A Comprehensive Model of Addiction Treatment

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Overview
I. Current practice
II. How is our field perceived?
III. What does the data tell us?
IV. The “Gaps”
V. What Works
VI. Practical Application

Substance Abuse Treatment Today

The Current Treatment Model

What Really Goes on in Treatment?

Current Practice
Patients with addiction, regardless of the stage and severity of their disease, typically receive a diagnosis followed by a swift course of treatment administered by individuals without any medical training and then minimal to no follow-up care.

Disease Severity Rarely is Assessed and Interventions Rarely are Tailored to Stage and Severity of Disease

Opiate Addict
- Physician
- MMT Clinic
- Drug Free OP
- Residential 1
- Residential 2
  - Suboxone
  - Methadone
  - Referral – PHP/IOP
  - Social Model Detox – 28 Days - Aftercare
  - Med Detox – 28 Days
  - Vivitrol – Continuing Care

How’s that working for us?

You know...

The First Outpatient Appointment

About 50% of people who schedule an appointment do not show up for their 1st session.

How Long Do They Stay?

Up to 50% of outpatients drop out within one month.

How Long Do They Stay?

40% of court-ordered patients do not complete treatment

And...Relapse Rates Are High
- About 60% use drugs within 6 mos. following discharge
- About 45% are readmitted within 12 months
Something’s Not Right……

...and it gets worse

How is our field perceived?

What do people think about what we do?

The New York Times

“The New York Times

“People typically do more research when shopping for a new car than when seeking treatment for addiction.”

“People typically do more research when shopping for a new car than when seeking treatment for addiction.”

“There are exceptions, but of the many thousands of treatment programs out there, most use exactly the same kind of treatment you would have received in 1950, not modern scientific approaches.”

A. Thomas McLellan

Co-founder

Treatment Research Institute

Phila, PA

PBS NEWSHOUR

“Why We Should Treat, Not Blame Addicts Struggling to Get ‘Clean’

It has been more than 40 years since Richard Nixon called for a “war on drugs,” and yet our prevention and treatment efforts have largely failed to address the chronic illness of substance addiction that affects one in 12 Americans and affects millions more friends and family members.

The Evidence Gap

Drug Rehabilitation or Revolving Door?

The Washington Post

“Inside Rehab”: How it could work better, and why it doesn’t

A startling new investigation of addiction programs says 28 day programs and 12 steps adds up to inadequate treatment.

We have little indication that this treatment is effective. When an alcoholic goes to rehab but does not recover, it is he who is said to have failed. But it is rehab that is failing alcoholics. The therapies offered in most U.S. alcohol treatment centers are so divorced from state-of-the-art of medical knowledge that we might dismiss them as merely quaint -- if it weren't for the fact that alcoholism is a deadly and devastating disease.
Addiction Medicine: Closing the Gap between Science and Practice
June 2012
The National Center on Addiction and Substance Abuse at Columbia University

Methodology

- Review of more than 7,000 scientific articles, reports, books
- Secondary analysis of five national data sets
- Focus groups/national population survey of 1,303 adults
- NY State surveys: 83 program directors; 141 staff providers
- Online survey of 1,142 members of professional associations involved in addiction care
- Online survey of 360 individuals with history of addiction who are managing the disease
- In-depth analysis of state/federal governments’ and professional associations’ licensing, accreditation and certification requirements for treatment providers, facilities and programs
- Case study of addiction treatment in NY State and City

Effective Treatment Options Exist

- Addiction is a disease that can be treated and managed effectively within the medical profession using an array of evidence-based pharmaceutical and psychosocial approaches.
- In accordance with standard medical practice for the treatment of other chronic diseases, best practices for the effective treatment and management of addiction must be consistent with the scientific evidence of the causes and course of the disease.

Most People in Need of Addiction Treatment Do Not Receive It

<table>
<thead>
<tr>
<th>Penetration Rate (% with Disorder who receive Treatment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorders</td>
</tr>
<tr>
<td>80%</td>
</tr>
<tr>
<td>60%</td>
</tr>
<tr>
<td>40%</td>
</tr>
<tr>
<td>20%</td>
</tr>
<tr>
<td>0%</td>
</tr>
</tbody>
</table>

Less Than Half (42%) of Treatment Admissions Complete Treatment

The highest completion rates were found in the treatment settings with the fewest admissions:

- 15% of admissions are to short-term residential treatment (<30 days) - they have the highest completion rate - 55%
- 11% of admissions are to longer-term residential treatment – they have completion rates of 46%
- 74% of all admissions are to outpatient services – they have the lowest completion rate - 39%
The Gaps.....

