Guiding principles in the treatment of SUBSTANCE USE DISORDERS

NEW DIRECTIONS®

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Preface

New Directions Behavioral Health created this document to capture and highlight key principles and evidence-based practices in the contemporary treatment of Substance Use Disorders (SUD). We are keenly aware that addressing the current SUD health crisis will require a multifaceted approach involving numerous stakeholders on the national, regional and local stages. Within that context, New Directions' role is twofold: support providers and facilities in their treatment of members with SUD, and ensure that members have access to timely, appropriate treatment.

In furtherance of our dual role, we envision using this document to foster dialogue with providers and facilities about the following topics:

- **Adopting evidence-based SUD treatment practices**
- **Addressing unmet needs of substance users through innovation**
- **Collaborating to improve systems of care for members with SUDs**

It is our sincere hope that the ensuing conversations, collaboration and alignments will positively impact the SUD care for New Directions members and others. Providers and Facilities are encouraged to contact our Network Operations/Provider Relations department at ProviderRelations@ndbh.com or 1-888-611-6285 to discuss these guidelines.

Using the Guiding Principles

The Guiding Principles were developed as a result of an internal multidisciplinary work group and are to be used as a reference guide in the treatment of SUDs, including Alcohol Use Disorders and Opioid Use Disorders. They are not intended to replace prudent clinical judgment. New Directions recognizes that the Guidelines are not exhaustive and will not cover all potential clinical situations.

Any questions or comments about the content of the Guiding Principles should be directed to:

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New Directions is a growing integrated health care organization serving over 13 million members nationwide. Our mission, commitment and daily work focuses on supporting members, providers, health plans and communities in improving health.

Executive Summary

The health care system in the U.S. must increase its focus on outcomes and value. This shift will require fundamental change. Unlike industries with healthy competitive marketplaces in which improvements drive down costs over time, the U.S. health care industry has not competed on value. Efforts to reduce health care costs have been largely unaffected by improvements in quality of care, processes and methods. What's more, the cost and quality of health care varies greatly among providers and across the country. According to Harvard business professor Michael E. Porter, "The differences in quality of care last for long periods because the diffusion of best practices is extraordinarily slow. It takes, on average, 17 years for the results of clinical trials to become standard clinical practice. Important constituencies in health care view innovation as a problem rather than a crucial driver of success."[1]

Today's volume-based health care is provider-centric, driven by fee-for-service payments that are unaffected by outcomes. The emerging value-based health care is patient-centric and, increasingly, population-centric. In an effort to align the industry's evolving emphasis on outcomes and value with the population's need for effective substance use disorders (SUD) care, New Directions has summarized current evidence about SUD treatment. Our purpose is to foster dialogue with stakeholders in an effort to obtain their commitment to:

- **adopt evidence-based SUD treatment practices**
- **innovate to address unmet needs of substance users**
- **collaborate with New Directions to improve systems of care for members with SUDs**

One of the most pressing and growing public health and safety concerns in the U.S. is the devastating impact of SUDs. According to the 2014 National Survey on Drug Use and Health, an estimated 20.1 million adults (8.4%) have a substance use disorder.[2] The impact of SUDs has led to increased health care utilization, workplace impairment and costs, criminal activity and mortality. The Drug Abuse Warning Network data estimates there were over 5.1 million alcohol and drug-related Emergency Department (ED) visits in 2011.[3] The Drug Abuse Warning Network data also revealed that between 2004 and 2011, the annual overall number of ED visits attributable to drug misuse or abuse rose

steadily each year for a total increase of 52 percent. National estimates suggest that workplace alcohol use and impairment directly affect an estimated 15% (19.2 million) of employed adults in the U.S., with an estimated $179 billion in 2010 in lost productivity due to excessive alcohol use.[4, 5, 6] From 1999 to 2016, more than 200,000 people in the U.S. died from overdoses related to prescription opioids.[7,8] In addition to the impact on human health, the CDC reports that abuse of tobacco, alcohol and illicit drugs costs our nation more than $740 billion annually in the areas of crime, lost work productivity and health care.[9]

