# Re-Considering Addiction Treatment

## How Can Treatment be More Accountable and Effective?

### Lessons from Mainstream Healthcare

# Parts of the Presentation

- What Does the Public Expect?
- What is Treatment?
- Can Treatment Work?
- What's Wrong With Treatment?
  - Infrastructure
  - Concept
  - Evaluation Model

# Part 1

# What Does the Public Expect?

- **Abstinence/Sobriety**
  - Is it too much to ask?
  - Is it enough to ask?
- **Lessons from Two Patients**

# Public Expectations of Substance Abuse Interventions

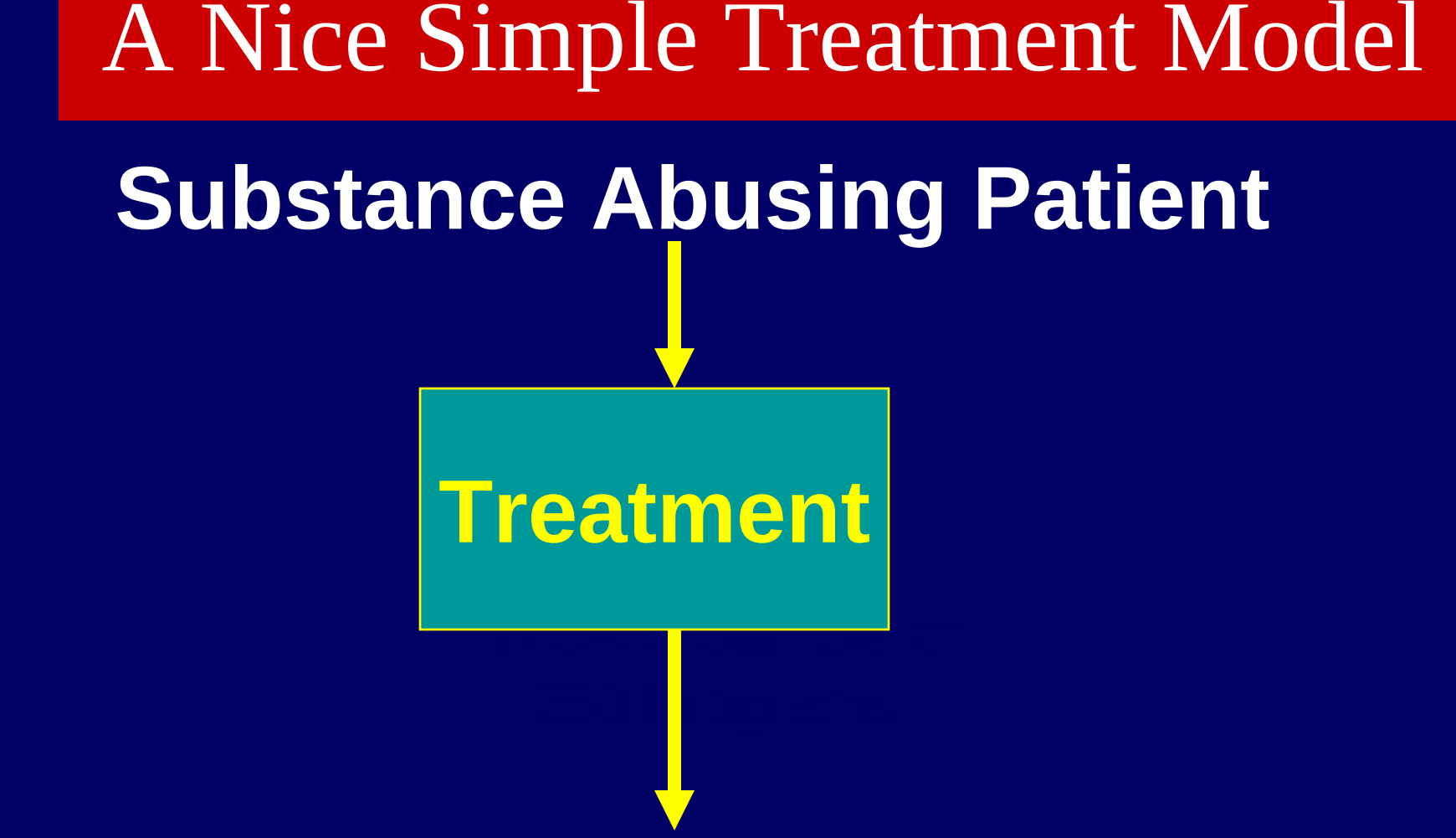
- **Safe, complete detoxification**
- **Reduced use of medical services**
- **Eliminate crime**
- **Return to employment/self support**
- **Eliminate family disruption**
- ***No return to drug use***

