RECOVERY FROM ADDICTION

Alberta Prevalence Program: Highlights of a Treatment Service Study and a Public Opinion Survey

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MOBILIZING KNOWLEDGE ABOUT ADDICTIONS AND MENTAL HEALTH FOR ALBERTA

Alberta family wellness initiative

Norlien Foundation

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1. Background and Aims of the Program

Background

- Approached by the Norlien Foundation to conduct a prevalence survey of a variety of traditional and non-traditional addictions
- Discussions led to approval of a program of research with several aims

Aims of the Prevalence Program

- To determine the prevalence of self-reported addictions across a wide variety of problem behaviours among Alberta adults
- To study relationships between early life adversity and later addictive behaviours
- To contribute to our conception of what counts as an “addiction” and how such problem behaviours are classified
- To develop accurate and effective measures of newly recognized problem behaviours
- To engage in knowledge exchange activities to increase awareness of these issues among researchers, practitioners, policy-makers

Phases of the Prevalence Program

PHASE 1

Foundational Research

PHASE 2

Development of Measures

PHASE 3

Province-wide Surveillance

2. Alberta Survey of Mental Health, Addictions, and Related Treatment Services (A-SMARTS)

Alberta Study of Mental Health, Addictions, and Related Treatment Services (A-SMARTS)

- Rationale:
  - In trying to identify the scope of problem behaviours in Alberta, it is important to identify and describe existing treatment resources and utilization
  - No known previous studies documenting the treatment system in Alberta
  - Current process of merging the public addiction and treatment systems offers an opportunity

Objectives

- Four objectives:
  - To describe current treatment services and supports available for addiction-related behaviours including substance use and gambling, mental health issues and problem behaviours (including eating, sex, shopping, etc.)
  - To describe referral patterns across the continuum of treatment services and supports
  - To identify gaps and unmet needs
  - To identify service delivery issues (e.g., waiting lists, eligibility criteria, timing and unmet needs)

Method

- Surveys of:
  - **Program directors** of AHS and non-AHS treatment services and programs
  - **Front-line practitioners** and supervisors of front-line practitioners employed by a larger program or service
  - **Solo practitioners** or independent service providers, such as psychologists, counsellors, etc.
- Excluded (i) primary care, and (ii) programs or services that were targeted primarily toward people with other mental health problems (e.g., depression, psychosis, anxiety), even if some clients happened to also have an addiction

Method

- Enumerated programs, services, and solo practitioners through:
  - Existing online databases
  - AHS records of former AADAC and AADAC-funded programs as well as relevant mental health programs
  - Professional accreditation and registration listings
- Cast net as widely as possible to ensure coverage of all eligible programs and services
- Program directors asked to disseminate practitioner surveys to appropriate staff

Method

- Sent invitations to non-AHS programs/services and all solo practitioners in December 2009 (Wave 1)
- Sent invitations to non-respondents of Wave 1 and all AHS-programs/services in March 2010
- To increase response rate: Post-card reminders, resending package, follow-up calls, online survey option, compensation ($20 for each practitioner or solo practitioner, $100 for every fifth program director)

Method

- You are eligible to take part if...
  - People seek (or are referred to) your service because of an addiction or concurrent addiction and mental health problem.
  - By “addiction” we mean **substance abuse** (e.g., misuse of alcohol, tobacco, illicit drugs, or prescription drugs) or **problem behaviours** (e.g., gambling, internet use, sex, eating disorders, or other compulsive behaviours) that impair normal functioning. You can take part, even if your program or service does not address with these problems from an addiction perspective.

Measures – Program Directors and Solo Practitioners

- Setting, modality
- Target population(s)
- Assessments
- Services provided
- Therapeutic approaches
- Client caseload
- Treatment staff composition

- Program needs
- Work climate
- Beliefs about and capacity to treat concurrent disorders
- Reactions to integration of mental health and addictions
- Demographics

Measures - Practitioners

- Work setting
- Profession and areas of specialty
- Work climate
- Perceptions of personal and program needs
- Work pressure and turnover intentions

- Treatment orientation
- Beliefs about and capacity to treat concurrent disorders
- Reactions to integration of mental health and addictions
- Demographics

Response Rates – Program Directors

	Number	Percent of Total
Total number in sample	200	--
AHS programs	156	78.0%
Non-AHS programs	44	22.0%
Number returned as ineligible	26	13.0%
Surveys completed	**53**	**30.5%***

**Ineligible programs removed from denominator*

Response Rates – Practitioners

	Number	Percent of Total
Number of programs sent practitioner surveys	200	--
Surveys completed	**517**	n/a

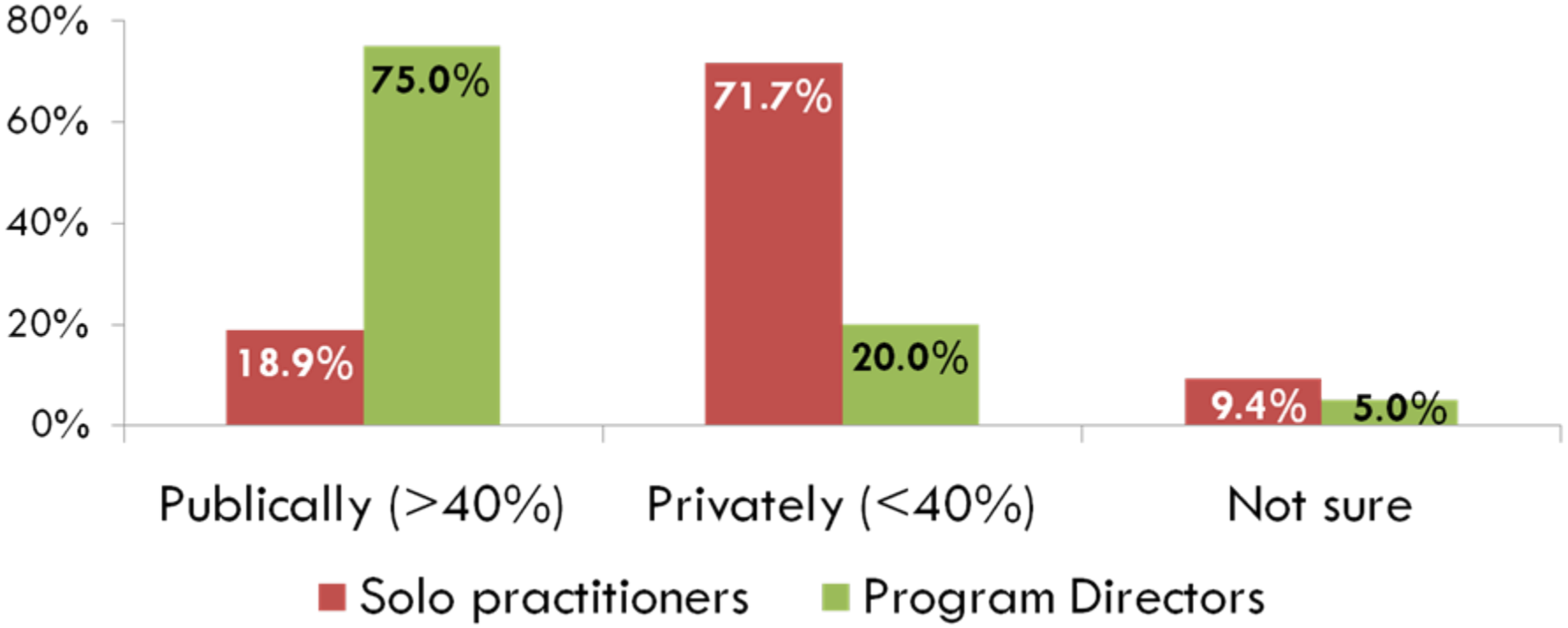
Response Rates – Solo Practitioners

	Number	Percent of Total
Total number in sample	230*	--
Number returned as ineligible	34	14.8%
Surveys completed	**55**	**28.1%***

**Ineligible practitioners removed from denominator*

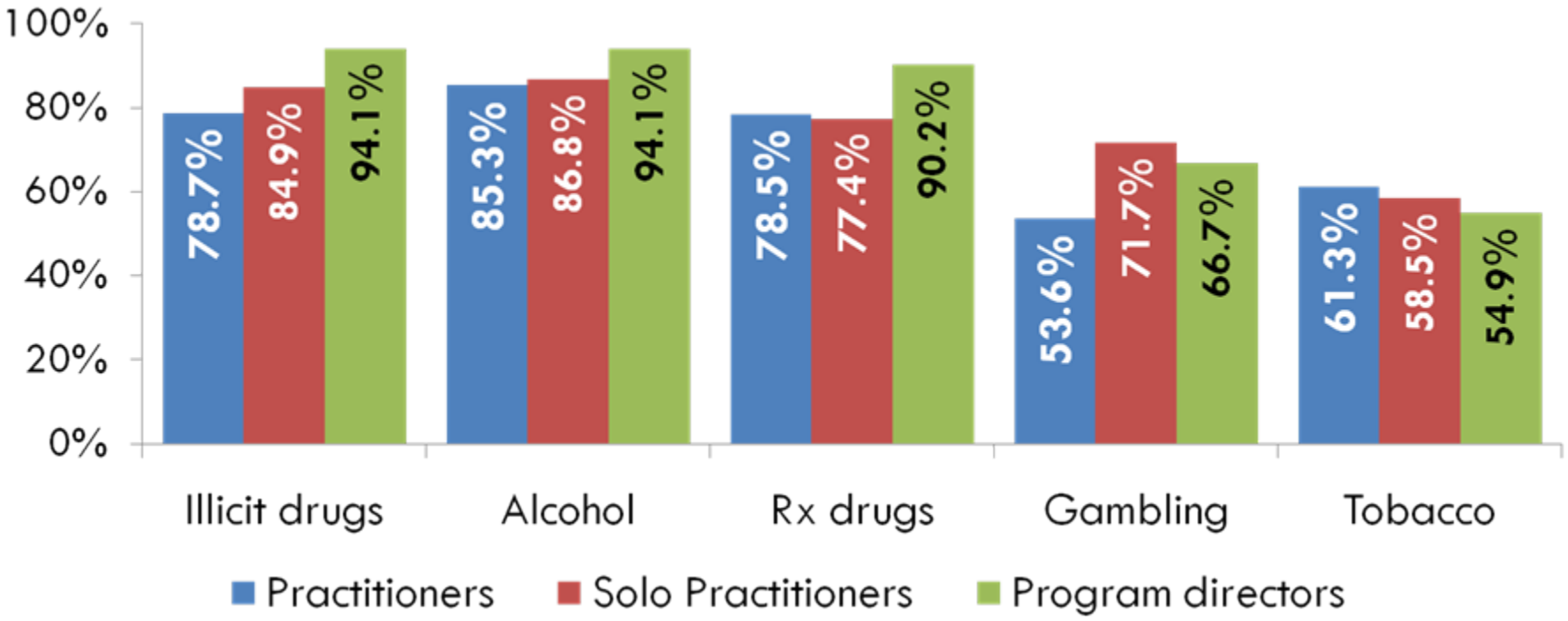
- Inclusion of solo practitioners in the sample was based on declared interest or specialization in an addiction or addiction-related disorder
- This resulted in inclusion of many who may have determined their practice ineligible