The opioid epidemic has been called the worst drug crisis in American history. The facts are staggering - 91 Americans die every day from an opioid overdose, and the number of opioid-related deaths has quadrupled since 1999.[10] According to the same source, more than six out of ten drug overdose deaths involve an opioid. The epidemic is so severe that the U.S. president declared a public health emergency.[11] Furthermore, it is a crisis that began in our nation's health care system and became the fastest growing chronic condition, with four out of five new heroin users beginning with prescription opioids.[12] As access to prescription opioids tightens, consumers are increasingly turning to street opioids: heroin, and illegally manufactured fentanyl, alone or combined. Partially as a result, many physicians report they are not confident they know how to safely prescribe opioids, screen or detect opioid misuse or diversion.[13]

The health consequences are acutely distressing: Injection drug use (IDU) is the primary risk factor for HCV (Hepatitis C Virus) transmission and the leading cause of incidence in the U.S., according to the research published in the February 2018 issue of the American Journal of Public Health.[14] Individuals aged 18 to 29 showed the most extreme increases in rates of injecting heroin and prescription opioid analgesics (POAs) coupled with acute HCV infections. These young adults had a 400% rise in HCV cases, a 603% surge in admissions for heroin injection, and an 817% jump in admissions for injection of POAs. Women of childbearing age had a marked rise in hepatitis C. Researchers found a fourfold increase from 2004 to 2014 in overall incident cases of neonatal abstinence syndrome (NAS), which occurs when a baby is exposed to drugs in the womb and goes through withdrawal after birth.[15]

New Directions supports the full integration of services for substance use disorders with the conventional health care system. True integration could significantly improve the quality, effectiveness and safety outcomes of all health care. Yet as discussed in "Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, 2016," this "has not been how substance use treatment has been delivered."[16] The Surgeon General's report highlights that, "...despite numerous research studies documenting high prevalence rates of substance use disorders among patients in emergency departments, hospitals, and general medical care settings, mainstream health care generally failed to

recognize or address substance use disorders. In fact, a recent study by the CDC found that in 2011, only 1 in 6 United States adults and 1 in 4 binge drinkers had ever been asked by a health professional about their drinking behavior."[17] The report further notes that historically, "only individuals with the most severe substance use disorders have received treatment, and only in independent "addiction treatment programs" designed in the early 1960s to treat addictions as personality or character disorders."[18] This separation of SUD treatment from mainstream health care has contributed to the dearth of information about the medical nature of these conditions and to the slow adoption of evidence-based medical treatments by addiction treatment providers.[19, 20, 21]

Additional realities support the need for integration: 1) SUD, mental health issues and general medical conditions are interconnected; 2) addressing substance use disorders in an integrated manner reduces health disparities; 3) providing substance use disorder services in conventional health care is cost-effective and offers increased access to care; and 4) delivering SUD, mental health and medical care in an integrated manner improves health outcomes via care coordination.[22]

Barriers to treatment present an ongoing challenge to effectively address Opioid Use Disorders (OUD) and other SUDs. Nearly 80 percent of individuals with an OUD do not receive treatment.[23] In 2013, an estimated 22.7 million Americans (8.6 percent) needed treatment for a problem related to drugs or alcohol, but only about 2.5 million people (0.9 percent) received treatment at a specialty facility.[24] The main causes for the under treatment are attitudes, stigma and shame related to substance use, lack of appropriately trained professionals, a complex payer system and the absence of coordinated, holistic and continuous care approaches.

In addition to the barriers to treatment, variation in treatment practice and lack of studied efficacy of applied treatments has led to a limited understanding of what works in treating substance use disorders, as summarized below by Carroll and Rounsaville:

> "…disparities between research and practice are particularly apparent in drug abuse treatment. For example, despite overwhelming empirical support for the efficacy and cost-effectiveness of methadone maintenance access to this form of treatment remains highly restricted in many areas of the United States … Similarly, behavioral treatments for which there is strong empirical support have rarely been implemented in clinical settings."[25]

National standardized quality and outcomes measures do not exist and consensus definitions of recovery and success are unclear.[26, 27] Systemic limitations include lack of systems that support translation of research into practice, lack of coordinated service delivery, pain management prescribing practices, clinician attitudes towards

and adherence to evidence-based practices, lack of appropriately trained addiction professionals, inadequate number of physician addiction specialists and inadequate training on evidence-based practices.[28, 29, 30, 31]

