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In This Issue...

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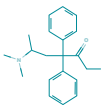

OPIOID TREATMENT PROGRAMS

Counselors approve of easy access to methadone treatment: Study

A study of counselor attitudes about an "open-access" methadone program they worked in found that patients and counselors benefit from same-day access and making treatment more individualized to patient needs. However, downsides were that for clinicians, some patients needed extra care and sometimes intensive interventions, making workload unpredictable, and the increased census resulted in some "chaos" in the building.

For the study published in the January issue of the *Journal of Substance Abuse Treatment*, 31 addiction treatment counselors employed at the APT Foundation, an open-access model for methadone maintenance based in New Haven, Connecticut, were asked about their perceptions of this model. Counselors described the benefits: "fewer demands" on clinicians, "individualized" treatment for patients and "crime reduced" for the community. They also described disadvantages, which clearly go along with the advantages: "uneven

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Bottom Line...

An "open-access" model of methadone treatment, in which ability to pay was not a barrier and individual counselor assignments were changed to walk-in groups, was largely favored by counselors.

Long-term study alters assumptions about what drives excessive drinking

Data from participants in the multi-year Chicago Social Drinking Project is helping the research community challenge long-held notions about the factors that make drinkers more susceptible to an alcohol use disorder (AUD), as well as what occurs after individuals' drinking has escalated to problematic levels.

Contrary to conventional wisdom that AUD risk is tied largely to not experiencing alcohol's reinforcing effects and thus needing more alcohol to reach that point, the latest results from the Chicago study suggest it's actually the rewarding effects of alcohol that mainly drive greater use. Moreover, these positive effects appear to increase over time, even after someone has developed an AUD.

These findings carry significant implications for both alcohol use prevention messaging and possible AUD treatment strategies, as most of the currently approved medication treatments for an AUD were not designed to address the reinforcing effects of alcohol.

"The key takeaway is when individuals are increasing their excessive drinking, this is characterized not

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Bottom Line...

Findings that the stimulating effects of alcohol persist over time even in people who develop an alcohol use disorder may cause a rethinking of the most effective approaches to alcohol prevention and treatment.

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workload" for clinicians, and some clients needing "more intensive services." There were also problems perceived for the program, such as "perceived lack of structure."

APT opened in 1970 and is not-for-profit, affiliated with the Yale School of Medicine. It operates four opioid treatment programs (OTPs) with about 4,500 patients and is one of the largest OTPs in New England.

APT developed its "open-access" model in 2006, trying to scale up methadone treatment to enroll patients rapidly regardless of their ability to pay. Patients are also given the opportunity for drop-in treatment options.

For the first nine years of this open-access model, the waiting time to treatment decreased from an average of 21 days to same-day, and the census increased from 1,431 to 4,051 of daily patients. This far exceeded the pace of increased patient census nationwide.

The biggest problem with non-open-access models is intake. The program was using procedures that weren't even required by regulations, which impeded access. So the program eliminated the requirement for written verification for eligibility, instead permitting verbal verification on the same day, allowing for rapid entry. With opioid use disorders, the medication needs to be given immediately or the patient will go into withdrawal and seek opioids elsewhere. In addition, the requirement for a physical exam prior to admission was removed, with the exam instead performed on a walk-in basis within two weeks of admission.

Per federal guidelines from the Substance Abuse and Mental Health Services Administration, methadone patients must attend at least one counseling session a month.

The study site that developed the open-access model made big changes from the beginning, in 2006, with the counseling caseload issue. At that time, counseling delivery changed from individual appointments to "drop-in" open-group sessions, with individual sessions available upon request. The program no longer assigned individual patients to specific counselors. Patients could choose which group

Description of the open-access model.

