



Medicaid Innovation Accelerator Program (IAP)



**Widening the Lens:
Treatment for Alcohol
and Stimulant Use
Disorders**

August 8, 2019

3:00 p.m. – 4:30 p.m. ET

Logistics

- Use the chat box on your screen to ask a question or leave a comment
 - Note: the chat box will not be seen if you are in “full screen” mode
- Moderated Questions & Answers will be held periodically throughout the webinar
 - Please submit your questions via the chat box
- Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience.

Welcome & Overview

Roxanne Dupert-Frank

Center for Medicaid and
CHIP Services (CMCS)

Centers for Medicare &
Medicaid Services (CMS)



Facilitator

Suzanne Fields, MSW

IAP Consultant and
Senior Advisor for Health
Care Policy & Financing,
University of Maryland



Purpose & Learning Objectives

- Persistent and increasing rates of alcohol, cocaine, and methamphetamine use indicate a need to continue to focus on substance use disorders (SUD) other than opioid use disorder (OUD).
- In this webinar, participants will learn about an integrated approach for treating alcohol use disorder (AUD)/risky drinking in primary care.
- Participants will also consider treatment options to address the challenges around retention in treatment for stimulant dependence.

Speaker

Connie Weisner, DrPH, MSW

Kaiser Permanente Northern
California Division of
Research and Professor,
Department of Psychiatry,
University of California, San
Francisco



Speaker

Rick Rawson, PhD

Research Professor, Vermont
Center on Behavior and
Health and Consultant, UCLA
Integrated Substance Abuse
Programs



Speaker

Marlies Perez, MA

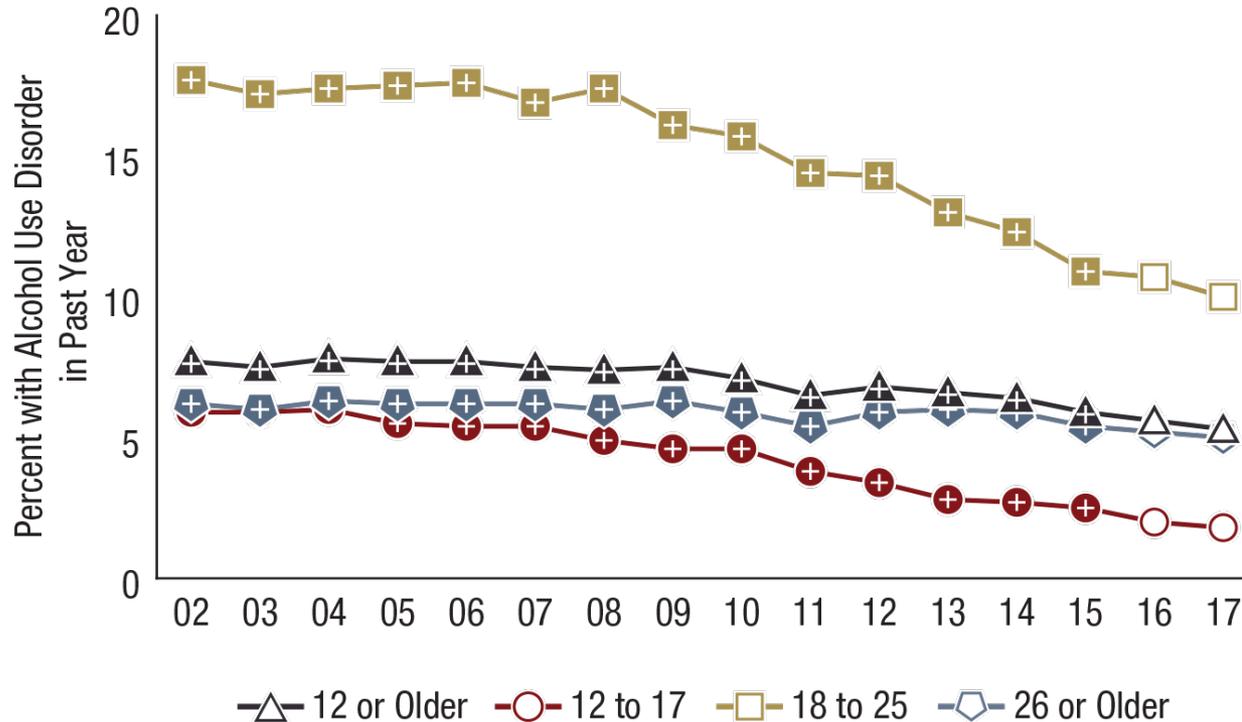
California Department of
Health Care Services



Background

- Recent headlines show an increasing interest among states & other stakeholders to address the range of SUDs
 - About 40 Percent of Americans Drink Too Much (Newsweek, 19 July 2018)
 - Meth Vs. Opioids: America Has Two Drug Epidemics, But Focuses On One (*Kaiser Health News*, 7 May 2019)
 - As Meth Use Surges, First Responders Struggle To Help Those In Crisis (*NPR*, 1 May 2019)
 - Opioids Are In the Spotlight. But Meth Hospitalizations Are Surging (*Time*, 21 November 2018)
 - SUD and Medicaid: 11% among Medicaid recipients and 14% among expansion states (CMS, 2014)

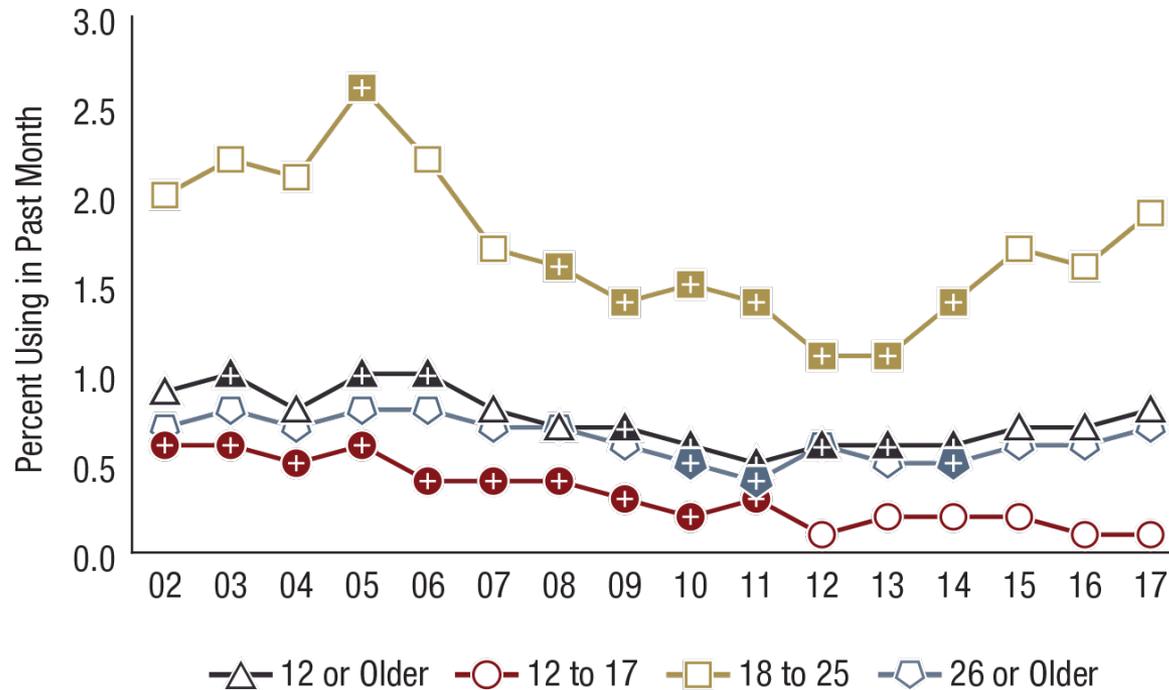
Alcohol Use Disorder in the Past Year Among People Aged 12 or Older, by Age Group: Percentages, 2002-2017



Age Group	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
12 or Older	7.7 ⁺	7.5 ⁺	7.8 ⁺	7.7 ⁺	7.7 ⁺	7.5 ⁺	7.4 ⁺	7.5 ⁺	7.1 ⁺	6.5 ⁺	6.8 ⁺	6.6 ⁺	6.4 ⁺	5.9 ⁺	5.6	5.3
12 to 17	5.9 ⁺	5.9 ⁺	6.0 ⁺	5.5 ⁺	5.4 ⁺	5.4 ⁺	4.9 ⁺	4.6 ⁺	4.6 ⁺	3.8 ⁺	3.4 ⁺	2.8 ⁺	2.7 ⁺	2.5 ⁺	2.0	1.8
18 to 25	17.7 ⁺	17.2 ⁺	17.4 ⁺	17.5 ⁺	17.6 ⁺	16.9 ⁺	17.4 ⁺	16.1 ⁺	15.7 ⁺	14.4 ⁺	14.3 ⁺	13.0 ⁺	12.3 ⁺	10.9 ⁺	10.7	10.0
26 or Older	6.2 ⁺	6.0 ⁺	6.3 ⁺	6.2 ⁺	6.2 ⁺	6.2 ⁺	6.0 ⁺	6.3 ⁺	5.9 ⁺	5.4 ⁺	5.9 ⁺	6.0 ⁺	5.9 ⁺	5.4 ⁺	5.2	5.0

[2017 NSDUH Annual National Report](#)

