Transcript: Alcohol is STILL a Drug An Exploratory Webinar Series – December 2021

Presenter: Joe Rosenfeld
Recorded on December 7, 2021

ANN E SCHENSKY: Good morning everyone and welcome. Going to give people just a couple of seconds to get in and settled. I think we'll just get started quickly with our intro slides, and then we will move on to Dr. Rosenfeld.

So again, good morning, and welcome to our series, alcohol is still a drug. Today's presentation is alcohol use disorder treatment and, as I said, Dr. Rosenfeld is our speaker. We will not have a session in January so we will start again in February. This presentation is brought to you by the Great Lakes ATTC, PTTC, MHTTC, SAMHSA.

The opinions expressed in this webinar are the views of the speaker and do not necessarily reflect the official position of DHHS or SAMHSA. The Great Lakes PTTC, ATTC, and MHTTC believes that words matter and use respectful languages in all of our activities. I have a couple of housekeeping details. If you are having any technical issues, please individually message Kristina Spannbauer or Stephanie Behlman in the chat section, and they will be able to help you.

If you have questions for the speaker, please put them in the Q&A pod at the bottom of the screen. We will be using automated transcriptions for today's webinar. This presentation will be recorded and posted on the websites within two weeks. And certificates of attendance will be sent to all who attend the full session. They will take about two weeks and will be sent to you via email. If you'd like to see what else we're doing, please follow us on social media.

And again, I am excited that Dr. Rosenfeld is our speaker today. Dr. Rosenfeld is a licensed clinical psychologist, a certified reciprocal alcoholism and other drug counselor, and Human Services board-certified professional. He is a Professor in the addiction counselor treatment program within the Human Services department at Elgin Community College, and I'm going to turn it over to you.

JOSEPH ROSENFELD: Thank you very much. I'd like to thank the ATTC for having me today, and I hope everybody enjoys the presentation. Here on the first slide is my direct email address should you have any questions you want

to send or comments you want to send me directly. In this session, we're going to look at the constancy and cost of alcohol use disorders. And we're going to look at the treatment for alcohol use disorders prior to the beginning of Alcoholics Anonymous in 1935, and then pick it up again sort of in the 1950s at the beginning of the modern treatment system.

And we're going to examine an array of evidence supported practices that are currently in use in the alcohol use disorder field. We talk about substances often coming and going in epidemic cycles. For example, the opiate epidemic that we have now is in it's fourth epidemic cycle, starting at the time of the Civil War for the first one.

But alcohol has been a constant in the United States and been a constant issue of discussion throughout that time. And I think we often just overlook it because we're so used to its being there. And just to highlight some of the impacts of alcohol, currently in the United States 25% or 26% of folks report binge drinking within the last month. 10% of children in the United States live in a household where there's an alcohol use disorder.

Currently there's estimated to be 14.5 million people with alcohol use disorders. And these are alcohol use disorders in isolation from other substance use disorders. So what we used to call, back when I started, the pure alcoholic which has become actually less frequent over time but still exists. 95,000 people die every year from alcohol-related illnesses.

And I just want to point out that we hit the unfortunate mark of 100,000 deaths this last year from various drugs, mostly opioids, fentanyl, and it made headlines everywhere. But the steady drumbeat of 95,000, 100,000, 110,000 people who die every year from alcohol-related diseases never makes the headlines. And this has been going on for decades, taking its toll for decades.

And we spend about $240 million in social costs as a result of alcohol use disorders every year. In addition, about 18.5% of emergency room visits, about 5 million visits a year, are alcohol related. And 22% of all overdose deaths are related to prescription opioids are also alcohol related in that the individual mixed the two together. Interesting enough, the rate of alcohol-related emergency department visits has increased by 47% between 2006 and 2014, resulting in an additional 210,000 visits to the emergency room during that time.

Alcohol-- you can read the next slide, the third bullet point. I won't go into it in detail except to say that alcohol is a full-body toxin, that it impacts virtually every organ of the body. And the abuse of alcohol results in the breakdown of those organs over time, be it the liver, the heart, the brain, the stomach.

2019-- alcohol-impaired drivers accounted for 10,000 deaths, about 28% of all overall driving fatalities. And approximately 30 out of every 1,000 children, ages 7 to 9, have some level of fetal alcohol spectrum disorder. So quite a few children are impacted by alcohol use disorders as well, which has both a social cost and a financial cost to society.

