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Searching objective criteria for patient assignment in addiction treatment

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ABSTRACT

The main aim of this study was to objectify the treatment assignment criteria used in a clinical centre for addiction treatment in Spain. A sample of 162 patients (87 inpatients and 75 outpatients) who sought treatment between 2010 and 2012 was assessed. Clinical characteristics (addiction severity, psychopathological symptoms, impulsiveness and maladjustment) of the two treatment groups (inpatient and outpatient) into which patients were assigned according to the clinical criteria of therapists were analysed to identify which variables were more relevant for patient placement. Moreover, the therapeutic progression of patients who met and did not meet the assignment criteria received was studied. According to the results, a score above 4 in the family/social support area of the European Addiction Severity Index (EuropASI), or, in cases of a score between 2 and 4 in the family/social area of EuropASI, a score above 2 in the partner subscale of the Maladjustment Scale correctly classified 73.5% of cases (96.6% of inpatients and 46.7% of outpatients). Comparisons of therapeutic results depending on matching or mismatching these assignment criteria showed a larger effect size in mismatching patient assignment criteria for outpatient treatment. The results obtained in this study provide an objective criterion for addicted patient placement. Moreover, from a cost-effective perspective, they question the necessity of inpatient treatment in most cases, demonstrating that outpatient treatment is a sufficient level of care. This study addresses the approach to assigning patients to the treatment modality that best fits them, implementing the least expensive level of care needed to achieve treatment success.

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1. Introduction

The cost-effectiveness of treatment for alcohol and drug abuse disorders is currently an important challenge in the field of addictions. Adequate treatment matching based on empirically established patient placement criteria becomes relevant to optimally provide cost- and outcome-effective treatment (McGee & MeeLee, 1997). The correct assignment to an inpatient or outpatient treatment modality based on the needs of patients is critical in optimizing the clinical intervention provided.

The literature about addiction treatment effectiveness explains that both inpatient and outpatient modalities have empirical evidence supporting their effectiveness (Fernández-Montalvo & López-Goñi, 2010; Fernández-Montalvo, López-Goñi, Illescas, Landa, & Lorea, 2008; Hubbard, Craddock, & Anderson, 2003; Magor-Blatch, Bhullar, Thomson, & Thorsteinsson, 2014; McCarty et al., 2014; Reif et al., 2014; Vanderplasschen et al., 2013; Wallace & Weeks, 2004). However, research with greater specificity and consistency is needed, taking into account the heterogeneity of both inpatient (e.g. therapeutic community versus short-term residential treatments) and outpatient (e.g. regular versus intensive) treatment programmes.

In clinical settings, the decision about which treatment modality (outpatient or inpatient) is the most appropriate for each patient is often based on the subjective criteria of therapeutic teams. There is an important lack of objective clinical criteria matching patients to the type of treatment best suited to their needs. Therapists use their clinical impression of the patient's situation and tend to assign inpatient treatment to those with more severe addictions as well as those who do not have good family or partner support to help them in the recovery process (Gregoire, 2000; Harrison & Asche, 1999). Another common criterion used to assign inpatient treatment is the lack of satisfactory results in outpatient programmes. Patients with frequent episodes of relapse or high dropout rates in outpatient treatment are usually moved to inpatient programmes (Gregoire, 2000; López-Goñi, Fernández-Montalvo, Cacho, & Arteaga, 2014).

However, it is necessary to determine objective criteria beyond the clinical impression of therapists that will enable decision making based on empirical evidence when assigning patients to the most appropriate treatment modality. Although there have been some attempts to establish objective patient placement criteria (American Society of Addiction Medicine, 1996; Hoffman, Halikas, Mee-Lee, & Weedman, 1991; McGee & MeeLee, 1997; McKay, Cacciola, McLellan, Alterman, & Wirtz, 1997; Stallvik, Gastfriend, & Nordhal, 2015), there is still not a

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scientific consensus on which criteria should be taken into account to place patients in the best level of care. This is an important issue because one of the main challenges in the treatment of addictions focuses on matching treatment to the specific needs of each patient (Camilleri, Cacciola, & Jenson, 2012; Gregoire, 2000; McGee & MeeLee, 1997; McKay et al., 1997; Rohrig, Buchholz, Wahl, & Berner, 2015).

Therefore, the main purposes of this naturalistic study were to objectify the treatment assignment criteria used in a clinical centre for addictions in Spain and to evaluate the subsequent treatment progression. The specific goals were first, to analyse the clinical characteristics (addiction severity, psychopathological symptoms, impulsiveness and maladjustment) of two treatment groups (inpatient and outpatient) in which patients were assigned according to the clinical criteria of therapists; second, to identify which variables were more relevant in the therapeutic assignment of patients; third, to determine the differential progression of both treatment groups to evaluate the utility of the assignment criteria; and fourth, to compare the therapeutic progression between patients who met and did not meet the assignment criteria.

2. Methods

The protocol for this study was approved by the ethics committees of the Universidad Pública de Navarra and the Fundación Proyecto Hombre de Navarra. Written informed consent was signed by all participants.

