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Daniel Carlat, MD
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Residential Treatment Programs Decoded

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Learning objectives for this issue: **1.** Catalog the wide range of options for addiction treatment available to patients. **2.** Describe the main elements of typical residential rehab programs. **3.** Understand how to discuss marijuana use with patients. **4.** Evaluate some current research regarding addiction treatment.

The Vast Landscape of Services that is "Rehab"

Susan Hochstedler, RN, LADC
Ms. Hochstedler works as a nurse and an alcohol and drug abuse counselor at Lahey Health Behavioral Services at Addison Gilbert Hospital, Gloucester, Massachusetts.

Ms. Hochstedler has disclosed that she has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

Summary

- There is a wide array of treatment options for patients with various levels of addiction issues.
- Arguments have been made both in favor of and against inpatient rehab as an effective method to combat addiction.
- Rehab frequently involves significant use of groups and a one-size-fits-all treatment process.

If a patient comes in and says, "doc, I think I need to go to rehab," what should you do? Most people think of rehabs as residential facilities, but these days, the term "rehab" includes a broad spectrum of treatment settings, most of which, in fact, are not residential—only

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Q&A With the Expert

The Case Against Residential Rehab
Mark Willenbring, MD

Founder and CEO, Alltyr Clinic, St. Paul, MN, Former Director, Division of Treatment and Recovery Research, National Institute on Alcohol Abuse and Alcoholism, Bethesda, MD

Dr. Willenbring has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CATR: Many clinicians don't really understand what goes on in residential rehab, or even if it works. What goes on in rehab?

Dr. Willenbring: Rehabs vary, but they generally consist of highly structured environments where patients receive lectures and group counseling. There are many lectures on disease concepts and AA principles. A patient might meet with a counselor individually for a half hour a week. There are many videos added to fill up the time.

CATR: What sort of counseling is offered?

Dr. Willenbring: Unfortunately, it is usually not truly therapy in the way we would usually define therapy. The group counseling sessions are run more like classes. The skill level of the average counselor is very low. In 13 states you don't need a high school education or even a GED to be an addiction counselor. Many states have requirements that you have to have two years of recovery in AA to be an addiction counselor. There is a 50 percent turnover in counselors per year across the industry. They are paid an average of about $18,000 a year.

CATR: Do the counselors use any particular therapeutic techniques?

Dr. Willenbring: In most cases they do not, and even when counselors are trained

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The Vast Landscape of Services that is "Rehab"
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10% of people receiving specialized addiction services go to residential rehab.

In this article, my goal is to help you understand the different levels of care that might be included under the rehab umbrella, so that you can get your patient the most appropriate care.

Before Rehab

Treatment of addiction should begin well before rehab, and here are the commonly used options.

12-Step programs. AA or other 12-step Programs are non-professional groups provided for free in the community. These aren't considered treatments *per se* since they don't involve licensed counselors providing care to patients. But in the real world, many clinicians will view a referral to AA meetings as a convenient first step. How well AA "works" is a source of enduring debate. I often tell my patients that "it only 'works' if you work it—recovery is not a spectator sport." AA is free and it provides your patient ongoing peer support from people who have achieved long-term recovery. In my opinion, everybody should at least give a 12-step program a try, because you never know who's going to click with one.

Individual treatment. Many clinicians will start treating their addicted patients themselves. This is entirely appropriate, especially for motivated patients who are not using substances dangerously. Individual treatment can range from primary care doctors simply advising patients to cut down, to psychiatrists prescribing medications such as naltrexone or Antabuse, to therapists engaging patients in motivational interviewing or other therapeutic techniques.

Referral to a specialist. You've tried your best, but your patient is still using. It's time to refer to a specialist. One of the key skills of addiction specialists is that they often understand *what's missing* in recovery. For example, patients may not understand how best to use 12-step programs, and they may need guidance in how to choose the best meetings to attend. Or, they may need someone who can understand their comorbid psychiatric issues through the specific lens of addiction.

Who should you refer to? There are many therapists with an interest or certification in addictions. The most well-known national certification is through NAADAC, the Association for Addiction Professionals (formerly called the National Association for Alcoholism and Drug Abuse Counselors). In terms of MDs, there are two addiction specialties—addiction medicine, open to all specialties, and addiction psychiatry, open only to psychiatrists.

Another type of specialist is an interventionist, who is an addiction professional who specializes in orchestrating the sometimes dramatic interventions that have become popular fodder for reality TV shows. Usually it is the emotionally exhausted family that seeks this kind of help. An interventionist generally offers three services: planning and executing the intervention, finding an appropriate treatment program for the patient, and providing "recovery coaching" after treatment, often for a year or more. There's usually a fee for each service, and insurance rarely if ever pays for this.

A great resource for locating specialists in your area is the SAMHSA treatment locator (https://findtreatment.samhsa.gov/). Just type in your Zip code and you'll get a list of nearby facilities.

Levels of Rehab

Patients who have tried AA and individual treatment, but who continue to endanger themselves because of their substance use, will need some type of rehab. Here's how the rehab landscape breaks down, with tips on who should be referred where.