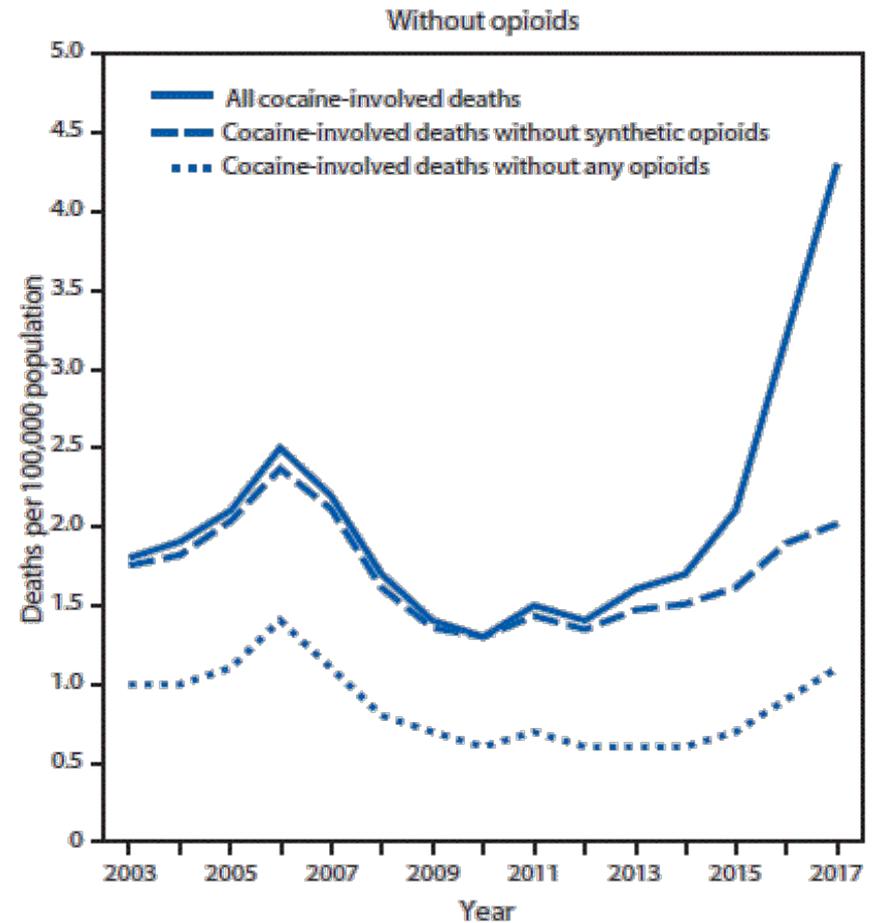
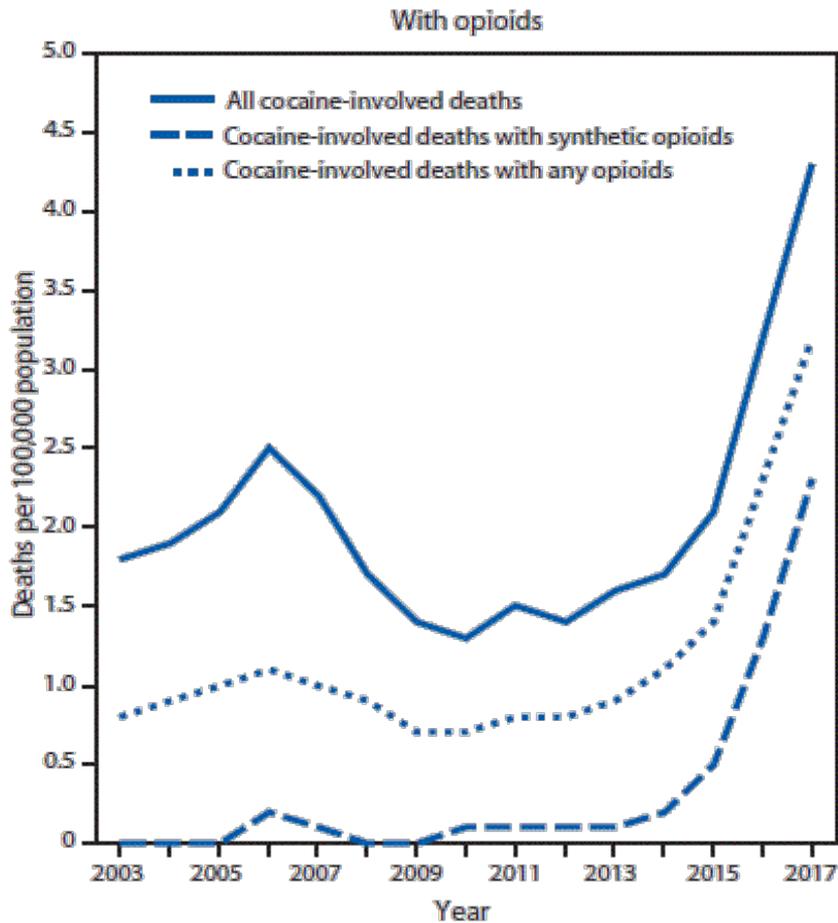
Past Month Cocaine Use Among People Aged 12 or Older, by Age Group: Percentages, 2002-2017



Age Group	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
12 or Older	0.9	1.0 ⁺	0.8	1.0 ⁺	1.0 ⁺	0.8	0.7	0.7 ⁺	0.6 ⁺	0.5 ⁺	0.6 ⁺	0.6 ⁺	0.6 ⁺	0.7	0.7	0.8
12 to 17	0.6 ⁺	0.6 ⁺	0.5 ⁺	0.6 ⁺	0.4 ⁺	0.4 ⁺	0.4 ⁺	0.3 ⁺	0.2 ⁺	0.3 ⁺	0.1	0.2	0.2	0.2	0.1	0.1
18 to 25	2.0	2.2	2.1	2.6 ⁺	2.2	1.7	1.6 ⁺	1.4 ⁺	1.5 ⁺	1.4 ⁺	1.1 ⁺	1.1 ⁺	1.4 ⁺	1.7	1.6	1.9
26 or Older	0.7	0.8	0.7	0.8	0.8	0.7	0.7	0.6	0.5 ⁺	0.4 ⁺	0.6	0.5	0.5 ⁺	0.6	0.6	0.7

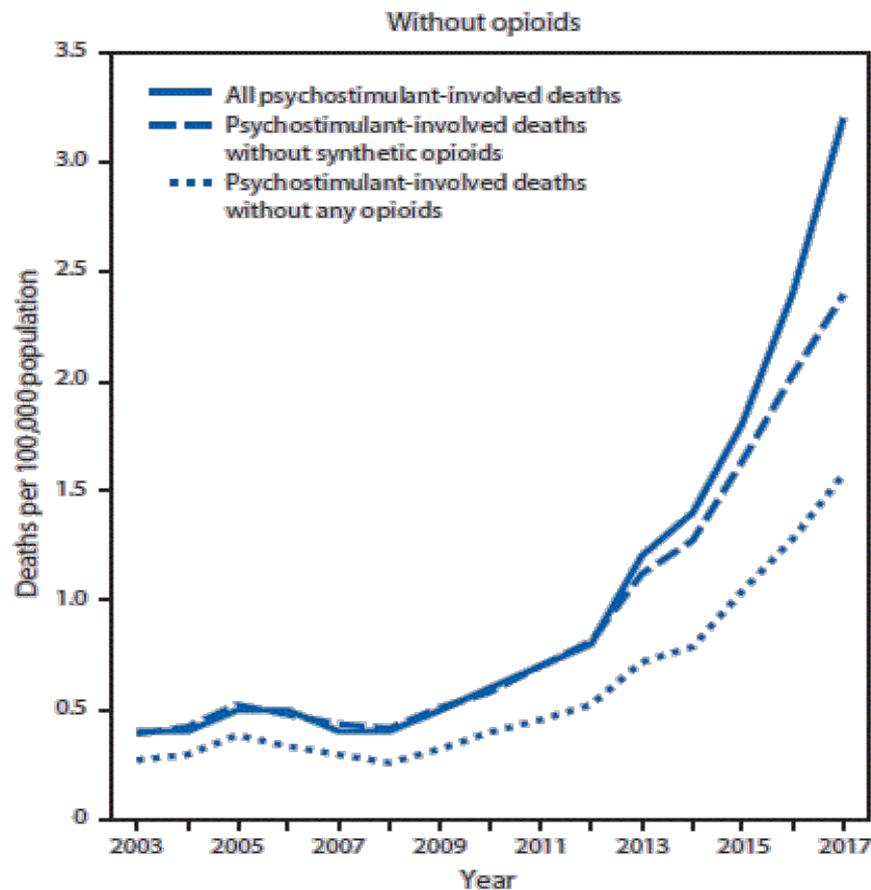
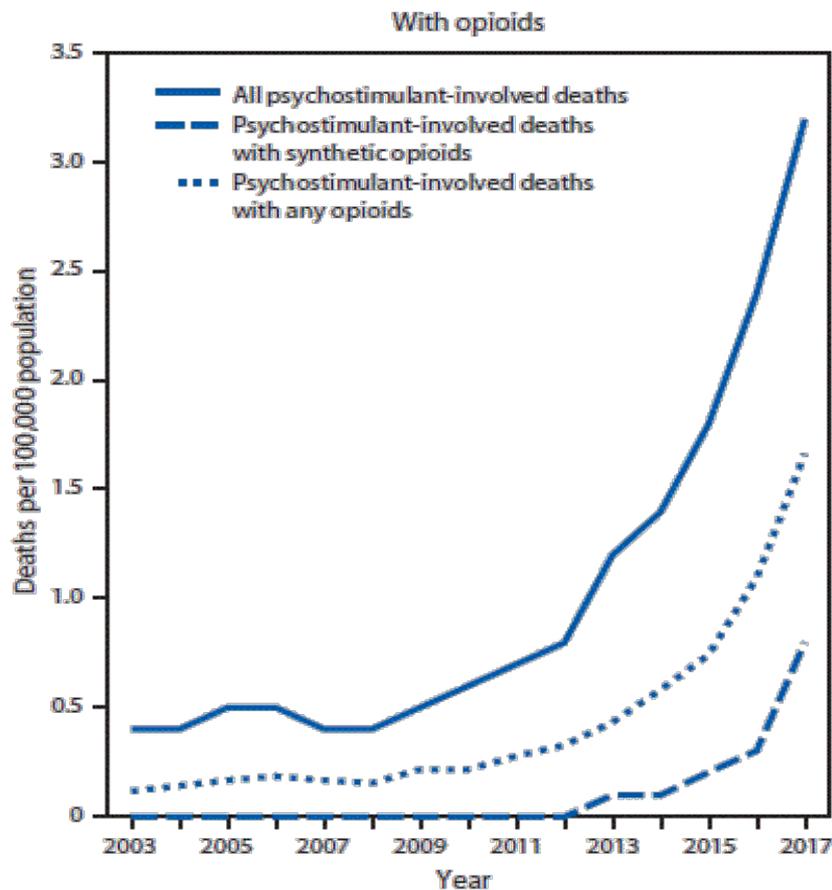
[2017 NSDUH Annual National Report](#)

