

Webinar Title: Non-Abstinent Approaches to Substance Use Disorders

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Moderator: Hello, and welcome to today's webinar, Non-Abstinent Approaches to Substance Use Disorders. This topical webinar is paid for by McLean Hospital, a top-ranked freestanding psychiatric hospital, a leader in psychiatric care, research, and education, and the largest psychiatric teaching hospital of Harvard Medical School. Some important points before we get started.

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Now let me introduce our presenters. First, Dr. Rocco Iannucci began his psychiatric career at Massachusetts General Hospital and McLean Hospital, where he served as Chief Resident in Addiction Psychiatry and as Assistant Director of Psychiatric Residency Training. He then practiced general community and hospital psychiatry at Berkshire Medical Center, shaping his collaborative approach. In 2012, he returned to McLean Hospital as Director of the McLean Fernside Residential Treatment Program, focusing on integrated treatment for substance use disorders and co-occurring mental health conditions.

He also directed Fernside's postdoctoral fellowship in addiction psychology for 10 years and has published extensively on related topics. Dr. Jesse D. Kosiba earned his doctorate in clinical psychology from Syracuse University, completed pre-doctoral training at McLean Hospital Harvard Medical School, and a postdoctoral fellowship in psychology for the treatment of substance use disorders and co-occurring conditions at McLean Hospital. He joined Fernside in 2021 and serves as an instructor in psychology at Harvard Medical School. With over a decade of experience, Dr. Kosiba specializes in acceptance and commitment therapy and has published research on substance use anxiety and behavioral medicine. Welcome, Drs. Iannucci and Kosiba.

Rocco Iannucci: Thank you so much, and thank you all for being here. I'm really honored and I appreciate very much being able to speak to such a, apparently a very large audience doing such important work. Just to give you a little idea about what to expect, I'm going to give some context, some of the background information on non-

abstinent approaches, and then Dr. Kosiba will hopefully bring things to life a bit more with a couple of clinical vignettes to think about how to apply these principles practically.

I will start by saying I'm going to speak about-- we'll talk about non-abstinent approaches and focus on that, but we both practice at McLean Fernside in a primarily abstinence-focused model. Even in such a model, in an abstinence-focused residential treatment program, most people don't necessarily say they plan to stop a substance forever or that they're going to entirely stop every substance, so it's a little bit of an artificial distinction when we think about is it an abstinent-only treatment or a non-abstinence-focused treatment.

Abstinence itself has a history in this country in terms of explaining why it is the predominant approach still to substance use treatment. It's rooted in historical development of our treatments and their foundations in moral temperance movements, in the Oxford group, which was a religious group that also was a predecessor to AA or at least influenced AA and focused on abstinence, and then Alcoholics Anonymous, which was baked into treatment programs for quite a while in the country and still is. It's still a predominant model that you find in treatment programs for substance use disorders, so it's kind of the default.

There's also in clinical research a reason that abstinence is useful in terms of giving a very clear binary indication of the outcome. Did it work or not? Yes or no? Yes or no is a very easy thing to understand, and it's a helpful way to be able to approve or not approve or at least identify treatments as evidence-based. Abstinence also as a goal and as an outcome are associated with improvements in substance use outcomes and with measures of social functioning, psychological, and mental health. It's not really a surprise that many of us hope for abstinence for our patients because we see many of the good things that come along with it.

On the other hand, what do people actually want for themselves? In a survey of people who use or have used substances, other things came up as priorities for them. Some of the very, very fundamental things like survival, having basic needs met, being connected to support services, self-efficacy, one of the reasons that I think people stay away from treatments that mandate a certain approach if they don't want it, taking away their own autonomy, a good quality of life, improved mental health, and then reduced but not necessarily abstinence substance use.

That is something that's important for people, but there were not a lot of people who said that abstinence was important to them in terms of recovery. SAMHSA has been reflecting this in their own definition of recovery. They're currently defining it as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potentials. That's a definition that can fit to recovery from different things. It doesn't have to be substance use, but it doesn't necessarily mention quantity of use, mention any abstinence from use. That also reflects how we define substance use disorders.

We don't actually require any particular pattern of use or non-use to have or to not have a substance use disorder. It's much more focused on behavioral manifestations and consequences of the substance use. On the other hand, what's a potential

rationale for a different approach, non-abstinent goals or outcomes? First of all, they're a potentially more sensitive marker of treatment response.

You oftentimes find clinical studies where the primary outcomes are negative or non-significant, but if you look at secondary analyses, you see improvement in people, and we may be losing out on important treatments that could be tweaked and improved to actually have stronger effects if we don't recognize those effects. They're oftentimes more acceptable to patients. Many people don't go to treatment because they don't want to embark on abstinence. Non-abstinent goals can also be touchstones or turning points that lead to other improvements. For instance, you have some people who come in with a goal of abstinence, but they're not able to accomplish that right away. Maybe they do later on.

