

Comprehensive Opioid Response with the Twelve Steps (COR-12)

*A Journey Towards Person-Centered Treatment Embracing Multiple
Pathways to Recovery*

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Why are we here today?

Mission

Why are we doing this work?

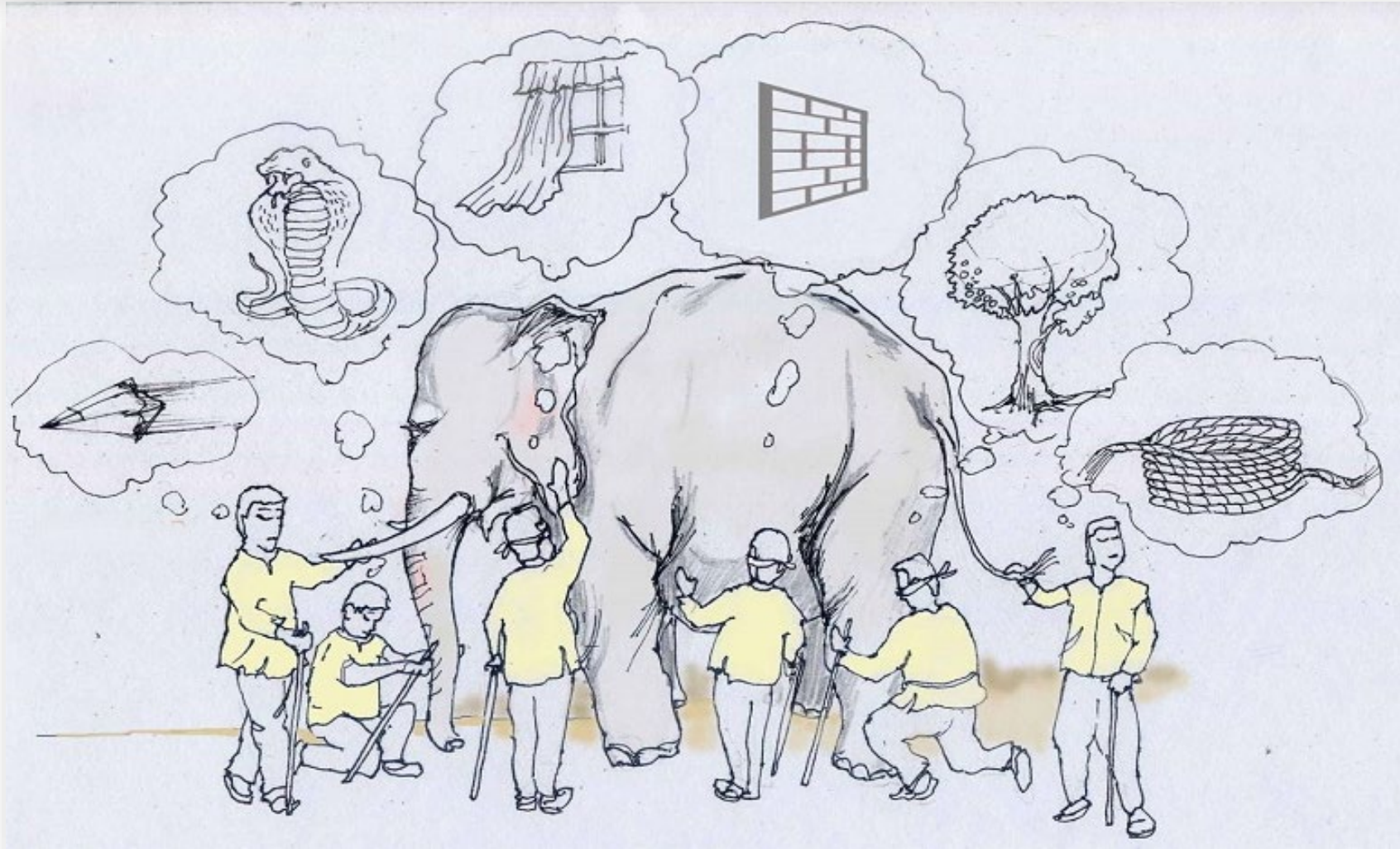
Calling

Ethics of Care

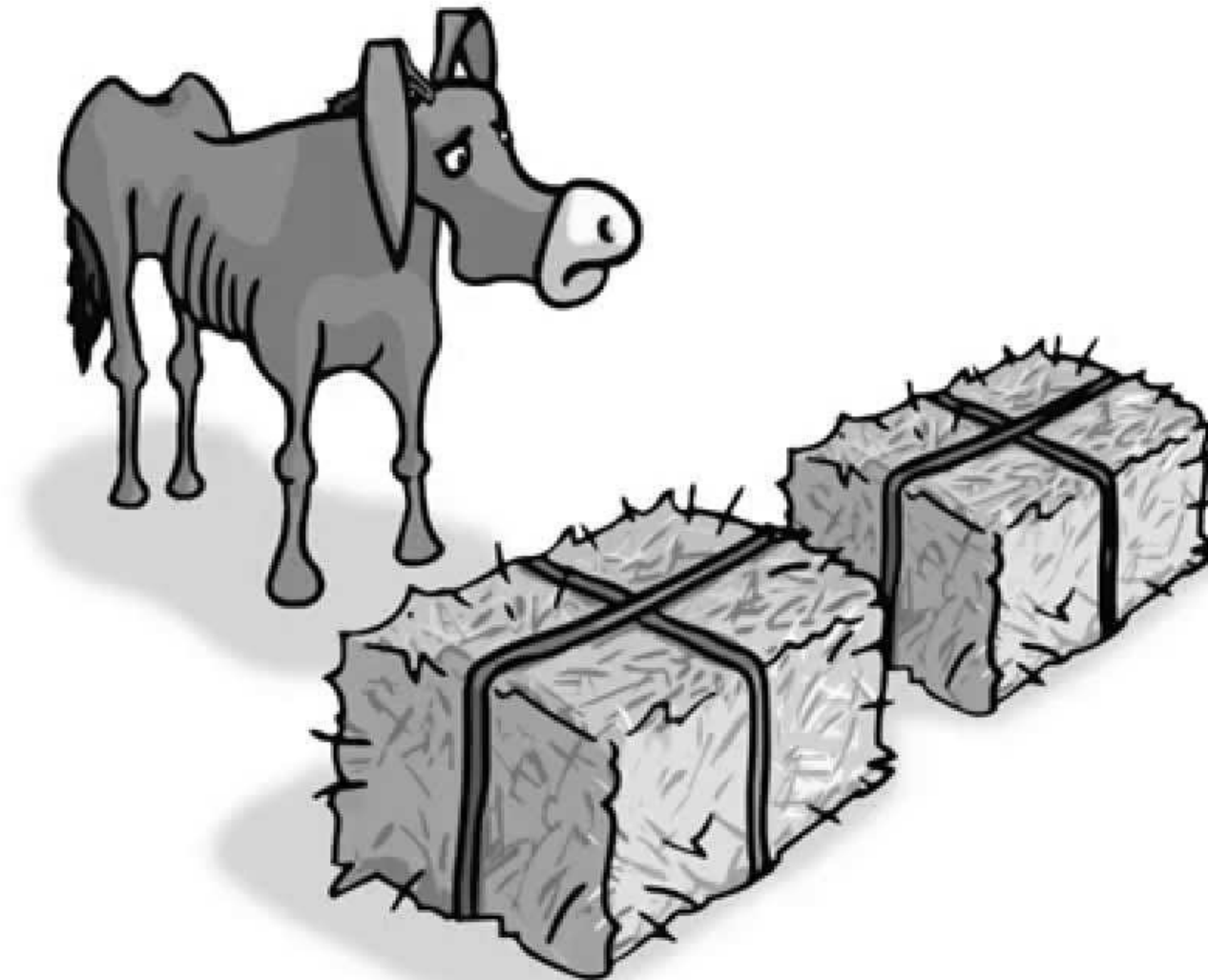
“Morality is primarily about caring. It is not about rules, universalizability, the impartial computation of consequences, or anything like that. It is about a direct relationship of emotional responsiveness to the suffering of persons, both self and other.”

-- Carol Gilligan

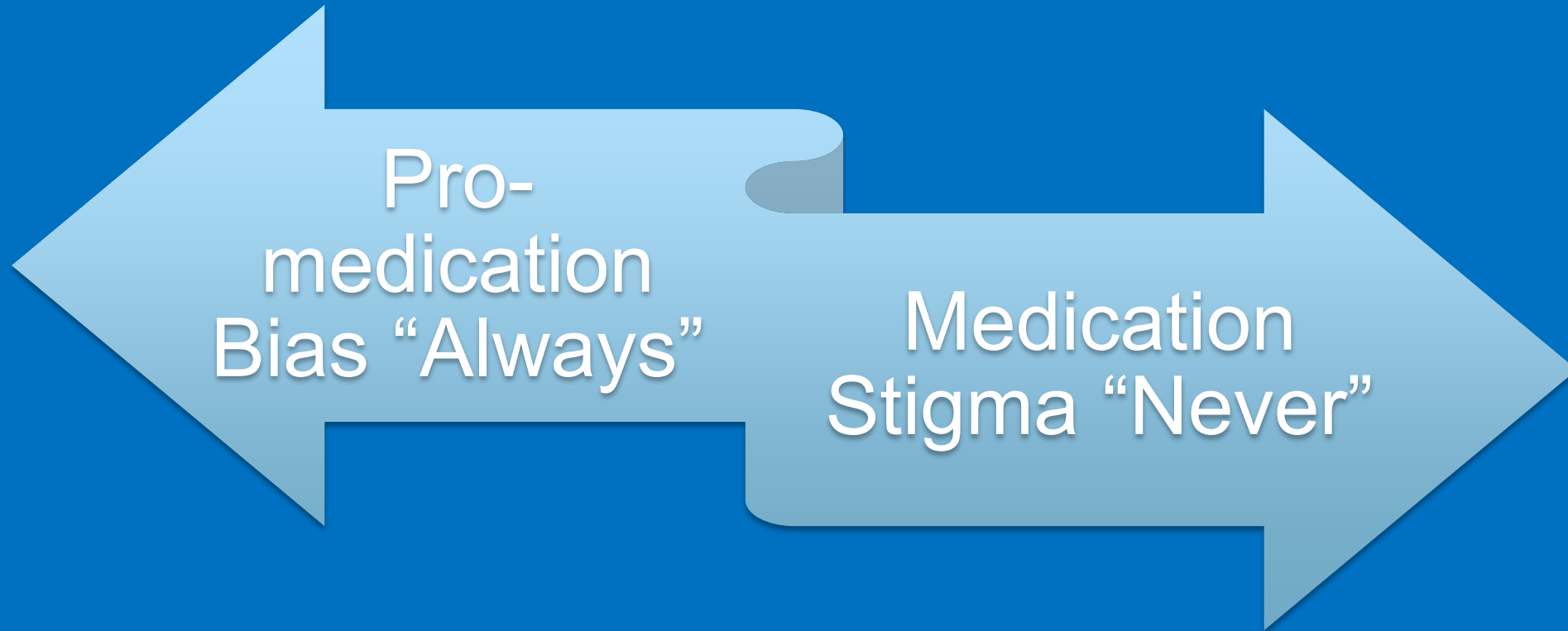
Understanding Addiction Treatment and Recovery