Increased acknowledgment of the impact of SUDs is abundant. From the daily local news to the Surgeon General (turnthetiderx.org) and U.S. president (opioid epidemic declaration), there is energy, advocacy and focus on the science and necessary services in treating addiction. Yet, the opioid and SUD crisis presents a significant multi-dimensional challenge to all stakeholders - policy makers, payers, heath care organizations, and providers alike - to adopt and apply evidence-based treatment for SUDs, including OUDs, and to collaboratively seek systemic solutions to improve access to integrated SUD care. Accordingly, New Directions emphasizes the need for a chronic care model of treatment that acknowledges addiction as a disease that affects both brain and behavior. Like other chronic illnesses, SUD treatment should seek to "eliminate or reduce the primary symptoms (substance use), improve general health and function, and increase the motivation and skills of patients and their families to manage risks of relapse."[32]

This document presents a set of guiding principles and evidence-based practices for substance use treatment espoused by New Directions. It is an effort to communicate a philosophy of care, grounded in the disease model of addiction and the chronic care model, and to serve as a framework from which to clarify, secure and measure essential services for persons with SUD, and especially those with Opioid Use Disorders and New Directions members. Measures to be followed include:

- **Evidence of engagement in recovery as measured by meaningful reduction in substance use**
- **Treatment adherence and retention**
- **Readmission rates**
- **Meaningful interventions to address co-occurring and psychosocial problems such as psychiatric severity, medical problems, legal concerns, family/social relations, and employment/vocational needs**
- **Evidence of member education on medications available to treat OUD and Alcohol Use Disorder (AUD)**
- **Prescribed medication-assisted treatment (MAT) for members with SUD**
- **MAT adherence rates**
- **Coordination of care activities with member's health care providers**

- **Utilization of Prescription Drug Monitoring Programs (PDMPs)[33]**

New Directions Guiding Principles on the treatment of Substance Use Disorders are based upon nationally recognized sources such as Substance Abuse and Mental Health Services Administration (SAMHSA), the American Society of Addiction Medicine (ASAM), and the National Institute for Drug Abuse (NIDA), as well as references explicitly documented herein. The Guiding Principles document is wholly separate from and does not replace New Directions medical necessity criteria (MNC). New Directions MNC is used to make benefit determinations and is internally developed and also based upon these and other nationally recognized sources.

General

SAMHSA guiding principles of recovery

The SAMHSA Guiding Principles of recovery, developed in 2009 by Sheedy & Whitter[34], serve as a unifying concept of recovery and the foundation from which New Directions intends to offer services for members:

- **There are many pathways to recovery.**
- **Recovery is self-directed and empowering.**
- **Recovery involves a personal recognition of the need for change and transformation.**
- **Recovery is holistic.**
- **Recovery has cultural dimensions.**
- **Recovery exists on a continuum of improved health and wellness.**
- **Recovery is supported by peers and allies.**
- **Recovery emerges from hope and gratitude.**
- **Recovery involves a process of healing and self-redefinition.**
- **Recovery involves addressing discrimination and transcending shame and stigma.**
- **Recovery involves (re)joining and (re)building a life in the community.**
- **Recovery is a reality. It can, will, and does happen.**

Chronic Disease Model

The disease model of addiction considers the biological, genetic, neurological, and environmental sources of origin. Drug addiction shares many features with other chronic illnesses (diabetes, cancer, cardiovascular disease), "including a tendency to run in families (heritability), an onset and course that is influenced by environmental conditions and behavior, and the ability to respond to appropriate treatment, which may include long-term lifestyle modification."[35, 36] Individuals do not choose to be addicted." Addicted individuals may manifest physical changes to the brain system in the course of addiction, similar to that of hearts of people with heart disease. According to NIDA, "long-term drug use results in significant changes in brain function that can persist long after the individual stops using drugs."[37] The chronic nature of disease means that symptoms may recur, relapse is likely, and does not indicate the previous treatment has failed, but rather

indicates the need for reinstated, adjusted or alternative treatment.[38] For these reasons, and consistent with other chronic illnesses, recovery is an ongoing, long-term process that requires coordinated, continuous and systemic approaches.