Detox. Detox is the process of quickly getting your patient off drugs or alcohol. It's often a prelude to rehab since it's hard to make any headway in recovery while someone is actually using. While detox can be either outpatient or inpatient, inpatient treatment is best for those withdrawing from substantial daily alcohol use (such as a pint of hard liquor or 12-24 beers per day), and for those with medical problems. Inpatient rehabs usually lasts 3-5 days for alcohol and benzodiazepines and 5-7 days for opiates. How do you get patients into detox? If you know about some specific detox facilities in your area, the best route is to call them. Some centers will do their own screening, whereas others will require that your patient go first to an ER before referral. Obviously, most patients would prefer to bypass the ER if they could. Another option is to start by calling the insurance company, which may have specific

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EDITORIAL INFORMATION

Editor-in-Chief & Publisher: **Daniel Carlat, MD**

Deputy Editor: **Talia Puzantian, PharmD, BCPP** is a clinical psychopharmacology consultant in private practice in Los Angeles, CA

Executive Editor: **Matt Phillion**

Founding Editor: **David A. Frenz, MD,** is medical director of addiction medicine at HealthEast Care System in St. Paul, MN.

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Steve Balt, MD, ABAM, is a psychiatrist in private practice and addiction psychiatry in the San Francisco Bay area.

Gantt P. Galloway, PharmD, is a senior scientist at the California Pacific Medical Center Research Institute in San Francisco, CA and executive and research director of New Leaf Treatment Center in Lafayette, CA.

Amy R. Krentzman, MSW, PhD, is an assistant professor at the University of Minnesota School of Social Work in St. Paul, MN.

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The Vast Landscape of Services that is "Rehab"
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hoops to jump through before it will authorize treatment.

Intensive Outpatient Treatment (IOP). IOP is usually 9 hours per week of outpatient treatment, divided into three 3-hour sessions. These are generally group therapy sessions that offer rehabilitative counseling and educational classes. These programs are offered in either day or evening formats. IOP is best for people who are struggling with sobriety after detox, and who have a job or family obligation that prevents more time-intensive treatment. In some cases, the person may have limited insurance benefits that only cover IOP.

Partial Hospitalization Programs (PHP). Also known as "day treatment," PHPs are usually 5 days a week, 6 hours per day, and last 10–15 days. These programs are much more comprehensive than IOPs. They tend to have more sophisticated therapy groups, such as dialectic behavior therapy, cognitive behavior therapy, and family therapy, and psychopharmacologists are available every day. In my experience, insurance companies will approve PHP primarily for patients with comorbid psychiatric disorders.

Residential Rehab. These are 30-day programs, and they vary widely in cost, philosophy, and personnel (see accompanying book review of *Inside Rehab* on p. 8). Residential rehabs are for patients who have a toxic or unsupportive home environment—they may live alone, or they may have family members who are actively using. They are also appropriate for those who have had repeated relapses at a lower level of care. The classic rehab is a very pricy, for-profit company providing a luxurious environment where payment is due up front. These can run $55,000 a month or more. A less expensive type of residential rehab is the 12-step immersion programs, which clock in at around $10,000/month. These less expensive facilities can actually be fairly luxurious (think big lodges and beautiful farms); they are cheaper because they are run primarily by people in recovery and by addiction counselors without advanced degrees. The programming in 12-step immersion is limited to AA—the minute you walk in you will be doing AA steps. Finally, there are some bare-bones residential rehabs covered by Medicaid. And for some patients, being in a less ritzy setting can serve as a motivator to avoid future rehab stints.

Long-Term Residential (also known as therapeutic communities or recovery houses). These programs last 6-12 months and are for people who relapse so frequently that they really need to be away from their community and spend time in a very structured environment. They learn to incorporate recovery skills in their lives and gain the self-esteem and confidence needed to create a network of people to whom they can reach out when they're stressed. Some long-term residential programs are called "working houses" because they have a return-to-work requirement after 1-2 months.

Sober Houses (also known as halfway houses). A sober house is an

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Flavors of Rehab: What Are the Options?

Format	Description	Duration	Staffing/programming
Detox	Get patients off substances	3–5 days for alcohol, 5–7 days for opiates	Hospital setting with counselors, nurses, physicians
Intensive Outpatient Treatment	Outpatient treatment that can accommodate job and family obligations	4–8 weeks total, often 9 hours per week, spread out over 3 days	Office setting with substance abuse counselors
Partial Hospitalization Program	"Full-time" outpatient treatment	2–3 weeks, 5 days per week, 6 hours per day	Hospital setting with counselors, nurses, psychopharmacologists
Residential Rehab	For those with toxic home environments and who have consistently failed outpatient treatment	30 days, residential	Primarily group treatments with counselors in recovery; most are based on AA model
Long Term Residential (a.k.a. therapeutic communities and recovery houses)	Patients who relapse frequently and need long-term structure	6–12 months, residential	Similar staffing and programming as 30-day rehab
Sober Houses (a.k.a. halfway houses)	Independent living arrangement with minimal staffing	1–2 years, residential	Residents expected to attend many community 12-step meetings; weekly urine drug testing
Holding Beds (a.k.a. transitional stabilization units)	Bare-bones residential facility while waiting for rehab placement	Up to several months	Minimal programming, some counseling and 12-step meetings

Willenbring Interview
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in evidence-based techniques, they don't seem to deploy them. I'll describe a couple of relevant studies that were done as part of the NIDA (National Institute of Drug Abuse) Clinical Trials Network (http://www.drugabuse.gov/about-nida/organization/cctn/ctn/research-studies). The first study tested whether having a one-hour motivational interviewing pre-session prior to starting the treatment program would improve engagement, retention, and outcomes. It turns out that it did increase engagement and retention, which is great, but it didn't change outcomes. Which implies that rehab treatment is not particularly effective—since enhancing retention with the treatment program does not seem to improve the chances of response. But the more interesting study was a follow-up study done by one of the investigators, Kathleen Carroll, at Yale. In this study, they made many audiotape recordings of counseling sessions during rehab. They looked at motivational interviewing, 12-step facilitation, cognitive behavioral therapy, and others. The counselors knew they were being recorded, so presumably they were motivated to do their best. The researchers used a coding system to determine whether the techniques were actually being used. It turns out that almost none of the therapeutic time involved any of these techniques. Almost all of the sessions were taken up with what the researcher called "chat," much of which ended up being about the counselor. Another recent study asked the clients about their views of therapy in rehab, and the percentage of time that the clients felt they were receiving unwanted self-disclosure from the counselor was extremely high. Clients were hearing about things like how the counselor's dog had to go to the hospital last night, but were not doing much CBT about their substance abuse issues.

