Recovery from addiction with or without treatment

Den Nationale Alkoholkonference 2018

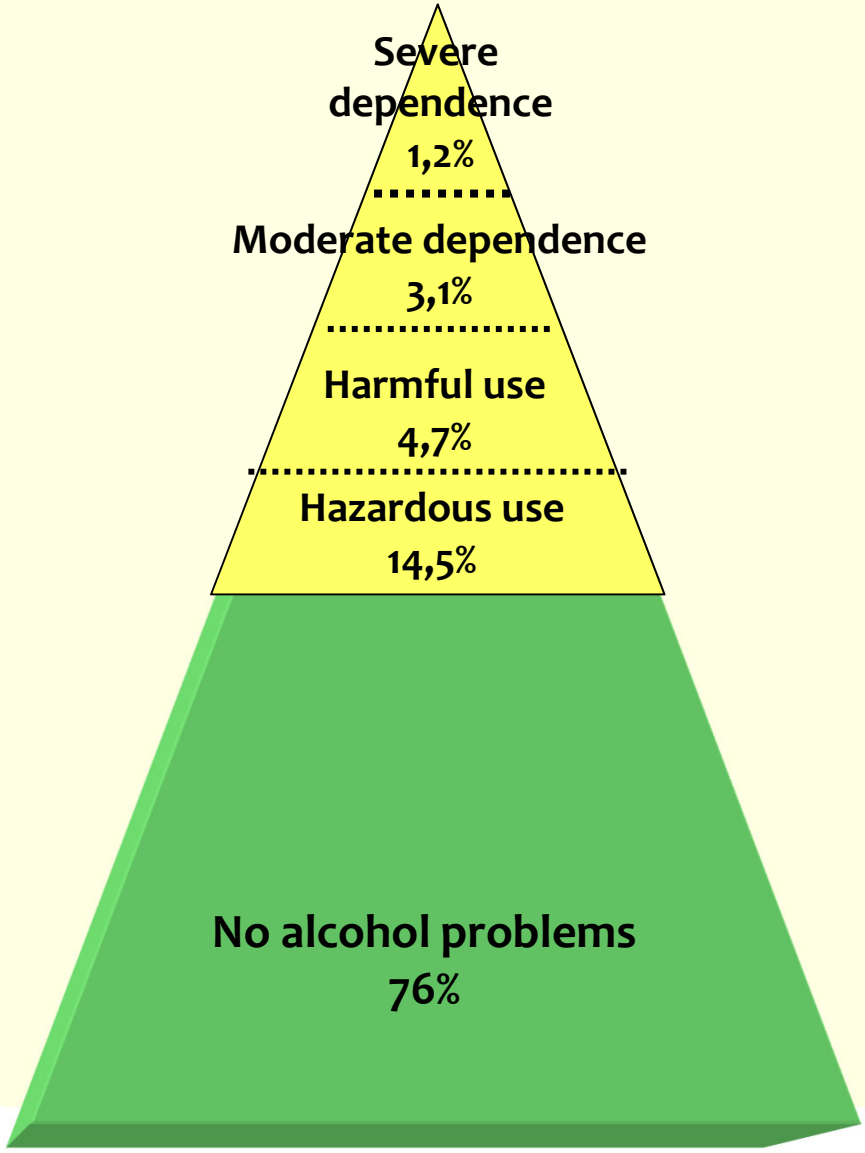
RIDDARGATAN 1
MOTTAGNINGEN FÖR
ALKOHOL OCH HÄLSA

Sven Andréasson, MD, Profes
Karolinska Institutet, Stoc

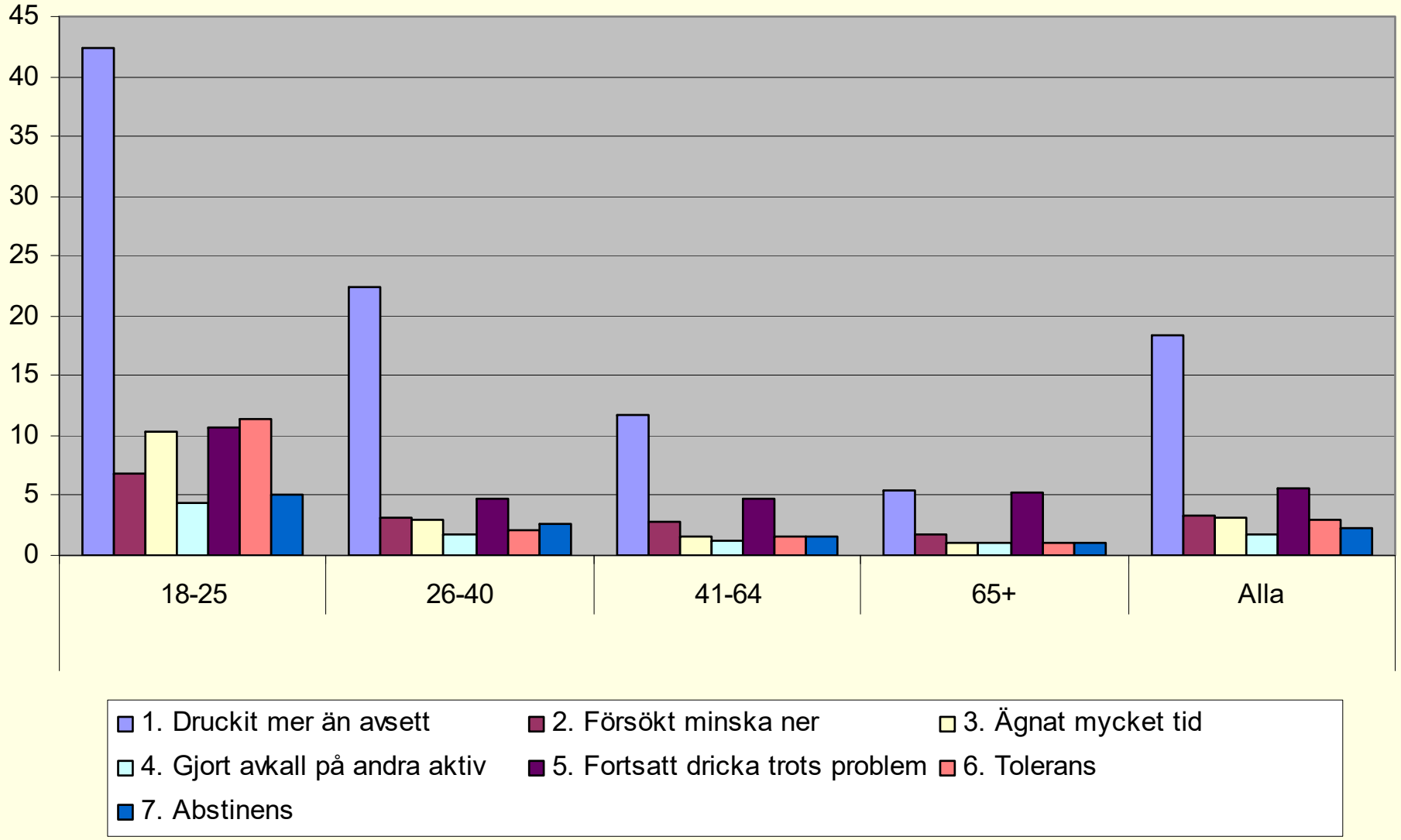
Four themes:

1. Epidemiology
2. Policy
3. Perceptions and stigma
4. Broadening the base of treatment

Alcohol use in Sweden

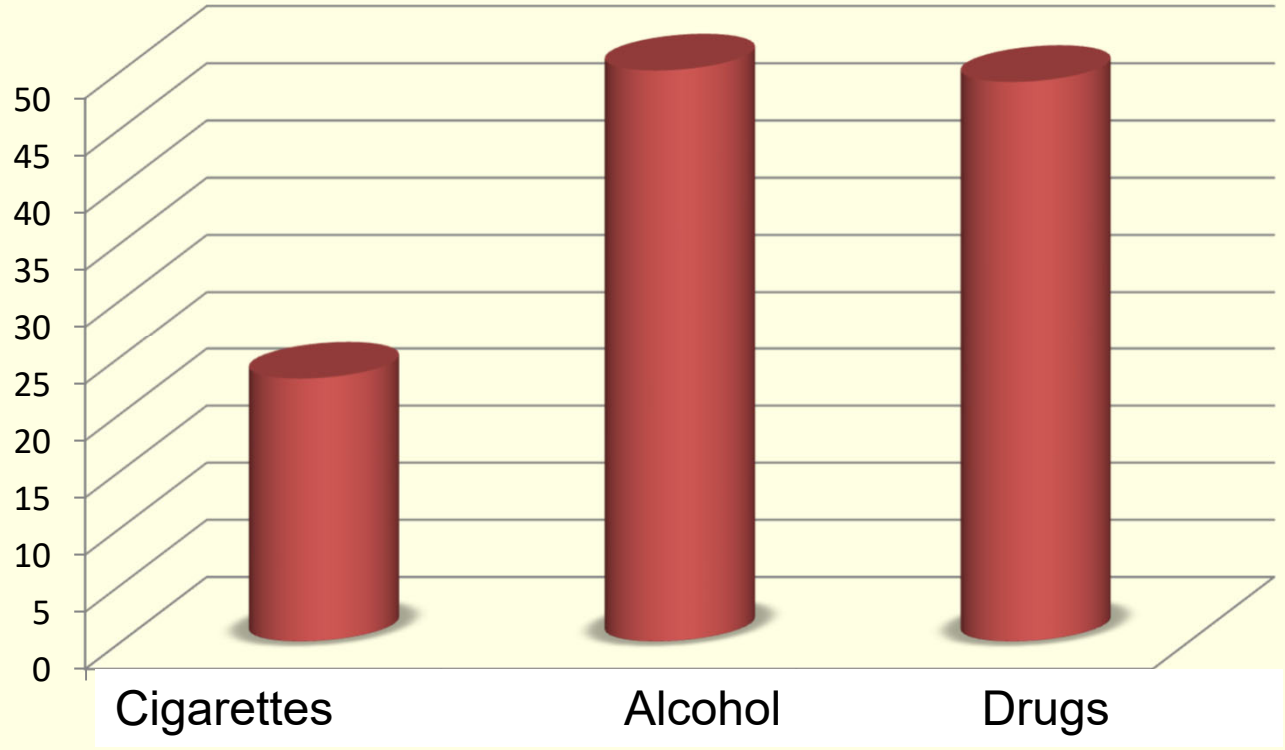


Alcohol dependence most prevalent among young people



Source: Andréasson et al, Alcohol 2013

Swedish study:
after 1 year 50,5 % of alcohol dependent individuals were in remission



Remission rates

Source: CAN-rapport 149, 2015

National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)

Table 3 Past-year status of US adults 18 years of age and over with prior-to-past-year DSM-IV alcohol dependence, by history of treatment for alcohol problems and interval since onset of dependence.

		Years since onset of dependence			
Past-year status	*Total*	*Less than 5*	*5–9*	*10–19*	*20 or more*
Total[a]					
Still dependent	25.0 (0.9)	64.9 (1.7)	25.2 (2.0)	14.5 (1.4)	6.9 (0.8)
Partial remission	27.3 (0.8)	24.6 (1.6)	40.3 (2.3)	30.6 (1.6)	20.1 (1.3)
DSM-IV abuse	10.5 (0.6)	9.1 (1.0)	16.0 (1.9)	11.8 (1.1)	7.7 (0.9)
Dependence symptoms only (subclinical)	16.8 (0.7)	15.5 (1.5)	24.3 (2.1)	18.7 (1.2)	12.4 (1.1)
Asymptomatic risk drinker	11.8 (0.6)	5.4 (0.9)	13.0 (1.5)	16.2 (1.5)	11.9 (1.0)
Low-risk drinker	17.7 (0.7)	4.3 (0.8)	12.3 (1.7)	20.6 (1.5)	27.4 (1.4)
Abstainer	18.2 (0.8)	1.7 (0.4)	9.2 (1.2)	18.0 (1.4)	33.6 (1.5)
Total	100.0 (0.0)	100.0 (0.0)	100.0 (0.0)	100.0 (0.0)	100.0 (0.0)
N	4422	970	658	1234	1475
Ever treated[a,b]					
Still dependent	28.4 (1.8)	64.9 (4.0)	28.7 (4.4)	27.3 (3.0)	13.6 (1.8)
Partial remission	20.4 (1.4)	25.4 (3.8)	36.1 (5.0)	22.5 (2.4)	10.6 (1.6)
Asymptomatic risk drinker	5.7 (0.7)	2.7 (1.4)	3.6 (1.5)	8.5 (1.6)	5.5 (1.2)
Low-risk drinker	10.4 (1.0)	4.0 (1.7)	7.5 (2.7)	10.4 (1.9)	14.3 (2.0)
Abstainer	35.1 (1.9)	3.0 (1.1)	24.0 (4.1)	31.3 (3.0)	56.1 (3.0)
Total	100.0 (0.0)	100.0 (0.0)	100.0 (0.0)	100.0 (0.0)	100.0 (0.0)
N	1205	189	157	365	467
Never treated[a,b]					
Still dependent	23.8 (1.0)	64.9 (1.9)	24.3 (2.3)	9.4 (1.1)	4.3 (0.7)
Partial remission	29.7 (1.0)	24.4 (1.8)	41.5 (2.9)	33.9 (1.9)	24.0 (1.7)
Asymptomatic risk drinker	13.9 (0.7)	6.0 (1.0)	15.7 (1.8)	19.3 (1.7)	14.5 (1.3)
Low-risk drinker	20.2 (0.9)	3.2 (0.8)	13.7 (2.1)	24.7 (1.8)	32.8 (0.6)
Abstainer	12.4 (0.8)	1.4 (0.5)	4.8 (1.0)	12.7 (1.4)	24.5 (1.8)
Total	100.0 (0.0)	100.0 (0.0)	100.0 (0.0)	100.0 (0.0)	100.0 (0.0)
N	3217	781	501	869	1008

Addiction

RESEARCH REPORT

doi:10.1111/add.12309

Predicting persistency of DSM-5 alcohol use disorder and examining drinking patterns of recently remitted individuals: a prospective general population study

Marlous Tuithof[1], Margreet ten Have[1], Wim van den Brink[2], Wilma Vollebergh[3] & Ron de Graaf[1]

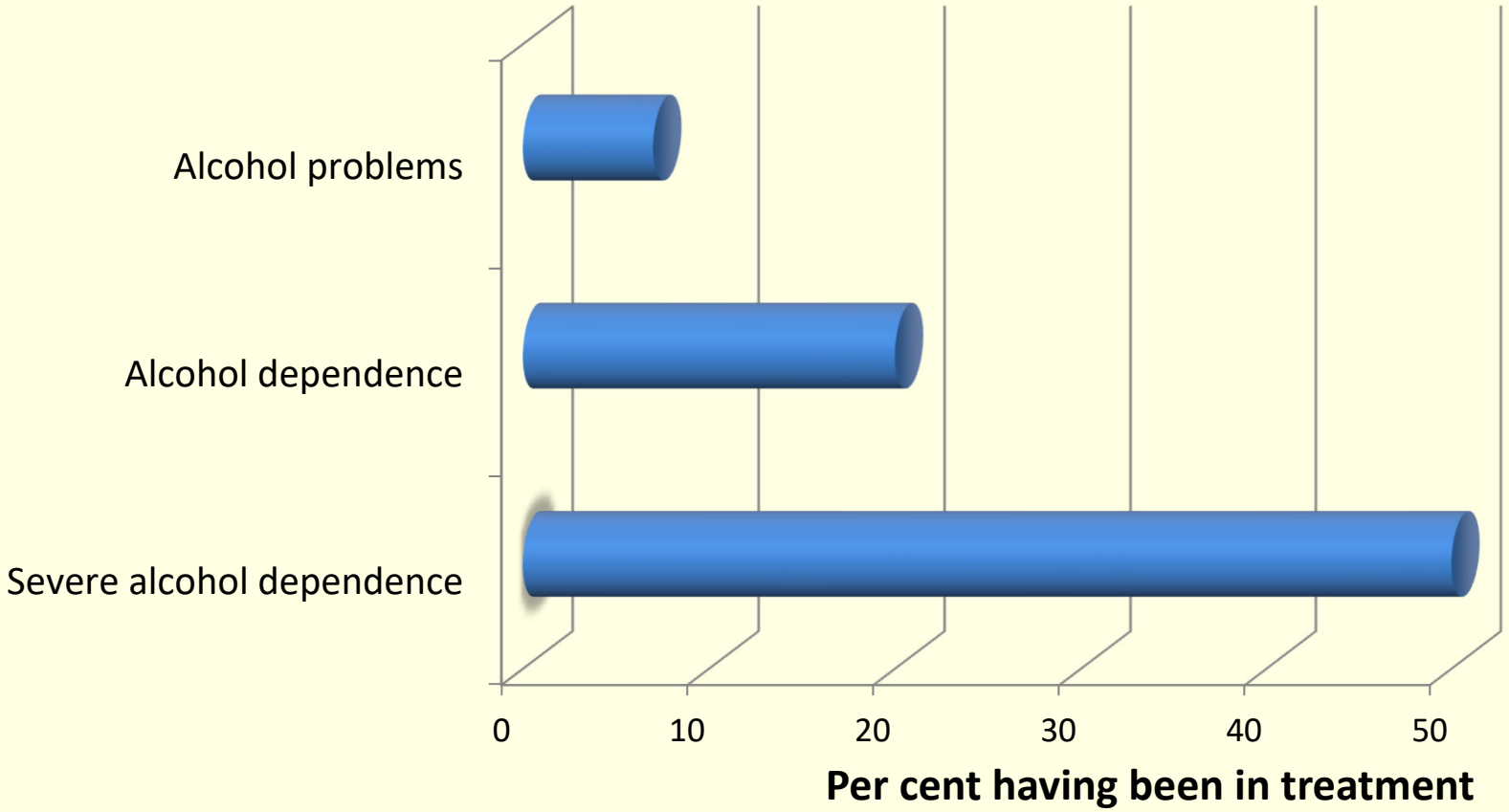
Netherlands Institute of Mental Health and Addiction, Utrecht, the Netherlands,[1] Department of Psychiatry, Academic Medical Centre, University of Amsterdam, Amsterdam, the Netherlands[2] and Department of Interdisciplinary Social Science, Utrecht University, Utrecht, the Netherlands[3]