Cocaine-related deaths 2003-2017



[CDC Report of Drug Overdose Deaths Involving Cocaine and Psychostimulants with Abuse Potential 2017](#)

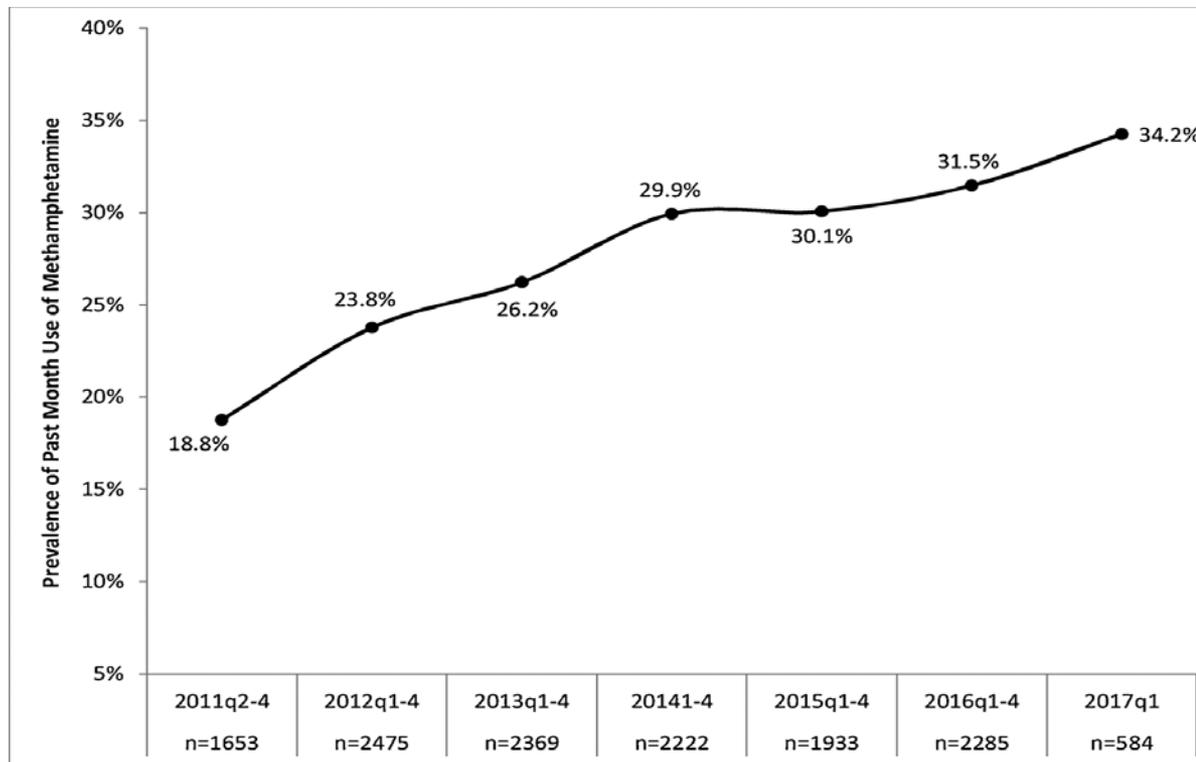
Psychostimulant-related deaths 2003-2017



[CDC Report of Drug Overdose Deaths Involving Cocaine and Psychostimulants with Abuse Potential 2017](#)

Twin Epidemics: The surging rise of methamphetamine use in chronic opioid users

Past month use of methamphetamine significantly increased among treatment-seeking opioid users (+82.6%, $p < .001$), from 18.8% in 2011 to 34.2% in 2017.



Ellis, M. Kasper, A., Cicero, T.
*Drug and Alcohol
Dependence*, 2018, 14-20

Alcohol, Cannabis, Opioid Use Disorders, and Disease Burden in an Integrated Healthcare System

- **Results:** Patients with these SUDs (alcohol, cannabis, and opioid use disorders) had higher prevalence of major medical conditions than non-SUD patients. Patients with these SUDs also had higher disease burden than non-SUD patients; patients with opioid use disorders had particularly high disease burden.
- **Conclusions:** Common SUDs, particularly opioid use disorders, are associated with substantial disease burden for privately insured individuals without significant impediments to care. This signals the need to explore the full impact SUDs have on the course and outcome of prevalent conditions and initiate enhanced service engagement strategies to improve disease burden.

Bahorik, A., Satre, D., Kline-Simon, A., Weisner, C., Campbell, C.

Journal of Addictive Medicine, 2017, 3-9

Polling Question

- What other health care issues have you seen in your Medicaid beneficiaries with SUD?
 - A. Infectious diseases (HIV, Hepatitis C)
 - B. Cardio vascular diseases
 - C. Neurological conditions
 - D. Gastro-intestinal conditions

Approaches to Addressing Alcohol in Health Care



Connie Weisner, DrPH, MSW
Division of Research
Kaiser Permanente
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Francisco



University of California
San Francisco

DIVISION OF RESEARCH
Northern California

Overview

- Background
- Integration with health care
- Treatment: non-pharmacologic and Medication Assisted Treatment
- Recovery

Background: Size of the Problem

- Meet diagnostic criteria for an AUD (over age 12)*
 - 14.5 million (5.3%)
- Binge drinking
 - 66.6 million (24.5%)
- Heavy drinking
 - 16.7 million (6.1%)
- Number in treatment: 1 in 11 of those who need it

*The next highest was marijuana (4.1 million, 1.5%) and dependence on all therapeutics: including pain relievers, tranquilizers, stimulants, and sedatives (2.7 million, 1%)

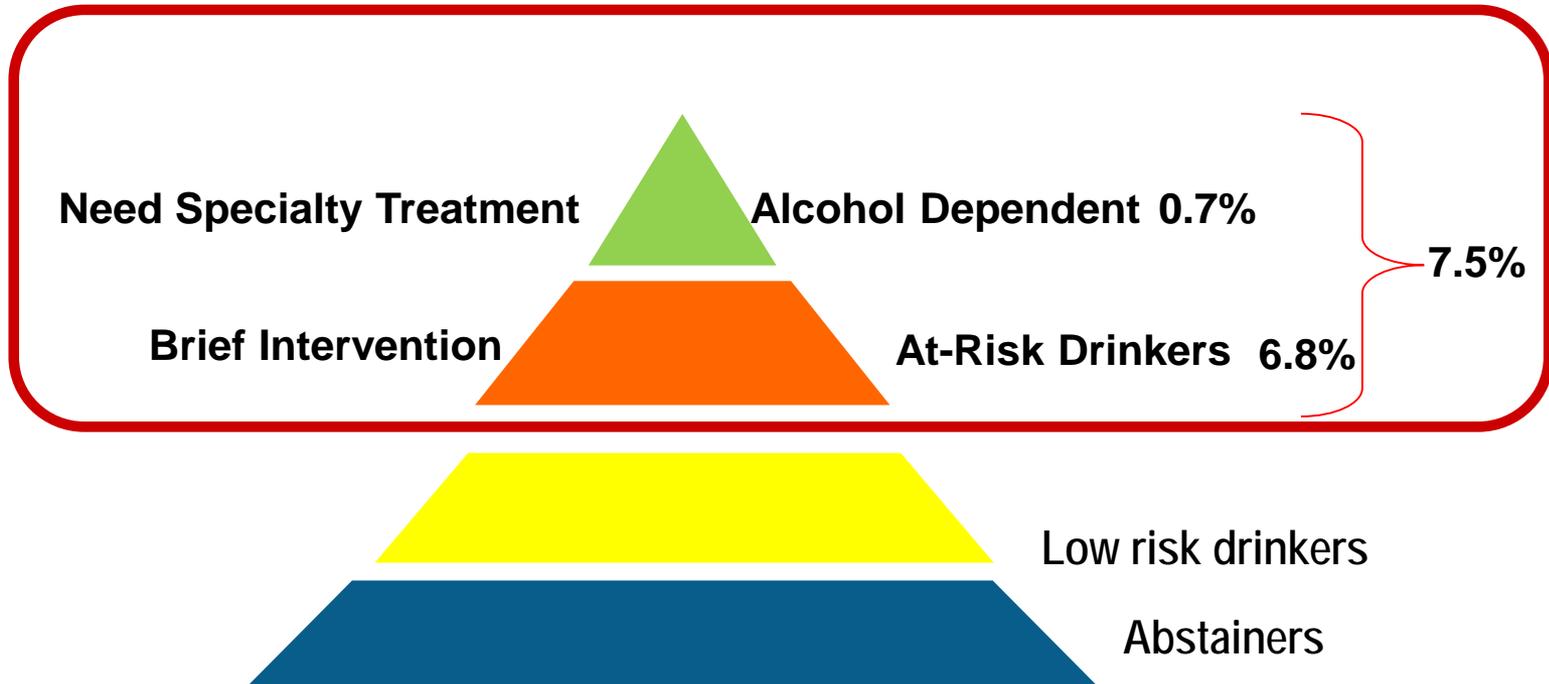
Source: Substance Abuse and Mental Health Services Administration. (2018). *Key substance use and mental health indicators in the United States: [Results from the 2017 National Survey on Drug Use and Health](#)* (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

<https://www.samhsa.gov/data/report/2017-nsduh-annual-national-report>

Demographic Characteristics of AUD

Characteristic	No. in Millions	%
Male	10.1	7.8
Female	5.6	4.1
White	10.4	6.1
Black or African American	1.6	4.9
American Indian or Alaska Native	0.1	9.70
Native Hawaiian or other Pacific Islander	0.04	5.4
Asian	0.5	3.2
Hispanic or Latino	2.8	6.4

Alcohol Problems in Primary Care



Sources: Institute of Medicine. *Broadening the Base of Treatment for Alcohol Problems*. Washington DC: National Academies Press; 1990; World Health Organization, Department of Mental Health and Substance Dependence. [Brief Intervention for Hazardous and Harmful Drinking](https://apps.who.int/iris/bitstream/handle/10665/67210/WHO_MS_D_MSB_01.6b.pdf?sequence=1). 2001.
[https://apps.who.int/iris/bitstream/handle/10665/67210/WHO MSD MSB 01.6b.pdf?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/67210/WHO_MS_D_MSB_01.6b.pdf?sequence=1)

What is At-Risk Drinking?

