

EXAMINING TREATMENT USE AMONG ALCOHOL-DEPENDENT INDIVIDUALS FROM A POPULATION PERSPECTIVE

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Abstract — **Aims:** To assess the prevalence of treatment use in lifetime and past year alcohol dependent respondents. To establish the proportion of problem drinkers who use alcohol treatment that just go to one treatment versus attending multiple different types of treatment in the same year. To explore what treatments are most likely to form part of a multiple treatment package. **Method:** Analysis of the 2001–2002 National Epidemiologic Survey of Alcohol and Related Conditions, a large ($N = 43\,039$), representative survey of the non-institutionalized adult population of the USA. There were 4781 respondents who met criteria for a lifetime definition of alcohol dependence and 1484 respondents who met criteria for past year alcohol dependence. **Results:** Prevalence of lifetime use of alcohol treatment was 25% among those with a lifetime diagnosis of alcohol dependence. Prevalence of past year use of alcohol treatment was 12% among respondents with past year alcohol dependence. Only one-third of past year treatment users had accessed just one type of alcohol treatment. **Conclusions:** While treatment services are only used by the minority of people with alcohol dependence, those people who do access alcohol treatment are likely to use several different alcohol treatment services in the same year.

INTRODUCTION

There are a number of different perspectives on the use and prevalence of treatment for alcohol problems. Reviews of treatment efficacy assume that problem drinkers receive one treatment type (limitation identified in, Finney, 2000; Miller and Wilbourne, 2002). In contrast, health services descriptions of treatment use sometimes describe alcohol problems as chronic conditions for which the drinker returns to treatment repeatedly (e.g. Dennis *et al.*, 2005). Some documents describe treatment resources that are strained by reductions in funding (Chen *et al.*, 2001). Yet others imply that treatment is an epiphenomenon that has little or no impact on the course of a person's alcohol problems (Peele, 1998).

Which of these descriptions is true? It is possible that they all are to a certain extent, depending on the perspective from which the treatment system is examined. The present paper takes a slightly different perspective, looking at treatment use from a population perspective. Using epidemiological survey data, several questions are addressed: (i) What proportion of alcohol-dependent individuals seek help? (ii) Among those who seek help, what proportion go to just one type of treatment and how many access multiple different types of treatment? and (iii) What is the most frequently used treatment modality and which treatments are most likely to form part of a package of several treatments versus a stand-alone modality? The intent will be to create a picture of how treatment services are used by a representative sample of people with alcohol dependence.

Some limited work has already been conducted in this area. Population surveys have been used to estimate the prevalence of treatment use (estimated ratio of treated to untreated

problem drinkers ranges from 1:3 to 1:14 in Canada and the USA, Burton and Williamson, 1995; Cunningham and Breslin, 2004; Hasin, 1994; Roizen *et al.*, 1978). Typically, estimates that restrict respondents to only those with more severe alcohol problems find a higher prevalence of treatment use. The present study will employ only those respondents who meet criteria for alcohol dependence. While those with alcohol dependence also vary in the severity of their problems (Dawson *et al.*, 2005), use of alcohol dependence as a selection criterion does allow confidence that all respondents in the analysis have (or had) fairly severe alcohol concerns. Some research has also been conducted that provides support for a population level impact of treatment (Weisner *et al.*, 2003; Cunningham, 2005; Dawson *et al.*, 2006). Finally, there is preliminary evidence indicating that many treatment users will attend multiple treatments over their career (Cunningham *et al.*, 2005). However, this latter work was limited by the small size of its population survey ($N = 3006$), making it impossible to conduct analyses of the types of treatment used that could be said to be representative of the general population. The present study will rectify this issue by employing a recent, large epidemiologic survey of the United States to explore patterns of treatment use.

METHODS

The 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions is a large ($N = 43\,093$), representative survey of the non-institutionalized population of the United States, 18 years of age or older (NESARC, Grant *et al.*, 2003). Interviews were conducted face-to-face and the overall response rate was 81%. In addition to assessing DSM-IV lifetime and past year status for alcohol dependence, the NESARC asked a fairly extensive set of questions about help-seeking for alcohol problems. The section on service utilization started with a screener question, “Have you ever gone anywhere or seen anyone for a reason that was related in any way to your drinking—a physician, counselor, Alcoholics Anonymous, or any other community agency or

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professional?' For those respondents who indicated that they had sought help, a series of questions were asked about a variety of different sources of help for alcohol problems (see Table 1 for a list of these services). For each of the services, respondents were asked if they had ever gone, and whether they had attended the service during the last 12 months only, before the past 12 months only, or during both time periods. In the present analyses, sample sizes are presented as unweighted values and proportions are presented as weighted values.

