

TREATMENT PRACTITIONER'S RESEARCH BULLETIN

Alcohol and drug research treatment advances and best practice summary

MEDICAL EDITOR

Richard Saitz, MD, MPH, FASAM, FACP

Professor of Medicine and Epidemiology,
Boston University Schools of Medicine and
Public Health, Boston, MA

ASSOCIATE EDITORS

Tommie Ann Bower, MA

Director of Program Development and
Quality, Gosnold, Inc., Falmouth, MA

Michael G. Boyle, MA

President & CEO, Fayette Companies,
Peoria, IL

Tom Delaney, MSW, MPA

Executive Director, Boston Alcohol and
Substance Abuse Programs, Inc.,
Boston, MA

Norma Finkelstein, PhD, LICSW

Executive Director, Institute for Health
and Recovery, Cambridge, MA

James Harrison, MHS, CADC

Lancaster Site Director, Brandywine
Counseling, Inc., Wilmington, DE

Michael Levy, PhD

Director of Clinical Treatment Services
CAB Health & Recovery Services, Inc.,
Peabody, MA

MANAGING EDITOR

Donna Vaillancourt

Boston Medical Center, Boston, MA

CONTACT INFORMATION

Treatment Practitioner's Research Bulletin
Join Together
580 Harrison Ave. 3rd Floor
Boston, MA 02118
tprb@jointogether.org

May/June 2009

Volume 2 No. 4

Contents

Computer Versus Therapist-Delivered Treatment for Co-occurring Depression and Alcohol/Cannabis Use

Reviewed by Michael G. Boyle, MA

Contingency Management Effective in a Community Adolescent Treatment Program

Reviewed by Michael Levy, PhD

Extended Outpatient Detoxification with Buprenorphine Demonstrates Better Outcomes than Short-Term Detoxification

Reviewed by Michael Levy, PhD

Treatment in Primary Care for Family Members Affected by Substance Abuse

Reviewed by Norma Finkelstein, PhD

Substance Abuse Linked to Tuberculosis Transmission and Treatment Failure in the United States

Reviewed by Tom Delaney, MSW, MPA

Abstinence after Diagnosis of Alcohol-Related Cirrhosis is a Key Factor in Prognosis

Reviewed by Tom Delaney, MSW, MPA

Produced by



JOIN TOGETHER

ADVANCING EFFECTIVE ALCOHOL AND DRUG POLICY,
PREVENTION, AND TREATMENT

A project of the National Center on Addiction and Substance
Abuse at Columbia University

Supported by an unrestricted educational grant from Alkermes, Inc.,
Cephalon, Inc., and Reckitt Benckiser.

Additional support provided by the Robert Wood Johnson Foundation.

The Treatment Practitioner's Research Bulletin is produced by Join Together, a project of the National Center on Addiction and Substance Abuse at Columbia University, in partnership with Boston University Schools of Medicine and Public Health. Copyright © 2009.

Available online at: www.jointogether.org/news/research/tprb

Computer Versus Therapist-Delivered Treatment for Co-Occurring Depression and Alcohol/Cannabis Use

When depression and substance abuse occur together, either condition can hamper effective treatment of the other. Behavioral interventions that address both conditions at once have not been rigorously tested. Although delivering such interventions by computer holds promise for extending their reach, the effectiveness of this approach remains unknown. In a randomized trial, researchers measured the effectiveness of an intervention combining principles of motivational interviewing (MI) and cognitive behavioral therapy (CBT) in treating both depression and comorbid alcohol and/or cannabis use. After a single baseline brief intervention (BI), 97 persons with co-occurring depression and heavy alcohol and/or cannabis use were randomized to receive either no further treatment (n=30) or nine 1-hour sessions of MI/CBT treatment delivered either by a therapist (n=35) or by computer (n=32). Sixty-seven patients completed the study. Depression and alcohol/cannabis use were assessed at 3, 6, and 12 months following treatment completion.

- The MI/CBT conditions were more effective for lowering depression symptoms than BI at 12 months.
- Therapist-delivered MI/CBT was more effective for depression than computer-delivered MI/CBT at 3 months, but there was no difference in results at 12 months.
- Problematic alcohol consumption was reduced in all 3 conditions, with best results observed in the therapist-delivered MI/CBT condition.
- The MI/CBT conditions were more effective than BI in reducing cannabis and hazardous-substance use, with best results observed in the computer-delivered MI/CBT condition.
- Computer-delivered MI/CBT saved 79% of therapists' time compared with face-to-face MI/CBT treatment.