Safe Drinking is:

- For Men up to age 65:

- ✓ No more than 4 drinks per day

- ✓ No more than 14 drinks per week

So... average no more than 2 drinks per day

- For Women (or Adults over 65 years old):

- ✓ No more than 3 drinks per day

- ✓ No more than 7 drinks per week

So...average no more than 1 drink per day



AUD and Heavy Drinking

Exacerbates

- hypertension
- diabetes
- depression
- sleep apnea
- insomnia
- anxiety & panic disorders
- atrial fibrillation
- gastrointestinal bleeding
- acid reflux/GERD

Increases risk for

- back & neck injuries
- motor vehicle crashes
- cancers: breast, colon, head & neck
- pedestrian injuries
- sexually transmitted infections (STIs)

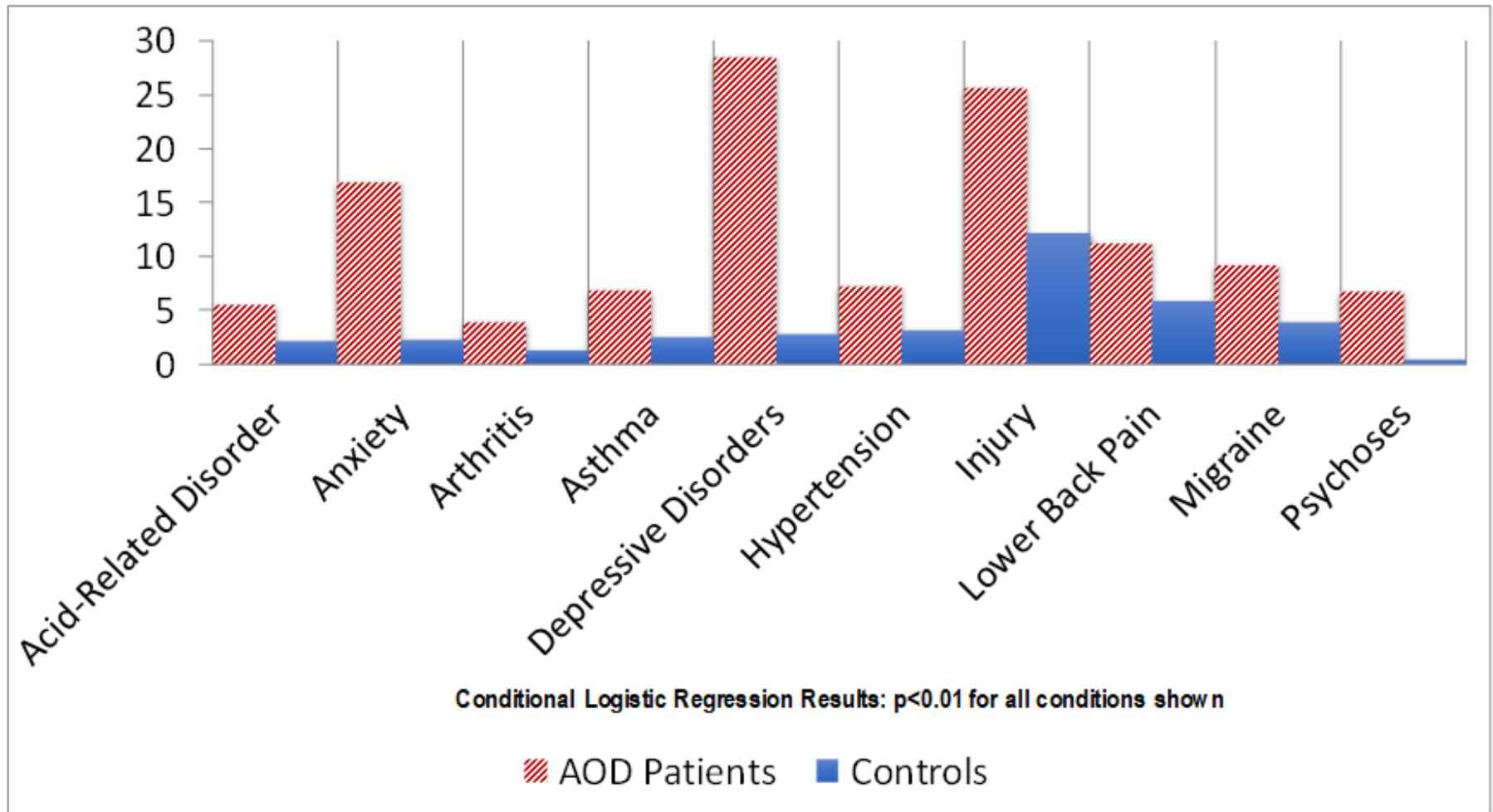
Causes

- alcohol use disorders
- cirrhosis, fatty liver
- pancreatitis

Reduces Rx Adherence

- statin
- diabetic
- antidepressant
- anti-hypertensive

Adult Addiction Treatment Patients Have More Medical and Mental Health Conditions Than Matched Controls



Mertens JR, Lu Y, Parthasarathy S, Moore C, Weisner CM. Medical and psychiatric conditions of alcohol and drug treatment patients in an HMO: Comparison to matched controls. *Arch Intern Med.* Nov 10 2003;163:2511-2517.

Hazardous Drinkers and Drug Users in Primary Care

- Prevalence of 10% for either alcohol or drug problems
- Hazardous drinkers and drug users had higher prevalence than other primary care patients of several common medical conditions, including:
 - Injury
 - Hypertension
 - Asthma, emphysema, chronic obstructive pulmonary disease (COPD)
 - Pneumonia
 - Depression, Anxiety, and Major Psychoses
- Higher health care costs

Mertens JM, Weisner C, Ray GT, Fireman B, Walsh K. Hazardous drinkers and drug users in HMO primary care: prevalence, medical conditions, and costs. *Alcohol Clin Exp Res*. 2005;29:989-98.

Why integration?

- Health care is the one service everyone will seek throughout life.
- New problems are often first identified there.
- Alcohol use disorders are a chronic neurological disorder and need to be treated as other chronic conditions are in health care.

Why integration? (continued)

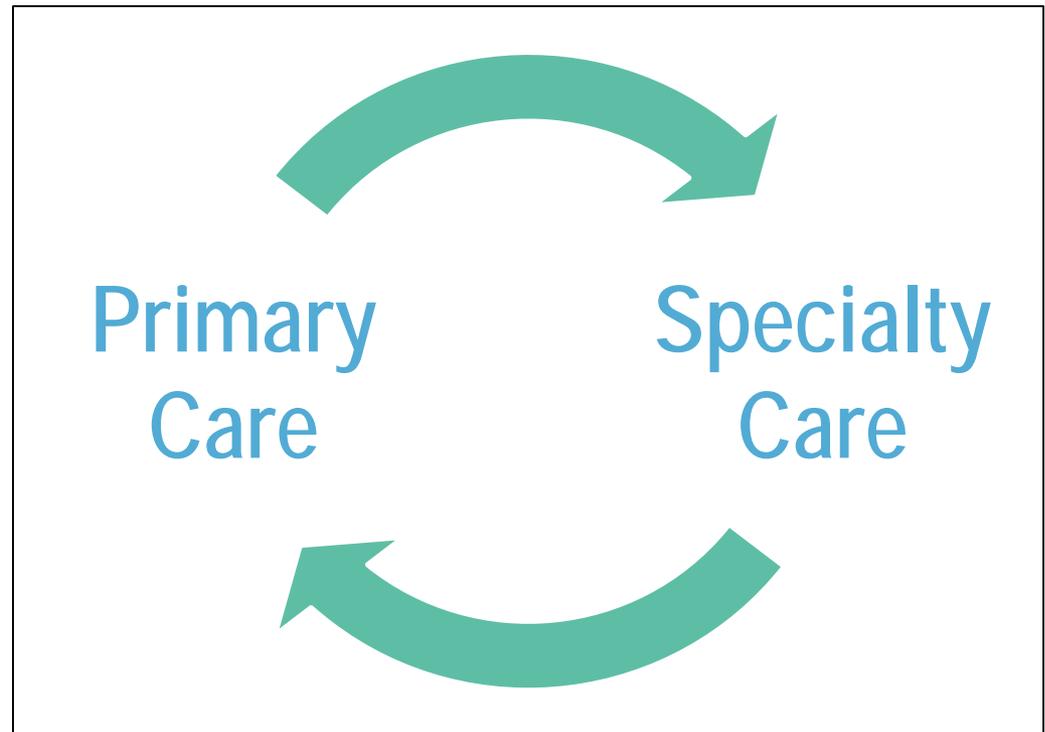
- Prevalence of co-occurring health and mental health problems is high – even in those whose problems are not severe.
- Integration can help address health disparities, reduce costs for patients and family members and improve health outcomes.

