Perspective: Four million Americans receive drug treatment at a cost of $20 billion per year, 2/3 of which is paid for by taxpayers. For too many people, treatment as an expensive revolving door, as described in this article. While "evidence-based" treatment is a step in the right direction, the key to getting better treatment is described late in the article when it discusses the program run by the Delaware Division of Substance Abuse and Mental Health. This program monitors treatment for results, including the simplest of all results, the percentage of patients who stay in treatment until it is completed. This new focus on accountability of treatment is welcome, and long overdue.

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THE EVIDENCE GAP

Drug Rehabilitation or Revolving Door?

By BENEDICT CAREY

Leah Nash for The New York Times

THERAPY Mark Wyatt leading a session at CODA, a treatment program in Oregon. CODA's director said a system that tracked clients and defined targets was needed.

ROSEBURG, Ore. — Their first love might be the rum or vodka or gin and juice that is going around the bonfire. Or maybe the smoke, the potent marijuana that grows in the misted hills here like moss on a wet stone.

But it hardly matters. Here as elsewhere in the country, some users start early, fall fast and in their reckless prime can swallow, snort, inject or smoke anything available, from crystal meth to prescription pills to heroin and ecstasy. And treatment, if they get it at all, can seem like a joke.

"After the first couple of times I went through, they basically told me that there was nothing they could do," said Angella, a 17-year-old from the central Oregon city of Bend, who by freshman year in high school was drinking hard liquor every day, smoking pot and sampling a variety of harder drugs. "They were like, 'Uh, I don't think so.' "

She tried residential programs twice, living away from home for three months each time. In those, she learned how dangerous her habit was, how much pain it was causing others in her life. She worked on strengthening her relationship with her grandparents, with whom she lived. For two months or so afterward she stayed clean.

"Then I went right back," Angella said in an interview. "After a while, you know, you just start missing your friends."

Every year, state and federal governments spend more than $15 billion, and insurers at least $5 billion more, on substance-abuse treatment services for some four million people. That amount may soon increase sharply: last year, Congress passed the mental health parity law, which for the first time includes addiction treatment under a federal law requiring that insurers cover mental and physical ailments at equal levels.

Many clinics across the county have waiting lists, and researchers estimate that some 20 million Americans who could benefit from treatment do not get it.

Yet very few rehabilitation programs have the evidence to show that they are effective. The resort-and-spa private clinics generally do not allow outside researchers to verify their published success rates. The publicly supported programs spend their scarce resources on patient care, not costly studies.

And the field has no standard guidelines. Each program has its own philosophy; so, for that matter, do individual counselors. No one knows which approach is best for which patient, because these programs rarely if ever track clients closely after they graduate. Even Alcoholics Anonymous, the best known of all the substance-abuse programs, does not publish data on its participants' success rate.

"What we have in this country is a washing-machine model of addiction treatment," said A. Thomas McClellan, chief executive of the nonprofit Treatment Research Institute, based in Philadelphia. "You go to Shady Acres for 30 days, or to some clinic for 60 visits or 60 doses, whatever it is. And then you're discharged and everyone's crying and hugging and feeling proud — and you're supposed to be cured."

He added: "It doesn't really matter if you're a movie star going to some resort by the sea or a homeless person. The system doesn't work well for what for many people is a chronic, recurring problem."

In recent years state governments, which cover most of the bill for addiction services, have become increasingly concerned, and some, including Delaware, North Carolina, and Oregon, have sought ways to make the programs more accountable. The experience of Oregon, which has taken the most direct and aggressive action, illustrates both the promise and perils of trying to inject science into addiction treatment.

Evidence-Based Treatments

In 2003 the Oregon Legislation mandated that rehabilitation programs receiving state funding use evidence-based practices – techniques that have proved effective in studies. The law, phased in over several years, was aimed at improving services so that addicts like Angella would not be doomed to a lifetime of rehab, repeating the same kinds of counseling that had failed them in the past — or landing in worse trouble.

"You can get through a lot of programs just by faking it," said Jennifer Hatton, 25, of Myrtle Creek, Ore., a longtime drinker and drug user who quit two years ago, but only after going to jail and facing the prospect of losing her children. "That's what did it for me — my kids — and I wish it didn't have to come to that."

When practiced faithfully, evidence-based therapies give users their best chance to break a habit. Among the therapies are prescription drugs like naltrexone, for alcohol dependence, and buprenorphine, for addiction to narcotics, which studies find can help people kick their habits.

Another is called the motivational interview, a method intended to harden clients' commitment upon entering treatment. In M.I., as it is known, the counselor, through skilled questioning, has the addict explain why he or she has a problem, and why it is important to quit, and set goals. Studies find that when clients mark their path in this way — instead of hearing the lecture from a counselor, as in many traditional programs — they stay in treatment longer.

