Is it really more treatment – or ”better methods” – that we need?

Challenges for the handling of addiction problems in Sweden

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A brief history of substance abuse care in Sweden:

1916 – 1950s:

Disciplining / keeping up of social order

(the alcoholic as ”dangerous”/morally inferior)

1960s – 1970s:

”The producers’ paradise” (Bergmark & Oscarsson, 1994)

- increasing trust in the welfare state and in treatment as a solution to various human troubles
- ideological convictions and shifting therapeutic crazes (“anything goes”)
- culmination of alcohol care
- drug abuse “discovered” as a “social problem”, the origin of special drug services

1980s:

”From ideology to economy” (Blomqvist, 1996).

- beginning questioning of the welfare state project
- new demands for economic rationality; ”marketisation”; buyer/seller-systems
- the culmination of drug services (”offensive drug care”)

1990s:

Economic recession (addiction care set aside)

2000 -

New millenium – new prerequisites:





The alcohol field:

Accession to the EU → disarmament of traditional alcohol policy → increasing consumtion; perceived need for alternatives

The drugs field:

Increasing abuse; increasing mortality → ambition to strengthen traditional restrictive policy





New interest in addiction care:

- **New resources for care of ”heavy” abusers (coerced care /”care chains”)**
- **National guidelines for treatment of substance abuse and dependence**

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Main strategies:

The development of ”evidence-based practices”

- Review of ”effective treatment methods” (RCT-studies; SBU, 2001)

- National guidelines for addiction care (NBHW, 2007)

More resources for the care of ”heavy” addicts:

- Economic incentives to use coercive care

- Local projects to develop ”care chains”

Improved documentation

Changing views of the need for knowlwdge

- **Thirty years ago** (”the social welfare debate”):

  (e.g. Wächter, 1977; Sunesson, 1981; 1985):

  - knowledge on problem-generating circumstances (”what turns people into clients?”)
  - knowledge about the local society (demography and life conditions)
  - goal: ”the welfare of the client”

    (find alternatives to bureaucratic and individualised handling of human beings as ”cases”)

- **Today** (”the evidence movement”):

  (e.g. Varg, 2004).

  - knowledge on how to detect, diagnose and classify various problems
  - knowledge of effective prevention and treatment methods
  - goal: ”the welfare of the client”

    (find alternatives to problem handling based on ideological beliefs and/or organizational rules)

⬇

Still a wish for better results, but a change ”from the society to the individual”

The main thrust of today: the call for evidence

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Arguments for EBP:

- **Humanism:**

  - focus on outcome, not on legislation/procedural rules or on ”filling beds”(clients’ welfare, rather than staff’s comfort or safety)

- **Certainty:**

  - focus on facts, not personal convictions or beliefs

  (what actually works, rather than guesswork or ”sunshine stories”)

- **Utility, economic rationality:**

  - tax payers can’t afford that money are spent on activities that do not effectively solve the problems in question

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The official version / “the ideal type”

(e.g. National guidelines for addiction care)

- The ambition: scientific support for clinical decisions
- Main strategy: systematic review and compiling of relevant ”good quality” research
- Ideal for knowledge syntheses: meta-analyses
- Evidence hierarchies (from meta-analyses with several converging controlled studies, over diverging results to simple follow-ups or ”expert consensus”)
- RCT as ”gold standard (but not undisputed)
- Efficacy studies (to isolate causal effects)*
- Main aim: to identify ”specific” (≈ manual-based) methods with good scientific underpinning (screening, assessment, treatment)

* vs. effectiveness studies (testing how treatments work “in reality”)

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… and practitioners' view

Peliminary results from an on-going study

Survey to addiction care practitioners in mid Sweden (N≈ 850)
(social services, health care, criminal care, coercive care; factor analysis results)

"What contributes to a successful outcome"

1. **"Evidence basing"** (research support, using manuals, systematic documentation)
2. **"Client orientation"** (respectfulness, users' perspective, sensitivity)
3. **"Well-tried experience"** (conferring with colleauges/bosses, "gut feeling")

"What does evidence based practice mean?"

1. **"Better care"** (professionalism, equity, better outcomes)
2. **"Technification"** (de-humanization, weaker commitment, temporary trend)
3. **"Cost effectiveness"** (saving money, winding up "bad care")

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What is to be resolved by the new initiatives?
A wider perspective (I):

What happens outside the system?

How important is treatment?