A Thought Experiment About Choices



Key Elements of Non-productive Debate



The Treatment Choice



The History of the Minnesota Model



The Hazelden Betty Ford Experience:

Five Factors That Caused Us To Change

1) Increased admissions for opioid dependence

- Adults: 19% (2001) → 30% (2011)
- Youth: 15% (2001) → 41% (2011)

2) Problems with treatment retention

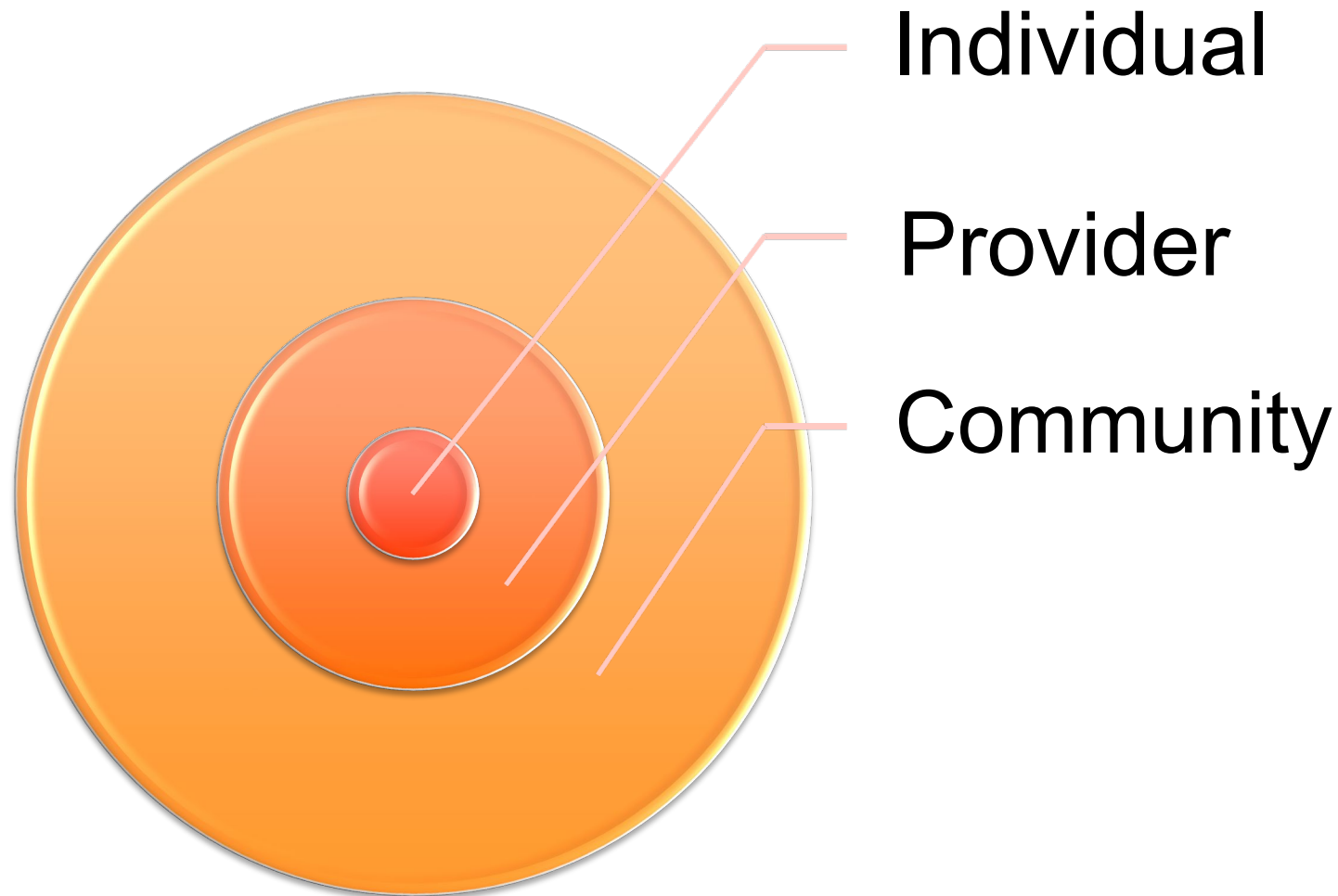
Significant increase in rate of “Against Staff Advice” discharges among patients with opioid use disorder

3) Unit milieu issues

4) Use of opioids during treatment

5) Increased incidence of overdose deaths following treatment

COR-12 and 12 Step Change: A Parallel Process



Phillip Wylie's Article in The Grapevine (1944)



“I quit solo - by which I mean that no organized group like AA was around to assist or advise. But I had plenty of assistance and expert advice, much of which curiously parallels what I know now about AA.”

“I know that if I were a doctor - and an alcoholic - I'd investigate this special aspect of the puzzle thoroughly. The possible future values of chemistry should not be overlooked by any of us in the presence of the proved value of psychological and philosophical regeneration.”

Bill Wilson's Response to Article and Debate



“Therefore, no AA should be disturbed if he cannot fully agree with all of Mr. Wylie's truly stimulating discourse. Rather shall we reflect that the roads to recovery are many; that any story or theory of recovery from one who has trod the highway is bound to contain much truth.”

The Third Tradition “a desire to stop”

“It reminded us that we must never take away anyone’s full chance for recovery,..... Excluding any of them from the Twelve Step community and the latest innovations in MAT could possibly condemn them to death from opioid overdose.”

(COR-12 Manual pg. 36)

My clients don't hit bottom; they live on the bottom. If we wait for them to hit bottom, they will die. The obstacle to their engagement in treatment is not an absence of pain; it is an absence of hope.

Outreach Worker
(Quoted in White, Woll,
and Webber 2003)

“We decided to move past any stigma associated with this form of treatment, letting evidence-based practices and compassion guide our response to the opioid crisis.”

(COR-12 Manual pg. 36)

Cultural and Systemic Transformation

- Recovery Management (RM) principles have guided our COR-12 initiatives from the beginning.
- RM requires programmatic, organizational, and systemic change because of a greater appreciation for the difference between acute illness and chronic illness and a comprehensive and long-term response to improve outcomes.

Cultural and Systemic Transformation, cont.

- Changing from an acute to chronic disease model requires cultural changes at staff and programmatic levels.
 - responsibility of disease/RM lies with the patient and the family with the interdisciplinary team (IDT) in the role of supportive, collaborative consultant
 - program design needs to promote patient self-management and self-efficacy early and throughout the recovery process

What The Evidence Shows (Decisions based on evidence not opinion)



ASAM Definition of Addiction

Addiction is a **treatable, chronic** medical disease involving complex interactions among brain circuits, genetics, the environment, and an **individual's life experiences**. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and **treatment** approaches for addiction are **generally as successful** as those for other chronic diseases.

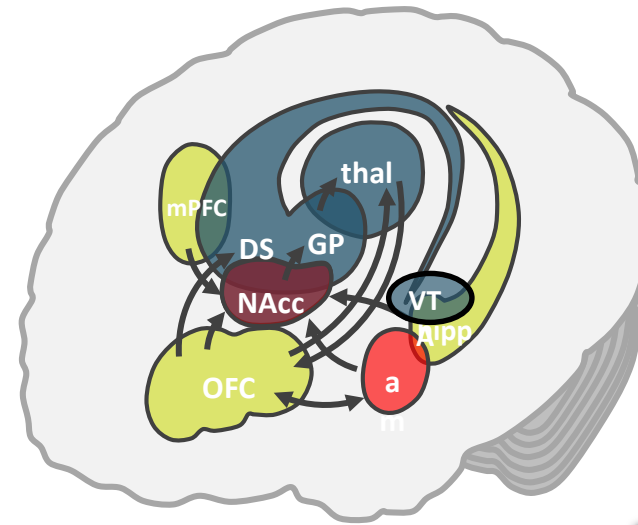
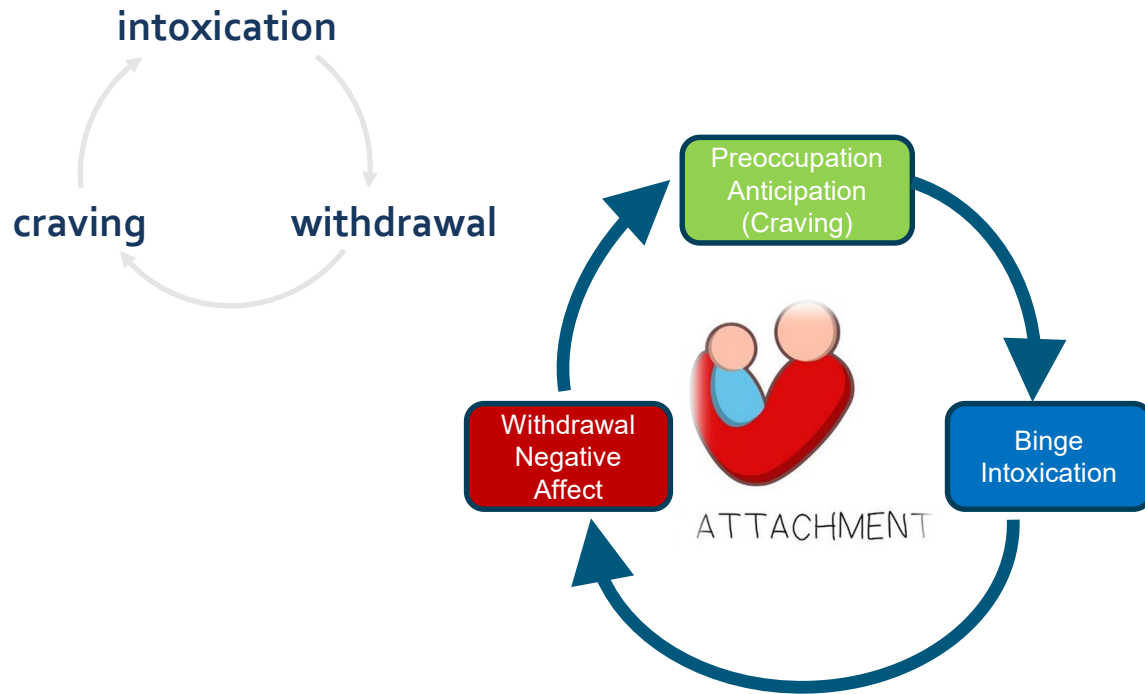
Addiction is a Brain Disease