Education, Training & Accountability
Primary Treatment Staff
Medical Staff
Evidence – Practice Gap
Medication Developed vs Delivered Gap

The Education, Training and Accountability Gap

• Most medical professionals are not sufficiently trained to diagnose or treat addiction

• Most treatment providers are not medical professionals and are not equipped with the knowledge, skills or credentials necessary to provide the full range of evidence-based services

• Addiction treatment programs are not held accountable for providing treatment consistent with medical standards and proven treatment practices

Who treats our patients?

• Primary person delivering care in addiction treatment programs is a counselor

• Many counselors, while highly dedicated to addiction care, have only a bachelor’s degree or, in some cases, no post high school education

Who treats our patients?

An example with one state – New York State Addiction Treatment Providers:

<table>
<thead>
<tr>
<th>Education</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduate Degree</td>
<td>35%</td>
</tr>
<tr>
<td>Bachelors Degree</td>
<td>28%</td>
</tr>
<tr>
<td>Some College</td>
<td>30%</td>
</tr>
<tr>
<td>High School or GED</td>
<td>7%</td>
</tr>
</tbody>
</table>

Most Treatment Providers Are Addiction Counselors

• 14 states – require no license or certification

• 6 states – require no minimum degree or education

• 16 states – require a high school degree

• 10 states – require an associate’s degree

• 6 states – require a bachelor’s degree

• 1 state – requires a master’s degree

Medical Staff

• ABAM has certified 2,584 addiction medicine specialists

• ABAM estimates there are about 1,200 fulltime practicing addiction medicine specialists.

• This estimate falls far short of the estimated minimum of 6,000 full-time addiction medicine specialists currently needed to meet addiction treatment demands.
Medical Staff

- 38% of publicly-funded programs do not have access to a prescribing physician
- 23% of privately-funded programs do not have access to a prescribing physician

(Evidence-Based) Practices?

The Evidence - Practice Gap

- Science has shown us what works for treatment of risky substance use & addiction
- The gap between what works and the currently available treatment and management of addiction is wide

Nothing short of a significant overhaul in current approaches is required to bring practice in line with the science and with care provided for other public health and medical conditions

The Medication Gap

Pharmaceutical Treatments are Underutilized

<table>
<thead>
<tr>
<th></th>
<th>Private</th>
<th>Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine</td>
<td>51%</td>
<td>25%</td>
</tr>
<tr>
<td>Acomprosat</td>
<td>40%</td>
<td>19%</td>
</tr>
<tr>
<td>Naltrexone</td>
<td>40%</td>
<td>19%</td>
</tr>
<tr>
<td>Disulfiram</td>
<td>30%</td>
<td>16%</td>
</tr>
<tr>
<td>Vivitrol</td>
<td>&lt;20%</td>
<td>&lt;10%</td>
</tr>
</tbody>
</table>

Pharmaceutical Treatments are Underutilized – con’t

CASA/Columbia’s survey of treatment providers in New York State found - Most program directors (52%) and counselors (55%) said that recreational therapy/leisure skills training are more important to offer clients than pharmaceutical treatment.

There is truth in what we read about our field.
Yet Therapy Works!

In most studies of treatment conducted over the last 40 years, the average treated person is better off than 80% of the untreated sample – this is a .8 effect size (ES).