Proportion who improved their drinking habits without treatment; representative population sample; N= 339/ 2862

Previous drinking:

Present drinking:	”Risk consumer”	”Problem consumer”	Dependent (ICD-10)
”Normal”	94 %	90 %	83 %
”Moderate”	85 %	72 %	44 %
Abstainer	55 %	48 %	28 %

(Blomqvist et al., 2007)

One year follow-up of previously untreated problem drinkers

	Treated (n= 136)	Untreated (n= 84)
Improved*	58 (43 %)	17 (20 %)
Not improved	78 (57 %)	67 (80 %)

*abstinent or problem-free drinking last 30 days

Predictors for improvement (logistic regressions):

Men:

- treatment

- low social pressure to drink past year ("dry" social network)

Women:

- university education

- low social pressure to drink past year ("dry" social network)

(The AHF-project: Blomqvist & Christophs, 2005; preliminary analyses of 1-year data)

Important influences in the recovery process

Blomqvist, 1999; 2002

COMMON FEATURES:

Recovery evolved over several years,

(as a result of) interplay between external influences and internal processes

Motivation built on combination of negative consequences and positive incentives

Strategies to cope with immediate hardships after treatment supported lasting change

Maintaning the resolution required social support, ”gains” from living sober, and new alternatives /comittments

Alcohol / drug problems were on a par with clinical populations

DIFFERENCES BETWEEN UNASSISTED AND ASSISTED RECOVERIES:

”SELF-REMITTERS”:	TREATED REMITTERS
Some remaining social capital (“more to loose”)	Exhausted personal and social resources
Positive incentives *before* the resolution; many alcohol misusers tapered drinking	Increasing substance use and life strains until treatment entry; treatment created hope / pointed to alternatives
Returned to a ”conventional” life-style	Substituted social networks; found new comittments
Some former alcohol misusers resumed moderate drinking	Most stayed abstinent
”Rational” adaptation to external influences and new conditions	”Transformation” of life-style

Reasons for not seeking treatment

(Blomqvist, 1999; 2002)

Self-changers from:	Women:	Men:
Alcohol	Fear of sanctions (stigma) Problems not so severe (the care systerm is for the destittue)	Problems not so severe (the care systerm is for the destittue) Own competence Fear of sanctions (stigma)
Narcotic drugs	Fear of sanctions (stigma) Distrust in the care system Own competence	Own competence Distrust in the care system Fear of sanctions (stigma) Pride

(No-one claimed total ignorance)

The path to recovery from addiction problems – the usual picture:

”problem” → treatment → (”aftercare”) → ”cure”

An emerging, alternative, picture:

- **Recovery is usually a long-term process**
- **Recovery is not *only* about treatment, but also about motives, alternatives, and environmental influences**
- **Good treatment is not *only* about ”methods”, but also about *for* whom, *by* whom, *how,* and in *which context* these methods are used**
- **The main role of treatment is bolstering ”natural” recovery processes (initiate, pave the way for, maintain)**
- **Treatment should ”start where the client is”, and interact with and strengthen ”healing forces” in his/her natural environment**