Maintaining behavior change over time can be more challenging than changing initial behavior; the chronic disease model therefore supports continuing patient-provider strategies, not acute care only, and is associated with sustained treatment outcomes.[39]

Chronic Care Model

The chronic care model is applicable to a variety of chronic illnesses, patient populations and health care treatment settings. The chronic care model focuses on six areas in order to move patients with chronic illness to more self-efficacy, while providing higher quality care and control costs:

- **Community**
- **Health System**
- **Self-management Support**
- **Delivery System Design**
- **Decision Support**
- **Clinical Information Systems**[40]

In 2002, the original model was revised to reflect changes in the health care system. These changes were based on more relevant evidence that added five additional elements:

- **Patient Safety (Health System)**
- **Cultural Competency (Delivery System Design)**
- **Care Coordination (Health System and Clinical Information System)**
- **Community Policies (Community)**
- **Case Management (Delivery System Design)**[41]

Individualized Treatment and Informed Consent

Much like treatment for other chronic medical conditions, treatment for SUDs should be individualized. The interventions and options offered should be flexible and customized to meet the unique needs of each individual based upon the severity of the condition, their biopsychosocial status, strengths and limitations.[42]

Treatment adherence and outcomes are enhanced by patient-provider collaboration and shared decision-making. To facilitate member engagement in treatment and recovery, person-centered services include the delivery of easily understood and concise information

on treatment available and recommended to members and their family members, as appropriate. This consumer education positions members to better participate in treatment and to self–advocate in the recovery process. “Health care treatment requires informed consent, indicating that the patient or family member has been made aware of the proposed modalities of treatment, the risks and benefits of such treatment and appropriate alternative treatment modalities, and the risks of treatment vs. no treatment.”[43]

Withdrawal Management/Detoxification

As discussed in The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions Publication Date: Oct. 24, 2013, physiological dependence warrants assessment of withdrawal management (WM) needs. The level of care or treatment setting should be aligned with the assessment of the patient’s medical needs. The setting should be reflective of an effective, least restrictive setting where withdrawal management can be provided safely and where the patient can be introduced to concepts of rehabilitation and recovery while being presented with treatment options and psychosocial services to achieve sustained recovery.[44, 45] In addition to the patient’s withdrawal management needs, medical symptoms and physical health status are important factors to consider when assessing the patient for the most appropriate level of care and setting.

The following factors should be considered in determining a safe and effective setting:

- **Current use of substances including polysubstance use**
- **Amount, route and history of use**
- **History of withdrawal management and relapse**
- **Co-occurring mental health issues**
- **Member’s motivation for change**
- **Support systems including family or other support**
- **Living situation - degree to which living environment is conducive to recovery**
- **History of DT, seizures & other complications of withdrawals**

Subacute or outpatient settings have been established to be safe and effective for those members who do not require acute 24-hour medical and nursing management.[46]

WM or MAT is often the first step in treatment and alone does not change the addiction process.[47, 48] Members will be encouraged to continue with the appropriate level of treatment for their substance use disorder as a part of a continuing care plan and aligned with the need for an ongoing and continuous recovery management process.

The National Institutes of Health and the National Institute on Drug Abuse recently indicated that the "standard of care for reducing illicit opioid use, relapse risk, and overdoses, while improving social function" includes opioid agonist treatment (OAT) with methadone or buprenorphine, typically delivered through outpatient treatment models. Withdrawal management (or detoxification) followed by treatment without medication should not be used as first line approach as it has a very high failure rate (>90% in 3 mos.).[49]

According to the American Society of Addiction Medicine, "Using medications for opioid withdrawal management is recommended over abrupt cessation of opioids."[50] Finally, an RCT conducted at Yale School of Medicine showed that buprenorphine detoxification is less effective for prescription opioid dependence than ongoing maintenance treatment.[51] Detoxification without MAT increases the risk of overdose (due to loss of tolerance) and other adverse events.[52]

