Experiences renovating the Dutch Addiction Treatment System - clinical and organizational aspects

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Beware of clinician’s fallacies

1. Substance dependency is always severe and almost untreatable
2. Clinician’s are - in person - indispensable for recovery
3. Clinician’s own methods are the best – even if science tells a different story
4. Recovered addicts are – by their experience – good clinicians
Topics

- Background – Substance Disorder Treatments: professionalization needed!
  in general, and in the Netherlands
- Design Renovation program
- Evidence based treatment
- Modules developed - three in detail:
  1. CBT
  2. Assessment and matching,
  3. eHealth
  4. Outcome monitoring and feedback
- Implementation – success and failures
Some reputation...

pragmatic approach towards the use of psychotropics ....

but also towards treatment
Dutch Substance Abuse Treatment Services

11 Regional organizations

Ca. 100 outpatient units, and ca 30 residential centres,
serving ca 60,000 new patients yearly
(ca 55% alcohol dependent)

16,5 Milj inhabitants
Some characteristics Dutch Substance Abuse Treatment Services

- Integrated services for alcohol and drugs
- Integrated social and health care services
- Almost monopolistically serving regions (very small private sector)
- Services covered by social insurances (free universal access, but waiting lists)
- Specialized certified professional education programs in addiction, for medical doctors and for psychologists
- Substance disorder and other mental disorders treatment service institutes gradually merging
Nevertheless, in the 90s, treatment services were publicly criticized for lack of success in healing addiction and in reducing public nuisance, which alarmed the management.
15-20 years ago

- Substance abuse treatment isolated from (mental) health services
- Irrational distinction (organizational and conceptual) between kind of substances (alcohol and drugs)
- Hardly any research
- Too much emphasis on abstinence oriented programs
- Undervaluation of medication supported therapies
- Too less attention for motivation enhancement
- Too less respect of the chronic relapsing nature of addiction of some
- Too less distinction between chronic and recoverable problems
Where did this lead to?

Designing a Treatment Renovation Program
“Scoring Results”

National Renovation Program
Dutch Substance Abuse Treatment Services
1998-2010

A cooperative effort of the managers of all larger treatment substance abuse institutions, with the help of additional funding from Ministry of Health
Designing a Treatment Reform Program

Reforming Dutch substance abuse treatment services

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Revamping Dutch addiction-treatment services

\textit{Die Innovation der niederländischen Suchthilfe}
Objectives Renovation Program

Improvement of services for substance abusers (primary processes) by

1. Implementing services based on scientific evidence and/or clinical consensus
2. Monitoring clinical results and feeding them back to professionals and the public
3. Creating and improving education and training
Organization

- National Steering committee, involving both treatment professionals, scientists, and managers
- Adopting a development and implementation (‘master’) protocol for developing and implementing selected service elements
- Granting small stimulation projects funded by Ministry of Health (‘seeding money’)
- Costs: ca 2.5 to 3 million euros over 12 years
Master protocol

1. Literature study reviewing evidence
2. Draft of manual/protocol as the combined effort of clinicians and scientists
3. Implementation in one (contributing) center
4. Implementation in more centers (based on a prefigured plan)
5. Evaluation and dissemination
Evidence on Effectiveness in Substance Abuse Treatment is Ample Available

concluding: Treating alcohol and drug disorder IS effective when delivered by qualified professionals, using empirically validated medications and therapies, applied for adequate durations and followed by monitoring and maintenance. (McLellan, 2004)
Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders

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Center on Alcoholism, Substance Abuse and Addictions (CASAA) and Department of Psychology, The University of New Mexico, Albuquerque, New Mexico, USA

ABSTRACT

Aim A 3-year update with 59 new controlled trials is provided for the ongoing Mesa Grande project reviewing clinical trials of treatments for alcohol use disorders. The project summarizes the current evidence for various treatment approaches, weighting findings differentially according to the methodological strength of each study.

Design The review includes 361 controlled studies that (1) evaluated at least one treatment for alcohol use disorders, (2) compared it with an alternative condition (such as a control group, a placebo, a brief intervention or an alternative treatment), and (3) evaluated related intervention traits.
Treating Alcohol and Drug Abuse

An Evidence Based Review
Implementing renewed services for Prevention, Treatment and Matching
Treatment Services Re-Designed

- Psychosocial behavior-oriented treatment (individual & group)
- Matching and assessment
- Detoxification procedures for in- and out-patients
- Treatment for dual-diagnosis patients
- Crisis intervention
- Case management
- Mutual and self help support programs
- After care
- Rehabilitation
- Outreaching care
- Methadone maintenance
- Housing facilities and guidance
- Outcome measurement and feedback
23 manuals/protocols;
>40 practical publications
Results of 8 years Dutch substance abuse treatment redesign

National program “Scoring Results” produced new evidence based interventions, protocols and guidelines on treatment and prevention.