ABSTRACT

Aims To establish the 3-year persistency rate of alcohol use disorder (AUD) and its predictors, and to examine drinking patterns of recently remitted individuals. **Design and Setting** The Netherlands Mental Health Survey and Incidence Study-2 (NEMESIS-2) surveyed a nationally representative sample of adults (aged 18–64 years) at baseline (response = 65.1%) and 3-year follow-up (response = 80.4%). **Participants** People with AUD at baseline, as defined by DSM-5 (n = 198). **Measurements** AUD, drinking patterns and mental disorders were assessed using the Composite International Diagnostic Interview 3.0. Other predictors were assessed with an additional questionnaire. Predictors of persistency were examined with univariable and multivariable logistic regression analyses. **Results** The AUD persistency rate was 29.5% [95% confidence intervals (CI) = 20.0–39.0]. In the multivariable model, the older (25–34 and 35–44) age groups had lower AUD persistency [odds ratio (OR) = 0.05; 95% CI = 0.00–0.49 and OR = 0.14; 95% CI = 0.02–0.79, respectively] than the youngest age group (18–24). A higher number of weekly drinks and a comorbid anxiety disorder predicted AUD persistency (OR = 1.03; 95% CI = 1.00–1.07 and OR = 4.56; 95% CI = 1.04–20.06, respectively). Furthermore, remission was associated with a reduction of six drinks per week between T_0 and T_1. It should be noted, however, that 35.8% (95% CI = 22.4–49.2) of people in diagnostic remission still drank more than the recommended maximum (more than seven/14 drinks weekly for women/men). **Conclusions** Only a minority of people in the Netherlands with alcohol use disorder as defined by DSM-5 still have the disorder 3 years later. Factors that help to identify people at risk of alcohol use disorder persistence are: younger age, a higher number of weekly drinks and a comorbid anxiety disorder. A substantial number of people recently in diagnostic remission still drink above the maximum recommended level.

RIDDAR
MOTTAGN
ALKOHOL

Treatment seeking among former problem drinkers



Source: Blomqvist et al , SORAD, 2007

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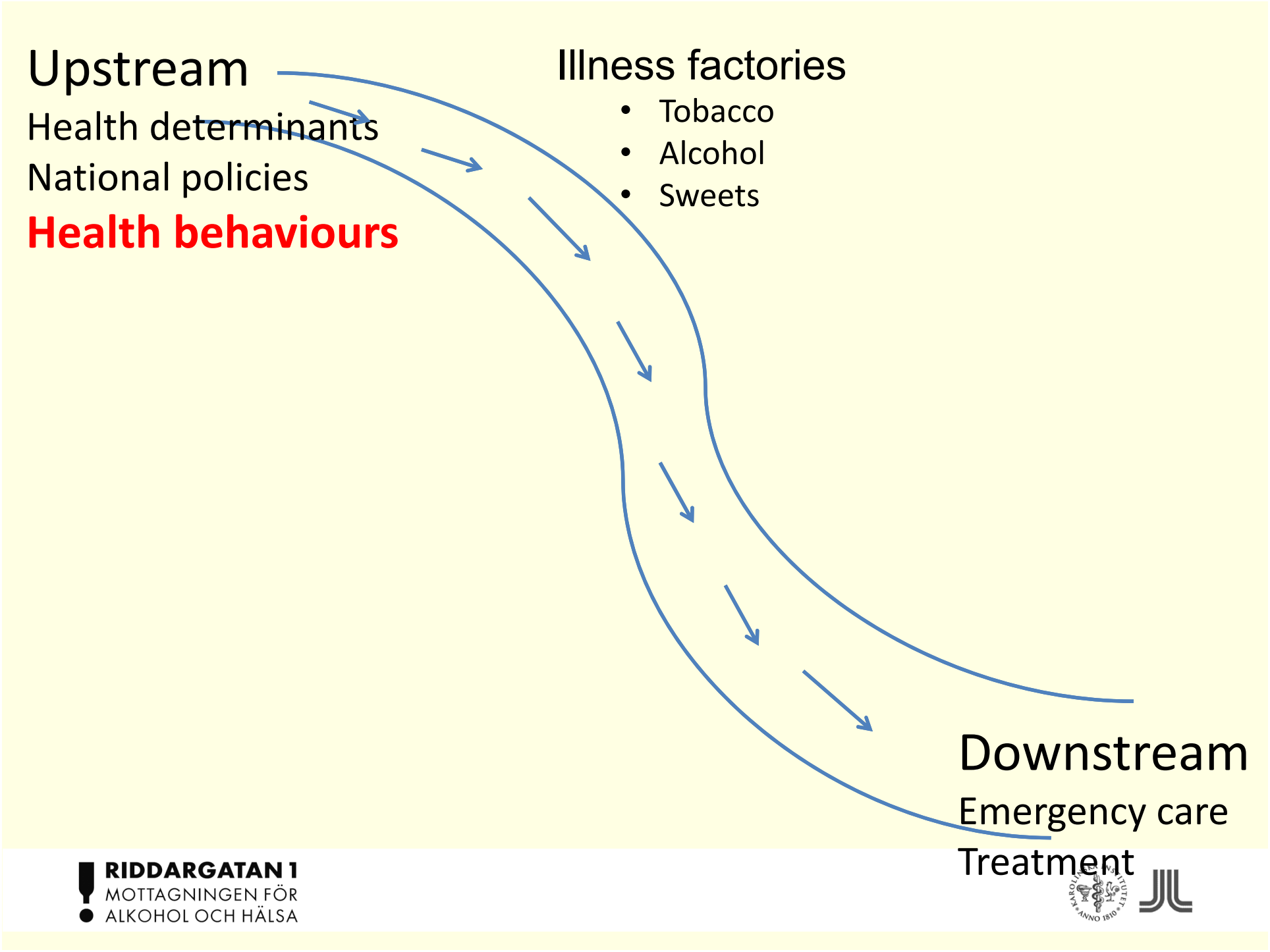
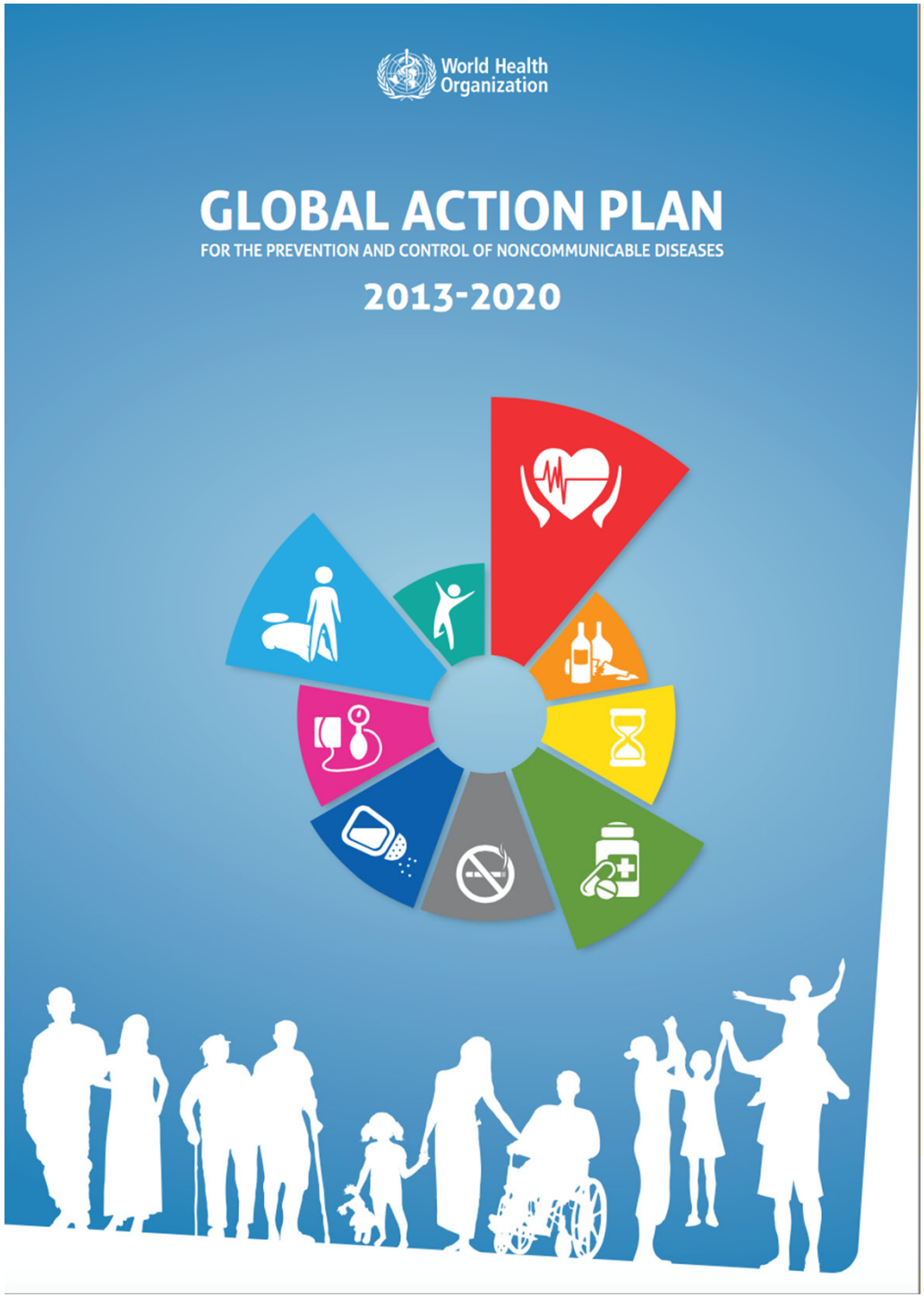
We only reach the most severe cases

