HEALTH SERVICES RESEARCH

Health services research is the study of how health care is organized, managed, financed, and delivered. This Alcohol Alert focuses on the issues of access, quality of care, and cost—important aspects of alcohol health services research. In an ideal world, treatment for alcoholism and alcohol abuse would be based solely on solid scientific evidence. It would be cost-effective, would target the most appropriate care to each patient, and would result in real, measurable outcomes—such as reduced rates of alcoholism, fewer incidents of drinking and driving, and the best possible use of limited resources.

In reality, though, there often is a disconnect between what is found in research and what is used in real-world treatment settings. Financial constraints, staffing issues, even a simple lack of understanding of what’s working—all can interfere with putting what is learned in the lab into clinical practice (1). Add to this the fact that millions of men and women have achieved stable recovery using treatments that are not based on empirical research, and the distance between research and practice becomes even greater.

This Alert examines the challenges researchers and clinicians face when translating scientific findings into practice. It describes how research is helping to inform treatment of special populations such as adolescents, women, and racial/ethnic minorities and the costs and benefits involved in providing treatment.

QUALITY OF CARE: WHAT’S WORKING?

Knowing what is working in the research field is only the first step to bridging the research–treatment gap. Research also plays an important role in helping to identify obstacles that clinicians face when using medications, such as naltrexone, and specialized treatment, such as motivational interviewing, in clinical practice.

Pharmacotherapy—Perhaps one of the greatest disconnects between research and practice involves the use of medications to treat alcohol-related disorders. For example, clinical trials suggest that naltrexone helps reduce the frequency of drinking and the severity of relapse among alcohol-dependent patients (2).

Although there are occasional reports of no effects (3), large-scale analyses of clinical trials have continued to support an improvement in treatment outcomes with the use of this medication (4,5).

Training materials on the use of medications in alcoholism treatment also are available. A Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocol was developed to provide detailed clinical guidance on how to use naltrexone in alcoholism treatment (2), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) published as part of its COMBINE Monograph Series the Medical Management Treatment Manual, which details the rationale and use of both naltrexone and acamprosate (6).

Despite the availability of training materials for professionals and consistent reports of significant reductions in alcohol use, medications such as naltrexone are not commonly prescribed. Members of the American Academy of Addiction Psychiatry and the American Society of Addiction Medicine prescribed naltrexone to only about 1 in 7 (13 percent) of their patients (7,8). A survey of counselors and physicians specializing in addiction medicine (9) found that few counselors (5 percent) recommended naltrexone to most of their patients, and more than half (54 percent) never suggested that patients try it. A higher percentage of physicians prescribed naltrexone for patients. Eight of 10 physicians (80 percent) reported current or prior use of naltrexone with patients, but only 11 percent prescribed it “often,” and only 4 percent prescribed it for “almost all patients” with alcoholism or alcohol abuse problems.
Adolescents—An increasing number of studies show that treatment is effective for adolescents with alcohol and drug-related problems (13,14), but there are unique challenges to assessing, diagnosing, and treating alcohol problems in young people. Adolescents need a treatment approach that is flexible and integrates all the aspects of their life—including school, family, work, and peers. Such an integrated approach can be difficult in treatment settings, especially in today's managed care treatment environment (15).

A recent study (16) examined the use of one model—the “research-to-practice integration model”—for treating adolescents within a managed health care plan. Key findings from this study include the following:

- Compared with matched control subjects, adolescents entering AOD treatment had higher rates of several psychiatric and medical conditions and more legal, educational, and family problems.
- Adolescents entering treatment reported high levels of AOD use and often fit the criteria for abuse and dependence, indicating that these patients were waiting until their problems were severe before seeking treatment.
- Patients came into treatment in a variety of ways. For example, boys were more likely than girls to have been referred to treatment from the legal system. Only a relatively small proportion were referred by one of their health plan's medical or psychiatric providers.
- Girls were significantly more likely than boys to have received previous mental health treatment.

Based on the results of this study, it appears that adolescents seeking AOD treatment often have serious problems in other parts of their lives, and that different health care professionals (treatment providers, primary care clinicians, and psychiatrists) who are likely to come in contact with adolescents need to consider this so that they can identify and refer patients for treatment before serious problems develop. The study also shows that increased integration between AOD and psychiatric programs (“one-stop shopping”) could significantly improve treatment outcomes.

Women—Women historically consume less alcohol than men, drink alcohol less frequently, and are less likely to develop alcohol-related problems. Yet when women do develop alcohol-related problems, they tend to develop them faster (17), and their problems are more severe (18). In fact, women develop higher blood alcohol concentrations than men, even when drinking the same amount of alcohol, which increases their risk of injury and illness from conditions such as alcohol-related liver disease (18).

Gender differences also exist in alcoholism treatment, beginning...
Women are less likely than men to be diagnosed with an AOD problem in health care settings.

With diagnosis. Women are less likely than men to be diagnosed with an AOD problem in health care settings (19). Primary care physicians may fail to accurately identify women with alcohol use disorders because women tend to seek treatment for nonspecific health complaints, nervousness, anxiety, or insomnia.

Once a woman decides to seek treatment, she faces different barriers than men do in finding and accessing services. Women are more likely to experience economic barriers to treatment, to report having trouble finding time to attend regular treatment sessions because of family responsibilities, and to have problems with transportation (20).

Women also tend to have a higher prevalence of anxiety and depressive disorders and more severe mental health problems (21). These co-occurring problems may make it harder for women to find and follow through with treatment (20).

