

Research Article

Treatment for Alcohol Use Disorders in Canada

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Abstract

Objectives: To compare how treatment programs for alcohol dependence differ regarding the kind of treatment offered available medication and treatment goal.

Methods: A survey of 128 alcohol dependence treatment agencies across ten provinces in Canada compared the following treatment characteristics: expected abstinence at start, acceptance of harm reduction as a goal, specific treatment types and availability of medication to mitigate withdrawal symptoms or to prevent relapses.

Results: Of 128 contacted treatment agencies, 44 consented to be included in the comparison. The most popular treatment styles were individual and group counselling, Motivational Interviewing (MI), Cognitive Behavioural Therapy (CBT) and the 12 step-based therapy program. The majority of agencies did not offer medication; however all provinces with the exception of Newfoundland and Prince Edward Island had at least one agency offering medication. Abstinence was required before treatment at approximately half of all agencies, with 20% of agencies using abstinence as the only acceptable treatment goal.

Conclusions: Little variation exists between provinces in regards to treatment types, however, the availability of medication between provinces varied greatly from 0% to 100%. There are no federal guidelines for alcohol dependence treatment in place, with agencies using provincial and other norms which differ across Canada. A reduction in alcohol consumption as treatment goal should become more open to potential patients to increase current treatment rates.

ABBREVIATIONS

AD: Alcohol Dependence; CAMH: Centre for Addiction and Mental Health; CBT: Cognitive Behavioural Therapy; CIHR: Canadian Institutes of Health Research; DATIS: Drug and Alcohol Treatment Information System; DSM-IV: Diagnostic and Statistical Manual of Mental Disorders (DSM-IV was the version used in Canada at the time when the empirical fieldwork took place); EU: European Union; MI: Motivational Interviewing; NIH: National Institutes of Health; PEI: Prince Edward Island; WHO: World Health Organization.

INTRODUCTION

Alcohol use has been a part of Canadian culture since its founding [1]. While level and pattern of alcohol consumption varies regionally [2], overall Canada's adult per capita

consumption clearly exceeds the global average, by more than 50% [3]. The high overall consumption coupled with some degree of binge drinking results in a significant health burden [4-6], with one of the worst health outcomes being alcohol dependence. Alcohol dependence (AD) is a maladaptive pattern of usage, characterized by a loss of control, leading to clinically significant impairment or distress [7].

The last survey to determine prevalence of mental and addictive disorders in the general population in Canada is the Canadian Community Health Survey (CCHS) 2012 (http://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SD DS=5015&Item_Id=119790&lang=en). This survey resulted in a 12-month prevalence of AD of 1.1% (women: 0.8% and men 1.4%) for the general population 15-64 years of age; for alcohol use disorders as defined in DSM IV (i.e., alcohol abuse and alcohol

dependence together), the respective prevalence was estimated to be 2.1% of women and 5.3% of men for the same age (3.7% for both sexes combined; see also [8]; <http://www.statcan.gc.ca/pub/82-624-x/2013001/article/11855-eng.pdf>). Alcohol use disorders, but especially AD, are not only potential negative health outcomes of heavy drinking over time [9,10], but also has been linked to a higher chance of attracting alcohol-attributable diseases (such as liver cirrhosis [11]) and associated mortality [12-14] and severe social problems (e.g., loss of productivity, divorce [15]), as well as potential societal costs [16].

Despite the relatively high prevalence of AD and its negative impact on public health in Canada, AD seems to be severely undertreated in Canada. While there are no national estimates, estimates for Ontario based on the Drug and Alcohol Treatment Information System (DATIS) showed a treatment rate of about 10% of all people with AD (treatment rate was defined as all people with the disorder who received treatment in the same year). This low treatment rate is comparable to the US [17,18] and to Europe [15,19].

Recent searches by the authors on Pub Med (<http://www.ncbi.nlm.nih.gov/pubmed>) using the keywords “alcohol dependence - treatment - Canada -review” and “alcohol dependence - treatment Canada” yielded no relevant results (searches were conducted August 1, 2012 and November 1, 2013). As little is known about the forms of treatment in Canada, the aim of this study is to analyze AD treatment in Canada. Specifically we hope to identify potential regional differences in general treatment goals, psychotherapeutic practices as well as in the type of pharmacotherapy preferred. In asking our questions we were aware of the fact that formal assessments for dependence criteria are not common in treatment agencies. Thus our results will be valid for people with alcohol use disorders treated in Canada, and we can only speculate, which proportion of these would qualify for AD and which for alcohol abuse as defined by DSM IV (the diagnostic system used in Canada at the time of the study).