RESULTS

A total 4781 respondents met criteria for a lifetime diagnosis of alcohol dependence (past year or prior to past year). Of these respondents, 24.7% had sought help for alcohol concerns at some point in their life. Of the 1484 respondents who met criteria for past year alcohol dependence, 12.2% had sought help in the last year (24% of respondents with past year alcohol dependence had ever sought treatment—prior to past year or past year).

For the present analyses, it was important to know the time frame within which respondents accessed treatment. The NESARC asked only about treatment use ever or during the last 12 months. Thus, the clearest way to examine what proportion of respondents attend multiple treatments in the same time period was to focus only on those respondents with past year alcohol dependence who had accessed some sort of help in the last year ($N = 185$). The majority of these respondents had attended multiple treatments in the past 12 months. Only 33% ($N = 62$) had attended just one of the 13 different treatment options listed on the NESARC in the past year (22.3% attended 2, $N = 43$; 44.7% attended ≥ 3 treatment modalities, $N = 80$). 72.2% of those who accessed treatment in the past year had also accessed treatment prior to the past year, indicating an extended treatment history.

What is the most frequently used treatment modality and which treatments are most likely to form part of a package

of several treatments versus a stand-alone treatment modality? Table 1 presents the proportion of past year alcohol-dependent respondents who ever accessed each of the 13 different treatment modalities. In addition, for the past year treatment use, the proportion of respondents accessing each treatment modality is listed for the subgroups that accessed at least one treatment, at least two different types of treatment and three or more treatment modalities. Inspection of Table 1 revealed that for those who accessed at least one treatment in the past year, Alcoholics Anonymous was the most common service utilized, followed by a private professional (physician, psychiatrist, psychologist, social worker or other), a rehabilitation program, or a detoxification ward/clinic. Alcoholics Anonymous remained the most common service used even among the subgroups of respondents who used two or more, or three or more treatments modalities in the last year. However, both Rehabilitation programs and Detoxification ward/clinics were interesting in that their use appeared proportionally more common among those respondents who had attended three or more treatment modalities as compared with the subgroup of respondents who had attended at least one treatment modality.

DISCUSSION

The analysis had three goals—to explore the prevalence of treatment use in a representative sample of people with alcohol dependence, to assess the proportion of treatment users who use multiple treatment services and to examine what particular treatments are most associated with multiple service use. Lifetime use of treatment services was roughly one in four for respondents who met criteria for alcohol dependence. Among respondents with a past year diagnosis, the prevalence of past year treatment use was 12%. Previous research has found a wide variation in the proportion of problem drinkers who ever seek treatment. Perhaps the most similar in characteristic to the current sample was an analysis of respondents from Ontario, Canada, that found that about one in three

Table 1. Treatment services used by past year alcohol-dependent respondents who ever accessed treatment

Treatment	Last year treatment use			Ever accessed ^a (%) ($N = 367$)
	At least 1 treatment (%) ($N = 185$)	≥ 2 treatments (%) ($N = 123$)	≥ 3 treatments (%) ($N = 80$)	
Alcoholics Anonymous	61.4	74.4	86.0	73.6
Private physician, psychiatrist, psychologist, social worker or other professional	55.5	62.4	67.3	45.0
Rehabilitation program	35.8	52.0	73.7	52.2
Detoxification ward/clinic	31.5	47.1	68.1	42.5
Outpatient clinic	26.2	38.1	54.1	33.4
Emergency room	22.4	31.3	37.8	33.6
Inpatient Psychiatric/General Hospital ward/Community Mental Health	21.3	31.3	46.9	29.9
Family or other social service agency	20.7	28.6	36.6	27.1
Clergy, priest, or rabbi	20.0	25.5	21.8	21.5
Halfway house/therapeutic community	5.4	8.1	12.1	10.2
Employee assistance program	5.4	8.1	9.8	8.5
Crisis center	2.6	3.9	5.9	5.0
Other agency or professional	6.6	9.9	10.7	13.6