Researchers and Statisticians tell us:

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>EFFECT SIZE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications</td>
<td></td>
</tr>
<tr>
<td>Prozac</td>
<td>.26</td>
</tr>
<tr>
<td>Zoloft</td>
<td>.26</td>
</tr>
<tr>
<td>Clexa</td>
<td>.24</td>
</tr>
<tr>
<td>Lexapro</td>
<td>.31</td>
</tr>
<tr>
<td>Bypass Surgery</td>
<td>.80</td>
</tr>
<tr>
<td>ECT for Depression</td>
<td>.80</td>
</tr>
<tr>
<td>AZT for AIDS mortality</td>
<td>.47</td>
</tr>
<tr>
<td>Medication for Arthritis</td>
<td>.61</td>
</tr>
<tr>
<td>Aspirin for Heart Disease</td>
<td>.03</td>
</tr>
</tbody>
</table>

Some Evidence

- First meta analysis of psychotherapy conducted in the 1970’s examined 475 separate studies and found an ES of .85
- More recent analysis of psychotherapy and its impact on symptomology showed an ES of .97
- Recent meta-analysis of 23 studies found that psychotherapy has a strong impact on physical complaints (cardiovascular, neurological, gastrointestinal, etc.), ES .59

The Evidence is Clear

- In most studies of treatment conducted over the last 40 years, the average treated person is better off than 80% of the untreated sample.
- The outcome of behavioral health services equals and, in most cases, exceeds medical treatments.
- On average, mental health professionals achieve outcomes on par with success rates obtained in randomized clinical trials (with and without co-morbidity).

So we know treatment works….what is the active ingredient that drives positive outcomes?
The Search....

- Meta-analysis of all studies published between 1960-2007 comparing bona fide treatments for alcohol abuse and dependence:
  - Approaches tested included CBT, 12 Step, Relapse Prevention, & PDT
  - No difference in outcome between approaches intended to be therapeutic

Reality is -

ALL treatment interventions work EQUALLY well with SOME people SOME of the time

But – What makes an intervention more likely to work?

Factors Influencing Ability to Change

Therapeutic Alliance is the most important factor in a positive outcome...

Outcome of Treatment:
- 60% due to “Alliance”
- 30% due to “Allegiance” Factors
- 8% due to model and technique

Why Does Therapy Work

Therapeutic Alliance

The Therapeutic Alliance

Agreement on Goals

Client feels listened to
Therapeutic Alliance Research Findings

- A positive alliance is one of the best predictors of outcome
- The amount of change attributed to the alliance is five to seven times greater than that of specific models or techniques
- Little or no correlation exists between the length of treatment and the strength of the alliance
- Alliance formation at the initiation of therapy is predictive of outcome

What Do We Know so Far?

- Therapy Works
- All Interventions work equally well
- The Therapeutic Alliance is the operative factor in what makes therapy work

A Client Directed Approach Drives the Strength of the TA

“So how did you decide to come for an appointment today and what is most important to you for us to explore together?”

A CDOI approach will continuously strengthen the therapeutic alliance.....

Client Directed Outcome Informed

A client-directed, outcome-informed approach begins with the experience and outcome the client desires and then works backwards to create the means by which those will be achieved. Even then, the client is in charge, helping to fine-tune or alter, continue or end treatment via ongoing feedback.

Feedback Helps

13 random controlled studies involving 12,374 clinically, culturally, and economically diverse consumers:

- Routine outcome monitoring and feedback as much as doubles the “effect size”
- Decreases drop-out rates by as much as half
- Reduces hospitalizations and shortens length of stay by 66%
- Significantly reduced cost of care (non-feedback groups increased)

What a novel idea....let’s ask our clients how it’s going.

Ask your client:
Are we working on what you want to work on?
Are you feeling better?
Am I hearing what you are saying?

Then...adjust based on their feedback.
Time in Treatment Matters

• Longer length of time in treatment predicts positive outcomes, not which therapy is delivered or types of patients treated.

• Minimum effective dose of treatment: 90 days

So...How does all this compare - with Treatment for “Real” Illnesses like...

Hypertension, Diabetes, Asthma

Data Supports the benefit of continuing treatment and involvement in support groups

<table>
<thead>
<tr>
<th>Treatment</th>
<th>6 Months</th>
<th>6 Months</th>
<th>12 Months</th>
<th>12 Months</th>
<th>Linear (12 Months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing</td>
<td>33%</td>
<td>45%</td>
<td>72%</td>
<td>72%</td>
<td>63%</td>
</tr>
<tr>
<td>AA + Weekly</td>
<td>44%</td>
<td>56%</td>
<td>78%</td>
<td>78%</td>
<td>63%</td>
</tr>
<tr>
<td>AA Weekly</td>
<td>46%</td>
<td>58%</td>
<td>80%</td>
<td>80%</td>
<td>63%</td>
</tr>
<tr>
<td>Outpatient Treatment</td>
<td>27%</td>
<td>35%</td>
<td>52%</td>
<td>52%</td>
<td>45%</td>
</tr>
<tr>
<td>Outpatient + Weekly AA</td>
<td>63%</td>
<td>86%</td>
<td>100%</td>
<td>100%</td>
<td>90%</td>
</tr>
</tbody>
</table>


Why These?

