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1-855-337-MACS

Maryland Addiction Consultation Service

Where Does My Patient Belong?

The Role of Context in Addiction Treatment

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Webinar Goals

- Review available treatment contexts in Maryland
- Discuss rationale and placement criteria
- Consider the evidence base for different contexts
- Provide resources to find additional levels of care

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Financial Disclosures

- None
- I will mention the names of some public, private, and nonprofit organizations here--this should not be construed as an endorsement of their services in particular.

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The Basic Question

Where should a patient be treated for optimal outcomes (clinical, economical, etc)?

- Crushing chest pain: Walmart clinic or academic medical center?
- Excision of eyelid melanoma: family physician or ophthalmologist?
- Upper respiratory infection: Level 1 trauma center or grandma?

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Nomenclature

- "Detox"
- "Rehab"
- "Treatment"

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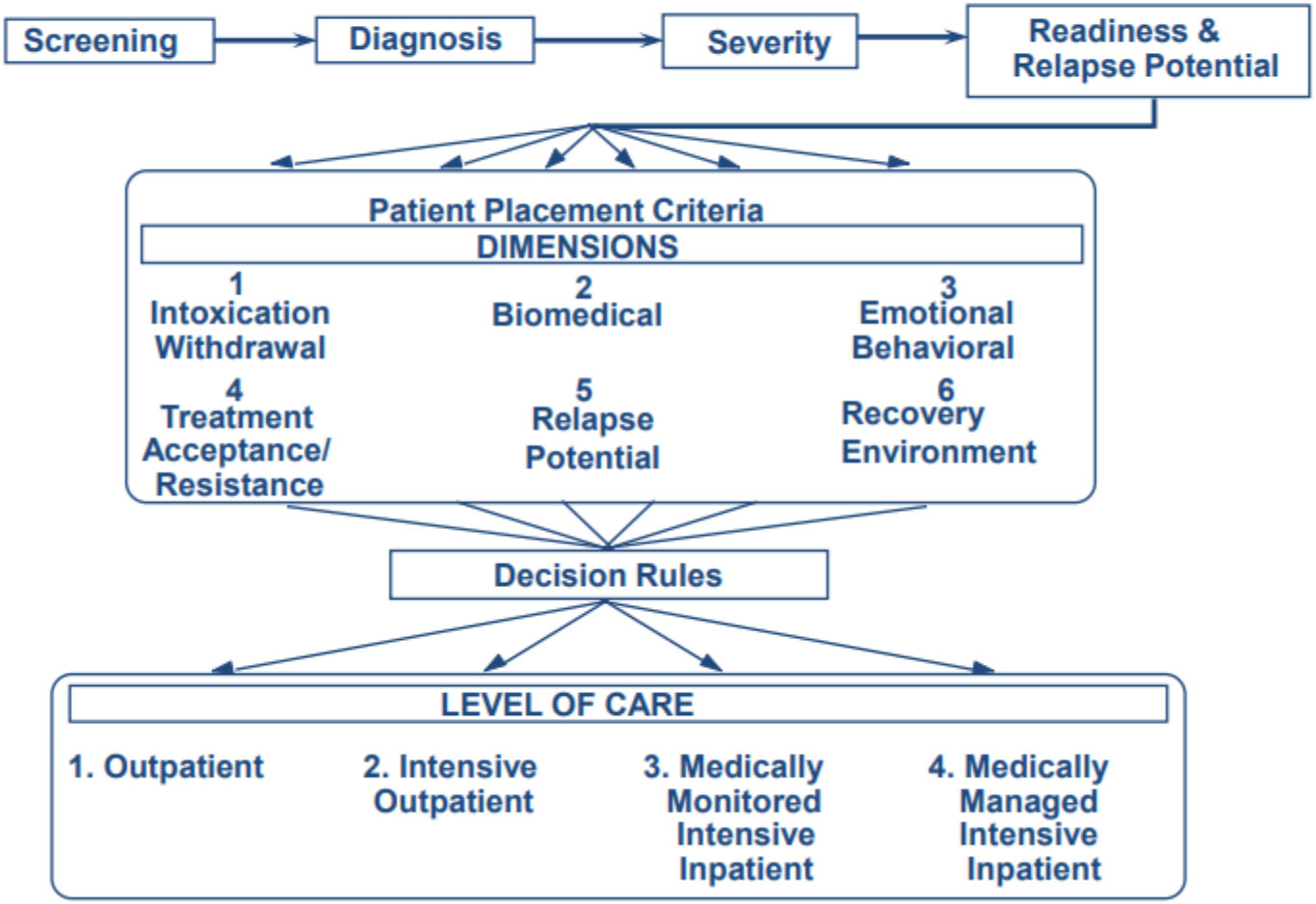
ASAM Patient Placement Criteria



