

# Best Practices & Effectiveness of Residential, Outpatient and Sober Living Services

Richard Rawson, PhD., Professor and Co-Director  
UCLA Integrated Substance Abuse Programs

CADPAAC/DHCS Quarterly Meeting  
March 26, 2014

# Today's Question

- What is the best evidence to guide the treatment of individuals with substance use disorders (SUDs) within California's new SUD financing structure?
- Specifically
  - What are the most effective elements of SUD treatment, regardless of the specific level of care?
  - What is the evidence for treating patients with SUD in specific levels of care?
  - What are the key issues in determining optimal patient placement in a specific level of care?

# A point of clarification

- There is very little research evidence to state that one level of SUD treatment is superior to another.
- There is evidence to say that certain practices are superior (associated with better patient outcomes) than others. These practices are referred to as evidence-based practices).
- Regardless of the level of care, evidence-based practices should be employed when possible to achieve best treatment outcomes.

# EVIDENCE-BASED PRACTICES

# Definition of EBP

- Institute of Medicine (2001):

Evidence-based behavioral practice (EBBP) "entails making decisions about how to promote health or provide care by integrating the best available evidence with practitioner expertise and other resources, and with the characteristics, state, needs, values and preferences of those who will be affected. Evidence is comprised of research findings derived from the systematic collection of data through observation and experiment and the formulation of questions and testing of hypotheses" ([www.ebbp.org](http://www.ebbp.org)).

# Criteria for EBP Designation for SUD Practices

- National Registry of Evidence Based Programs and Practices (NREPP)
  - The approach has demonstrated positive outcomes ( $p \leq 0.05$ ) in  $\geq 1$  studies
  - The results of the research have been published in a peer-reviewed journal or documented in a comprehensive evaluation report
  - Sufficient documentation exists in the form of manuals, training materials, etc. to facilitate dissemination of the approach

# Benefits and Cautions of EBPs

- Accurate implementation of EBP protocols is associated with positive clinical outcomes. (McHugo et al., 1999; Jerrell & Ridgley, 1999)
- Providers may overestimate the extent to which they utilize EBPs when surveyed. (Miller & Meyers, 1995)
- Ongoing clinical supervision is a critical component of successful EBP implementation.

**Which Evidence-Based Practices can  
be implemented into community  
SUD treatment settings?**

# What are the most important EBPs?

- **Behavioral Approaches**
  - Motivational Interviewing/Brief Intervention
  - Contingency Management
  - Cognitive-Behavioral Coping Skills Training
  - Couples and Family Counseling
  - 12 Step Facilitation and 12 Step Program Participation
- **Medications**
  - Methadone
  - Buprenorphine
  - Naltrexone (oral and extended release)
  - Naloxone (for overdose prevention)
  - Acamprosate
  - Antabuse

# Motivational Interviewing: Definition

Motivational interviewing is a client-centered style of interaction aimed at helping people explore their ambivalence about their substance use and begin to make positive behavioral and psychological changes.

# Summary of Motivational Interviewing

- Goal is to enhance motivation to change behavior and elicit self-motivational statements using a supportive, non-confrontational style.
- The 5 principles of M.I. are:
  1. Express empathy
  2. Develop discrepancy
  3. Avoid argument
  4. Roll with resistance
  5. Support self-efficacy

# Contingency Management

## ■ Basic Assumptions

- Drug and alcohol use behavior can be controlled using operant reinforcement procedures
- Incentives can be used for money or goods
- Incentives should be redeemed for items incompatible with drug use
- CM can be extremely useful in promoting treatment retention and promoting medication adherence
- CM for drug free urine tests can be useful in decreasing drug use.

# Contingency Management

- Key concepts
  - Behavior to be modified must be objectively measured
  - Behavior to be modified (e.g., urine test results) must be monitored frequently
  - Reinforcement must be immediate
  - Penalties for unsuccessful behavior (e.g., positive urine test) can reduce voucher amount
  - Incentives may be applied to a wide range of prosocial alternative behaviors

# Principles of Cognitive Behavioral Therapy (CBT)

- CBT is used to teach, encourage, and support individuals about how to reduce / stop their harmful drug use.
- CBT provides skills that are valuable in assisting people to achieve initial abstinence from drugs (or to reduce their drug use).
- CBT also provides skills to help people sustain abstinence (relapse prevention).

