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
“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
A Thought Experiment About Choices
Key Elements of Non-productive Debate

Pro-medication Bias “Always”

Medication Stigma “Never”
The History of the Minnesota Model

Main Building, State Hospital  
Willmar, Minn.
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
“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.”
“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.”
“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)
“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.
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)
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)

Adapted from: Koob GF, Lloyd GK, Mason BJ (Nat Rev Drug Discov 2009) and Koob GF, Volkow ND (Neuropsychopharmacology 2010)
Neurobiology of Addiction – Reward/Intoxication

Adapted from: Koob GF, Lloyd GK, Mason BJ (Nat Rev Drug Discov 2009) and Koob GF, Volkow ND (Neuropsychopharmacology 2010)

Relative DA release

Baseline, Food, Sex, Heroin, Meth

reward!!!

Adapted from: Koob GF, Lloyd GK, Mason BJ (Nat Rev Drug Discov 2009) and Koob GF, Volkow ND (Neuropsychopharmacology 2010)
Neurobiology of Addiction – Withdrawal

Adapted from: Koob GF, Lloyd GK, Mason BJ (Nat Rev Drug Discov 2009) and Koob GF, Volkow ND (Neuropsychopharmacology 2010)

control
1 mo. cocaine

intoxication

withdrawal

craving

dopamine

NAcc
Limbic

am
VTA
hipp

blah …
Neurobiology of Addiction – Craving/Anticipation

Adapted from: Koob GF, Lloyd GK, Mason BJ (Nat Rev Drug Discov 2009) and Koob GF, Volkow ND (Neuropsychopharmacology 2010)

withdrawal

LTP - Glutamate

dopamine

NAcc

VTA

limbic

Prefrontal Cortex

am

hipp
Neurobiology of Opioids

Adapted from: Koob GF, Lloyd GK, Mason BJ (Nat Rev Drug Discov 2009) and Koob GF, Volkow ND (Neuropsychopharmacology 2010)

- **mu (µ)**: euphoria, reinforcement
- **kappa (κ)**: stress, negative affect

**Diagram:**
- Prefrontal Cortex
- NAcc
- VTA
- Limbic
- am
- hipp
- Attachement

**Note:**
- NAcc (Nucleus Accumbens)
- VTA (Ventral Tegmental Area)
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

Adapted from: Rudd RA, Seth P, David F, Scholl L. MMWR 2016;65:1445–1452
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

<table>
<thead>
<tr>
<th>Medication Management</th>
<th>Psychosocial Therapies</th>
<th>Recovery Management</th>
<th>Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>MET</td>
<td>Peer Specialists</td>
<td>Community Teams</td>
</tr>
<tr>
<td>Buprenorphine &amp; Naloxone</td>
<td>CBT</td>
<td>12 Step fellowships</td>
<td>Home Visits</td>
</tr>
<tr>
<td>Oral or IM Naltrexone</td>
<td>TSF</td>
<td>Celebrate Recovery</td>
<td>Telephonic Support</td>
</tr>
<tr>
<td>No Medications</td>
<td>DBT</td>
<td>RCOs</td>
<td>Referral Networks</td>
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<tr>
<td></td>
<td>Group</td>
<td>Peer Coaching</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual</td>
<td>Recovery Housing</td>
<td></td>
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<tr>
<td></td>
<td>Family</td>
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**Hazelden Betty Ford Foundation**
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
<table>
<thead>
<tr>
<th>No Medications</th>
<th>Oral/ IM Naltrexone</th>
<th>Bup-Naloxone</th>
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<tr>
<td>• Withdrawal Management utilizes medication</td>
<td>• May involve extended taper while in inpatient</td>
<td>• Recovery Housing and aftercare established</td>
</tr>
<tr>
<td>• Recovery Capital assessment</td>
<td>• Requires abstinence period before initiation</td>
<td></td>
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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
### Compatibility with 12-Step Abstinence-based model?

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

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

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

Source: Excerpt of a 2015 presentation for CHCF by addiction specialist R. Corey Waller, MD, medical director of the Center for Integrative Medicine at Spectrum Health Medical Group in Michigan

National Institute on Drug Abuse
Remember those receptors?

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<th>mu (μ)</th>
<th>euphoria reinforcement</th>
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<td>kappa (κ)</td>
<td>stress negative affect</td>
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Adapted from: Koob GF, Lloyd GK, Mason BJ (Nat Rev Drug Discov 2009) and Koob GF, Volkow ND (Neuropsychopharmacology 2010)
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
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
• Participants Self-selected into treatment based on Provider recommendations and personal preferences
• Buprenorphine-naloxone patients reported higher cravings at start of study

% 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

- Buprenorphine: 75%
- Naltrexone: 82%
- No meds: 64%

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

Groups with the same superscript \textsuperscript{abcd} significantly differ

Abstinence at 1 month as a function of medication compliance

Groups with the same subscript $^{abc}$ significantly differ

Opioid craving at 6 months as related to medication compliance

Important: No statistically significant differences

Abstinence at 6 months as a function of medication compliance

Important: No statistically significant differences

Thank you!

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