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Towards an integrated treatment system for opioid addicts: Arguments, models and outcomes

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Overview

- What should be available in the treatment system?
- Arguments for a comprehensive treatment system
  - A competitive market of therapeutic approaches
  - Conflicting values and interests
  - Evidence based preferences
- Concept and models of comprehensive treatment systems
  - Basic principles and rules
  - Networks and systems
  - Towards an integrated drug policy approach
- A way forward

What should be available ?

Checklist substance abuse treatment and care (1)

- **Emergency care (intoxications, complex withdrawal states, exacerbations of somatic / psychiatric comorbidities, safety risks e.a.)**
- **Detoxification (psychosocially assisted pharmacological therapy, referral for aftercare)**
- **Early brief interventions by trained staff (in specialist and non-specialist settings)**
- **Outpatient therapy and care (assessments, counselling, psychotherapy, pharmacotherapy incl. opioid replacement therapy , monitoring, referrals e.a.)**
- **Semi-residential treatment programmes (medically or non-medically directed)**
- **Residential therapy and care (TC's, specialised hospitals, nursing homes for palliative care e.a.)**

Checklist substance abuse treatment and care (2)

- **Rehabilitation services (vocational rehabilitation, accommodation, debt management, legal guidance e.a.)**
- **Sheltered living and workplace opportunities**
- **Family / key person counselling and support**
- **Social welfare support**
- **Links to self-help organisations and groups**

- **Independent outcome control (routine monitoring)**
- **Independent quality control (audits)**

Which priorities in substance abuse treatment and care ?

- **Improvement of existing services**
- **Reduce waiting times (shorten administrative processes, increase availability if need is evident)**

- **Check on availability and affordability of options**
- **Improve systematic collaboration at the system level**

Service improvement findings

Main strategies for service improvement

- Categories: Professional, Consumer, Organisational, Financial, Regulatory (Cochrane Collaboration 2013)

Evaluation of improvement strategies

- „The strongest research evidence supports educational outreach, audit and feedback, use of local opinion leaders and reminders as generally effective“ (CADTH 2013)
- Outcome-focused strategies are successful, process-focused strategies have little impact on outcomes (Humphries & McLellan 2011)
- Complete needs assessment for new clients (Gerstein et al 1997)

Crossing the quality chasm
(Institute of Medicine 2003)

Rules for an improvement of psychiatric care:

1. **Constant availability of care(also via Internet)**
2. **Consider individual preferences**
3. / 4. **Patient is fully informed and takes decisions**
5. **Evidence-based «best practice»**
6. **Reduce sources of errors and misinformation**
7. **Transparency for all options**
8. **Anticipation of future needs**
9. **Careful use of resources and time**
10. **Coordinated collaboration of GP's and institutions**

Arguments
for a
comprehensive treatment system

Conflicting concepts, values and interests

- **Conceptual issues**
  - **Medical or criminal interventions?**
  - **Public health interests or individual recovery?**
- **Priority values**
  - **Drug-free lifestyle or acceptable self-medication?**
  - **Model citizens or acceptable neighbours?**
  - **Limits of self-determination?**
- **Invested interests**
  - **Institutional interests: economic investments**
  - **Institutional interests: ideological investments**
  - **Public interests: drug-free society or avoiding drug-related problems?**
  - **Public interests: economic limits and returns**

A competitive market of therapeutic approaches

- **Diversity of funding schemes for different approaches**
  - **Health insurance paying for substitution treatment, welfare for drug-free residential treatment**
  - **Lesser payments for voluntary as compared to drug-ordered treatment**
  - **Payment per day / consultation vs. Payment per economic input vs. Payment per result**
- **Diversity of trajectories/pathways into treatment**
  - **Preferences of referring agencies (costs, type of approach etc.)**
  - **Role of patient preference**
  - **Role of availability and disponibility (waiting lists, location etc.)**