Did a little research on alcohol abuse during the COVID epidemic, and drinking has gone up. I suppose no surprise to anybody watching this. It's gone up significantly among women. 41% increase versus a 14% increase overall, and you can speculate on why that may be.

But the burden of all the children coming home, and social isolation, and helping the kids with their school homework, and maintaining the home, and being locked in the home seems to have fallen much heavily on the women homemakers than on the men. Again, I think no surprise to a lot of people, and it's caused a significant increase in heavy drinking among women.

About 26 million people overall report that they've increased their drinking during COVID. I did some research on suicide during COVID, alcohol-related suicide during COVID. And the research on that is very interesting, and that has not gone up. But the researchers all point out that suicide is a back end issue when people have substance use or alcohol use disorders.

So they're predicting that due to COVID, and the increase in drinking, that down the road suicides are going to markedly increase. And those will be traceable back to the increased drinking during the COVID epidemic. And there's been a 61% increase during COVID in liver disease and alcoholic hepatitis.

I would just point out that the last time I saw liver disease increase, not personally, but that liver disease increased was during Prohibition-- was the last time we saw a sharp increase in liver disease. So I think private drinking is an issue. And since you can't go out to bars drinking, and people are drinking at home, we're seeing more alcohol-related illnesses as a result to that.

So this is the summation of the impact that alcohol has on us as a society every year. It is significant. And again, because it is so omnipresent and so socially accepted we have a tendency to ignore it. Which is why this sort of a conference over time is a very good idea.

About one million people every year seek treatment for alcohol use disorders. Again, what we call the pure alcoholics. And another seven million people are

seeking treatment for a mixture of alcohol use disorders along with other substance use disorders. What I want to talk about next is the history of alcohol treatment, alcohol use disorder treatment.

And I know I'm going to jump back and forth between calling it alcoholism, alcohol use disorders, as I do this because the data, being older, it all says alcoholism. So I have a tendency to flip back and forth on that. But treatment for alcohol use disorders stems back to the beginning of the United States of America.

Alcohol again, has been this constant problem that we've dealt with for the whole history of our country. And the first was the temperance movement, 1774, and ran all the way up into the 1900s. I think many of you are familiar with the temperance movement because it was instrumental in pushing for the ban on alcohol production and consumption in the Constitution through the 18th Amendment later on.

But the original temperance movement encouraged the inebriates to switch from hard liquors to beer and wine. As you might imagine, that didn't work out so well. And the focus then became abstinence. I would also add that the temperance movement was built on a moral model of drinking. And again, we've had this discussion in the United States forever whether an alcohol use disorder is a moral illness or moral failure or whether it's a physical disease or physical illness.

And if we were to trace the progression of treatment it follows one of those two tracks, generally, where the treatment is morally focused or the treatment is disease focused. And the temperance movement was morally focused. Mutual aid organizations-- we think about Alcoholics Anonymous, but that wasn't the first organization. First mutual aid organizations identified in the United States were among Native Americans, such as the Handsome Lake organization.

In 1800, this migrated into the non-Native populations in around the 1830s. And the largest of these non-Native more secular-- well, not really more secular, but not affiliated with a religious organization-- was the Washingtonians Total Abstinence Society which was open from about 1830 to the 1860s, and at its peak had about 500,000 members.

But there were many, many total abstinence society. There was the Runaways, there was the San Francisco Firemen's Association. There were many, many mutual aid organizations that sprang up in the 1800s with people with alcohol use disorders reaching out to other people with alcohol use disorders. And we'll come back to that in a little bit.

The early official treatment programs where people would go away for treatment or go someplace for treatment again followed two paths, either the moral model or the disease model. The disease model was first posited by Dr. Benjamin Rush, one of the signers of the Declaration of Independence. In 1784, he was the first one to publish an article and say, this isn't a moral issue, this is a disease.

The 1870s, the American Association for the Cure of Inebriates was formed, which followed the moral treatment practices. And this is only significant in that D.T. Crothers, one of the founders of the American Association, was also one of the first presidents of the American Medical Association. As you may know, physicians have struggled, whether they follow the moral model or the disease model.

And even though the American Medical Association has voted three times that alcohol use disorders are a disease, most physicians, in a recent poll, actually feel that it's more of a moral model or a personal-will model than a disease. And so subsequently, many physicians still do not address it with their patients even though many of their patients have alcohol use disorder-related physical problems, such as those emergency room visits.