NOT:

- Secondary to another psychiatric illness
- A moral or ethical problem
- A choice
- A personality disorder

Neurobiology of Addiction

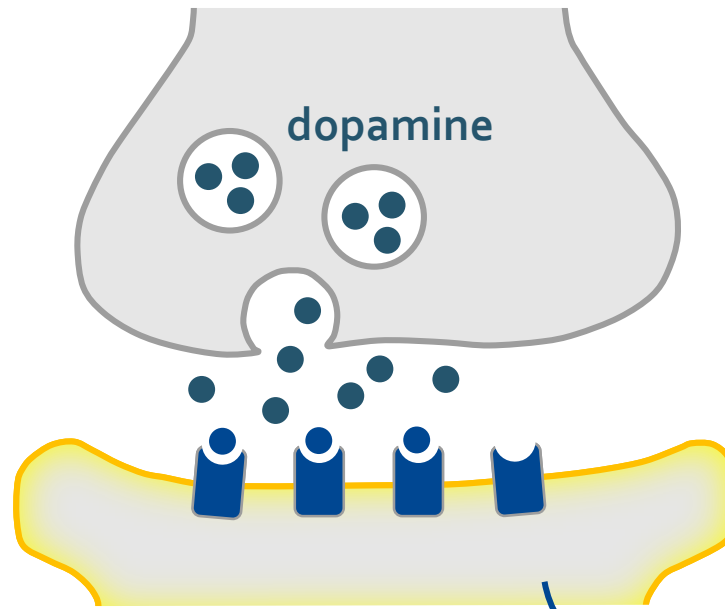
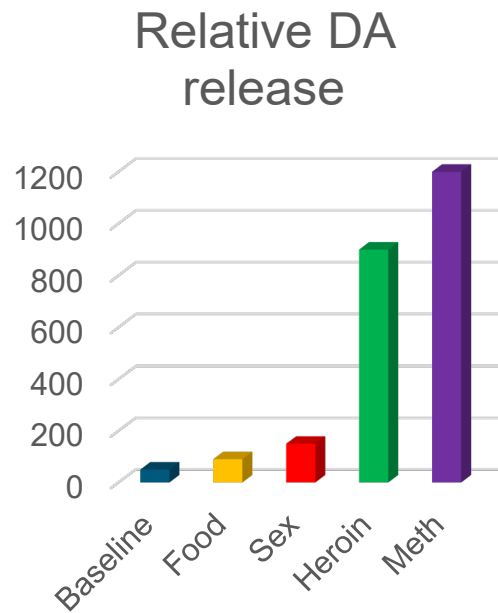
(Why people use intoxicants and why they can't just stop)



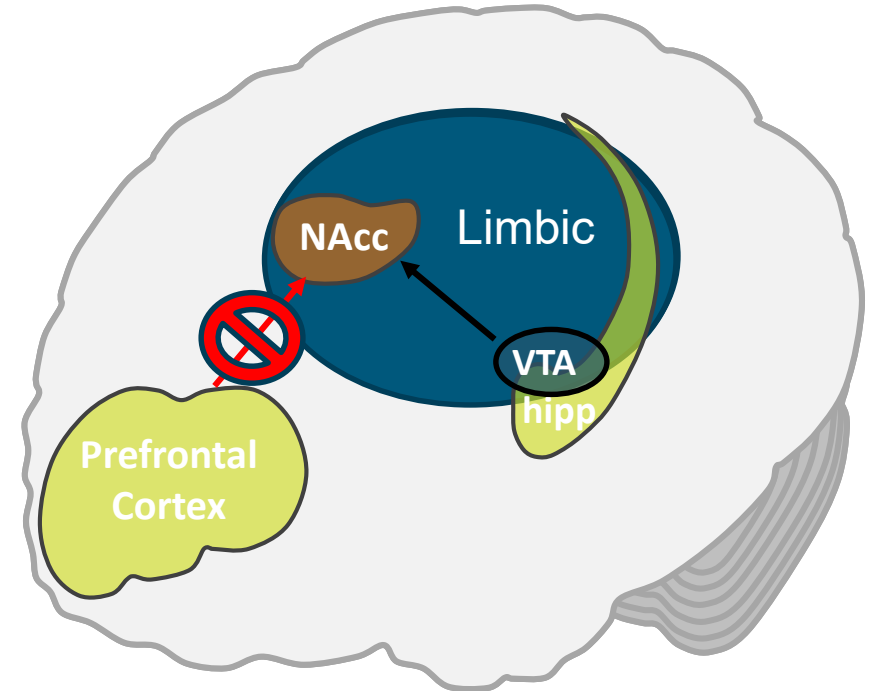
PAIN

euphoria

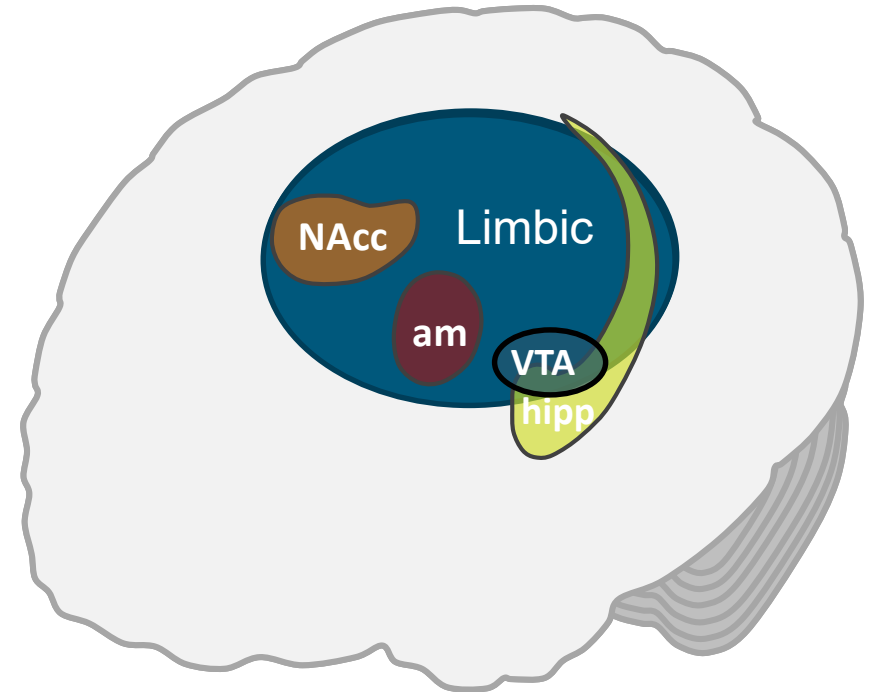
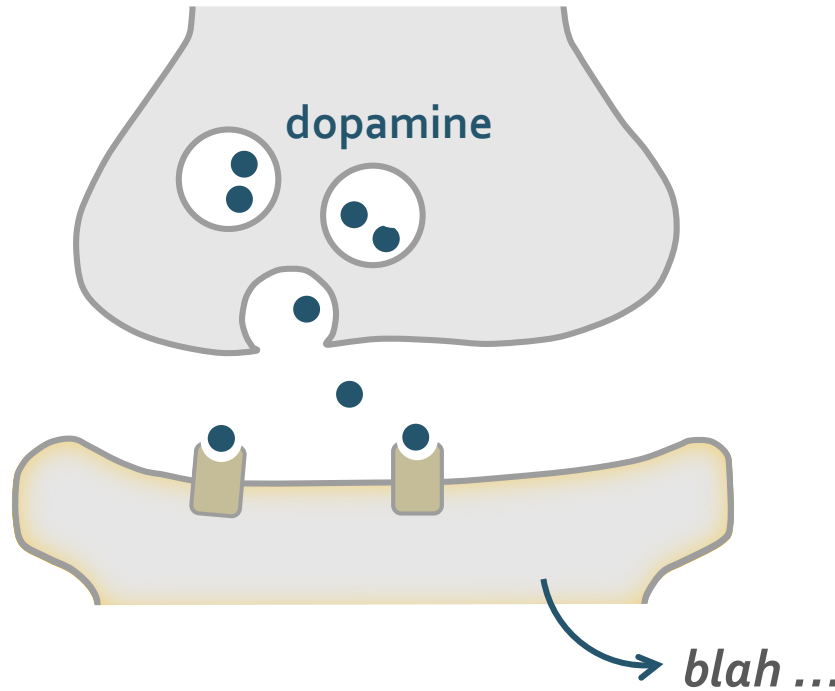
Neurobiology of Addiction – Reward/Intoxication



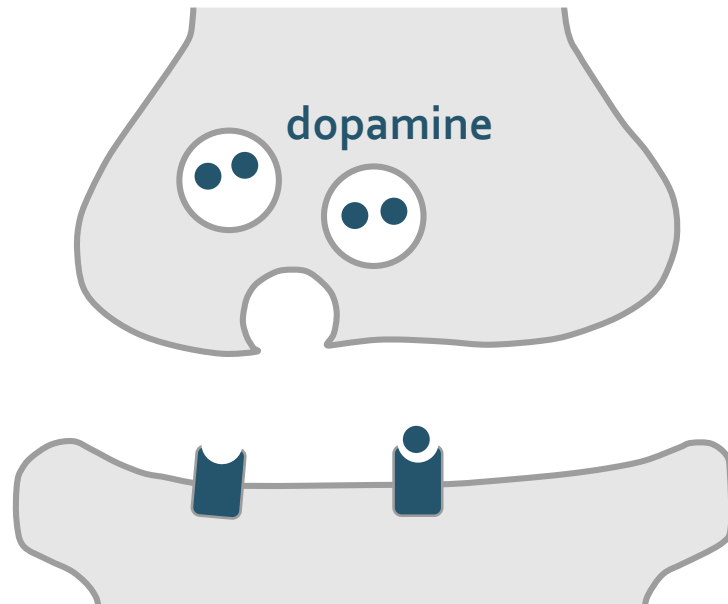
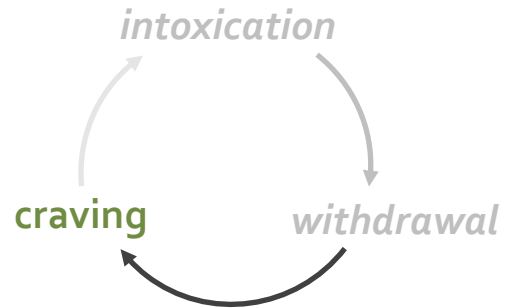
→ **reward!!!!!!!!!!**