# Part 2

# What is Treatment?

## A 3-Stage Description

# A Nice Simple Treatment Model



# A Continuing Care Model

Substance Abusing Patient

**Detox**

**Duration Determined by Performance Criteria**

**Rehabilitation**

**Duration Determined by Performance Criteria**

**Continuing Care Recovering Patient**

# Stages of Treatment

1. ACUTE CARE
   Detoxification/Stabilization

Purposes:

- Remove toxins
- Physical/Emotional Stabilization
- Promote Problem Recognition
- Engage patient into rehabilitation

# Stages of Treatment

## 2. Rehabilitation

**Purposes:**

- Sustain stable abstinence
- Teach self-management skills
- Identify & reduce threats to progress
- Engage in Continuing Care

# Stages of Treatment

## 3. Aftercare-Continuing Care

**Purposes:**

- **Monitor & Support Abstinence**
- **Encourage Self-Monitoring**
- **Intervene Upon Threats to Relapse**

# Part 3

# Can Treatment Work?

- **Compared to What?**
  - What would you do if you didn't treat?
  - Lessons from comparisons

# Treatment Comparisons

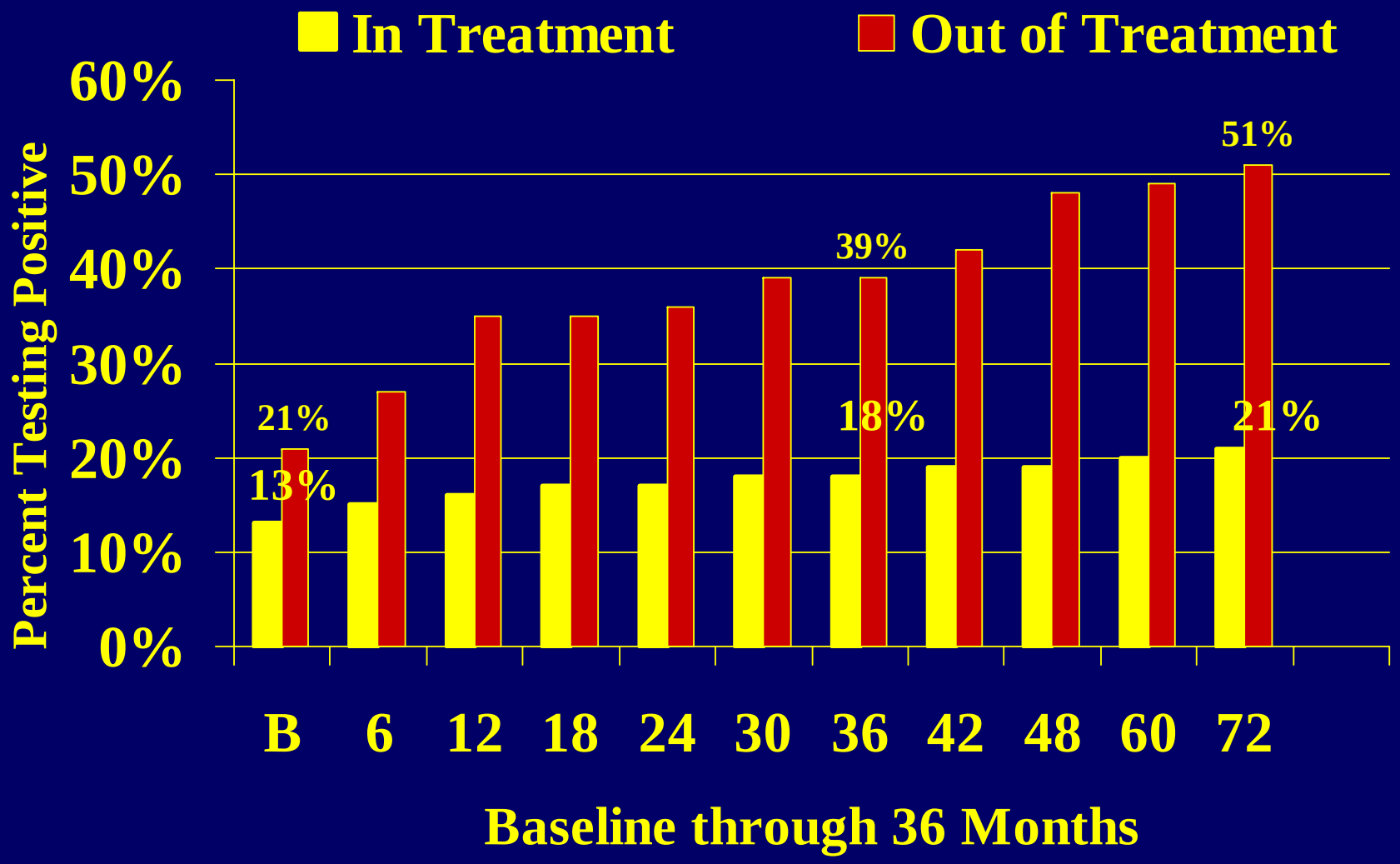
a. **No Treatment**
b. **Role of Motivation**
c. **Incarceration/Parole**
d. **Other Chronic Illnesses**