Theme	Subtheme	N	%	Example
Clinician level	*Personal evaluation positive*	5	16%	Excellent; wonderful, it works
	Team approach	5	16%	Support each other; no caseloads
	New experience	4	13%	New experience; adaptation; no caseloads
	Disadvantages to clinician	3	10%	Safety concerns; lack of physical boundaries
	Total	12	39%	
Client level	*Client autonomy/responsibility*	5	16%	system/model supports autonomy and growth
	Individualized/needs met	5	16%	Flexibility in the system to meet all client needs
	Staff/system is responsive	4	13%	Clinicians and the system are eager to adapt to client needs/interests
	Total	19	61%	
Community level	*Same day access/admission*	20	65%	Clients can walk in when ready; no wait list
	Services provided on same day as admission	10	32%	Provide medication, medical care, mental health care same day as requested
	Ongoing care barriers reduced	18	58%	Access to everything needed for addiction; no appointments; financial barriers reduced; reduced physical boundaries
	High acuity clients served	8	26%	"Last resort"; provide care and open door to all clients
	Total	26	84%	

Source: Journal of Substance Abuse Treatment

ALCOHOLISM & DRUG ABUSE WEEKLY
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they wanted to go to, based on time and subject.

Counselor attitudes to the open-access model were obtained by 45-minute interviews during 2015–16 with the researchers. Specifically, researchers asked open-ended questions about:

- experiences treating patients,
- suggestions for optimizing work life and training,
- views of optimal treatment,
- attitudes on interventions and
- perceptions and experiences of the model.

A multidisciplinary team analyzed the transcripts. The team, which included clinical psychologists, a social psychologist, a medical anthropologist, a physician and a senior administrator with a doctorate, coded the interviews focusing on specific issues. The themes that were coded represented at least 10% of the interviews. Participants were only counted once each per major theme.

Advantages of the open-access model.

Theme	Subtheme	N	%	Example
Clinician level	*Positive assessment*	11	35%	"Good", "great"
	Positive personal assessment	5	16%	"Like it", "love it", "enjoy it"
	Positive clinician outcome	4	13%	Clients choose you; less demands; clients more engaged
	Total	20	65%	
Client level-barriers reduced	*General*	6	20%	Barrier reduction broadly; treatment of last resort/accepts all clients
	Waiting time reduced	5	17%	Scheduled appointments not needed; less waiting for care
	Same day access	2	7%	Receive treatment on the day requested when initiating treatment
	Total	13	43%	
Client level—outcomes improved	*Client well being*	4	13%	"It works"; better outcomes; clients' are comfortable
	Patient autonomy, access, & individualization	14	47%	Choice of modalities, clinicians, and groups; individualized; access to building and clinicians
	Robust services	4	13%	Access to physical healthcare, mental health care, substance use treatment
	Total	20	65%	
Community level	*Open door philosophy*	8	26%	Friendly; needs met; open to all; more served
	Safety increased for clients and community	5	16%	Deaths reduced; decreased overdoses; crime reduced
	Total	13	42%	

Source: Journal of Substance Abuse Treatment

Results

Of the 31 counselors, 77% were white, 13% Hispanic and 10% African-American. Eighteen were women. The mean age was 47 years, and 71% had a master's degree (16% had a four-year degree and 6% had a two-year degree; one of the other two counselors (6%) had a doctorate in a nonclinical field, and one had a law degree).

Two primary themes emerged in the interviews: one at the clinician level and one at the patient level.

Two further themes — community-level advantages and program-level disadvantages — were also noted.

Counselors correctly identified the open-access components: enrolling patients rapidly into methadone treatment regardless of ability to pay and providing multiple group treatment options to choose from. Counselors also noted that patients had immediate access to a range of services in addition to methadone, including medical and mental health.

In the words of one counselor: "[Patients have] access to move around freely; to be part of the milieu. They have services available in the moment. It has reduced wait time for psychiatric and medical treatments.… This is a place where they can come and there's not that division of us and them."

In general, the open-access model was helpful to clinicians, as it resulted in "limited client care responsibilities" when counselors were out of the office. They had coverage when they were on vacation, for example. And it meant they could "more effectively detach psychologically from work tasks" during their off time. "There's no caseloads," one counselor said. "[Y]ou don't have specific patients on your caseload. It's rotating. Anyone can come in and speak to whatever counselor is available." And from another: "It helps the counselors. The responsibility is to focus on the client that's in front of you at the time.… [O]ur main goal is just to meet clients' needs, where they're at, and go from there."

And trying to speak for the patients, one counselor said, "When a person comes into the clinic, they can be treated, their needs will be met … as soon as possible. They don't have to worry about waiting around, that's what I see as open-access."

