

Re-Considering Addiction Treatment

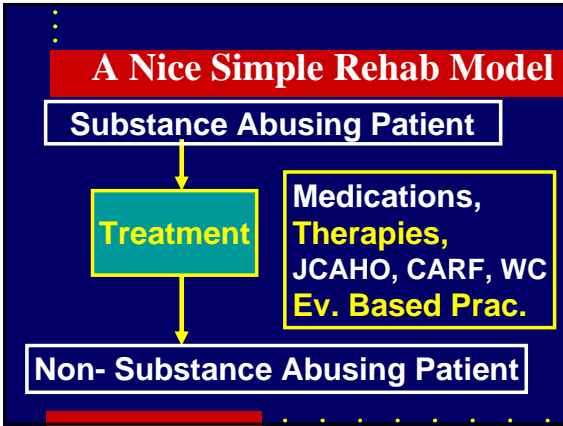
Quality, Accountability
and Outcomes in a
Chronic Care Perspective

Public Expectations of Substance Abuse Interventions

- Safe, complete detoxification
- Reduced use of medical services
- Eliminate crime
- Return to employment/self support
- Eliminate family disruption
- **No return to drug use**

How is Treatment Supposed to Work?

What is the model ?



What is the Evidence So Far?

- ### Treatment Compliance Is Low
- >50% of outpatients drop out of treatment within one month.
 - >40% of court-ordered patients do not complete treatment
 - Prop 36, Drug Courts, TASC

Relapse Rates Are High

About 60% use drugs within 6 mos. following treatment discharge

About 45% apply for re-treatment within 12 months

Studies show few differences between...

- Brief and Intensive Treatments
- Inpatient and Outpatient Treatments
- Conceptually Different Treatments
- "Matched" and "Mismatched" Trt.
- Gender or Culturally Oriented Trt.

Points

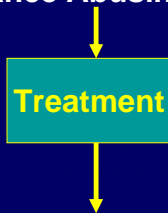
- Public Expectations have not been met
- Either treatment is not very good...or
- We have the wrong model

Let's Look at the Model Again?

Are Expectations and Evaluation Methods Appropriate?

A Nice Simple Model

Substance Abusing Patient



Non- Substance Abusing Patient

ASSUMPTIONS

- Some fixed amount or duration of treatment will resolve the problem
- Match patients to the right treatment
- Get patients to complete treatment
- Evaluation is an audit or research duty – it is done following completion
 - **Poor outcome means failure**

How Do Other Treatments Work?

Chronic Illness & Continuing Care

In Chronic Illnesses....

1 – There is no Cure - the effects of treatment do not last very long after care stops

2 – Patients who are out of treatment/contact are at elevated risk for relapse

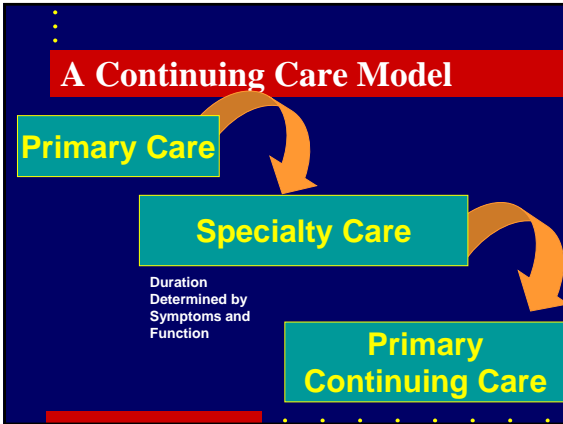
So, in Continuing Care

1 – One goal is to retain patients

2 – Early stages prepare patients for less intense care – ultimately **Self-Management**

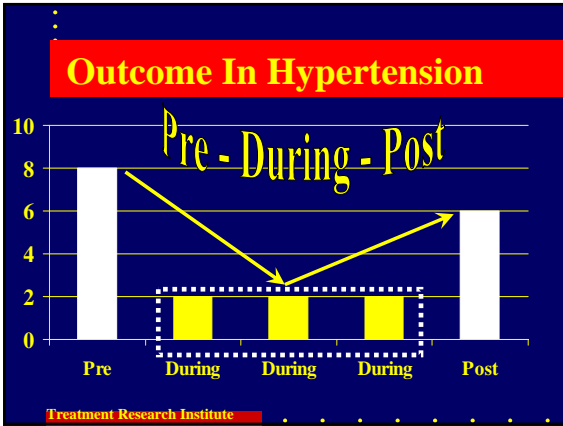
3 – Patient symptoms and function determine movement across stages

