



Innovations in the Use of Financial Incentives in Chronic Addiction Treatment

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Re-Thinking Addiction Treatment?

Lessons From
Mainstream Healthcare



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A Nice Simple Rehab Model

Substance Abusing Patient

```
graph TD; A[Substance Abusing Patient] --> B[Treatment]; B --> C[Non-Substance Abusing Patient]
```

Treatment

Non- Substance Abusing Patient

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ASSUMPTIONS

- Some fixed amount or duration of treatment will resolve the problem
- Clinical efforts put toward **correctly placing** patients and getting them to **complete** treatment
- Evaluation of effectiveness should occur following completion
 - **Poor outcome means treatment/patient failure**

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But this hasn't worked well...

- **80% of all treatment is Outpatient**
- **About 60% of outpatients drop out prematurely.**
- **Relapse rates are high – 50% @ 6-mos.**
- **Relapsers use 10 X medical services
(Their families use 5 X med services)**

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A Continuing Care Model

Primary Care



```
graph TD; A[Primary Care] --> B[Specialty Care]; B --> C[Primary Continuing Care];
```

Specialty Care

Primary
Continuing Care

⋮



In Chronic Illnesses....

1 — The effects of treatment do not last very long after care stops

2 — Patients who are out of treatment/contact are at higher risk for relapse



But Those are Real
Illnesses!

Addiction is Different –

Isn't it ?

A Comparison With Three Chronic Medical Illnesses

Hypertension

Diabetes

Asthma



All 3 Illnesses

Adherence to medication : ~ 50%

Adherence to diet and exercise: ~ 30%

Retreated in 12 months: 50 - 70%

(by Physician, ER, or Hospital)

McLellan et al., JAMA 2000

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

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So then

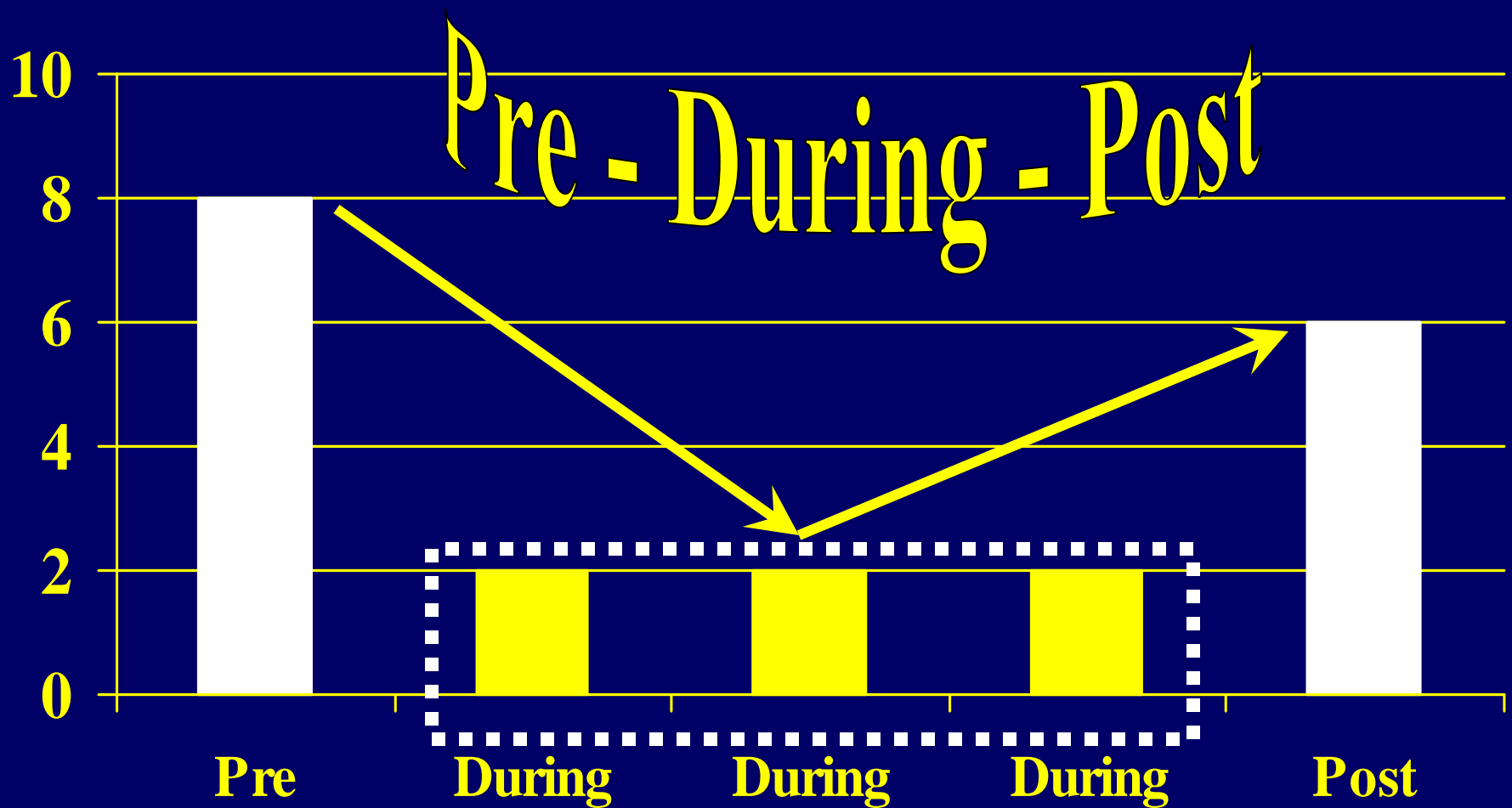
Addiction may be
best considered a
Chronic Illness?