Comments by Michael G. Boyle, MA

These results support the development of clinical algorithms that are population-based and provide stages of treatment. For example, BI for alcohol use disorders may be the first intervention, followed by more intensive ongoing treatment if the desired results are not obtained. Addiction treatment is very labor intensive with 75% of its costs related to staffing. Computerized interventions are a means of increasing access to treatment while potentially lowering costs per episode of care. The combination of computerized interventions with brief therapist contact is particularly well-suited for federally qualified health centers, which receive an enhanced rate for brief treatment encounters.

Reference

Kay-Lambkin FJ, Baker AL, Lewin TJ, et al. Computer-based psychological treatment for comorbid depression and problematic alcohol and/or cannabis use: a randomized controlled trial of clinical efficacy. *Addiction*. 2009;104(3):378-388.

This summary was adapted from text previously published in *Alcohol, Other Drugs, and Health: Current Evidence*.

Contingency Management Effective in a Community Adolescent Treatment Program

While many studies have shown that contingency management (CM)—i.e., the use of motivational incentives—can help reduce drug use, widespread adoption of CM has been slow, due at least in part to concerns about cost. This observational study measured the effect of low-cost CM on urine drug tests and attendance at partial-hospitalization and intensive-outpatient treatment programs for adolescents aged 12–18. Patients with perfect attendance and negative urine tests earned chances to draw prizes of varying value (\$0–\$15). The number of draws increased with each consecutive negative urine test. Researchers compared patients treated in the 3 months before CM was introduced (n=83) with those treated after (n=264).

- The proportion of positive urine tests for any drug decreased significantly (from 33% to 23%) after CM.
- Patients treated with CM had significantly fewer positive urine tests for opioids and cocaine and fewer (though not significantly) positive urine tests for marijuana, benzodiazepines, and amphetamines.
- Attendance did not improve with CM, but length of stay increased from 13 to 15 days.
- Total cost of the 12-month CM program was \$1524.58, or \$0.39 per patient per day. This cost was more than offset by billed charges for clinical services, which increased substantially due to the greater length of stay.

Comments by Michael Levy, PhD

These results demonstrate that adolescent substance users who attend a treatment program may benefit from very low-cost CM. Programs that work with adolescents should consider implementing low-cost CM to improve outcomes since it appears not to add a substantial financial burden. In some cases, CM may even reduce overall program costs.

Reference

Lott DC, Jencius S. Effectiveness of very low-cost contingency management in a community adolescent treatment program. *Drug Alcohol Depend.* 2009;102(1–3):162–165.

Extended Outpatient Detoxification with Buprenorphine Demonstrates Better Outcomes than Short-Term Detoxification

Although outpatient detoxification with buprenorphine is widely used for opioid dependence, little research has addressed how best to maximize completion rates, reduce drug use after completion, and facilitate transition to longer term treatment. This study compared data from two consecutive studies: one among 364 individuals with opioid addiction entering 6-month treatment by receiving brief (5-day) buprenorphine detoxification, the second among 146 individuals entering 6-month treatment by receiving extended (30-day) buprenorphine detoxification.

Successful completion was defined as attending a counseling session and submitting a drug-negative urine specimen at the end of detoxification. Transition to ongoing care was defined as attending at least 1 post-detoxification counseling session. Treatment engagement was measured by the total number of counseling sessions attended and the number of drug-positive urine specimens submitted during the first 30 days of treatment.

Patients who received extended versus brief detoxification:

- Were more likely to successfully complete detoxification (16% versus 4%).
- Were more likely to transition into ongoing care (41% versus 26%).
- Attended more counseling sessions (2.9 versus 1.7) and submitted fewer drug-positive urine specimens (4.3 versus 4.8; range, 0–5) during the first 30 days of treatment.

Comments by Michael Levy, PhD

This study demonstrates that longer term detoxification with buprenorphine can increase completion rates, transitions to ongoing treatment, and treatment engagement, as well as decrease drug use in patients with opioid dependence. Programs offering detoxification with buprenorphine should consider offering longer courses. However, even with a 30-day detoxification, a substantial number of patients failed to achieve abstinence. This suggests an even longer term of detoxification with buprenorphine may be needed for many individuals, if not a maintenance regimen.

Reference

Katz EC, Schwartz RP, King S, et al. Brief vs. extended buprenorphine detoxification in a community treatment program: engagement and short-term outcomes. *Am J Drug Alcohol Abuse*. 2009;35(2):63–67.

Treatment in Primary Care for Family Members Affected by Substance Abuse

Studies indicate that individuals who have a close family member with addiction suffer from multiple symptoms of physical and psychological stress. However, service interventions for family members are not routinely available. Researchers in England used a stress-strain-coping-support model of addiction to compare two family interventions in 136 primary care practices.