a.

# No Treatment

**Out of treatment groups**

# Six Year HIV Infection Rates by Treatment Status at Time of Enrollment



b.

# Role of Motivation

**Pregnant Cocaine Users in Prenatal Care**

# Un-Motivated Drug Users

- **Svikis et al. Johns Hopkins**
  **146 Cocaine Abusing, Pregnant Women**
- **Seeking Pre-Natal Care - Not Treatment**
- **100 Received - 1-Week Residential Tx.**
- **46 Received - Standard Pre-Natal Care**
- **Costs and Complications of Delivery**

# Cocaine + Urine at Delivery

- **100 Treated Women**

***37%**

- **46 Control Women**

**63%**

# NICU Stay and Costs

- **100 Treated Women**

***7 days**

***$14,500**

- **46 Control Women**

**39 days**

**$46,700**

# Summary - No Treatment

- **1. Treated patients show far more improvements than non-treated patients.**
- **2. Motivation is an important but not critical ingredient.**
- **BUT**

  **Is Treatment better than Other Options?**

c.

# Incarceration

- **Why Bother – Just Incarcerate**
  - –Treatment During Incarceration
  - –Treatment During Parole/Probation

# Re-Addiction After Incarceration

| | | |
|---|---|---|
| Vaillant | 447 opiate addicts | 91% |
| Maddux & Desmond | 594 opiate addicts | 98% |
| Nurco & Hanlon | 355 opiate addicts | 88% |
| Hanlon & Nurco | 237 mixed addicts | 70% |

Many Other Studies Including:
(Simpson, Wexler, Inciardi, Hubbard, Anglin)

# Summary - Incarceration

- **Treatment can be added to incarceration**
- **Public safety and public health concerns can be addressed**
- **BUT even large “doses” of treament in jail don’t produce lasting change**
- **Only those in continuing care seem to show the cost effectiveness of treatment**

# Other Illnesses

**Addiction Treatment Compared With Treatments for Other Illnesses**

# A Comparison With Three Chronic Medical Illnesses

**Hypertension**

**Diabetes**

**Asthma**

# **Why These**?

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

# HYPERTENSION

Adherence to **medication**: **< 60%**

Adherence to **diet and exercise**: **30%**

---

**Retreated** in 12 months: **50 - 60%**

(by Physician, ER, or Hospital)

# DIABETES (Adult Onset)

Adherence to **medication**: **< 50%**

Adherence to **diet and exercise**: **30%**

**Retreated** in 12 months: **30 - 50%**

(by Physician, ER, or Hospital)

# ASTHMA

Adherence to **medication**: **< 30%**

---

**Retreated** in 12 months **60 - 80%**

(by Physician, ER, or Hospital)

# RELAPSE

## Predictive Factors - All 3 Illnesses

**#1 - Lack of Adherence to diet, medications, or behavior change**
**#2 - Low Socioeconomic status**
**#3 - Low Family Supports**
**#4 - Psychiatric Co-Morbidity**

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

# Summary – Treatment "Efficacy"

- **Efficacy is impact under carefully controlled conditions –**
  **what treatment CAN do.**
- **Most efficacy studies show that treatment CAN work – CAN meet public expectations**
- **So…**

# SO…

Why Does Treatment Seem So **Ineffective**

# The “Gap”

Why the Gap Between What Treatment Can Do and What it Does?