Public vs. Private Funding



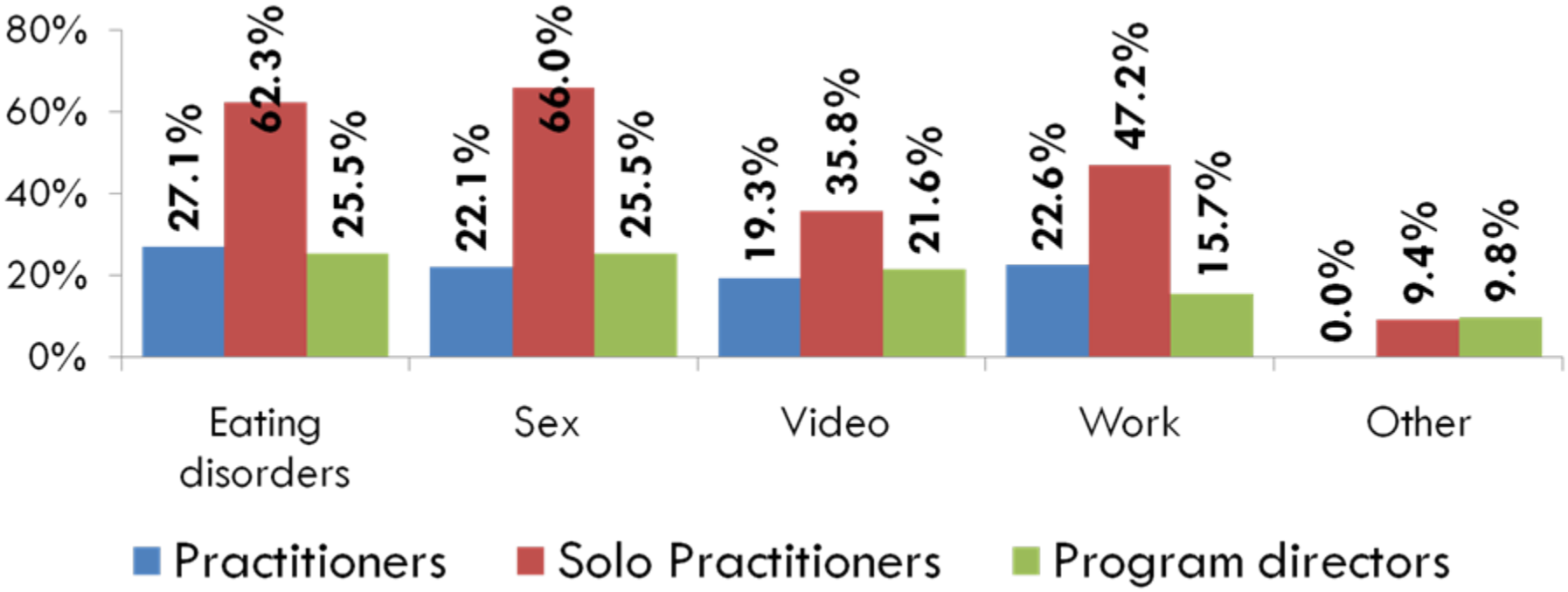
- Most solo practitioners receive the majority of funding from private sources; most programs are primarily publically funded

Percentage of Respondents Capable of Providing Service for Traditional Addictions



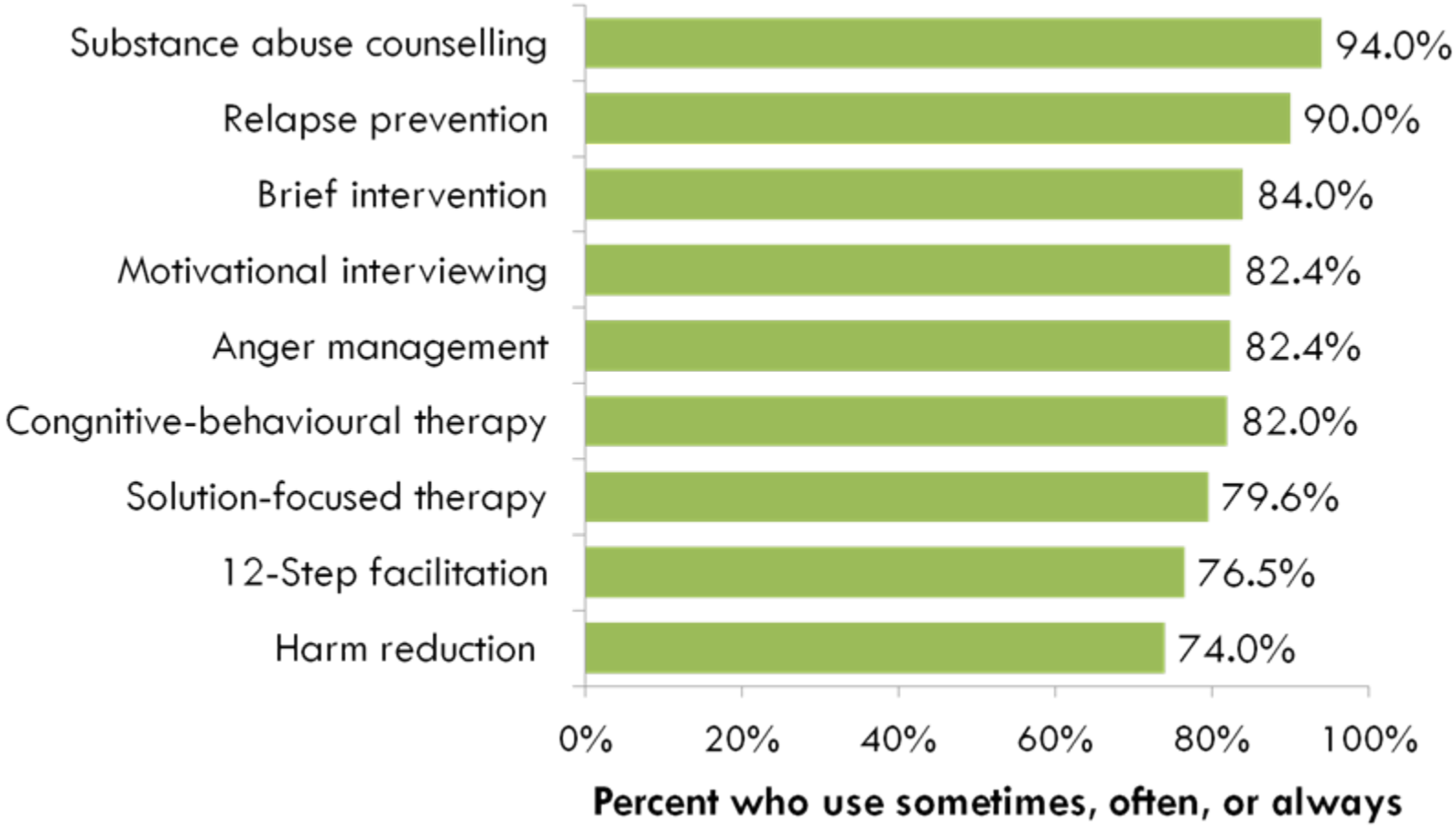
- Treatment capacity is highest for substance abuse disorders

Percentage of Respondents Capable of Providing Service for Non-Traditional Addictions

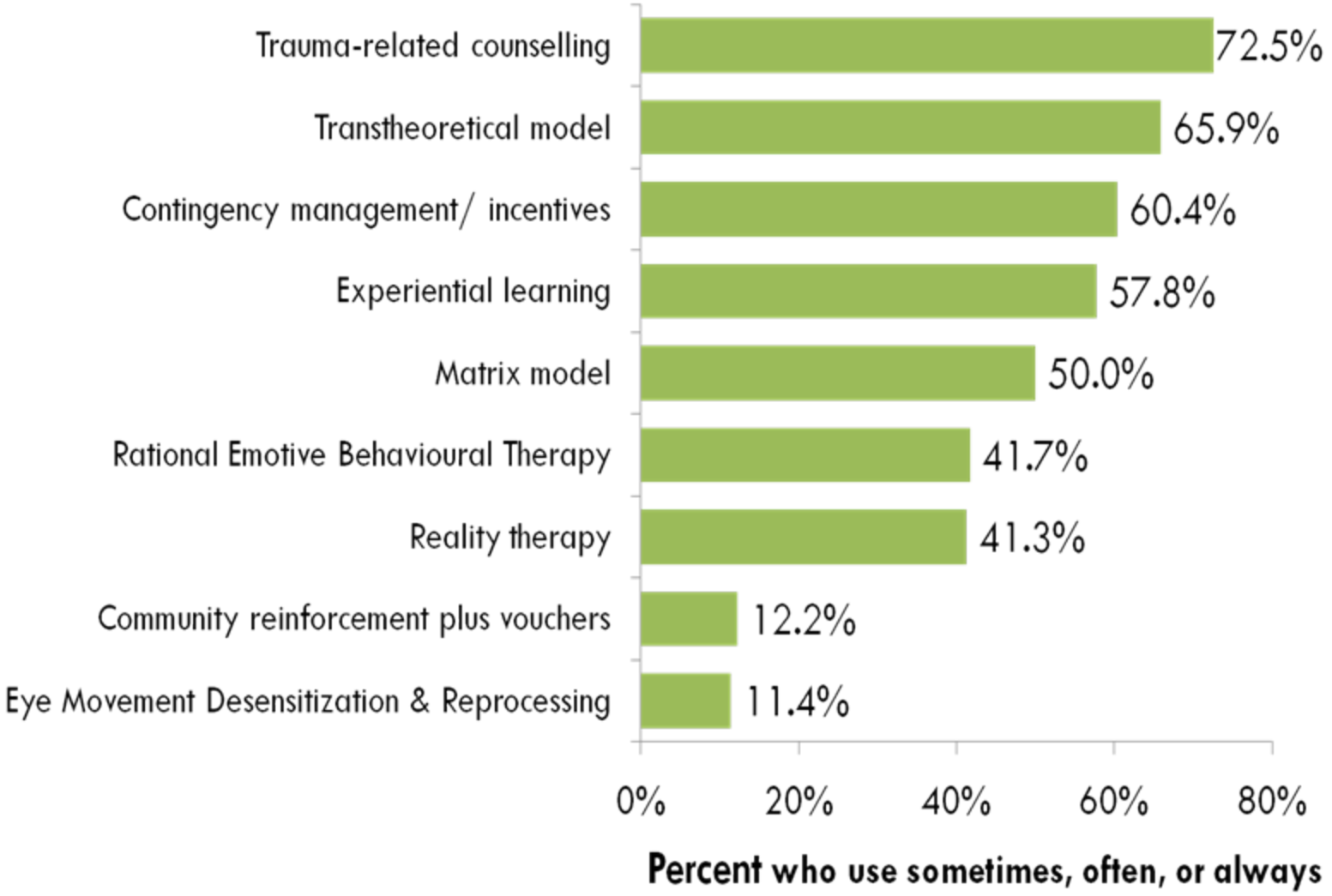


- Greater capacity to treat people with “non-traditional” problems was reported among solo practitioners

Treatment Approaches Reported by Program Directors



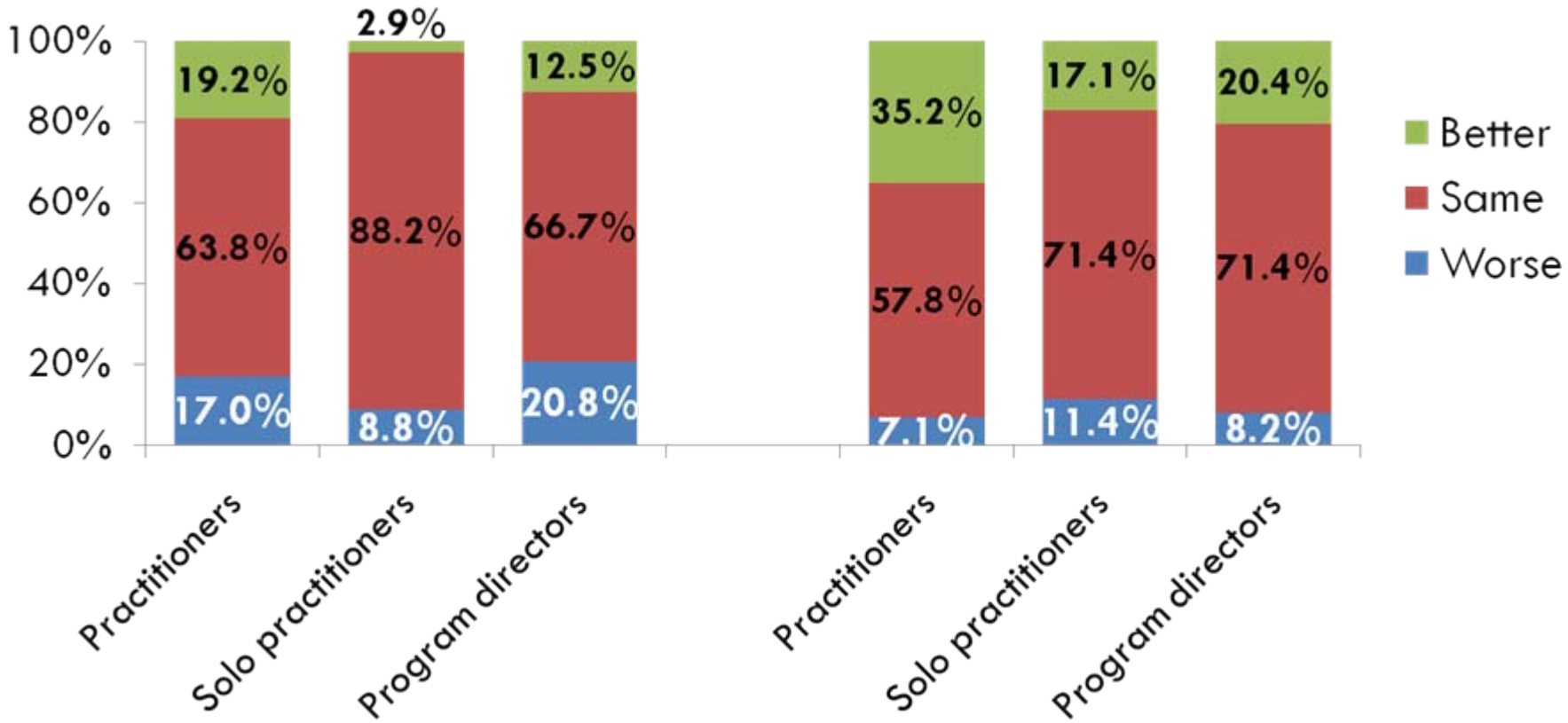
Treatment Approaches Reported by Program Directors



