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Best Practice in Treatment

A. Uchtenhagen
Research Institute for Public Health and Addiction
WHO collaborating centre associated with
Zurich University
Overview

• Why best practice guidelines? What does it mean?

• The role and limitations of scientific evidence

• About the applicability of guidelines

• Best practice at the system level

• And the future?
Why best practice guidelines?

- Diversity of therapeutic approaches
- Diversity of evaluation methods and criteria
  - Treatment objective
  - Outcome criteria
  - Patient selectivity
  - Evaluation design
- Lack of adequate evidence
- Role of expert opinion
  - Selectivity of experts
  - Lack of systematic consensus building process
What does best practice mean?

- **Best practice** is “the best application of available evidence to current activities in the drugs field” (EMCDDA 2012).

- **Best practice guidelines** are “informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options” (Institute of Medicine, 2011).
Best practice is evidence-based practice

- Grading of evidence
  - GRADE system (Guyatt et al 2008)
  - The „gold standard“ are RCT

- Agreement in expert opinion
  - Consensus building standards (Appraisal of Guidelines for Research and Evaluation AGREE II, 2009)
  - The best standard at present is set by AGREE II
About the applicability of guidelines

• It is possible that the expected outcomes as predicted by efficacy studies will not be attained when implemented under field conditions and in different socio-cultural settings (Lohr, Eleazer and Mauskopf, 1998)

• External validity (generalisability) of findings from RCTs are often inadequate and make applicability difficult (Rothwell 2005)

• Also relevant are: availability and affordability of recommended treatment, adequate training of therapists, patient preference
An adapted concept of best practice

„Best practice is not treatment in some centres of excellence, but a treatment system providing all those in need of treatment, responding to their individual situation in the best possible way“
Best practice at the system level

- Deficiencies of treatment coverage and quality
  - Coverage: WHO Atlas report 2010
  - Quality: substandard services in USA and EU

- Priorities for best practice at the system level
  - Balancing coverage and quality in an integrated system
  - Masking best use of resources in stepped care models
  - Minimum quality standards allow for better coverage
  - From process-focused to patient-focused services
Deficits in treatment coverage
(WHO Atlas Report 2010)

• Only 40% of countries have treatment services for IVDU

• In 40% of countries agonist maintenance treatment covers <10% of opioid dependent persons

• In-patient detoxification is the prevailing approach for alcohol and drug use disorders
Deficits in treatment coverage

- Only 11% of all inmates with substance abuse and addiction disorders in US prisons and jails receive any treatment during their incarceration (CASA report „Behind bars II“, 2010)

- By 2007, 934 compulsory „treatment centers“ in China, Vietnam, Malaysia & Cambodia have estimated 377‘850 inmates; relapse rates are 60-100% (WHO 2009)
Deficits in treatment quality

- EU project on Minimum Quality Standards EQUS
- 52 experts from 27 countries contribute to establish inventory of quality standards in treatment and harm reduction
- 300 stakeholders participate in a consensus building process to define minimum quality standards (>80% of agreement)
- High discrepancy between acceptability and implementation of standards
- Final report 2011 on <www.isgf.ch>
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<th>Already implemented %</th>
<th>Feasible without problems %</th>
<th>Problems expected %</th>
<th>Not feasible %</th>
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Integrated services

- **Beckley report** (Stevens, Hallam & Trace 2006)
- **Continuum of care through integrated services**
  
  - Easily accessible low threshold services that meet the immediate needs of continuing drug users.
  - Clear processes for motivating users to move away from drug dependent lifestyles.
  - Clear processes for referring users into structured treatment programmes that promote stabilization or abstinence.
Stepped care (1)

- **ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders (2001, 2nd ed.)**
  - Individualised assessment (biomedical conditions, emotional-behavioral-cognitive conditions, readiness to change, continued problem potential, recovery environment)
  - Matching to levels of treatment intensity (outpatient, intensive outpatient, residential, medically managed intensive inpatient)
Stepped care (2)

• **Mate** (NL, BRD)
  • Assessment, intake & treatment indications are made in regional Research and Development Centers, based on evidence based protocols
  • ([www.resultatenscoren.nl](http://www.resultatenscoren.nl)), ([www.mateinfo.eu](http://www.mateinfo.eu))

• **Outcomes**
  • Good protocol implementation in participating services (Grol & Wensing 2005)
  • Good acceptance by patients (Mercx et al 2006)
Minimum treatment/rehabilitation standards (22)

1. Structural standards of services (6)
   - Accessibility, physical environment, diagnosis based indication, staff qualification and composition

2. Process standards of services / interventions (9)
   - Assessment procedures, treatment planning, informed consent, records, confidentiality, cooperation, staff training

3. Outcome standards at system level (7)
   - Goals, monitoring, evaluation

Final report 2011 on <www.isgf.ch>
Improved outcomes (1)
(Friedman et al 2004)

National Treatment Improvement Evaluation Study (NTIES)

• Assessing the individual needs at entry in 5 domains (medical, mental health, family, vocational, housing)

• The higher the rate of matched needs, the lower the rate of continued use 1 year after treatment (urine controls, p=0.01)

• Best effects in case of expressed needs concerning housing and work
Improved outcomes (2)
(McLellan & Humphries 2012)

- Process focused quality improvement strategies
  - Improving retention, better use of best practice rules
  - Minimal impact on outcomes

- Patient-focused strategies
  - Rewarding outcomes directly through contingency management, payment by results by providers
Thank you!