CATR: So true evidence-based counseling is not being done much. But I could imagine that the entire package of programming might be helpful, particularly since it is happening 24/7. What sort of empirical research has been done on how effective rehab treatment is?

Dr. Willenbring: We've known for a long time that there is no outcome advantage between, say, 30-day residential treatment, a 4-6 week intensive multimodal IOP, and 12 weekly sessions with a therapist. In 1977, Griffith Edwards did the first study of this in England. These were alcohol-dependent patients, and they were randomly assigned to two groups. One group got a research-style evaluation, really comprehensive and then they just got advice. And that was it. They got no more treatment except for whatever effects there might have been due to follow-up visits with research personnel. The other group got a variety of treatments depending on their needs. Some got residential and some got intensive outpatient treatment. The one-year outcomes for both groups in terms of recovery rates were identical. There was no evidence whatsoever that residential or even IOP treatment confers any outcome advantage, compared to simple advice (Edward G, *J Stud Alcohol* 1977;38(5):1004–1031). More recently, a literature review of a dozen studies published between 1995 and 2012 found no difference in outcome between IOPs and residential programs—both settings led to comparable decreases in substance use. Obviously, IOPs are quite a bit cheaper than residential rehab (McCarty D et al, *Psychiar Serv* 2014;65(6):718–726.)

"The common view of rehab, and certainly one that is marketed by the high-end programs, is that you go to rehab, and the clouds part and the light shines through and the angels sing, and you have this wonderful transformative experience and you never use again. And that is an extraordinarily rare outcome. It is the wrong treatment for the disease that they are treating."

Mark Willenbring, MD

CATR: Aren't you being a little hard on rehab? It seems to me that one thing we can say about rehab is that if somebody is using substances to the extent that they are about to wipe out their savings, destroy relationships, and destroy their lives, at least let's put them somewhere they can be observed all the time so we can prevent further damage. Isn't that a reasonable idea?

Dr. Willenbring: If it could be shown to work, then it would certainly be reasonable. To your point, there's no question that some people need a high degree of structured supportive housing and they may need it for a long time or a short time. But the current treatment system is built around an antiquated notion that there is something magical about a 30-day rehab. The common view of rehab, and certainly one that is marketed by the high-end programs, is that you go to rehab, and the clouds part and the light shines through and the angels sing, and you have this wonderful transformative experience and you never use again. And that is an extraordinarily rare outcome. It is the wrong treatment for the disease that they are treating. What works best is separating the need for structured sober housing and for treatment, then individualizing each need. There is no evidence that intensity of counseling improves outcomes. What matters is the length of engagement. It is like when we used to send TB (tuberculosis) patients to sanatoriums and we put them on big sleeping porches at night so they could get fresh air and then in the daytime we'd park them in the sun. One reason we did this was that there were no other treatments for TB other fresh air and sunshine. Most rehabs are relics of the days when we had no specific treatments for substance abusers. But in fact, we have multiple effective medications and evidence-based therapies—which are not offered in most residential or outpatient rehabs.

CATR: What would be reasonable, in your view, for the average psychiatrist or other clinician dealing with a very sick addicted individual? You are saying residential rehab is essentially worthless—what's the alternative?

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The Vast Landscape of Services that is "Rehab"
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independent living arrangement with minor oversight, and residents can stay for 1–2 years. Most have one full-time staff member who runs the office or a house manager but they lack professional counselors or programming. Residents are sometimes told, "Here's your key. You can come and go as you want but everyone here is sober." At other places, there is a curfew or restrictions on weekends away, especially for newcomers to the house. At some houses, individuals may move up along a "levels" system gaining increasing privileges with each level. There are expectations that residents will go to outside 12-step meetings frequently, at least 4 times a week, and that they will have weekly random drug testing. There is sometimes a requirement to find at least part-time work in the community. This is often a good segue from a residential program, because it provides some level of support and teaches people to take more responsibility for their recovery. Some people find that cannot maintain sobriety outside of sober houses.

Holding beds. Sadly, there has long been a shortage of residential beds. Because of this, there are many transitional stabilization units, otherwise known as holding beds. They are usually federally funded, and they provide a bare-bones facility where people wait for residential beds. The usual scenario is a patient who was just detoxed and needs residential treatment to maintain sobriety, but does not have the funds needed for a deluxe rehab. People may stay here for up to a few months as they are wait for placement.

A word on court-mandated treatment

Referring patients to treatment is all well and good, but up to a third of patients in rehab facilities are there by court order, usually involuntarily. As a clinician, you might be involved in the process of forcing a patient into treatment, so it's important to understand the process.