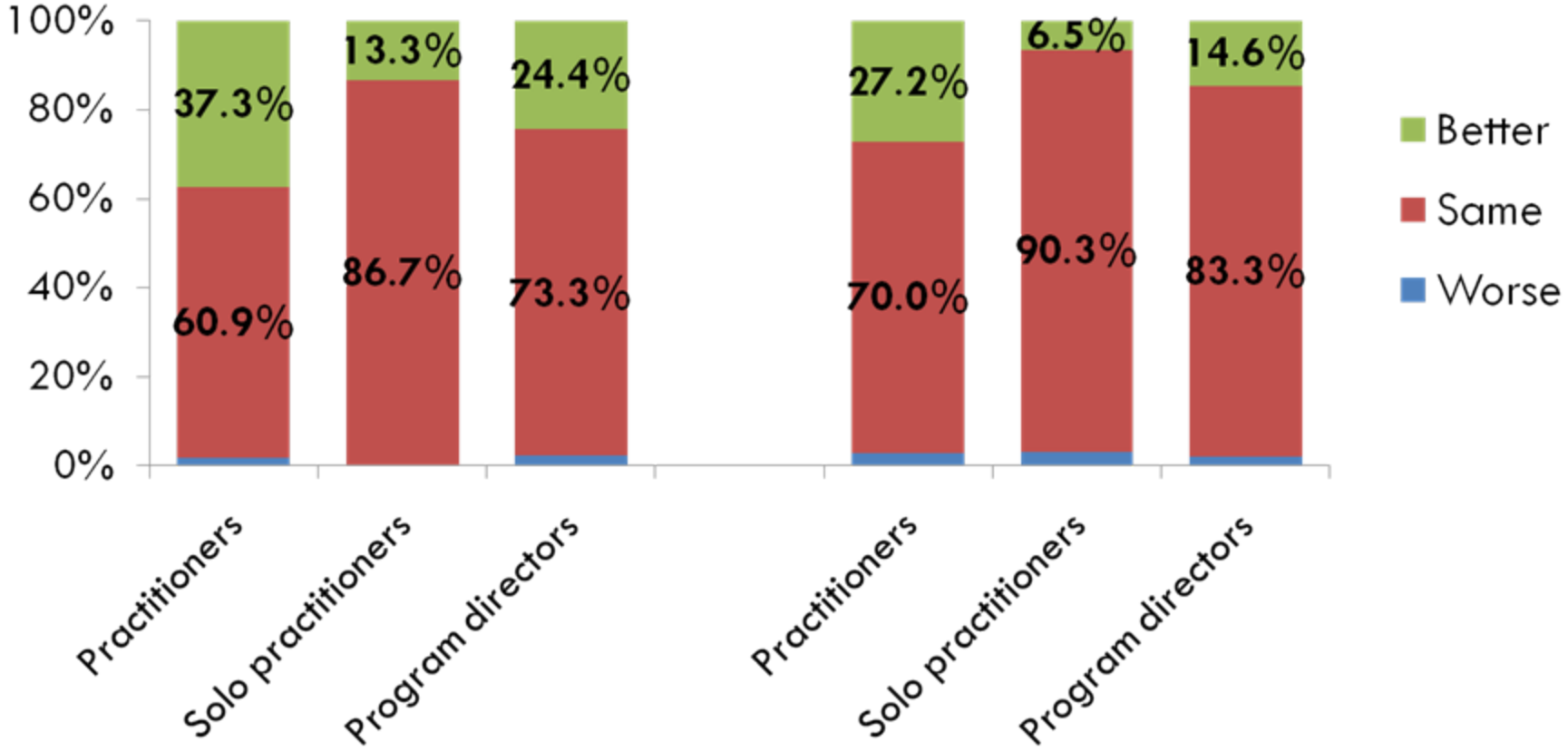
Impact of Integration

- Most respondents felt that there had been no impact of the integration of MH and addiction services on either clients or staff
- Practitioners were more likely to say that the integration had made things better for clients than were other respondents
- Respondents believed that today there is a greater priority placed on serving clients with concurrent disorder and a higher capacity for serving this group

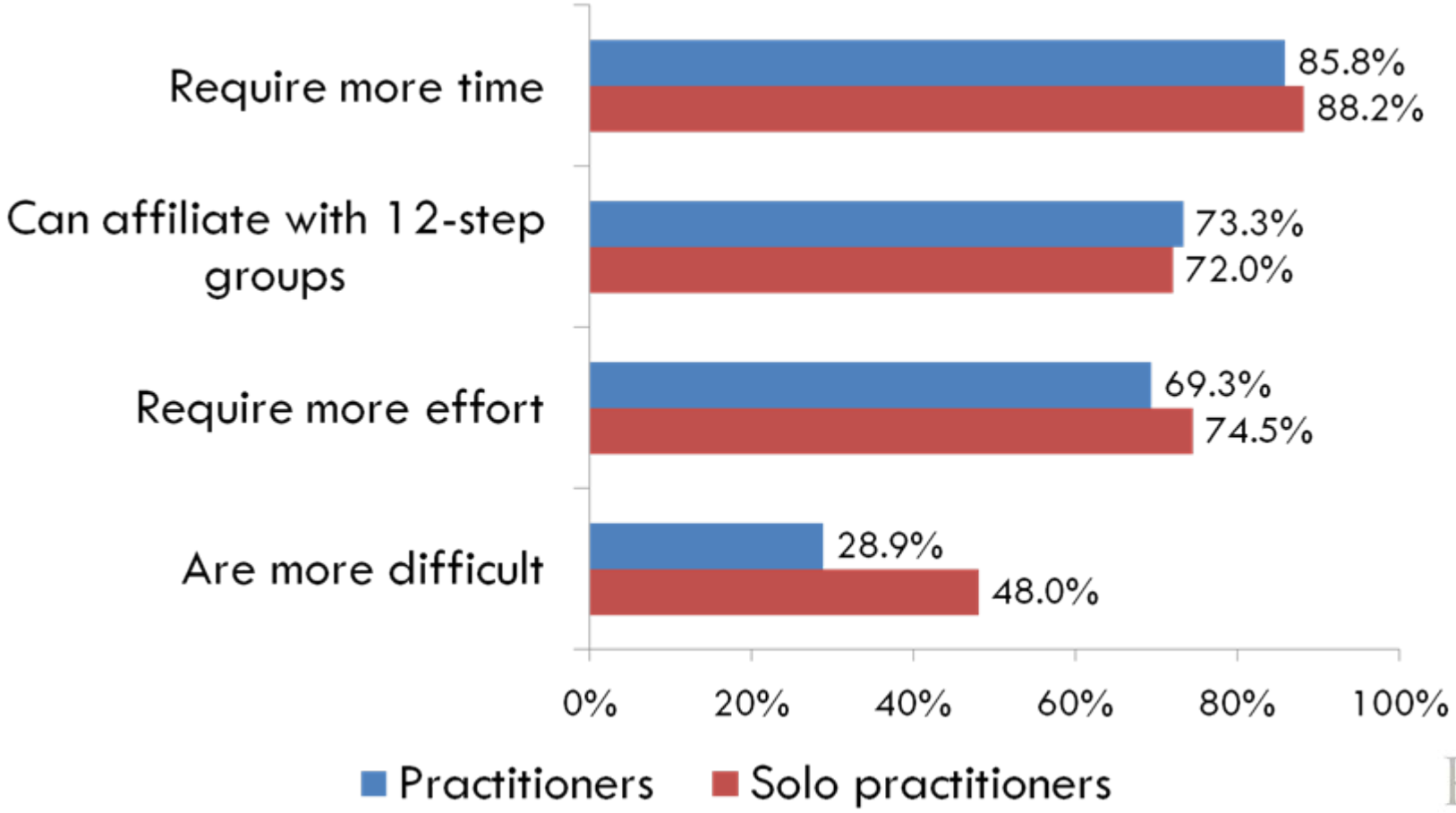
Perceptions of Impact of Integration on Staff and Clients



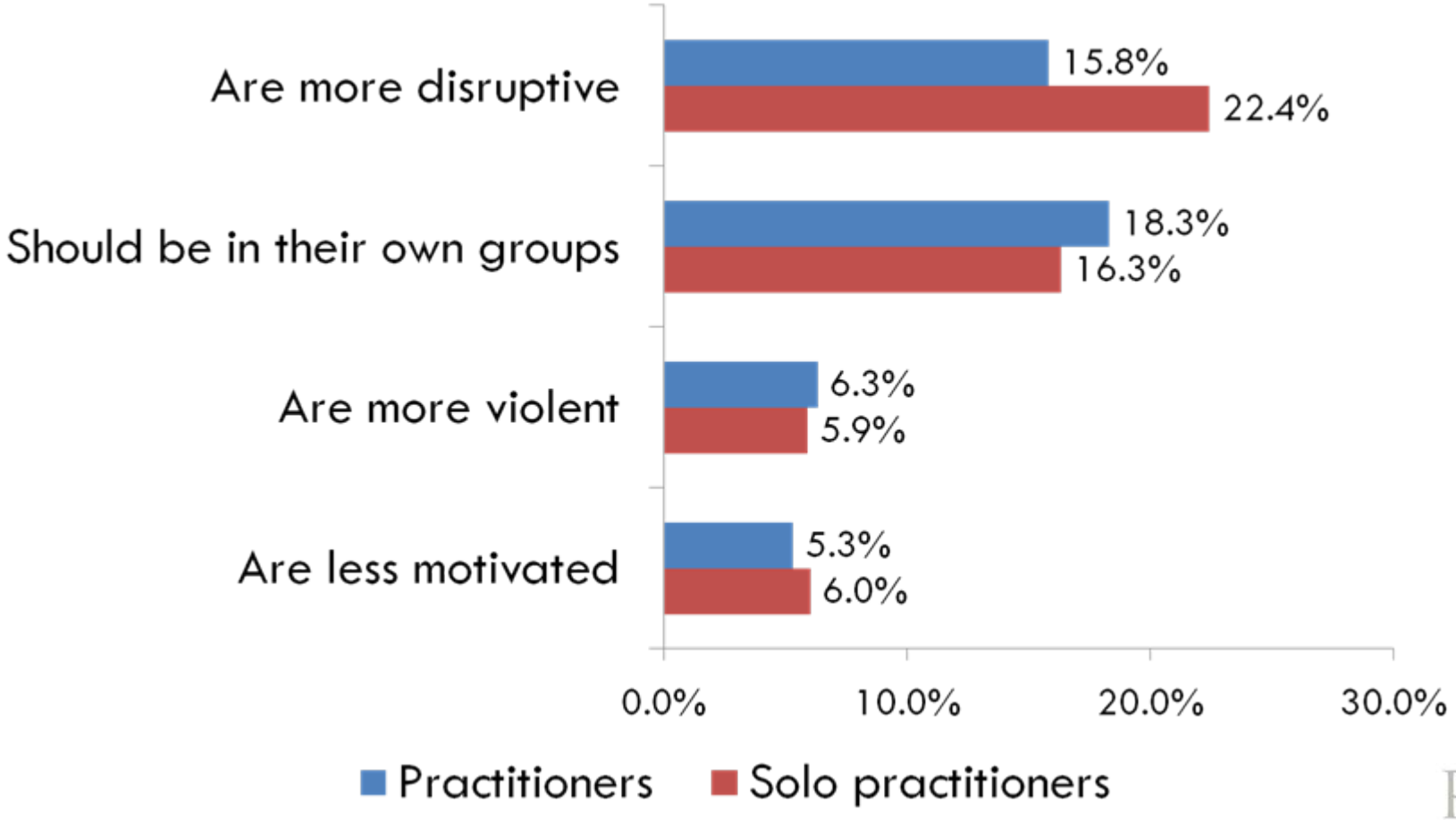
Perceptions of Impact of Integration on Priority Given to CD and Capacity to Treat CD