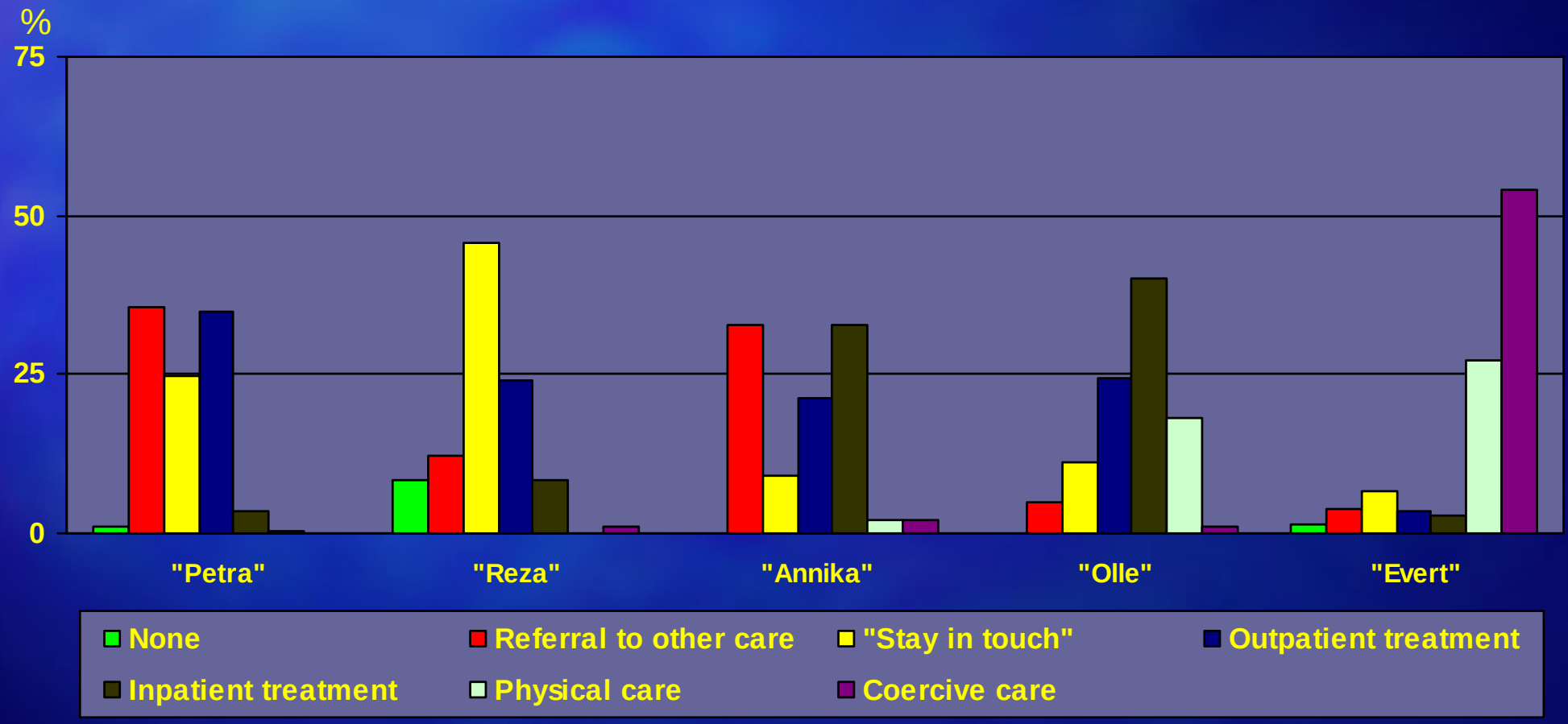
What is to be resolved by the new initiatives?
A wider perspective (II):

Some snapshots of the state-of-art of addiction care in Sweden

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(a) How do professionals choose what to do?

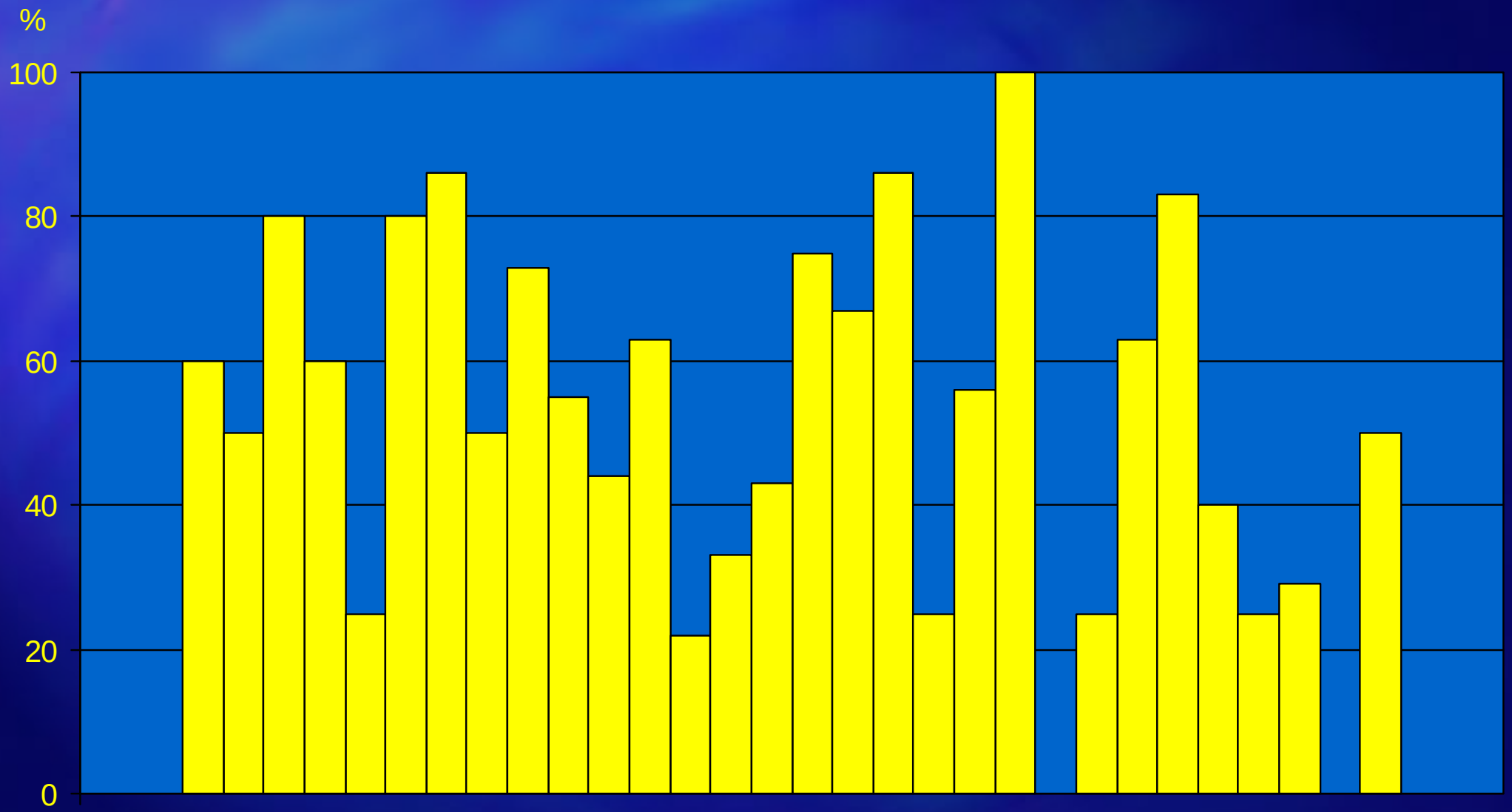
A vignette study. Exampel 1: type of intervention for five ”cases”