Many, but not all, states have a provision allowing court-mandated treatment. In Massachusetts, the process is called a "section 35," which refers to a particular section of state law. This is used for patients who are out of control with their use but refuse treatment. The family comes to you and explains the ways in which their family member is a risk to themselves or others, such as: "He's falling and hurting himself when he's drunk," "she overdosed on heroin and we barely got her to the ER on time," etc… "What can we do, doctor?"

The procedure is the following. The family has to prepare a case for involuntary commitment. It will be in the form of testimony, but it is often augmented by medical reports, and even photographic evidence (I advise these families keep their cell phones at the ready and to take videos of the intoxicated behavior). A hearing is scheduled, and a judge weighs the evidence, and if he or she agrees that the situation is dire, will issue a writ of apprehension. The police will then go to the person's location and bring him or her in handcuffs to court, where the patient hears the evidence, has a chance to refute it before the judge, and to state whether they will go willingly into treatment. If the person is committed involuntarily he or she will be taken to a state-funded residential rehab facility for up to 90 days. Do such involuntary commitments work? Often not so much. Patients are often released early if they agree to outpatient counseling and AA meetings, but this may be a ruse for getting back to the bottle. Nonetheless, this does give the family some respite, and it creates the chance, no matter how unlikely, that the patient will eventually buy into the need for treatment. Section 35 can be initiated by the family, the police, or any physician. The limiting factor is you have to go to court—something physicians are rarely willing to do.

A final word of advice—I recommend that you put in the effort needed to get to know the treatment centers and providers in your area. Go to a local IOP or PHP and sit in on a staff meeting. The more working relationships you have with addiction professionals, the more efficient you will be at referring your patient to the right treatment at the right place and at the right time.

Willenbring Interview
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Dr. Willenbring: Substance use treatment should be no different from any other specialty of medicine, such as psychiatry or cardiology. Take the treatment of depression as an example. Depressed patients do not automatically get sent to a 30-day depression rehab. Instead, they are evaluated individually and are offered any of a range of evidence-based treatments. Certainly if someone is suicidal they will have to be closely observed, which might be in a partial hospitalization program or hospital. But there's not a one-size-fits-all approach. The trouble with addiction treatment is it is like trying to treat a disorder with only one level of care. It is as if all we had for depression was a partial psychiatric hospital program, time-limited—let's say it's 4–6 weeks, relatively intensive, and there is no outpatient level of care. So the best thing that a psychiatrist could do, certainly for alcohol, would be to go the NIAAA website, where there is a online training for how to treat this disease (http://www.niaaa.nih.gov/guide). There are many people for whom we can prescribe medications, and who have good prognoses with appropriate treatment.

CATR: Thank you Dr. Willenbring

The Substance Abuse Interventionist
Paul Gallant, MC, BRI-II

Founder of Gallant and Associates, and board registered interventionist through the Association of Intervention Specialists.

Mr. Gallant has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CATR: Hi Mr. Gallant. You are an interventionist. What is it, exactly, that you do?

Mr. Gallant: We take a family systems approach to getting people into treatment. So, a typical scenario is that we will get a call from a psychiatrist who says "my client's spouse has approached me," or "the father has approached me regarding this person." We then put together a group of people that care about the identified patient, we help identify a treatment center based on the clinical needs of the patient and the resources available to the family, and we have a pre-intervention meeting followed the next morning usually by the intervention.

CATR: What happens at the "pre-intervention" meeting?

Mr. Gallant: The pre-intervention meeting is the night before the intervention. I ask each person on the team to write a letter describing four things: number one, how much they care about the patient, number two, how concerned they are, with behaviorally specific examples of that, number three, the offer of solution—would you please go to inpatient treatment today. And number four is an "or else," a boundary or an ultimatum if the patient doesn't agree to go into treatment.

CATR: Can you give me an example of the process?

Mr. Gallant: Sure. We did a structured family intervention in Manhattan a couple of weeks ago. There was a mom, a sister, two aunts and uncles and a grandfather. And the client, John, was 22 years old, and had polysubstance abuse disorder—mainly cocaine and marijuana. He also had major depression. He had failed outpatient treatment on a couple of occasions, both with a psychiatrist and in an IOP, and his mom was just fed up with his drug use and fearful about his depression. So we were called in, and I went and met with the whole family.

CATR: Was this the pre-intervention?

Mr. Gallant: Yes. I asked each person on the team to rehearse reading the letter aloud. Each person had written their letter beforehand. Some of the people in the group had emailed me their letter so I had given them some pointers.

CATR: And the next morning you appeared with this group and knocked on John's door?

Mr. Gallant: Yes, we showed up, and his mother woke him up and said, "Good morning John, we're having a family meeting, come on downstairs." He came into the living room and I introduced myself and said "John, your family has asked me here to help them talk with you about a few things." He knew what it was the minute he walked into the room. And he sat down and we went through the letters. We didn't get his agreement just through the letters, and I think the value of my participation in this particular intervention came after the letters when I was able to address his objections. And in 28 years of doing this, I've heard a lot of different objections—I can't go because, or I won't go because. So I was able to address each one of those, answer questions about treatment—this kid was fearful that he was being sent to a locked psychiatric unit, and that was not the case. He was being sent to a very nice treatment center out in Minnesota that has more of a college campus feel—so I was able to describe what the treatment looked like, and after about 20 minutes he was able to accept the help that was being offered. In the case he didn't, his mom was ready to send him out into the world that day.

CATR: So mom was ready to give him an ultimatum?