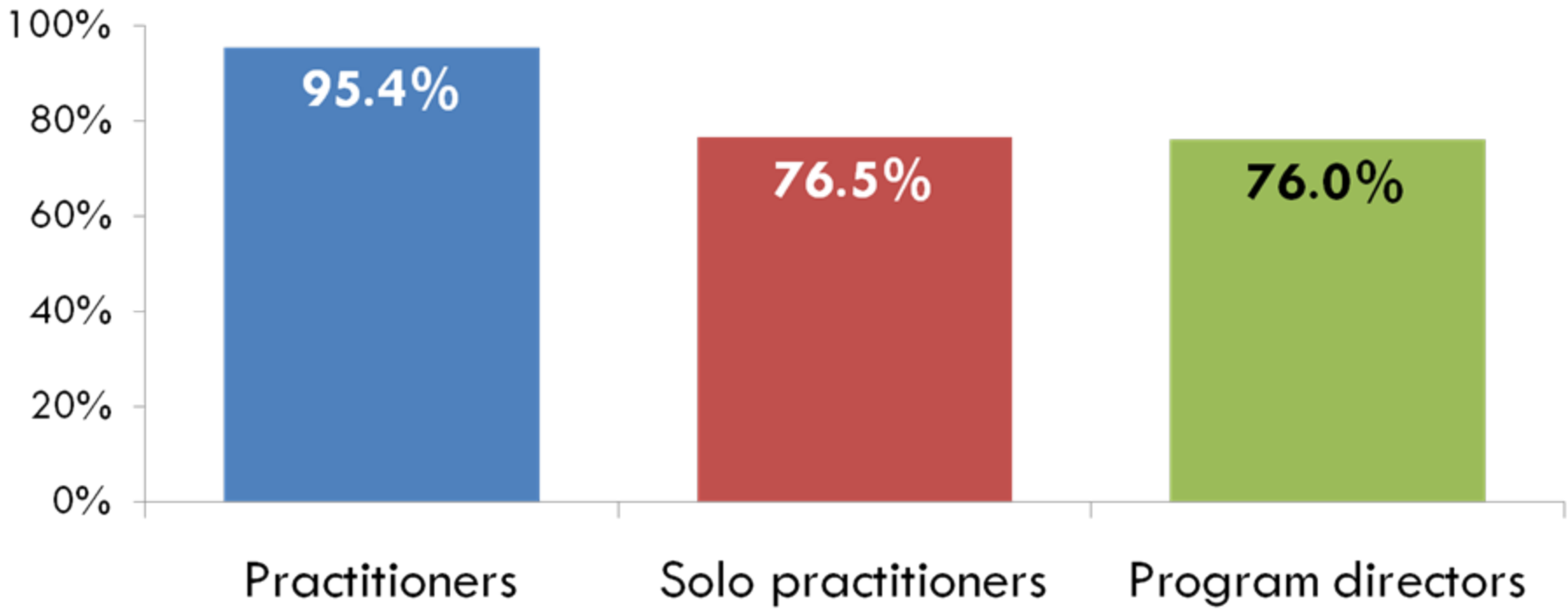
Beliefs about Concurrent Disorder Clients



Beliefs about Concurrent Disorder Clients

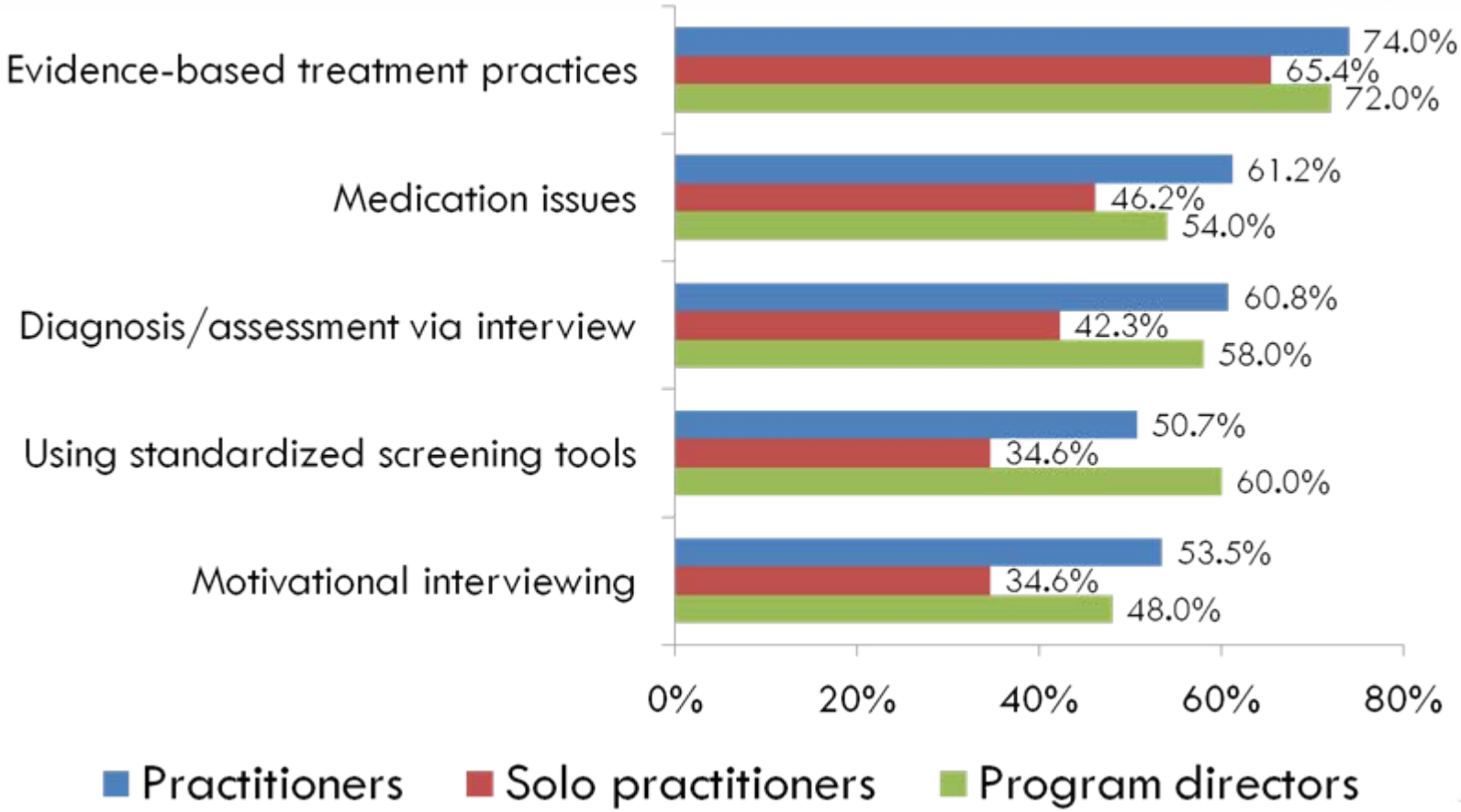


Who Would Benefit from Concurrent Disorder Training

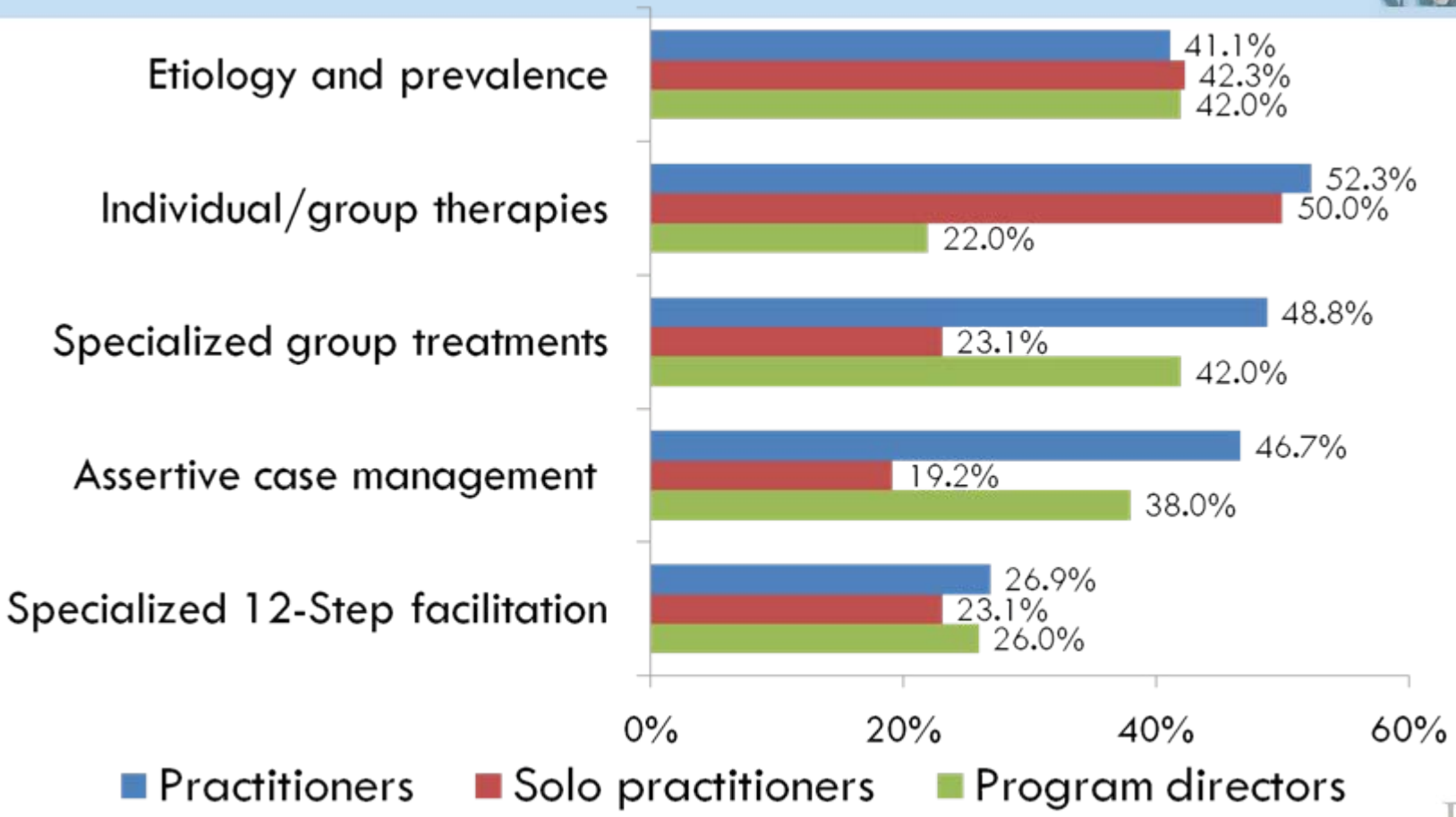


- A majority of all respondent groups felt they or their co-workers would benefit from concurrent disorder training