# Behavioral CBT Concepts

In the early stages of CBT treatment, strategies emphasize behavior change, and include:

- Setting a schedule to promote engagement in behaviors that are inconsistent with substance use
- Recognizing and avoiding “high risk” situations
- Facilitating positive coping skills

# Cognitive CBT Concepts

As CBT treatment continues into later phases of recovery, more emphasis is given to the “cognitive” part of CBT. This includes:

- Psychoeducation regarding addiction
- Teaching clients about triggers and cravings
- Teaching clients cognitive skills (e.g., “thought stopping” and “urge surfing”)
- Identifying “red flag thoughts”

# Family and couples counseling

- There are a number of evidence-based family and couples treatment interventions for SUD.
- Although the intensity and specific techniques for working with couples and families, there is one overarching finding: Treatment programs that engage the significant others/families into the SUD treatment process result in better retention and outcomes for the individual in SUD treatment.

# 12 Step Facilitation Therapy

- Project Match and a number of other studies have demonstrated that 12 Step facilitation therapy (an approach that educates patients about the 12 Step program and promotes 12 step program involvement) can increase involvement in 12 Step program participation.

# 12 Step Participation

- There is an expanding body of research literature that documents the benefits of 12 Step program participation. Researchers at Stanford University (Moos, Finney, Humphreys and others) have amassed a substantial body of evidence that individuals who engage in the 12 Step program have better SUD outcomes and more improvement in the quality of life measures, than individuals who do not participate.

# Medication Assisted Treatment

- Medications with evidence of efficacy.
  - Methadone
  - Buprenorphine
  - Naltrexone (oral and extended release)
  - Naloxone (for overdose prevention)
  - Acamprosate
  - Antabuse