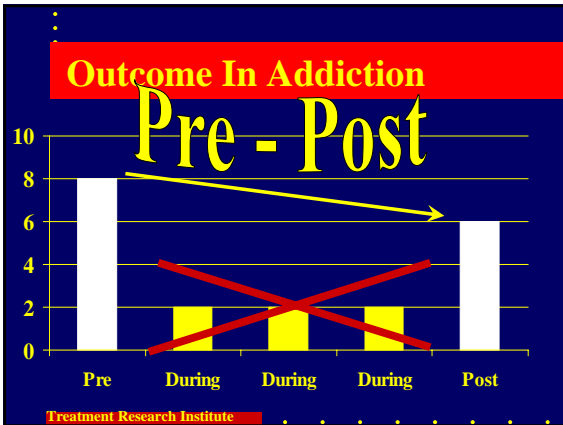
4 - Evaluation is a clinical duty during treatment – poor results mean change care



- ASSUMPTIONS**
- 1) Patient will continue in treatment
 - 2) Early stages prepare for later stages
 - 3) Patient symptoms and status determine movement over stages
 - 4) Evaluation is an essential clinical task, it is done during treatment.
- Poor results mean change in treatment content

Implications for Outcome Evaluation





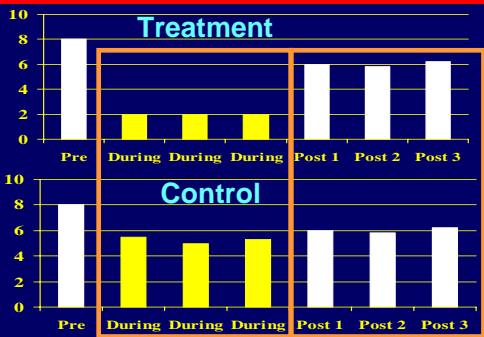
Consider....

If – in addiction treatment - effects are also significant but not long lasting after discharge...

Then....

Post Discharge Evaluations will **NOT** be able to differentiate conceptually or procedurally different treatments

Comparing Rehabilitation Treatments



So maybe this is why...

Studies show few differences between...

- Brief and Intensive Treatments
- Inpatient and Outpatient Treatments
- Conceptually Different Treatments
- “Matched” and “Mismatched” Trt.
- Gender or Culturally Oriented Trt.

Two Studies:

A Comparison of
Acute vs Chronic
Care Perspectives

Comparing Treatments

Example
Testing Three Treatments in
a Rehabilitation Model

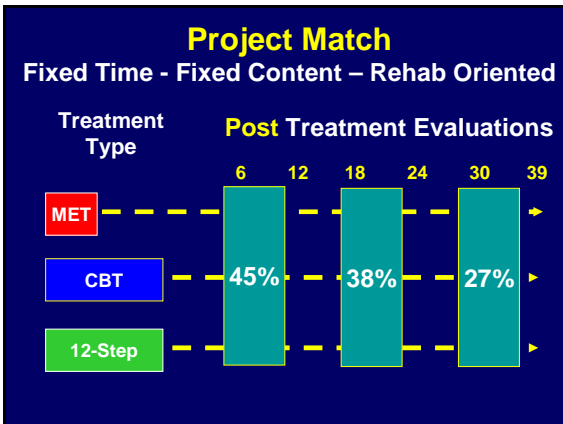
Treatment Research Institute

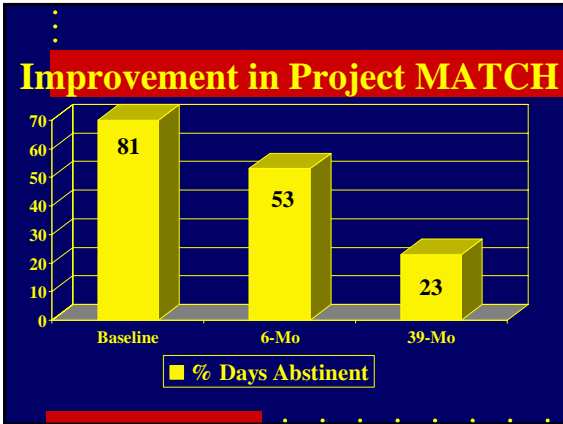
Project MATCH

- RCT - 3 Research-Derived Therapies
 - \$27 Million Dollar NIAAA Study
- Different Mechanisms of Action
- Fixed Interventions – All Patients
- **Goal** – Achieve Lasting Abstinence **Post Completion**

MATCH Results

- Significant but **Equal** Improvements
- **Equal** Outcomes at all points
- **No** Significant Matches Confirmed
- What does this say about treatment?