Concurrent Disorder Training Needs



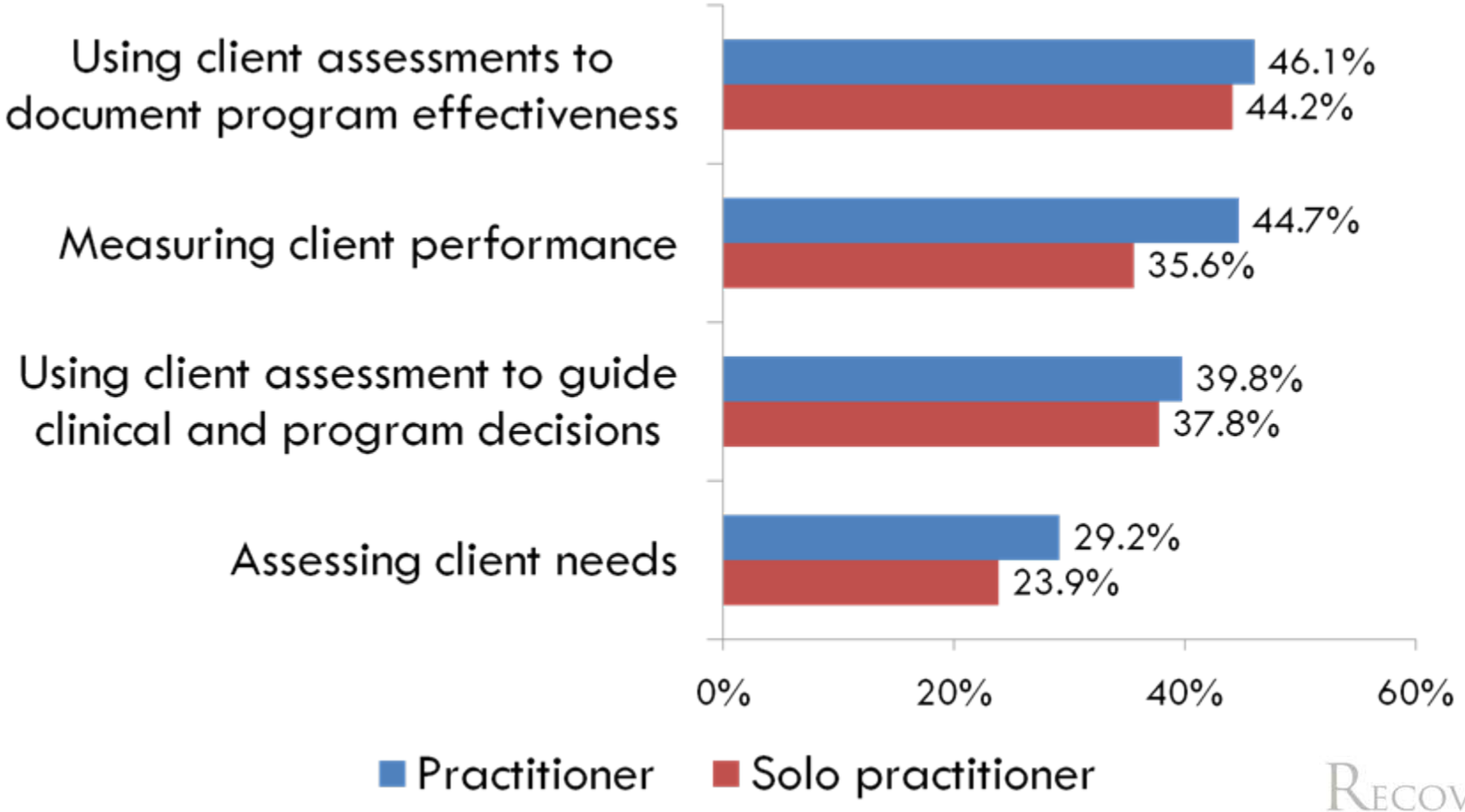
Concurrent Disorder Training Needs



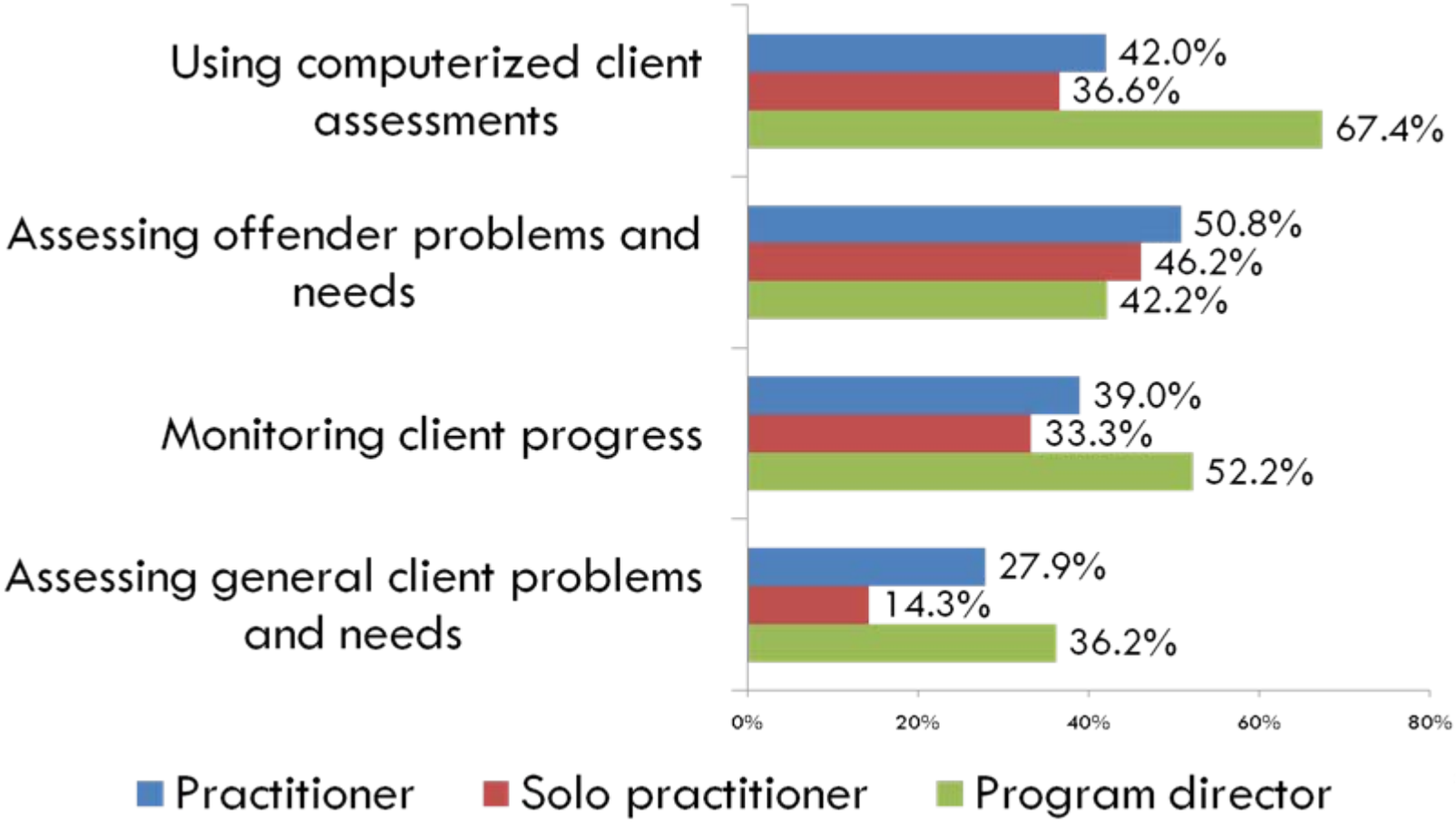
Summary of Concurrent Disorder Training Needs

- Most believe CD clients require more time and effort and also reported a need for continuing education around CD
- **All groups**: evidence-based treatment approaches, and education around medication issues
- **Practitioners and Program Directors**: assessment via interview and standardized screening
- **Front-line and solo practitioners**: individual and group psychotherapies
- **Practitioners**: motivational interviewing