Mr. Gallant: Yes, he was a failure-to-launch guy, he had been living there through high school and really never had a job—just was on the Internet all night, slept through the daytime, did his drugs, that sort of thing.

CATR: And he went to a 30-day residential program?

Mr. Gallant: Yes, and this was a few days ago.

CATR: Now what's the difference between getting you to do this persuasion vs. someone else? I've certainly talked to parents and have had that kind of discussion—"Look, your kid is abusing substances, is abusing your trust, is mooching off of you and stealing from you—you need to tell him that he needs to get some help or he can't live there anymore."

Mr. Gallant: Often the family doesn't feel like they have the courage to confront the person's illness on their own, so they would look to a professional interventionist for help in that way. The structure that we bring, such as intervention letters, tends to keep the family out of that dance that they've been doing over and over again, where the dad yells and the mom wrings her hands, and they've done it 16 times already, so if they want to have a different dance, we're able to come in and play some different music, allowing people to act in a different way.

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Gallant Interview
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CATR: I'm sure the interventions don't always work so well. Do you have an instructive example of one that didn't?

Mr. Gallant: I have an example of a similar kind of guy in Los Angeles, and the intervention was a failure. The problem was that when we got to the time for boundaries, where this young man was to be told, you know, no more trust fund, no more living in this house—he's living in a beautiful home, couple of expensive cars out in the driveway—the parents collapsed on their boundaries. They wouldn't enforce them. And I was left high and dry, and the kid's smiling at me and the parents are not following the format that we had discussed the night before. They were all on board and that morning they lost their courage. And that was very disappointing for everybody involved.

CATR: One of the things we're exploring this issue of CATR is the value of residential rehab versus outpatient facilities, and as you know there has been a lot of debate about that. As an interventionist, you make referrals to residential treatment, rather than intensive outpatient. Why is that?

Mr. Gallant: Not every call that comes through is appropriate for an intervention. So there are times that I get phone calls from moms that have caught their kids smoking pot and I make a referral to a counselor. But we generally don't get called until somebody is pretty far down the scale. So when looking at whether inpatient is the right setting, I ask "Has this person failed intensive outpatient treatment (IOP)? Have they been treated by a psychiatrist? Have they been in counseling before? I try to assess the setting. Is this person in a supportive setting? or "Is he at college and in a fraternity?" The likelihood that he's going to find abstinence while he lives in a fraternity house is pretty slim. So if the setting is not supportive to recovery I might then say, an inpatient treatment setting would be a better place for this kid to be right now.

CATR: We certainly know that not all inpatient settings are created equal—some of them are more expensive than others, sometimes insurance covers some of it, sometimes it doesn't. Do you help families with these nuts-and-bolts issues?

Mr. Gallant: Part of my job is treatment consulting, and that comes with the intervention. There are times I get calls from people who just want to talk about different treatment centers. Their son or daughter is ready to go to treatment, they just don't know which one to choose. What I'll try to do is gather as much clinical data as I can, which includes interviewing family members. So after collecting data I'll then get an idea of what the resources are. Some families I work with have unlimited resources, so the money part doesn't come in. Others have to go with their insurance—they have little to no money to spend. What I'll do is preview their insurance with some treatment centers I know do a good job with 3rd party payers. Some of the places that I work with are well known to be on different panels, to be providers in network for these people. So I'll do that, and then we give them a couple of different places. I always try to give two or three different options to a family so they can call, they can interview the staff, they can look at the website, even sometimes go and take a tour. It's not unlike putting a kid in college on some occasions.

"Often the family doesn't feel like they have the courage to confront the person's illness on their own, so they would look to a professional interventionist for help in that way. The structure that we bring, such as intervention letters, tends to keep the family out of that dance that they've been doing over and over again."

Paul Gallant, MC, BRI-II

CATR: Does insurance cover any of your services?

Mr. Gallant: Insurance doesn't recognize intervention as of yet. They will sometimes pay some of the bill for family consultation services. People can call me—we work on a sliding scale—so if people are interested in our fee structure they can certainly call us and we can talk about that. I think we're affordable to most families.

CATR: So you do the intervention, you find a place for them to go, they're there. Then what do you do? Do you follow the client's progress?

Mr. Gallant: Yes, we do intensive case management while the patient is in treatment. I do this to hold that treatment center accountable. I get clinical updates daily in the beginning, and then weekly as time goes on. They know that an external clinician is watching over this person, so he or she is less likely to fall through the cracks or get substandard treatment. And of course I am one of their sources of referral, and they know that I will refer another client if things work out well.

CATR: It sounds like you have a great personal relationship with some of these centers so you can have good oversight. But as psychiatrists we have much less experience with these facilities. What can we realistically do to improve the prospects of success for our patients?

Mr. Gallant: Once the proper consents are in place, the referring psychiatrist can talk to the medical director or the attending psychiatrist. The good treatment centers are going to recognize the importance of the patients' relationship with their psychiatrist back home. So if somebody comes in and they're on Cymbalta and Abilify, and it's been successful in controlling a kid's

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Book Review: *Inside Rehab*—What Really Goes On in Rehab Facilities?

Daniel Carlat, MD
Editor-in-Chief and Publisher of the Carlat Addiction Treatment Report

What goes on inside a residential rehab program? Inquiring minds would love to know, especially those of us who are treating addicts and counseling concerned family members. Rehab has traditionally been a kind of black box, an opaque entity where addicts enter, and 30 days later exit with an epiphany and a lifelong commitment to sobriety. Until they relapse and go back to another rehab, that is.