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ASAM PLACEMENT CRITERIA

LEVELS OF OF CARE	1. OUTPT	2. INTENSIVE OUTPT	3. MED MON INPT	4. MED MGD INPT
CRITERIA				
Intoxication/ Withdrawal	no risk	minimal	some risk medical	severe risk 24-hr acute
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Relapse Potential	maintains abstinence	more symptoms, needs close monitoring	unable to control use in outpt care	
Recovery Environment	supportive	less support, w/ structure can cope	danger to recovery, logistical incapacity for outpt	

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ASAM Patient Placement Criteria Evidence Base

- Evidence base for ASAM-PPC: Replicable. Evaluated naturalistically-placed patients with ASAM Criteria (both pro- and retrospectively) and found that appropriately-matched patients did better: showed up more, stuck around longer, and used the hospital less.
- BUT: is naturalistic approach more patient centered?

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ASAM-PPC is here to stay

- Payers
- SAMHSA
- Reflect treatment services currently available

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Other Considerations

(besides the ASAM dimensions)

- Who is paying?
- What's around?
- Personal connections?
- Who is going to be there?

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ASAM Criteria: "Detox"

TABLE 27-2 ASAM CRITERIA LEVELS OF CARE

ASAM CRITERIA LEVEL OF WITHDRAWAL MANAGEMENT SERVICE FOR ADULTS	LEVEL	(NOTE: THERE ARE NO SEPARATE WITHDRAWAL MANAGEMENT SERVICES FOR ADOLESCENTS)
Ambulatory withdrawal management without extended on-site monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery
Ambulatory withdrawal management with extended on-site monitoring	2-WM	Moderate withdrawal with all-day withdrawal management support and supervision; at night, has supportive family or living situation; likely to complete withdrawal management
Clinically managed residential withdrawal management	3.2-WM	Minimal to moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase the likelihood of continuing treatment or recovery
Medically monitored inpatient withdrawal management	3.7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring
Medically managed inpatient withdrawal management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify the withdrawal management regimen and manage medical instability

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ASAM Criteria: "Rehab"

ASAM Criteria Levels of Care	Level	Same Levels of Care for Adolescents except Level 3.3
Early intervention	0.5	Assessment and education for at-risk individuals who do not meet diagnostic criteria for substance-related disorder
Outpatient services	1	Less than 9 h of service/week (adults); <6 h/week (adolescents) for recovery or motivational enhancement therapies/strategies
Intensive outpatient	2.1	9 or more hours of service per week (adults); 6 or more hours per week (adolescents) in a structured program to treat multidimensional instability
Partial hospitalization	2.5	20 or more hours of service per wk in a structured program for multidimensional instability not requiring 24-hour care
Clinically managed low-intensity residential	3.1	24-hour structure with available trained personnel with emphasis on reentry to the community; at least 5 h of clinical service per week
Clinically managed population-specific high intensity residential	3.3	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less-intense milieu and group treatment for those with cognitive or other impairments unable to use a full active milieu or therapeutic community
Clinically managed high-intensity residential	3.5	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use a full active milieu or therapeutic community
Medically monitored intensive inpatient	3.7	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 h/d counselor ability
Medically managed intensive inpatient	4	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3. Counseling available to engage the patient in treatment
Opioid treatment program	OTP	Daily or several times weekly opioid medication and counseling available to maintain multidimensional stability for those with opioid use disorder

