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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 ?

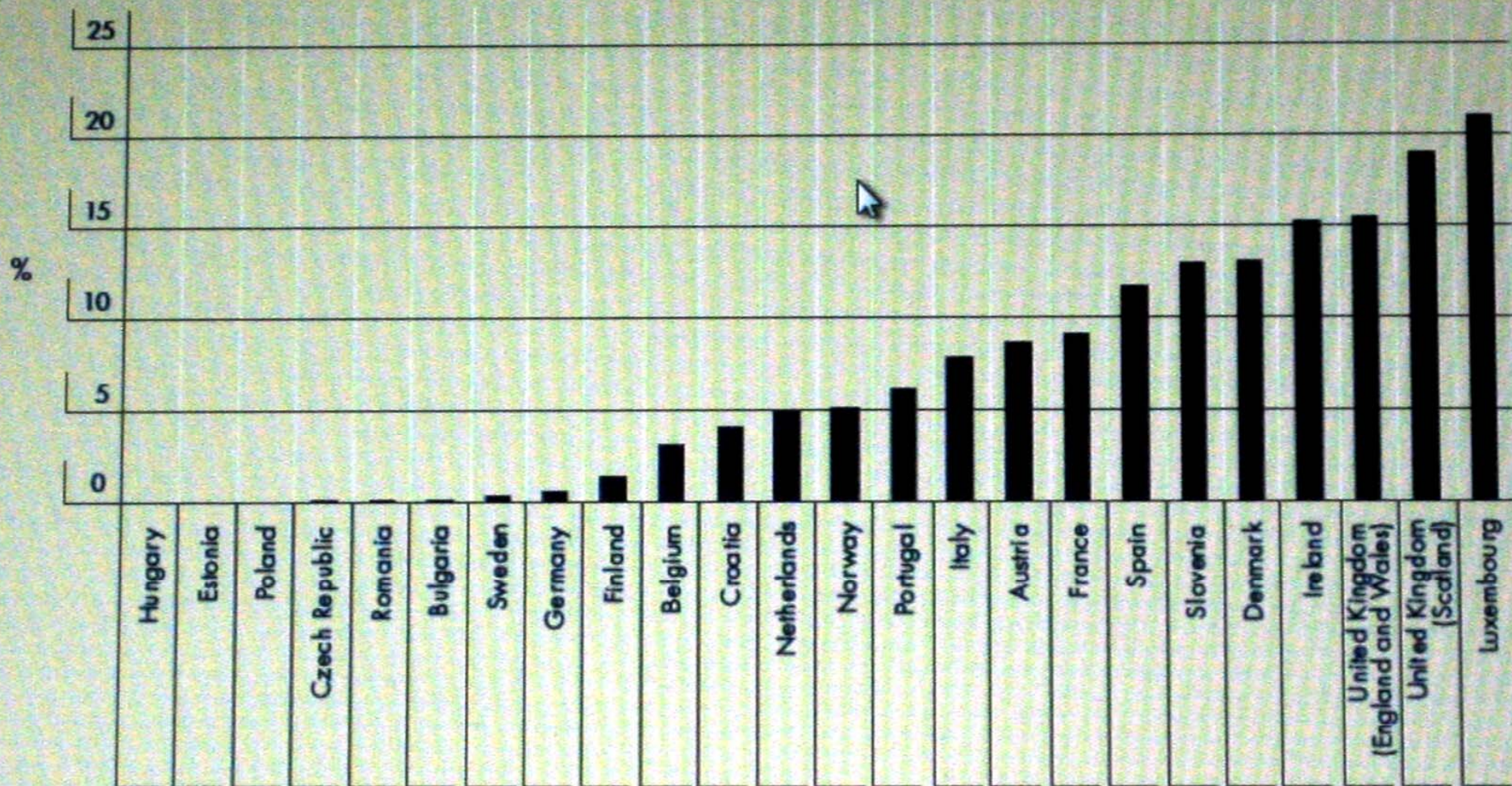
- Only a cooperating system of various approaches and competencies can meet the diverse care and treatment needs of people with addiction problems
- A cooperating system is indispensable for a satisfactory coverage of treatment needs in a given population