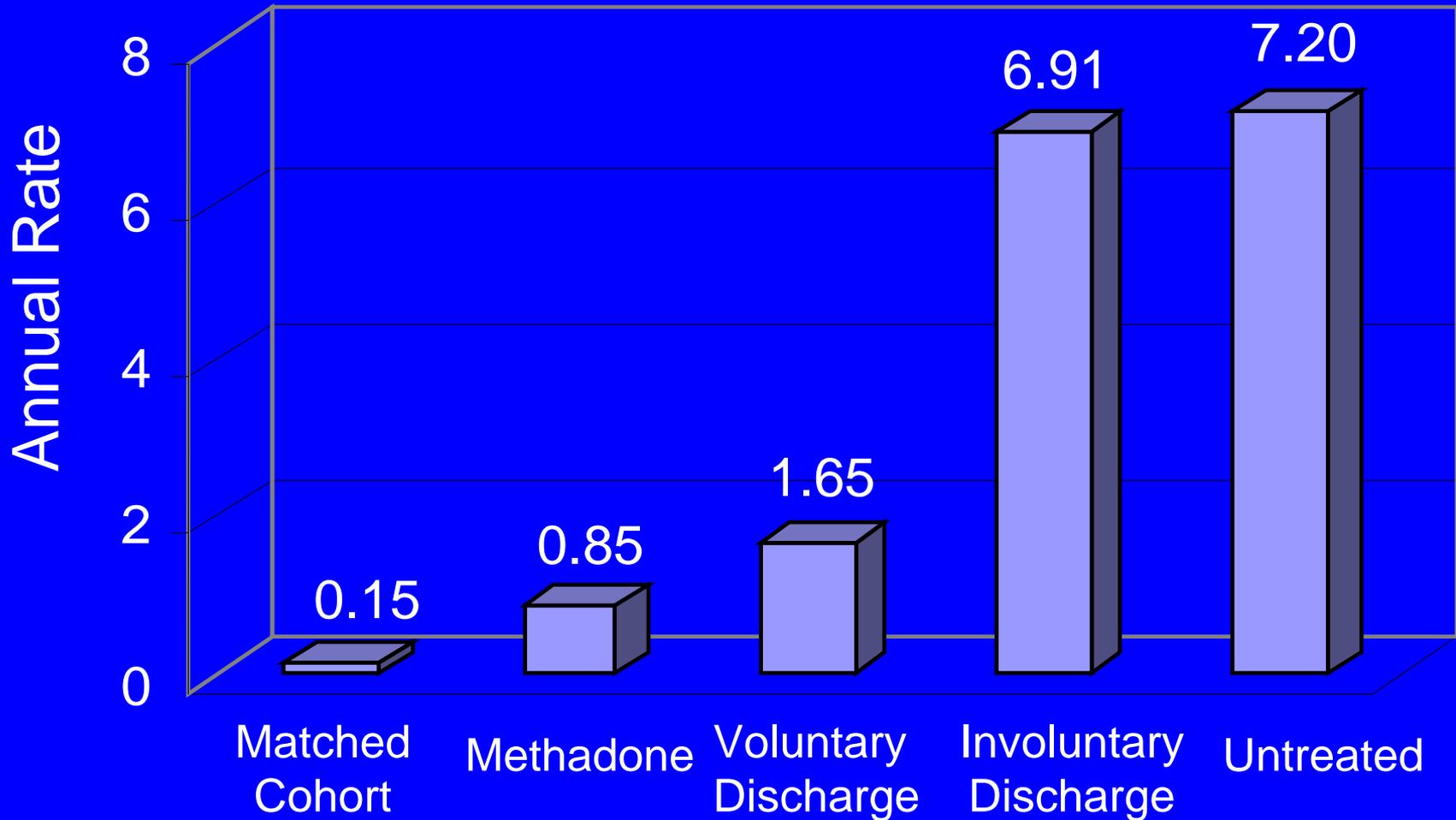
# Methadone: Clinical Properties

- Synthetic opioid with a long half-life
- $\mu$  agonist with morphine-like properties and actions
- Action – CNS depressant
- Effects usually last about 24 hours
- Daily dosing (same time, daily) maintains constant blood levels and facilitates normal everyday activity
- Adequate dosage prevents opioid withdrawal (without intoxication).

# Rationale for methadone treatment

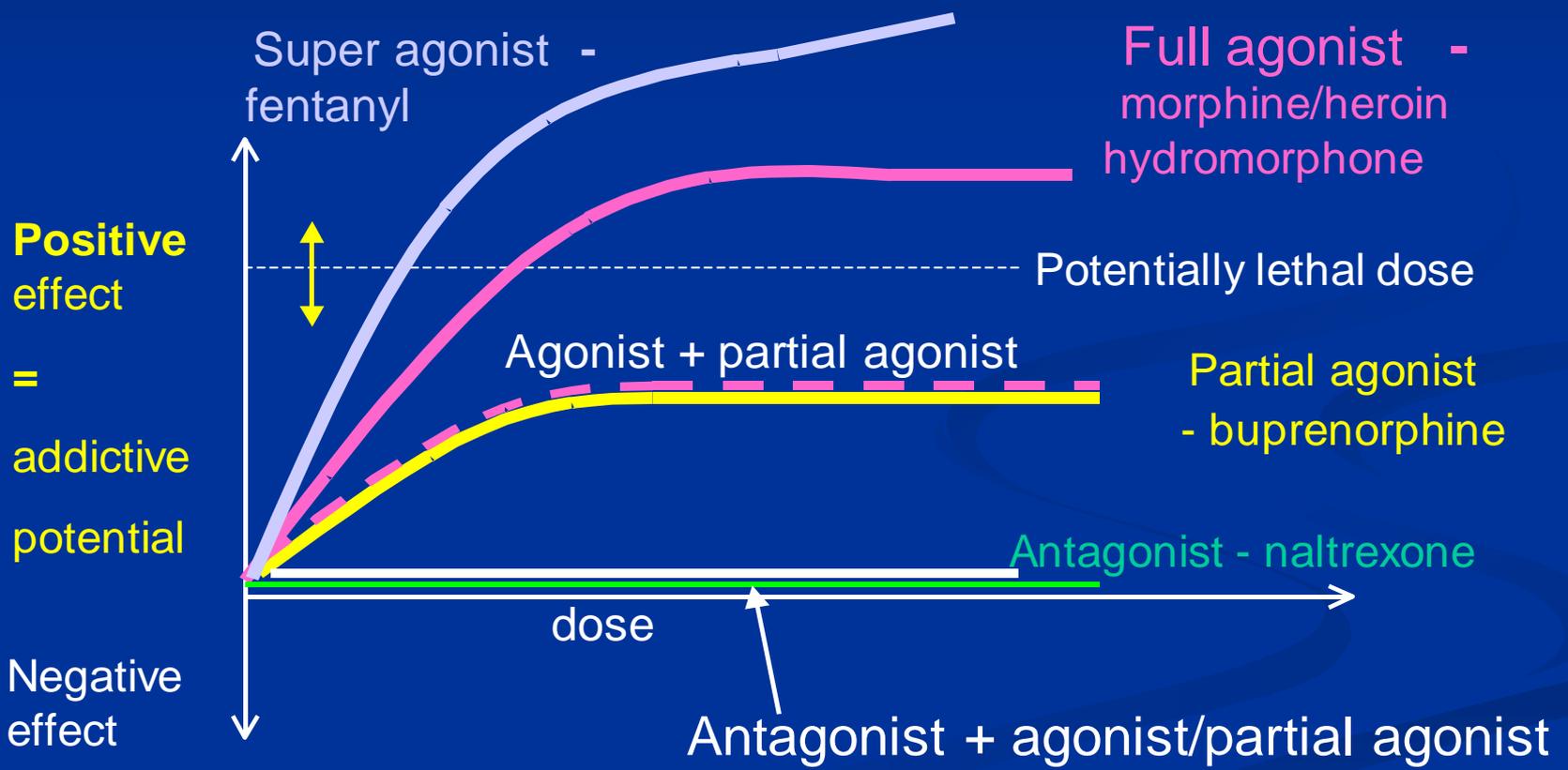
- Highly effective treatment for opioid dependence
- Controlled studies have shown that with long term maintenance treatment using appropriate doses, there are significant:
  - Decreases in illicit opioid use
  - Decreases in other drug use
  - Decreases in criminal activity
  - Decreases in needle sharing and HIV transmission
  - Improvements in prosocial activities
  - Improvements in mental health

