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Best Practice in Treatment

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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

- Deficiences 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 partcipate in a consensus building process to define minimum quality standards (>80% of agreement)*
- *<u>High discrepancy between acceptability and implementation of standards</u>*
- *Final report 2011 on <www.isgf.ch>*

Minimum quality standards for treatment services (EQUS project 2011)

Standard	Already imple-mented %	Feasible without problems %	Problems expected %	Not feasible %	No answer %
Assessment substance use	44	38	12	1	5
Assessment somatic status	36	39	16	2	7
Assessment psy-chiatric status	24	32	32	4	8
Written patient records	43	26	19	4	8
Confidentiality of patient data	56	26	12	0	3
Continued training staff	30	24	41	0	6
Diagnosis mandatory	41	23	27	1	7

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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), (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 !

Uchtenhagen, A: What means best practice ?

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