Given the efficacy of MAT in reducing cravings and increasing retention in treatment, New Directions expects providers to fully evaluate, consider and educate members on MAT options, the risks of abrupt cessation for OUD, and other appropriate harm reduction strategies. "The choice of available treatment options for addiction involving opioid use should be a shared decision between the clinician and the patient."[53]

Assessment

Members should be assessed using a multidimensional approach to account for critical domains that impact individualized selection of level of care and treatment planning that address multiple needs of the individual. The American Society of Addiction Medicine (ASAM) advocates the use of six dimensions in a multidimensional assessment:

1. **Acute Intoxication and or withdrawal potential, exploring the individual's past and current experiences of substance use and withdrawal**
2. **Biomedical Conditions and complications, exploring health history and current physical condition**
3. **Emotional, behavioral, or cognitive conditions or complications, exploring and individual's thoughts, emotions and mental health issues**
4. **Readiness to change. Exploring an individual's readiness and interest in changing**
5. **Relapse, continued use or continued problem potential, exploring an individual's unique relationship with relapse or continue use or problems**

6. **Recovery/living environment, exploring an individual's recovery or living situation, and the surrounding people, places, things**[54, 55]

Treatment Planning

The rehabilitative-relapse prevention phase of treatment begins when the acute physiological effects of withdrawal, as well as the emotional effects of recent substance use, have been addressed.[56] Like withdrawal management, the rehabilitative phase can occur in various level of care settings. The selection of settings should be based upon the multidimensional assessment noted above.

ASAM recommends that the treatment plan should be developed in collaboration with the patient and the treatment team and should:

- **Focus on priority problems that constitute obstacles to recovery**
- **State goals that guide realistic and measurable progress**
- **Promote accountability by listing methods or strategies that identify the personal actions of the patient and the services to be provided by the staff**
- **Be written to facilitate measurement of progress.**[57]

An effective treatment plan must be continually assessed and modified to meet the member's evolving needs. Changes may be needed to the intensity of services, strategies and interventions, and recovery and support services offered. Inpatient level of care treatment plans should be updated twice weekly during treatment team meetings. Residential and PHP levels of care treatment plans should be updated weekly. IOP level of care treatment plans should also be updated weekly.

Patient engagement and self-efficacy are critical areas to focus on early in treatment. Core to the principles of effective treatment, "motivational enhancement and incentive strategies, begun at initial patient intake, can improve treatment engagement."[58] Establishing stable and consistent social, family and recovery support is a critical component of the treatment plan. Treatment planning should also occur with a consideration for the patient's safety; any concerns about patient safety should be documented as part of the treatment plan, noting appropriate interventions. Informed consent is a critical part of engaging members in their care. New Directions considers providers to be the critical agents in educating and informing members about the range of options that exist (including those not offered by the provider), the risks and benefits of treatment options, the chronic disease model, the continuous nature of recovery, self-management resources (peer support, support groups, community services) and medication-assisted treatment.

The treatment plan must address psychosocial needs and improvement of personal resources including vocational, parenting, financial, social or legal services. Employment problems, poor health, and social functioning are top predictors of substance use post treatment.[59] Co-occurring mental health and comorbid medical conditions should be treated concurrently with the substance use condition in order to expect optimal outcomes.[60] New Directions recommends that all treatment providers make the best effort to coordinate with other providers for any co-occurring mental health or comorbid medical conditions to provide concurrent treatment.

Medication-Assisted Treatment

Medication-assisted treatment (MAT) effectively treats opioid, alcohol and tobacco use disorders. MAT is "the use of medications, in combination with behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Individuals receiving MAT often demonstrate dramatic improvement in addiction-related behaviors and psychosocial functioning."[61]

Growing evidence supports the benefits of using medication to manage cravings and prevent relapse. The FDA has approved medications for use in treating Opioid Use Disorder, Alcohol Use Disorder, and Tobacco Use Disorder. New Directions recommends that providers will educate members regarding all evidence-based treatment options, including medications, even if not offered by the provider or program. Optimal outcomes are associated with the use of combination approaches including medication, counseling, group and behavioral therapies and peer support.[62] In a study of 33,923 Medicaid patients diagnosed with opioid dependence in Massachusetts, mortality during the four-year study period (2003-2007) was double among patients receiving no treatment versus patients treated with buprenorphine.