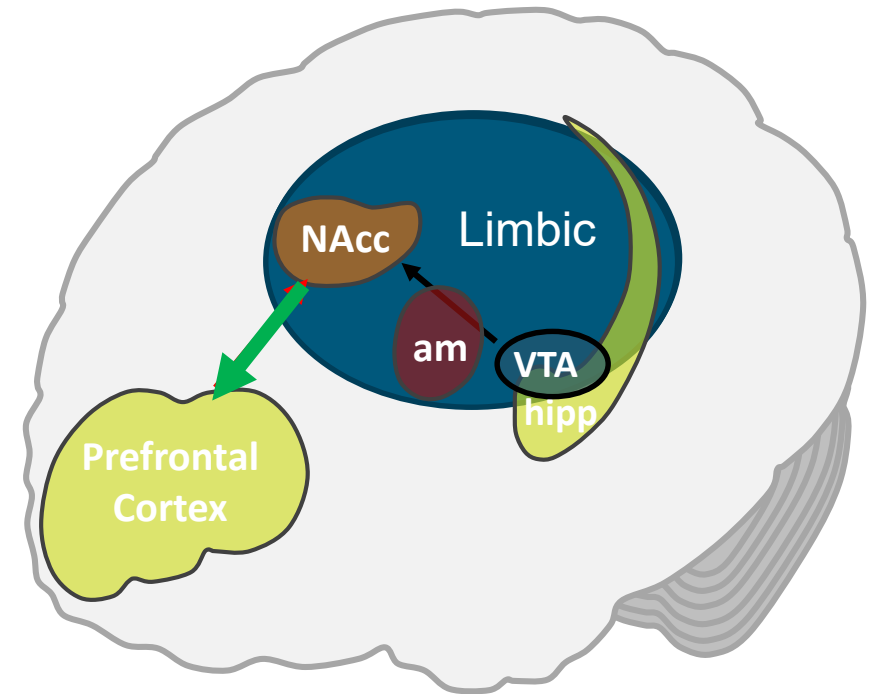
Neurobiology of Addiction – Withdrawal



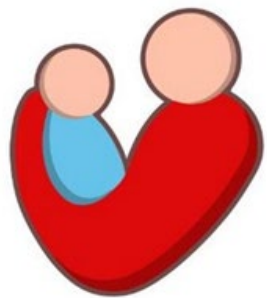
Neurobiology of Addiction – Craving/Anticipation



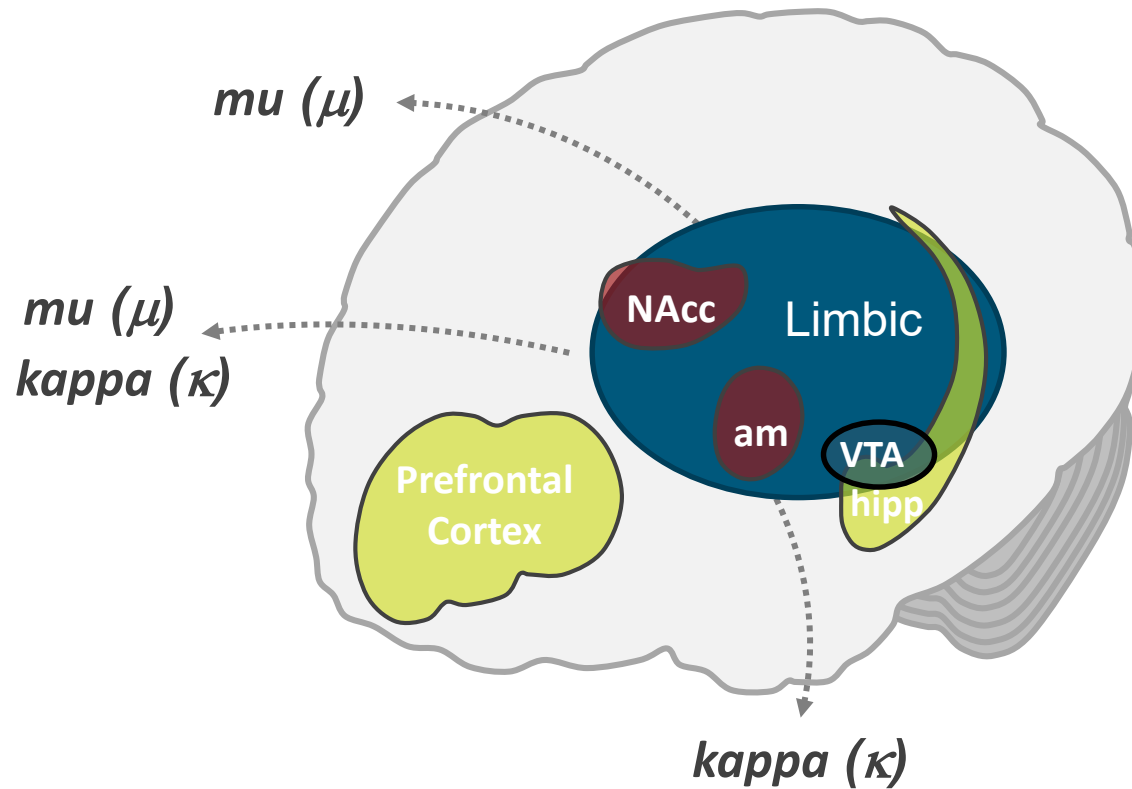
LTP - Glutamate



Neurobiology of Opioids



ATTACHMENT



mu (μ)
euphoria
reinforcement

kappa (κ)
stress
negative affect

Challenges in Treating Opioid Use Disorders

1. Potent stimulator of dopamine release in brain

- No “Pink Cloud” with opioid addiction
- Profound “salience”
- Powerful physical dependence, withdrawal is uncomfortable, and protracted post-acute withdrawal

2. Diverse population

- Young population → early substance use with alcohol, cannabis and pills. Progress to smoked or IV heroin before completion of brain development
- Older population → prescription opioids. Chronic pain issues lead to chronic prescriptions. Often concomitant use of benzodiazepines, sleep medications and/or alcohol

3. Low distress tolerance and opioids involved in attachment

4. Mismatch between traditional treatment and biological reality

5. Both Acuity and Complexity need to be addressed

What is Needed? A Multifaceted Approach

1. Multiple pathways to recovery that are person-centered
2. Enhanced access to evidence-based treatment, including medication assisted treatment
3. Improved linkage to treatment – chronic disease management
4. Harm reduction efforts and increased distribution of naloxone to reverse overdoses
5. Improvement in prescribing practices for opioids
6. Increased access and use of prescription monitoring programs
7. Law enforcement strategies to reduce illicit opioid supply

Treatment as More Than an Episode

- Treatment is designed to begin a process of lifelong sustainable recovery.
- Treatment is not seen as a “fix all”
- Aftercare moves to Recovery Management

Comprehensive Treatment factors

Medication Management

- Methadone
- Buprenorphine & Naloxone
- Oral or IM Naltrexone
- No Medications

Psychosocial Therapies

- MET
- CBT
- TSF
- DBT
- Group
- Individual
- Family

Recovery Management

- Peer Specialists
- 12 Step fellowships
- Celebrate Recovery
- RCOs
- Peer Coaching
- Recovery Housing

Case Management

- Community Teams
- Home Visits
- Telephonic Support
- Referral Networks



COR-12 Track

- Opioid Support Group (not separation)
- Medication Trainings to ensure safety and compliance (Psychiatric and MOUD)
- Community Outreach to improve housing and peer recovery support options
- Multidisciplinary Team Involvement

COR-12 Principles



Abstinence May Include Medication Use

Recovery Management Focus

No Separation Based on Medication

Client Choice & Family/supporter
Involvement

Medication Pathways

No Medications

- Withdrawal Management utilizes medication
- Recovery Capital assessment

Oral/ IM Naltrexone

- May involve extended taper while in inpatient
- Requires abstinence period before initiation

Bup-Naloxone

- Recovery Housing and aftercare established

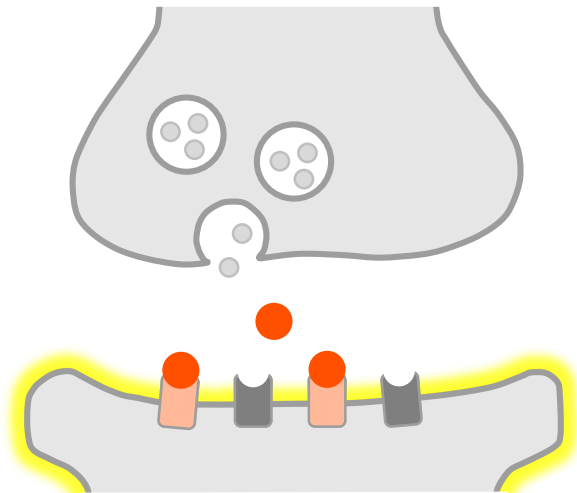


Medication for Opioid Use Disorder (medication assisted recovery)

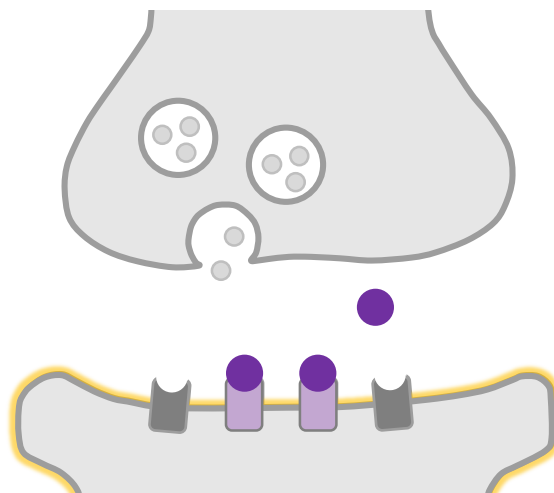
- Great benefit in appropriate patients
- Reduces all-cause mortality
- Not one-size fits all
- Medications not suitable (or desirable) for all patients