Integration of Alcohol and Drug Services with Primary Care (PC) as the Anchor (Health Home) *NO WRONG DOOR*

Screen and treat in PC
(if moderate problem
continue monitoring)

Specialty care if
needed

Back to Primary Care
for monitoring



Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness: *JAMA* 2002; 288:1775-9

Chi FW, Parthasarathy S, Mertens JR, Weisner C. (2011) Continuing care and long-term substance use outcomes in managed care: initial evidence for a primary care based model. *Psychiatric Services*. 62(10):1194-200.

Parthasarathy S, Chi FW, Mertens JR, Weisner C. (2012) The role of continuing care on 9-year cost trajectories of patients with intakes into an outpatient alcohol and drug treatment program. *Med Care*. 50(6):540-46.

Rankings of Preventive Services



National Commission on Prevention Priorities

25 USPSTF- recommended services ranked by:

❑ Clinically preventable burden (CPB)-

How much disease, injury, and death would be prevented if services were delivered to all targeted individuals?

❑ Cost-effectiveness (CE)- return on investment

How many dollars would be saved for each dollar spent?

Alcohol Screening and Brief Intervention was ranked 4th highest out of 25

Maciosek MV, Coffield AB, Edwards NM, et al. Priorities among effective clinical preventive services: results of a systematic review and analysis. *Am J Prev Med.* 2006;31(1):52-61.

Solberg LI, Maciosek MV, Edwards NM. Primary care intervention to reduce alcohol misuse ranking its health impact and cost effectiveness. *Am J Prev Med.* 2008;34(2):143-152.

Fleming, M. F., M. P. Mundt, et al.. "Brief physician advice for problem drinkers: Long-term efficacy and benefit-cost analysis." *Alcoholism: Clinical and Experimental Research.* 2002; 26(1): 36-43.

Most Cost-Effective Preventive Services

Ranking*	Service
1	Aspirin (Men 40+; Women 50+)
2	Childhood immunizations
3	Smoking cessation
4	Alcohol Screening & intervention
5	Colorectal cancer screening & treatment
6	Hypertension screening & treatment
7	Influenza Vaccination
9	Cervical cancer screening
10	Cholesterol screening (men 35+: women 45+)
12	Breast cancer screening
18	Depression screening
21	Osteoporosis screening
23	Diabetes screening - adults

* Highest Ranking = 1

Maciosek MV et al. Am J Prev Med. 2006;31(1):52-61.

Solberg LI et al., Am J Prev Med. 2008;34(2):143-152

Brief Intervention is Effective

Decades of research demonstrates

Brief Intervention for At-Risk Alcohol Use:

- Lowers proportion of risky drinkers
- Lowers overall alcohol consumption
- Reduces Cost and can improve health

**For every \$1 spent on screening and intervention,
health care costs are reduced by \$4**



Chi et al., *JSAT*, 2017

Beich et al. *BMJ* 2003;327:536

Bertholet et al. *Arch Intern Med.* 2005;165:986

Fleming et al. *JAMA*, 1997; 1030-1045

Fleming, et al.; *Alcoholism: Clinical and Exp Res* 2002;26; 36-43.

Behavioral Therapy

Important components of treatment:

- Cognitive-behavioral therapy,
- Contingency management,
- Motivational enhancement therapy,
- 12-step facilitation therapy,
- Marital, couples and family therapy

Effective in:

- Inducing and sustaining abstinence,
- Improving relationship functioning; and
- Reducing intimate partner violence, and reducing emotional problems of children.

These treatment strategies are most effective when clinicians are trained and able to follow the treatment protocols.

Medications for Alcohol Use Disorder

- Naltrexone – antagonist which blocks some opioid receptors and counteracts some of the pleasurable aspects of drinking
 - Tablets or Extended-release injectable suspension
 - Reduces cravings, and diminishes the rewarding effects of alcohol
 - Extended release injectable naltrexone is recommended to prevent relapse to alcohol

Medications for Alcohol Use Disorder (continued)

- Acamprosate - normalizes the alcohol-related neurochemical changes in the brain glutamate systems and reduces the symptoms of craving
 - Delayed release tablet
 - Used for the maintenance of alcohol abstinence
- Disulfiram
 - Tablet – inhibits breakdown of acetaldehyde, producing an aversive response
 - Causes severe physical reactions when taken in combination with alcohol (nausea, flushing, heart palpitations)

What are the elements of integrated, continuing care?

Three components of continuing care related to recovery:

- 1) Regular primary care as an anchor
- 2) Addiction treatment when needed
- 3) Psychiatric services when needed

Nine-Year Integrated, Continuing Care: Outcomes and Costs

- Patients receiving continuing care*
 - were more than twice as likely to be remitted over 9 years ($p < .0001$).
 - were less likely to have emergency room(ER) visits and hospitalizations ($p < .05$).

*mixed-effects logistic regression model controlling for time/follow-up wave; demographic characteristics; alcohol and other drugs (AOD), medical & psychiatric severity; and completion of index AOD treatment

Chi FW, Parthasarathy S, Mertens JR, Weisner C. (2011). Continuing care and long-term substance use outcomes in managed care: initial evidence for a primary care based model. *Psychiatr Serv* 62(10):1194–1200.

Parthasarathy S, Chi FW, Mertens JR, Weisner C. (2012). The role of continuing care on 9-year cost trajectories of patients with intakes into an outpatient alcohol and drug treatment program. *Medical Care* 50(6):540–546.

A Continuum of Collaboration between Health Care and Specialty Services - Feasible in Public and Private Systems

Key Element	Coordinated Key Element: Communication		Co-located Key Element: Physical Proximity		Integrated Key Element: Practice Change	
LEVEL	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5	LEVEL 6
Amount of Collaboration	Minimal Collaboration	Basic Collaboration at a Distance	Basic Collaboration Onsite	Close Collaboration Onsite with Some System Integration	Close Collaboration Approaching at Integrated Practice	Full Collaboration in a Transformed/ Merged Integrated Practice
Where behavioral health, primary care, and other health care professionals work	In separate facilities	In separate Facilities	In same facility not necessarily same offices	In same space within the same facility	In same space within the same facility (some shared space)	In same space within the same facility, sharing all practice space

Source: Heath, et al., 2013.

Recovery

- This affects a huge number of people but is rarely discussed, chance to give voice.
- About 1 in 10 American adults (250 M) are in remission
- Subjective definitions of recovery are somewhat diverse – but in one survey **23 M** reported being in stable recovery.

Recovery-Support Services

- A mix of funded and voluntary services
- Evidence base for Alcoholics Anonymous
- Evidence base for role of health care
- Recovery movement
 - Based heavily in recovering people's knowledge
 - Usually staffed and created by people in recovery
- Strongest *current* evidence for recovery housing and recovery case management
- Recovery-Oriented Systems of Care

Summary

There are **effective** strategies and services, ranging from self-change to specialty treatment for the full spectrum of problems:

- **to screen,**
- **to intervene early,**
- **to treat (both medications and behavioral)**
- **to manage**

Many of these can be accomplished within health care
– all can be done when integrating health care and specialty care

Questions and Answers



Treatments for Stimulant Use Disorders

(METHAMPHETAMINE/COCAINE)

Aug 8, 2019

Disclosure Information

Richard Rawson, PhD

No disclosures

Clinical Challenges with Stimulant Dependent Individuals

- Limited understanding of stimulant addiction
- Ambivalence about need to stop use
- Cognitive impairment and poor memory
- Anhedonia
- Powerful Pavlovian trigger-craving response
- **Very poor retention in outpatient treatment**
- Elevated rates of psychiatric co-morbidity

Special Treatment Consideration Should Be Made for the Following Groups

- Injection users
- Users who take stimulants daily or in very high doses
- Homeless, chronically mentally ill and/or individuals with high levels of psychiatric symptoms at admission
- Men who have sex with men (MSM)
- Users under the age of 21
- **Individuals in medication treatment for OUD**

Response to Behavioral Treatments: Cocaine vs Meth

- In published research studies where treatment response to behavioral treatments have been compared with cocaine users vs meth users, there has been no evidence of differential response. Treatments with evidence for treatment of cocaine dependence should be used with individuals with methamphetamine use disorder and vice versa.

Meta-analysis of Treatment Efficacy for Individuals with Stimulant Use Disorders

Citation: De Crescenzo F, Ciabattini M, D'Alò GL, De Giorgi R, Del Giovane C, Cassar C, et al. (2018) *Comparative efficacy and acceptability of psychosocial interventions for individuals with cocaine and amphetamine addiction: A systematic review and network meta-analysis.* PLoS Med 15(12): e1002715.

Meta-Analysis Findings

Network meta-analysis was used to analyze 50 clinical studies (6,943 participants) on 12 different psychosocial interventions for cocaine and/or amphetamine addiction.

- The combination of contingency management and community reinforcement approach was the most efficacious and most acceptable treatment, both in the short and long term.

Psychosocial Interventions for Cocaine and Psychostimulant Amphetamines Related Disorders.

Werner Paulo Knapp, Bernardo Soares, Michael Farrell, Maurício Silva deLima. (2009)

The Cochrane Collaboration

- Main results: Twenty-seven randomized controlled studies (3663 participants) fulfilled inclusion criteria and had data that could be used for at least one of the main comparisons.
- The comparisons between different type of behavioral interventions showed results in favor of treatments with some form of contingency management in respect to both reducing dropouts and lowering cocaine use.

