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Treatment, substitution,recovery: integrative approaches

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Overview

- Structural integration
  - Recent priorities in integration
  - Stepped care models
- Functional integration
  - Quality standards
  - Education and training
- Conceptual integration
  - Understanding therapeutic interventions
  - Recovery

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Why structural integration ?

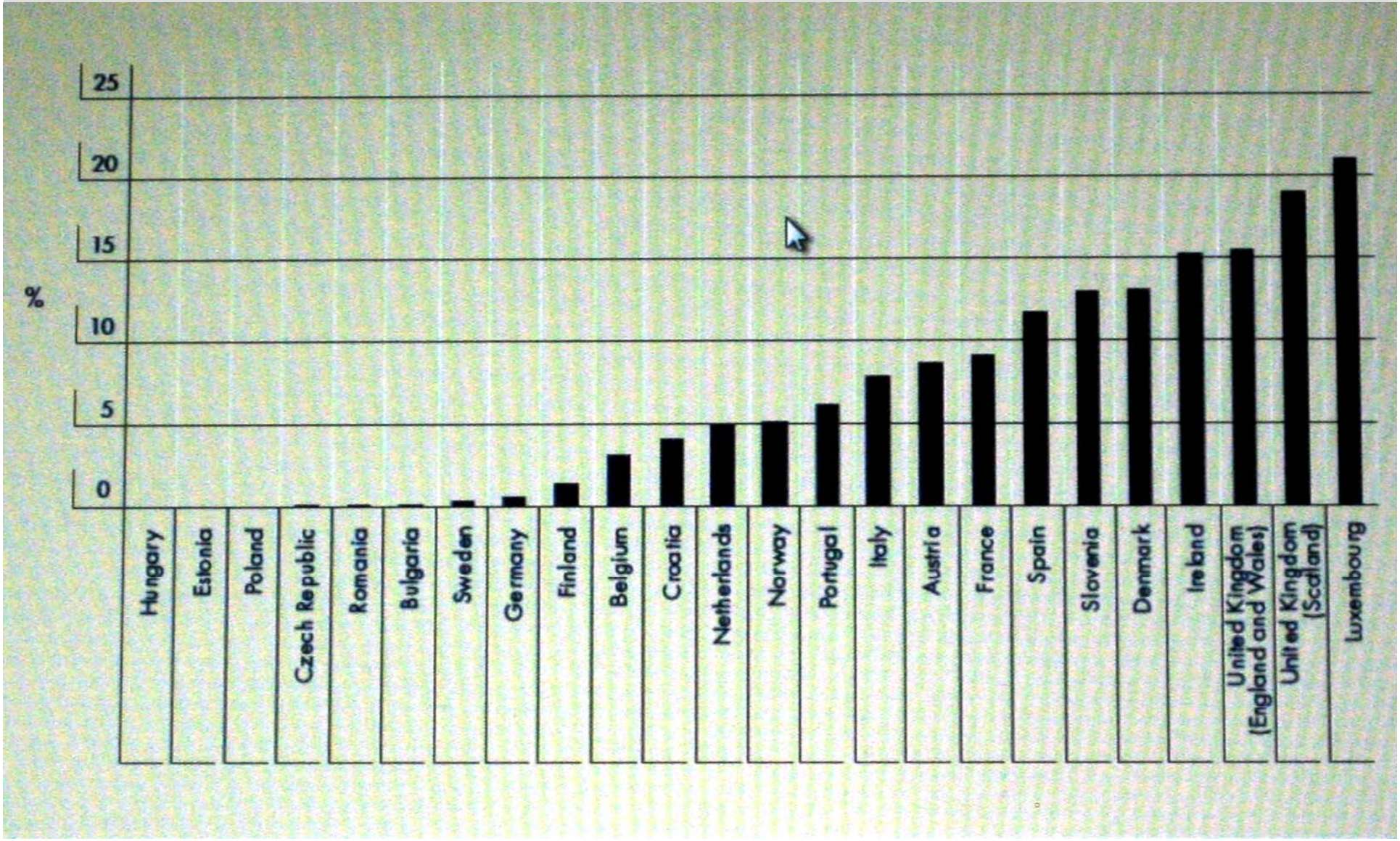
- Only a cooperating system of various approaches and competencies can meet the diverse care and treatment needs of people with addiction problems
- A cooperating system is indispensible for a satisfactory coverage of treatment needs in a given population

Treatment coverage in Europe
EMCDDA Annual Report 2010

- Ca. 3.5 Mio opioid users, 4.5 Mio cocaine users, 29 Mio cannabis users, 6-7 Mio amphetamine/ecstasy users (World Drug Report 2010)