# Death Rates in Treated and Untreated Heroin Addicts



# Buprenorphine (Suboxone)

# Buprenorphine and opiate addiction



# Maintenance Treatment Using Buprenorphine

*Studies conclude:*

Buprenorphine equally effective as moderate doses of methadone (e.g., 60 mg per day)

Not clear if buprenorphine can be as effective as higher doses of methadone and therefore may not be the treatment of choice for some patients with higher levels of physical dependence.

Withdrawal symptoms from buprenorphine less severe than from morphine or methadone.

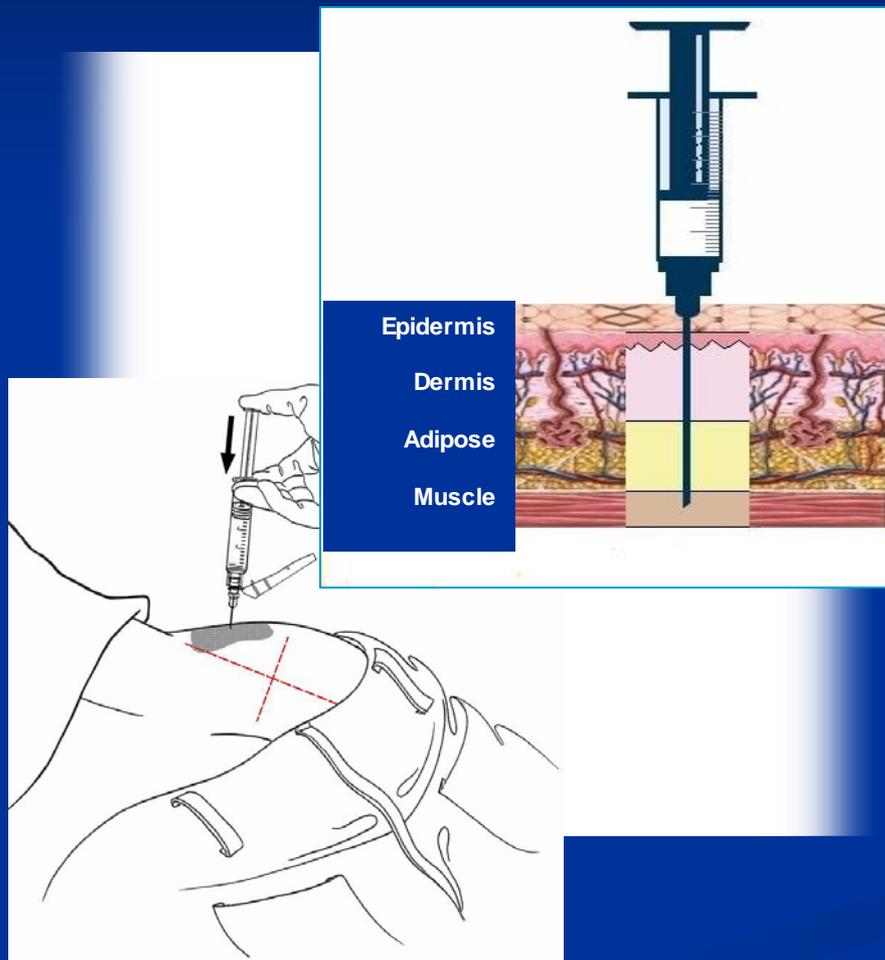
# Buprenorphine safety

- Low risk of clinically significant problems
- No reports of respiratory depression in clinical trials comparing buprenorphine to methadone
- There is concern about increasing evidence that buprenorphine is being abused and sold to non-patients.