The Public Health Approach: Upstream - downstream


Upstream
Health determinants
National policies
Health behaviours
Illness factories
• Tobacco
• Alcohol
• Sweets
Downstream
Emergency care
Treatment



NCD and health behaviour

”Best buys” in the alcohol field

1. Price/taxation
2. Regulating physical availability
3. Banning or regulating marketing of alcohol

Minimum pricing

Increasing minimum prices 10% in British Columbia

- 32% fewer alcohol related deaths
- 9% fewer hospital admissions
- Improves health expecially in lower socio-economic groups
  - Those most affected by alcohol related harm

Bars opening hours

Norway: study from 18 cities

- 1 hour longer opening:

→ 20% increase violent assaults

Warning labels

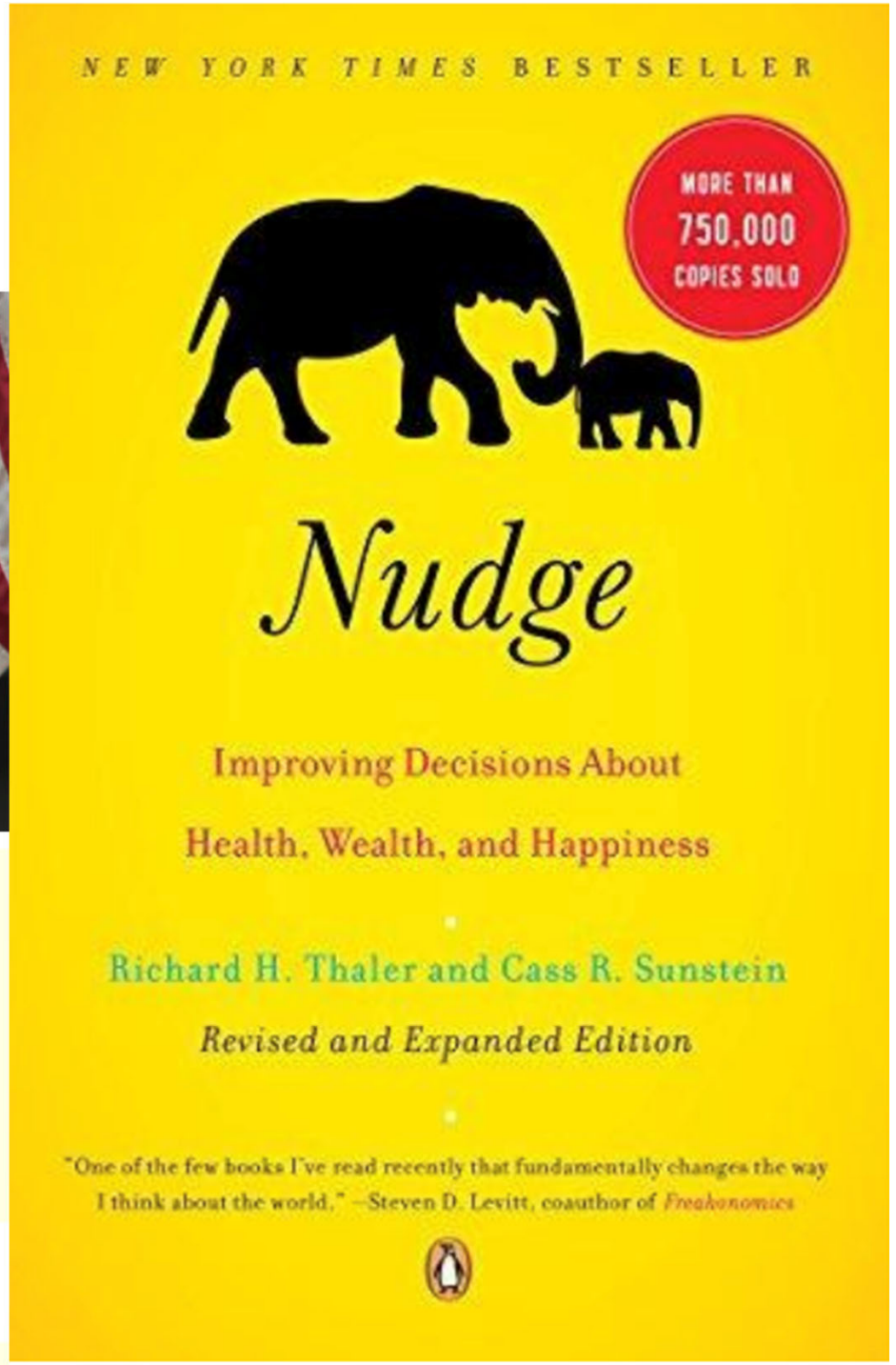
Wide public support

In Sweden 72 %
favour warning
labels

Nobel prize in economics awarded to Richard Thaler

Pioneer of behavioural economics is best known for 'nudge' theory, which has influenced politicians and policymakers

- What is behavioural economics?



How to start nudging people less alcohol

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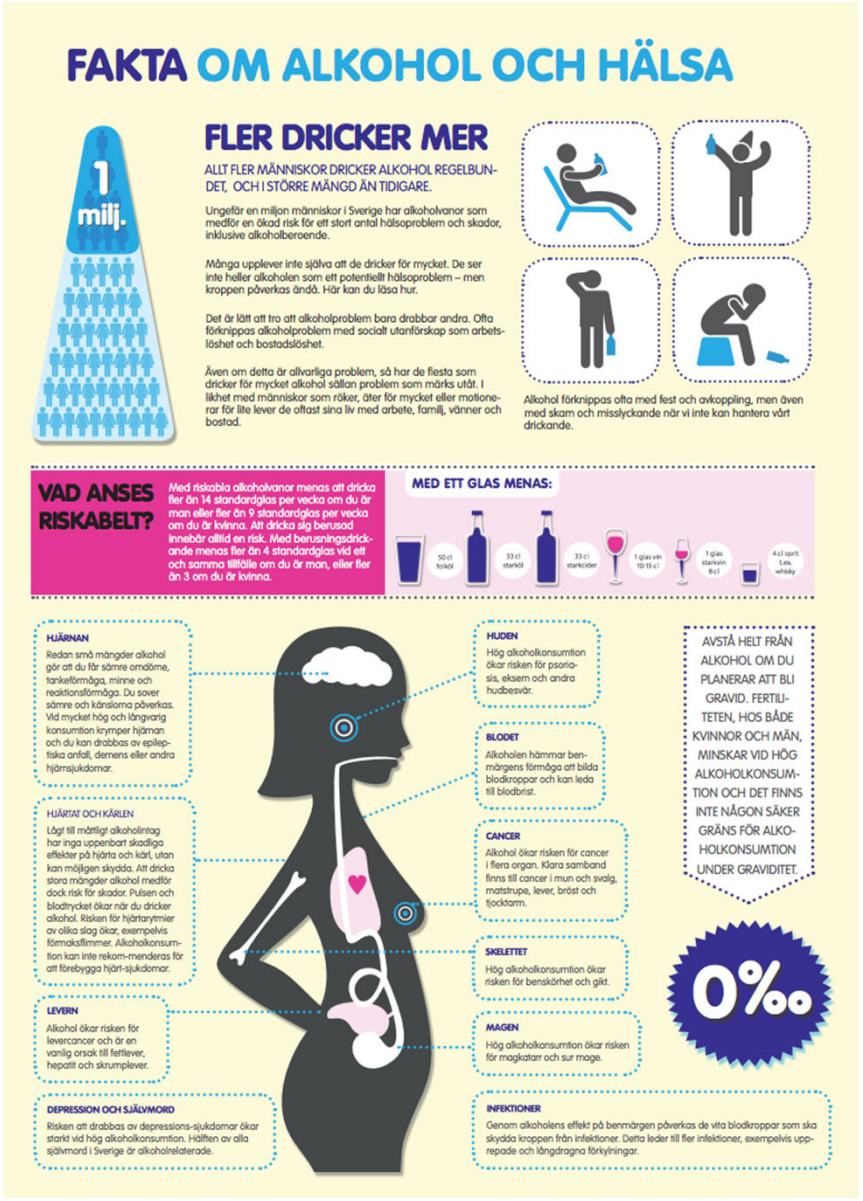
Nudging in health care:
Screening and brief intervention in primary health:



Why aren't they coming:
biased perceptions of alcohol problems

→ Stigma

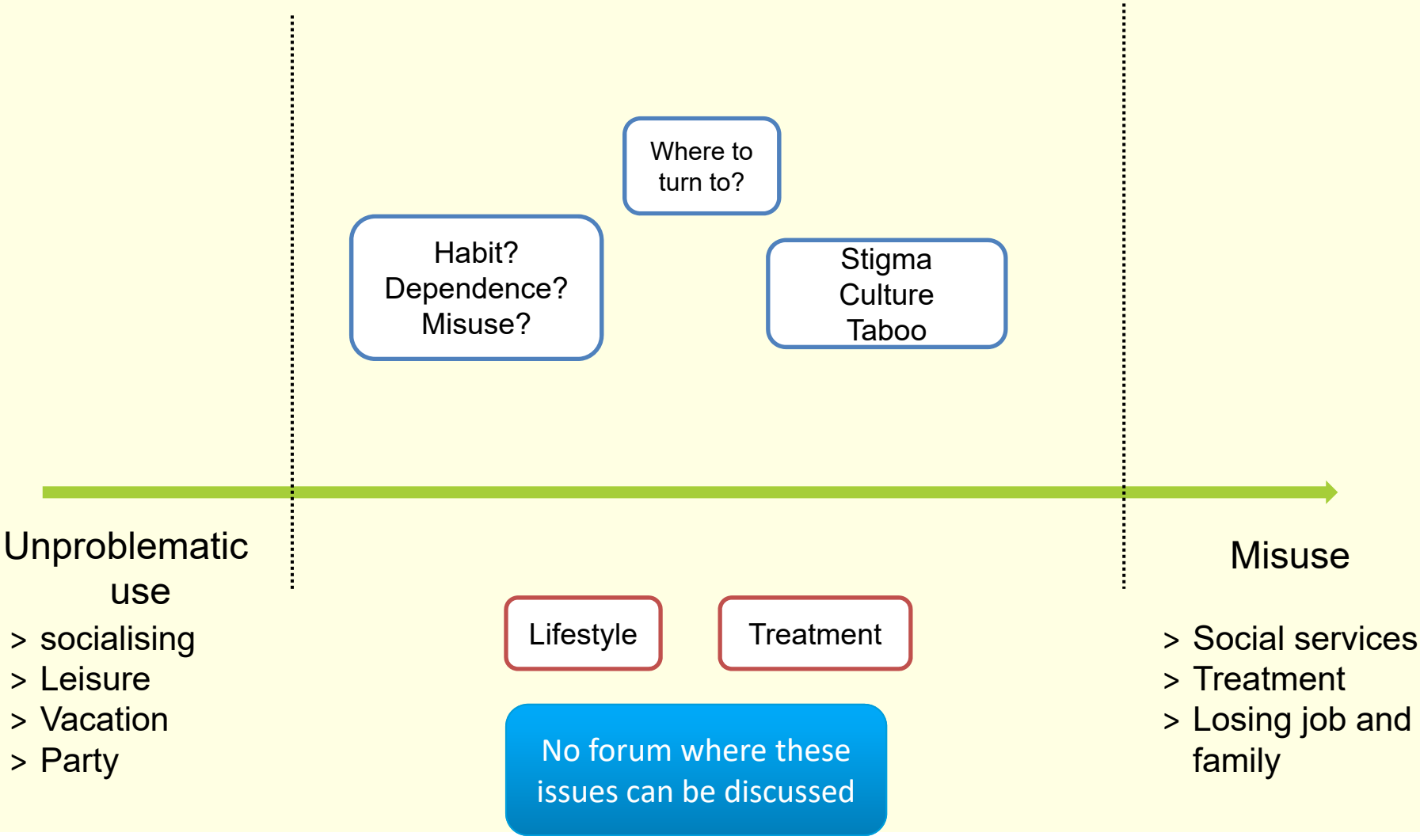
Market research

How do alcohol dependent persons view their drinking?
- and what kind of help do they want?

Concerned – but do not find available treatment options attractive

Gap between general information and specialist treatment

Difficult to navigate and find relevant assistance



Making treatment more attractive

Treatment barriers

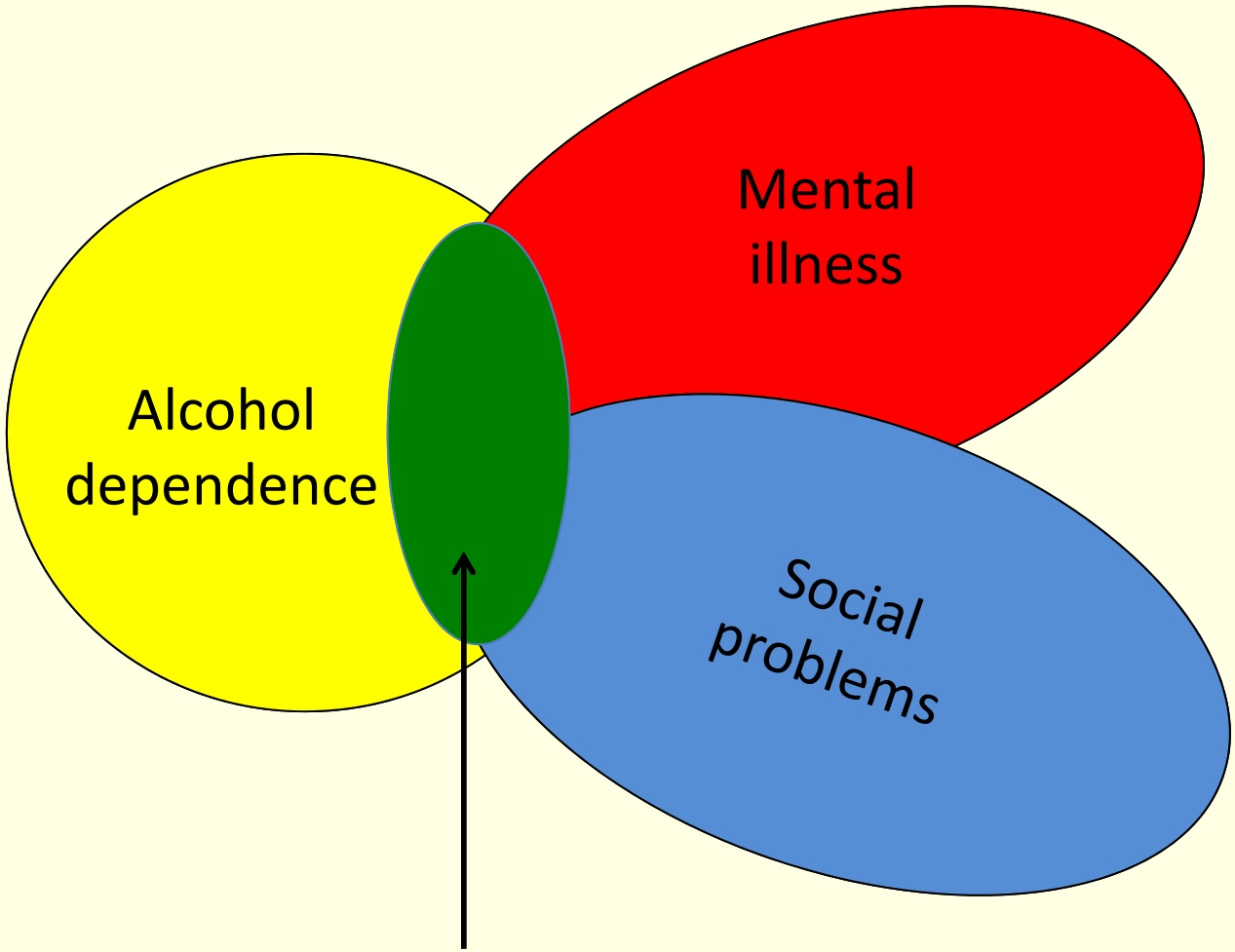
- Stigma
- Important to hide drinking problems
- Shameful and a personal failure

Requires the adoption of a new identity: from well adjusted member of society to the least Respected of all.

Perspectives on treatment

- Participants knew very little about treatment
- Residential treatment, Antabuse and total abstinence
- No attractive options!
- Huge invasion in daily life
- Stigmatising if it became known

- Very shameful!



Today's focus in the addiction system

- Reactive
- unattractive

Focus groups with non-treatment seekers

➡ **Do not accept the terminology**

”Abuse” feels distant, and even ”dependence” feels scary – these are terms the groups find it difficult to relate to.

”If someone were to talk about abuse with me I would turn off – but I do have thoughts about my drinking now and then”

➡ **Need to dedramatise**

The key is to dedramatise and be available ” if you’re uncertain, call us”

You need to be careful: it easily becomes too official sounding if the sender is a public agency.