# Part 4: Two Problems With Addiction Treatment

**Treatment Infrastructure:**

*Infrastructure and Expectations*

**Treatment Concepts:**

*Acute vs. Continuing Care Model*

# Problem 1

# The National Treatment Infrastructure

# Program Survey - 1

Program Changes In 16 Months:

- 12% had closed
- 13% had changed service operation
  **RESULT – 25% FEWER PROGRAMS**
- 31% of the rest had been taken over, usually by MH agencies
  **RESULT – STAFF CONFUSION**

# Program Survey - 2

**STAFF TURNOVER!**

- **Counselor** turnover is 50% per year
- **50-60%** of Directors in job **Less Than 1 year**

# Program Survey - 3

Other Staff :

- 54% Had no physician
  34% Had P/T physician
  39% Had a Nurse (part of full time)

- < 25% Had a SW or a Psychologist

- Major professional group - **Counselors**

# Problem 2

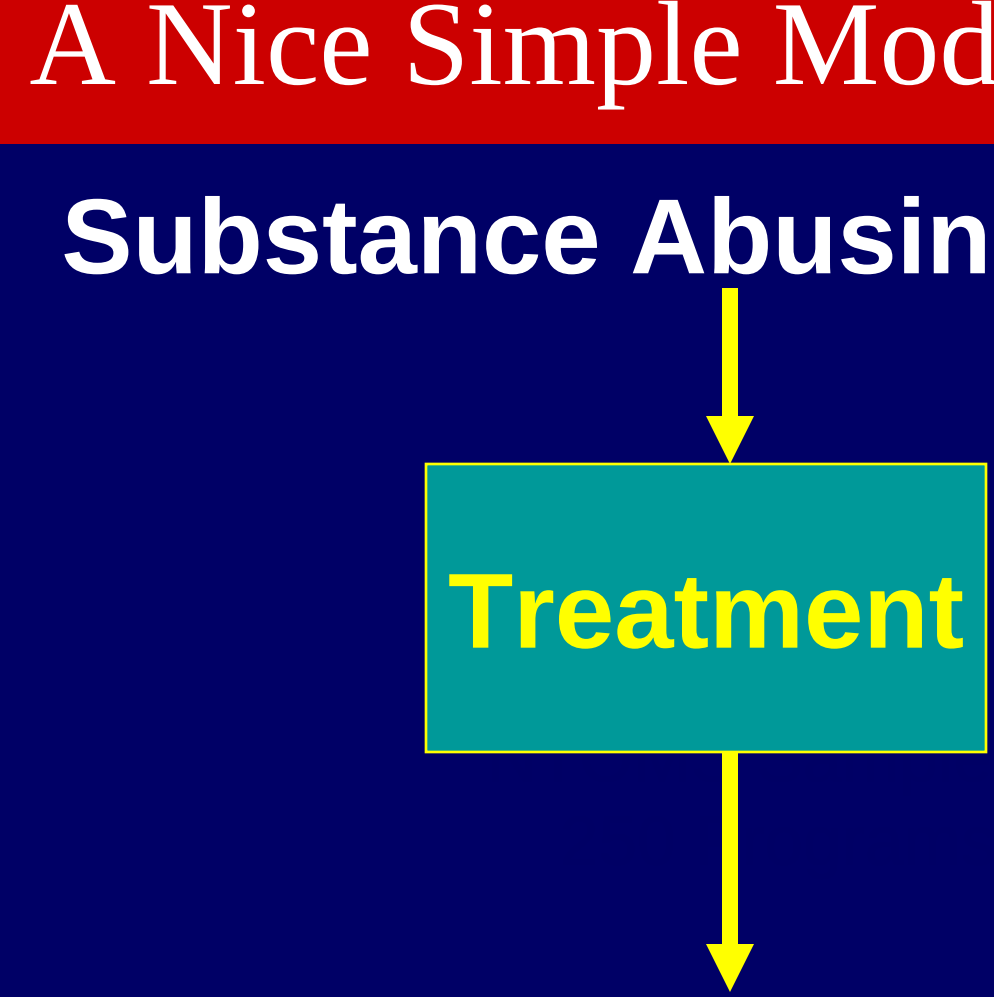
## How Do We Deliver and Evaluate Addiction Treatment ?