MATERIAL AND METHODS

Sampling and contacting procedures

The aim of the study was to gather a representative sample of agencies for the treatment of alcohol dependence and other alcohol use disorders. Representative here is not defined in the strict statistical sense, as there is no Canada-wide list of treatment providers as sampling frame. We therefore had to rely on various lists from different provinces identified via Google. When selecting the participating agencies, we adopted the following strategy: from the exhaustive list of the agencies from Google we randomly selected a number of agencies taking into consideration the following stratification criteria (PG oversaw the whole sampling):

- Urban and rural areas;
- Geographical location trying to cover different regions within each province;
- Size of the agency in number of treatment places, looking for medium and large organizations that would be typical for each province;

- Public-vs. private organizations with or without religious/ethnic affiliation.

We aimed at minimally 2 agencies responding from smaller provinces, and 5 agencies from larger provinces.

Trained interviewers called organizations and private centres by telephone and spoke with the individual in charge of the treatment program. Using the standard script approved by the Research Ethics Board interviewers introduced themselves as a researcher representing CAMH that was investigating treatment for alcohol use disorders across Canada. The interviewer requested that the individual participated in a voluntary interview regarding specific details of the agency's strategies and opinions regarding treatment. Agencies that consented to participate engaged in a phone interview with researchers answering specific questions (see below), with the researcher transcribing verbal answers into predetermined categories. Names of participating organizations and their corresponding answers were kept confidential, with response data only identifying the province where the agency was located.

The empirical data collection for the study started in August 21 2012 and lasted until September 28, 2012.

MATERIALS

Service providers were contacted via telephone and were asked to respond to five questions regarding clients who have undergone treatment at their agency.

Six organizations were asked to respond via fax or email.

The five questions were as follows:

- (1) *Do you expect your clients to be abstinent when they come in for treatment?*
- (2) *What is the treatment goal?*
- (3) *Do you accept harm reduction/reduced drinking as a treatment goal?*
- (4) *What is the most common form of treatment? Is it a structured form of treatment? Please explain:*
- (5) *Does your institution use any pharmacotherapeutic aids for treatment? If yes, which one(s)?*

In cases when the call was accepted, the purpose of the survey was further explained, and depending on the agency therapists, managers, regional directors, or other subject matter experts, answered the questions. Most calls took under 15 minutes.

Research Ethics Board Approval

The study was approved by CAMH REB on August 20, 2012 (#134/2012).

RESULTS AND DISCUSSION

Participating agencies

This study targeted organizations offering rehabilitation treatment for people with alcohol use disorders, with or without withdrawal of any kind. A total of 128 agencies were contacted, with 44 agencies across all provinces participating in the study. As per sampling scheme, participating agencies were situated in

both rural and urban settings, ranging from large scale provincial agencies for addiction treatment to moderate scale private agencies. As planned, the study included both privately and publically operated agencies that varied with cultural specificity; for example one agency in Saskatchewan offered healing programs targeting Métis and off-reserve First Nations people.

In 65.6% of cases we were not able to obtain an answer, mainly because the potential participant was too busy and concerned about the time lost with the interview. In single cases, the purpose of the interview was questioned, and the professional answering the line was offering service in multiple locations. Generally, the larger government-funded treatment centers were more willing to participate.

To compare alcohol treatment programs across Canada, agencies were asked to describe forms of treatment available to their clients and implemented within the agency. The following forms of treatment were described by the agencies (for an overview of common psychosocial treatments and their effectiveness see [20]):

- Group and individual counseling
- Motivational Interviewing (MI)
- Cognitive Behavioural Therapy (CBT)
- 12 step-based treatment programs
- AA meetings
- Alcochoix + formule guidee

Treatment types offered had little variation across provinces, with individual and group counselling available in every province, as well as motivational interviewing in 80% of the provinces with the exception of Prince Edward Island (P.E.I.) and Quebec. Cognitive Behavioural Therapy (CBT) was offered at 70%, and 12 step-based therapy programs at 50% of all provinces. Less frequent were ongoing AA meetings after detoxification, which were common only in Saskatchewan and Ontario. In Quebec, all agencies consulted used a specific treatment model, based on the Alcochoix + formule guide [21]. This specific model enables

the client to choose between a manually guided auto remission process, and / or individualized professional help to using the guide, or 6 groups meetings of 90 minutes each. The guide is based on evidence-based principles of psychosocial treatment. Other than Alcochoix + formule, most treatments were not manualized in the strict sense. Agencies claimed to follow provincial norms and kept in contact with other local organizations. There are no federal guidelines in regards to alcohol addiction centers as of yet, and provinces have differing orientations in regards to policy and code.

Medication was available at individual agencies where an M.D. was present. In cases where there was no M.D. on site, a registered nurse referred clients to an M.D. that was available to the centre. However, many of the medications offered were only to reduce withdrawal symptoms at the beginning of the therapy, and not to support the actual treatment, or relapse prevention. For withdrawal, the most frequent drug class used were benzodiazepines. While in P.E.I. and Newfoundland, none of the agencies asked offered drug-assisted treatment; in other provinces, pharmacological treatment was available in at least one agency, with rates ranging from 12.5% in British Columbia to Newfoundland and Nova Scotia with 100%. The differences of pharmacologically assisted treatment rates between provinces, as well as expectations of abstinence in treatment, treatment goals, acceptance of harm reduction and most common treatments are summarized in Table 2.