➡ **Role of health care**

Many, especially the elder, think that primary care or occupational care are fora that could be used more effectively. Use the existing network that people are part of.

➡ **Selfhelp and tools**

You need a little nudge – perhaps a conversation with a doctor, a selftest or a campaign. Something that makes you take a stance. Health care could serve as an alarm bell.

Effective treatment is available – but people don't want it

major challenge for the treatment system:
reduce stigma

Some ideas:

1. Stop stigmatising language:
   ”abusers”, ”alcoholics”
2. Dedramatise, normalise
3. Patient centred approach
4. Treatment in regular health care

→ A smarter approach to the problem!

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+ FÖR DIG SOM ARBETAR INOM VÅRDEN

Välkommen till Riddargatan 1

Om du känner att du borde dricka mindre eller avstå helt, är du välkommen till oss på Riddargatan 1. Idag har över 100 000 stockholmare problem med alkohol. De flesta är som vem som helst, människor med både jobb, bostad, familj och ett gott socialt liv, långt ifrån bilden av en person med alkoholproblem. Men även den med måttliga problem kan behöva hjälp att ändra sina alkohol(o)vanor. På Riddargatan 1 vänder vi oss i första hand till dig som inte har andra sociala hjälpbehov, men behöver hjälp och stöd att dricka mindre. Så att du kan få kontroll över alkoholen. Istället för tvärtom.

AKTUELLT

Ny mottagning för vanliga människor

Den 9 september slår portarna upp på den nya alkoholmottagningen Riddargatan 1, mitt i centrala Stockholm. Grannar till mottagningen är Stureplan och gräddan på Östermalm.
Läs mer

HÄLSA

Hur påverkas din kropp?

För den som dricker sig berusad och dessutom gör det för ofta, är risken stor att drabbas av en alkoholrelaterad sjukdom. Även om du i första hand inte ser alkoholen som ett hälsoproblem kan det vara bra att veta att kroppen påverkas. Läs mer

BEHANDLING

Hur går behandlingen till?

Till att börja med tar vi tillsammans reda på hur ditt alkoholproblem ser ut, genom att du får svara på ett antal frågor. Behandlingen utformas sedan utifrån vilken hjälp du behöver och vill

VANLIGA FRÅGOR OCH SVAR

Hur vet jag om jag dricker för mycket?

Många som dricker för mycket känner på sig att det inte enbart är positivt med drickandet, men fortsätter då vanans makt är stor. Man kan gärna

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Patient centered approach

Patient in the driver's seat:

Choose aim

”Stop drinking”
”Reduce drinking”

Choose treatment

- Pharmacological
- CBT
- 12-steps treatment
- Motivation enhancement

Consider…
and reconsider

Thinking outside the box

Most people don't want "treatment"

– but is is "treatment" they need?

Many options possible:

- Support from personal networks;
- Self-help
- Using new digital technology

”Self help”

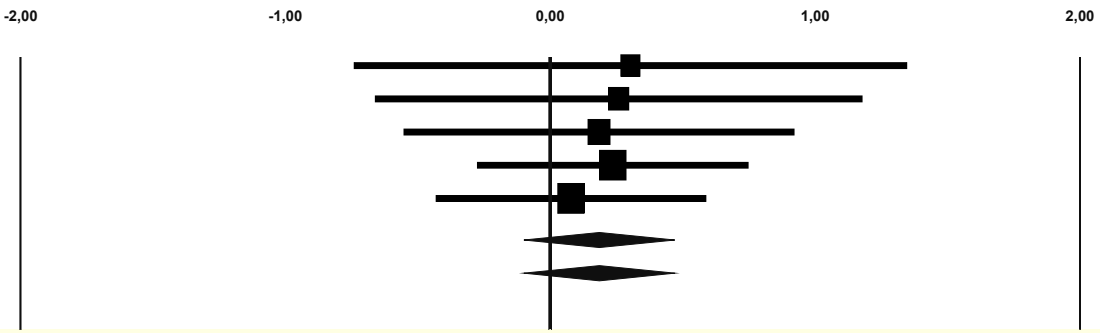
Self help – *Bibliotherapy:*

– equally effective as therapist led treatment

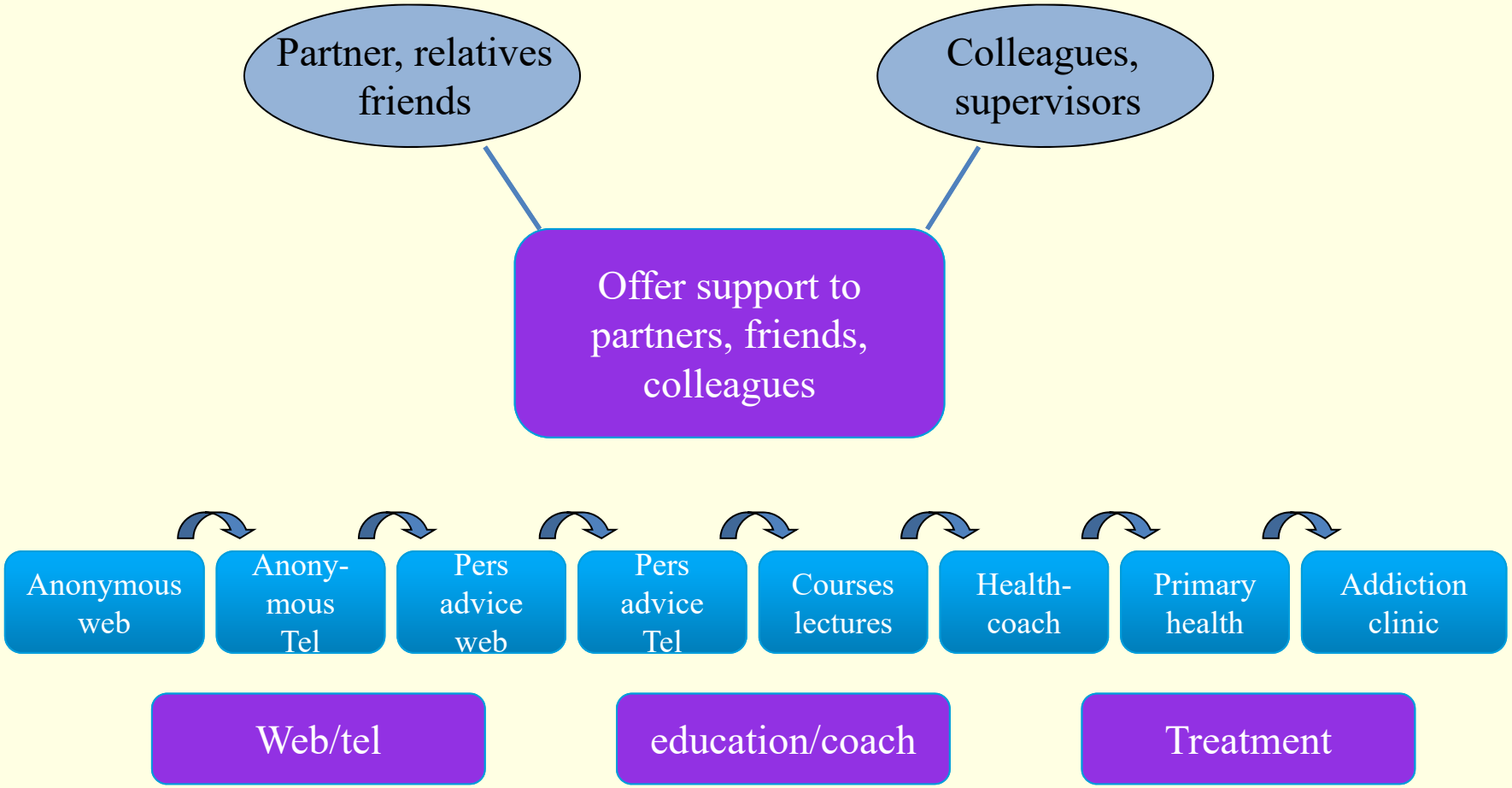
5 RCT trials: for patients with moderate problem severity:

- all show the same or better effect as regular treatment

behandling	Citation	EffectName	Year	N1	N2	Effect	Lower	Upper	NTotal	PValue
	1	Harris 90	abstinence	9	8	,30	-,74	1,35	17	,52
	1	Miller 80	abstinence	10	11	,26	-,66	1,18	21	,54
	1	Miller 81	abstinence	16	15	,19	-,55	,92	31	,60
	1	Sanchez-Craig 89	abstinence	33	29	,24	-,27	,75	62	,35
	1	Sanchez-Craig 91	abstinence	33	29	,08	-,43	,59	62	,75
Fixed	**1 (5)**			**101**	**92**	**,19**	**-,10**	**,47**	**193**	**,20**
Random	**1 (5)**			**101**	**92**	**,19**	**-,10**	**,47**	**193**	**,20**



Thinking outside the box



Reaching a larger part of the target group

…. in primary care?

…or in occupational health care?

… or through the Internet?