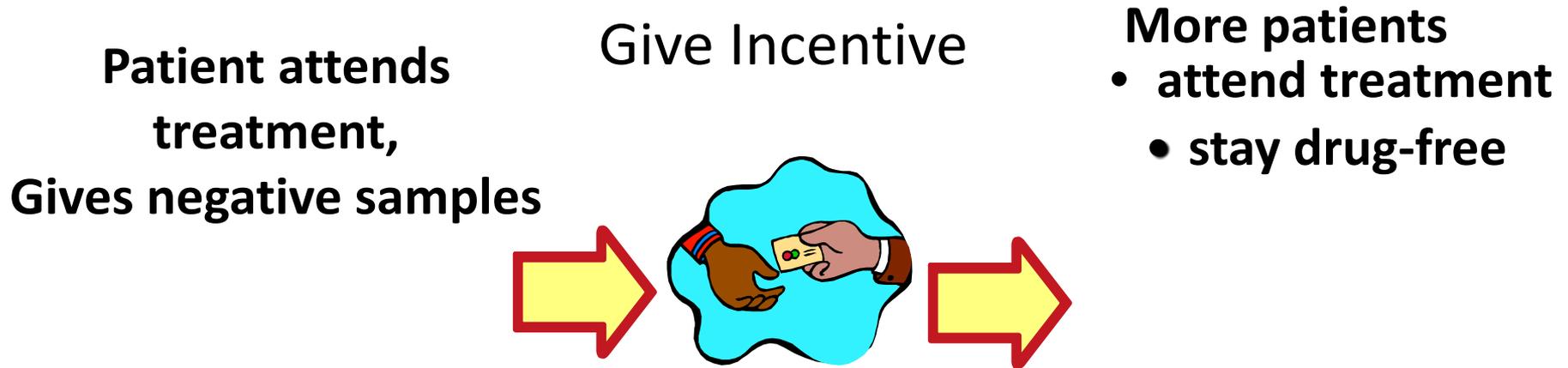
Treatments for Stimulant Use Disorders (SUDs) with Empirical Support

- Contingency Management/Incentives (CM/I)
- Community Reinforcement Approach (CRA)
- Cognitive-Behavioral Therapy (CBT)
- Other approaches with interest
 - Matrix Model
 - Motivational Interviewing
 - Physical Exercise
 - Mindfulness Meditation

Contingency Management (Also Known As Motivational Incentives)

A technique employing the systematic delivery of positive reinforcement for desired behaviors. In the treatment of methamphetamine dependence, vouchers or prizes can be “earned” for submission of methamphetamine-free urine samples. Cash is never given.

How Incentives Work



Basic Behavioral Principles

- 1. Frequently monitor** target behavior
- 2. Provide incentive** when target behavior occurs
- 3. Remove incentive** when target behavior does not occur

Contingency Management for the Treatment of Methamphetamine Dependence.

Roll, John, et al. American Journal of Psychiatry. 163: 1993-1999, 2006.

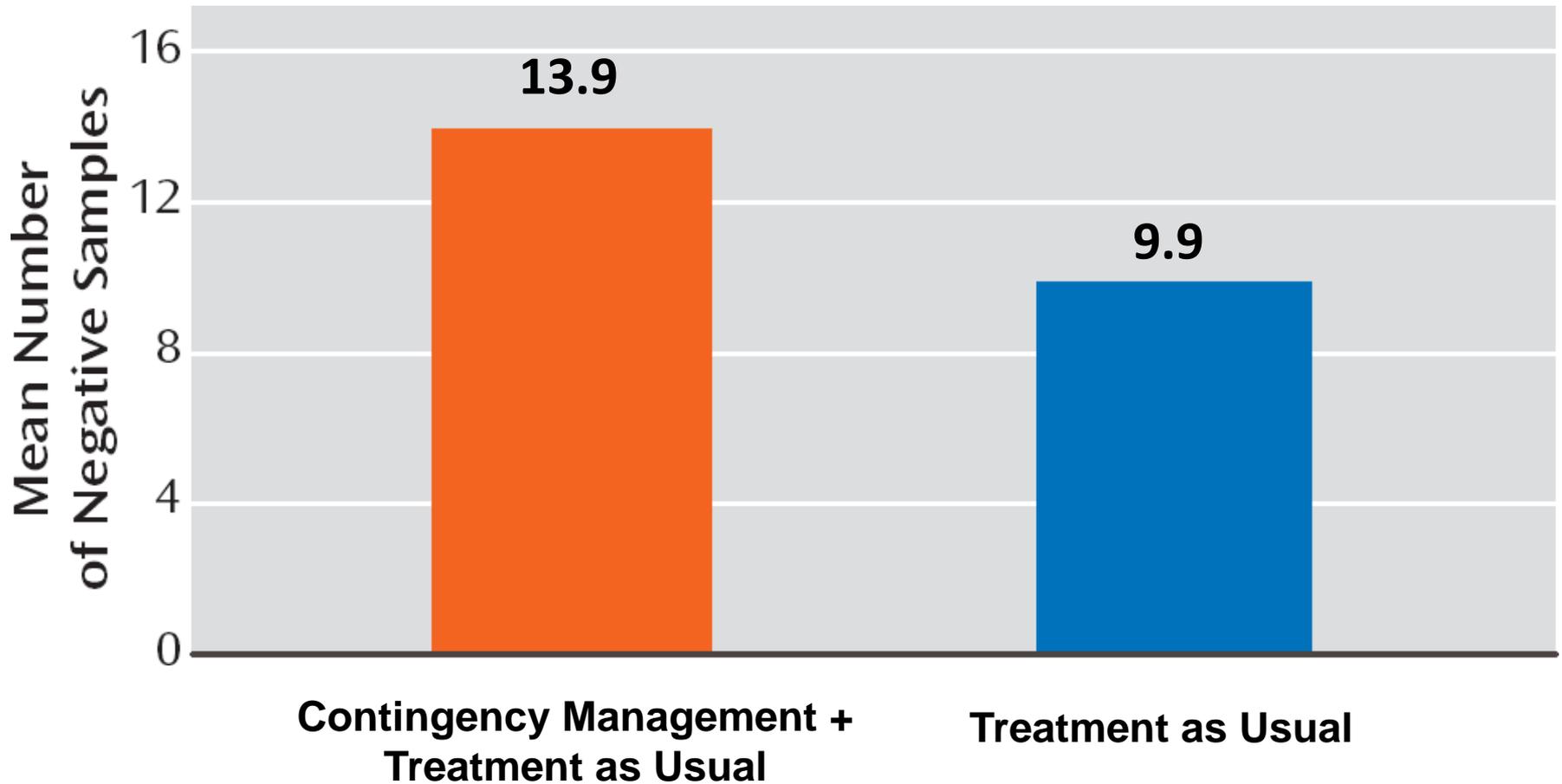
- **METHOD:** The authors report data on 113 participants who were diagnosed with methamphetamine abuse or dependence. They were randomly assigned to receive 12 weeks of either treatment as usual or treatment as usual plus contingency management.
- **RESULTS:** The participants in both groups remained in treatment for equivalent times, but those receiving contingency management in addition to usual treatment submitted significantly more negative samples, and they were abstinent for a longer period of time (5 versus 3 weeks).

Contingency Management: Fish-Bowl/Prize/Variable Magnitude of Reinforcement Procedure

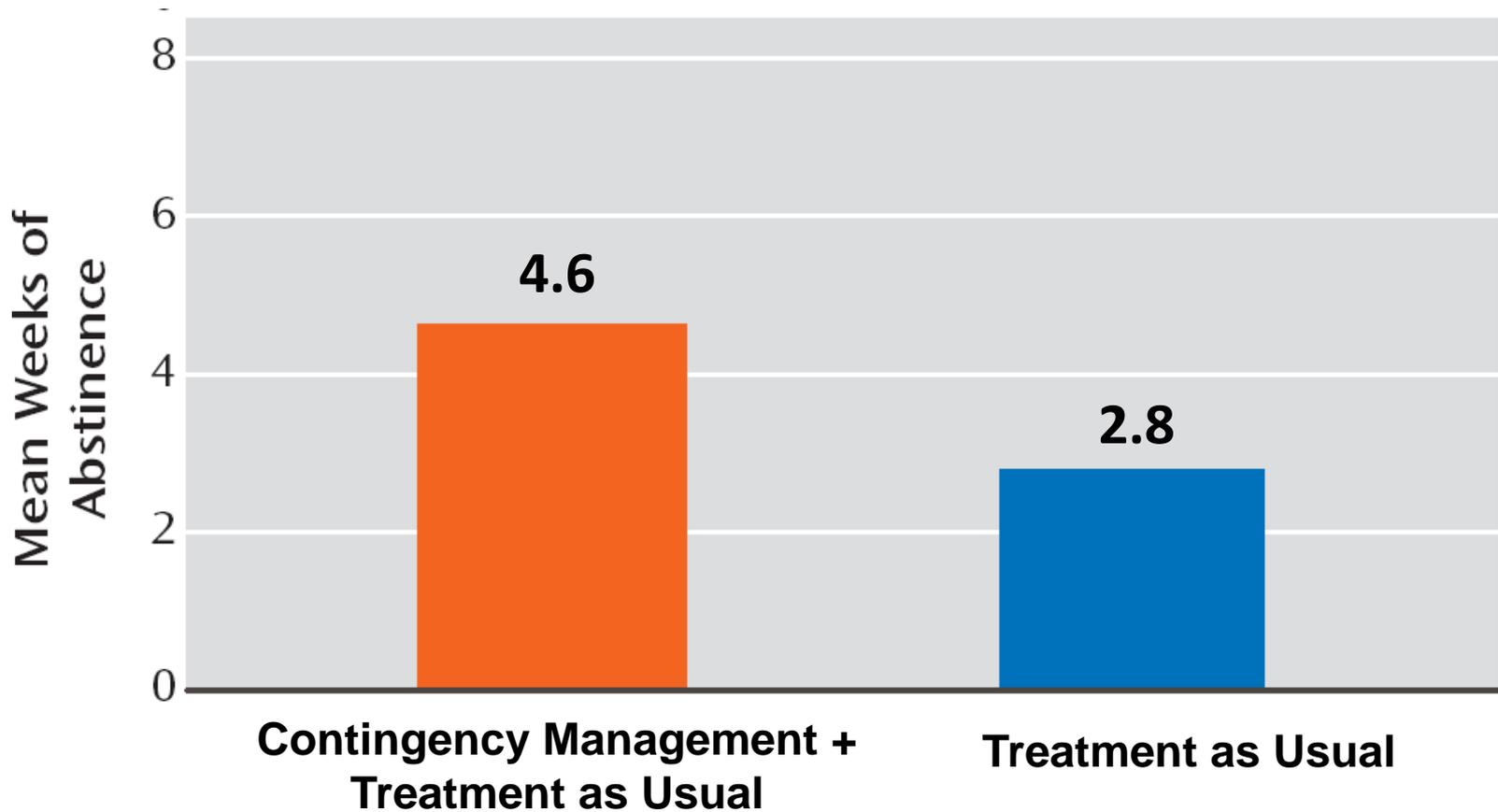
- Developed by Petry
- Participants earn draws from a container containing 500 chips. Some of these chips can be exchanged for prizes
 - 50% (250) are labeled “Good Job” - No monetary value
 - 41.8% (209) are labeled “Small” - \$1-5.00 value
 - 8% (40) are labeled “Large” - \$20.00 value
 - 0.02% (1) are labeled “Jumbo” - \$80-100.00 value