Toward the end of the 1800s, we started to see-- towards the end of the 1800s, after the introduction of morphine into the United States, we began to see pharmaceutical treatments for alcohol use disorders begin to emerge. And there's a very good reference book, if anybody wants to really kind of nerd out, by Anderson at the end of this presentation called Strychnine & Gold. It's a recent publication, and it traces the formation of many of the early pharmaceutically-based treatments for alcohol use disorders.

The largest of these was probably the Keeley Institutes. And one of the things the Keeley institutes did, as well, was to supplement their pharmaceutical treatment which was, as you can tell from the title of the book, strychnine or morphine, other drugs along with mutual support and mutual aid organizations. So we began to see in things like the Keeley Institute-- we began to see the merger of pharmaceutical treatments with mutual aid support.

And the Keeley institutes, there were hundreds of them around the country at its peak in the early 1900s. All these early treatment programs, not only the Keeley Institute, but many other treatment programs which really took off in the late 1800s and early 1900s, they began to close following the passage of the Harrison Narcotics Act in 1914 and then the 18th Amendment to the Constitution in the 1920s.

Not only was the Harrison Narcotics Act in the 18th Amendment the high point of the moral approach to treatment-- and we can see how that's progressed into our large number of incarcerated individuals and a large amount of money that we still put into the criminal prosecution of people with substance use disorders. But what we also saw with the passage of the Harrison Narcotics Act in the 18th Amendment was pretty much the end of the treatment systems that were being created from the 1840s on into the early 1900s.

In part, because the use of morphine and other opiates in the treatment of alcohol use disorders was outlawed. Many physicians who continued to try and treat people with alcohol use disorders were actually arrested in the early 1900s. But the treatment programs had to change what they do, they had to shut down.

They were no longer as effective as they were. And so we found ourselves with what was a lapse of treatment following the 1920s into the late 1950s. We saw a lapse of treatment availability. Into this void Bill and Dr. Bob, Bill Wilson and Dr. Bob Smith, formed Alcoholics Anonymous in 1935.

And just to make a comment about Alcoholics Anonymous and the early mutual aid societies that proliferated around the United States during the 1800s-- if one looks at the 12 traditions of Alcoholics Anonymous and sort of deconstructs them-- in the 1940s members of Alcoholics Anonymous leadership developed the 12 traditions. What they really studied-- and Bill Wilson was a master at this really-- what they really studied was why did all those other mutual aid organizations fail?

And if you look at the 12 traditions, they're all about avoiding the downfall of the previous mutual aid organizations. And apparently they've been fairly successful at it because Alcoholics Anonymous is still a dynamic organization today, shows no signs of slowing down. In addition to folks with alcohol use disorders being able to reach out to Alcoholics Anonymous meetings between 1935 and the late 1950s, anybody else with an alcohol use disorder who felt the need for treatment ended up in the state hospital system.

Around the United States, in the state hospitals at the time, there pretty much followed what I call a detox discharge model, where the person with the alcohol use disorder would spend a few days in treatment getting a detox. And then they would just be discharged with no support, no community support, no professional support. And obviously the treatment outcomes-- it wasn't really treatment-- but the outcomes of that kind of detox and discharge were very poor, as you can imagine.

This all started to change in 1954 at Willmar State Hospital when the physicians there allowed volunteers from the local Alcoholics Anonymous group to start running groups. And to their credit, those physicians at Willmar State Hospital did a couple of things, noticed a couple of things. One is, first of all, they noticed that these untreatable, revolving-door alcoholics that they were serving prior to that time were coming back six months later as members of this AA organization and were sober. And they were pretty impressed by that.

The next thing they did was they hired those folks on an equal footing with the social work and therapy staff to work with people. And the third thing they did, which was revolutionary at the time, is they made it, instead of a detox and discharge program, they made it a detox and 28-day treatment program. There was heavily, heavily-- and I think this is important-- heavily bridged the local AA community. So that at the end of the 28 days, people were pretty well situated in our local AA communities.

Later on in 1959, a group of these folks left Minnesota and came down and started Parkside Lodge in Park Ridge, Illinois. And this was, I guess, the breaking out of the Minnesota model which became the dominant treatment model throughout the United States from the 1950s on, even to the present time.

I promised in the description of this presentation that I would slay a sacred cow. And this is the sacred cow I'm going to slay. What I have here on the slide is a quote from the letter from Bill White to I.W. I know the professor at one of the universities, and she was inquiring about the 28-day model.

And Bill had actually-- Bill White had actually looked into this quite closely, and came away with the conclusion that the best explanation for why we have a 28-day treatment model, which is still the dominant treatment model in the United States today, is that there were 28 lectures. And so everybody got a lecture, and then when the lectures were over you were done.