Additionally, patients treated with buprenorphine experienced a 75% reduced mortality versus patients treated with psychosocial interventions alone.[63]

Beyond the issue of mortality, evidence shows that medications improve patient adherence to treatment, reduce criminal activity and decrease the transmission of HIV and hepatitis C as a result of the reduction in injection use.[64, 65, 66] Furthermore, evidence shows that initiating MAT in emergency departments reduces mortality, improves treatment retention and reduces illicit drug use.[67, 68, 69]

The Surgeon General's 2016 report notes the following:

> "Use of medications to treat addiction has been controversial at times because of a longstanding misconception that methadone and, more recently, buprenorphine, which control opioid craving and withdrawal,

merely "substitute one addiction for another." This belief has reinforced scientifically unsound "abstinence-only" philosophies (meaning abstinence from opioid-based medications as well as from illicit and misused drugs) in many treatment centers and has severely limited the use of these medications. Restrictions on how these drugs may be prescribed or dispensed have also reduced their availability for many people who could benefit from them. Abundant scientific data show that long-term use of maintenance medications successfully reduces substance use, risk of relapse and overdose, associated criminal behavior, and transmission of infectious disease, as well as helps patients return to a healthy, functional life."[70]

Given the evidence for the use of medication in treating opioid and alcohol use disorders, New Directions measures provider use of medication in the treatment of addiction as a means to determine the degree to which evidence-based approaches are exercised by providers.

Physicians who are contracted through New Directions should adhere to federal and state standards related to the practice of prescribing medications for substance use disorders. Physicians should consult with member's individual health plan for specific benefits and coverage information. Payment of benefits are subject to all terms, conditions, limitations and exclusion of the member's contract at time of service.

Pharmacotherapy/MAT

The following medications are approved by the FDA for the treatment of the Substance Use Disorders referenced:

Alcohol Use Disorder (AUD)

Disulfiram, acamprosate, and naltrexone are FDA approved to treat AUD.

Opioid Use Disorder (OUD)

Methadone, buprenorphine, and naltrexone are FDA approved to treat OUD.

Per federal regulations, methadone must be administered in a licensed opioid treatment program (OTP). In accordance with federal law, buprenorphine may only be prescribed by providers who have obtained a DEA waiver to prescribe these buprenorphine based drugs.

Tobacco Use Disorder (TUD)

Bupropion, Nicotine Replacement Therapies or NRTs (transdermal nicotine patches, gum, lozenges), and varenicline are FDA approved to treat TUD.

MAT Assessment

According to SAMHSA, a comprehensive MAT assessment includes:

- **A medical and psychiatric history, a substance use history, and an evaluation of family and psychosocial supports to include linkage/ referral to indicated external resources such as community based services and other health care providers.**
- **A physical examination that focuses on physical findings related to addiction and its complications.**
- **Review of the patient's prescription drug use history through the state's prescription drug monitoring program (PDMP) to detect unreported use of other controlled substances.**
- **Laboratory testing to assess recent opioid use and to screen for use of other drugs. Useful tests include a urine drug screen or other toxicology screen, urine test for alcohol (ethyl glucuronide), liver enzymes, serum bilirubin, serum creatinine, as well as tests for hepatitis B and C and HIV[71, 72]**

Prescription drug monitoring programs (PDMPs)

Prescription drug monitoring programs are state-managed databases that allow prescribing providers to see their patients' prescribing histories during the prior 12-month period. This includes medications the patient can purchase on a cash basis. Using the PDMP, a provider has the ability to validate the historical controlled substance use as reported by the individual and to be able to see how many pharmacies and controlled substance prescribing providers the individual is accessing. PDMPs should be utilized before initially prescribing an opioid and routinely thereafter. For example, the PDMP should be accessed prior to initially prescribing an opioid and at least every three months thereafter.[73]

Evidence-based Best Practices in SUD Treatment

In addressing the rehabilitative needs of SUD members, evidence-based treatment approaches should be focused on member skill acquisition to enable rehabilitation and recovery maintenance.[74] Evidence-based approaches include, but are not limited to:

- **motivational interviewing to engage the member in recovery goals**
- **Cognitive Behavior Therapy (CBT) to address beliefs that underpin addictive behaviors**