Across Canada abstinence was cited as a prerequisite for treatment for about half (46%) of the agencies. In terms of final treatment goals, 20% of treatment agencies had complete abstinence as the only treatment goal, whereas a reduction in harm (usually operationalized by a reduction of drinking or drinking in a more controlled way) was accepted at 50% of all agencies, with a further 30% basing their treatment goals on the wishes of the client. However, in practice, the large majority (96.7%) of all agencies allowed harm reduction as a treatment goal from clients, meaning they did not expel clients who did not reach abstinence.

CONCLUSION

Looking at a representative sample on specialized AD treatment agencies in Canada, and their variation in treatment goals and methods we found a high level of variation in treatment practices in this age of evidence-based medicine [22]. Secondly, we noted that some of the recent evidence with respect to the effectiveness of different treatment modalities (see especially the various Cochrane reviews; [20,23-25], for psychosocial treatment) did not seem to be integrated into the treatment plans. Taken together, these two observations would point towards the need for development of comprehensive national treatment guidelines for alcohol use disorders which could integrate all the evidence to date. Although there are quite comprehensive guidelines available from other countries, most notably the recent NICE guidelines in the UK [26], this may not be enough to improve the current treatment gap for alcohol use disorders in general, and alcohol dependence in particular, and to decrease alcohol-attributable mortality and burden of disease [27,28].

Table 1: Response of contacted agencies by province.

Province	Total Agencies Contacted	Refused or unable to connect (%)	Responded (%)
Alberta	10	5 (50%)	5 (50%)
British Columbia	23	15 (65.2%)	8 (34.8%)
Saskatchewan	11	7 (63.4%)	4 (36.6%)
Manitoba	12	8 (66.6%)	4 (33.3%)
Newfoundland	16	11 (68.8)	5 (31.2%)
Nova Scotia	8	6 (75%)	2 (25%)
New Brunswick	9	7 (77.8%)	2 (22.2%)
Ontario	5	0 (0%)	5 (100%)
Quebec	30	23 (76.7%)	7 (23.3%)
Prince Edward Island	4	2 (50%)	2 (50%)
Total	128	84 (65.6%)	44 (34.4%)

Table 2: Characteristics of alcohol treatment in Canada 2012.

Province	Expected Abstinence	Treatment Goal	Harm Reduction Acceptance	Most common treatment	Use of medication to support treatment goals
British Columbia	12.5%	100% Client based	100%	- CBT - Motivational interviewing (MI) - Counseling - 12 steps oriented treatment	12.5%
Alberta	40%	20% Abstain 80% Reduce Harm	100%	- CBT - MI - Counseling - 12 steps	40%
Saskatchewan	25%	100% Abstain	100%	- CBT - MI - Counseling - 12 steps oriented -AA meetings	50%
Manitoba	50%	100% Client based	100%	- CBT - MI - Counseling - 12 steps	25%
Newfoundland	100%	100% Abstain	100%	- CBT - MI - Counseling	100%
Nova Scotia	50%	50% Abstain 50% Reduce Harm	100%	- CBT - MI - Counseling	100%
New Brunswick	0%	100% Client based	100%	- MI - Counseling	0%
PEI	0%	100% Reduce Harm	100%	-Counseling	0%
Ontario	80%	20% Abstain 80% Reduce Harm	80%	- CBT - MI - counseling - 12 steps -AA meetings	20%
Quebec	100%	14.3% Abstain 85.7% Reduce Harm	85.7%	-Alcochoix + formule guide - Counseling	28.5%

We recommend two strategies specifically to increase treatment rates: firstly, the role of primary care should be reconsidered (see [29], for empirical background). Many types of alcohol use disorders can be treated in primary care, especially as there are effective medications which can be used in this setting (especially naltrexone and nalmefene; [23]; for barriers to use pharmaceutical treatment in general see [30]). Such a treatment would differ from unspecific counselling which seems to dominate current interventions in this setting, especially in Europe [29]). Secondly, treatment should be more open to patients with AD, who seek to reduce their drinking rather than strive for abstinence. It has been shown that this goal is relatively prevalent among potential patients ([31]; for a Canada example see: [32]). Also, treatment goals change in the course of treatment, so many patients with an initial goal of reduced drinking switch to abstinence and vice versa [31]. The outcome of interventions did not seem to be linked to original treatment goals [33]. Finally, the most important pathway in all therapy for AD is the reduction of alcohol consumption, as reduced drinking has been linked to decreased mortality and hospitalizations [34,35].

CONFLICT OF INTEREST

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