Anne Fletcher, who is both a science writer and addiction counselor, has written a book that finally peels back the layers of mystery surrounding rehab. Those of you who are long-time Carlat Report groupies will remember an issue I wrote years ago in which I reviewed self-help books for patients (*TCPR*, December 2005). Fletcher's first book about addiction, *Sober for Good*, won my top prize in the substance abuse category. She brings the same intelligence and perspective to her new project, *Inside Rehab*.

Residential rehabs have been increasingly criticized for outdated treatment methods, exorbitant prices, and a tendency for graduates to relapse over and over. In order to provide a realistic picture of what people experience in rehab, Fletcher received permission to visit 15 residential rehabs of various types and sizes in different parts of the country. She sat in on sessions, interviewed patients and staff, gave questionnaires to administrators and counselors, and thoroughly reviewed the scientific literature on the efficacy of these programs.

Here are some major take-home lessons that clinicians might find useful.

1. A day in the life of rehab: Groups, groups, and more groups.

An eye-opening discovery is that regardless of the cost or exclusivity of rehabs, the "treatment" provided amounts to little more than an endless series of group activities, usually managed by counselors without advanced clinical degrees.

Here is a typical day in a residential rehab, according to interviews with patients and staff. The day begins early, around 6 a.m., with chores, breakfast, then a large lecture at 8 a.m., which commonly covers one of the 12 steps of AA. At 9 a.m., there's a "process group," covering topics such as 12 steps; how to cope with substance abuse triggers; and relationship problems. After short break, there's a mid-morning group, followed by treatment work time. "Treatment work" consists of written assignments that are often workbooks or worksheets on 12 steps or on skills that will help people stay sober. One example is a goodbye letter to the drug of choice. After lunch there are two more groups, followed by free time. After dinner? Yep, more groups—usually two process groups and a group lecture.

If you're keeping track, a typical rehab day consists of about 8 hours of group activities. There's not much individual counseling—even at the highest-end rehabs, there is typically no more than 5 hours of one-on-one work per week. Clearly, group therapy can be valuable in a variety of ways—patients can learn from one another, and simply sharing one's personal struggles in a group format can be powerfully validating. However, one gets the sense that rehabs are over-relying on groups as a cost-effective way of filling time. In addition, Fletcher interviews some patients who found the group emphasis off-putting and who felt uncomfortable with self-revelation in a group context.

2. Individualized assessment, but one-size-fits-all treatment.

A corollary of the reliance on group activities is that treatment tends to be a one-size-fits-all affair. Fletcher found that while the initial assessment of a patient by rehab staff was quite comprehensive, that comprehensive assessment does not necessarily lead to a treatment plan tailored to that patient. Patients, regardless of circumstances and comorbidities, tend to be offered the same treatments as everyone else—mostly based on the 12-step philosophy. Even when patients relapsed, they tended to be offered the same programming over and over, rather than new approaches that might be more beneficial.

3. The cost of rehab.

Rehabs vary widely in cost. Contrary to popular belief, the majority of rehabs depend on public insurance, such as Medicare and Medicaid, and lower-end rehabs might charge as little as $10,000/month. Private for-profit rehabs are in the minority, and their average cost is around $30,000 for a month—though it can go up to $100,000/month for celebrity-caliber rehabs in places like Malibu. While $30,000 may not sound like an enormous sum for a month of treatment, Fletcher talked to one psychiatrist who pointed out that if you were to pay an addiction psychiatrist $300/hour, you could see him or her 25 hours/week for an entire month for the same amount of money—but insurance would never cover it.

Fletcher's book ends with a useful consumer checklist for evaluating whether a rehab is right for them or for their family. It includes questions about the program's philosophy, the credentials of staff, policies on use of medications, and others.

Along the way, she interviews national experts about the problems with the current system and how it can be improved. One of the most disheartening quotes was from Tom McLellan, former deputy director of the Office of National Drug Control Policy under the Obama administration, who says, "There are exceptions, but of the many thousands of treatment programs out there, most use exactly the same kind of treatment you would have received in 1950, not modern scientific approaches."

Let's hope things improve.

Inside Rehab: The Surprising Truth About Addiction Treatment—And How to Get Help That Works was published by Viking in 2013 and came out in paperback by Penguin Books in 2014.

Marijuana in 2015: What Should We Say to Our Patients?

Kevin P. Hill, MD, MHS
Director, Substance Abuse Consultation Service, Division of Alcohol and Drug Abuse, McLean Hospital, and Assistant Professor of Psychiatry, Harvard Medical School

Dr. Hill conducts clinical research on marijuana funded by NIDA and the Brain and Behavior Research Foundation. He is the author of *Marijuana: The Unbiased Truth About the World's Most Popular Weed* (Hazelden).

How should we talk about marijuana with our patients? For psychiatrists, the topic usually arises with respect to two key areas:

1) the potential adverse effects of marijuana use, especially upon those with other psychiatric disorders and our youth, and
2) the question of the legitimate medical benefit of medical marijuana for particular medical and psychiatric conditions (Hill KP, *J Psychiatric Practice* 2014;20(5):389–391).

In both of these areas, it might seem easy to deliver a harsh anti-marijuana message, emphasizing the harms of marijuana use and the notion that medical marijuana is not supported by scientific evidence. However, an evidence-based perspective is closer to a middle ground than either of the extreme views, and being a "moderate" on these issues will give you greater credibility in the eyes of patients.