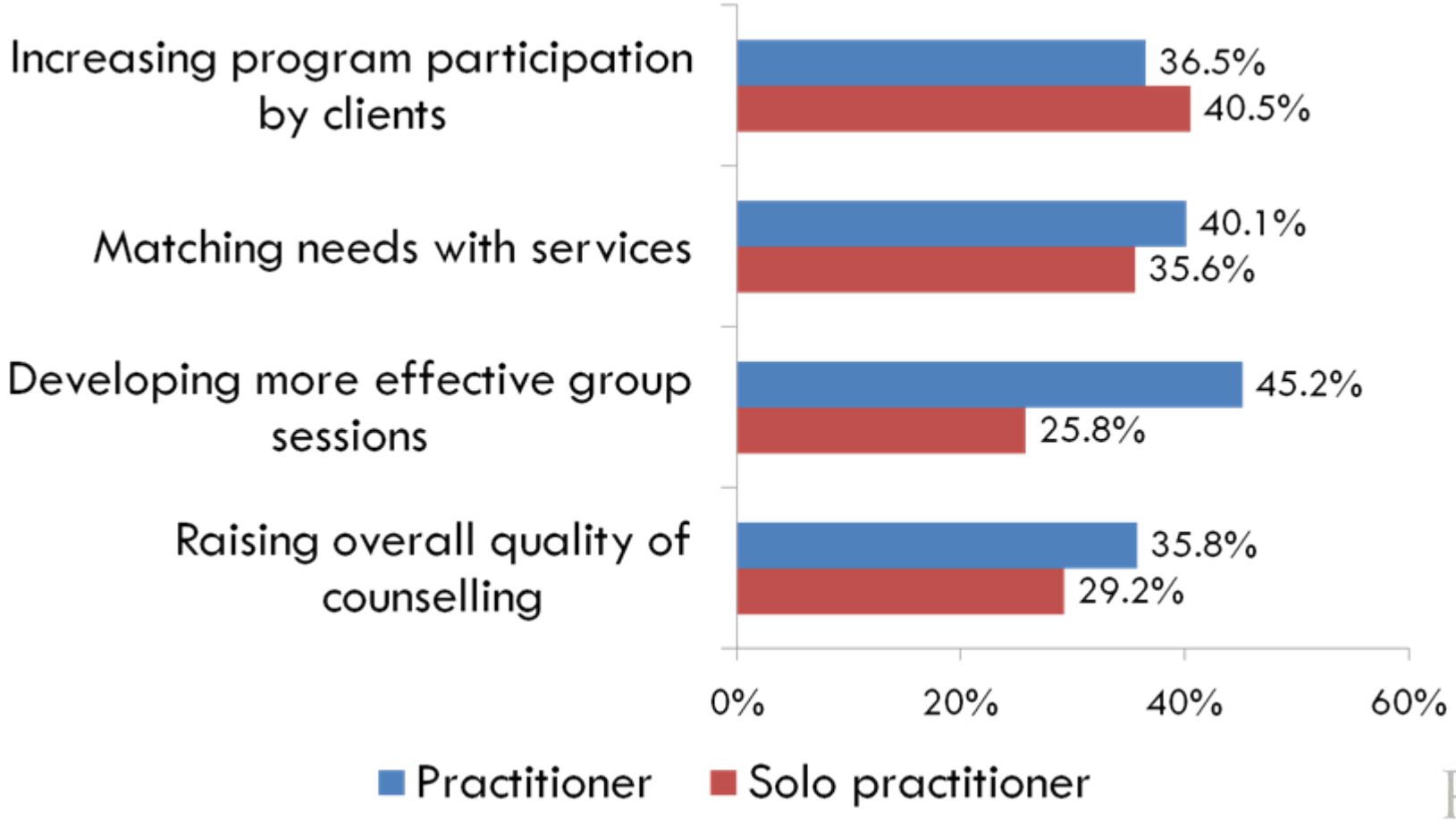
Need for Guidance in Assessment



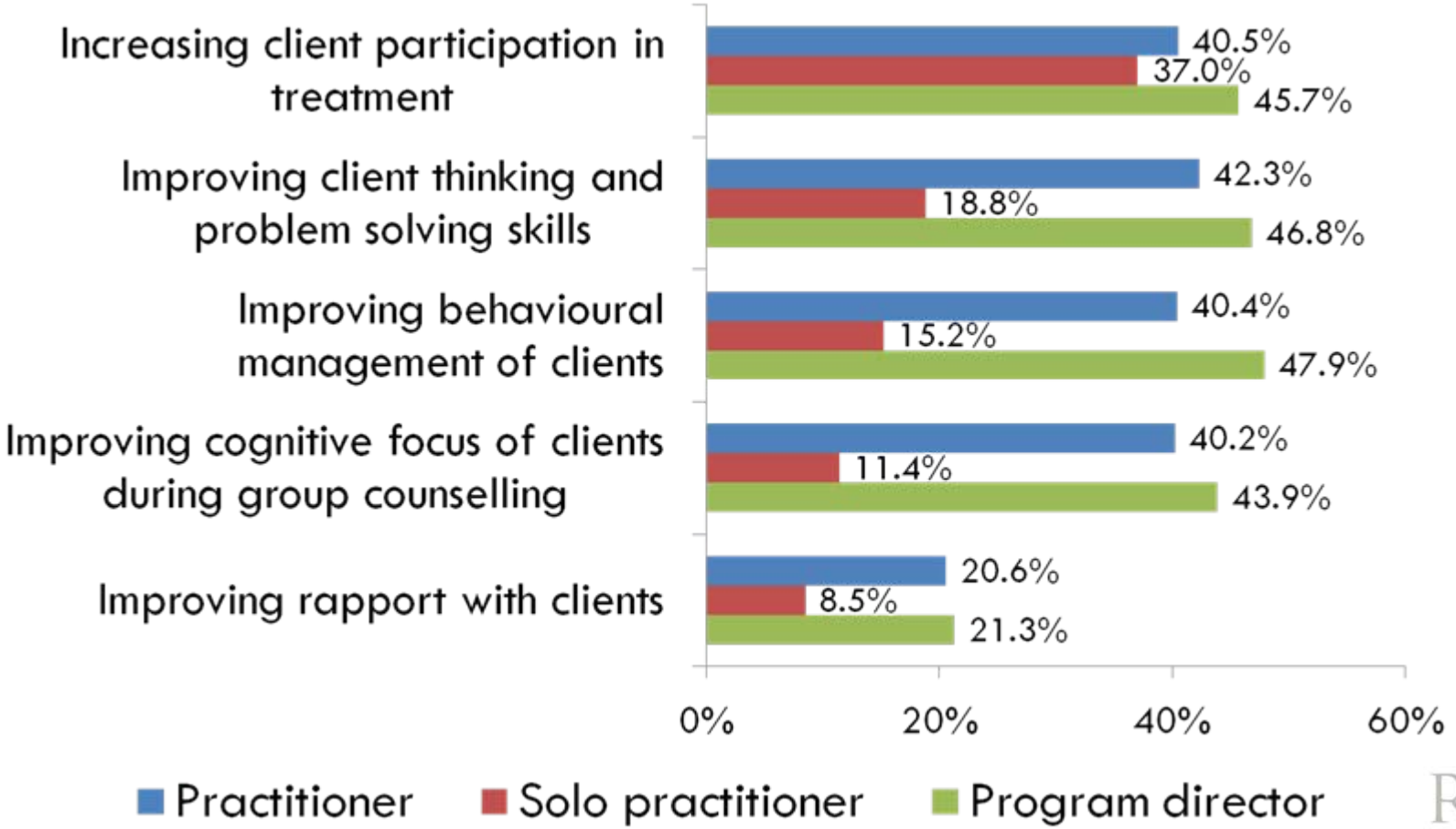
Assessment Training Needs



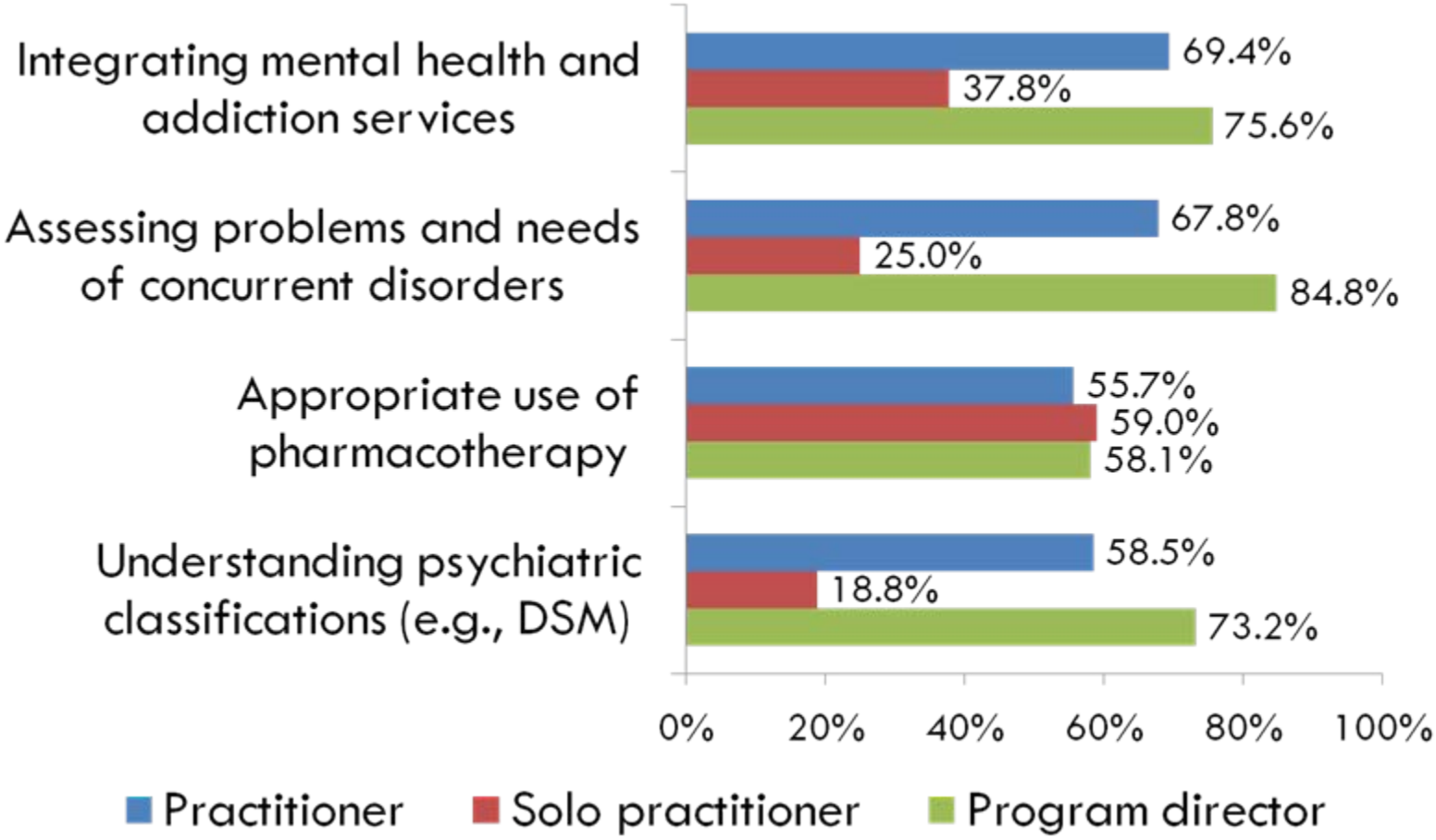
Need for Guidance in Clinical Areas



Clinical Skill Training Needs



Integration Training Needs



Summary of Training Needs

Assessment

- More specialized training in use of assessment to measure program and client outcomes, make decisions, and in assessment of offenders
- Program directors also interested in computerized assessment

Summary of Training Needs

Clinical Skills

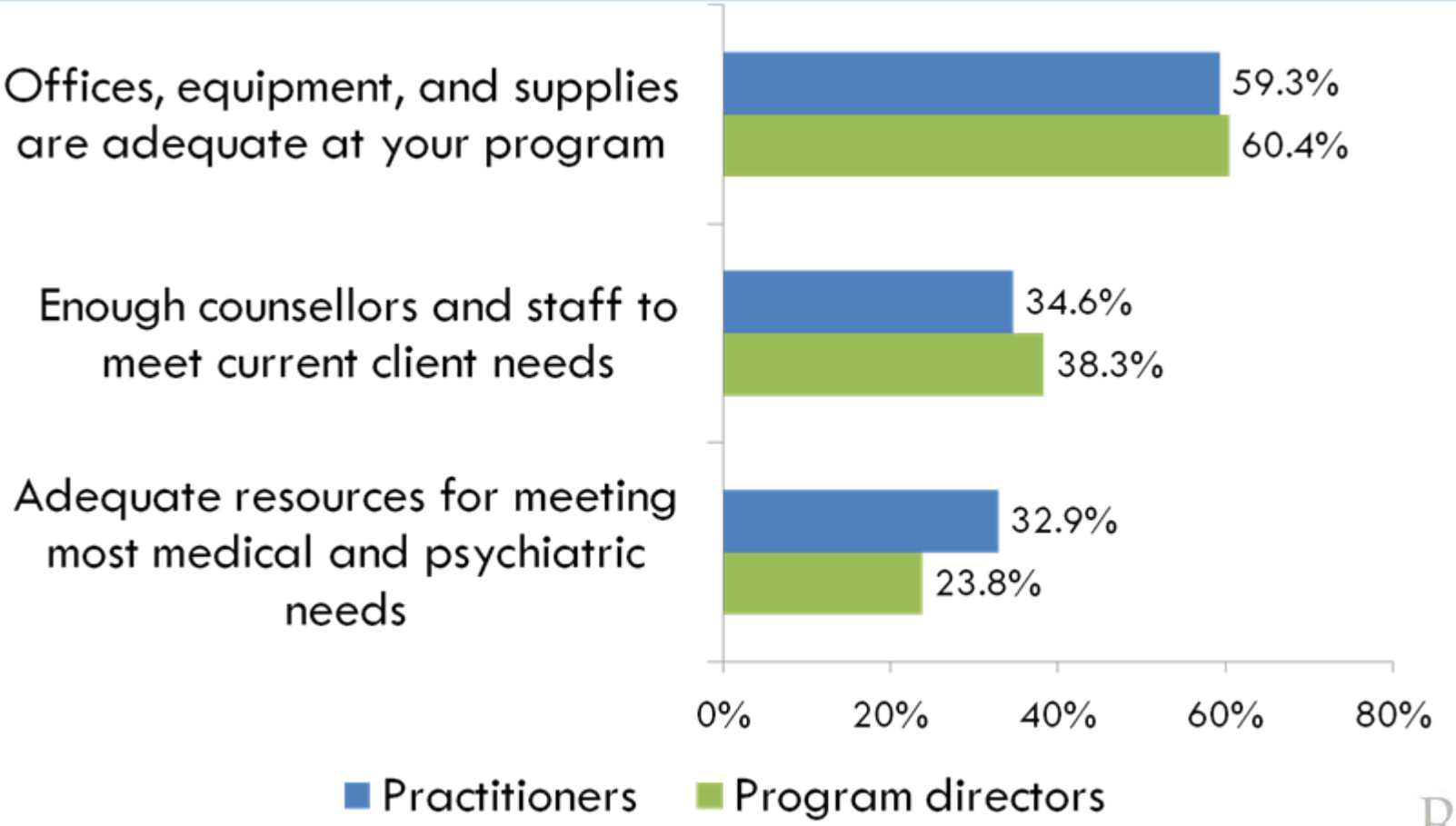
- Practitioners and Program directors generally more interested in a variety of clinical skills
- In particular: Cognitive and behavioural techniques and improving the effectiveness of group sessions
- All groups were interested in training to increase client participation and matching services with client needs