BMJ 2017;356:j116 doi: 10.1136/bmj.j116 (Published 2017-01-19 2017-01-19 2017-01-19)

ANALYSIS

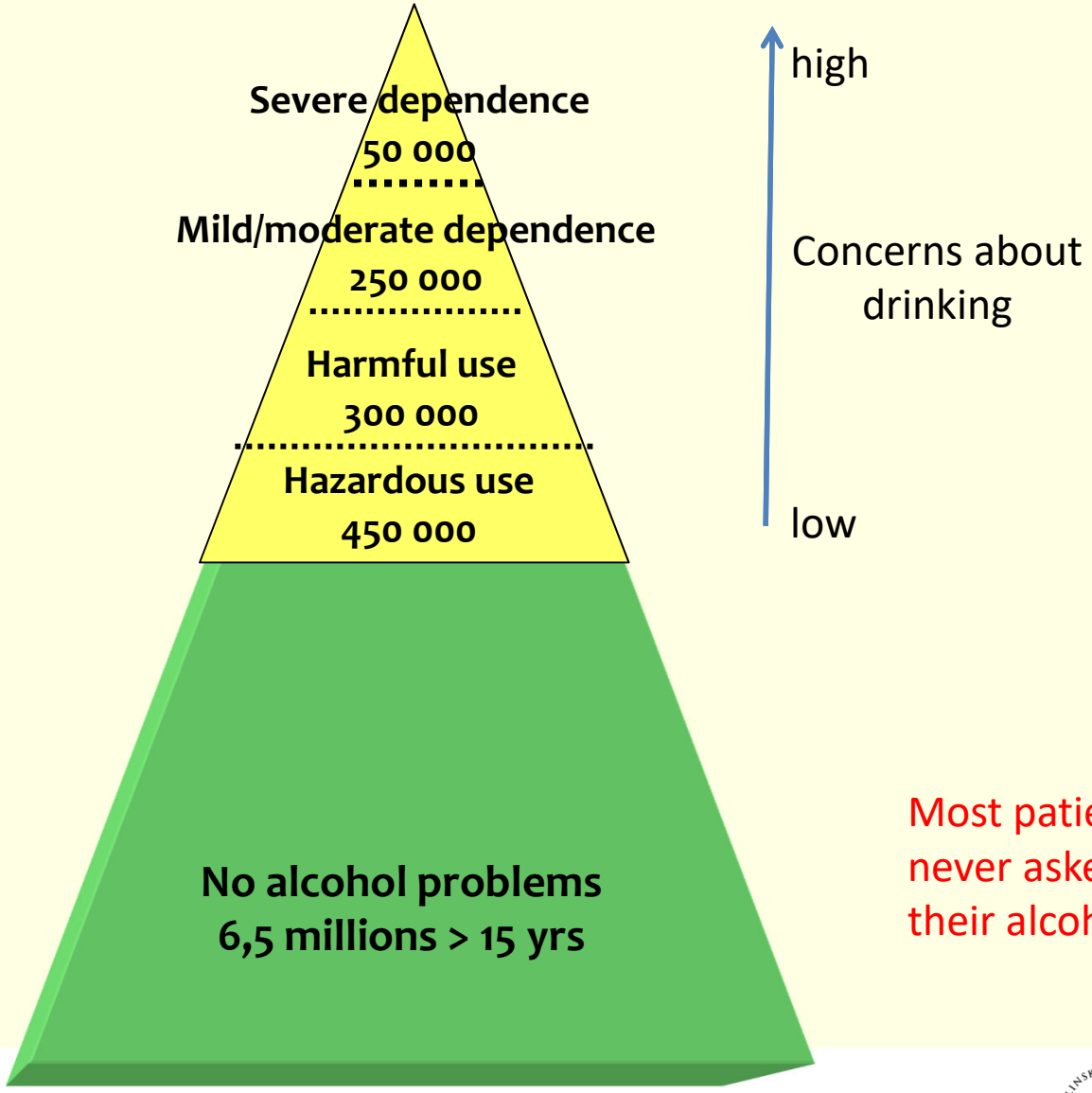
Rethinking brief interventions for alcohol in general practice

Jim McCambridge and **Richard Saitz** question the effectiveness of brief advice and counselling in primary care to prevent harm from heavy alcohol use and call for a more strategic approach

Jim McCambridge *professor of addictive behaviours and public health*[1], Richard Saitz *professor of community health sciences*[2]

MOTTAGNINGEN FÖR ALKOHOL OCH HÄLSA

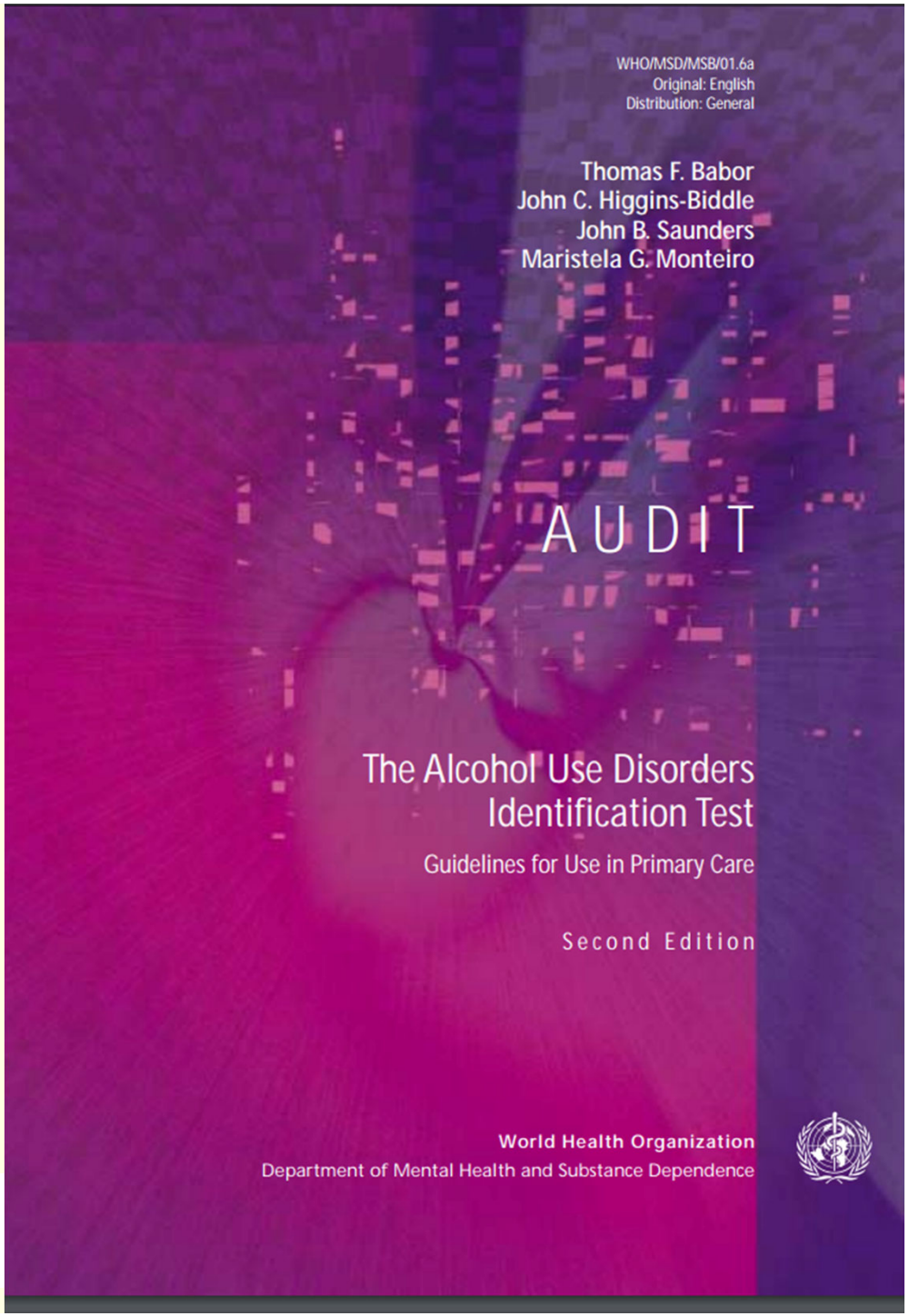
Risky drinking at different levels



Most patients are never asked about their alcohol use

After 30 years of SBI

- Doctors don't ask
- If they do ask, they don't follow up with advice
- If they do give advice to hazardous and harmful drinkers, they don't have anything to offer patients with dependence
  - and they don't refer these patients to specialists