Other people come in with a goal of moderation, and they find that it's not satisfying or it's not attainable for them, and they'll move to an abstinent-based goal, and many people are able to achieve that. I think we have to recognize these as points of oftentimes progress for people, even if it's not the ultimate helpful goal for them. As I said, during any treatment episode, many patients, even if they're trying to attain abstinence, that won't be the initial outcome. Non-abstinent goals or outcomes can also be meaningful because some measures of heavier use of some substances, such as alcohol, cannabis, cocaine, opiates, they're associated with worse downstream, worse consequences later on.

The rationale is that reducing use may decrease negative consequences, and we have some evidence to suggest that. Finally, the abstinence violation effect, whereby if people use a little bit of a substance, they just say, "Well, I failed. I might as well just keep using." A discussion of how to manage recurring uses, and at least anticipate that abstinence, complete abstinence forever may not be the initial outcome or even the ultimate outcome for people, and how do they handle it if it's not. The other question is, do people need to quit everything at once? We have a little bit of information on this. I think this is an important question.

I see that all the time in our work, where there's a primary identified substance that people want to stop, and other things that they're more ambivalent about. Cannabis use in people in treatment for opioid use disorder is not necessarily associated with worse opioid-related outcomes, and heavy use has even been associated with less injection and improved retention in treatment. That is not a recommendation for people to use cannabis as part of their opioid treatment, but we have this information at least about it.

On the other hand, we used to maybe even discourage people from quitting cigarettes when they went into treatment for other substances, and we now know that cessation of tobacco use is probably a helpful thing in terms of being able to stop alcohol and other substances. The FDA still largely has a focus on abstinence-based outcomes in clinical trials, and only abstinence is accepted for clinical trials of substances other than alcohol. For alcohol, the concept of no heavy drinking days is also an acceptable outcome to assess treatments in clinical trials.

Since there's no heavy drinking days or, a non-heavy drinking day, looking at proportions, it can still be a binary yes or no answer, which is helpful. However, some medication trials have shown improvements in non-abstinent outcomes in

secondary analysis, and I'll come back to that in a little bit. Just defining a heavy drinking day a little further, I think many of you are familiar with this graphic showing a standard drink. These are standard drinks as they're defined in the US, and they amount to 0.6 fluid ounces of pure alcohol in different concentrations, so it's different fluid amounts.

For women, because of differences in how alcohol distributes in the body, it's metabolizing the effect it has, a heavy drinking day is considered four or more standard drinks in a day, and for men it's five or more standard drinks. We have some evidence that this is a valid outcome, or at least a meaningful outcome, looking at the combined study that looked at-- it was an assessment of naltrexone, acamprosate, and cognitive behavior therapy, as well as medication management for alcohol use disorder.

If people were able to maintain no heavy drinking days for three months, it was found that they were likely to be able to do that for one year post-treatment, at least 50% reduction in their risk of having heavy drinking days. It seems to be able to persist, and over the course of a longer time period, as long as nine years, it's associated with better alcohol-related and psychiatric outcomes. It's both a sustainable outcome for many people, and it's a meaningful outcome.

It helps improve some other potential problems that they may have. It's still not the most sensitive measure, so there's a new way of thinking about this that's being talked about, which is to use the World Health Organization drinking risk stratification, which stratifies people into different risk levels, and I'll explain this graphic. We're not all used to thinking in grams of alcohol, so on the side there, those red, they're supposed to be wine glasses stacked. The idea is if you're trying to convert from grams to the number of drinks, you can see a ballpark of that if you look at that graphic.

If you can look at low risk, blue is women, and 20 grams a day, or between, it's a little over one drink, is considered low risk per day on average, and generally averaged over a month. For men, it's twice that, for the reason that I said, 40 grams, which is under three drinks a day, is considered low risk. Then you can see where medium risk is, high risk, and very high risk is anything more than 60 grams per day of alcohol for women and 100 grams a day for a day of alcohol for men. Again, generally averaged out over some time period. Each of these risk levels is associated with a certain risk of medical problems, psychological problems, substance-related problems, and social problems.

They seem to be meaningful stratifications. What's more, if people are able to reduce their risk, for instance, through treatment, if they have a one- or a two-level risk reduction, if they go from, say, high risk to low risk or high risk even to moderate risk, over time there's a decreased risk of some medical complications, including liver disease, decreased risk of subsequently continuing to have alcohol use disorder, alcohol dependence, as they defined it, or drug use disorder, and then a reduced risk of depression and anxiety, all associated with people being able to reduce their risk level. This is a somewhat more permissive level of reduction than even not having heavy drinky days because they can drink quite a bit.