- A pill can't provide meaning, compassion, and human connection, BUT some people can't access meaning, compassion, and human connection without a pill

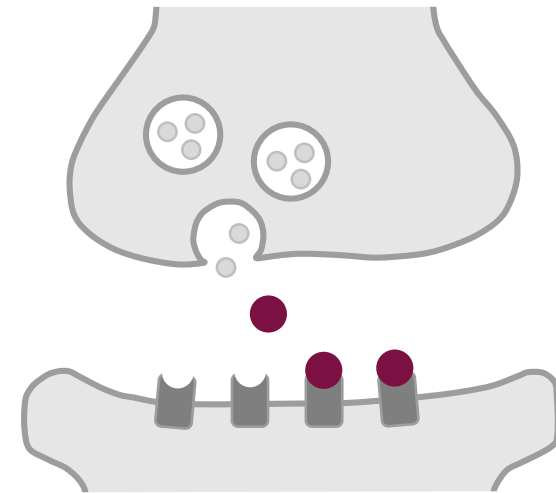
Medications Approved for Opioid Use Disorder



full agonist
methadone

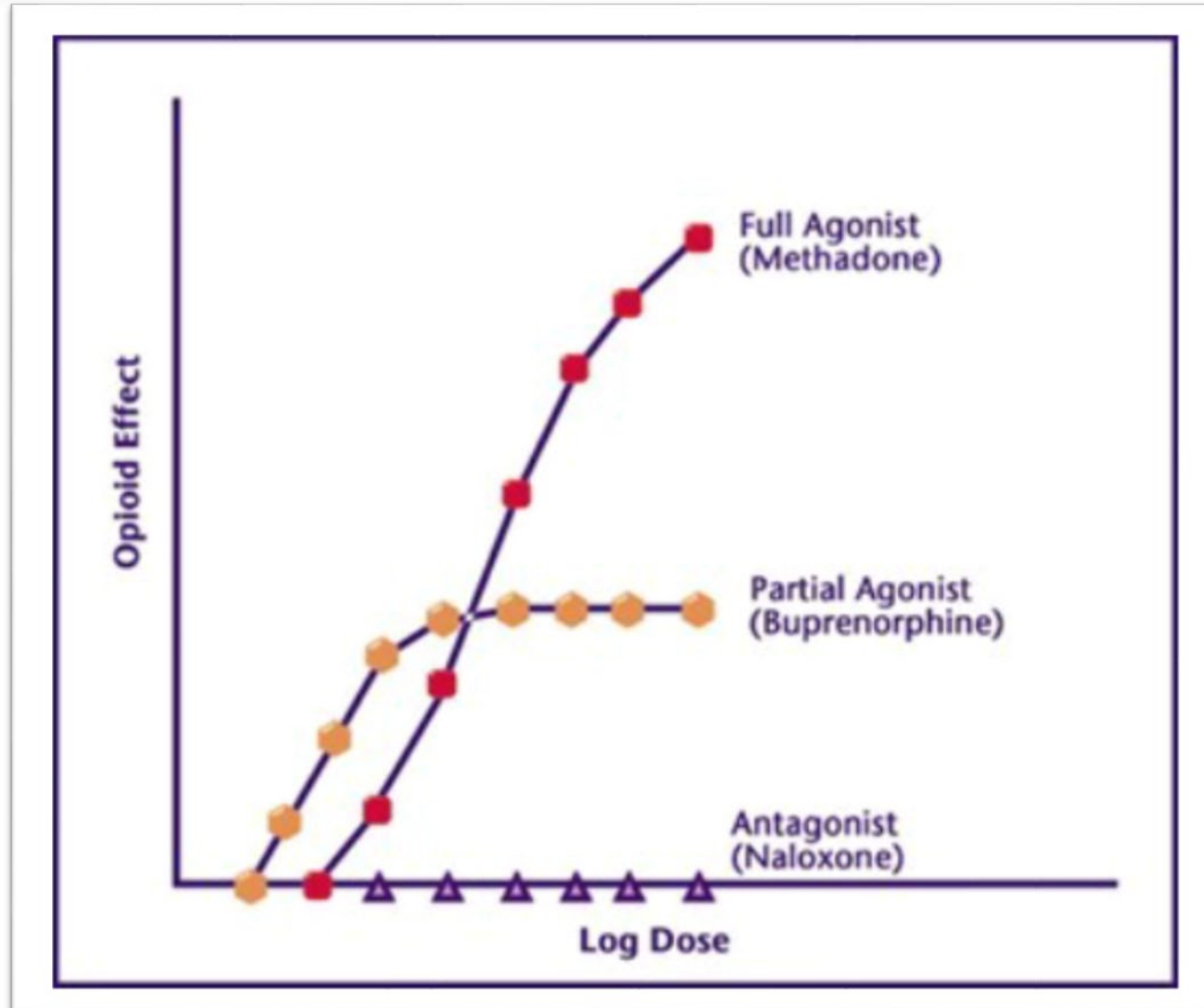


partial agonist
buprenorphine



antagonist
naltrexone

Medications Approved for Opioid Use Disorder



Just one drug for another drug?

Compatibility with 12-Step Abstinence-based model?

Drug	Medication
Used for euphoric effect	Used to prevent or treat disease
Used intermittently, when one wants	Used regularly, as prescribed
Used to avoid withdrawal	Used to prevent/reduce drug use
Often obtained illicitly off the street/internet	Prescribed by treating physician/provider

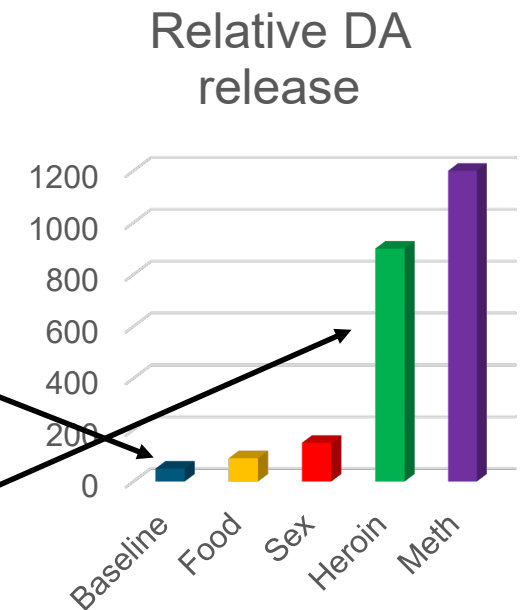
- Framing and context important for successful integration
- Helpful for patients, family and staff training
- Increases patient and family “buy-in”

Just one drug for another drug?

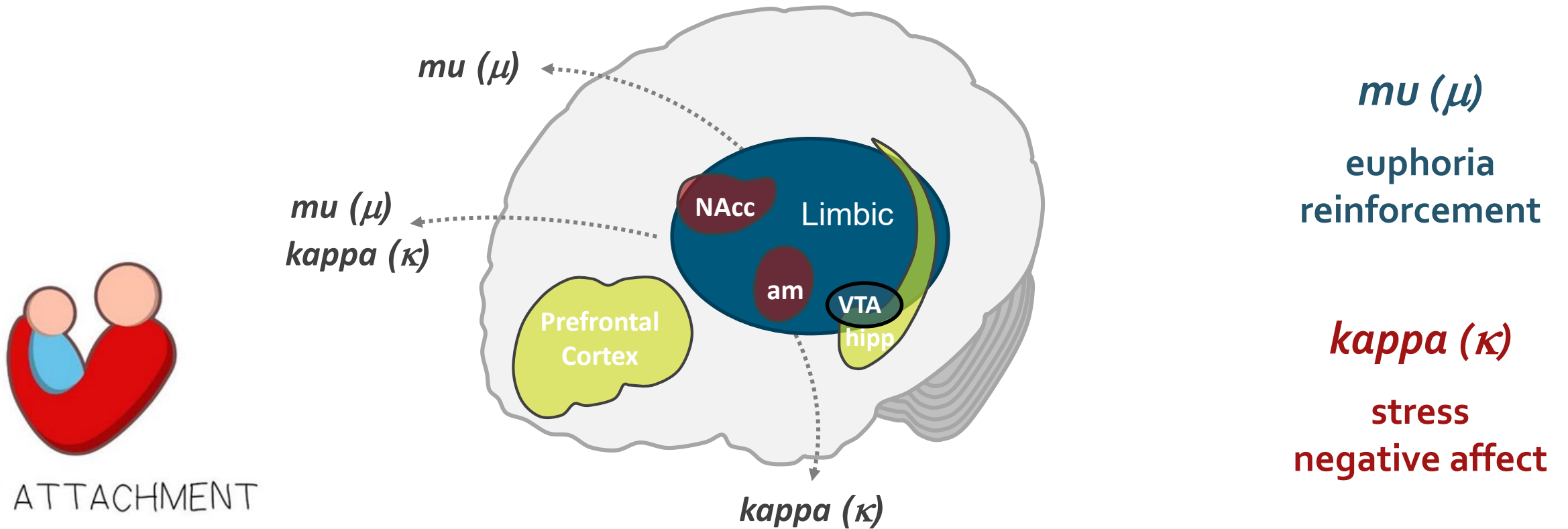
Further noteworthy dopamine levels..

- Dopamine levels after opioid detox....**10ng/dL**
- Dopamine levels during MAT...**50-60ng/dL**

NOT this



Remember those receptors?