- **contingency management to reinforce gains, connection with recovery support**
- **education of family/friends on constructive approaches to support**
- **relapse prevention-teach ways to avoid use, prevent relapse and respond when relapse occurs**[74]

Effective psychosocial treatments for SUDs may include the following ingredients: enhancing and maintaining motivation, teaching and learning new coping skills, modifying the social environment, fostering management of pain affects, changing conditioned responses, enhancing social supports, fostering adherence and retention in pharmacotherapy, and enhancing self-efficacy.[75, 76]

Motivational Interviewing Motivational Interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. This style and the associated therapy techniques are based on the stages of change model developed by Prochaska and DiClemente. Therapeutic techniques are catered to the patient's needs based on an assessment of the patient behaviors associated within the five stages of change. These stages are precontemplation, contemplation, preparation, action and maintenance. The assumption of this model is that patients will vacillate between the stages at different points in treatment and the goal of the clinician is to help advance the patient to the next stage.

This technique has been highly successful with the population who have substance use disorders. Developed by Rollnick and Miller, motivational interviewing helps the member address the ambivalence of changing their use behavior and move through the stages of change, utilizing these five principles:

1. **Express empathy through reflective listening.**
2. **Develop discrepancy between clients' goals or values and their current behavior.**
3. **Avoid argument and direct confrontation.**
4. **Adjust to client resistance rather than opposing it directly.**
5. **Support self-efficacy and optimism.**[77, 78, 79]

Cognitive Behavioral Therapy Cognitive Behavioral Therapy for substance use disorders has been shown to be effective in skills training in the following areas: understanding the patterns of substance use; strategies for recognizing and coping with craving; problem solving; managing thoughts about drug of choice and improving decision-making skills. CBT for SUDs can encompass multiple interventions, including

Motivational Interviewing, relapse prevention, and contingency management. Consistent across interventions is the use of learning-based approaches to target maladaptive behavioral patterns, motivational and cognitive barriers to change, and skills deficits.

"One of the core principles underlying CBT for SUDs is that substances of abuse serve as powerful reinforcers of behavior. Over time, these positive (e.g., enhancing social experiences) and negative (e.g., reducing negative affect) reinforcing effects become associated with a wide variety of internal and external stimuli. The core elements of CBT aim to mitigate the strongly reinforcing effects of substances of abuse by either increasing the contingency associated with non-use (e.g., vouchers for abstinence) or by building skills to facilitate reduction of use, maintenance of abstinence, and opportunities for rewarding non-drug activities."[80]

Contingency Management Contingency Management is a behavioral strategy used in SUD treatment to promote positive behavior change, following the principle that behavior that is rewarded will be more likely to persist. Research has demonstrated the effectiveness of treatment approaches using contingency management (CM) principles, which involve giving patients tangible rewards (vouchers, prizes, recognition) to reinforce positive behaviors such as abstinence, attendance and attainment of behavior goals.[81] Studies conducted in both methadone programs and psychosocial counseling treatment programs demonstrate that incentive-based interventions are highly effective in increasing treatment retention and promoting abstinence from drugs.[82]

Recovery Oriented System of Care (ROSC) "A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems."[83] The goal of this coordinated network is to ensure that the member receives care for all behavioral health and physical issues present and the treatment providers accomplish this through coordination of care. In this system, prevention and aftercare are as important to helping with SUD as treatment and intervention (Whitter, Hillman, & Powers, 2010). Recovery Support Services are a large part of the ROSC.

Recovery Support Services (RSS) Recovery support services are non-clinical services that assist individuals and families working towards recovery from substance use disorders. They incorporate a full range of social, legal and other resources that facilitate recovery and wellness to reduce or eliminate environmental or personal barriers to recovery. RSS include social supports, linkage to and coordination among allied service providers, and other resources to improve quality of life for people in and seeking recovery and their families. RSS are provided by professionals and peers and are delivered through a variety of community and faith-based groups, treatment providers,

and RSS providers. Provision of RSS is based upon the needs expressed in a person's individualized recovery plan."[84]

Peer Support Services - Peer Recovery Support Services Studies have shown the importance of social support in successful recovery.[85] Peer recovery support services are designed and delivered by people who themselves have been successful in recovery. These peers offer non-clinical assistance to other people to help them become and stay engaged in long-term recovery from alcohol and/or other drug-related problems. Through the Recovery Community Services Program, SAMHSA funds grant projects across the country in an effort to develop and deliver peer support services. Peer counselors are typically credentialed to assist others in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery. Many states are offering Credential for Peer Support Specialist or Peer Coaching. Four major types of peer recovery support activities exist: (1) peer mentoring or coaching, (2) recovery resource connecting, (3) facilitating and leading recovery groups, and (4) building community.