Evidence based results and preferences

- **Epidemiological data**
  - **Majority of heroin addicts recovers without treatment (Kaya et al 2004)**
- **Comparative treatment evaluation**
  - **Outcomes in MMT favourable in comparison to treatment without opioid substitution (Mattick et al 2009)**
  - **Equal long-term outcomes of maintenance and drug-free treatments (Gossop et al 2003)**
- **Patient preference**
  - **Preference for out-patient treatment (Merkx et al 2007)**
  - **Preference for agonist maintenance treatment (EU: >90% EMCDDA 2011)**
- **Public health preference**
  - **Preference for good coverage (WHO 2012)**
  - **Preference for outcome oriented quality and clinical governance (NTA 2009)**

Concept and models of comprehensive treatment systems

The concept: basic principles and rules

- **Principles**
  - **Understanding addiction treatment**
  - **A hierarchy of treatment goals**
  - **Complementary, not conflicting approaches**

- **Rules**
  - **Make best use of available resources**
  - **Optimal coverage and quality**
  - **Evidence based indications**

Main models

Networks

Integrated care

- Integrated care toolkit (UNODC 2003)
- Integrated care for drug users (Scottland 2008)
- Network for improvement of services (USA 2008)
- Implementing change at a network level (USA 2012)

Systems

Stepped care

- Sobell model (USA)
- ASAM model (USA)
- MATE model (NL, BRD)
- TC intake potocol (USA)

UNITED NATIONS OFFICE ON DRUGS AND CRIME
Vienna

Drug Abuse Treatment and Rehabilitation:

a Practical Planning and Implementation Guide

UNITED NATIONS
New York, 2003

UNITED NATIONS
PUBLICATION

Sales No. E.03.XI.II

ISBN 92-1-
148160-0

Why an integrated network of services?

The key to successful responses to drug abuse is partnership and active cooperation between central and local governments, non-governmental agencies, service providers and the community.

Drug abusers are often a stigmatized population and the community partners may need to take an advocacy role along with opinion leaders to promote understanding of drug abuse problems and how they can be effectively treated.

UNODC 2003

Example: the Australian national drug strategic framework
1998/99 – 2002/03

Priority areas for the development of services:

- **Access to treatment**
- **Building partnerships**
- **Links with other strategies**
- **Professional education and training**

http://www.health.gov.au/pubhlth/publicat/document/ndsf.pdf

Example: the Spanish treatment and rehabilitation network

http://www.mir.es/pnd/presenta/html/user.htm

- Consolidated and diversified network of programmes and resources offered to drug abusers and their families.
- Partnership of communities and autonomous cities, local entities and non-governmental organizations that deal with drug addiction
- Substantial increase in methadone maintenance and in harm reduction approaches (vaccination programmes, syringe dispensation and exchange, sanitary kits etc.)
- Professional training and integration into the labour force (work in handicraft workshops, specific employment programmes, promotion of self-help cooperatives etc.), as well as residential support (by means of half-way houses or foster families etc.
- Alternatives to custodial sentences; programmes in police stations and courts; and intervention programmes in penitentiary institutions.

What is integrated care ? SACDM 2008

Integrated care is an approach that aims to combine and co-ordinate all the services required to meet the assessed needs of the individual.

It requires:

- **treatment, care and support to be person-centred, inclusive and holistic to address the wide ranging needs of drug and alcohol users;**
- **the service response to be needs-led and not limited by organisational or administrative practices;**
- **collaborative working between agencies and service providers at each stage in the progress of the individual in treatment, from initial assessment onwards.**

Scottish Advisory Committee on Drug Misuse SACDM Report 2008

Checklist for partnership building (SACDM 2008)

- **To what extent is there clarity about the role of each partner agency in the planning, design and delivery of services?**
- **Is there written documentation outlining the shared short- and long-term aims and objectives of the integrated services?**
- **Has there been any consultation with service providers to ascertain whether there has been sufficient time and resource dedicated to partnership building?**
- **How could service planners establish whether all members, including community and user representatives, had received adequate training?**
- **What measures have been taken to provide a supportive atmosphere where discussion and new ideas are welcome?**

Checklist operational level (SACDM 2008)

- **Has agreement been reached locally on the development of common or core assessment procedures and datasets ?**
- **Have systems and protocols for sharing information been agreed by all participating agencies ?**
- **Are there systems and protocols in place for referral and joint working ?**

Network for the Improvement of Addiction Treatment

Hoffman K.A., Ford J.H., Choi D. et al. (2008). Drug and Alcohol Dependence:98, 63–69.