- Ca. 1 Mio in any kind of treatment (2007)
- Ca. 440‘000 new entries per year (180‘000 first time)
- Ca. 42‘000 in inpatient treatment
  - Waiting time 0-4 weeks (max 25 weeks)
- Ca. 670‘000 in OST
  - Waiting time 0-30 days (max 300 days)

Proportion of prison population in OST
(EMCDDA 2010)



Recent priorities in integration

- Specialist services and primary health/social care
- Treatment services and low-threshold / harm reduction approaches
- Treatment system and criminal justice system
- Professional care and self-help

Integration specialised addiction treatment and primary care

- Assessment and early interventions in hospitals (emergency units), private practice, social services, private and state enterprise
- Locale/regional networks; addiction specialists as a resource for non-specialists , joint continued education
- Evaluation of practice models(Miller & Weisner 2002)
- Integration into health policy (UK workforce plan 2006)

Organisation of substitution treatment in the European Union (2006)

- ***General practitioner's:***

  Austria, Belgium, France (buprenorphine), Germany, Ireland, Luxembourg, UK

- ***Specialised centres:***

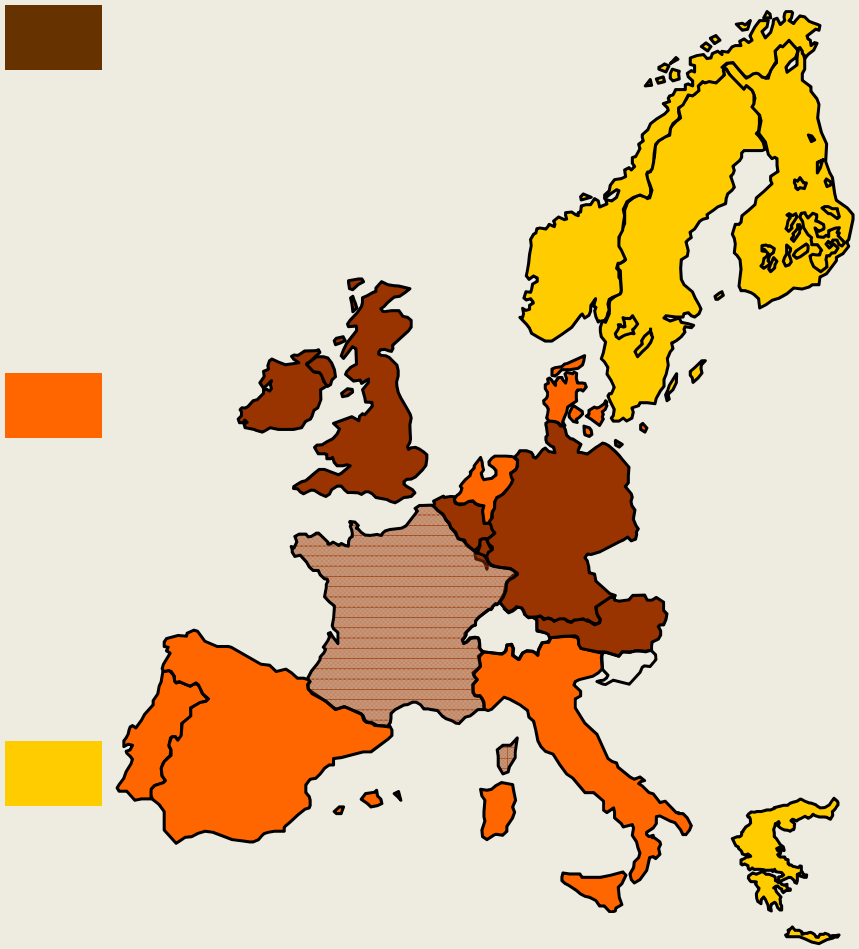
  Denmark, France (methadone), Italy, the Netherlands,

  Portugal, Spain

- ***Specialised centre, limited number***

  Finland, Greece,

  Sweden, Norway



Integration addiction treatment and harm reduction

„

„Develop an integrative treatment system enabling a cooperation of abstinence oriented therapy with harm reduction measures as a therapeutic continuum where

-*Low threshold services are available for the needs of active users*

-*Motivating approaches for discontinuing or changing addictive behaviors*

-*Facilitating pathways into structured therapies aiming at stabilisation and recovery.*

(Beckley Foundation, Stevens et al 2006)