.....

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If this is true then...

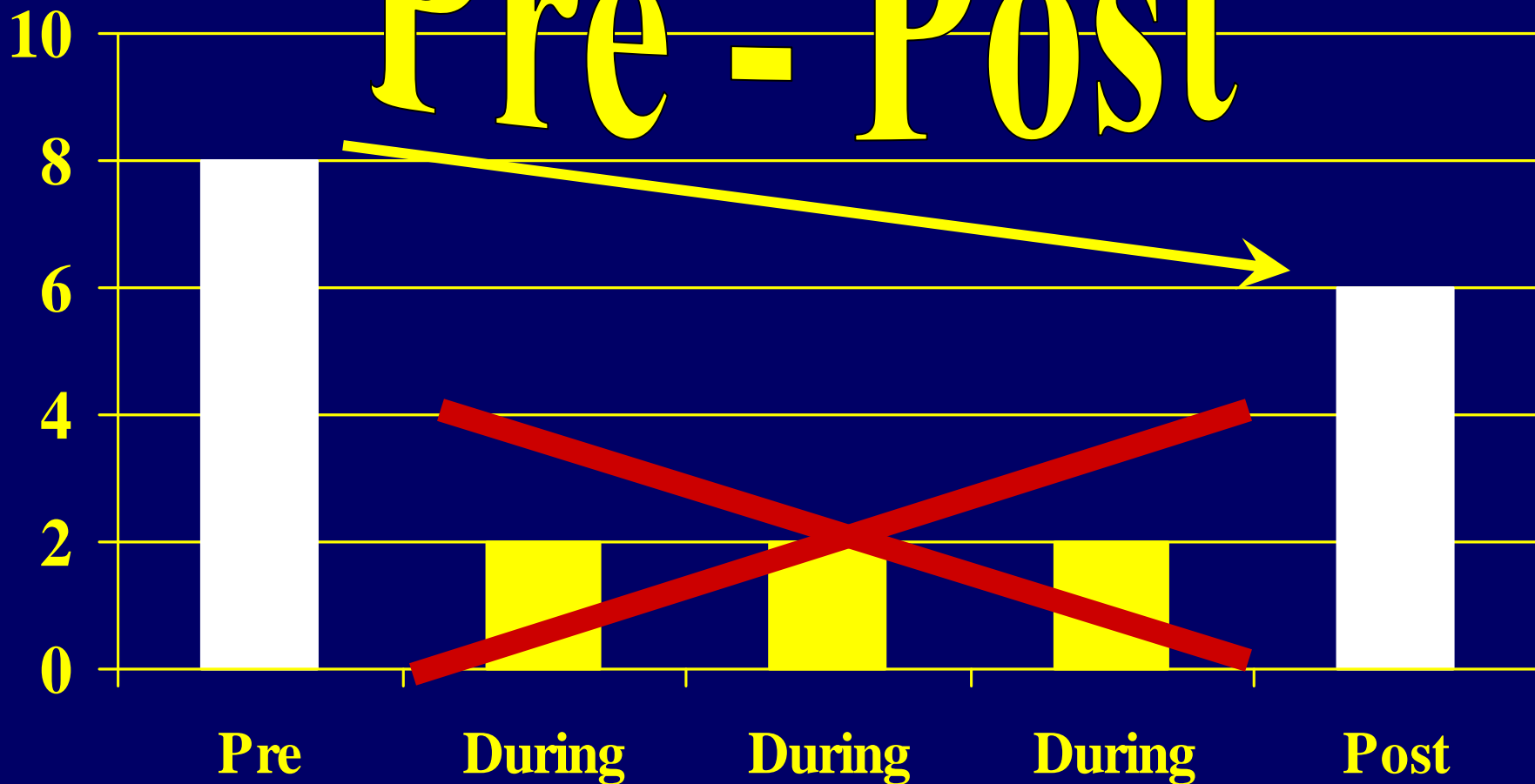
Addiction Also
Has the Wrong
Evaluation Model?

Outcome In Hypertension



Outcome In Addiction

Pre - Post



In Summary

Lessons Learned From Chronic Illness Management

Lessons from Chronic Illness:

1. Medications relieve symptoms but.... **behavioral change** is necessary for sustained benefit

- There are effective medications for many addictions
- Most programs don't offer them.

Lessons from Chronic Illness:

2. Treatment effects don't last very long after treatment stops.

- Treatment response in addiction is similar to other chronic illnesses
- Need to move from *placement* thinking to *management* thinking - goal is **Self Management**.

Lessons from Chronic Illness:

3. Patients who are not in some form of treatment or monitoring are at elevated risk for relapse.
 - As in other chronic illnesses, monitoring is an important *clinical* activity in addiction tx.

Lessons from Chronic Illness:

4. Continuity is Cost-effective –

BUT you need a system that:

- Is integrated – capable of transitioning patients
- Is attractive – offers choices
- Tracks and monitors patients' symptoms, function, and QoL



- The End -



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ASAM Levels – The Continuum?

Cont Care

1 – 2 / mo.

OP

1/wk; 30 – 180 days

Intensive Care

7 – 90 days

Detox

3 - 7 days

**Good Placement
Criteria.**

**What if These Levels are Owned
By Different Organizations?**

Transfer
Criteria
How to Use
Ev. Evid. Prac.



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A Continuum of Care – The Tools

Levels of Care

EBPs in Each

Cont Care

2x per mo.

Outpt

1x per wk.

IOP

3x per wk.

Resid Care

7 – 30 days

6 - Case Mgmt

5 - MH Meds

4 - SA Meds

3 - Fam Involve

2 - Ind Therapy

1 - Group Couns

Progress