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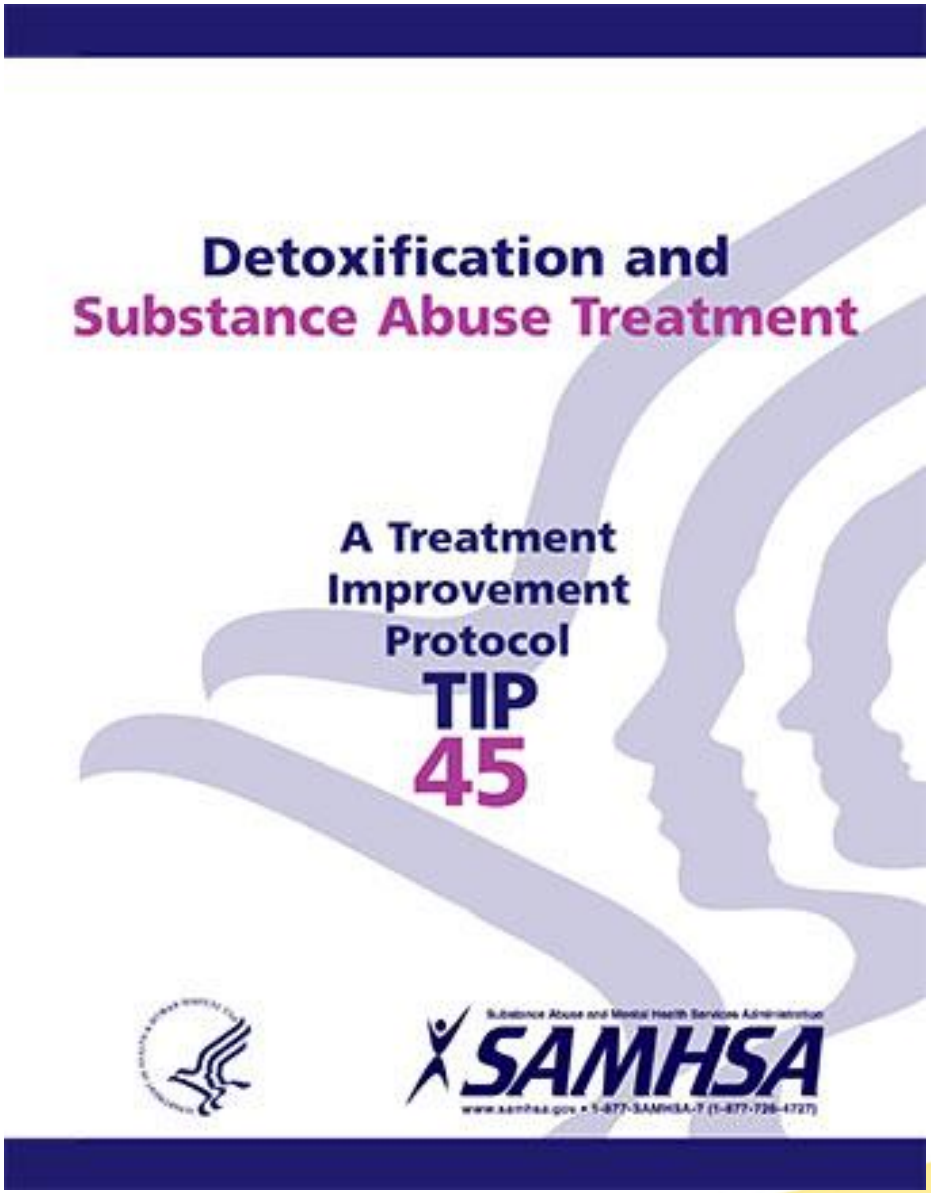
Why “Detox?”