What is the model ?

# Let's Look at the Model Again?

Are Expectations and Evaluation Methods Appropriate?

# A Nice Simple Model



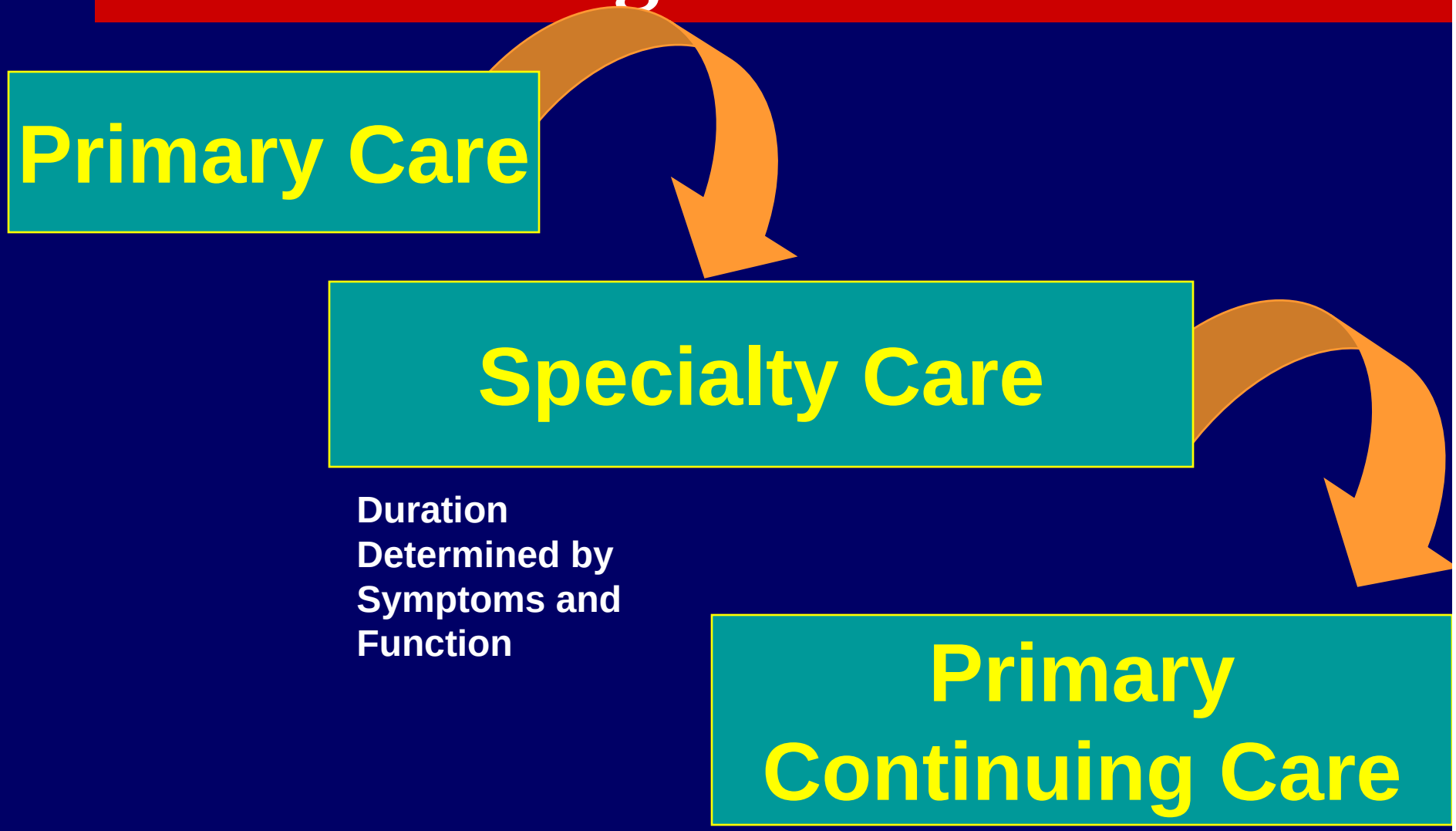
# ASSUMPTIONS

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

# How Do Other Treatments Work?

## Chronic Illness & Continuing Care

# A Continuing Care Model



# In Chronic Illnesses….