I'll flip this back, if you look, moving from very high risk to high risk, a male could be drinking six drinks a day and still have had a meaningful reduction in risk if they move from very high risk to high risk. That may not be a satisfactory outcome for a lot of us, even for the patients, for loved ones. Most people hope better from their family than what most people have in terms of risk levels with six drinks a day, but it is a meaningful improvement. I think where my take-home from this, the way I think about this, is we should recognize that. We should recognize that there's some improvement. It doesn't mean we have to say, "That's it, I'll discharge from care, no more help needed here," but we should at least recognize those improvements as they happen as meaningful.

They're also sustainable. Analysis of COMBINE and then Project MATCH, which looked to match people based on different characteristics to optimal care for alcohol use disorder, a majority of people with alcohol dependence, which was the term used at the time of those studies, if they reduce their drinking risk level by the end of treatment, they were able to maintain that for three years. Many people can reduce and can keep things reduced even with alcohol dependence, and that's if they were able to do that within treatment, so some people find they cannot do that.

We hear this term harm reduction, and I want to shift to talking a little bit more about drugs use. I've been focused on alcohol use primarily because there's more information that we have on. I've been talking about paradigm two, which is treatment should reduce use in some way. Quantity of alcohol, frequency of alcohol, and that's how we reduce risk and consequences of substance use. The paradigm that's mostly been applied to drug use for harm reduction is the directly try to reduce the risk. Forget about the drug use, but try to reduce the consequences directly. I'll talk a little bit about what we know about ways to do that.

I think this has been a somewhat hot topic lately, supervised injection facilities. These are places where people generally bring drugs and they get clean materials to inject with, and a place that's supervised in some way so that if there's overdoses, someone is there to try to intervene. We have a bit of information on this. These harm reduction techniques, it's hard to do clinical trials of where you randomize individuals, so oftentimes we have community-based information, and that's what this is. If you put a supervised injection facility into a community, what happens? Then you can do quasi-experimental designs where you look at if people use it a lot, how do they do if they actually use that facility?

You do see reductions in overdose deaths and use of emergency services for overdose, decreased risk of needle sharing and skin infection. People are more likely to enter other substance use care. The worry about it encouraging drug use, these are generally people who are using drugs pretty heavily anyway, they might get some care. Some of them may actually end up with abstinence as their outcome. Crime in the area is always a worry. It seems like it decreases relative to other parts of cities where this has been actually looked at.

Syringe service programs, that's what sometimes called needle exchanges. They've been shown to decrease risky injection practices, like using dirty or sharing needles, decreased HIV and hepatitis C transmission. However, most of these studies are, again, they're observational, but I think there's enough information to say it's a potentially helpful thing to do for people. Naloxone has been something that's been

quite common to distribute both to bystanders and to patients. It's a blocker of the opioid receptor. It's been used for a long, long time in emergency rooms and by emergency responders to reverse overdoses.

The community distribution of it is really something that's newer, and those are generally called overdose education and naloxone distribution programs. On a community level, if you try to get a lot of naloxone into the community, it does decrease overdose deaths on that level. Finally, I have no real information. I'm putting this in because people will hear about fentanyl and xylazine test strips. I couldn't really find any clinical assessments of how useful they are, so there's really limited data on this. I'm not saying not to use it. It can be potentially helpful for people. We just haven't seen those studies yet.

All right. I'm about wrapping up. Yes. Sorry. I was a little out of order with slides. I wanted to just move to thinking about other harm reductions types of approaches, and some of these may decrease the substance use, and this has generally been looked at with stimulant use and with what sometimes referred to as chemsex. That's using different substance cocktails to enhance sexual performance, to enhance sex itself, and sometimes to self-medicate, being stigmatized, essentially, for belonging to certain sexual identity or sexual orientation groups.

There's some interventions that show promise for men who have sex with men. Some are educational interventions, general overall CBT or peer-led interventions have all been shown to reduce some risky sexual practices in men who have sex with men. Interestingly, mirtazapine, it may reduce some use in terms of stimulant use, but it's also been shown to reduce risky sexual practices among men who have sex with men. That's an interesting result because it's generally not thought to be an antidepressant that reduces-- it doesn't cause sexual side effects.

You could understand why this might be the case for something like Prozac, where people oftentimes have sexual side effects, lose sexual interest, but it doesn't really happen with mirtazapine, so it's working by some other mechanism, but is potentially helpful for people in reducing risk, even without necessarily reducing substance use. I'm going to just roll back here. Dr. Kosiba will talk a little bit more in terms of case-based, some case-based discussions here, but I want to give just a couple of examples of moderation-focused treatments, because I conflated three things, it's a brief talk. One is abstinence-based and non-abstinence-based goals, and that's a question of what does the patient want to do?