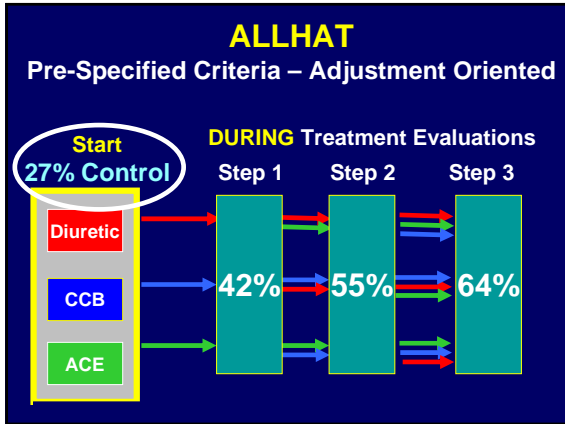


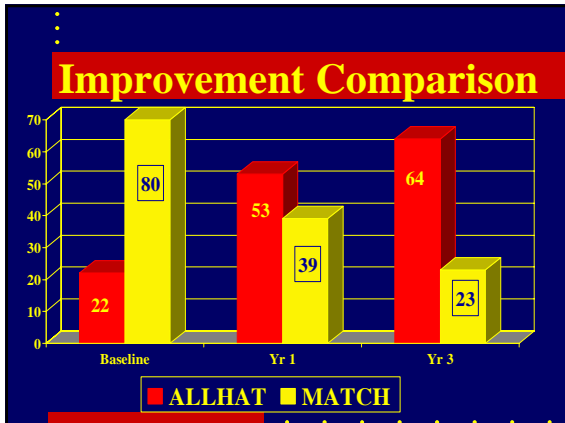
ALLHAT

The Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack

Treatment Research Institute

- # ALLHAT
- \$63 million – 61 sites
 - Three Groups – Different drug actions, Different drug costs
 - Diuretic - \$0.10 / pill
 - Calcium Channel Blocker - \$1.50 /pill
 - Ace Inhibitor - \$4.00 /pill
 - Goal – Improvement on Pre-Specified Criterion DURING TREATMENT





Can These Concepts Be Implemented?

One Example:
The State of Delaware

State of Delaware

**Performance Contracting
&
Concurrent Recovery Monitoring**

Delaware Mandate 2003:
Legislature and Drug Courts

- Manage Addiction Patients
keep them in treatment
- Reduce Drug/Alcohol Use
- No new arrests
- Off Welfare
- Reduce ER and Inpatient days

Delaware Situation 2003

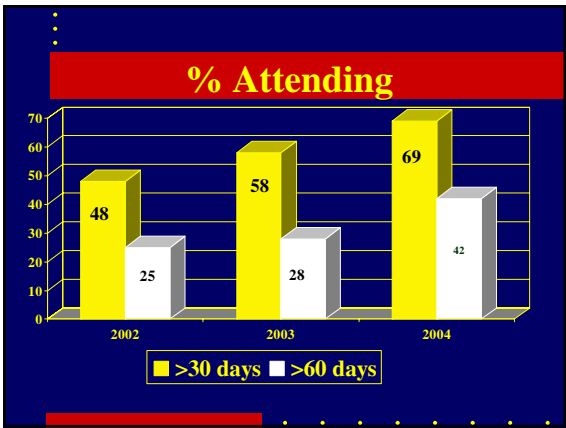
- 11 Outpatient Providers
- Limited Budget
- No success with outcome evaluation
- Providers won't/can't use EBPs
- Pressure to increase admissions

Delaware's Performance Based Contracting

- 2003 Budget – **90% of 2002 Budget**
- Opportunity to Make **105%** of 2002
- Implement ASI system-wide
- One Criterion: **Retention/Participation**
- Audit for accuracy and access

Delaware's Results Years 1 & 2

- Two programs lost contract
- Two new providers replaced them
 - **Mental Health and Employment Programs**
- Programs worked together
 - **First, common sense business practices**
 - **Second, incentives for teams or counselors**
- 5 programs learned MI and MET



Delaware Mandate 2005:
 Legislature and Drug Courts

- Continue to Manage Addiction Patients

ADD TWO MEASURES

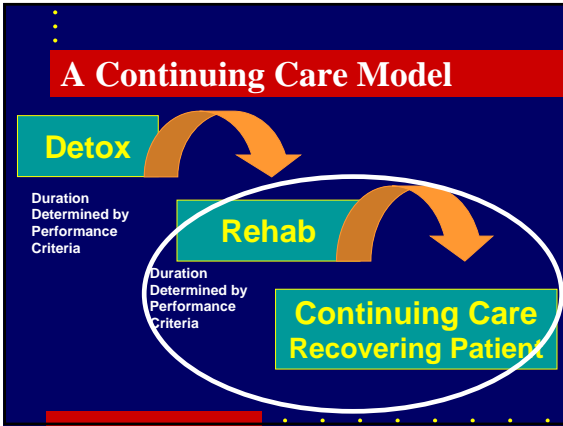
- Reduce Drug/Alcohol Use
- No new arrests

How without resources?