COR-12 Research Study

- Most studies are RCTs (Randomly Controlled Trials)
 - Typical finding: patients who receive either buprenorphine or naltrexone do better than placebo (no meds) patients in treatment engagement and opioid use
 - Most studies use minimal individual and group counseling as the psychosocial component
- Our study: not is an RCT
 - Naturalistic observation of clinical practice
 - Clinical practice drives care decisions, the research follows
 - Significant individual and group counseling services provided

COR-12 Research Study

- We are conducting a naturalistic, observational study of patients who are attending our COR-12 programming and who agree to be part of a COR-12 research study.
- 253 OUD patients attending Center City residential from June 2013 – June 2017
- All patients had an ICD dx of opioid dependence/opioid use disorder
 - 58% heroin
 - 30% oxycodone
 - 12% other

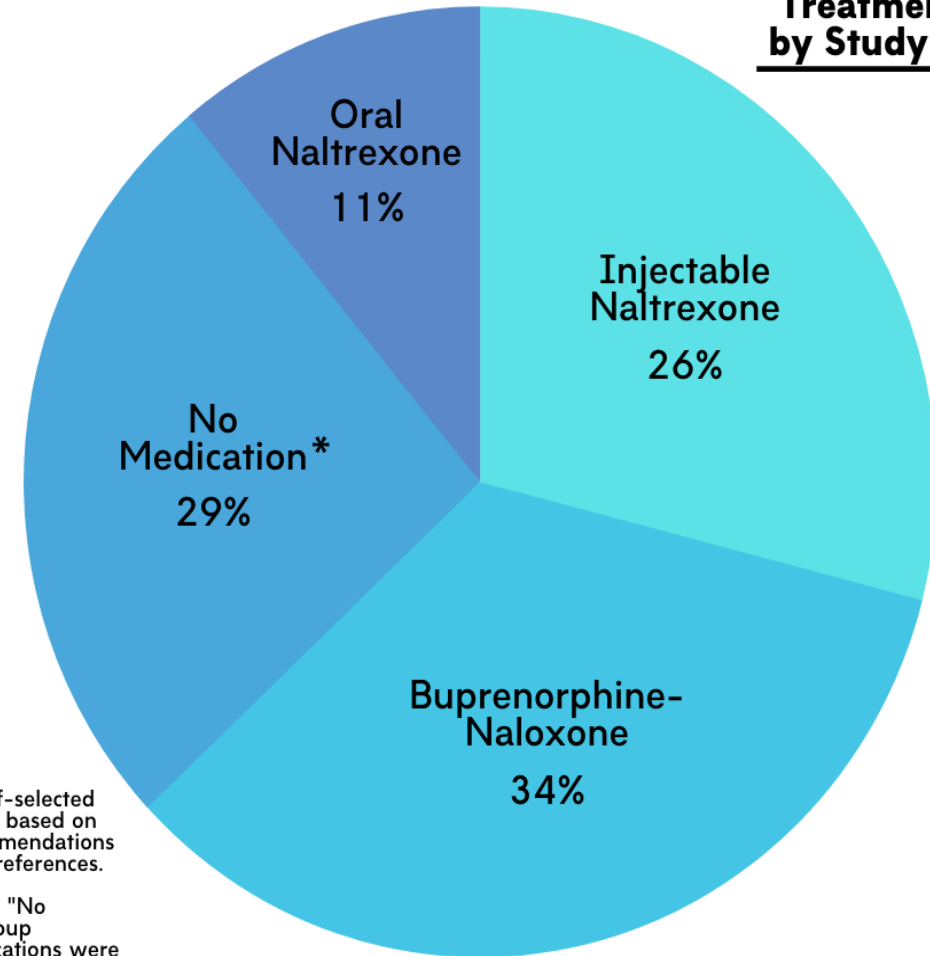
Patient Demographics

- 68% male
- Mean age: 30 yrs; 69% were 30 years or younger
- 48% had an AUD
- 21% had 3 or more SUDs besides OUD
- 90% had at least 1 MH disorder
- 20% had ≥ 3 past SUD treatment episodes
- 34% buprenorphine, 35% naltrexone, 31% no meds
- Severity consistent with other studies

COR-12 Research Study

- Participants Self-selected into treatment based on Provider recommendations and personal preferences
- Buprenorphine-naloxone patients reported higher cravings at start of study

Treatments Selected by Study Participants

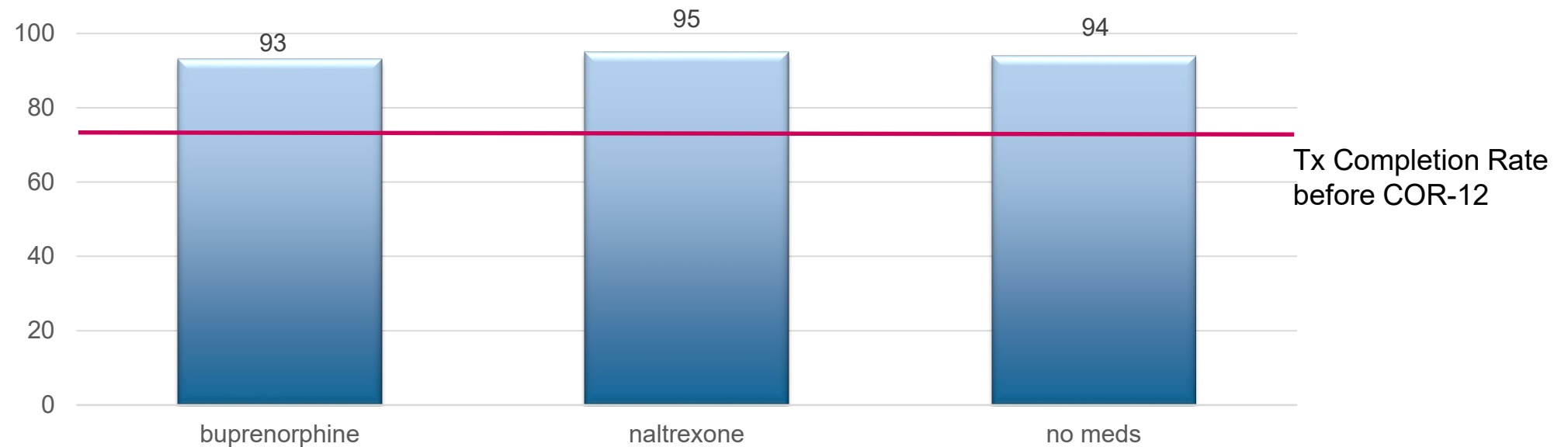


* Participants self-selected into treatments based on provider recommendations and personal preferences.

Reasons for the "No Medication" group declining medications were not examined in this study.

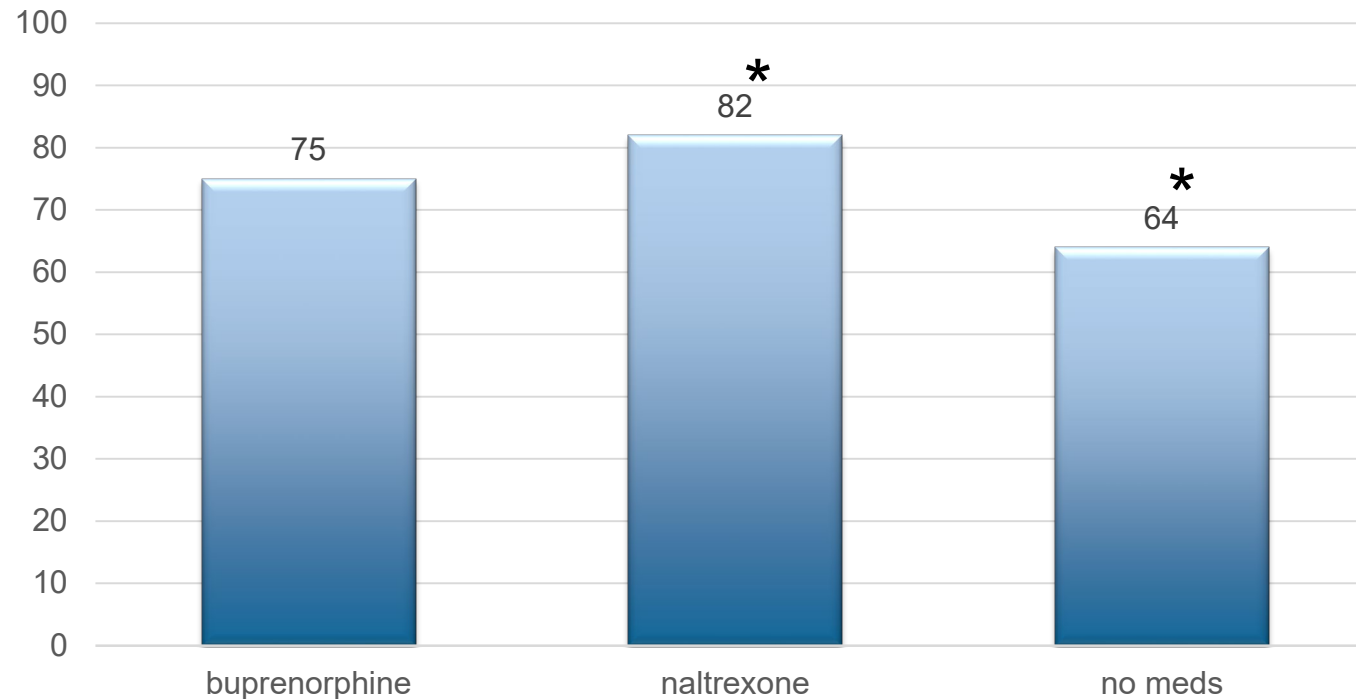
Treatment completion: Residential Treatment