Partners: US government and a major US philanthropic foundation

Objectives:

- reducing waiting time between client's first treatment-seeking contact and start of treatment;
- cutting the number of missed appointments ('no-shows');
- increasing the number of clients admitted to treatment;
- increasing proportion of treatment-starters retained for >3 treatment sessions

Key approach: “Placing staff in the clients' shoes”

Evaluation results: halved waiting times and increased retention without limiting patient numbers.

Implementing evidence-based treatment for substance use disorders at the systems level

Schmidt L.A., Rieckmann T., Abraham A. et al. (2012) Studies Alcohol Drugs 73:413–422.

- **Testing strategies for networking at the state level in 12 US jurisdictions**
- **5 «change levers»:**
  - **Financing analysis: reallocation of funds**
  - **Regulating and policy analysis: change in certification standards, changes in contracting**
  - **Inter-organisational relationship analysis: stakeholder groups supporting innovation**
  - **Operations analysis: senior staff admitted as «patients», testing changes**
  - **Customer analysis: patients consulted as customers, build stakeholder groups**
- **Evaluation results:**
  - **New medication schemes adopted**
  - **6 initiatives for continued care adopted**
  - **Best results from cooperation policymakers and providers**

Stepped care models

A concept for patient placement

- **Main principle**: matching treatment intensity to patient characteristics.

  Screening the new patient for specific characteristics provides the basis for treatment indication and placement, starting with the least intensive intervention and stepping up intensity for non-responders only (except emergencies and special cases)

- **Expected benefits:**
  - **protect patients from intrusive care they do not need**
  - **make best use of available treatment resources by avoiding misplacements**

Sobell model

- **Start with the least restrictive intervention in terms of cost and personal inconvenience for patients**
- **First step might even involve facilitating “natural recovery” outside of professional services**
- **Stepping up requires a decision about patient progress and depends on the type of disorder and the effectiveness of available treatments**
- **Decisions may be made on the basis of guidelines, but should not disregard the risk of inappropriate stepping up and of missed stepping up**
- **Include considerations about costs of treatments at different levels**

Sobell MB, Sobell LC (2000) Stepped care as a heuristic approach to the treatment of alcohol problems. J Consult Clin Psychol 68:573–579

Comparison of ASAM and MATE models

- **Patient characteristics**
  - **Which characteristics indicate the appropriate level of care for a given patient?**
- **Treatment typology (levels of care)**
  - **Which types of services indicate a relevant difference in intensity of care?**
- **Assessment and referral procedures**
  - **Which guidance for assessment and treatment indication?**

Patient characteristics used for determining appropriate level of care

ASAM assessment dimensions

- Acute intoxication and/or withdrawal potential
- Biomedical conditions and complications
- Emotional, behavioural, cognitive conditions/complications
- Readiness to change
- Relapse/continued use, continued problem potential
- Recovery environment

MATE patient indicators

- Addiction severity (ASI)
- Psychiatric impairment
- Social stability
- Treatment history 0-1
- Treatment history 2
- Treatment history 3-5
- Treatment history >5

Treatment typology

ASAM level of care

- 0.5. early intervention
- I. outpatient treatment
- II.1. intensive outpatient
- II.5. partial hospitalisation
- III.1. low intensity residential treatment
- III.3. medium intensity residential treatment
- III.5. medium/high intensity residential treatment
- III.7. medically monitored intensive inpatient
- IV. medically managed intensive inpatient
- OMT. Opioid Maintenance Therapy

MATE levels of care

- 1. Short outpatient
- 2. Outpatient
- 3. Day care / residential
- 4. Care (in- and outpatient)

Assessment and referral procedures in ASAM

Patient Placement Criteria – 2r

Multiaxial DSM diagnoses

Immediate needs with immediate risks?