- Minimize discomfort of withdrawal
- Facilitate transition to abstinence
- Point of first contact with treatment system
- Protect against severe morbidity/mortality
  - Alcohol, benzos, some others
- NOT as a mainstay of treatment (see TIP 45)



SAMHSA TIP 45: Detox & Substance Abuse Treatment

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Predicting Seizures from Alcohol Withdrawal

Impossible to predict with 100% certainty.

- Most important risk factor is prior seizures. Others:
- Having drunk for more than two decades
- Having poor general medical health and poor nutritional status
- Having had previous head injuries
- Electrolyte abnormalities
- BZDs similar

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"Detox"/Withdrawal Management: Examples

- Office based: you
- Outpatient: Univ. of Maryland Ctr for Addiction Med
- Kolmac Outpatient Recovery Centers
- Clinically Managed Residential Withdrawal Management: not much, but not nonexistent (Gaudenzia, Powell Recovery)
- Inpatient: UMMC Midtown, Mercy, Hopkins ITU, Bayview, BCRI

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Rationale for Inpatient Treatment

1. Respite from bad environments
2. More intensive treatment/more treatment hours
3. Other services available (sometimes)
4. Inpatient facilitates transfer to ongoing care
5. More dramatic

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Rationale for Outpatient Treatment

1. More accurate assessment of ongoing drug use and coping skills. Better able to assess success
2. Mobilize help in the patient's natural environment
3. More successful transition to continuing care

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Intensive Outpatient

- Defined as more than 9 hours per week of group & individual counseling.

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Evidence Base: Inpatient vs Outpatient

- Few RCTs, even fewer for patients with opioid use disorder.
- No RCT evidence to support longer treatment, but naturalistic studies suggest that longer stays associated with better outcomes. (Selection bias?)
- Ethical and economic considerations

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Table 2

Studies of intensive outpatient programs (IOPs) included in the review[a]

Study	Design, participants, setting	IOP treatment	Comparison treatment	Primary outcome measures	Summary of findings
RCT					
Schneider et al., 1996 (6)	Day treatment (N=32) versus inpatient (N=42). Individuals seeking treatment for cocaine dependence from a large health maintenance organization in metropolitan Boston	Day treatment: 2 weeks, Monday through Friday, 5 hours of services per day; weekly aftercare for ≤6 months (47% completed 14 days of IOP services)	Inpatient care: 14 days in a nonhospital facility with 6 hours of services per day; referral to halfway house, aftercare, or a mental health provider (95% completed 14 days of inpatient care)	ASI scores at baseline and telephone interviews at 3 months (completed by 91%) and 6 months (completed by 85%) after treatment; self-report of abstinence	ASI problem severity declined for both groups at 3 and 6 months and did not differ between groups. At 3 months, inpatients were more likely to report abstinence (63%) than the day treatment group (38%); no significant difference at 6 months (46% versus 35%, respectively).
Guydish et al., 1998 (7) and 1999 (8)	Day treatment (N=114) versus residential treatment (N=147) in a therapeutic community drug treatment program	Day treatment: 8 hours of treatment per day, 7 days per week for 6 to 8 months	Residential therapeutic community with 1-month orientation; 3 to 6 months active treatment; 3 to 6 months reentry	ASI scores at baseline and 6-, 12-, and 18-month follow-ups; treatment retention; days of treatment	ASI problem severity scores declined significantly from baseline; improvements were maintained at 6, 12, and 18 months. Residential patients had more improvement on social and psychiatric problems; remaining outcomes did not differ.
Rychtarik et al., 2000 (9)	Individuals seeking treatment for alcohol dependence randomly assigned to IOP (N=63) versus inpatient and outpatient (N=58) versus outpatient (N=61)	IOP: 5 days per week for 28 days; 3 months of weekly aftercare	Inpatient and outpatient: 28 days plus 8 sessions of outpatient plus weekly aftercare; or outpatient: 8 sessions in 28 days	Percentage of days abstinent	Days abstinent increased from pretreatment for all groups, and groups did not differ at 18-month follow-up: inpatient, 37% to 81%; IOP, 50% to 75%; outpatient, 41% to 76%. Patients with high alcohol involvement had better outcomes when treated in inpatient care.
Weithmann and Hoffmann, 2005 (10)	Day hospital (N=56) versus inpatient (N=54) care in a German psychiatric hospital	Day hospital: same services and staff as inpatient	Inpatient: same services and staff as day hospital	Percentage of days abstinent, assessed quarterly	Days abstinent increased for both groups. There were no differences between levels of care.
RCT included those who refused randomization					
McKay et al., 1995 (11)	Day hospital versus inpatient care; patients randomly assigned (N=48) and patients who refused randomization and self-selected their level of care (N=96)	Day hospital: 27 hours per week for 4 weeks	Inpatient: 48 hours per week of group and individual counseling plus psychoeducation	ASI scores at baseline and at 3-, 6-, and 9-month follow-ups after treatment	ASI problem severity declined in both groups at all measurement intervals. There were no differences between levels of care. Randomly assigned and self-selected participants had similar outcomes.
Witbrodt et al., 2007 (12)	Day hospital versus residential care; patients randomly assigned (N=293; day hospital=154, residential care=139) and patients who refused randomization and self-selected their level of care (N=403; day hospital=321, residential care=82)	Day hospital	Social model residential care	ASI scores at baseline and at follow-up interviews at 6 and 12 months	ASI problem severity declined in both groups at both measurement intervals. There were no differences between levels of care.

