Role Clarification: The Addiction Counselor in MATR Settings

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Learning objectives

01. Describe the counselor’s role in treating the opioid public health crisis.

02. Implement workforce development solutions tailored to addiction treatment professionals in Opioid Use Disorder settings.

03. Conceptualize evidence-based treatment (including MATR) for Opioid Use Disorder.
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BRIEF HISTORY LESSON

- Narcotics were first made illegal at the federal level in 1914
- The first heroin/morphine maintenance clinics opened shortly thereafter
- Some were good, many were shady and basically just replaced drug dealers
- These were all banned in the early 1920s and no maintenance was allowed until...
- Methadone in the mid-1960s

BRIEF HISTORY LESSON - CONTINUED

- Methadone first thought of in mid 1960s in our 3rd heroin epidemic
- Dole and Nyswander thought of it like insulin for diabetes
- The idea didn’t get mainstream acceptance until 1974
- NATA passed largely due to fears of crime
- From the outset there was tension between what maintenance was supposed to do for individuals versus communities.
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42 CFR Part 8

- Licensing requirements
- Who can be admitted
- What services are offered
- Staff positions
- Maximum first day dose
- “Take home” doses
  - Time in treatment
  - Stability criteria

Many states add additional regulations

- Limit number of OTPs
- Limit where OTPs can operate
- Enforce patient: counselor ratios
- Mandate frequency of counseling
- Mandate frequency of urine drug screens
- Mandate observation of urine drug screens
- Limit when take home doses can be given
- Add criteria for take home dose qualification
- Mandate program discharge for ongoing drug use
- Force discussions about program discontinuation
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Regulatory Oversight of OTPs

- Federal
  - SAMHSA/ CSAT
  - Drug Enforcement Administration
- State
  - State Opioid Treatment Authority (SOTA)
  - State Licensing (e.g. Dept. of Substance Abuse Services, Dept. Behavioral Health)
  - In many states, Board of Pharmacy as well
- Professional (mandatory for federal licensure)
  - The Joint Commission
  - Council on Accreditation of Rehabilitation Facilities (CARF)

OTPs get conflicting messages from different stakeholders...

- **Public Health**
  - Prioritize access to medications
  - See regulations as barriers
  - Indifferent or even hostile to counseling

- **Recovery Community**
  - See recovery as the goal
  - Want to see progress in treatment

- **Social Control**
  - See OTPs as a necessary evil
  - Want strong regulations to ensure our patients don’t harm the rest of the community
The net result... no group is satisfied with the status quo

Public Health

“You’re too punitive and are killing people by preventing people from getting medication or by kicking them out of your program!”

OTPs

“You don’t get people better, you keep them chained to your clinic and your medication!”

Recovery Community

Social Control

“Your not punitive enough and let them get away with too much!”

The truth is, they all have a point!

- Public Health
  - We SHOULD do everything we can to lower barriers and retain patients
  - We have a vital role to play in preventing overdoses

- Recovery Community
  - We SHOULD have a clear path to get people to recovery
  - We SHOULD offer more than “gas and go” operations

- Social Control
  - We SHOULD take care to ensure our patients aren’t harming others
  - We don’t want things to be like the “bad old days” 100 years ago
We need a new clinical model...

- The historical model is “one size fits none”
- No one programmatic approach can treat all patients and satisfy all stakeholders
- We need to rethink the model entirely
  - Move from programmatic thinking: “The patient adapts to us…”
  - Move to individualized thinking: “We adapt to the patient”
- The patient, not the stakeholder and not the program, is at the center

**ADDITIONAL RESOURCES**

**Putting best practices into practice. BHG’s Integrated Dynamic Care Model (IDCM)**

Download our White Paper to learn more.

WHAT’S AN OTP?

Opioid Treatment Programs (OTPs)
An FDA-approved program or practitioner engaged in opioid treatment of individuals using all three approved medications (opioid agonist and partial opioid agonist).

- Emphasizes person-focused care
- Integrated and individualized approaches to OTP services
- Dispenses opioid agonist treatment medication, such as Methadone, and incorporates a comprehensive range of treatment services
- OTPs are the only program FDA-approved to dispense methadone

Behavioral Health Group (BHG) is the largest network of Joint Commission-accredited OTPs in the U.S. We integrate care providers from every appropriate discipline, (i.e., mental health counselors, behavioral health specialists, social workers, case managers, care coordinators, peers, nurses, and physicians)
WHAT’S AN OBOT?

Office Based Opioid Treatment (OBOT)

OBOTs are the most common type of opioid treatment program and uses the partial opioid agonist buprenorphine.

- Allows for expanded access to treatment in areas where an OTP is not accessible, or for patients who may not need OTP services during their current episode of care
- Permits physicians the opportunity to provide treatment for OUD within their regular medical practice

WHAT’S AN OBOT?

Office Based Opioid Treatment (OBOT)

OBOTs are the most common type of opioid treatment program and uses the partial opioid agonist buprenorphine.

- Promotes the treatment of addiction in the primary care setting
- Program is predominantly prescription based
- OBOTs are not FDA-approved to dispense methadone
- Counseling is not a requirement
- Requirement for linkage to counseling was removed in 2021
Understanding Today’s SUD Population

The vast majority of individuals who meet criteria for a Substance Use Disorder and are not receiving treatment do not feel they need treatment.