If immediate risks in intoxication/withdrawal potential, biomedical, emotional, behavioural,cognitive dimensions: placement in **level IV**

If imminent risk in relapse, continued use, recovery environment: placement in **level III**

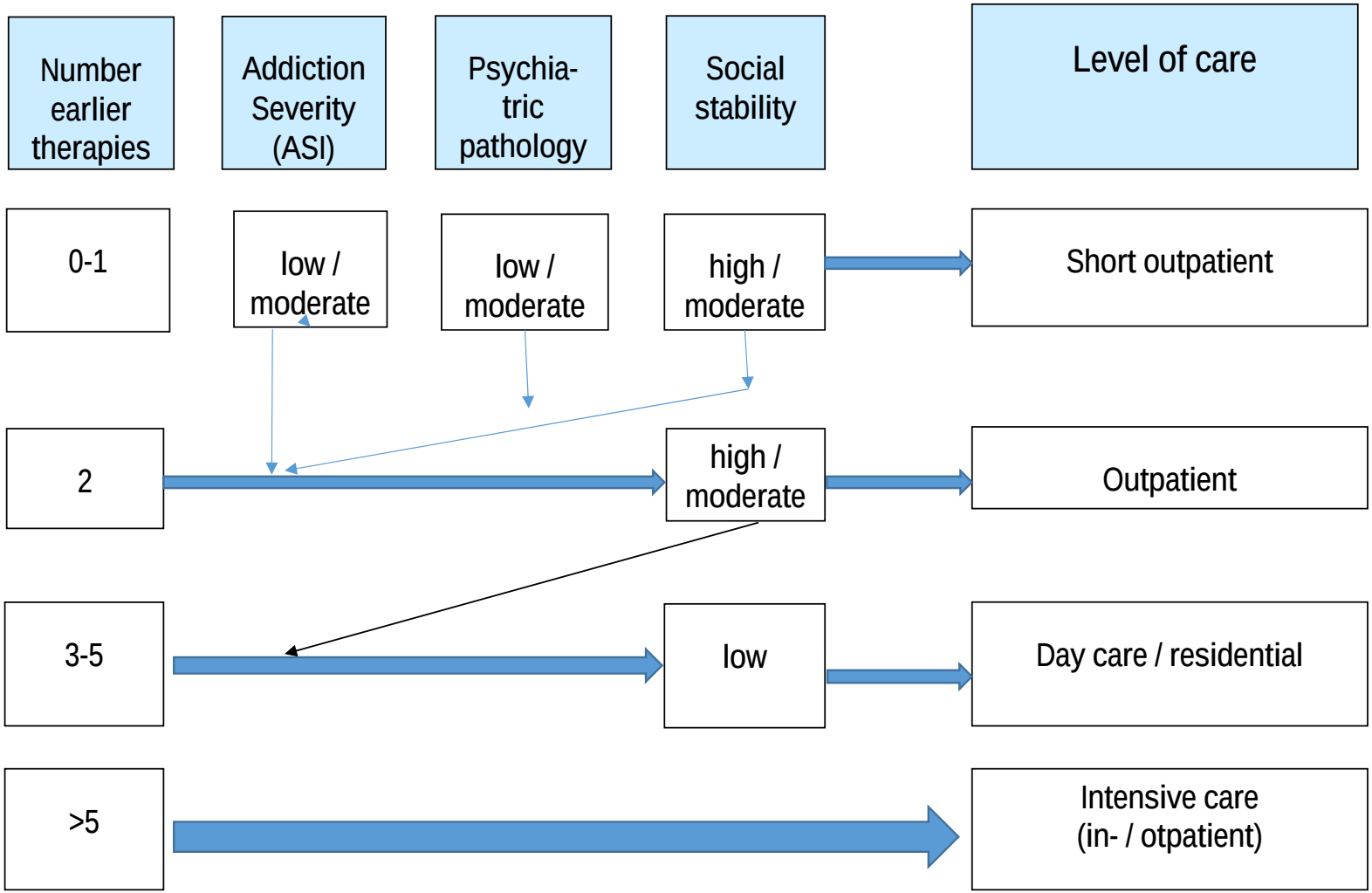
If no immediate needs, evaluate multidimensional severity and level of function to determine treatment priorities and intensity of treatment needed