Psychotherapy techniques in which people learn to expect and tolerate restless or low moods are also on the list. So is cognitive behavior therapy, in which addicts learn to question assumptions that reinforce their habits (like "I'll never make friends who don't do drugs") and to engage their nondrug activities and creative interests.

For Angella, this kind of counseling made a difference. She spent several months in a program run by Adapt, an addiction treatment center here in Roseburg, a small city about 175 miles south of Portland.

In treatment, she said, she learned how to "just be with, and feel" bad moods without turning to drink or drugs; and to throw herself into creative projects like collage and painting. The program has helped her reconnect with her father and to enroll in college beginning in January.

"I want to be a teacher, and someone at the program is advising me on that," she said in an interview. "That's the plan, to just move out and away from my old life."

A friend of hers in the program, Alex, a 16-year-old from Roseburg, said that the therapy helped him monitor his own emotional ups and downs, without being swept away by them. The counselors "are always asking about our stress level, our anger, so you become more aware and have a better idea what to do with it," he said.

Almost 54 percent of Oregon's $94 million budget for addiction treatment services now goes to programs that deploy evidence-based techniques, according to a state report completed last month. The estimated rate before the mandate was 25 to 30 percent. The state has not yet analyzed the impact of this change on clients.

"Before the mandate, most programs had some evidence-based practices, and since then there has been a lot more interest and awareness of them," said Traci Rieckmann, a public health researcher at Oregon Health and Science University, who is following the policy implementation with support from the Robert Wood Johnson Foundation and the National Institutes of Health.

Culture Clash

Yet interest and awareness may not translate into good practice, and Dr. Rieckmann says it is not at all clear how many rehabilitation programs claiming to use evidence-based techniques actually do so faithfully. About 400 programs receive state money, and most of them are small, rural outfits that are already stretched to provide counseling, to say nothing of paying for extensive training.

"You're talking about therapies, like cognitive behavior therapy, that take time to learn," said John Gardin, the behavioral health and research director at Adapt in Roseburg, who travels the country to teach the skills. "Most places don't have a person like me to do that training, so they're getting two to three days of training, if that; and that's just not enough time to get it."

In studies looking at hundreds of programs nationwide, researchers have found a similar gap between what programs may want to do and what they're able to do. "For instance, most programs don't have an M.D. on staff," said Aaron Johnson, a sociologist at the University of Georgia who has led many of the studies. "Without that, of course, you can't prescribe any medications."

Tim Hartnett, the executive director of a Portland treatment program called CODA Inc., which does its own research on patient outcomes, said that the mandate had raised the level of conversation statewide, but that true reform would mean "an integrated system that tracks clients as they move from residential to outpatient treatment, and that defines clear targets" for what a person should expect from each kind of program.

"Our goal at CODA is to create a system of care that uses evidence-based practices at just the right dose and just the right time," Mr. Hartnett said. "As with many chronic diseases, figuring out dosage and timing are critical."

For some addicts, a standard program may not help at all, according to Anne Fletcher, who for her book "Sober For Good" interviewed 222 men and women who had been clean for at least five years. "A lot of these people overcame an alcohol problem on their own, or with the help of an individual therapist," Ms. Fletcher said.

To complicate matters in Oregon, the state mandate has stirred a kind of culture clash between those who want reform — academic researchers, state officials — and veteran counselors working in the trenches, many of whom have beaten addictions of their own and do not appreciate outsiders telling them how to do their jobs.

"I'm a counselor, and I'd be defensive, too: 'What do you mean, all this stuff I've been doing my entire life is wrong?' " said Brian Serna, director of outpatient services at Adapt, who has traveled the state to monitor the use of scientific practices. "So the challenge is to build a bridge between what the science says is effective and what people are already doing."

One way to do that, some experts now believe, is to combine evidence-based practice with "practice-based evidence" — the results that programs and counselors themselves can document, based on their own work. In 2001 the Delaware Division of Substance Abuse and Mental Health began giving treatment programs incentives, or bonuses, if they met certain benchmarks. The clinics could earn a bonus of up to 5 percent, for instance, if they kept a high percentage of addicts coming in at least weekly and ensured that those clients met their own goals, as measured both by clean urine tests and how well they functioned in everyday life, in school, at work, at home.

By 2006, the state's rehabilitation programs were operating at 95 percent capacity, up from 50 percent in 2001; and 70 percent of patients were attending regular treatment sessions, up from 53 percent, according to an analysis of the policy published last summer in the journal Health Policy.

"We basically gave them a list of evidence-based practices and told them to pick the ones they wanted to use," said Jack Kemp, former director of substance abuse services for Delaware, in an interview. "It was up to them to decide what to use."

For those who are trying not to use, it doesn't much matter how rehab services are improved — only that it happens in time. "Honestly, you just don't care how or why something works for you," said Ms. Hatton, the 25-year-old from Myrtle Creek, Ore. "Just that it does."

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