What are they trying to achieve? A lot of times people whose goal is abstinence, they're more likely to achieve abstinence, but that's not necessarily what they get. A lot of them actually reduce substance use, and that's a meaningful outcome, even if it's not their goal. People who set up with a non-abstinent goal, they want to reduce their substance use, some of them get that, and I can give you some outcomes from this particular brief self-control training, I'll describe it, but it's somewhere around 40% managed to reduce their substance use meaningfully, but another 25% decide to stop for different reasons. The goal matters, but the goal and the outcome are not the same thing.

Outcomes, I think it's important to consider non-abstinent goals as well because, as I said before, we're likely to miss out on understanding that treatment was actually

helpful for the person, they are doing better, or in a clinical trial, these are reasonable treatments to try to offer to people, understanding that the benefit may not be an abstinence-based benefit, but it may be something meaningful to them. Then abstinence-focused treatments or non-abstinence-focused treatments. I'm giving a couple of examples of non-abstinence-focused treatments here. These are treatments that are specifically designed to help people control and drinking.

That's where the only place where clinical trials really have happened with non-abstinence approaches, so reducing their drinking. I will say some of the treatments that are **[unintelligible 00:23:27]** not necessarily with a non-abstinence focus are compatible with non-abstinence, like motivational interviewing, or even relapse prevention treatment, or an abstinence-based treatment where the person is still smoking cigarettes or vaping tobacco and you're trying to help them move to safer use or less use, but you're helping them stop heroin use. All these things can happen at the same time.

There are some treatments that have been designed and tested for use with moderation approaches for alcohol, not really so much for other substances. Breathe self-control training was developed by William Miller of Motivational Interviewing fame along with Ricardo Muñoz. It's essentially a CBT, an educational intervention. People learn to track their drinking, set goals, learn to drink more slowly, refuse drinks. Then there's some relapse prevention techniques like managing triggers and coping strategies. They did find that many people reduced total alcohol, about 40%, people reduced alcohol-related problems, and 25% became abstinent for different reasons.

Maybe we'll have time to talk about why they became abstinent, because there's a few different reasons in the question and answer. There's programs for college students. Some are like the brief self-control training. They're more CBT based. The alcohol skills training program is a somewhat common one that has that kind of an approach. The brief alcohol screening and intervention for college students or basics is a two session. It's an educational and motivational interviewing, and then they're given feedback to say, "Well, here's how much you drink, here's how many of your peers drink that much."

Generally young people, they're often surprised by how much less their peers drink than what they think and then how much they drink because people tend to seek out similar drinking level peers. That has been shown to reduce drinking and its consequences as well. I'm going to circle back for the last two slides just to talk about drug use because there's less known about reductions in drug use and whether that's meaningful. That's the big question. If people cut down their use, can that provide some harm reduction, some reduction in consequences from them?

In 2019, there was a pooled analysis of 716 subjects from different clinical trials with cocaine use, and they decided to stratify people by a use pattern. Five or more days a month was considered heavy. One to four days a month were moderate and then abstinent. What they found was if you could drop one level, so five or more days dropped down to one to four days, that was associated with better functioning, better psychological outcomes, improved employment situations, legal situations, and fewer drug-related problems on the addiction severity index.

That's a step towards understanding if this can be helpful. We need to learn how to measure other substance use. We don't have a standard drink version for cocaine or the same thing for cannabis. We have grams, but how many grams is light use and low risk? We don't really know that yet. For cannabis, we do know, again, looking at frequency, because that's an easier thing to look at. How many days a week did the person use? A reduction in frequency level of cannabis use also showed some improvements, anxiety, depression, and cannabis-related problems.

Their stratifications were low risk, one to two days a week, abstinent, obviously none, medium, three to five days a week, and high, six to seven days a week. I think I'm close to on time, so I hope that provided some useful context for things. I realize it's a lot of material in a short period of time, and I'll turn things over to Dr. Kosiba now so he can take you through some clinical cases. I think you're controlling the slides now, Dr. Kosiba.

Jesse D. Kosiba: I hope so. Let's see. Yes, okay. Yes, thanks. I'd like to talk a little bit, I think, about the clinical approach here to non-abstinent goals and also to provide a couple of examples that I hope will help illustrate this a little bit. I'll go all the way back to graduate training where I remember having one advisor who really hammered home like, "Look, Jesse, the modal number of visits to treatment is one. It's one, so keeping people engaged with the care is really important."

While I hope that's changed some, I think we're seeing some of the attitudes change a bit around therapy in particular, but we know that just consistent engagement in treatment, and in psychotherapy in particular, is lower than recommended, substantially lower, and that rates of treatment sinking among people with substance use disorders is especially low. For some data, we might put it in the single digits for folks that would probably benefit from it or meet criteria for a substance use disorder at some point. Furthermore, treatment completion rates are particularly low as well.