Assessing the Evidence Base Series

Substance Abuse Intensive Outpatient Programs: Assessing the Evidence

Dennis McCarty, Ph.D.
Lisa Braude, Ph.D.
D. Russell Lyman, Ph.D.
Richard H. Dougherty, Ph.D.
Allen S. Daniels, Ed.D.
Sushmita Shoma Ghose, Ph.D.
Miriam E. Delphin-Rittmon, Ph.D.

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Table 2

Continued from previous page

Study	Design, participants, setting	IOP treatment	Comparison treatment	Primary outcome measures	Summary of findings
Natural cohort analysis					
McLellan et al., 1997 (13)	Adults (N=918) from 10 outpatient programs (N=338) and 6 IOPs (N=580)	IOP: ≥3 hours per day, ≥3 days per week	Outpatient: ≤2 hours per session, ≤2 days per week	ASI scores at baseline and 7 months after baseline	ASI problem severity declined in both groups. There were no differences between levels of care. IOP patients had more severe problems at admission.
Harrison and Asche, 1999 (14)	Inpatient (N=1,156) versus outpatient programs (including IOPs) (N=3,007)	Outpatient: 145 programs in Minnesota providing intensive levels of care (median of 9 hours of care per week)	Inpatient: 38 programs in Minnesota (minimum of 30 hours of service per week)	ASI scores at intake and 6 months after intake	ASI problem severity declined in both groups. There were no differences between levels of care. Patients with recent suicidal ideation had better outcomes in inpatient care.
Pettinati et al., 1999 (15)	Alcohol-dependent patients admitted to inpatient (N=93) or outpatient (N=80) care in a psychiatric hospital	IOP: 8 weeks of 12-step program plus individual, group, and family therapy	Inpatient: 4 weeks of 12-step program plus individual, group, and family therapy	SCL-90R scores; number of drinking days; return to significant drinking (days of drinking ≥3 drinks) or return to inpatient care	Survival analysis suggested that IOP patients returned to significant drinking more quickly (50% at 2 months) than inpatients (25% at 2 months). Six months after discharge, the percentage of patients with heavy drinking stabilized at about 50% in both groups.
Simpson et al., 1999 (16)	Secondary analysis of data from DATOS assessing cocaine-dependent patients in 3 levels of care: outpatient drug free (including IOP) (N=458), long-term residential (N=542), short-term inpatient (N=605)	Outpatient drug free: 24 programs	Residential: 19 long-term programs; inpatient: 12 short-term programs	Weekly cocaine use 1 year after discharge	Weekly cocaine use declined from 73% before treatment to 23% at follow-up and did not differ across groups. A significant interaction between level of care, problem severity, and retention in care suggested that patients with more severe problems were less likely to report weekly cocaine use after long-term residential care (23%) versus short-term residential care (37%).
McKay et al., 2002 (17)	Patients in Washington state receiving inpatient plus outpatient care (N=167) versus IOP services only (N=96)	IOP: 2 programs	Inpatient: a 28-day inpatient program	ASI scores at baseline and 3 and 9 months after baseline	ASI problem severity declined in both groups at 3 and 9 months. Participants in inpatient plus outpatient programs improved more because their symptoms were more severe at baseline.
Tiet et al., 2007 (18)	Veterans Affairs clients receiving outpatient (N=410) or IOP services (N=601) versus inpatient and residential care (N=1,520)	IOP or outpatient	Inpatient and residential: inpatient (N=224), residential (N=390), and domiciliary (N=906) settings	ASI scores at baseline and 6 months after baseline	ASI problem severity declined in both groups after baseline. There were no differences between levels of care except for the most severe cases.