The full intervention consisted of five face-to-face, manual-guided counseling sessions focused on identifying stressors, providing information on alcohol and other drugs, and developing coping behaviors and sources of support. The brief intervention consisted of one face-to-face session and provision of a self-help manual based on the principles used in the full intervention. Eighty-six percent of the 143 participants were women. The substance-using relative was a male partner for 42% of participants and a child for 36%.

- Family members in both groups showed significant reductions in stress and improvement in coping skills at 12-week follow-up.
- There were no differences in outcomes between groups; the brief intervention was as effective as the full intervention.
- Despite the similarity in outcomes, both family members and primary care workers preferred the more frequent face-to-face contact provided with the full intervention.

Comments by Norma Finkelstein, PhD

Family members can play a critical role in the prevention and treatment of addiction and mental health problems. Unfortunately, understanding addiction as a family disease, while accepted theoretically, is not widespread in terms of service interventions. This study suggests that a brief family intervention by primary care staff can make a difference in a family member's well-being, although recruiting and engaging primary care workers presented a challenge for these researchers. In addition to incorporating family interventions in primary care, family support is critically needed in treatment programs to improve the emotional health of both patients and families.

Reference

Copello A, Templeton L., Orford J., et al. The relative efficacy of two levels of a primary care intervention for family members affected by the addiction problem of a close relative: a randomized trial. *Addiction*. 2009;104(1):49-58.

Substance Abuse Linked to Tuberculosis Transmission and Treatment Failure in the United States

Although tuberculosis (TB) prevalence is low in the United States, local outbreaks among people with substance abuse have been reported. Researchers from the Centers for Disease Control and Prevention analyzed records of all reported TB cases in the United States from 1997–2006 to assess the role of substance abuse in the transmission and treatment of TB.

- Of the 153,268 people with TB included in the analysis, 19% overall reported substance abuse (defined by self-reported excessive alcohol use, non-injection drug use, or injection drug use in the year before TB diagnosis). Of the 76,816 US-born TB cases, 29% reported substance abuse.
- Prevalence rates were higher for substance abuse than for other risk factors, including recent immigration to the United States, HIV infection, residing in a congregate setting, homelessness, or working at a high-risk occupation (e.g., healthcare, correctional-facility, or migrant worker).
- A TB-positive sputum smear was more common among people with substance abuse, both in persons with HIV infection and without HIV infection.
- Treatment failure was more common among people with substance abuse, especially among women but also among men.
- People with substance abuse were more likely to be in a county-level genotype cluster (defined as 2 or more patients from the same county with identical TB genotypes).

Comments by Tom Delaney, MSW, MPA

This article is a timely reminder to substance abuse treatment providers that the incidence of TB among persons with substance abuse has decreased less than it has for the general population. Substance abuse clinicians and staff should not be lulled into overlooking TB as a health threat to their patients because of its lowered incidence overall. The treatment community has an important role to play in referring patients for TB screening, taking steps to reduce transmission, and encouraging client adherence to TB treatment regimens. This study also reinforces the need for substance abuse treatment to be integrated into the total health care of the patient.

Reference

Oeltmann JE, Kammerer JS, Pevzner ES, et al. Tuberculosis and substance abuse in the United States, 1997–2006. *Arch Intern Med.* 2009;169(2):189–197.

This summary was adapted from text previously published in *Alcohol, Other Drugs, and Health: Current Evidence*.

Abstinence after Diagnosis of Alcohol-Related Cirrhosis is a Key Factor in Prognosis

Rates of cirrhosis are influenced by alcohol consumption, which doubled in the United Kingdom between 1960 and 2002. As a result, deaths from liver cirrhosis also increased substantially. This article reported on 7-year survival among 100 consecutive patients with alcohol-induced liver cirrhosis treated in a UK general hospital. Researchers scored liver biopsies from each patient for severity of cirrhosis then reviewed medical records to determine other clinical factors including drinking status. Results were compared with mortality data obtained from the UK National Health Service Strategic Tracing Service.

- Severity of cirrhosis had little impact on patient survival. Similar results were obtained if survival was measured from the time of first presentation of liver disease, so this effect was not related to patients undergoing biopsy later in the course of disease.
- Abstinence from alcohol one month after diagnosis was the most important factor determining survival. The 7-year survival rate was 72% for abstinent patients versus 44% for patients who continued to drink.

Comments by Tom Delaney, MSW, MPA

This article provides yet another reason to integrate substance abuse treatment with general medical care. The relationship between heavy alcohol use and cirrhosis is well known, and as such, they should be addressed concomitantly. All too often, the treatment focus is on cirrhosis. Substance abuse counselors should bring their skills to the cirrhosis treatment team immediately after a diagnosis of alcohol-related cirrhosis and provide continued abstinence support for patients over the long-term course of treatment.

Reference

Verrill C, Markham H, Templeton A, et al. Alcohol-related cirrhosis—early abstinence is a key factor in prognosis, even in the most severe cases. *Addiction*. 2009;104(5):768–774.