# Naltrexone and Acamprosate

- Effective
- Work well with variety of supportive treatments e.g. brief intervention, CBT, supportive group therapy
- Start following alcohol withdrawal – proven efficacy where goal is abstinence, uncertain with goal of moderation
- No contraindication while person is still drinking, although efficacy uncertain
- Generally safe and well tolerated

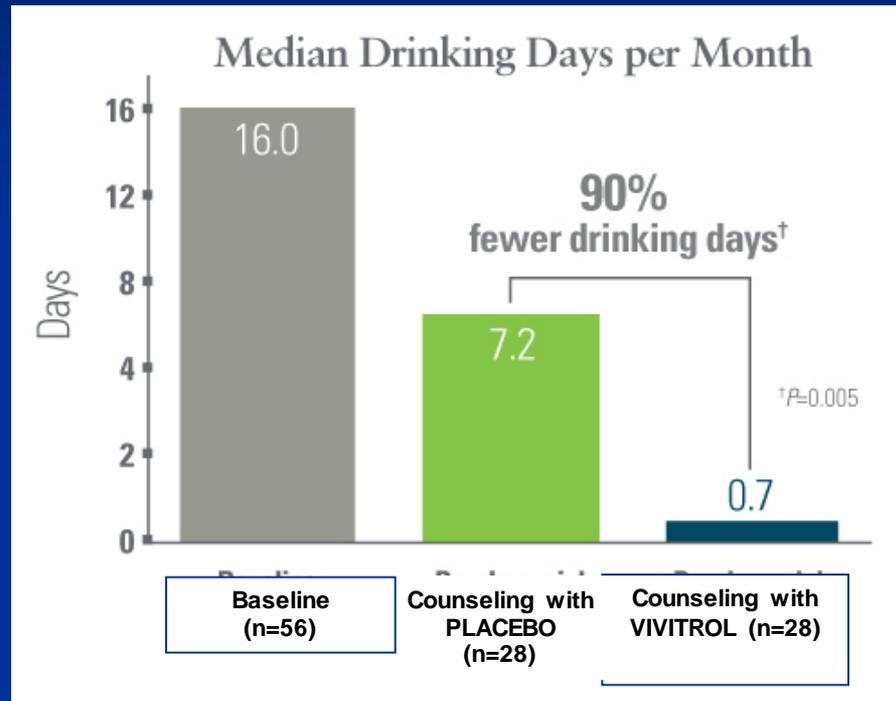
# Vivitrol Dosage and Administration



- VIVITROL is given as an intramuscular (IM) gluteal injection every 4 weeks or once a month
  - VIVITROL should not be given subcutaneously or in the adipose layer
- VIVITROL must not be administered intravenously
- VIVITROL should be administered by a healthcare professional, into alternating buttocks each month
- VIVITROL should be injected into the upper outer quadrant of the buttock, deep into the muscle-not the adipose.

# Extended Release Naltrexone Significantly Reduces Drinking Days<sup>1,2</sup>

Reductions were substantial<sup>1†</sup>



† These results are from a post hoc subgroup analysis of a 6-month, multicenter, double-blind, placebo-controlled clinical trial of alcohol dependent patients. This subset analysis evaluated patients who were abstinent for 4 or more days prior to treatment initiation<sup>1</sup>

1. O'Malley SS et al. *J Clin Psychopharmacol.* 2007;27(5):507-512.

2. Drug and Alcohol Services Information System, The DASIS report: discharges from detoxification: 2000. <http://oas.samhsa.gov/2K4/detoxDischarges/2000Discharges.pdf>. Published July 9, 2004. Accessed January 23, 2008.

# Disulfiram

- Acetaldehyde dehydrogenase inhibitor – 200 mg daily
- → unpleasant reaction with alcohol ingestion
- Indications: alcohol dependence + goal of abstinence + need for external aid to abstinence
- Controlled trials: ↑ abstinence rate in first 3–6 months
- Best results with supervised ingestion & contingency management strategies

# Naloxone for overdose prevention



OVERDOSE PREVEN  
PREVENCIÓN DE  
EQUIPO DE



Walley AY, et al "Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: Interrupted time series analysis" *BMJ* 2013; DOI: 10.1136/bmj.f174.

# Lawsuits change clinical practice

- **Osheroff vs Chestnut Lodge (1984).** A lawsuit in which a depressed patient who had been treated for over a decade with psychotherapy, successfully sued the treatment center where they had not offered him treatment with antidepressant medication. This landmark case was a major turning point in widespread acceptance of the use antidepressant medication for the treatment of severe depression. “Philosophical opposition” to the use of effective medications for the treatment of depression was established as grounds for medical malpractice.

# “Osheroff” and opiate dependence treatment

- An increasing number of lawsuits in which family members of patients who have been discharged from residential care without the benefit of medication and who subsequently overdosed and died are being filed and “settled” with sealed results.
- Opiate overdose is a medically preventable condition. Providers who refuse to educate patients about the availability and potential benefits of opioid medications will likely face legal liability when patients die from preventable overdoses.