**1 – <u>There is no Cure</u> - the effects of treatment do not last very long after care stops**

**2 – Patients who are out of contact are <u>at elevated risk for relapse</u>: Retention is essential**

# In Chronic Illnesses….

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

- **Goal is Self-Management**

**4 – Symptoms & function determine care intensity**

# In Chronic Illnesses….

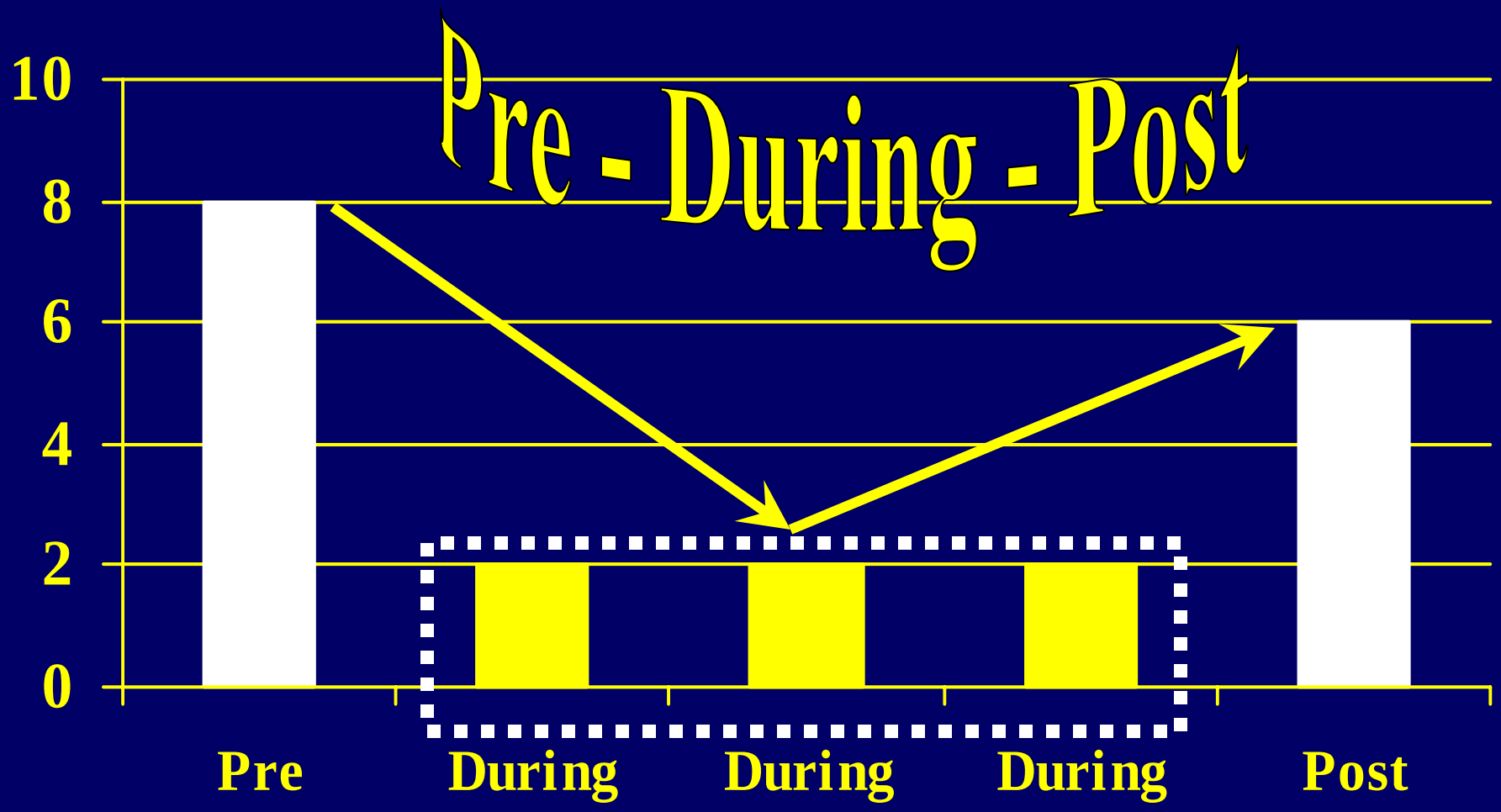
**5 - Evaluation is a *clinical* duty during treatment :**