Adverse Effects

Acute effects of getting high

The adverse effects of marijuana use are well-documented (Volkow ND et al, *N Engl J Med* 2014;370(23):2219–2227). The immediate effects of getting high are not particularly controversial. They include impaired judgment and short-term memory, as well as impaired driving. Patients often ask about the difference between alcohol and marijuana's effects on driving. The evidence shows that both marijuana and alcohol can impair driving, but in different ways. Drunk driving is associated with careless mistakes, or "errors of omission"—driving too fast while not checking your mirrors, for example, where driving under the influence of marijuana may lead to "errors of commission"—being overly cautious but driving 30 miles per hour in a 55 miles-per-hour zone, for example (Sewell RA et al. *Am J Addict* 2009;18(3):185-193).

The bottom line is that getting high causes acute cognitive impairment and is not compatible with doing well at many of life's important tasks, such as work, studying, and driving. Given that many psychiatric patients are already struggling with such tasks, it is useful to consider the degree to which marijuana may be hampering these tasks—this is one way to use motivational interviewing techniques to broach the topic of reducing or stopping recreational marijuana use.

Chronic effects: Low IQ and psychosis

What about the effects of long-term, chronic use of marijuana? My biggest concern is that chronic use can affect young people, whose brains are still developing. The most publicized study about long-term effects was the Meier et al (2012) study. This study reported that early (teen) and regular use of marijuana is associated with up to an 8-point decline in IQ (Meier MH et al, *Proc Natl Acad Sci USA* 2012;109(40):642–649). Subsequently, a paper was published in the same journal that questioned the causal inferences made by Meier's group, so more research is needed (Rogerberg O, *Proc Natl Acad Sci USA* 2013;110(11):4251–4254). (Editor's Note: For further reading, see the attached *Washington Post* article: http://www.washingtonpost.com/news/wonkblog/wp/2014/10/22/no-marijuana-use-doesnt-lower-your-iq/).

My take on the studies thus far is that long-term regular use is almost certainly a cause of long-term decrease in intelligence. I tell my younger patients that if they are smoking daily they are likely to be permanently sabotaging themselves. There are better ways to deal with life's stresses, and both therapy and medications can help without causing what is essentially brain damage.

Another potential effect of early and regular marijuana use is increased likelihood for developing psychosis. For example, DiForti et al (2015) showed that young regular users of high-THC marijuana in the UK (average THC content in the United States) were five times more likely than others to develop a psychotic disorder (Di Forti M et al, *The Lancet Psychiatry* 2015;2:233–238). While such retrospective studies do not imply causality, the evidence is concerning and is another reason to steer psychiatric patients away from frequent pot use.

Does marijuana use interfere with psychiatric treatment?

We are reasonably concerned that marijuana use will adversely affect how our patients respond to medications or psychotherapy aimed at treatment of other psychiatric disorders. It's quite clear that the drug can worsen depression and anxiety (Crippa JA et al, *Hum Psychopharmacol* 2009; 24(7):515–523, and Degenhardt L et al, *Addiction* 2003;98(11):1493–1504). The effect on anxiety is especially difficult for patients to grasp because marijuana users often feel less anxious immediately after using. When the effects of marijuana wear off, however, there is a "rebound" phenomenon whereby the patient's baseline level of anxiety actually increases.

What about marijuana's effects on treatment outcome? There's not too much research to guide us here. We published one study examining whether pot use adversely affected treatment outcome in adolescents with opioid use disorder (Hill KP et al, *Drug Alcohol Depend* 2013;132(1–2):342–345). In a secondary data analysis of 152

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Gallant Interview
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depression, but the kid's been using cocaine and marijuana, the psychiatrist at the treatment center should not take this person off of those meds. Good coordination between the home psychiatrist and the psychiatrist at the treatment center is really important.

CATR: What about after your client leaves rehab? Do you maintain your involvement?

Mr. Gallant: Yes—some call this "recovery coaching" or "recovery mentoring." We call it intensive case management. It's the post-treatment support that's given to a patient after they discharge. It's really all about structure and accountability. Treatment centers do their best when it comes to continuing care planning, but oftentimes the treatment center will be in Arizona and the patient lives in Boston, so what we do is we help coordinate the continuing care plan, and then we help make sure that it is followed through.

CATR: How do you do that?

Mr. Gallant: In many ways. We make sure folks are getting to their meetings, and we sometimes actually go and take them by the hand, bring them to 12-step meetings, bring them to IOP sessions. We're available 24/7 so if someone is having cravings at 11 o'clock at night, they can pick up the phone and call one of our case managers. At a more basic level we closely monitor sobriety by doing random alcohol testing with a device called Soberlink, which is a facial recognition device for at-home testing. You program this ahead of time, such as for three times a day, or once a day randomly, and they'll be signaled by the device to blow into the unit. It captures their image and the blood alcohol content, and it sends that information to us in real time.

CATR: What kind of prognostic signs tell you if a particular person is going to do well with treatment over the long term?

Mr. Gallant: Well certainly if a person is ready and willing to go into treatment, that's helpful. But I honestly cannot tell you ahead of time if a person is going to do well or not. I stopped betting on people years ago. I cannot find a socioeconomic or educational factor that will show me he or she is going to make it. The greatest indicator of a successful outcome comes after rehab, and that is willingness to follow continuing care planning. So if a person is compliant with medication they've been given, with their appointments with their psychiatrist, with their attendance in 12-step meetings and IOP—if they're doing everything on their treatment plan, there's a high likelihood of success. What happens is when people become noncompliant, and start missing those appointments—that's when we see relapse.