Harm reduction approaches across Europe

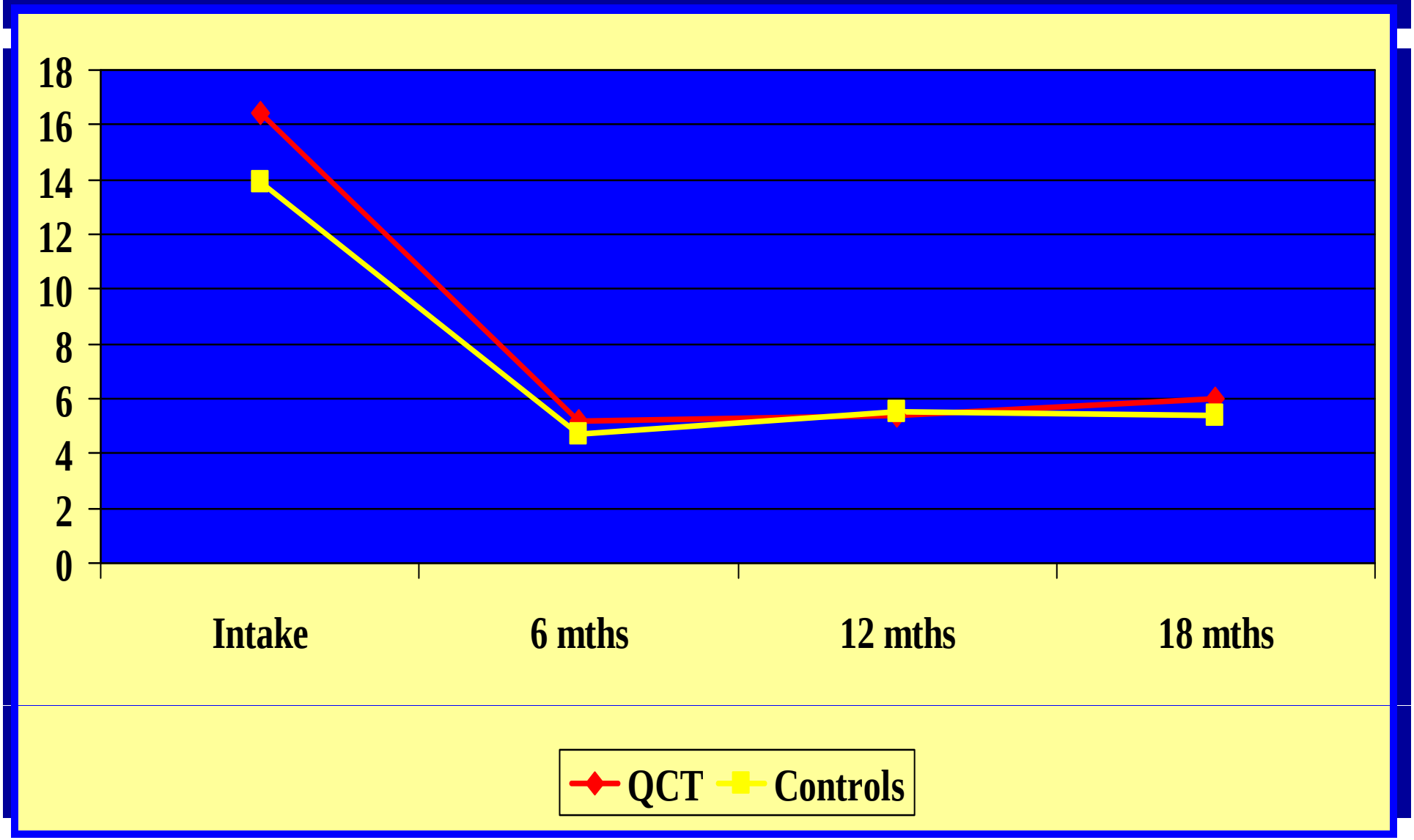
Needle / syringe exchange programs NEP	31 countries (exc. Iceland, Macedonia, Turkey)
Opioid substitution treatment OST	31 countries (exc. Iceland, Macedonia, Turkey)
Drug consumption rooms (safe injection rooms SIR)	6 countries
Prison NEP	6 countries
Prison OST	23 countries

Integration with the law enforcement system

- „Treatment instead of punishment“
  - Drug courts (USA, Canada), Drug treatment and testing orders DTTO (UK)
  - Quasi-compulsory treatment als Option (Europa)
- Treatment during imprisonment
  - Special units I TC, special regimes
- Cooperation of intra- und extramural services
  - External services participate in the internal programming and preparation of discharges (Antennes toxicomanie en France)