We might see anywhere from say 50 or 60% in some studies in terms of completing an outpatient-based substance use disorder program or a residential substance use disorder program. The way I would generally think about this is that first experience with treatment is a really critical opportunity to engage with care, have a positive experience with treatment, and as Dr. Iannucci was talking about here a moment ago, the public health perspective, there's significance there of meeting people where they're at and working with them where they're at can have some really positive effects.

While many folks feel like they have to stop because of health reasons or something along those lines, and many folks will want to stop, perhaps ideally both at the same time, it's not the case for most people and who would benefit from changing their relationship with substances. From a scientific perspective, I would say that a more flexible approach to abstinence reflects our modern understanding of substance use disorders as being an executive functioning problem, a motivational problem, and an affective problem. Changing goals, patients who change their goals, patients who are wrestling with ambivalence, this is expected, and it's expected as part of the disorder itself.

I think a lot of this, again, follows some of the insights from motivational interviewing or motivational enhancement therapy, that motivation to make change is something

that's elicited from the patient, it's not something that we can just sort of assume. Motivation itself becomes a primary focus of treatment in that sense, and so as folks' goals wax and wane or change, we're trying to work with it rather than setting a, say, an abstinent goal and just saying that's the only one worth approaching. If we force those goals on patients, we just get worse outcomes, so collaboration tends to be the key focus here.

I would also say that many of the substance use disorder treatment approaches, so our evidence-based therapies for substance use disorders, work pretty darn well from a harm reduction framework, so to speak, or with non-abstinence or fluctuating goals. Things like CBT for substance use disorders, DBT-based substance use disorder treatment, mindfulness and acceptance-based approaches, and more explicitly was integrative harm reduction psychotherapy, which takes this and says we're going to approach this with a non-abstinence goal first and foremost, or at least with that flexibility.

These treatment packages contain a lot of specific strategies and processes that don't presuppose that binary outcome goal and don't necessarily require a long-term commitment to abstinence to have some meaningful beneficial effect for patients. I can think of how many folks, 20-year-olds present to treatment and just say, "Oh, my God, the idea of never drinking again or never smoking again for the next 60, 70, 80 years, oh, my God, I can't even think about it. It's just overwhelming." If that was something that we said you had to commit to, they just wouldn't receive the treatment. I think, again, it speaks to meeting folks where they're at.

Many of these strategies we've been talking about, like urge surfing, improved metacognitive monitoring or awareness of triggers, reducing stress generally and managing some of the psychiatric conditions, coping with high-risk situations, reducing self-criticism generally, and promoting more flexible thinking in terms of approaching that abstinence violation effect we mentioned through the dialectical abstinence lens can certainly be done regardless of the goal, we can work on these things. I'd like to go through the structure of what some of these non-abstinent treatment might look like and maybe highlight a few key differences here from a more typical abstinence-only approach.

I think understanding what changes the patient wants to make and why is right there first and foremost as an initial goal. I think it's an opportunity for us to clarify the consequences of use. If we're thinking about substance use disorders as primarily being defined by the consequence of continued use despite consequences, that ends up being a really important one. I think it's an opportunity for us to affirm or validate patients' understanding of their substance use and the consequences. Yes, anxiety can get worse with continued cannabis use.

Very reasonable to do, and there's a lot of opportunities, I think, for validation there and psychoeducation, but rather than bulldozing all that information up front and just like, "Oh, these are all the problems with using and this is why you should stop and all the rest," that you might see or you might hear even from some of the-- certain AA meetings, things like that, mutual support groups where you get a lot of that up front, I think slow rolling it, so to speak, a little bit more is more helpful and not as counterproductive for many folks.

We often start with this motivational enhancement therapy or motivational interviewing approach here, focusing on collaboration, focusing on empowering the patient, getting on the same page as far as goals go, and starting to create a shared understanding of what treatment looks like. We often borrow from this ORS framework of lots of open-ended questions, affirmations, reflections, and summary statements. "Can you tell me a little bit more about your alcohol use? Yes, it sounds like it's been really hard. It is really difficult to stop. You're noticing worse anxiety, okay," and again, trying to get on the same page with the patient and keep them engaged.

I think then beginning to map out the function of that substance for the individual patient. As if our field needed more acronyms, I tend to borrow the EMS one here just as my own memory tool. What's the ideology here? When did this start? What's the pattern of use look like now? What seems to be continuing it? What strategies have you tried so far? Have they been helpful? Have they not been helpful? Again, rather than saying, "This is what you should use, this is how people quit, this is how people do sobriety, this is how people do recovery," really sort of helping the patient explore it with some support rather than going through a checkbox, for example, of what helps you stop and what helps you or what leads you to continue for this.

Again, some of these can be very specific, "I had the first onset of a depressive episode and this is how I'm coping," and some are just much more vague. "I'm just feeling burned out at work," for example, "and I'm drinking more than I was before." As far as the structure of treatment goes, I think creating a plan for treatment that really meets the patient where they're at, again, with some collaborative goals, multiple collaborative goals in particular, is often quite helpful here.