And this is one of the things about the 28-day treatment program, is that it has virtually no scientific support as a freestanding entity. We're going to look at later that folks need a minimum of 90 days of treatment as the research supported length of time before treatment actually starts to really lock in.

And so the 28-day model, even though so many of us are still married to it today and every new program that opens seems to be 21 or 28 days long, it's

really not, in and of itself, a sufficient length of stay. And it's something we can take a look at in the future and start to work to undo once we can let go of it.

And the next slide that I'm going to show-- I have a list of evidence supported practices for alcohol use disorders. But before I get to that slide, I do want to make a couple of preliminary comments. One is, my first one is, that there is a science of treatment. What we're going to look at the next slides, what the Addiction Technology Transfer centers do, is try to integrate what we know about the science of addiction treatment and to alcoholism treatment into practice. And this becomes quite a challenge.

As you can see the 28-day program, for example, has very little scientific support. But it persists, as do many other things that we do in treatment, such as harsh confrontation or discharging clients for using and other things that are not evidence supported. But there is a science of treatment.

And so we can create treatment systems that are not-- when I started in the business back in the 1970s we were working on a folklore system. We really had no idea what we were doing, but that's not true today. And the research does exist, and there is a science of treatment. The lengths of care-- we now know from research after research after research that clients need 90 days at a minimum of services. And this is a minimum. A year, year and a half would be ideal for people seeking services.

And that can be in multiple modalities. That can be inpatient, inpatient plus outpatient, outpatient plus inpatient. It doesn't have to be 90 days of inpatient to be effective, but it's a lock-in number. And when we look at-- so many agencies have not only 28-day treatment programs but six-week treatment programs, 10-week treatment programs, and those kinds of things, all of which fall short.

I would add that the original 28-day treatment program, by the way-- and I mentioned this, but I'll just repeat it-- did have an integration into the indigenous mutual aid communities like Alcoholics Anonymous. At its peak, in fact, Parkside Lodge in Park Ridge had 1,000 AA volunteers. And they would come every night, these volunteers, and pick up clients and drive them to meetings in their own communities. We don't see that much done today but that was—

So even though it was a 28-day model, and even though it was revolutionary at its time, it was highly integrated into a continuing care model. There is a neuroscience of alcohol use disorders and recovery. I have the laureate reference at the end of this slide set which I think is a great place to start. And they have many lectures and things online you can watch.

But as the neuroscience of substance use disorders, alcohol use disorders, has evolved since the 1990s, it has, and will continue to have, a significant impact on how we do treatment, how we approach clients, and how we stage treatment. We know in the alcohol use disorders business there's-- starting with the Jellinek chart-- there's many models that follow a staged recovery process.

And I think that the neuroscience of alcohol use disorders will also provide us with that staged model of recovery. And again, the necessity that clients undergoing a neurological recovery will require recovery support for many more than 30 days, up into six months, a year, year and a half.

And the last point I want to make-- and we look at success data from alcohol use disorders-- I want to encourage everybody not to conflate the success data with retention data. We know from study after study after study after study after study that substance use treatment, alcohol use treatment, is successful. People stay in treatment for a year. They have upwards of an 80% chance of recovery.

One of the challenges we have with really any disease that's a chronic lifestyle disease, be it hypertension, diabetes, type 2 diabetes, or anything, is retaining clients and treatments, getting clients to stick with their treatment regimens. And so retention research is very different than success research. But a lot of people conflate the two. And they'll say, oh, you know, this agency has low retention so it has low success. Which is true on its face.

They have low success because they have low retention. But the issue isn't whether treatment is successful if a person sticks with it. Agencies will vary in their retention rates from retaining 25% of their clients for 30 days or 60 days, to retaining 75% of their clients for 30 days or 60 days.

And there's quite a bit of research on how to improve retention. And as Rudolf Moos, a researcher from California states, the only predictor of outcome in substance abuse treatment is length of time and treatment. And this is true for alcohol use disorders as well. It's not how many groups you go to, it's not how many lectures you get, it's how long you stay in a recovery process dictates how successful you're going to be. And so retaining people in that process is very, very important. And I would encourage you to not conflate the two.

So what are some evidence supported practices for alcohol use disorders? There's a list here. Virtually every ATTC out there pretty much specializes in one or more of these evidence supported practices. And you can access that

through either this ATTC or through the National Addiction Technology Transfer Center.