- No Doubt They Are Illnesses
- All Chronic Conditions
- Influenced by Genetic and Behavioral Factors
- No Cures - But Effective Treatments Are Available

Who Relapses?

Predictive factors: Different for different illnesses?

<table>
<thead>
<tr>
<th>Illness</th>
<th>Relapse Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>30 - 50%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>50 - 60%</td>
</tr>
<tr>
<td>Asthma</td>
<td>60 - 80%</td>
</tr>
<tr>
<td>Addiction</td>
<td>50 - 60%</td>
</tr>
</tbody>
</table>
Predictors of Relapse

Which Illnesses?
1. Lack of Adherence to Treatment
2. Psychiatric Co-Morbidity
3. Poverty
4. Low Family Supports

Sources: Natl Ctr Health Stats; Harrison, 13th Ed.; 30+ studies

In Chronic Illnesses we know:

- There is no Cure - the effects of treatment do not last very long after care stops
- Patients who are out of contact are at elevated risk for relapse: Retention is essential
- Early, intensive treatment prepare patients for later, less intensive care:
  - goal is Self-Management
- Symptoms & function determine care intensity
- Evaluation is a clinical duty during treatment

Outcome In Hypertension

Outcome In Addiction

Addiction as a Chronic Medical Illness

Implications for Treatment

Treatment of Chronic Illness:
The Continuing Care Model

Evidence of Success

Retention in treatment
Reductions in symptoms DURING treatment
Move to lower intensity treatment
Improved functional status
**Concurrent Recovery Monitoring**

- Concurrent Recovery Monitoring (CRM) is a process by which information is gathered across the course of treatment to monitor progress and help guide treatment.
- CRM consists of a brief set of standard items that are asked of a patient on an ongoing, regular basis.

**What Works in Drug & Alcohol Treatment or How to Achieve Better Outcomes**

- **Client Directed** - Develop a highly individualized treatment plan that is created by the patient.

**What Works in Drug & Alcohol Treatment or How to Achieve Better Outcomes**

- **Outcome Informed** – Provide for formal, ongoing feedback from clients regarding the plan, process and outcome of treatment that informs the treatment.

**What Works in Drug & Alcohol Treatment or How to Achieve Better Outcomes**

- Integration of both plan and feedback into a flexible continuum of care that is maximally responsive to the individual client and keeps people in treatment for at least 90 days.

**So What Are We Going To Do?**

One System’s Answer .......

**Key Elements of the CRC Care Model**

- A strong Therapeutic Alliance is critical to a positive outcome while the patient is in treatment.
- Your clinical impressions and your involvement in developing a robust Continuing Care Plan is critical to driving positive outcomes.
- Clinical Supervision is the foundation for good treatment and the continuous development of counselor skills.
- Time in treatment impacts outcomes. 60 days of treatment is essential, six year is ideal.
Clinical Supervision – A Solid Foundation

One hour of supervision for every 20 hours of direct service.

30 hours of Supervisor training
- Counselor video tapes
  individual session
- Counselor brings video to group and individual supervision
- Supervisor sends video to supervisor and receives supervision

Counselor Competencies – Continuous Improvement

Quarterly Clinical Supervisor Assessment of Counselors to Competencies
- Clinical Supervision Ensures Quality Care & IDP Implementation
- Counselor Assigned to Specific Job Level (and Pay Range) Based on Assessment
- IDP Developed for each Counselor based on Assessment