From a CBT for addictive behaviors, would often recommend a structure of something like, "We'll structure this therapy, there's going to be collaboration, we're going to have a case conceptualization, we're going to do our psychoeducation, and then we add in the more standardized techniques," perhaps something from the brief skills training or something similar. Again, I think especially with these non-abstinence goals, having a gain-framed approach to talking about the goals and monitoring them, really trying to draw any positive attention to any progress, whatsoever, I think is quite helpful, both in terms of just insight building and all the rest.

For example, we've had a number of studies looking at just self-monitoring and its effect on outcomes, and how we understand a lot of that is just tracking and monitoring substance use, particularly, I'm more familiar with alcohol and tobacco, but can have an impact on people reducing use over time. That's the only intervention, just track it, how much was it this week? I had this experience with a patient, I think last week, where they came and said, "Yes, I didn't realize how much I was drinking. That seems like a lot to me now that I look at it."

Balancing a treatment plan and a treatment approach somewhere between the substance use and then something else that the patient, I think, wants to work on or that brings them to treatment is both necessary sometimes to get the right outcomes for as far as substance use goes, but also can be really helpful for folks that are feeling less confident in their ability to make some of the changes around substance use.

If they can see themselves starting to make some changes in terms of how they manage their personal life, their social life, if they can see that they're having better sleep, that they're feeling less depressed rather, that they might be more likely to feel confident to make some decisions around substance use. I would say that patient feedback is often really helpful to guide these sorts of things. Behavior, I often find, is more illuminating than the verbal report is.

Really what I mean by that is you might have somebody who's a little ways into each session and as you keep bringing it back to, "All right, per the structure here, I was hoping we could talk a little bit about your alcohol use this week," they say, "Yes, we could do that, but I really want to speak about my relationship with my brother. I really want to talk about my panic attack last week," it might be an opportunity to reflect on that a little bit with them, I think continue to collaborate in terms of defining the goals and how you can balance the treatment approach and the intervention strategies with this.

I would also say that willingness and change talk often comes with increasing confidence. As people become more and more confident in their ability to make changes, you may often start hearing more change talk from folks, "Yes, I'm thinking about maybe not drinking this weekend," or, "Yes, I'm really thinking about maybe cutting back on my cannabis use." Again, regardless of the specific strategies, just thinking about that overall motivation to change.

I'll go through just a couple of cases here, vignettes. We'll start with Mary. Mary was our 39-year-old separated mother of three who presented to treatment following the urging of a close friend. Her concern really was that didn't want to be drinking on weekends with her two kids around. Noticed it's been harder to stop drinking on weekends. She didn't have the kids **[unintelligible 00:39:59]** came back to her early in the week. Her friends had said, started to notice like, "Hey, it seems like you're drinking a lot more when you're spending time with us. We're a little concerned."

She was highly motivated to stop or to cut back. The motivation, again, I wasn't sure exactly where it was in terms of stopping or cutting back, but it certainly was alcohol use, not wanting to put her kids in danger or her relationships, said something along the lines of, "They're all I have now." The function, we go back to the function of the alcohol as well, began in college, infrequent after, worse after a sudden divorce, and reporting that she's using it to cope with feeling alone, overwhelmed, anxiety, and grief. Has tried to do some of the brief skills type interventions on her own, so trying to count drinks, stopping hard alcohol, and just hasn't had the success she was hoping with this and worried what her friends might say if she set a goal and then failed at it.

If she came to her friends and said, "I'm going to stop drinking for six months," something along those lines, and then gets two months in and thinks, "Geez, it's not working" or has a lapse based on that goal, and that was certainly having her hit pause on setting those goals in the first place. The structure then balances out between focusing, I think, equal parts on grief, anxiety, as well as the brief skills training we mentioned before around alcohol use, starting with the more high-risk behaviors and working toward less high-risk behaviors. Starting with those binge episodes and working on those to eliminate those, reducing alcohol at home, certainly with the kids around.

This is one that after about three months or so, had completed what we sometimes call a sobriety sample of about a month, so 30 days without drinking, "Noticed I didn't struggle as much as I did before, I'm more confident managing my psychiatric symptoms, and I think I'm just going to stop altogether. Maybe some special events, but that's it." Again, at no point along this treatment was there ever a goal in mind of abstinence forever or even abstinence right now per se, just in certain parts, but it was so positive and rewarding after that month that it's time to have to make a larger change. Felt capable of doing it. Another one here, we'll talk about Stevens. This is a 26-year-old single bisexual man who presented to treatment following hospitalization for depression, possible bipolar disorder, bipolar II, and suicidal ideation.