Factsheets In English
www.resultatenscoren.nl
Treatment Services Re-Designed

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- Outcome measurement and feedback
1. Psychosocial behavior-oriented treatment modules

1. Brief CBT (intake + ca. 4 sessions)
2. Standard CBT (intake + ca. 10 sessions)

- formatted after project MATCH modules
- for individuals and groups
- general applicable for any substance
- based on cognitive behavior therapy
- motivational interviewing as basic counseling style
2. Matching and Assessment

Treatment indication and routing

This module has been developed in order to determine on the basis of protocols and objectivity the clients’ need for help and their problems, as well as the kind of care or treatment that is to be advised. The module precedes the treatment and care, and is meant for all clients or people involved that approach the institute with a request (for help).

important role in treatment indication:
• The severity of the addiction.
• The nature and extent of psychiatric co-morbidity.
• The nature and stability of the social circumstances.

To ensure that treatment takes place along certain protocols, a decision tree has been developed.

The structure of the module
The module comprises three and a maximum of four ses-
Dutch Treatment Centers adopted Central Intake & Stepped Care: Main characteristics

- Individualized trajectories
- Evidence based treatments
- Least restrictive (but still effective) have priority
- Next step based on evaluation outcome earlier steps

**Treatment System Overview**

1. **Brief outpatient intervention**
2. **Long outpatient intervention**
3. **Interventions with day (night) lodging/stay**
4. **Interventions with 24-hours lodging/stay**
5. **Outreaching case management and time out**

- **Internet**
- **Prevention**
- **Selfhelp**
Interventions: Levels of Intensity (after Detoxification)

1. Brief outpatient intervention: 4 sessions
2. Standard outpatient intervention: 10 sessions
3. Clinical intervention (day/night structure ‘bed’)
4. Continuous out-reaching care
Matching Criteria to Level of Care

Hardly any evidence in the literature for matching patient to treatment modalities (method) on the basis of patient characteristics. Nevertheless, some evidence for matching to

Intensity of Treatment (‘Level of Care’)
to be based on

• Social integration
• Psychopathology
• Addiction severity
• + number of unsuccessful treatments inj the recent past
Stepped Care Matching Criteria
Patient Placement Decision Tree

- Addiction severity
- Psychiatric impairment
- Social stability

Treatment history: [0-1]
- Low or moderate: Yes
  - Addiction severity
    - Low or moderate: Yes
      - Social stability
        - Good or moderate: Yes
          - Brief outpatient
        - Severe: No
          - Outpatient
    - Severe: No
      - Brief outpatient
  - Severe: No
    - Outpatient

Treatment history: [2]
- Yes: Good or moderate
  - Addiction severity
    - Low or moderate: Yes
      - Social stability
        - Good or moderate: Yes
          - Day/Residential
        - Severe: No
          - Outpatient
    - Severe: No
      - Outpatient
  - Severe: No
    - Outpatient

Treatment history: [3-5]
- Yes: Severe
  - Addiction severity
    - Low or moderate: Yes
      - Social stability
        - Good or moderate: Yes
          - Day/Residential
        - Severe: No
          - Outpatient
    - Severe: No
      - Outpatient
  - Severe: No
    - Outpatient

Treatment history: [> 5]
- Yes: Care (in- and outpatient)
Decision tree leads to change

- Decision tree implemented in 8 from 10 centres, although adapted in some
- Ca 25,000 has gone through the system by now
- In the Jellinek it led to ca 20% less inpatient treatment in favor of outpatient treatments
- The length of outpatient treatments was shortened by ca 15%, without losing effectiveness!
Decision tree is feasible in practice

RESEARCH REPORT

Allocation of substance use disorder patients to appropriate levels of care: feasibility of matching guidelines in routine practice in Dutch treatment centres

Maarten J. M. Merkx1,2, Gerard M. Schippers1,2, Maarten J. W. Koeter1,2, Pieter Jelle Vuijk1, Suzan Oudejans1, Carlijn C. Q. de Vries1 & Wim van den Brink1,2

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Addiction, 102, 466–474
Decision tree is feasible in practice

... the concordance with the broad criterion for matching is 60.8% (1,073 out of 1,765). Thirty-five percent (n = 618) entered a more intensive LOC (over-treated) than recommended by the algorithm, and only 4.2% entered a less intensive LOC (under-treated).
and have predictive validity

Validity of Treatment Allocation Guidelines for Predicting Alcohol-Dependent Patients’ Drinking Outcomes
Maarten J.M. Merkx\textsuperscript{1}, Gerard M. Schippers\textsuperscript{1}, Maarten W.J. Koeter\textsuperscript{1}, Pieter Jelle Vuijk\textsuperscript{1}, Suzan C.C. Oudejans\textsuperscript{a,b}, Ragna K. Stam\textsuperscript{c}, Wim van den Brink\textsuperscript{1}

Addictive Behaviors, in press
Measurement in the Addictions for Triage and Evaluation

Gerard M. Schippers, AIAR-AMC Amsterdam
Theo Broekman, Bureau Beta, Nijmegen
Angela Buchholz, Universitat Freiburg

www.mateinfo.eu
The MATE

- modern alternative for the ASI, European oriented
- valid and reliable assessment of patient characteristics
- has proven to be functional in everyday practice
- gives an appraisal of both patients’ limitations and their strengths
- is based on WHO classification systems ICD and ICF
- modular design, including the best available tests and subtests

www.mateinfo.eu
Besides measuring substance use disorders, the MATE includes modules to assess activities and participation.
Available in English, German, Dutch, Italian, & Spanish
In the public domain - free of charge
well tested in the Netherlands (standard instrument) and in Germany