% of COR-12 study participants completing residential treatment by med condition



Step down program engagement

% of COR-12 patients who stepped down to another Hazelden Betty Ford program



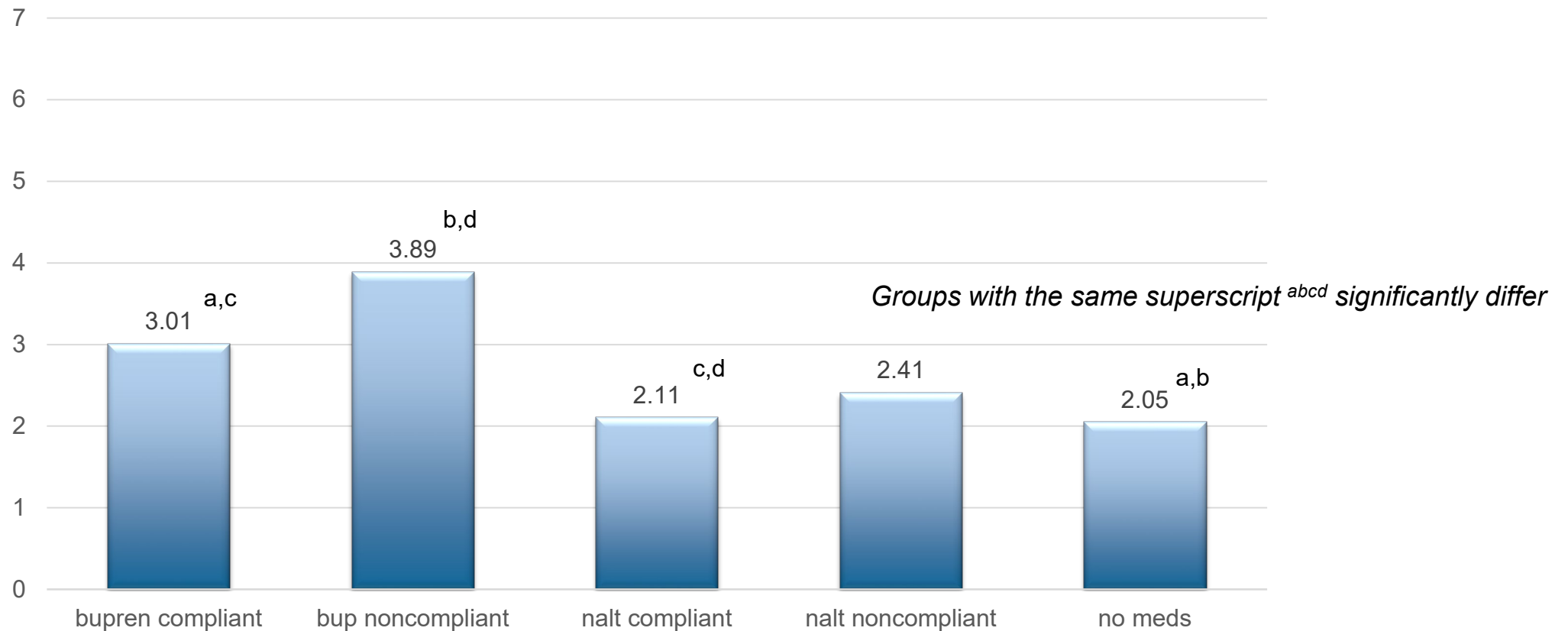
* These groups significantly differ at $p < .05$

Medication compliance after residential treatment

- At 1 month, 89% of buprenorphine patients reported complying with their meds, vs. 78% of naltrexone patients
- At 6 months, compliance rates were 72% for buprenorphine and 47% for naltrexone ($p = .01$)
- We examined abstinence and opioid craving as a function of medication compliance...

COR-12 Research Study

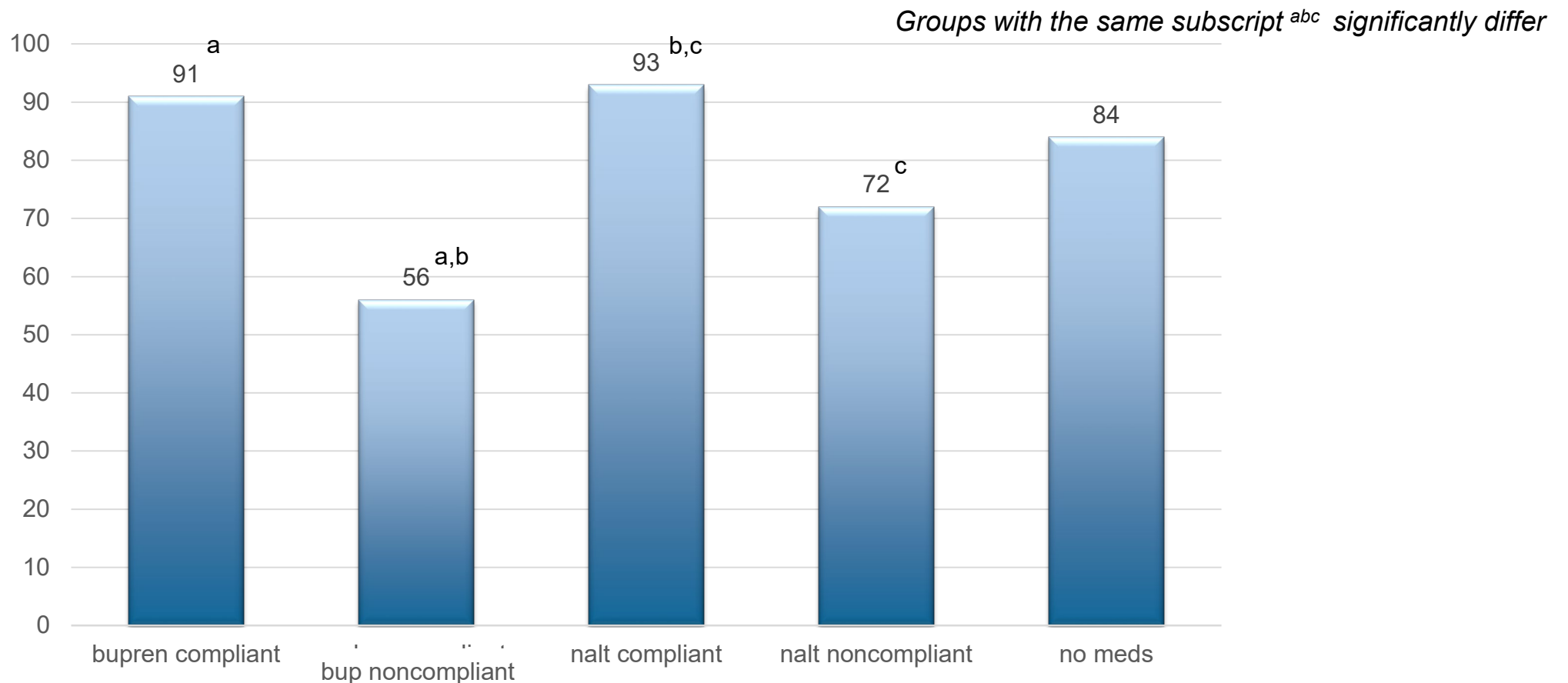
Opioid **craving** at 1 month as a function of medication compliance



Klein, A. A. & Seppala, M. D. (2019). [Medication-assisted treatment for opioid use disorder within a 12-step based treatment center: Feasibility and initial results](#). Journal of Substance Abuse Treatment, 104, 51-63. doi: 10.1016/j.jsat.2019.06.009