Excuse me. Primary motivation here was, "I'm just not doing anything, I'm just a failure." Had, again, not primarily coming to treatment for substance use, at least at the outset, but reporting that his cannabis use began in high school, benzos began in college, felt like he was using to cope with being a sense of failure after not getting a job he wanted upon graduating, some relationship difficulties, was endorsing some internalized stigma around his sexuality, excuse me, and has not yet tried to cut back or stopped using cannabis in particular, but he is worried about some of the cognitive issues from benzo use, right or wrong, and really relying on those substances to manage boredom, trouble with sleep, restlessness.

The structure of treatment in this case focused much more on the mood disorder, trying to follow, again, Steven, where he was at, so focusing more on the substance use disorder and, of course, suicidal ideation and sleep, insomnia, a lot of mindfulness skills, CBT for insomnia, and an act-based psychotherapy with, I think, a particularly strong behavioral focus, really trying to build some skills, particularly for relapse prevention around the benzodiazepine use.

Again, about six months into this, you've got someone here who had stopped their benzodiazepine use, despite continuing to use cannabis, but is no longer using high-dose cannabis products and starting to experiment with some of the CBT-only products. Despite, again, cannabis not being something that might be contributing to perhaps even hypomanic episodes, we go all the way back to our, I think it was our 2019 report on cannabis use that there was moderate evidence to support increased episodes of hypomania or mania with cannabis, we might've focused on that, but it wasn't something he was motivated to do, so we focused it elsewhere.

By the end of six months or so of treatment or six months into treatment, he's already starting to make some changes there that weren't really even talked about. Again, I think meeting people where they're at here and working with what we've got tends to produce some pretty positive outcomes. If we come back to that definition of recover where you had at the start of this talk from SAMHSA that a process of change through which individuals improve their health and wellness and live self-directed lives and strive to reach their full potential, I think this is all pretty consistent with that. Again, not presupposing any particular outcome here. I think I'll hit pause there. How's the Q&A?

Rocco: I think everyone will get this slide so you can see the-- if you want to look at the sources more closely, if there's things you want to dig into a little more deeply. We'll answer some questions. We had some questions that were submitted beforehand as well as I see there's some in the chat here, so maybe we'll just take

turns. Dr. Kosiba, I think is going to take the first or read the first question and we can both try to answer it or one or the other.

Jesse: Yes. One of the questions we get here was what was the some ways to navigate abstinence supports following a harm reduction model or non-abstinent outcome model? It's a great question. I think we're talking really about the mutual support groups, things like AA, SMART Recovery, Recovery Dharma. There's some other fitness-based recovery groups out there like the Phoenix, and all of these can be very helpful.

We have data that suggests the more frequently you go and if you feel like you have a community that you can be open with and engage with, that in particular, those are the main active ingredients in many of those approaches, AA in particular, I guess that data comes from. Often I would say that if folks are willing to consider a sobriety sample, whether it's a month or a couple of weeks, that's often a really good time to try some of those mutual support groups.

Rocco: All right, I'll take what I may. Actually, Elena Stein put in not a question, but something worth sharing here, which is that the FDA recently approved a two-level World Health Organization drinking level reduction as a qualified endpoint in alcohol clinical trials. That's, I think, very promising, and, yes, it's a helpful thing to know. Thank you for that. Yes, I guess I'll pull one of the questions that was put in previously, how do you determine what patients are appropriate for a non-abstinent approach? I guess I'd say a couple of things. Mostly, if patients are willing to take an abstinent-based approach, why not?

We had in the last few years increasing information that no level of alcohol is completely safe. It's not completely without risk. Even pretty low levels can be associated with a number of cancers. There's consideration of even labeling containers of alcohol the way cigarettes have been labeled as potential carcinogens. If people are willing to not drink or if they're already not drinking, this is a basic principle of screening and brief intervention, don't encourage them to continue to not drink, or if they don't want to drink, don't fight it. I would also say there's certain people that you would rule out as making a recommendation.

Generally, I recommend if you're willing to stop, stop. It's the least risky thing. If people have a mental health condition where substance use is likely to make it harder to recover from, that's something that they should know about. If they're pregnant, certainly there can be problems with substance use to the pregnancy if the person is planning to complete the pregnancy. People have substance-related suicidality, state-based suicidality. I would consider that a contraindication. People who've done very dangerous things like driving while intoxicated, that would be a rule out for these approaches.

There's others. Some of it is you kind of know which patients. Beyond that, the patients often tell us. They tell us what they plan to do. You have people who try a non-abstinence-based approach and they decide, "No, I'm an abstinence-based person." That tends to be people with more severe or longer-lasting, like more problems, longer-lasting substance use disorders, and they generally don't do as well anyway with a moderation-based approach even if that's what they want to more severe, longer lasting.