Summary of Training Needs

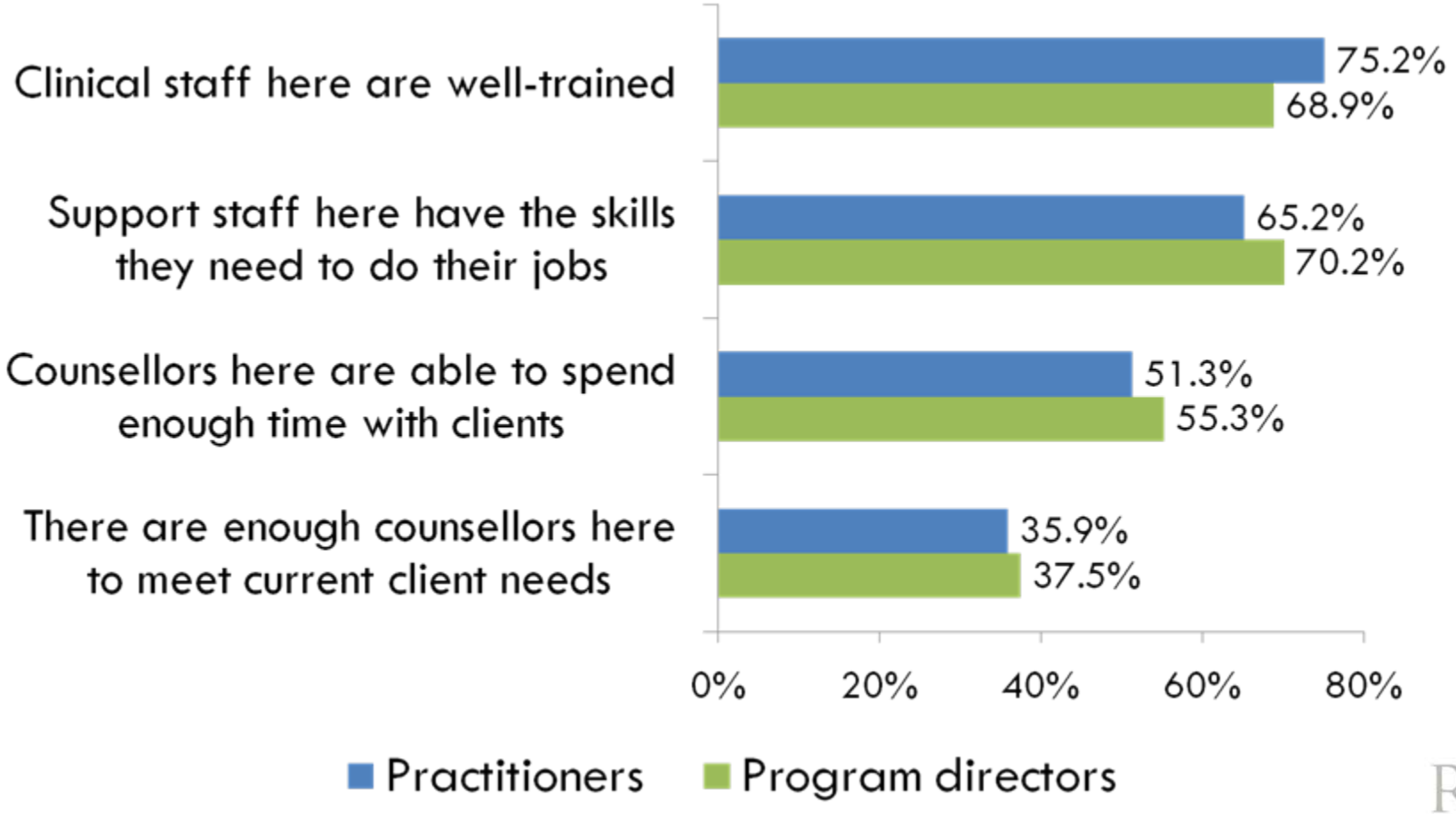
Integration of Mental Health and Addictions

- All groups were interested in learning more about pharmacotherapy
- Practitioners and Program directors also wanted training in integration of mental health and addictions more generally, assessing needs of clients with concurrent disorders, and understanding psychiatric classifications

Adequacy of Facilities



Perceptions of Staffing



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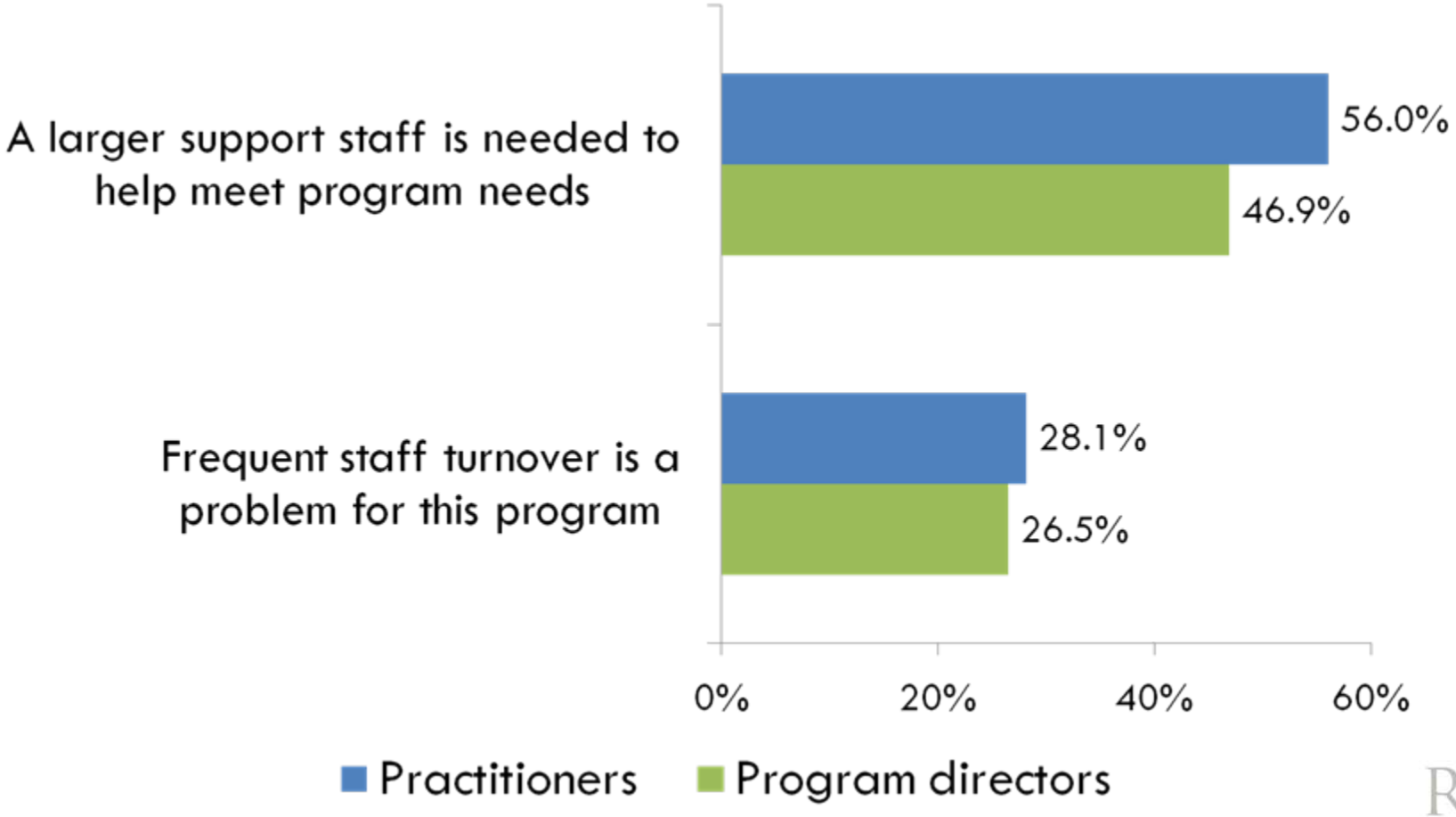
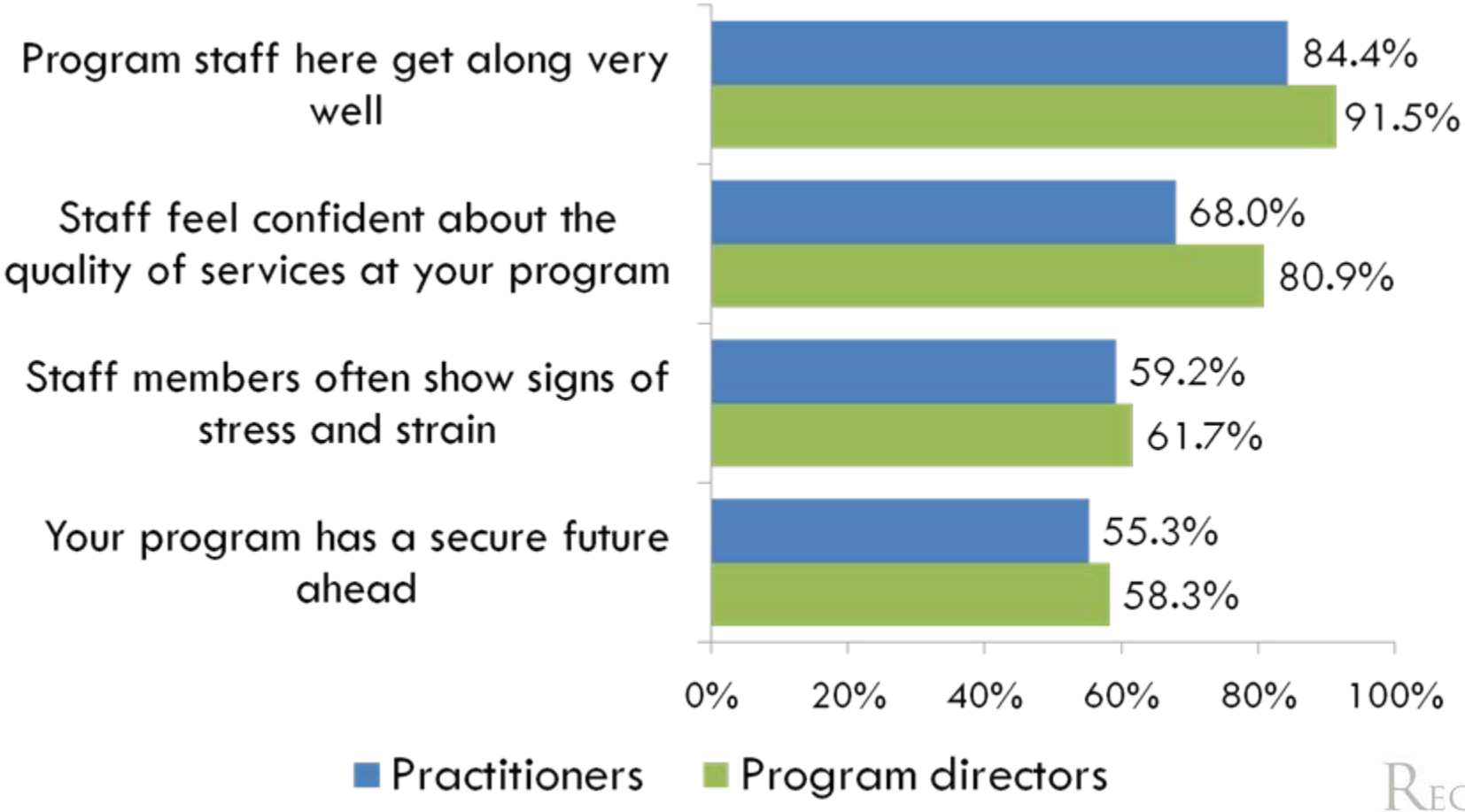
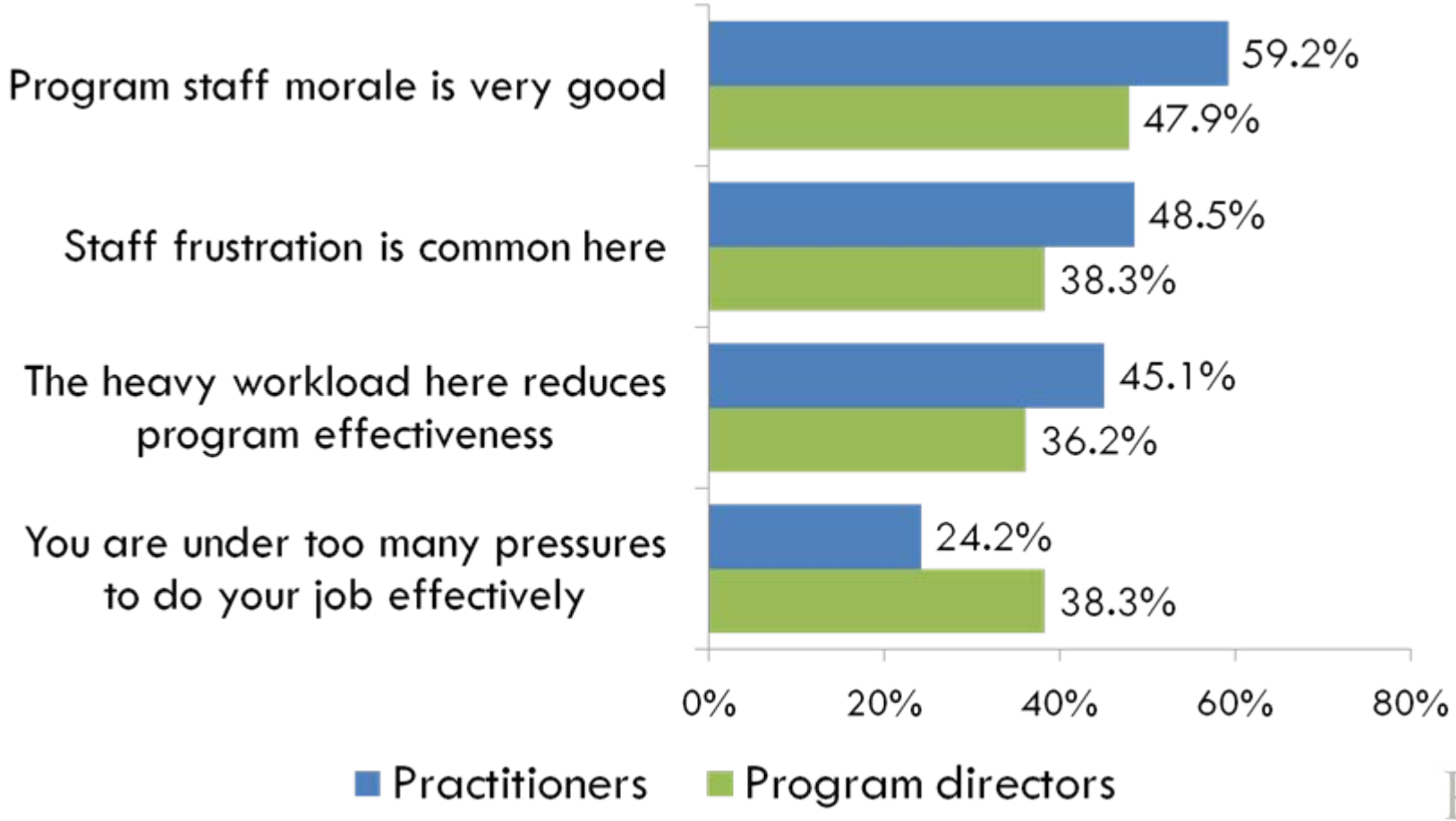


