"Buyer Beware": Deceptive and Unneeded Treatment

- **Treatment Admissions Practices and Costs of Residential Treatment for Opioid Use Disorders[1]**

FROM THE RESEARCH CENTER AT HARVARD (

Goal: Provide data driven information on What Works for Recovery,
(*versus following unproven, out of date advice that too often leads to relapse).*

From **Harvard's Recovery Research Institute (RRI)** (RecoveryAnswers.org).

Research Data on In-Patient Treatment for Opioids

A new report from RRI on In-Patient Opioid Treatment

For family members and users seeking help, the bottom line:

- In-patient treatment does not reduce the risk of overdose
- But continuous use of Methadone or Buprenorphine for at least six months cuts the risk of overdose in half.

Take Away: In patient and out-patient are both just as effective for treating opioid addiction. The key is continuous use of an opioid substitute, usually in combination with an active recovery program.

The lead off to the title of the article is **Buyer Beware**. A survey of nearly 300 treatment centers found:

- Many admission practices are both deceptive and fail to follow ASAM practice standards, leading to unnecessary (and costly) in-patient admissions.

While only a minority of treatment centers engage in questionable admission practices, the number is large enough to warrant educating consumers about these tactics when seeking help

Alternative Model: Detox, Out-Patient, Long-Term Recovery Management

Many parents exhaust their resources on in-patient, believing it will be successful, only to realize later that it would have been better to pay for an effective post-treatment recovery management program. *This report provides further support for redirecting family attention from in-patient treatment to a combination of detox/out-patient, medication and recovery plan oversight as a successful model for recovery from opioid dependence (as well as other substances).*

1. Residential (Inpatient) Treatment DOES NOT Reduce Risk of Overdose

> *When examining first treatment received after an opioid use disorder diagnosis, receipt of agonist medications such as buprenorphine for 6 or more months is associated with reduced overdoes risk, but residential treatment is not associated with this reduced overdose risk[2]*

Note that only a minority of treatment centers in the survey offered agonist medications (Methadone and Buprenorphine), so ask whether these medications are available when talking to in-take personnel at a treatment center.

Treatment in the Report Refers to In-Patient, not Short-Term Detox.

Treatment, as used in the report refers to traditional in-patient, not to a short stay in a detox center.

In my view, in-patient/hospitalization is good for detoxing from opioids, with successful recovery then dependent on taking opioid substitute medications for at least six months. Outcomes improve if users are also involved in a supervised active recovery management program, in addition to taking medication.

- But the bottom line here is that in-patient treatment does not improve outcomes for opioid users unless combined with on-going medication for six plus months.

Unfortunately, many parents are very aware of this fact after paying for multiple treatments and enduring relapses when there was ineffective follow up to assure medication compliance. While the report uses the phrase, *six plus months,* our experience supports monitoring and oversight for at least three years.

2. The Substantial Majority of Opioid Users do not Receive or Require Residential Treatment.

> *…the substantial majority of people who resolve a substance use problem do not receive, nor require, residential treatment - which can be both costly and may unnecessarily remove people from their homes and work situations. Many respond well to less expensive outpatient level care….*

The key piece here is to understand that when seeking help, families often are directed to in-patient treatment as the first option, rather than seeking community resources. The study points to out-patient as an equally viable treatment alternative, assuming detox is successfully managed.

Finding effective, competent community-based help can be a challenge. One excellent resource is ASAM – the American Society of Addiction Medicine website – to find a qualified practitioner in your area. Because prescribing the correct substitute medication and managing medication use over time is proven to be successful in improving outcomes, why not start with a knowledgeable, trained professional?

3. Over the Phone Admissions w/o Screening or Intake Evaluation

Screening and evaluations are standard practices to make sure in-patient is necessary and the patient's needs can be met by the treatment center. ASAM has established placement criteria that indicates whether or not a substance abuser needs in-patient or out-patient treatment. (*For more on the ASAM criteria See my blog: Looking for Help - Who do you believe?)* But many centers do not follow ASAM placement guidelines.