OK, So How to Monitor & Evaluate?

Concurrent Recovery Monitoring

- The Basic Assumptions
- The Evaluation Points
- Standard Outcomes
- The Measurement Points



- ## The Assumptions
- Program is held responsible for **Outcomes DURING Treatment**
 - Evaluation is a Clinical Activity
 - Information will guide care
 - Every Patient is Evaluated
 - Patient Agrees on Goals/Measures
 - Ultimate goal is Self-Management
 - Simple (**No Burden**)

- ## Concurrent Recovery Monitoring
- From the Start of Outpatient Care
 - Suggest: **Weeks 2, 4, 6, 8**
Monthly thereafter
 - Clinician as Evaluator
 - Brief "Check Up" Starts Sessions
 - Patient works on a few measures

Standard Measures

- Substance Use
Urine Test-Cup or Oral Swab
- Basic Needs
Self-Reported Days of:
Safe Housing
Adequate Food
Adequate Clothing

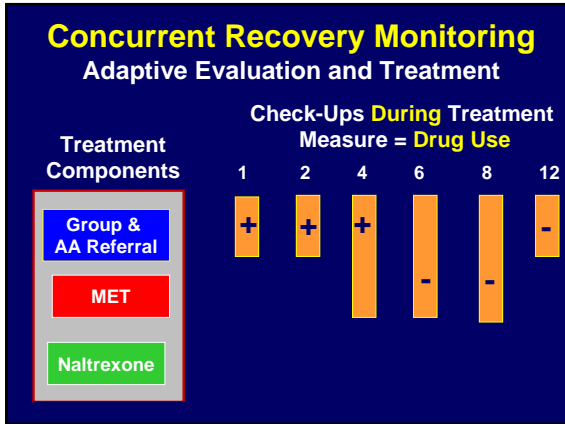
Standard Measures

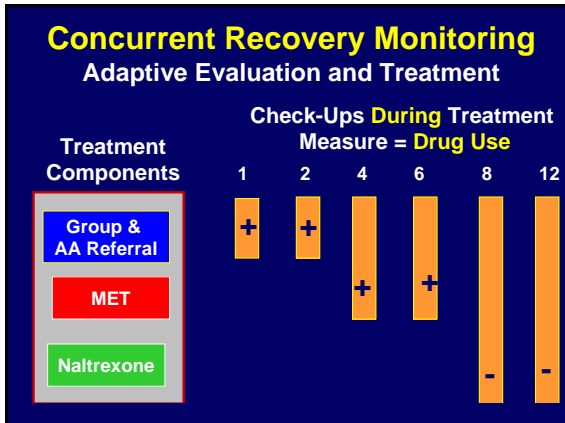
- Healthcare Utilization
Admissions to ER or Inpatient Hosp.
- Self Support
Days Employed or in School/Training
- Crime
New Arrests

The Blood Pressure Model



Using CRM and EBP to Adapt
and Improve Treatment





Concurrent Recovery Monitoring

- Individual Patient Record
 - Used by Counselor to guide care
- Aggregated by Counselor
 - Used by Clinical Supervisor
- Aggregated by Program
 - Used by Program Director - Planning
- Aggregated by County

Clinical Considerations

Not Just More of Standard Care

- **Questions:**
 - Which interventions produce the target changes?
 - How soon should they work?
 - When to try something else?

Wrap Up

In Chronic Illnesses....

1 – There is no Cure - the effects of treatment do not last very long after care stops

2 – Patients who are out of contact are at elevated risk for relapse:
Retention is essential

In Chronic Illnesses....

3 –Early, intensive stages prepare patients for later, less intensive care:

– ultimately **Self-Management**

4 – Patient symptoms, function determine care type & intensity

In Chronic Illnesses....

5 - Evaluation is a clinical duty during treatment :
Good function = continue care
Poor function = change care

What Continuing Care Does NOT Imply

- Not every case of abuse or addiction needs Continuing Care
- Some Patients Do Show Continuing Benefits Even From Acute Care
 - **Brief Interventions**
 - **Untreated Individuals**
 - **Also Happens in Other Illnesses**

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What Continuing Care Does NOT Imply

- A Continuing Care Strategy Does Not Imply Lack of Responsibility
 - Just the Opposite
 - Purpose is to Teach Self Management

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- The End -