# Other evidence-based treatment principles

- Programs with poor rates of treatment engagement have poorer treatment outcomes
- For individuals with severe SUD, longer treatment episodes (across levels of care) are associated with better outcomes.
- Residential programs that successfully “step patients down” to IOP or OP produce better long term outcomes.
- For patients with co-occurring psychiatric or medical disorders concurrent treatment of these conditions improves SUD outcomes.

# Conclusions

- Training clinicians to use evidence-based practices is essential to having effective treatment outcomes regardless of the treatment setting.
- Evidence-based Behavioral Treatments include: Motivational interviewing, contingency management principles, cognitive-behavioral and relapse prevention techniques, 12 Step facilitation therapy and 12 Step Program participation, and couples and family counseling.
- Evidence-based Medications include: Methadone, buprenorphine, naltrexone, naloxone, acamprosate, antabuse
- Useful resources include SAMHSA TIPS and TAPs

# DEFINITIONS AND SERVICES

# Drug Medi-Cal SUD Benefits

## ■ Base DMC benefits:

- NTP outpatient treatment (methadone)
- Outpatient naltrexone services
- Outpatient group counseling, limited individual counseling
- Perinatal intensive outpatient
- Perinatal residential services

## ■ Expanded benefits:

- Intensive outpatient, ALL adults
- Residential services, ALL adults
- Inpatient detox

# ASAM Levels\*

- Level 1: Outpatient

- < 9 hours of service /week (recovery or motivational enhancement therapies/strategies)

- Level 2.1: Intensive Outpatient

- 9+ hours of service /week (to treat multidimensional instability)

- Level 3.1-3.5: Residential

- 24-hour structure with available trained personnel; at least 5 hours of clinical service /week

\* **ASAM Criteria are a consensus-based document, not an evidence-based practice**

# Level I: Outpatient Treatment

- PROGRAMS AT THIS LEVEL ARE DESIGNED TO: TREAT THE INDIVIDUAL'S LEVEL OF PROBLEM SEVERITY, ASSIST IN ACHIEVING PERMANENT CHANGES IN USING BEHAVIORS, AND IMPROVE MENTAL FUNCTIONING. 8 OR FEWER HOURS OF SERVICE PER WEEK,
- IT IS IMPAIRATIVE THAT PROGRAMS ADDRESS PERSONAL LIFESTYLES, ATTITUDES, AND BEHAVIORS THAT CAN IMPACT AND PREVENT ACCOMPLISHING THE GOALS OF TREATMENT
- LEVEL I MAY BE: THE INITIAL PHASE OF TREATMENT; A STEP DOWN PHASE; OR FOR THE INDIVIDUAL WHO IS NOT READY OR WILLING TO COMMIT TO A FULL RECOVERY PROGRAM (PRE-CONTEMPLATION)
- LEVEL I IS AN EXCELLENT WAY TO ENGAGE RESISTANT INDIVIDUALS

# Covered Outpatient Services

- At least 2 group counseling sessions per month
  - Up to 90 minutes
- Individual counseling
  - Up to 50 minutes per session per day
  
- Editorial Comment: This benefit is inadequate. There is no rational foundation for the limits on individual counseling

*Source:* TAC and Human Services Research Institute. California Mental Health and Substance Use System Needs Assessment and Service Plan. Volume 2, Sept 30, 2013.

# Outpatient Admission Guidelines

- Minimal risk of severe withdrawal
- No or stable/monitored biomedical complications
- No or stable/monitored behavioral complications
- Ready for treatment but needs motivating to strengthen readiness; or low interest in treatment but low severity in other dimensions
- Able to maintain abstinence or control use with minimal support
- Supportive recovery environment or individual has skills to cope

# Level II: Intensive Outpatient

- PROVIDES 9 OR MORE HOURS OF STRUCTURED TREATMENT PER WEEK FOR ADULTS
- CONSISTS OF COUNSELING AND EDUCATION RELATING TO SUBSTANCE-RELATED AND MENTAL HEALTH PROBLEMS AND/OR DISORDERS
- PSYCHIATRIC AND MEDICAL SERVICES ARE ADDRESSED THROUGH CONSULTATION AND REFERRAL ARRANGEMENTS DEPENDING ON THE STABILITY OF THE INDIVIDUAL
- IOP'S GENERALLY DO NOT HAVE THE CAPACITY TO TREAT INDIVIDUALS WITH UNSTABLE MEDICAL AND PSYCHIATRIC PROBLEMS

# Covered IOP Services under Drug Medi-Cal

- Services received 3+ times /week, 3 hrs /day
  - Intake
  - Individual counseling
  - Group counseling
  - Medication services
  - Collateral services
  - Crisis intervention
  - Treatment and discharge planning

*Source:* TAC and Human Services Research Institute. California Mental Health and Substance Use System Needs Assessment and Service Plan. Volume 2, Sept 30, 2013.