Use of Medications

<table>
<thead>
<tr>
<th>Medications</th>
<th>2013 H1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vivitrol Data</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total</th>
<th>Opiate Clients Injected</th>
<th>Opiate Clients Enrolled but not Injected</th>
<th>All Other Opiate Clients</th>
<th>Variance ( Denied )</th>
<th>Variance (All Other)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Clients:</td>
<td>372</td>
<td>285</td>
<td>607</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>24.52</td>
<td>21.25</td>
<td>16.68</td>
<td>15%</td>
<td>47%</td>
</tr>
<tr>
<td>% Treatment Complete:</td>
<td>87%</td>
<td>60%</td>
<td>66%</td>
<td>40%</td>
<td>27%</td>
</tr>
<tr>
<td>% AAA:</td>
<td>1%</td>
<td>17%</td>
<td>17%</td>
<td>-2%</td>
<td>65%</td>
</tr>
<tr>
<td>Readmission Rate:</td>
<td>10%</td>
<td>9%</td>
<td>12%</td>
<td>-10%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Suboxone Program

An outpatient treatment for Opiate addiction...

Induction: 3-5 days
PHP/IOP: 4-6 weeks
Maintenance: 1 year
Detox: 2 months
The Therapeutic Alliance

Therapeutic Alliance Measurement Tool

"Please indicate how much each statement applies to your recent interactions with your counselor."

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at All</th>
<th>A Little Bit</th>
<th>Somewhat</th>
<th>Quite a Bit</th>
<th>Very Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>My counselor and I agree on what is important for me to work on.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am working together with my counselor in a joint effort.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The things I do in counseling will help me accomplish the changes I want.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am able to focus on what is of real concern to my counselor.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My counselor pays close attention to what I'm saying.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have been feeling better recently.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My counselor is helping me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Therapeutic Alliance Measurement System Process

Upon admission patient assigned unique PIN number by counselor through the intranet

Immediately prior to an individual therapy session (weekly in residential, monthly in CTC)

Patient uses telephone to dial TH system and enters PIN. Please note that takes them through 7 questions

Counselor enters system through intranet and answers the same 7 questions from their point of view

Counselor can see the results of the current questionnaire and any previous administrations immediately and use data in that session

Screen Shot of Data Immediately Available to Counselor During Session
Results for one patient over two month period

Data for Clinical Supervisor

Continuing Care

While the strength of the Therapeutic Alliance is the most important factor in a positive outcome while the patient is in treatment....... What happens after treatment when they return home is the most important factor in a long term positive outcome!

Concurrent Recovery Monitoring (CRM)

<table>
<thead>
<tr>
<th>Standard Continuing Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Develop D/C Plan</td>
</tr>
<tr>
<td>Warm Transfer</td>
</tr>
<tr>
<td>Call or Email</td>
</tr>
<tr>
<td>Concurrent Recovery Monitoring</td>
</tr>
</tbody>
</table>
## Enhanced Continuing Care
### Sierra Tucson Pilot - Connections

<table>
<thead>
<tr>
<th></th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participant Contact</strong></td>
<td>1x / week</td>
<td>2x / month</td>
<td>1x / month</td>
</tr>
<tr>
<td><strong>Primary Collateral Contact</strong></td>
<td>1x / week</td>
<td>2x / month</td>
<td>1x / month</td>
</tr>
<tr>
<td><strong>Collateral Contacts</strong></td>
<td>(for example...)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Psychiatrist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- IOP / Sober Living</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1x / week</td>
<td>2x / month</td>
<td>1x / month</td>
</tr>
<tr>
<td><strong>Contact with Discharging Treatment Facility</strong></td>
<td>Month 3</td>
<td>Months 6 &amp; 9</td>
<td>Month 12</td>
</tr>
<tr>
<td><strong>Toxicology Screening</strong></td>
<td>1x / week</td>
<td>2x / month</td>
<td>1x / month</td>
</tr>
<tr>
<td><strong>Resource planning &amp; referrals</strong></td>
<td>As needed</td>
<td>As needed</td>
<td>As needed</td>
</tr>
<tr>
<td><strong>24-hour crisis support</strong></td>
<td>As needed</td>
<td>As needed</td>
<td>As needed</td>
</tr>
</tbody>
</table>

**Our Mission**

To inspire our employees to deliver clinical excellence and lead CRC to be the preferred treatment provider to individuals and families in need.