**Good function = continue care**

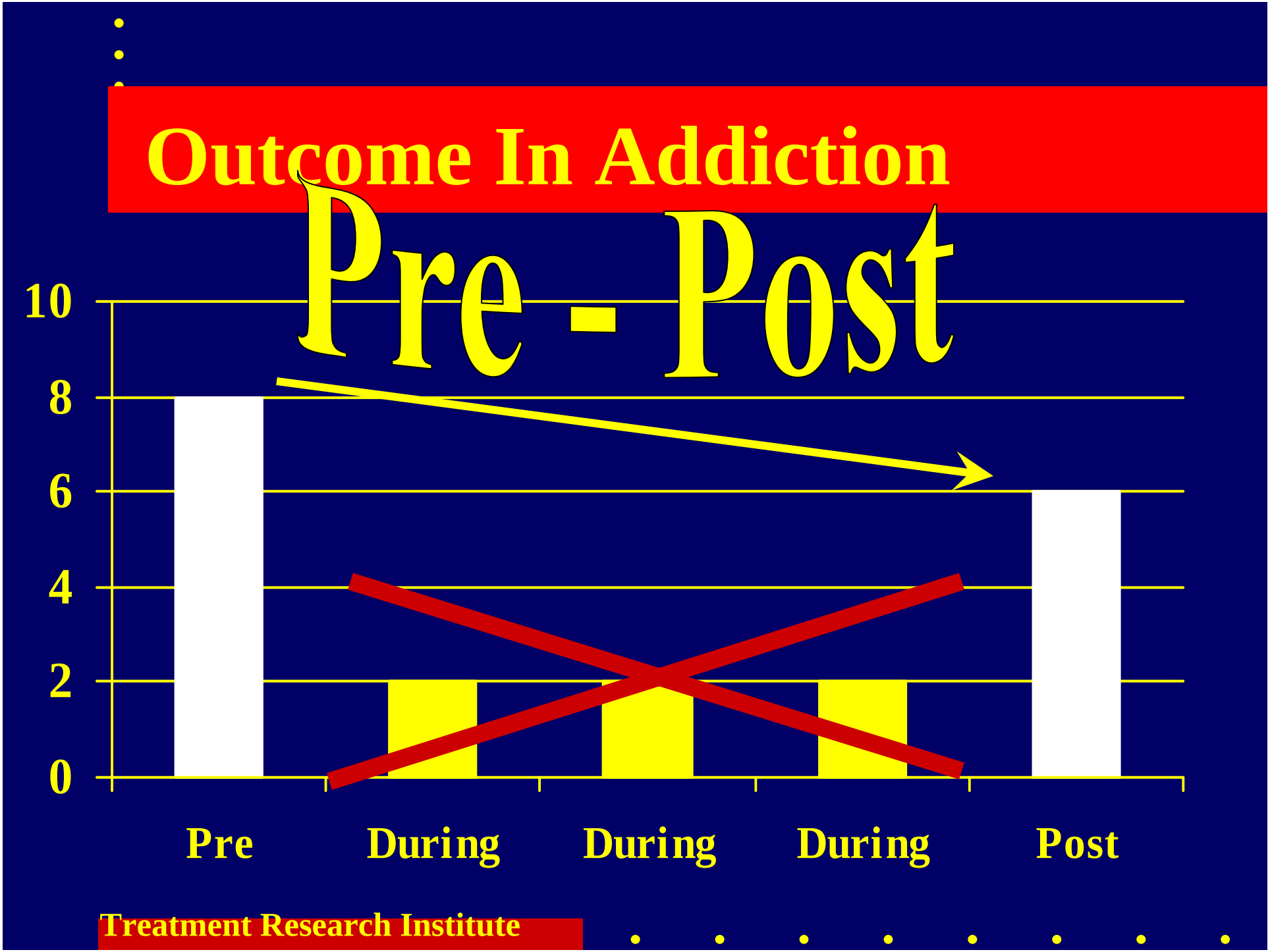
**Poor function = *change care***

# So What?

# Outcome In Hypertension



# Outcome In Addiction




Treatment Research Institute

# Summary

- **Addiction Treatment Can be Evaluated – Same scientific standards as FDA**
- **Abstinence is not enough – Use public health and public safety domains**
- **Programs can and should be held accountable – DURING TREATMENT**
- **Practical monitoring systems are in operation in several states,**