# IOP Admission Guidelines

- Minimal/manageable risk of relapse with withdrawal
- Biomedical conditions not a distraction from treatment
- Mild behavioral complications with potential to distract from recovery
- Variable or poor engagement in treatment
- Intensifying symptoms show high likelihood of relapse
- Unsupportive recovery environment, but patient can cope with structure and support

# Level III: Residential Services

## GENERAL CHARACTERISTICS OF LEVEL III:

- INDIVIDUAL'S NEEDING THIS LEVEL OF CARE HAVE FUNCTIONAL DEFICITS ; REQUIRE SAFE AND STABLE LIVING ENVIRONMENTS TO ASSIST IN DEVELOPING THEIR RECOVERY SKILLS
- TREATMENT SERVICES ARE PROVIDED IN A 24-HOUR RESIDENTIAL SETTING AND ARE STAFFED 24 HOURS A DAY
- SELF-HELP MEETINGS ARE USUALLY AVAILABLE ON SITE
- THE LIVING ENVIRONMENT AND THE TREATMENT PROVIDER MUST BE CLOSE ENOUGH SO THE TREATMENT PLAN CAN BE ADDRESSED IN BOTH FACILITIES

# Low Intensity Residential Services

- SUBSTANCE ABUSE SERVICES ARE PROVIDED FOR A MINIMUM OF 5 HOURS PER WEEK
- THE TREATMENT FOCUS IS ON RECOVERY SKILLS, PREVENTING RELAPSE, IMPROVING EMOTIONAL FUNCTIONING, AND WORKING
- TOWARD INTEGRATION INTO PRODUCTIVE EMPLOYMENT, FAMILY LIFE, AND/OR EDUCATIONAL PROGRAMS
- SELF-HELP MEETINGS ARE TYPICALLY PROVIDED ON SITE

# Low Intensity Residential Services

**NOT INTENDED TO INCLUDE SOBER HOUSES, BOARDING HOUSES,  
OR GROUP HOMES WHERE TREATMENT SERVICES ARE NOT  
PROVIDED**

# MEDIUM-INTENSITY RESIDENTIAL SERVICES

## DIFFERENCES FROM LEVEL III.

- SUBSTANCE USE HAS SIGNIFICATELY IMPAIRED THE INDIVIDUAL'S LIFE TO THE EXTENT THAT OUTPATIENT MOTIVATION AND/OR RELAPSE PREVENTION STRATEGIES ARE INEFFECTIVE
- FUNCTIONAL DEFICITS ARE PRIMARILY COGNITIVE AND ARE EITHER TEMPORARY OR IN SOME CASES PERMANENT
- TEMPORARY DEFICITS CAN BE THE RESULT OF THE SUBSTANCE USE (ORGANIC BRAIN SYNDROME)
- TREATMENT NEEDS TO SLOWER, MORE REPETITIVE, AND CONCRETE IN NATURE
- AS THE IMPAIRMENT CLEARS, TREATMENT CAN BE PROVIDED AT A LOWER LEVEL OF CARE

# MEDIUM-INTENSITY RESIDENTIAL SERVICES

## CRITERIA FOR REMAINING IN LEVEL III.3

- CHRONIC BRAIN SYNDROME, OLDER ADULTS WITH COGNITIVE DEFICITS, INDIVIDUAL'S WITH TRAUMATIC BRAIN INJURY, OR INDIVIDUAL'S WITH MENTAL RETARDATION
- FOR THESE INDIVIDUAL'S WITH THESE IMPAIRMENTS OUTPATIENT TREATMENT WOULD NOT BE CLINICALLY APPROPRIATE

# HIGH-INTENSITY RESIDENTIAL SERVICES

## INDIVIDUAL'S IN LEVEL III.5

- PRESENT WITH MULTIPLE ISSUES; SUBSTANCE USE DISORDERS, CRIMINAL ACTIVITY, PSYCHOLOGICAL PROBLEMS, IMPAIRED FUNCTIONING, AND DIFFICULTY IN CONFORMING TO MAINSTREAM VALUES
- DSM - AXIS I MENTAL HEALTH DISORDERS ARE OF A SERIOUS NATURE: SCHIZOPHRENIA, BIPOLAR, AND MAJOR DEPRESSION ALSO PRESENT ARE DSM - AXIS II DISORDERS –BORDERLINE, NARCISSISTIC AN
- D ANTISOCIAL PERSONALITY DISORDERS