Petry et al., 2000; 2002; 2004; 2005

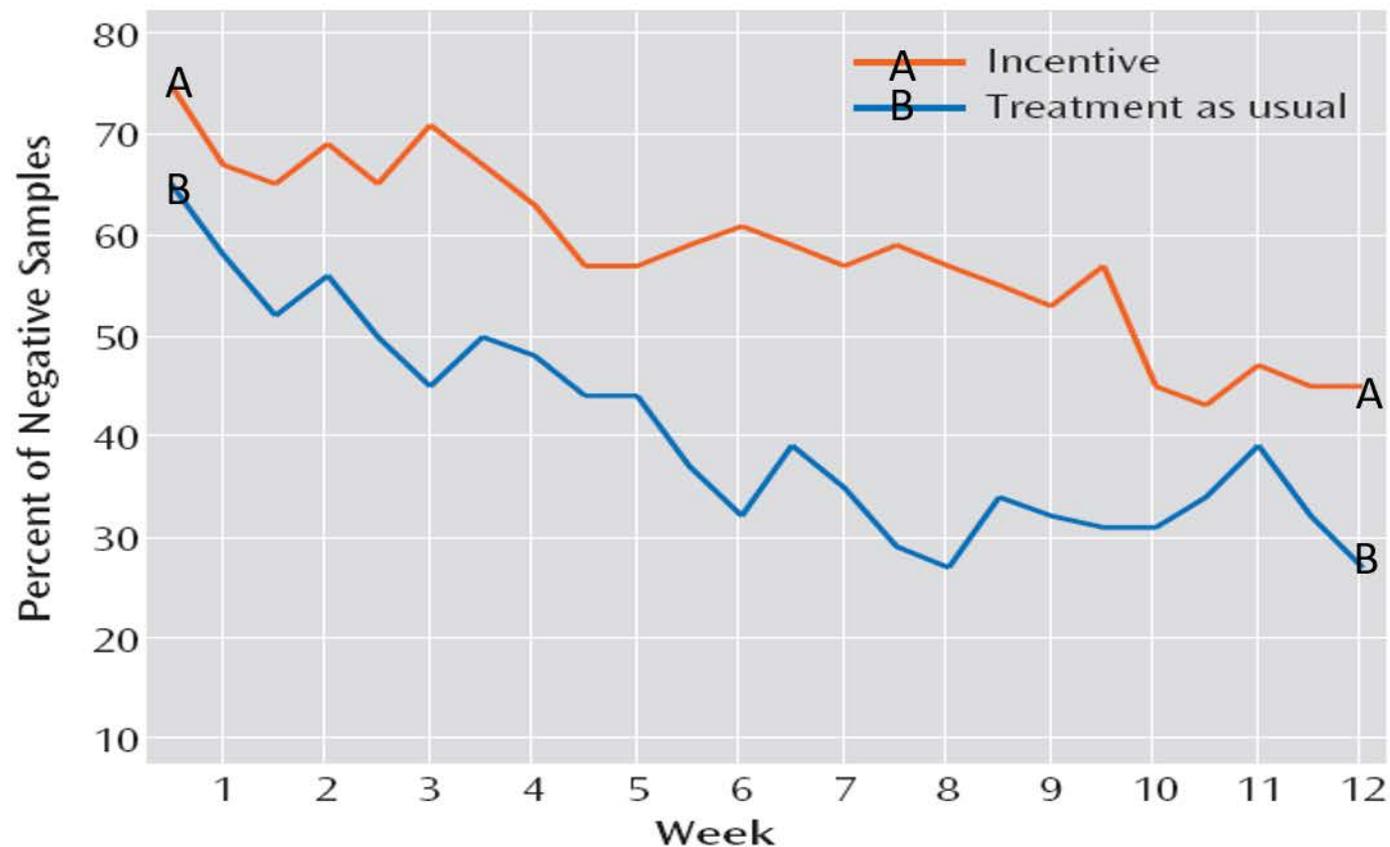
Meth Negative Samples: Roll et al 2006



Longest Duration of Abstinence: Roll et al 2006



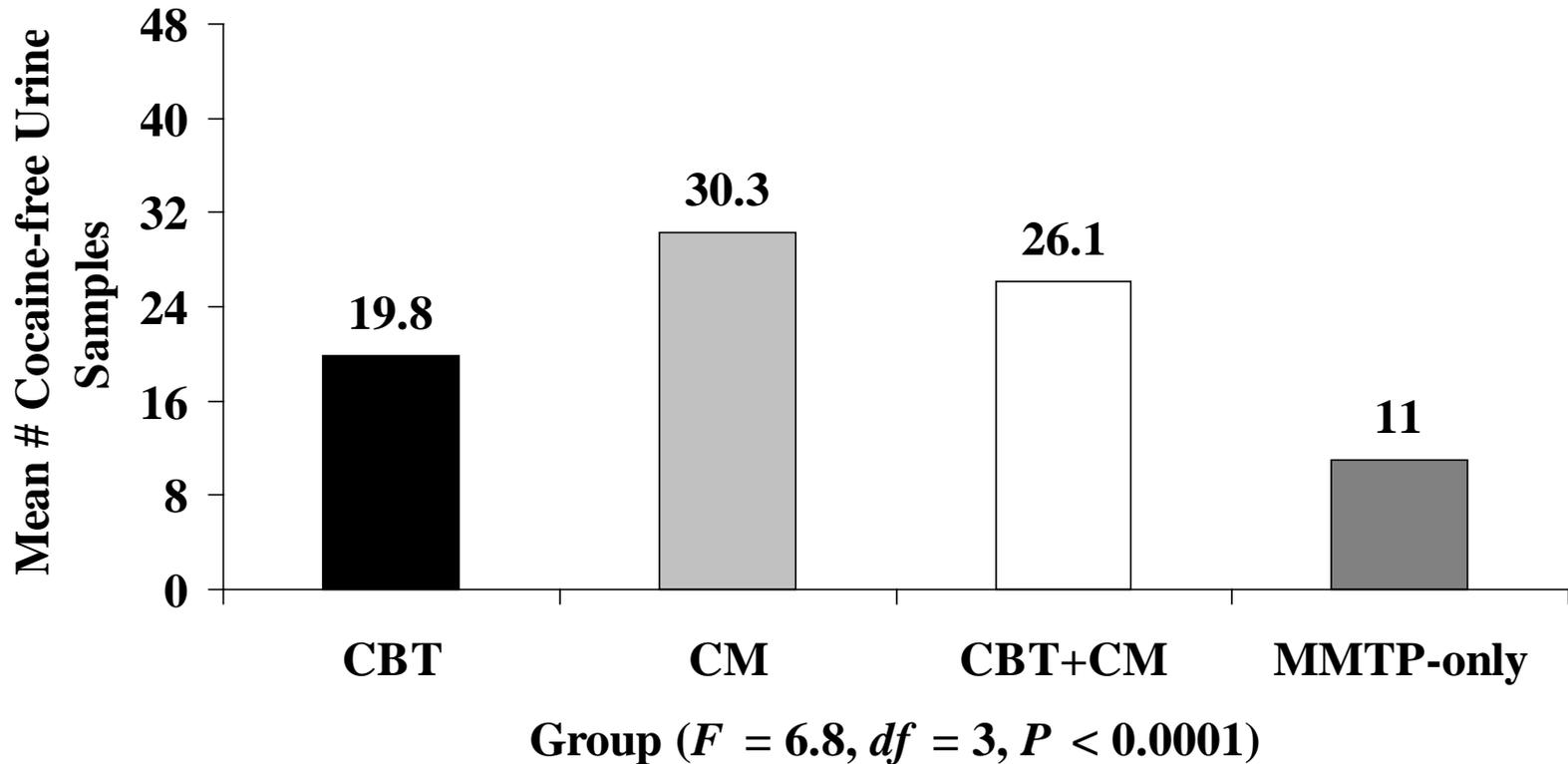
Retention Rate: Roll et al 2006



A Comparison of Contingency Management and Cognitive-Behavioral Approaches During Methadone Maintenance Treatment for Cocaine Dependence. *R. Rawson, et al. Archives of General Psychiatry 2002;59:817-824*

- **INTERVENTIONS:** 120 participants were randomly assigned to 1 of 4 conditions: CM, CBT, combined CM and CBT or methadone treatment as usual for 16 weeks.
- **RESULTS:** Urinalysis results show that participants assigned to the 2 groups featuring CM had significantly superior in treatment urinalysis results, whereas urinalysis results from participants in the CBT group were not significantly different than those from the MMTP-only group.
- **CONCLUSIONS:** Study findings provide solid evidence of efficacy for CM (with and without CBT). There was no evidence of a combined effect.