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Who Might Benefit from Inpatient?

- Inability to commute to treatment, homelessness, medical and psychiatric disorders, insufficient resources, lack of telephone
- "More impaired patients"
- Patients with personality or psychiatric disorders?
- Socially UNSTABLE alcoholics (socially stable ones might to better outpatient)

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Transitional Housing

- Transitional housing + Treatment—Powell Recovery, Mosaic
- Halfway houses
- ¾ houses
- Sober living environments
- Salvation Army
- Helping Up Mission

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Residential with Detox

- Detox with transition to abstinence-only or XR-NTX
- Many do not continue buprenorphine after the first few days

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Outpatient Methadone and Buprenorphine

- OTPs ("Methadone Programs")
  - Lots of variability in quality and monitoring
  - Some include buprenorphine but then have to follow the methadone rules
- Buprenorphine/naloxone
  - Many waivered physicians are self-pay only
  - Access better if they (you) are not
  - Some programs include (or "require") IOP

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Outpatient

- Outpatient programs: primarily relapse-prevention, dual-diagnosis, groups, 2-3 hours/week
- See treatment locator

J Subst Abuse Treat. 2014 Feb;46(2):87-97. doi: 10.1016/j.jsat.2013.08.022. Epub 2013 Sep 26.

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AA/NA

- Lots of meetings
- Just google to find them or visit:
  - Alcoholics Anonymous
  - Narcotics Anonymous
- Print out a list of meetings for your AVS
- Anticipatory guidance
  - "What To Expect At Twelve-Step Meetings"

Finding Resources

- Call MACS: 855-337- MACS (6227)
- Maryland Certified Treatment Directory
- SAMHSA Treatment Locator

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www.marylandMACS.org

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Case 1

- Ms. S, 54 year old F
- History of hypertension, CHF (NYHA Class 3)
- Crack cocaine use--$20 every two days

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Case 2

- Mr F, 52 year old M
- History of heroin addiction, on MMT
- History of head trauma and seizures
- Prior clonazepam prescription, now buys on the street (2-4mg/daily)
- Drinks 1 pint/day

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Case 3

- Mr. J, 25 year old M
- Drank heavily starting at age 17
- Abstinent for 2 years until 1 month ago
- Now drinking 2 40-oz Steel Reserves daily
- Has a sponsor, trying to quit again
- Complains of “the shakes” when stops drinking

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