2.1. Participants

The initial sample consisted of 227 patients seeking treatment for addiction in the *Proyecto Hombre de Navarra* addiction treatment programme (Spain) from May 2010 to December 2012. This programme, which offers two modalities of intervention (outpatient and inpatient), is public and attends to patients from all over the region and who are representative of Spanish patients with addiction problems. Payment for treatment is not required. Every patient who consecutively attended the clinical centre was considered for study inclusion.

Study admission criteria included the following: a) meeting the diagnostic criteria for substance dependence disorder according to DSM-IV-TR (American Psychiatric Association, 2000), b) being between 18 and 65 years old, c) beginning the assigned treatment for drug-addiction, and d) giving consent to participation in the study. Following the above mentioned admission criteria, 46 people (20.3%) were excluded from the study and 19 (8.4%) refused to participate in the study. The reasons for exclusion were: a) not meeting DSM-IV-TR criteria for substance dependence (13 cases), b) refusing to receive treatment (13 cases), c) being derived to other service because of different reasons (11 cases), and d) being older that 65 (9 cases). Therefore, a total of 162 (71.4% of total) subjects were studied.

2.2. Instruments

The instruments used in this study formed part of the clinical centre assessment package, and therefore they were not specifically selected for this research.

The EuropASI (Kokkevi & Hartgers, 1995) is the European version of the Addiction Severity Index scale (ASI) (McLellan, Luborsky, Woody, & O'Brien, 1980). In this study, the Spanish version by Bobes, González, Saiz, and Bousoño (1996) was employed. This interview assesses seven different areas: general medical condition, employment situation, alcohol consumption, use of other drugs, legal problems, family and social relationships, and psychological state. In this study, the Interviewer Severity Rating (ISR) was used. These ratings have shown their usefulness in different studies developed in treatment settings (López-Goñi, Fernández-Montalvo, & Arteaga, 2012; López-Goñi et al., 2010). Although the Composite Scores provided by this instrument are usually used in the research field, in Spain the studies of López-Goñi et al. (2012) showed the utility of the ISRs for research purposes. Each area ranges from 0 (no problem) to 9 (extreme problem). The higher the score, the more need for treatment. The one-week test-retest reliabilities ranged from 0.67 to 0.96 in the seven different areas (González et al., 2002).

The Symptom Checklist (SCL-90-R) (Derogatis, 1992) is a self-report that assesses psychopathological symptoms. It is composed of 90 items, which are answered in a five-point Likert scale, from 0 (nothing) to 4 (extremely). It is comprised of nine primary symptom dimensions (somatisation, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism), and of three global indices of severity (the Global Severity Index (GSI), which reflects overall symptom severity, the Positive Symptom Distress Index (PSDI), which indicates symptom intensity, and the Positive Symptom Total (PST), which includes the number of items answered with a score different from 0). The internal consistency ranges from .70 to .90. In this study, the percentiles of each dimension have been considered.

The Barratt Impulsiveness Scale (BIS-10) (Barratt, 1985) aims to assess the degree of impulsivity of the subjects. It consists of 33 items scoring from 0 to 4 on a five-point Likert scale, and is composed of three factors having each one 11 items: motor, cognitive and non-planning impulsiveness. The total score ranges from 0 to 132 (the higher the score, the greater impulsiveness). The internal consistence is .84.

The Maladjustment Scale (Echeburúa, Corral, & Fernández-Montalvo, 2000) reveals how each patient is affected in six different areas of everyday life (labour, social, leisure, partner, family and general). Each area ranges from 0 (nothing) to 5 (extremely) on a six-point Likert scale. The total scale range is 0–30. The higher the score, the higher the level of maladjustment. The internal consistency is .94.

2.3. Treatment modalities

2.3.1. Outpatient treatment

This is a cognitive-behavioural programme aimed at abstinence. The main therapeutic techniques are stimulus control, in vivo exposure and relapse prevention. Successful programme completion usually requires 12 months. The treatment includes weekly sessions (45–60 min) during the first 6 months, and biweekly sessions during the rest of time. The effectiveness of this programme in the addiction treatment has been proven (Fernández-Montalvo & López-Goñi, 2010).

2.3.2. Inpatient treatment

This treatment comprises 2 therapeutic phases: residential therapeutic community and reinsertion. The first phase (therapeutic community), which has an estimated duration of 1 year, is inpatient-based and has 2 main goals: a) to develop or modify behaviours that will increase personal autonomy, and b) to learn coping skills to achieve relapse prevention. In this phase, group and occupational therapies are provided. The second phase (reinsertion), with a duration of approximately half a year, consists in a progressive reduction in the intensity of treatment. The goal of this phase is the reinsertion in social, family and employment areas through individual and group therapies on an outpatient basis. Successful programme completion usually requires 18 months. The effectiveness of this programme in the addiction treatment has been proven (Fernández-Montalvo et al., 2008).

Both programmes take into account the patients' family, involving the family members in the recovery process and giving them specific support to deal with the patient through specific support groups. Anyway, it is not compulsory the family participation to provide treatment to the patient.

2.4. Experimental design

A two-group experimental design (with two treatment groups for addiction) with repeated measures (pretreatment and 6-month

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