A Comparison of Contingency Management and Cognitive-Behavioral Approaches During Methadone Maintenance Treatment for Cocaine Dependence. *R. Rawson, et al. Archives of General Psychiatry 2002;59:817-824*



CBT: Cognitive-Behavior Therapy; CM: Contingency Management;
MMTP-only: Methadone Maintenance Treatment Program only

Community Reinforcement Approach

Community Reinforcement Approach (CRA) is a combination of behavioral strategies that address the role of environmental contingencies in encouraging or discouraging drug use, and attempts to rearrange these contingencies so that a non-drug using lifestyle is more rewarding than a using one.

Components of CRA

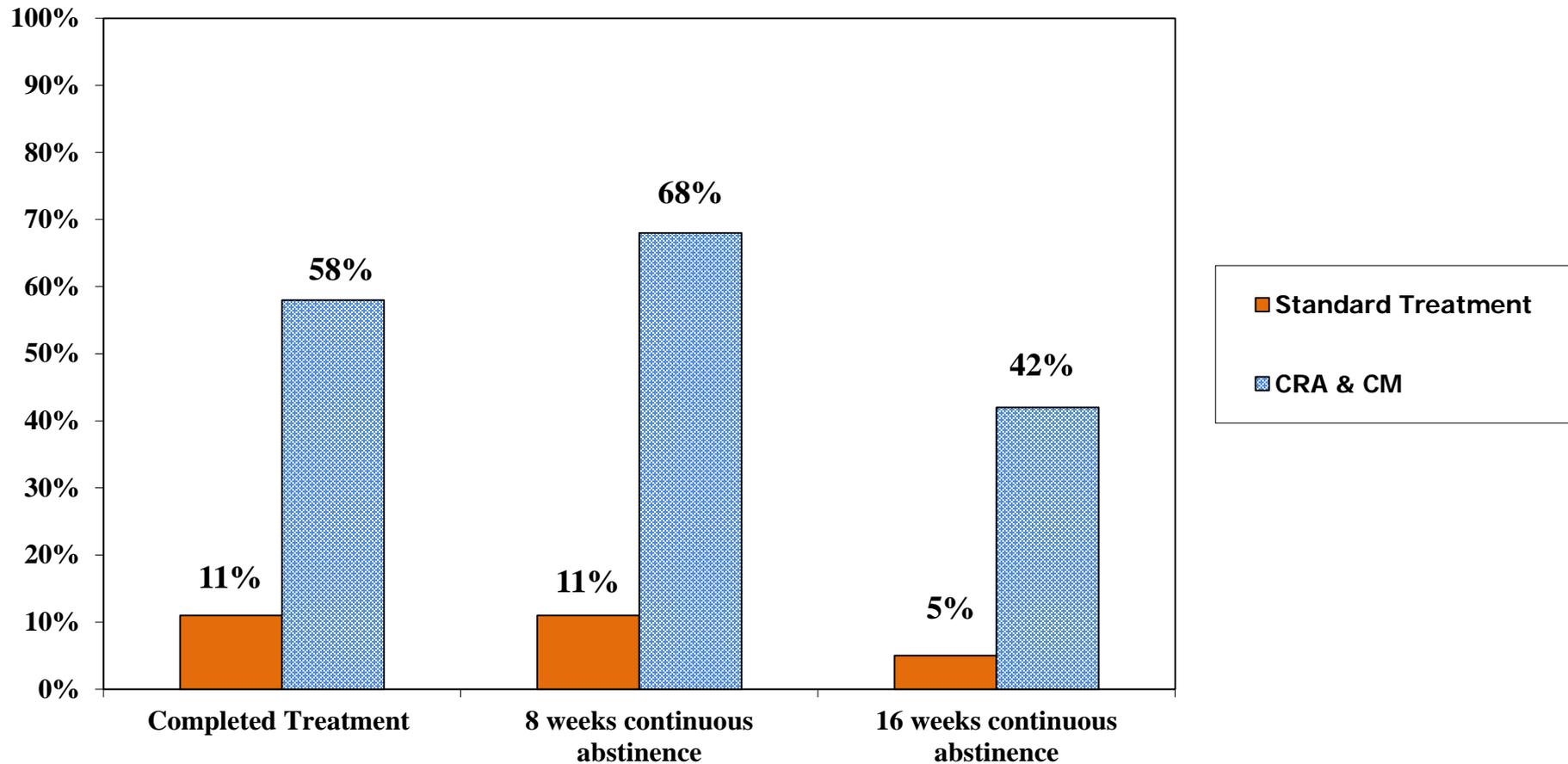
- CRA Components include:
 - **behavioral skills training**
 - **social and recreational counseling**
 - **marital therapy**
 - **motivational enhancement**
 - **job counseling**
 - **relapse prevention**
- For application to the treatment of cocaine dependence, a voucher based reinforcement program is added.

Achieving Cocaine Abstinence with a Behavioral Approach. Higgins et al.

*Am J Psychiatry.*1993; 150: 763-769

- **METHOD:** The 38 patients were enrolled in outpatient treatment and were randomly assigned to the two treatments. Counseling in the behavioral treatment was based on the community reinforcement approach, while the drug abuse counseling based on the 12 step model.
- **RESULTS:** Of the 19 patients who received CRA, 58% completed 24 weeks of treatment, versus 11% of the patients who received counseling. In the CRA group 68% and 42% of the patients achieved at least 8 and 16 weeks of documented continuous cocaine abstinence, respectively, versus 11% and 5% in the drug abuse counseling group.

CRA and Contingency Management: Higgins et al., 1993



National Institute on Drug Abuse

THE THERAPY MANUALS FOR DRUG ADDICTION

Manual 2

A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction

U.S. Department of Health and Human Services
National Institutes of Health

Cognitive Behavioral Therapy (CBT)

- CBT is a form of “talk therapy” that 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 in gaining initial abstinence from drugs (or in reducing their drug use).
- CBT also provides skills to help people sustain abstinence (relapse prevention)

Research on CBT for SUD

- Carroll, K. M., Rounsaville, B. J., Gordon, L. T., Nich, C., Jatlow, P. M., Bisighini, R. M., et al. (1994). Psychotherapy and pharmacotherapy for ambulatory cocaine abusers. *Archives of General Psychiatry*, 51, 177-197.
- Carroll, K. M., Rounsaville, B. J., Nich, C., Gordon, L. T., Wirtz, P. W., & Gawin, F. H. (1994). One year follow-up of psychotherapy and pharmacotherapy for cocaine dependence: Delayed emergence of psychotherapy effects. *Archives of General Psychiatry*, 51, 989-997.
- Carroll, K.M., Ball, S.A., Martino, S., Nich, C., Babuscio, T. A. & Rounsaville, B.J. (2009). Enduring effects of a computer-assisted training program for cognitive behavioral therapy: A six-month follow-up of CBT4CBT. *Drug and Alcohol Dependence*, 100, 178-181. PMID: PMC2742309
- CBT for CBT Website: <http://www.cbt4cbt.com/>

Matrix Model

- A manualized, 16-week, psychosocial approach used primarily in outpatient settings for the treatment of drug dependence.
- Manuals can be downloaded at SAMHSA.gov
- Designed to integrate several interventions into a comprehensive approach. Elements include:
 - Individual counseling
 - Cognitive behavioral therapy
 - Motivational interviewing
 - Positive reinforcement for behavior change
 - Family education groups
 - Urine testing
 - Participation in 12-step programs

Other Approaches with Support/Interest

- **Motivational Interviewing:** [Randomized Trial of Intensive Motivational Interviewing for Methamphetamine Dependence.](#) [Polcin et al. 2014.](#) No direct evidence with meth users, but support with other SUDs.
- **Physical Exercise:** [Impact of an exercise intervention on methamphetamine use outcomes post-residential treatment care.](#) [Rawson et al, 2015.](#) Evidence of reduction of meth relapse among less severe users; enhancement of dopamine receptor recovery, reduction in depression and anxiety during early meth abstinence.
- **Mindfulness Meditation:** [Mindfulness-Based Relapse Prevention for Stimulant Dependent Adults: A Pilot Randomized Clinical Trial.](#) [Glasner-Edwards et al 2017.](#) Evidence of reduced anxiety and depression during early meth abstinence.

Medications for Methamphetamine Use Disorder

Positive/Under Consideration

Bupropion (better in low severity users)

Mirtazapine

Naltrexone

Methylphenidate

Dextroamphetamine (craving/WD)

Topiramate (better if abstinent at treatment entry)

Medications Considered for Cocaine Use Disorder

Positive/Under Consideration

Topiramate

Modafinil

Bupropion

Amphetamine salts

Isulfiram (mixed, worse retention)

Propranolol (WD)

Buprenorphine+naltrexone

Thank you
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Questions and Answers



Q&A with Marlies Perez, California Department of Health Care Services

Discussion & Questions



Key Takeaways

- Need to focus on SUD more broadly than just OUD.
- AUD shows up in primary care - an integrated approach can provide treatment for the addiction as well as other comorbidities.
- Retention in treatment is a challenge for treating individuals with stimulant dependence. New treatment options including contingency management are showing promising results.

References

- Meth Vs. Opioids: America Has Two Drug Epidemics, But Focuses On One: <https://khn.org/news/meth-vs-opioids-america-has-two-drug-epidemics-but-focuses-on-one/>
- About 40 Percent of Americans Drink Too Much, Study Says: <https://www.newsweek.com/study-40-percent-americans-drink-too-much-1029294>

Thank You!

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