# 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



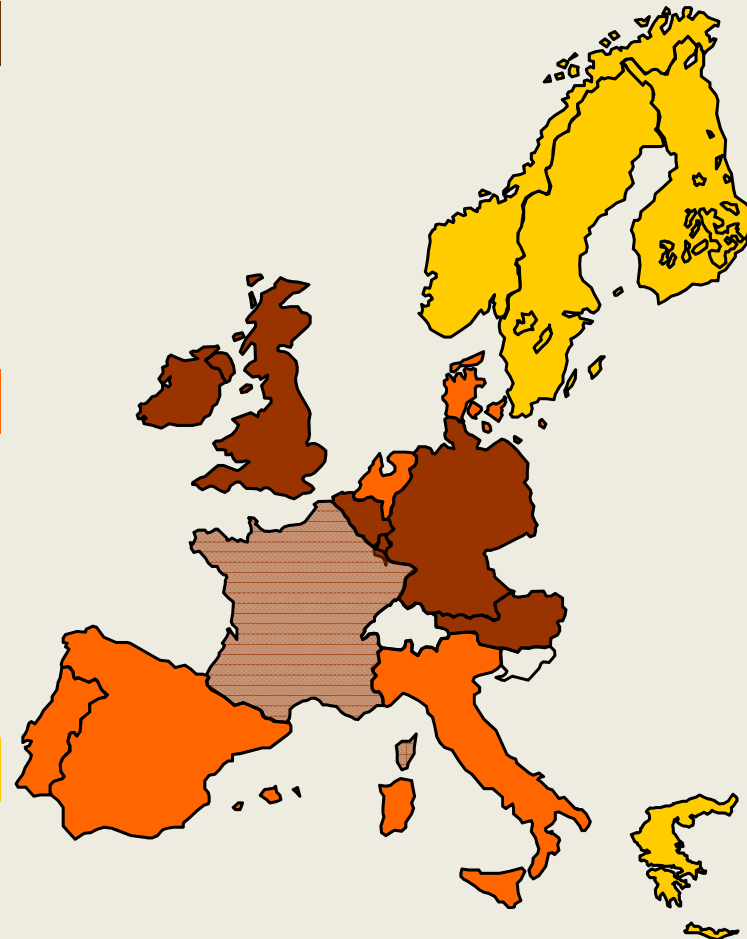
- **Specialised centres:**

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



- **Specialised centre,  
limited number**

Finland, Greece,  
Sweden, Norway



# Integration addiction treatment and harm reduction

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„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

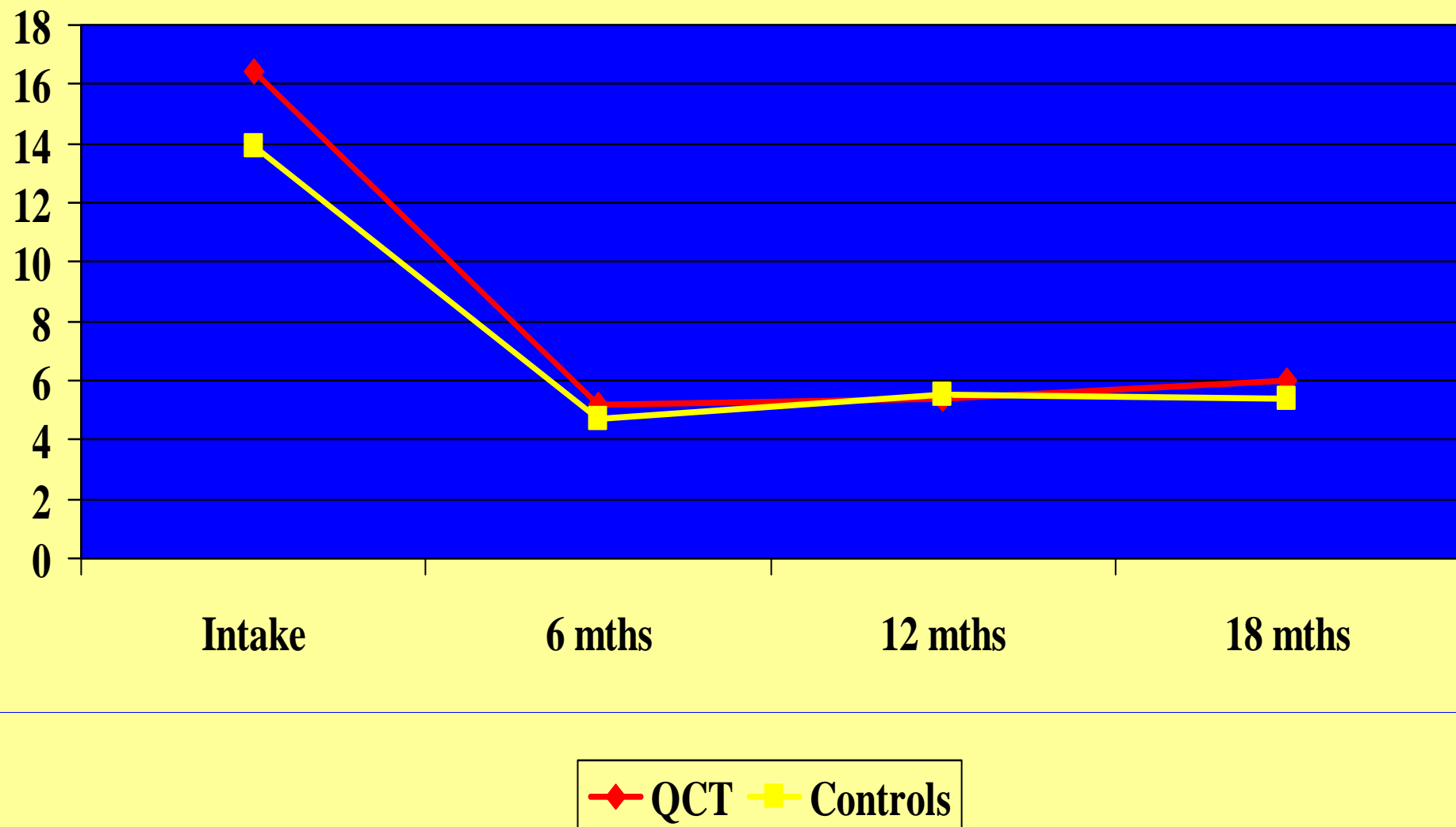
23 countries

# 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)

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	<u>Estimated Number of Groups Worldwide</u>
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)

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- 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 unconscious 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](http://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 deficiencies 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, Daepfen 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 enduring 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](http://www.addictionrecoveryguide.org))
- Recovery community ([www.werecover.org](http://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 .*