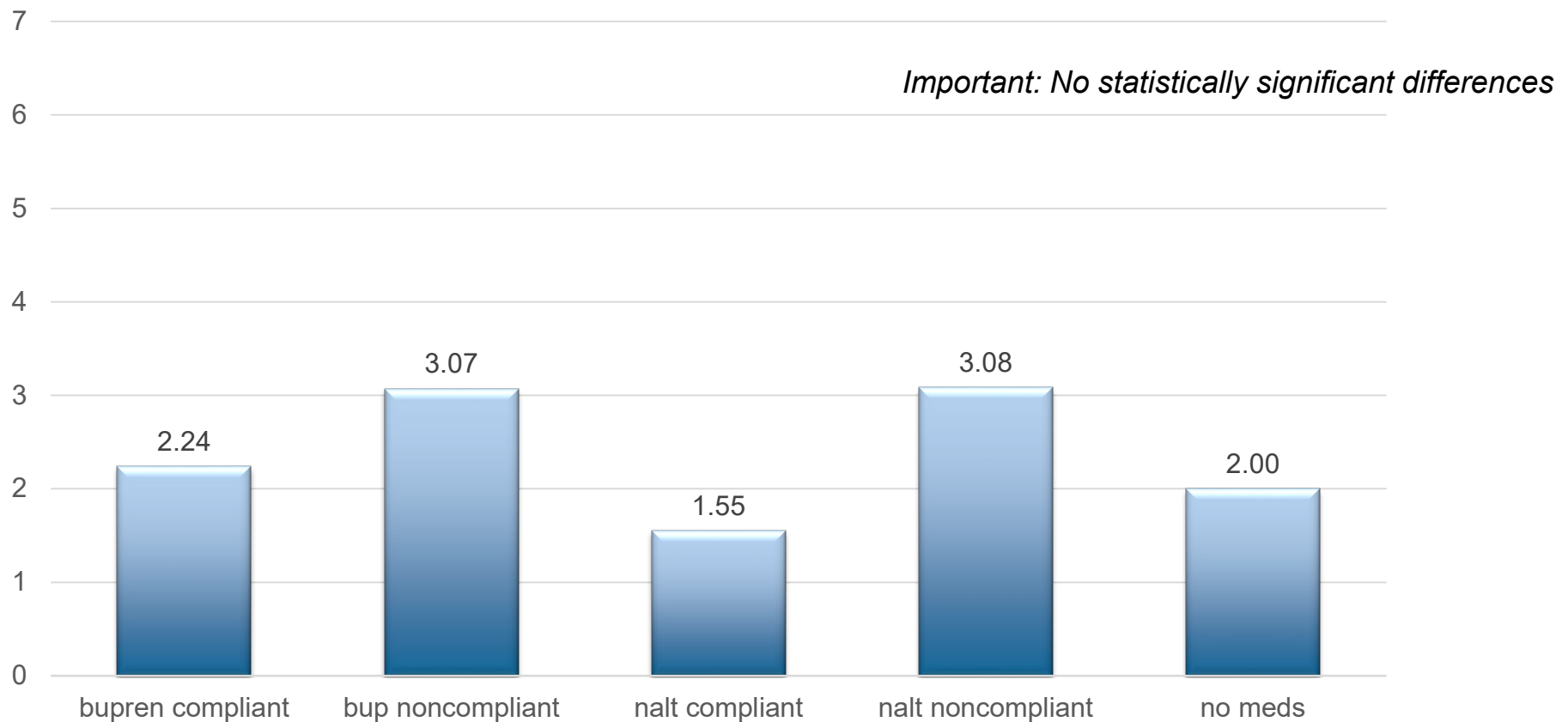
COR-12 Research Study

Abstinence at 1 month as a function of medication compliance



COR-12 Research Study

Opioid **craving** at 6 months as related to medication compliance

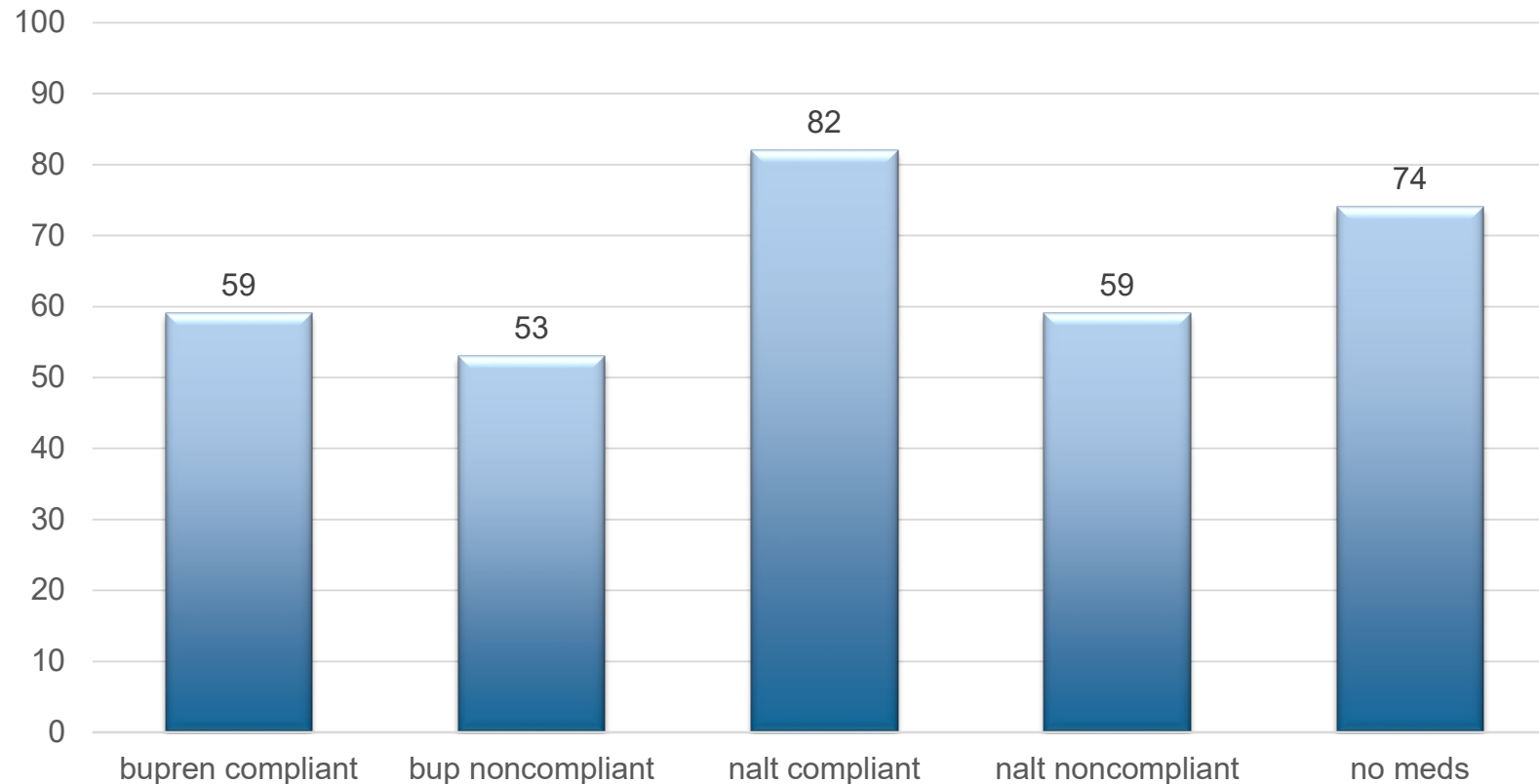


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COR-12 Research Study

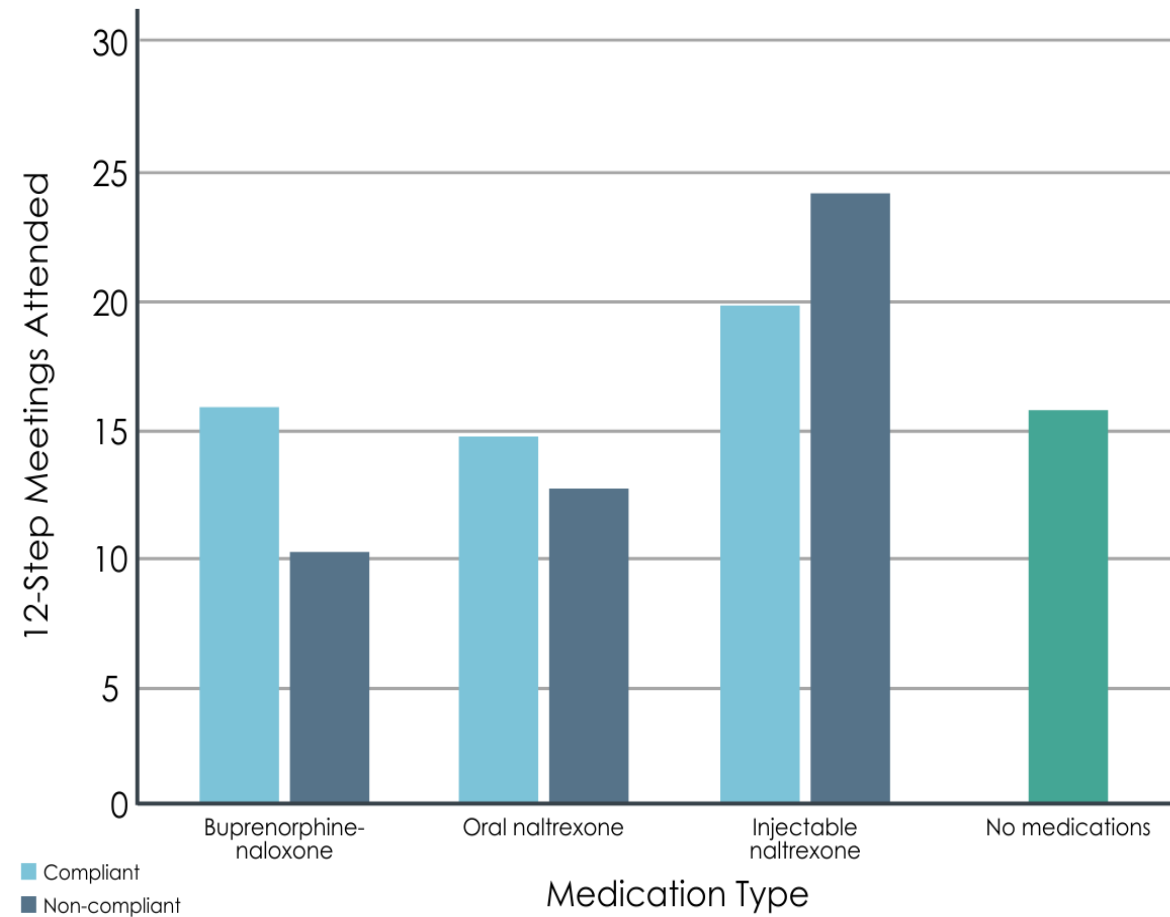
Abstinence at 6 months as a function of medication compliance

Important: No statistically significant differences

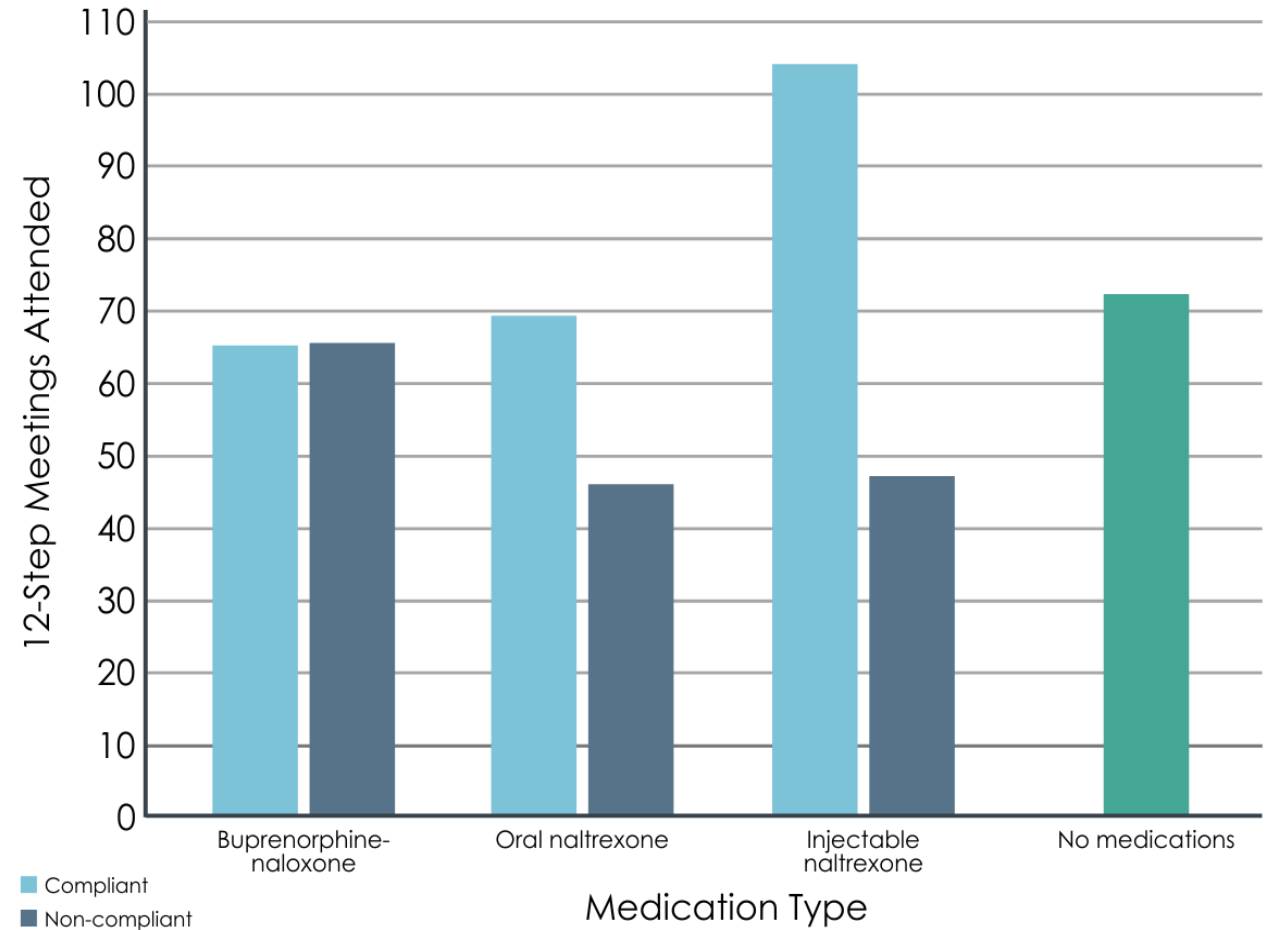


COR-12 Research Study

One Month 12-Step Meeting Attendance by Medication Type



Six Month 12-Step Meeting Attendance by Medication Type



Thank you!

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