And one noted that patients could partake of as many groups as they wanted, as a benefit. "[Y]ou can stay for 6 groups a day, or you can come [for] one. It's treatment a la carte. … [T]he clients pick what they're interested in."

Disadvantages

However, there were open-ended questions about disadvantages, including the fact that demands can in fact be high because the workload is uneven, with some patients needing extra care. "We have heavy volume.… [I]t can be unpredictable," one counselor said. "[E]ven the building [is not able] to support the amount of people coming through here."

And from another counselor: "There's a lot of people hanging out.… [M]any of them spend the

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whole day here. They're loud. We can hear them in my office. They're distracting.… I've lost 2 iPhones and my eyeglasses, and I'm blind as a bat!"

Disadvantages to the patients, predictably, came out as a possible negative impact on the therapeutic relationship. "It can feel chaotic," said one, adding that "if someone can see a different counselor every time, they're able to fly below the radar. That's a concern here."

As for program-level disadvantages, one was that some patients actually did need more structure, and it wasn't there for them.

Disadvantages of the open-access model.

Theme	Subtheme	N	%	Example
Clinician level	*Uneven workload*	3	10%	Some staff work harder than others
	Demands high	5	16%	Unpredictable workload; feeling of being rushed
	Total	10	32%	
Client level	*Therapeutic relationship*	3	10%	More difficult for clients to form relationships with staff
	Scheduling challenging	3	10%	No scheduled appointments; feels chaotic to clients
	Total	6	20%	
Program lack of intensity and structure	*More structure needed*	8	26%	Clients can "fall through the cracks"; more guidance for clients needed; increased intensity of service needed for some clients
	Total	8	26%	
No disadvantages	*None*	11	35%	

Source: Journal of Substance Abuse Treatment

Implications

The goal of open access was to reduce barriers to methadone treatment, and that was successful, previous research has shown, and this study showed counselors bought into that goal. "Counselors brought up client-level benefits of the open-access model both when asked directly about advantages and when asked to describe the model," the researchers concluded. "When describing the open-access model, counselors stated that the structure of the open-access program fostered choice and this choice empowered clients. As expected this theme emerged when asked about the advantages of the open-access model, with participants saying it fostered client choice, autonomy, and well-being."

Autonomy is a well-known component of self-efficacy with chronic medical conditions, which is what addiction is.

Reduced waiting time and same-day treatment access should be goals of all OTPs. So should enrolling patients immediately, regardless of their ability to pay. These patients have the choice to go buy illicit fentanyl in the street, and possibly become another statistic in the mounting opioid OD deaths. It's unfair to them and to their loved ones to have this occur because of red tape.

But for counselors to agree with these moves is key. So this study, in which counselors view these goals—broadening access to treatment—as advantages, is crucial. "Future research should systematically examine if demographic changes occur following a program's transition to the open-access model," the researchers concluded, adding that historically marginalized groups may be particularly affected.

And finally, the researchers speculate whether the open-access model could reduce the stigma of methadone maintenance.

There were also disadvantages, mainly having to do with increasing census — which is another way of saying broadening access, without adding any red tape and in fact with removing some of the rules. "These concerns may be important for any opioid treatment program to consider when attempting scale up," the researchers concluded.

The study, "A qualitative investigation of addiction counselors' perceptions and experiences implementing an open-access model for treating opioid use disorder," was funded by the APT Foundation and presented in part at the College on Problems of Drug Dependence in Texas in June 2019. The authors, headed by Lindsay M. S. Oberleitner at Yale, had no conflicts of interest to declare. •

SAMHSA head leaves, new head appointed

On Jan. 7, the day after the riots in Washington, D.C., when Trump supporters violently invaded the Capitol, Elinore McCance-Katz, M.D., Ph.D., announced her resignation from the administration as assistant secretary for mental health and substance use at the Substance Abuse and Mental Health Services Administration (SAMHSA), giving the White House incitement of the riots as the reason. "I have chosen to resign today as the Assistant Secretary for Mental Health and Substance Use. I am, and will be, forever grateful to have had the opportunity to lead SAMHSA and to contribute to improving prevention, treatment and recovery resources to those with mental and substance use disorders and their families," she wrote in a statement. "I want to express my gratitude to all SAMHSA staff and to my colleagues in the Department of Health and Human Services [HHS] for their support and sharing of their expertise with the