Psychosocial Interventions to Address Relapse

Relapse A relapse is defined as "a setback that occurs during the behavior change process, such that progress toward the initiation or maintenance of a behavior change goal (e.g., abstinence from drug use) is interrupted by a reversion to the target behavior. It is also considered a complex and dynamic, ongoing process rather than a discrete or terminal event."[86] Within the context of the chronic disease model, addiction is a chronic relapsing brain disease similar to other chronic conditions such as diabetes, asthma and heart disease. As with other chronic conditions, it requires condition management approaches. It is not uncommon for people with addiction to experience relapses, (not treatment failures), calling for modifications in treatment plans, relapse plans and self-management approaches.[87, 88]

Relapse Prevention (RP) "Relapse prevention is an intervention strategy for reducing the likelihood and severity of relapse following the cessation or reduction of problematic behaviors." There are many empirically validated RP approaches, considered skill-based treatments that emphasize cognitive-behavioral skill building and coping responses, and integral to psychosocial treatments for substance use. The general focus is in two areas: minimizing the impact of high-risk situations by increasing awareness and building coping skills, and limiting relapse proneness by promoting a healthy and balanced lifestyle.[89]

Recovery Management The recovery management approach shifts care from an acute care model to a chronic care approach. By doing so, it assists individuals with chronic substance use conditions to focus on management of the condition

over time, and by doing so, achieve long-term recovery. Based on individual needs, recovery management may offer early intervention service and acute care services, as well as chronic care services. By offering such comprehensive strategies of care – from early intervention to recovery checkups - individuals are better prepared to sustain recovery. Through recovery management, individuals and their families and support systems are encouraged to access resources that meet the individual's specific needs. "ROSC coordinate the layers of multiple systems that can produce those resources. As a result of the collaborative work done by a ROSC, these systems—including criminal justice, education, child welfare, and primary care—can provide the supports necessary to sustain recovery management activities."[90]

Self-Management and Self-help tools Self management tools increase the ability of members to lead their change process and relapse prevention plans. Self-change toolkits, such as those created by Cambridge Health Alliance Division on Addiction, are intended to help people change their behaviors even if they do not enter treatment. "These toolkits are designed to do three things:

- **They will help people gain information about addiction-related problems.**
- **They will help people evaluate their own addiction-related behavior.**
- **They will help people develop change strategies, should they decide that change is the best course."[91]**

Laboratory Services in assessing and treating SUD

Monitoring for use during treatment has been shown to increase accountability and aid in resistance to urges. In addition, monitoring demonstrates early indication of use and allows adaptations to treatment plans.[92] Random urine drug screens help patients with treatment goals of accountability as well as provide the treatment provider with the baseline and throughout the treatment process. The preferred method is the use of dipsticks with the use of lab tests when the results are uncertain.

Boarding and SUD Treatment

Member participation in treatment in the least restrictive level of care facilitates application of ascertained recovery skills to daily living. Outpatient substance use rehabilitation (IOP/PHP/OP) is designed to deliver treatment and education, and address critical psychosocial issues, while allowing members to implement recovery in everyday life. Boarding options while participating in IOP or PHP should not interfere with the

patient's ability to integrate and apply learned recovery skills into everyday living. (ASAM).[93] Boarding during treatment works best as a short-term intervention to facilitate a return to longer-term, community-based everyday life, preferably in an area where the member will live, work and engage in activities to sustain recovery. New Directions recommends that providers of SUD services support application of learned recovery skills to daily living (for most members this should occur in their home community) and to demonstrate such in treatment planning and utilization review activities.

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