If dose and intensity of services require less than 9 hours/week: placement in **level I**

If dose requires 9-19 hours/week: placement in **level II.1**

If dose os 20 hours/week or more: placement in **level II.5**

Assessment and referral in MATE model



Evaluation of ASAM model

- "More than a decade of research of the ASAM PPC supports the predictive validity and the cost-effectiveness of the use of PPC. Based on this research, a variety of computer assisted assessment and placement tools are in development"

  (Mee Lee D, Gastfriend DR (2008). Patient placement criteria. In Galanter M, Kleber HD Eds.). Textbook of Substance Abuse Treatment, 4th Edition, p.79-90. The American Psychiatric Publishing).

Evaluation of MATE model

- Feasibility and field testing of the MATE in a treatment seeking population was performed in two large treatment settings. Construct validation with related instruments and evaluation of the dimensional structure of modules were performed. Among the results are a satisfactory inter-rater reliability and concurrent validity, indicating the usefulness of the instrument for allocating patients to substance abuse treatment, even in a heterogeneous population

  Schippers et al (2010). Measurements in the Addictions for Triage and Evaluation (MATE): an instrument based on the World Health Organisation family of international classifications. Addiction 105:862-871

- However, there were some problems with clinicians not complying with the guidelines, resulting in mismatched patients usually allocated to outpatient treatment instead of early interventions

  Merkx et al (2007). Allocation of substance use disorder patients to appropriate levels of care: F easibility of matching guidelines in routine practice in Dutch treatment centres. Addiction 102:466-474

Client-treatment matching protocol for Therapeutic Communities

Melnick G et al (2001). A client-treatment matching protocol for therapeutic communities: first report. J Subst Abuse Treatment 21:119-128

- **Exclusion criteria**
  - **Safety risks**
  - **Practicability problems**
- **Inclusion criteria**
  - **Considerable severity of addiction**
  - **Dependence during > 5 years without a break of min. 1 years**
  - **Crime involvement**
  - **No supportive social milieu or no perspectives for vocational rehabilitaion**
- **Evaluation**
  - **Better outcomes for matched vs. mismatched patients**

Reviews of other stepped care models

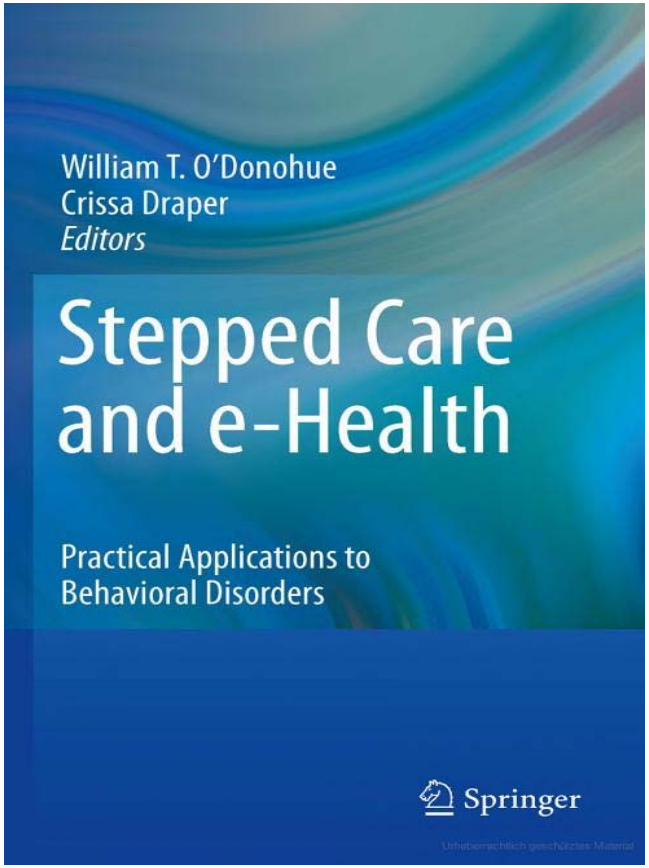
- **A systematic review of stepped care in psychological interventions identified the underlying assumptions on which the benefits of stepped care depend: equivalence in terms of clinical outcomes, efficiency in terms of resource use and costs, and acceptability of 'minimal interventions' to patients and therapists.**

