use disorder (*some* evidence):**
  - Bupropion + naltrexone
  - Bupropion (Wellbutrin, antidepressant) - less severe use
  - Mirtazapine (antidepressant)

Cannabis

- No medications have been shown to be reliably useful
- N-acetylcysteine (NAC) – has shown promise in adolescents with cannabis use disorders
- Gabapentin – well tolerated, may decrease withdrawal symptoms

Relapse Prevention Plan (Maintenance Stage)

- Potential triggers
- Early warning signs
- Strategies to respond
- Name sponsors, family members, or friends who have agreed to help
- Clinicians, crisis lines, and their contact information.

Continuing Care

- Pro-recovery activities:
  - Employment
  - Education
  - Mutual help groups
  - Volunteer work
  - Pursuit of hobbies or other meaningful activities
- Sources of support:
  - Parenting classes
  - Child care
  - Medical care
  - Mental health care

Summary

- Shared decision making and agreeing on goals significantly increases the likelihood of success
- Harm reduction strategies are important to prevent the negative consequences of substance use and improve health
- SMART Goals can increase sense of accomplishment and improve commitment
- One of the most important aspects of treatment is assessing the client's *stage of change* and ***tailoring*** the intervention/level of care to match

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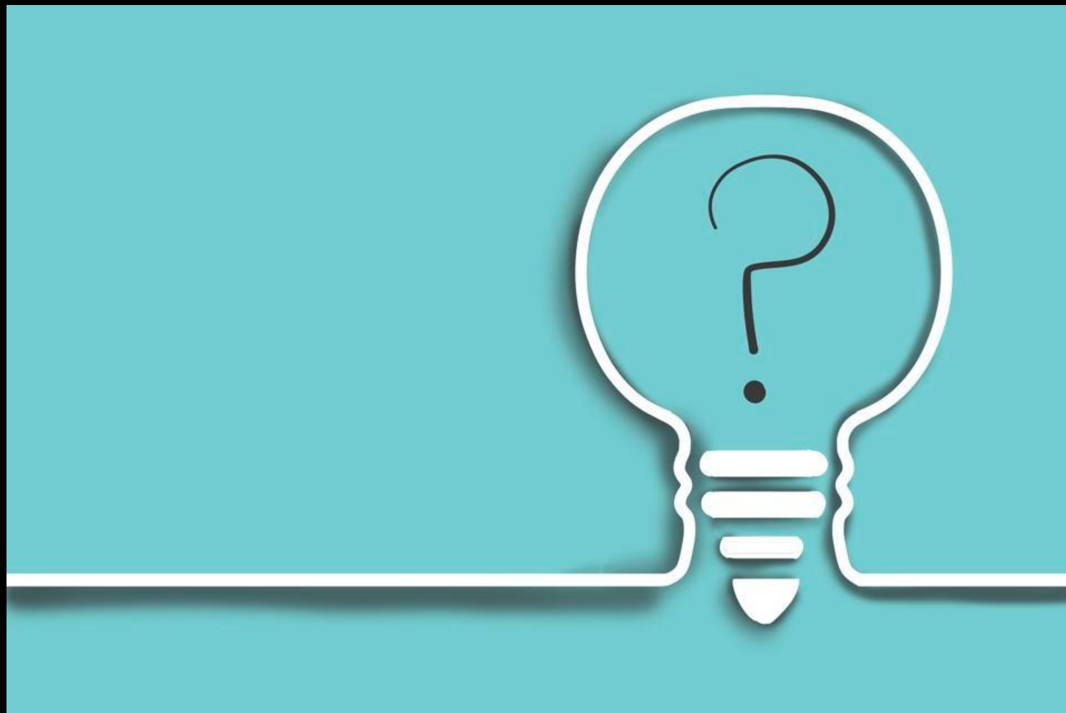

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