# HIGH-INTENSITY RESIDENTIAL SERVICES

## PLACEMENT IN LEVEL III.5

- IS APPROPRIATE FOR THE INDIVIDUAL WHO PRESENTS WITH CHAOTIC, NON-SUPPORTIVE, AND ABUSIVE INTERPERSONAL RELATIONSHIPS
- THERE IS ALSO A LONG HISTORY OF TREATMENT ATTEMPTS OR CRIMINAL JUSTICE HISTORIES, AND LIMITED WORK AND/OR EDUCATIONAL EXPERIENCES
- ANTISOCIAL VALUE SYSTEMS ARE ALSO PRESENT

# Covered Residential Services under Drug Medi-Cal

- Intake
- Individual counseling
- Group counseling
- Medication services
- Collateral services
- Crisis intervention
- Service access\*
- Beneficiary education\*
- Coordination of ancillary services\*
- Treatment and discharge planning

*Source:* TAC and Human Services Research Institute. California Mental Health and Substance Use System Needs Assessment and Service Plan. Volume 2, Sept 30, 2013.

# Residential Admission Guidelines

- Minimal risk of severe withdrawal (high risk needs medical monitoring)
- No or stable/monitored biomedical conditions
- Range of minimal to moderate severity behavioral complications; needs a co-occurring capable program
- Range from open to recovery, to opposition to treatment
- Low skills to prevent continued use; needs structure or potentially imminent/dangerous consequences
- Environment is dangerous; patient needs 24-hour structure to cope

# Sober Living

- Initial research on SLEs seems to support reduced AOD use
  - Limitations: no RCTs; research on benefits of linking SLEs with outpatient treatment is limited
- Social support and involvement in 12-step groups correlated with improved outcomes (Polcin et al., 2010a)

## *Sources:*

Polcin et al., 2010a. Sober living houses for alcohol and drug dependence: 18-Month outcomes.

Polcin et al., 2010b. Eighteen-month outcomes for clients receiving combined outpatient treatment and sober living houses.

Polcin et al., 2010c. Recovery from addiction in two types of sober living houses: 12-Month outcomes.

Polcin & Borkman, 2008. The impact of AA on non-professional substance abuse recovery programs and sober living houses.

Polcin & Henderson, 2008. A clean and sober place to live: Philosophy, structure, and purported therapeutic factors in sober living houses.

# Sober Living

- NARR Standards
  - Recovery Support Standards include:
    - Inform residents on range of local tx and recovery support services available (12-step groups, recovery ministries/advocacy opportunities)
    - Provide access to structured peer-based services such as didactic presentations
    - Offer life skills development services

*Source:* National Association of Recovery Residences (NARR). Standard for recovery residences, 2011.

# RESEARCH ON EFFECTIVENESS

# OP vs. IOP

- A study by McLellan et al. (1997) compared 6 IOP and 10 OP programs
  - Treatment duration:
    - IOP ranged from 30-90 days, 3-5 sessions /week
    - OP ranged from 45-60 days, 1-2 sessions /week
  - Services:
    - IOP programs provided more SUD counseling, but OP programs more likely to offer medical appointments, family therapy sessions, psychotherapy, and employment counseling
  - Both groups show significant reductions in AOD, and improvements in personal health and social function.

# Inpatient vs. IOP

- Studies slightly favor inpatient, but patients benefit from both levels of care
- The important question: which level is more appropriate at a given time for each client?
  - Using patient placement criteria to optimally match patient needs with level of care is key.
  - Length of stay should be based on degree of functional improvement and patient strengths/challenges.
  - Availability of a broad continuum of treatment options benefits the client.

*Source: SAMHSA CSAT TIP 47: Clinical Issues in Intensive Outpatient Treatment*

# Utilization Management and SUD Services

- Utilization management is the evaluation of the appropriateness, medical need and efficiency of health services, including SUD services.
- Utilization management describes proactive procedures, including pre-certification for admission, concurrent planning, transition planning, and clinical case appeals.
- Utilization management is prospective and intends to manage health care cases efficiently and cost effectively before and during health care administration

Thank you  
[rrowson@mednet.ucla.edu](mailto:rrowson@mednet.ucla.edu)

# CATES Training Series

- UCLA is planning trainings to meet the 4-hour SBIRT requirement **(June-September 2014)**
- Call for host counties:
  - Northern California
  - Bay Area
  - Central Valley
  - Southern California