Reduction main substance use

mean consumption days last 30 days (Uchtenhagen et al 2008)



Integration with self-help

- Self-help of addicts
  - AA, NA provide support for professional care, including aftercare and relapse prevention
- Self-help of partners and families
  - Alanon etc provide support for treatment motivation and compliance
  - Alanon etc. provide mutual support in coping with their own problems
- Essential part of stepped care models
- Evaluated for effectiveness (Humphries 2011)

Estimated substance-related self-help/mutual aid organizations (12 step in blue, Humphries 2011)

	Estimated Number of Groups Worldwide
Alcoholics Anonymous	101,000
Al-Anon	30,000
Narcotics Anonymous	21,000
Cocaine Anonymous	2,000
LifeRing/Secular Organization for Sobriety	1,800
Adult Children of Alcoholics	1,500
Marijuana Anonymous	1,000
SMART Recovery	1,000
Moderation Management	500
Women for Sobriety	350

Sources: White and Madara (1998). Self-help sourcebook. Denville, NJ: American Self-help clearinghouse; Humphreys, K. (2004). Circles of Recovery: Self-Help Organizations for Addictions. Cambridge, UK: Cambridge University Press; Consultation with Experts in Field.

Summary of What We Know (Humphries 2011)

- 12-step group participation significantly reduces drug and alcohol use.
- 12-step group involvement reduces surplus health care utilization.
- Benefits of 12-step groups mediated both by psychological and social changes.

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Integrated models of „stepped care“

- Principle
  - Starting with low-threshold and non-intensive interventions (referral to self-help)
  - If not effective, try more professional and intensive approaches (brief interventions – outpatient care, residential care)
- Models
  - ASAM placement model
  - From first-line to intensive care (Sobell & Sobell 1999)
  - Dutch model : scoring results (Schippers et al 2006)

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Optimising treatment

- Learning from evidence (process analysis, outcome research)
- Learning from patient / client satisfaction and staff satisfaction
- Learning from societal response to treatment and treatment effects

Development of Therapeutic Communities

- First Generation: self-help of addicts (Synanon, Dederichs 1958)
- Second Generation: Professionalisation (collaboration (guidance by professionals; Daytop O‘Brien 1964)
- Third Generation: ideological opening (no exclusion of medical interventions; Koyman 1993)
- *Fourth* Generation: systematic research and conceptual adaptations (de Leon 2003)

Behavioral therapy from start to present practice

- Focus on „here and now“ in Gestalt therapy, as opposed to psychoanalytic unmasking of personal history and uncoinscious dynamics (Perls 1969)
- Importance of learning theory, behavior training and empirical evaluation of theory and practice (Deutsche Gesellschaft für Verhaltenstherapie 1981)
- Evidence of superior outcomes in comparison to psychodynamic therapies (Grawe et al 1994, NIDA 1996)

Opioid substitution Therapy

- Roman emperor Marc Aurel maintained on opium by Galenus (2.centura a.d..)
- Mogul emperor Jahangir maintained on opium as replacement for alcohol (16.century a.d..)
- People dependent on opium in South-East Asia receive daily rations (bis 1961)
- *Methadone maintenance tested and introduced as a replacement for street heroin(Dole & Nyswander 1964)*
- *Comprehensive evidence-based guidelines for OST(WHO 2008)*
- *OST recognised as the primary and most cost-effective treatment of opioid dependence (UN 2010)*

EU minimum quality standards for treatment services and interventions (EU project DG Justice 2010-2011)

- **Structural standards for services**
- **Process standards for interventions**
- **Outcome standards at the system level**

Structural standards for services

Physical environment: space (e.g. service has separate rooms for individual counselling)

Exception: non-specialized teams

Indication criteria: diagnosis (treatment indication is always made on the basis of a diagnosis)

Exception: office-based services and non-specialized teams

Staff composition: education (e.g. at least half of staff has a diploma in medicine, nursing, social work, or psychology)

Exception: office-based services and non-specialized teams

Process standards for interventions (1)

Assessment procedures: substance use history, diagnosis and treatment history have to be assessed.
Exception: none

Assessment procedures: somatic status and social status have to be assessed. Exception: none

Assessment procedures: psychiatric status has to be assessed

Exception: none

Process standards for interventions (2)

Individualised treatment planning (treatment plans are tailored individually to the patients needs)

Exception: none

Informed consent (patients must receive information on available treatment options and agree with a proposed regime or plan before starting treatment)

Exception: none

Written client records (assessment results, intervention plan, interventions, expected changes and unexpected events are documented complete and up to date for each patient in a patient record)