You'll have some people who've tried moderation, or they will try, they'll try not sobriety sampling but controlled drinking sampling, find it doesn't work for them and then decide to do something different. Then, for some people they just find it too effortful. They can do it, but it's a lot of work. I have to track my drinking. I have to sample more than goals. I have to use all these coping strategies, or I can just not drink and not think about it.

For some people, it's that simple. They can stop, and if they stop, it's just way less effortful. Then finally, you have a group of people for whom what they like is to be intoxicated. They don't like to have a glass of wine at dinner. They like to feel intoxicated, so there's no point to moderate drinking, and so they don't do it. You can find that with other substances as well.

For a lot of people, I would say if people come to you and say that's what I'm doing, then it probably makes sense to say, even if we say, okay, well, it's maybe not the best idea, but if you're going to try it, let's see what we can do and see. Then how are we going to track it? What are your goals? How do we know that you're meeting the goals? What are you going to do if you don't meet the goals? That's actually an opening for abstinence for a lot of people as well. I don't know if you have anything to add, Dr. Kosiba, if you want.

Jesse: No. I think there's a lot of really good questions here in the chat. I appreciate it. I think some questions we've got here too that what do we do in session if we suspect that folks are using in sessions or they're having relapses, so to speak, in the course of a non-abstinent approach, or when folks hear, "Cannabis is not an issue, it helps me relax," how do you respond to some of this?

I think that we come back to some of those really wise principles of motivational enhancement therapy, motivational interviewing of, "All right, you feel like cannabis isn't an issue, it helps you relax. What else does it do for you? What else is happening for you when you feel like you need to relax, can you tell me a little bit more about that experience and how often is that happening?" Somewhere along the line, you'll often hear some change like, "Yes, I know it's really expensive," for example, and you're like, "Yes, all right. If you had more of that money back, what would you do with it?"

Sometimes it's just trying to amplify that change talk over the course of the sessions, even by way of just simple reflections back to the patient, like, "Yes, it does sound like you're spending a lot of money," can be really helpful, or, "Could I talk to you a little bit about some other ways to relax?" That might be helpful too. That would be perhaps another way to approach some of that too.

I would say that from approaching different goals with you, some people may look at a relapse as being that high-risk use, or a relapse was, "I was drinking and driving," but the other stuff, that's not a relapse, that's just not it. "I can use once or twice, a couple of drinks here or there, and that's not a relapse for me." Sometimes, again, going back to that initial engagement of just trying to get on the same page with how they understand their substance use and what they're aiming for, sometimes requires more effort, I think, over the course of treatment. More attention.

Rocco: Maybe I'll try to quickly say something. It's a little hard to, but I think it's an important question. There were a few questions on what about relapse rates? Of course, you get to the question of what do you mean by a relapse if you're talking about controlling substance use? I think we could say a treatment that's worked versus a treatment that's not working for the patient might be if they're hitting whatever goals are specified, so going down a risk level, two risk levels, managing to use cocaine in a moderate risk category.

Again, there's a few questions on controlled studies of this approach for drug use, and there really aren't any. Mostly alcohol use is where we have an evidence base for trying some of these approaches. I think they happen with people with substance use with other substances because they decide to do that. With an abstinence-based approach, I think Project MATCH had a 30% of people in the longer term being abstinent, so that gives you a number there, but that's like completely abstinent. That's a tough one to actually achieve. Most people reduced, they had, I think, two-thirds more abstinent days in that study. That's another way to look at it, and that's a more, I think, a promising result around abstinence.

Reductions in substance use, I think I went through that already in terms of at least the brief self-control training, what their outcomes that they have, which was a majority of people, they either reduced it to their goals or reduced it meaningfully, or decided to be abstinent and were able to do that. It was only 15% that actually reduced to their goals, though, so it's a small amount of people that hit exactly what they say they're going to hit.

Then, there was an 18-year study still going on in Australia of heroin use. It looked at people initially entering the study through detox, residential treatment, or medication treatment, and there's a hopeful message there that they started out with 98.7% of people were current users, and at the end, over 75% of people were not current users. That doesn't mean that they never used in 18 years.

That means in the last 30 days, they hadn't used heroin. There's a hopeful message there, too. That's just general outcomes. I haven't seen anything comparing abstinence-focused versus not, other than people's goals. If you have an abstinence-based goal, you're more likely to hit abstinence goals and some moderation goals. If you have a moderation goal, you're more likely to hit some other moderate outcomes. I hope that somewhat answers the question, and I think we're out of time. Thank you all, and I think they're going to wrap up for us.

Jesse: Yes, thank you. Appreciate it.

Moderator: Thank you so much for joining us, Drs. Iannucci and Kosiba, and thank you to all our listeners for your participation. We'd also like to thank McLean Hospital for making this webinar possible. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. As soon as the webinar has ended, a short survey will appear on your screen. Please take the survey and give us your feedback. We thank you for your attention and hope you have a great day.

[00:57:10] [END OF AUDIO]