- 42% of for-profits and 20% of non-profits did not screen or perform an intake evaluation.

As the consumer, avoid these treatment centers at all costs. Their selling point is immediate admission, no questions asked. But an unscreened patient population is a big unknown. And if there are no evaluations, how does the center even know what kind of treatment is appropriate for each patient? This is not "best practices", it is "worst practices".

4. **Families Seek Residential Treatment on Their Own**

Despite the failure of in-patient to be successful in reducing relapses, families still spend a lot of time seeking in-patient treatment for their loved ones without through going through their health care providers or addiction counselors in their community.

The report states:

…many desperate families and individuals seek residential treatment on their own.[3]

Families often turn to the internet looking for help only to find treatment centers paying to promote their services, often with multiple websites. Shows like intervention also create the impression that in-patient is the only option for families, who are usually in crisis, looking for an immediate solution, and are vulnerable to patient recruitment techniques.

Perhaps, the self-help approach reflects a desire for privacy or fear that disclosing an addiction concern to a health care provider may lead to increased rates. Or families may not know that out-patient when combined with medication is an equally effective alternative model.

Practice Pointer: Your LO may be reluctant to go in-patient. Offer the option of going to an ASAM addiction medicine specialist – a doctor – and emphasize seeing the doctor as an alternative to traditional treatment.

5. Patient Recruitment Techniques

These are practices designed to encourage a caller to sign up for in-patient care during the call.

<u>Immediate Admission versus Waiting a Week or More</u>

- For-Profits: 79% offered same day admission versus a 7 day wait for a bed.
- Non-Profits: 36% offered same day admission versus waiting 23 days.

This is the "Buy now or lose your Spot" psychological pressure tactic.

<u>Other Recruitment Techniques</u>

- Promoting luxury amenities
- Justifying cost based on quality
- Offering transportation assistance
- Offering to talk to family members
- Urging use of credit cards for payment

A tactic not mentioned is when treatment centers refer callers to interventionists who then use pressure tactics to get the families to sign up for services. Some interventionists are said to overstate recovery rates and engender fear by telling callers their loved ones could easily die unless families sign up for an intervention

Practice Point If you are feeling pressured by these or other techniques, a good out is to say you have to talk to other family members or your "advisor" before making a decision. Get out of the emotional pressure cooker and contact your health care provider for a counselling referral.

Conclusion:

This RRI Report reflect the tension between a prevailing in-patient treatment model versus the rising model of long-term, supervised recovery management in the community over many months, if not years. Critics of the in-patient model have long been concerned about these programs focusing on profits rather than quality of care. As the report states:

> *While these findings concern a minority of (largely for-profit) treatment programs across the country, they nevertheless raise questions about <u>the potential exploitation of a clinically and financially vulnerable population.</u>*
> *In turn such abuses point to ways that some programs are incentivized to prioritize profits over best-practices and high-quality clinical care.*[4]

One purpose of this blog is to alert consumers to practices they may encounter when seeking help and also become educated on research said to improve outcomes for opioid abusers.

About The Recovery Research Institute (RRI) out of Harvard publishes a monthly newsletter reviewing research on effective approaches in treating substance use disorders.

- *RRI has really good information that often contradicts or significantly modifies current recommendations from treatment centers, professionals and amateurs offering advice as "interventionists"*

RRI is a non-profit. I hope readers who find their research beneficial will consider donating to RRI. See RecoveryResearch.org. There is an incredible amount of misinformation about addiction and recovery that is downright dangerous, given the lethal nature of SUDs. Time to turn to rely on science from **reliable institutions.**
<u>The advent of academic research from respected universities is a welcome and much needed addition to the field.</u>

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[1] June 2021 Newsletter
[2] p.2
[3] p. 3
[4] p. 8