^aPast year and prior to past year access combined.

respondents who met criteria for alcohol abuse or dependence had ever sought treatment (Cunningham and Breslin, 2004). While it is possible that this slightly higher estimate of treatment use could reflect differences between the Canadian and American addictions treatment system, another likely explanation is that the structure of the Canadian questionnaire differed. In the Canadian questionnaire, all respondents were asked about use of each of the treatment services. On the NESARC, only respondents who endorsed that they had sought help on a screener question were asked about use of each of the different treatment services. This difference in questionnaire structure might explain the variation in prevalence of service estimates. Such differences also emphasize the limitations of any estimates of this type—that there could be variation solely due to the way the questions are asked. Further, it is important to recognize that the NESARC is a cross-sectional data set, meaning that the prevalence of treatment use was estimated based on respondents' experience up until the age they were interviewed rather than over their whole lifespan.

Also evident from this analysis was that use of just one treatment service appeared to be the exception rather than the rule. Almost three-quarters of past year treatment users had also accessed treatment services at some point in the past. Further, only 33% of past year treatment users went to just one type of treatment in the past year. The repeated use of treatment by a subset of individuals has been noted by other researchers (e.g. Dennis *et al.*, 2005). In particular, two analyses conducted by Blomqvist (1998; Blomqvist and Christophs, 2004) found that only 6–12% of alcohol treatment users who accessed care had never used the Swedish treatment in the past (variation in estimate depended on time frame and treatment type). While multiple treatment access appears to be the rule rather than the exception in several countries, the use of the Swedish example highlights one of the limitations of the present analysis—that the data is from the USA and cannot necessarily be taken as representative of the situation in other countries where treatment systems are different (Klingemann *et al.*, 1992). In the UK, only 1 in 18 alcohol-dependent individuals (6%) are in contact with treatment services (though this figure did not include contact with Alcoholics Anonymous; Drummond *et al.*, 2005).

Another limitation of the current analysis is that there is no way of knowing whether any of these respondents went to several treatments of the same type. As an example, a respondent who only endorsed going to an outpatient clinic might have actually accessed multiple treatments because they attended several different outpatient clinics in the past year. It is also unclear how people might have responded if they went to a treatment program that contained several different treatment modalities (e.g. inpatient treatment followed by Alcoholics Anonymous as an aftercare program). Nevertheless, despite these limitations it is clear from the present analysis that single treatment access is the exception rather than the rule.

In interpreting these findings, it is also important to recognize that the various treatment modalities surveyed are significantly different in their make-up. As examples, an emergency room visit resulting from an alcohol-related injury might contain no intervention directed at alcohol consumption. Also, a self-help organization like Alcoholics Anonymous is different in many ways from formal outpatient or inpatient treatment.

Alcoholics Anonymous was by far the most common form of help sought. This remained true when just those respondents who had accessed multiple treatment services were examined. Also interesting was the extent to which rehabilitation programs and detoxification services appeared to be more often used by respondents who had accessed multiple treatment services. One logical explanation for this could be that people with more severe alcohol problems are both more likely to access rehabilitation and detoxification services, and to employ multiple different types of services. Other explanations for this finding could be that rehabilitation and detoxification services are most often located in large cities where many other addictions services are also located. Alternatively, problem drinkers who are willing to use these services might be different in some other way that is also associated with multiple treatment use. Unfortunately, there may be no way to disentangle these competing explanations using population data sets. This limitation makes it clear that a population perspective, as with the other means of examining addictions treatment access (e.g. health service records, treatment efficacy studies), only provides a partial perspective of the ways in which people with drinking problems employ treatment for their drinking concerns.

Despite these limitations, there are several implications that can be drawn from these findings. First, the results point to treatment users as active consumers of different help services. It is possible that some people with alcohol concerns might 'shop around,' looking for the type of treatment that best matches their needs. This type of active consumption could be facilitated by a case management approach to the delivery of services (Dennis *et al.*, 2005). Second, most people with drinking problems are reporting no use of any treatment services. As there are treatments available that can help, more attention needs to be devoted to making these treatments attractive and accessible to those with alcohol concerns.

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