(Blomqvist & Wallander, 2004)

(a) How do professionals choose what to do?

Exampel 2: proportion at each unit that recommended coercion



(Blomqvist & Wallander, 2004)

(b) Who are the clients?

-”A group of social outcasts” (The state of temperance care; 1967)

- The proportion of marginalised persons in in-patient addiction care increased considerably from 1983 to 1993 (Blomqvist, 1996)

- Clients in social services based addiction care in Stockholm: 74 % men; 79 % single; 85 % not in work; 54 % no permanent housing; 38 % primary school at most; 6 % not treated before (Eriksson et.al., 2003)

- Clients in health care based dependence care in Stockholm: 70 % men; 73 % single; 77 % not in work; 35 % no permanent housing; 30 % primary school at most; 9 % not treated before (Palm & Storbjörk, 2003)

- Previous treatment experience and external pressure - rather than severity of drinking – main predictors for being in alcoholism treatment (Storbjörk & Room, 2008)

The state-of-the art of addiction care – ideals and realities…

- **The official/manifest goal:**
  - **To reach everyone with an addiction problem and make them quit (National Alcohol- and Drug policy plans)**
- **The actual situation:**
  - **The care system deals to a large extent with a small group of clients with severe social and psychological problems, who turn up repeatedly**
  - **The majority of problem users stay outside the system**
- **The latent goals:**
  - **To diminish suffering and mortalilty /create more tolerable life conditions/ relieve some pressure from relatives and friends (Lindström, 1994)**
  - **”To control the uncontrolable” (Bergmark & Oscarsson, 1988)**
  - **To assist society in ”living with its addicts” (Kühlhorn, 1983)**
- **Both aims are legitimate – none them is particularly well fulfilled**

So what is most needed?

Better methods, more resources, or something else….

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”Method” in substance abuse care

- **From**
  name / ”brand”
  (theoretical reference; ideological ”marker”, ”model”)

  Critique of ”the uniformity assumption myth” ⟶
  demands for specifying ”what is done”

- **To**
  technique / procedure
  (”manual based”)

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Some issues concerning the knowlwedge base…

- RCTs good at isolating causal effects, but…
- do not capture important contextual influences (motivational factors; treatment choice; the ”natural environment”; the long-term course)
- and have limited external validity (standardization of interventions, clients, and therapists)
- Categorising problems in reviews (”apples and pears”)
- Unstable state-of-the-art (between reviews and over time)
- Moderate effect sizes – limited guidance on the individual level
- ”The treatment equivalence paradox”*/ ”common factors”†

* ≈ no clear evidence that any ”specific method” is better that any other (or that some methods are better than other for some clients”)

† ≈ (”unspecific”) factors that are present in *all* effective treatments

(Bergmark, 2001; 2007; Blomqvist, 1996; Blomqvist & Oscarsson, 2006; Orford, 2008; Tucker & Roth, 2005)

Clients' views on successful treatment (potential "common factors")

(Blomqvist, 1999, 2002)

- Having been "seen" and taken seriously
- Having felt that own ideas and views were respected
- Having received trustworthy explanations and been shown attractive alternatives
- A close and confiding relation to some individual helper
- A safe and drug-free environment
- At least some emotionally shakening experience
- Having received help to master life problems outside the treatment setting
- Having receieved – and could name - some specific form of therapy

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”Method” ≈ a rituale,

that makes the therapist and the client spend time together,

that demands an active commitment from both,

that structures their interaction,

and that strengthens the latter’s confidence in the former

(after Jerome Frank)

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How ”evidence based” is Swedish addiction care?