But one of those is SBIRT-- Screening, Brief Interventions and Referrals for Treatment. We saw how many people end up in the emergency room for alcohol related impacts. And SBIRT is designed for use in the emergency room to encourage people to take a look at their drinking and to take a look at going into treatment. And it's been found to be very successful.

Once again, we refer to things as evidence supported practices because they've been studied by multiple researchers, over multiple years, with multiple populations, and published in various peer-reviewed scientific journals. So when things make this list, they've gone through a very rigorous process of reviewing, what we call the gold standard of evidence support. There are many, many retention strategies that you can look at that are published.

But one of my favorites, least expensive, is if you put a candy bowl out in your waiting room, your client returns will actually improve. So just doing a little thing like being hospitable will increase your retention rates and your client return rates. And these things do not have to be expensive, I would also point out.

Motivational interviewing, I think everybody knows what that is. But that goes to retention strategies as well as moving clients through the stages of change. Contingency management, out of John Hopkins University, is a behavioral modification techniques that we use to keep people coming back to treatment and coming back to treatment in a consistent manner.

Bill White wrote an article about how drug dealers use contingency management and how it's appropriate-- and bartenders use contingency management-- how it's absolutely appropriate for treatment programs to use contingency management strategies to get people to return to treatment. People like Carlo DiClemente have written extensively about therapeutic relationship building and strategies for that.

Also Duncan, Hubble, and Miller in books like The Heroic Client and The Heart & Soul of Change have written extensively about the importance of the therapeutic relationship between the helper and helpee in terms of bringing about motivation to change. And so there's a lot of research, a lot of research supported things you can do to improve your relationship with your clients.

Case management, particularly around employment services, education, health care, and stable housing, has been found to greatly increase the retention of clients and the positive outcomes for clients. A 12-step facilitation by Nowinski has been around for decades. And it's a manualized intervention to help people make that migration from the treatment program into the 12-step communities or the indigenous support communities that surround the treatment programs.

The rapid intake and seamless transfer-- another University of Wisconsin organization called NIATx has been promoting this again for decades-- on the importance of rapid intake. We know the client's motivation to go into treatment drops off really rapidly. So developing systems that not only make treatment available but lower barriers to people getting into treatment quickly exist. And we can integrate those as well as seamless transfer from one level of care to another.

Alan Marlatt and Terry Gorski pioneered the idea of relapse prevention and relapse prevention strategies as well as what are called return to use strategies, or return to use termination strategies, that get people back into treatment as quickly as possible. Family therapy-- we know that, particularly with young people living at home, that if we don't include the family in treatment there's a very, very low probability of success.

I think once we start to merge family treatment with our understanding of neuroscience, I think we're going to see a new model of family therapy emerge. But right now, for adults, cognitive behavioral family therapy is the gold standard treatment of choice and is very important in recovery. The one pharmaceutical that we still use, since we're not using opiates anymore for treatment, is disulfiram or Antabuse. There are other medications out there such as ReVia, naltrexone, but, for at least my list, they don't meet that gold standard yet. But the use of Antabuse or disulfiram certainly does.

And lastly, as we're running out of time here, to develop what are called treatment systems versus-- one of the criticisms that Marlatt makes, and a couple of other folks, is that we still continue to treat alcohol use disorders as though they are a discrete, acute illness, like a broken leg or an infection, rather than lifestyle diseases or chronic lifestyle diseases that require intervention and support over long periods of time.

And so one of the things we want to look at is sort of deconstructing our siloed acute care model of alcohol use disorders, and begin to construct treatment systems that move people from one level of care to another. Part of this is the recovery oriented systems of care, or ROSC, which seeks to reach out to clients who are pre treatment and not treatment ready. Do harm reduction,

stays with the clients through their treatment episodes and for an extended period of time into the recovery phase of treatment.

So those are some current evidence supported practices. If there's any time left, which I believe there is not, I'd be happy to answer any questions. If there are questions, and you've been sending them through the chat, we will get back to you as soon as we are able. So once again, I'd like to thank the ATTC for allowing me to do this presentation and I hope you enjoyed it. Thank you. Have a great day. Bye.

ANN E SCHENSKY: Thank you very much Dr. Rosenfeld. That was a very good presentation. And we will save the questions that you've put in Q&A, and we will have Dr. Rosenfeld answer them. And that information will also be posted on our website.

So we'll give you a minute or so if you want to put a question in the Q&A. Otherwise, thank you all for your time. Thank you especially, Dr. Rosenfeld, and have a great afternoon.