Exception: none

Process standards for interventions (3)

Confidentiality of client data (patient records are confidential and exclusively accessible to staff involved in a patient's treatment or regime)

Exception: none

Routine cooperation with other agencies (whenever a service is not equipped to deal with all needs of a given patient, an appropriate other service is at hand to referral)

Exception: none

Continued staff training (staff is regularly updated on relevant new knowledge in their field of action)

Exception: none

Outcome standards at the system level (2)

Utilisation monitoring (services must report periodically the occupancy of treatment slots or beds)

Exception: office-based services and non-specialized teams

Internal evaluation (services must regularly perform an internal evaluation of their activities and outcomes)

Exception: office-based and prison-based services and non-specialized teams

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An International Think Tank on Continued Education and Training on Addiction
I-THETA

www.i-theta.org

(Country reports)

Main findings

- Continued education and training are fairly high valued, but mainly driven top-down by providers and rarely based on needs assessment. Incentives for services and professionals to engage in E & T are rare.
- In most countries there are little efforts to systematise E & T, to develop conceptual frameworks for form and contents and to care for quality. There is little transfer research on the effects of E & T on the provision of services. Providers operate in a market competition rather than a guided structure.
- These deficiences seem to get increasingly political attention in some countries.

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How to understand substance dependence and it‘s treatment?

- Substance dependence
  - Is a (reversible) brain disease
  - Is a consequence of traumatizing life experience
  - Is understood as „unbalanced motivational state““
  - Is or a risk period in life or a chronic condition
- Treatment
  - Is a professional support of self-healing forces
  - Muste be needs-oriented, individually tailored and perceived as support rather than as directive intervention

Chronic condition or risk period ?

- „Chronic, relapsing disorder“ - asks for long-term continuous care (McLellan et al 2000)
- „Recovery“ – treatment terminates the condition (Heroin 22%, Kokain 14% , Review Calabria et al 2010)
- „Maturing out“, spontaneous recovery – terminating the condition without formal interventions, but frequently with social support (Winick 1962, Klingemann & Sobell 2008, Calabria et al 2010)

Needs Orientation and Motivation

- Better reduction of addictive behavior if individual care needs are assessed and taken care of (NTIES project, Gerstein et al 1997)
- „Working style“ of therapists is more important for outcome than contents (Karno et al 2007, Daeppen et al 2010),
- Procedure as manualised is less effective than empathic observation of patient‘s present state („reflective listening“) (Moyers et al 2009, Lundahl et al 2010)
- „Motivation for change“ does not develop schematically(Callaghan 2007), depends on changing situational factors (West 2006)
- Reduced addictive behavior is not an effect of treatment, but of a decision to seek treatment (Bergmark 2008)

The role of treatment

- To provide assistance to those unable to quit a substance abuse problem through self-help (stepped care concept, *Schippers et al 2006*)

- To provide appropriate assistance at any phase of the process (concept of integrated services: from harm reduction to social reintegration, *Beckley Foundation Stevens et al 2006*)

- To help clients to make best use of their own self-help potentials (to find alternative sources of satisfaction, *West 2006*)

- To respect the limitations for improvement (intra-personal and environmental)

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About recovery

- No generally accepted concept
  - A.T. McLellan TRI (2007), Laudet (2007)
- Prominent concept: BFI definition (2007)
  - Sobriety: abstinence from all drugs of abuse
  - Personal health: improved quality of personal life, measured by WHO-QOL (physical and psychological health, independence, spirituality scales,1998)
  - Citizenship: „living with regard and in respect to those around you“ (WHO-QOL social function and environment scales, 1998)
- Agreement of a consensus panel of 12; not evidence-based

About recovery

- Open questions (White 2007)
  - Who has the authority to define recovery ?
  - When does it begin and end ? Is it a long-term process ?
  - Is complete and enduting abstinence required ?
  - Is medicine-supported recovery acceptable?
  - Is it yes or no, or are shades /degrees acceptable ?
  - Must it be conscious, voluntary, self-managed ?

  And: „average citizen“ or „model citizen“ ?

- Guidance
  - Recovery Guide 2011 (*www.addictionrecoveryguide.org*)
  - Recovery community (www.werecover.org)

Some strategic consequences

- Addiction treatment is a *spectrum of diversified approaches; in each case the most appropriate must be chosen. There is no universally best model.*
- An *integrated network of care services has the best chances to meet the individual treatment needs of clients and to make best use of the available resources*
- *Systematic continued education and implementation of minimal quality standards are the best guarantee for adequate services and an appropriate political status of services and teams .*