EDITORIAL BOARD

MEDICAL EDITOR

Richard Saitz, MD, MPH, FASAM, FACP

Professor of Medicine and Epidemiology
Boston University Schools of Medicine and Public Health, Boston, MA

At Boston University Medical Center, Dr. Saitz is a Professor of Medicine and Epidemiology, Associate Director of the Office of Clinical Research, Director of the Clinical Addiction, Research and Education Unit, Scientific Director of the NIH Youth Alcohol Prevention Center, and a primary care general internist and health services researcher. He is also Immediate Past President of the Association for Medical Education and Research in Substance Abuse. He mentors research trainees and is the associate director of the Boston University K30 clinical research training program.

ASSOCIATE EDITORS

Tommie Ann Bower, MA

Director of Program Development and Quality
Gosnold, Inc., Falmouth, MA

Tommie Ann Bower is the Director of Program Development and Quality at Gosnold on Cape Cod. Tommie has been running programs for many years. Beginning in 2005, she became a Process Improvement Coach with NIATx, and has coached on several other projects in Massachusetts and Maine. She is a Certified ARISE Interventionist and is currently working on creating a continuum of family services for Gosnold.

Michael G. Boyle, MA

President & CEO
Fayette Companies, Peoria, IL

Michael G. Boyle is President and CEO of Fayette Companies, a behavioral health management firm that provides comprehensive mental health and substance abuse services. Michael is the Director of the Behavioral Health Recovery Management project, serves as a coach to the State of Florida for the Robert Wood Johnson Foundation's Advancing Recovery project, is on the NASADA/NASMHPD National Task Force on Co-occurring Disorders, and is actively involved in the Network for the Improvement of Addiction Treatment and the American College of Mental Health Administration.

Tom Delaney, MSW, MPA

Executive Director
Boston Alcohol and Substance Abuse Programs, Inc., Boston, MA

Tom Delaney is the Executive Director of Boston Alcohol and Substance Abuse Programs, Inc., a non-profit outpatient clinic. He is the vice-president of the Massachusetts Organization for Addiction Recovery and chair of the DUI/Second Offender committee of the Mental Health and Substance Abuse Corporations of Massachusetts. Tom is a Massachusetts Licensed Certified Social Worker and a Licensed Alcohol and Drug Counselor (LADC I). He has a MPA in addition to his MSW degree from the State University of New York at Albany.

Norma Finkelstein, Ph.D., LICSW

Executive Director
Institute for Health and Recovery, Cambridge, MA

Norma Finkelstein is founder and Executive Director of the Institute for Health and Recovery, a statewide policy, program/systems development, training, services and research organization. Prior to

this, Dr. Finkelstein was the founder and Executive Director of the Women's Alcoholism Program/CASPAR, Inc., a comprehensive prevention, education, and treatment program for chemically dependent women and their families. She received her MSW from the University of Michigan and her Ph.D. from the Florence Heller School, Brandeis University.

James Harrison, MHS, CADC

Lancaster Site Director
Brandywine Counseling, Inc., Wilmington, DE

James Harrison, process improvement coach, serves as the Site Director for Brandywine Counseling's Opioid Treatment Program in Wilmington, Delaware, and oversees the agency's administrative and clinical services. He serves as the Change Leader for Brandywine Counseling, an early member of NIATx. A licensed and certified Drug and Alcohol Counselor, he holds a Master's in Human Services from Lincoln University in Pennsylvania.

Michael Levy, Ph.D.

Director of Clinical Treatment Services
CAB Health & Recovery Services, Inc., Peabody, MA

Michael Levy is the Director of Clinical Treatment Services at CAB Health & Recovery Services, Inc. He is a lecturer in psychiatry at the Cambridge Health Alliance and at Harvard Medical School, and he maintains a private practice in psychotherapy. He writes extensively on substance abuse and its treatment.

MANAGING EDITOR

Donna M. Vaillancourt

Boston Medical Center, Boston, MA

Donna Vaillancourt is the Managing Editor of Alcohol, Other Drugs, and Health: Current Evidence. She has nearly two decades of experience editing and publishing in the medical and social sciences and has launched publications for a broad range of audiences including oncologists, pain management specialists, recreation therapists, dementia researchers, and hospice clergy and caregivers. Donna has extensive experience in print production and website management, and most recently served as Editor-in-Chief of the independent peer-reviewed quarterly, Journal of Forensic Anthropology and Archaeology.

Treatment Practitioner's Research Bulletin

Join Together

A project of the National Center on Addiction and
Substance Abuse at Columbia University
580 Harrison Avenue, 3rd Floor
Boston, MA 02118
editor@jointogether.org