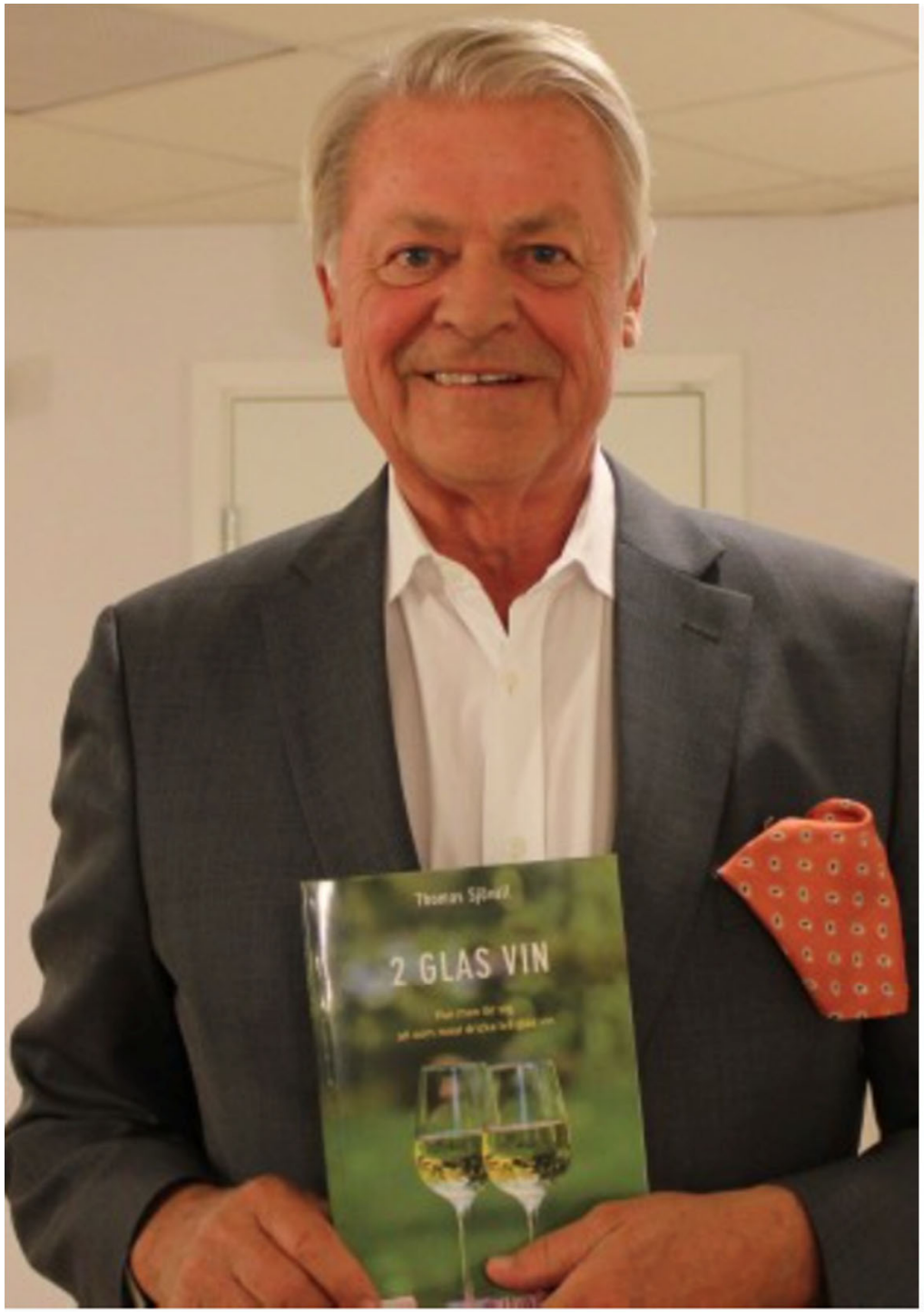
Main question for the SBI field today:

How do we overcome the reluctance from practitioners to raise questions about alcohol?

Here is one approach:
train them to treat alcohol dependence

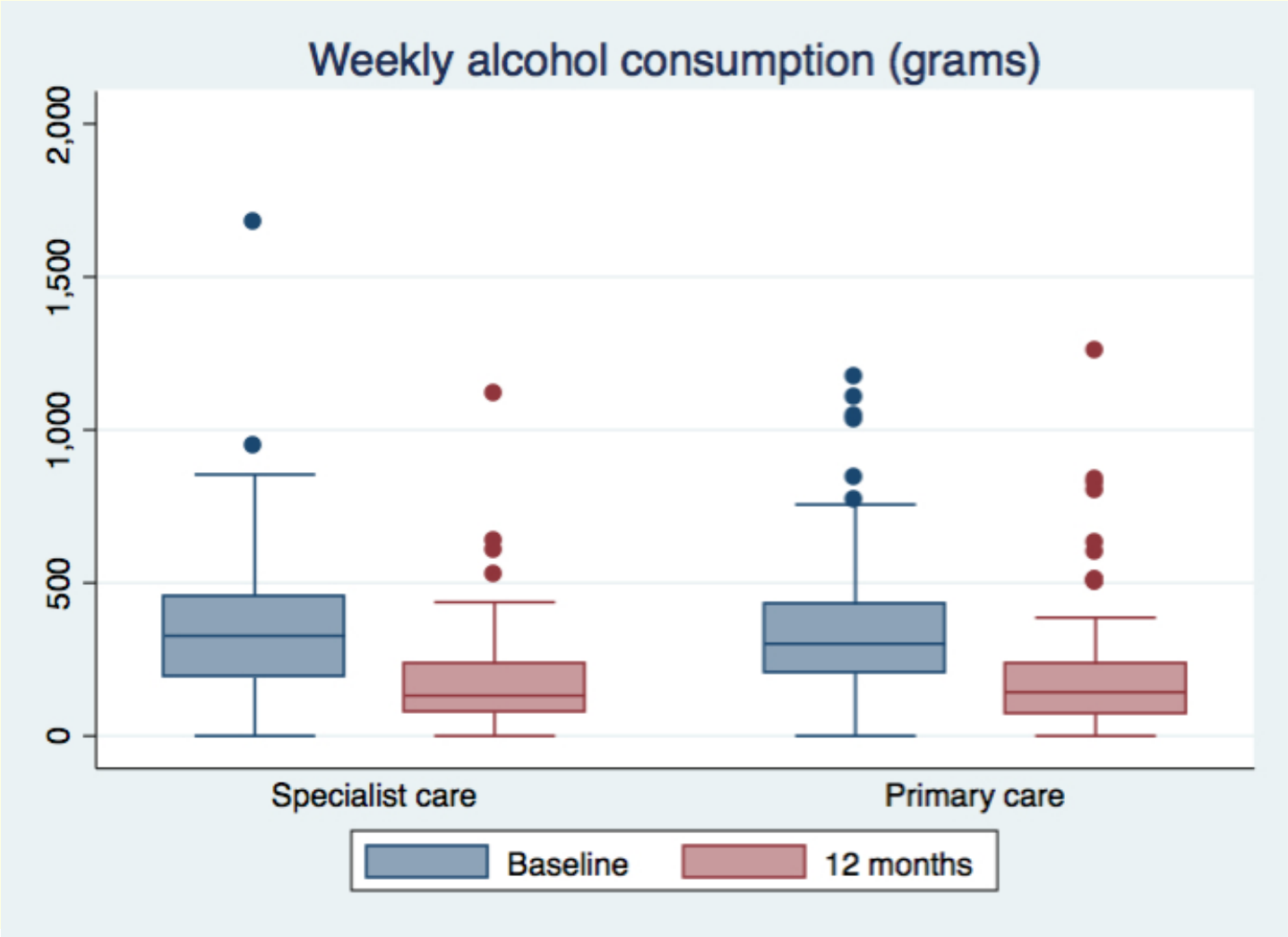
TAP TREATMENT OF ALCOHOL DEPENDENCE IN PRIMARY CARE

But can it work?


2 GLAS VIN


KJELL-OLOF FELDT
BIRGITTA VON OTTER
VÄGEN UT
EN LOGGBOK OM ALKOHOLISM
OCH MEDBEROENDE
ALBERT BONNIERS FÖRLAG

Results: reduced drinking at 12 month follow-up



More results

Variable		SU Baseline n=144	SU 12 months n=120	PC Baseline n=144	PC 12 months n=111	p-value 12 months
Weekly consumption of alcohol (gram)	mean (SD)	349.2 (216.5)	173.2 (157.4)	343.6 (206.6)	191.6 (197.5)	0.43
ICD-10	mean (SD)	4.4 (1.0)	1.9 (1.7)	4.2 (1.0)	2.1 (1.6)	0.57
AUDIT	mean (SD)	23.6 (5.0)	13.0 (6.5)	22.6 (5.7)	13.7 (5.9)	0.45
SIP	mean (SD)	16.2 (6.6)	7.4 (6.0)	15.6 (7.5)	8.3 (6.2)	0.29
CDT	mean (SD)	2.3 (1.8)	1.9 (1.5)	2.5 (2.1)	1.9 (1.5)	0.97

Interviews with GP:s

Treatment of alcohol problems before TAP

- No systematic structure or method
- *"We wanted to participate because we needed more training on treatment of alcohol patients. I really think we have some out here, and, then, we need these tools, some kind of structure to the whole thing"*

Conclusions from this presentation

- For most people alcohol dependence is a time limited disorder
- For a few, dependence becomes chronic
- Most people improve without treatment
- But treatment can reduce the risk period
- Problem: treatment unattractive to most people
- Need to rethink form and content of treatment

Where should our focus be?

Prevention

Treatment

Get them early!