(National inventory, 2005; ”bearing ingredients”)

- Social skills training (32 %)
- Ego-strengthening therapy / suport (31 %)
- 12-step treatment / Minnesota model (25 %)
- Cognitive behavior therapy (19 %)
- Solution-focused treatment (16 %)
- Social-pedagogical model (responsibility training) (11 %)
- Motivational interviewing (10 %)
- System-theoretical model (10 %)
- Behavior therapy (10 %)
- Acupuncture (9 %)
- .....
- Community Reinforcement Approach – CRA (1 %)
- .....
- About 1/3 of all units offer pharmacologically assisted treatment

Actual vs. recommended methods in Swedish addiction care

(" matches" & "mismatches" with National guidelines, 2007)

- Social skills training (32 %)
- Ego-strengthening therapy / suport (31 %)
- *12-step treatment / Minnesota model (25 %)*
- *Cognitive behavior therapy (19 %)*
- Solution-focused treatment (16 %)
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- .....
- *Community Reinforcement Approach – CRA (1 %)*
- .....
- *About 1/3 of all units offer pharmacologically assisted treatment*

The challenge:

- **Adapting the solution to the problem:**

  finding the means to meet the widely varying needs of a variegated and heterogenous group of people with a variety of substance use problems

- **Keeping the knowledge process going:**

  widening the knowledge base; reconsiling everday experience and scientific proof; creating an on-going dialouge between practice and research

Towards a solution:
(a) changes at the structural level:

- **Facilitating ”self-change” / helping people help themselves:**
  - counteracting moralism and simplistic categorisations; information about the high prevalence of ”self-change” and how the environment can help; internet based information and support; social policies that reduce social exclusion and create attractive alternatives

- **Making services attractive and relevant to the large majority of problem users:**
  - high availability; flexibility; ”starting where the client is”; follow-up /revision in dialouge with each client; broad menue of well-tried methods; cross-disciplinary teams etc.

- **Improving the situation for the ”revolving-door” group of ”heavy addicts” or ”chronic cases”: new thoughts more urgent than new resources**
  - from ”intensity” / ”more of the same” (irregular episodes of – voluntary or coerced – long-term in-patient care)
  - to ”extensity” (continuous, low-intensive support; focus on making clients’ ”natural environments” conducive of a decent and sober life)

(Humphreys & Tucker, 2002; Blomqvist et al. 2007)

Towards a solution:

(b) EBP in a wider perspective

Three interpretations of EBP:

- **The informed practitioner – consulting research data bases for each individual case**
- **The guidelines-directed and manual-abiding practitioner**
- **The pragmatic practitioner – trying to balance scientific evidence, well-documented clinical experience, and clients' needs and whishes**

(cf. Sacket et al., e.g., 1997)

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What does it take to develop a “pragmatic” practice?

Research needs:

- (Continued efficacy studies of un(der)researched practices)
- More effectiveness studies of promising treatment methods
- Far more studies of the treatment process and ”common factors”
- Far more long-term, naturalistic studies (users’ perspective; organizational aspects, a s o)

Developing a basis of well-documented clinical experience:

(”gut feeling” doesn’t work)

- Systematic documentation – follow-up – collective scrutiny of own practices
- Fora for collegial dialouge – within and between practices

Putting the single client in focus:

- Keeping track of the development in the single case (corrections / adaptions to new circumstances / increased motivation / better outcome)

A model for the encounter between research and practice:

Research:

contribute 'abstract' knowledge
(causes; methods; principles)

(advise practice on documentation and self-scrutiny)

Practice:

(translate and adapt abstract knowledge to shifting concrete circumstances)

Scrutinise, articulate and systematise own experiences

… in dialouge with users/clients…

and…

on-going ethical discussion

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The social-political framing

“To be able to ‘say no’ to alcohol or drug abuse (and other destructive habits) it takes something else and better to ‘say yes’ to”

(after Granfield & Cloud, 1999)

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