For those individuals who DID perceive a need for treatment in the past year, but who did not receive it, one of the most cited reasons for not receiving treatment was:

“Not ready to stop using...”

Most Common Reasons For Not Receiving Substance Use Treatment

- Not being ready to stop using: 36.70%
- Having no health care coverage and not being able to afford: 24.90%
- Not knowing where to go for treatment: 17.90%
- Not finding a program that offered the type of treatment: 15.80%
- Thinking they could handle the problem without treatment: 15%
- Being concerned that getting treatment might have a...: 14.70%
When we think about our response to relapse...

“It’s important to meet people where they’re at, but not leave them where they’re at.”

What are examples of interventions that meet people where they are?

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1. **Motivational Interviewing:**
   MI uses preparatory talk during sessions, encouraging open yet directed questioning to evoke conversation about change. In essence, the client talks themselves into being ready by uncovering their desire, ability, reasons, and need for change (Miller & Rollnick, 2013).

2. **Cognitive Behavioral Therapy:**
   “If you have one drink, it’s a relapse...you have to go back to the beginning again. In harm reduction, we take the attitude, "Hey, lots of people have slips. Let’s look at what happened. You made a mistake. How can you learn from it?" We’re not saying, “You’ve got to go back to the beginning.” (Marlatt, 2011)
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MI:
- OARS
- Readiness Ruler
- EARS
- Discuss Risk

CBT:
- Exploring objections scale
- Rethinking objections scale
- CBT Decisional balance
- Goal charting

Evidence-Based Clinical Interventions
Interventions ideal for low-engaged patients

Comparing Private Practice to MATR Settings

PRIVATE PRACTICE
- Promote autonomy (counselor expectations)
- Clinical assignments / homework
- Private and individualized
- What else?

MATR SETTINGS
- Track autonomy (patient engagement)
- Clinical monitoring / reporting
- Collaborative and integrated

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Comparing Residential to MATR Settings

**RESIDENTIAL**
- Relinquished personal control
- Typically abstinence driven
- High engagement, around the clock care/support

**MATR SETTINGS**
- Graduated/moderate control
- Harm reduction, safety promotion
- Low engagement, available support

• *What else?*

THE HATS A COUNSELOR WEARS

1. **Counselor**
2. **Case Manager**
3. **System Navigator**
4. **Care Liaison**
The Hats a Counselor Wears

**COUNSELOR**
- Assess and treat the cognitive, behavioral, and emotional aspects of behavioral health disorders
- Help patients gain insight, define goals, and develop meaningful behavior changes
- Support their *bounce back* whenever targeted goals feel unmet – return and reevaluate treatment

**CASE MANAGER**
- Provide a well-documented plan, and track patient’s adherence to plan
- Help maintain and advocate for the health and wellness of their patients
- Work with patient and collaterals (family members, medical professionals, human services, insurance)

**SYSTEM NAVIGATOR**
- Our system is complex, and patients are assigned to a counselor to help them navigate it
- As that navigator we are responsible for our patient’s records

More Hats a Counselor Wears

**COMMUNITY EDUCATION**
- Provide education on support group availability (12-step and non 12-step options)
- Educate collaterals (medical professionals, human services workers, legal system representatives) on patient’s needs

**REFERRAL**
- Teaching patient how to attain services, provide referrals, and track referrals
- Follow up to ensure the connection was made and the necessary task was completed/service was obtained

**CARE LIAISON**
- Patient advocate in overall system of care
- Provide connections in navigating recovery supporting systems and resources
- Manage case record, sometimes on behalf of collaborative care team
### Medications for OUD

**WHAT THEY DO**
- Reduce the risk of overdose deaths
- Reduce use of illicit opioids
- Retain people in treatment
- Reduce risk of behaviors associated with transmissions of blood borne infections
- Reduce criminal behavior in criminally-offending OUD patients

**WHAT THEY DON’T DO**
- Reduce use of non-opioid substances
- Help people understand and identify internal and external triggers
- Teach people how to cope with craving
- Give people new skills to relate to unpleasant feelings
- Repair broken relationships
- Create new peer affiliations

### Opioid Abstinence ≠ Recovery

- Recovery is a multidimensional construct
- MOUD can keep someone alive, off opioids, and connected to care but...
- COUNSELORS help them attain, or regain, what the disease took from them
- OUD patients should not have less access to recovery than people with other SUDs
Modernizing Opioid Treatment Access Act

- In front of Congress now
- If passed, would make methadone for OUD available by prescription
- Does not require any counseling contact or even referral
- Risks both safety to the community AND relegating OUD patients to a second-class status

Be THAT Person

- Willing to ask the tough questions:
  - “are you sure this current treatment model is still best for you?”
  - “have you spoken to a doctor recently about your overall health, including your recovery plan?”
  - “when was the last time you spoke to a qualified healthcare professional about medication?”

- Willing to walk with your patient to a referral partner:
  - “let’s explore alternative treatment options together”
  - Video Story on the path of MATR

Decisions in Recovery: Treatment for Opioid Use Disorder

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Are we assessing if this patient would benefit from MAT?
Discuss Treatment Options for Shared Decision-Making

Introducing MAT

1. "Have you ever heard of MAT?"
2. "Would you like additional support with managing withdrawal symptoms?"
3. "Reducing the severity of relapse is just as important as achieving sustained sobriety"

How do you discuss treatment options with your patients?

References