Given the obstacles women face in seeking treatment, it seems to follow that women would be less likely to seek, initiate, or complete treatment, and would therefore have poorer long-term outcomes. But this is not the case. A recent study found that men and women were equally likely to complete treatment, but women who completed treatment were nine times more likely to be abstinent than women who did not complete, whereas men who completed treatment were only three times more likely to be abstinent than men who did not complete treatment (22).

Are specialized women-only programs needed? In one study, women who lived with their children in a residential program remained in treatment significantly longer (average of 300 days) than did women whose children were placed with caretakers (average of 102 days) (23). Thus, providing services such as child care may help to keep women in treatment (20).

Ethnic and Minority Groups—According to national surveys, alcohol consumption and alcohol-related problems among White Americans have declined since the mid-1980s (24). At the same time, however, alcohol consumption and alcohol-related problems have remained stable or even increased among Blacks and Hispanics. Studies also show that, for any given level of alcohol consumption, ethnic minority populations experience more negative health and social consequences of drinking (e.g., unemployment, poor education outcomes, and alcohol-related legal problems) than Whites (25).

Most of the studies of treatment effectiveness have compared Whites with the largest minority groups, primarily Blacks and Hispanics. Although some studies reported poorer treatment outcomes for minority patients, most found no significant differences in treatment effectiveness across groups (26).

In many studies, minority patients enter treatment with more characteristics that predict lower rates of success (e.g., lower income, less education, more extensive family histories of alcoholism, more co-occurring drug abuse, and poorer physical health) compared with Whites (27).

But even with poorer odds of success at the beginning of treatment, minority patients often appear to be as successful as Whites when followed for a year or more after treatment.

Although research on alcoholism treatment with these groups is very limited, some studies have suggested ethnic differences that may be relevant for treatment planning.

Kaskutas and colleagues (28) found that a higher proportion of Blacks in treatment (76 percent) report having had some previous treatment compared with Whites (65 percent). Blacks are almost twice as likely as Whites to have gone to Alcoholics Anonymous (AA) meetings as a part of their treatment. Arroyo and colleagues (29) found that although Hispanics attended more formal alcoholism therapy sessions and fewer AA meetings than Whites, both groups had similar treatment outcomes. The authors speculate that Hispanics may make greater use of their existing social support system and thus may not need AA as a support system, or their treatment preferences simply may reflect a belief that AA is not as effective as formal treatment programs. The NIAAA Project MATCH study showed that Native American patients experienced better outcomes from motivational enhancement therapy than from cognitive-behavioral therapy or 12-step facilitation (such as AA) (30).

Mandated Treatment—Many people enter alcoholism treatment through the legal system (31), a large proportion of them for driving under the influence (DUI) (32). Research on mandated treatment for DUI offenders consistently shows that treatment has a modest effect on reducing drinking—driving and alcohol-impaired crashes among offenders who were mandated to attend and who actually received the intervention (33,34).

Research has not specifically examined the cost-effectiveness of mandated treatment for drinking and driving. However, considering that alcohol was a factor in 41 percent of U.S. traffic deaths in 2002 (35), and that in 1998 the U.S. economic costs related to alcohol use problems was $185 billion (36), the design of cost-effective treatment is imperative. Developing cost-effective alcoholism intervention and treatment for mandated populations could mean a decrease in alcohol-related problems nationwide.

Treatment efforts aimed at DUI offenders also need to consider the changing characteristics of the DUI offender population. For example, stricter laws, such as zero-tolerance laws for underage drinkers (which set the legal blood alcohol limit for drivers younger than age 21 at 0.00 or 0.02 percent) have led to a 19-percent reduction in drinking-driving and a 20-percent reduction in fatal crashes among young drivers (37,38). Still, many young people continue to drink
Studies of the cost and cost-effectiveness of alcoholism treatments are essential to ensure that people with alcohol-related problems receive appropriate care.
AOD treatment field, as well as for health insurance companies, managed care organizations, and policymakers who require solid information regarding the economic implications of alcohol-related services to fund these services.

REFERENCES

Source material for this Alcohol Alert originally appeared in Alcohol Research & Health, Volume 29, Number 1, 2006. For more information on recent advances in alcoholism treatment, see also:

- **COMBINE Monograph Series: Volume 1, Combined Behavioral Intervention Manual: A Clinical Research Guide for Therapists Treating People With Alcohol Abuse and Dependence—**Highlights the use of Combined Behavioral Intervention, an intensive treatment that combines several successful features from previously evaluated interventions.

- **COMBINE Monograph Series: Volume 2, Medical Management Treatment Manual: A Clinical Research Guide for Medically Trained Clinicians Providing Pharmacotherapy as Part of the Treatment for Alcohol Dependence—**Describes the use of medical management and brief counseling sessions to enhance medication adherence and abstinence from alcohol.

- For these and other resources, visit NIAAA’s Web site, www.niaaa.nih.gov

Full text of this publication is available on NIAAA’s World Wide Web site at http://www.niaaa.nih.gov.

All material contained in the Alcohol Alert is in the public domain and may be used or reproduced without permission from NIAAA. Citation of the source is appreciated.

Copies of the Alcohol Alert are available free of charge from the National Institute on Alcohol Abuse and Alcoholism Publications Distribution Center, P.O. Box 10686, Rockville, MD 20849–0686.

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
NIAAA Publications Distribution Center
Attn.: Alcohol Alert
P.O. Box 10686
Rockville, MD 20849–0686

Official Business
Penalty for Private Use $300