CATR: Thank you, Mr. Gallant.

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opioid-dependent youth ages 15–21 on buprenorphine, we found that both past marijuana use and current marijuana use had no effect upon opioid use in the sample. While the evidence is mixed on the issue of whether marijuana affects treatment outcome, most papers found results similar to ours. In general, I tell patients that marijuana is likely to worsen depression and anxiety, but I don't withhold medication treatment from such patients because there just isn't enough evidence that the drug actively interferes with such treatment.

Medical Marijuana

As the debate over the utility of marijuana for a host of medical conditions continues, patients wonder if medical marijuana might help them. Some patients may not ask about it and just announce that they have obtained a medical marijuana card and are using it for self-treatment. Here's how I approach this difficult but increasingly common situation.

First, I make sure my patients understand the evidence for medical marijuana's efficacy. There are only two FDA indications for cannabinoids, which are nausea and vomiting associated with chemotherapy and appetite stimulation in certain wasting illnesses like HIV. There is also strong evidence that marijuana helps chronic pain, neuropathic pain, and muscle spasticity associated with multiple sclerosis (Hill KP, *JAMA* 2015;313(24):2474–2483). Beyond these indications, though, the evidence is either negative or lacking.

In my experience, patients will say that medical marijuana essentially treats whatever ails them, from PTSD to anger issues to aches and pains of all varieties. I tell them that the evidence is just not there and that they may well be doing themselves more harm than good. I emphasize that even for the short list of conditions for which there is some evidence, marijuana is never considered the first-line treatment.

To sum up, while there are some legitimate medical uses for marijuana, most psychiatric patients are going to experience more harm than benefit. Take each case individually, but don't hesitate to lay out the evidence, and to educate your patients even if they might be dismayed. In the long run, they'll be grateful.

CE/CME Post-Test

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Below are the questions for this month's CE/CME post-test. This page is intended as a study guide. Please complete the test online at www.carlataddictiontreatment.com. Note: Learning objectives are listed on p. 1.

1. A typical outpatient intensive program (IOP) for substance abuse involves the following:
   [ ] a) Three hours per week of intensive individual therapy with a certified addiction counselor
   [ ] b) Nine hours per week of outpatient group treatment, lasting 4-8 weeks
   [ ] c) Five days per week of outpatient group and individual treatment
   [ ] d) Outpatient detox followed by weekly sessions with a psychopharmacologist

2. Typical inpatient detox for alcohol lasts __________.
   [ ] a) 24 hours [ ] b) 1-3 days [ ] c) 3-5 days [ ] d) 1-2 weeks

3. True or false: The majority of counselors in residential rehabs are Master's Level clinicians.
   [ ] True [ ] False

4. A study of therapists using evidence-based therapy techniques with patients in rehab found that:
   [ ] a) Therapists were more competent at motivational interviewing than cognitive behavior therapy
   [ ] b) Therapists did not understand the elements of dialectic behavior therapy
   [ ] c) Supportive therapy was the most effective treatment
   [ ] d) Much of the therapy time was taken up with "chat"

5. According to Anne Fletcher's *Inside Rehab*, a typical day of rehab includes how many hours of group work?
   [ ] a) 4 [ ] b) 6 [ ] c) 8 [ ] d) 10

6. The majority of rehabs depend on:
   [ ] a) public funding
   [ ] b) private donations
   [ ] c) fees paid by patients
   [ ] d) insurance payments

7. At a pre-intervention meeting, team members are asked to write a letter to the client describing how much they care, how concerned they are, specific behaviors illustrating their concern and:
   [ ] a) a recommended solution for the patient
   [ ] b) an expression of anger and resentment
   [ ] c) an ultimatum if the patient doesn't enter rehab
   [ ] d) their vision for the patient's future

8. A 2015 study showed that young regular users of high-THC marijuana in the UK (average THC content in the United States) were how much more likely than others to develop a psychotic disorder?
   [ ] a) Twice as likely
   [ ] b) Five times as likely
   [ ] c) Ten times as likely
   [ ] d) Equally likely

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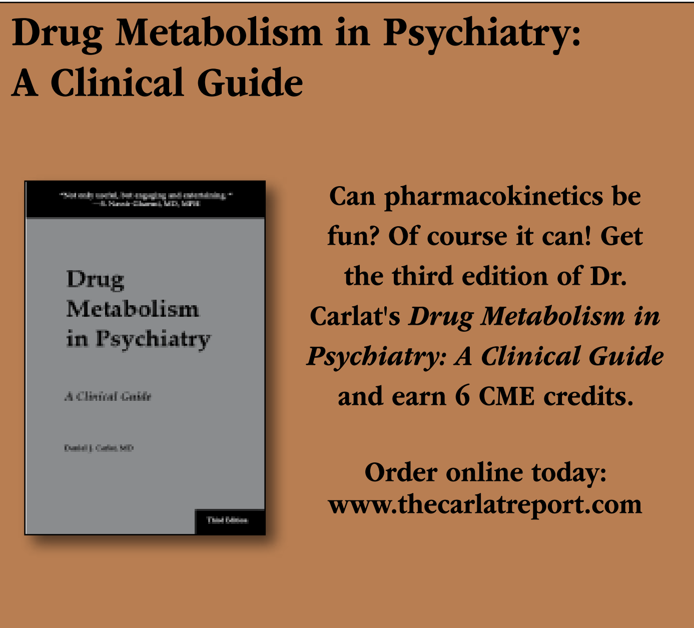

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