MATE-Outcomes
MATE-Y (Youth)
MATE-Crimi

www.mateinfo.eu

Topics

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- Design Renovation program

- Evidence based treatment

- Modules developed - three in detail:
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- Implementation – success and failures
eHealth well developed in the Netherlands
Many Internet Intervention sites available
Internet Self Help Intervention (www.Jellinek.nl)
Internet selfhelp is feasible

- Many participants, despite lack of marketing initiatives
- Jellinek site reaches ca 150 new individuals p. month, of whom ca 1/3 more than moderate adhere to the program
- Attractive for: highly educated; working; relatively many women, treatment-naive
Original Paper

Effectiveness of E-Self-help Interventions for Curbing Adult Problem Drinking: A Meta-analysis

Heleen Riper¹,²,³, PhD; Viola Spek³,⁴, PhD; Brigitte Boon³, PhD; Barbara Conijn³, MSc; Jeannet Kramer³, PhD; Katherina Martin-Abello³, MA; Filip Smit³,⁵, PhD
Comparison Self-Help and Internet Treatment (chat sessions included)

Internet Self-help (IS)

Internet Therapy (IT)
Alcohol reduction (TLFB)

Drinks per week (TLFB)

baseline 3 months 6 months

Time

IT WL IS

Internet Therapy Versus Internet Self-Help Versus No Treatment for Problematic Alcohol Use: A Randomized Controlled Trial

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Academic Medical Center, University of Amsterdam, and Arkin

Maarten W. J. Koeter
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Evaluation Requires Outcome Assessment

Piloting: Outcome monitored, analysed 2005-2010 in four centres

Since 2009 ROM is obligatory for all through Dutch financing insurance companies and the government
53% follow-up rate was achieved; 35% of the patients could not be contacted, 3% explicitly refused and in 8% other reasons accounted for non-participation. About 50% of the interviews took place in the intended time-frame. Costs were €40 ($57) per completed interview.
Benchmarking outpatient services in 4 treatment centres 2005-2010

• Telephonic 9 months follow up MATE interview
• Intake: 15,619 clients
• Response FU: 52,1%
• Concluding: Differences in treatment modalities and treatment exposure
• No differences in outcomes between treatment centers
• Relation between outcome and treatment exposure
Outpatient Treatment Compliance

- Drop out: 24%
- Completed: 32%
- Over treated: 44%
Substance Use Outpatients in Past 30 Days 9 Months after Intake (N>8,000)

- Abstinence: 21%
- No problematic use: 26%
- Problematic use: 52%
IMPLEMENTATION
How Well are the New Modules Implemented?

- In 2005 20 and in 2011 23 modules disseminated
- Evaluation study in fall 2005, 2008, and 2011
- 10 Out of 11 institutions observed, covering 3,800 (77%) of the 5,000 patient-related workers
- Interview with 40 key persons
- Questionnaire survey with 196 counsellors (27% non-response)
Level of Implementation of 23 protocols

- Brief CBT individual
- Standard CBT individual
- Brief CBT group
- Standard CBT group
- Screening, Needs & Allocation
- User Rooms
- Crisis intervention
- Detoxification
- Self Help Groups & Regular Care
- After Care
- Opiate Substitution Treatment
- Suicide in addiction care
- MATE: Triage & Patient Placement
- Adolescent Cannabis Abuse
- Substance Abuse & Depression

% treatment centers
Level of implementation in 11 treatment centers

2011, 23 modules
Dissemination & Implementation

Slow, but steady

Strong points:
• centralized organization and support
• renewal is seen as survival strategy

Weak points:
• underdeveloped education/training infrastructure
Necessary (although not Sufficient) Conditions for Implementation

• Adequate resources
• A reasonably well managed institute
• Coalition of multiple stakeholders: financers, centres administrators; clinicians, and service consumers
• Support on central management level
• Trusted enthusiastic mediator (“champion”)
• Training, supervision and booster training
• Protection of innovative (young) professionals
Lessons learned

- Minor local variations should be possible (‘not-invented-here-syndrome’)
- Instability in team management and team personnel are hindering
- Changes should not be too large and too quick
- New modules should replace old practices
- *Continuation in* coercion and support from central management are essential
REQUIRED:

Coalition of multiple stakeholders: financers, centre administrators; clinicians, scientists, and service consumers (!)
Suggestions

• Use carrot and stick
• Provide stimulation projects and ‘seeding’ trials (compare NIDA-CTN program)
• Identify and promote key persons: ambitious managers and enthusiastic clinicians
• Employ evidence based policy:
• Reinforce system change by material consequences of not following guidelines
Dutch treatment professionals are alike their colleagues all over the world in eagerness and willingness to learn and change.
... the changing of habitual behavior is tedious and takes a long breath.