Bower P, Gilbody S (2005). Stepped care in psychological therapies: access, effectiveness and efficiency. narrative literature review. British Journal of Psychiatry 186:11-17

- **Little evidence was found to suggest that stepping up non-responders to more intensive therapy improved outcomes. In one study, the application of a stepped care approach was found to reduce treatment costs compared with usual care. There was some evidence that the greater differentiation between the intensity of the interventions offered at each step, the better the outcome.**

Jaehne A etal (2012). The Efficacy of Stepped Care Models Involving Psychosocial Treatments in Alcohol Use Disorders and Nicotine Dependence: A Systematic Review of the Literature. Current Drug Abuse Reviews 5:41-51

Present range of stepped care models



Contents

- **Depression**
- **Anxiety**
- **Panic disorder**
- **Posttraumatic stress disorder**
- **Social phobia**
- **Substance abuse**
- **Pediatric obesity**
- **Chronic disease management**
- **Autism**
- **Grief**
- **Sexual disorders**

Towards an integrated drug policy approach

- Step 1: **Treatment system as a Public Health intervention**
  - **Combining effects on drug using individuals with effects on population level (serving all in need of treatment, reducing secondary effects of drug use non-users,e.g. on economic and public safety consequences of untreated drug use)**

Babor et al (2010). Drug Policy and the Public Good. Oxford University Press

- Step 2: **Harmonizing demand reduction and supply control interventions**
  - **Integrated prevention and treatment approaches (evidence based primary prevention, early identificaion, treatment, social rehabilitation)**
  - **Integrated criminal justice measures (evidence based treatment in the prison milieu, diversion to regular treatments, aftercare and rehabilitation following imprisonment)**

UNODC Political Declaration and Plan of Action on International Cooperation Towards an Integrated and Balanced Strategy (2009). UNODC, Vienna

A way forward

Know your services

- **Are accessibility and affordibility of services adequate ? Waiting times/waiting lists? Who pays for treatment?**
- **Are there standards for structural and performance quality?**
- **Is good coverage a goal besides good outcomes?**
- **Is «walkthrough» experience available ?**
- **Are services ready for networking and coordination ?**

Know your patients

- **Are admitted patients representative for data on populations in need of treatment? Which part is underrepresented in treatment services?**
- **Are all needs of patients assessed at entry to treatment and met during treatment?**
- **Are patient preferences part of treatment planning?**
- **Do you monitor satisfaction of patients in treatment and rehabilitation?**

Know the evidence

- **Are there treatment protocols and guidelines based on research evidence? Are these periodically updated and adjusted to changes in the field?**
- **Is there continued education for staff in treatment and rehabilitation? How is it guided and evaluated?**
- **Does research know the needs of practice and does practice participate in research surveys and projects?**
- **Is drug policy evidence-based?**

Know your problems and aims

- **What is problematic about your treatment system?**
  - **Results of the services review**
  - **Results of the patient survey**
- **What can realistically be changed?**
  - **Limits of voluntary collaboration for change**
  - **Legal, administrative and professional options for change**
- **In which direction should change go?**
  - **What do we want?**
  - **Listen to evidence**
- **Where do we need consensus building?**
  - **Identify areas for directive and for consensual procedures**

Thank you
and all the best!

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