Work Stress



Work Stress



Summary of Resourcing Needs

- Participants indicated a need for increased resources to meet psychiatric and medical needs
- Most feel that staff are well trained and competent
- Majority feel that more staff are needed and that not enough time with clients is available
- About half feel that staff are experiencing some stress and uncertainty about the future of their program
- Most feel that the quality of service provided is not impacted by the work overload/understaffing

Caveats and Limitations

- Identifying what counts as a unique “program” has been challenging at the sampling stage and for respondents (sometimes the same manager was sent multiple A-SMARTS invitations for different programs but may have responded only once aggregating across programs)
- Considerable diversity apparent in how treatment services are offered – difficult to design a single questionnaire appropriate to all treatment providers
- Conflict with H1N1 vaccination program and other AHS surveys distributed in early 2010

3. Alberta Addictions Survey (AAS 2009)

Background

- To date, no research has been conducted to determine the prevalence of a wide range of addictive behaviours among Albertans
- There is little agreement about how “non-traditional” addictive behaviours such as shopping or video gaming addiction should be defined or measured
- Assessing self-reported problems is one way of understanding how the public defines different addictions

Purpose

- To provide preliminary estimates of the prevalence of self-attributed problem behaviours among the general population of Alberta adults
- 10 problem behaviours were selected:

Alcohol	Eating
Tobacco	Shopping
Marijuana	Sex
Cocaine	Video gaming
Gambling	Work

Sampling

Online Panel Survey: 4,000 Alberta adults randomly selected from a pool of people who had registered to take part in a variety of public opinion and marketing surveys

CATI Survey: a computerized assisted telephone interview (CATI) survey of 2,000 Alberta adults recruited through a random digit dialling procedure, and consisting of a subset of the online survey items

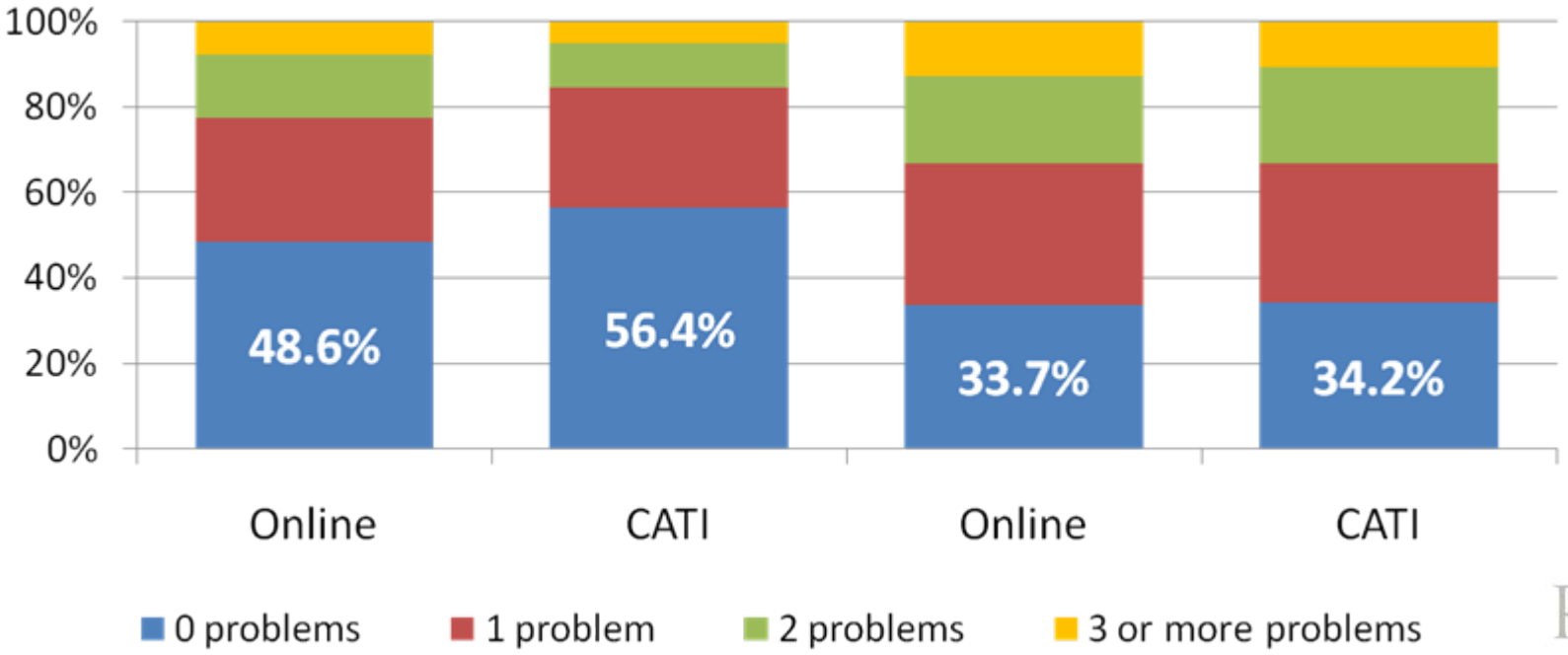
- Both surveys filled quotas to accurately represent the actual sex, region, and age distribution of Alberta adults and data were weighted to reflect actual population distributions

Survey Design and Data Collection

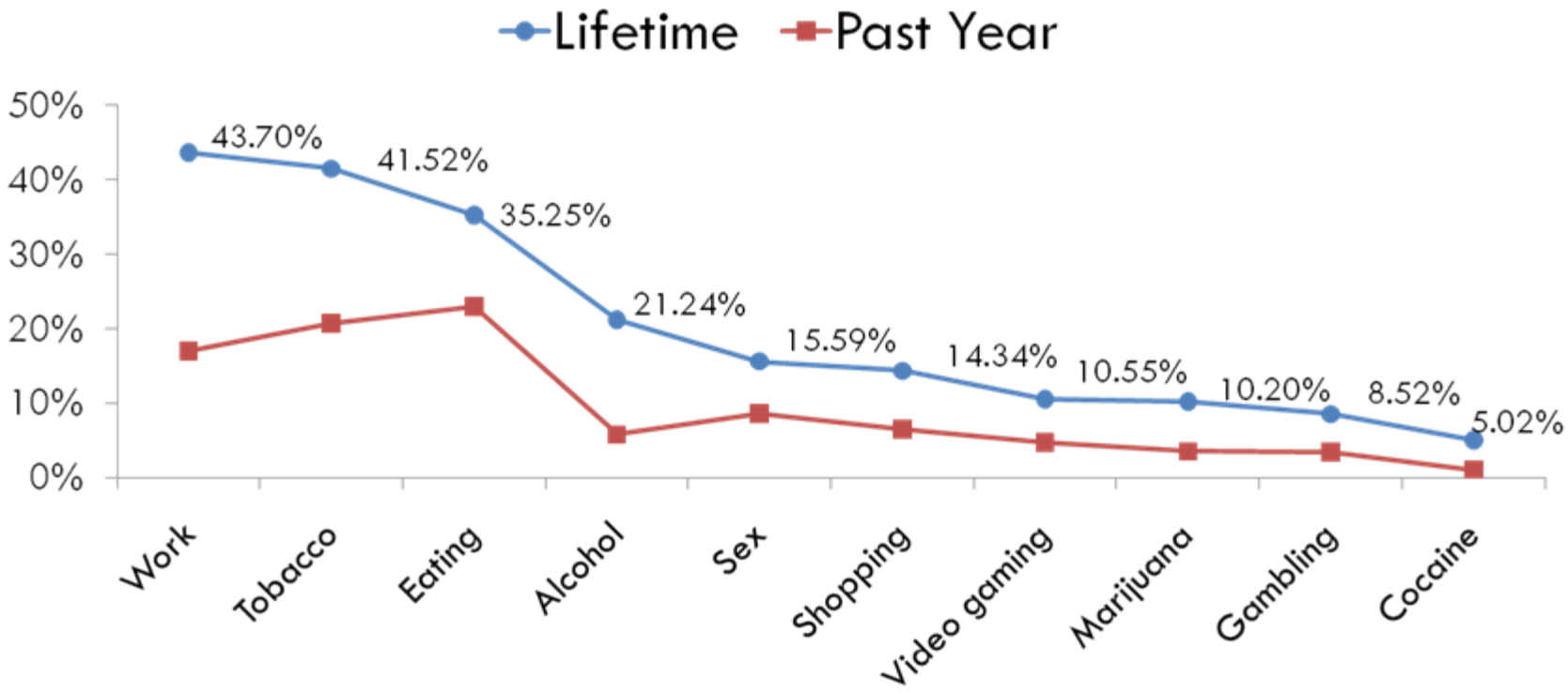
- Survey data was collected between December, 2009 and May, 2010
- Questions included:
  - personally experience of the10 problem behaviours
  - friend or family member experience of each problem
  - percentage of Alberta adults that had experienced each problem within the past year
  - Perceptions of the adequacy of current treatment for one random problem type
- Response rates were 21.1% for the online panel survey and 19.1% for the CATI survey

Prevalence of Self-Reported Problems

- More respondents had experienced at least one non-traditional problem in their lifetime than had experienced at least one traditional problem

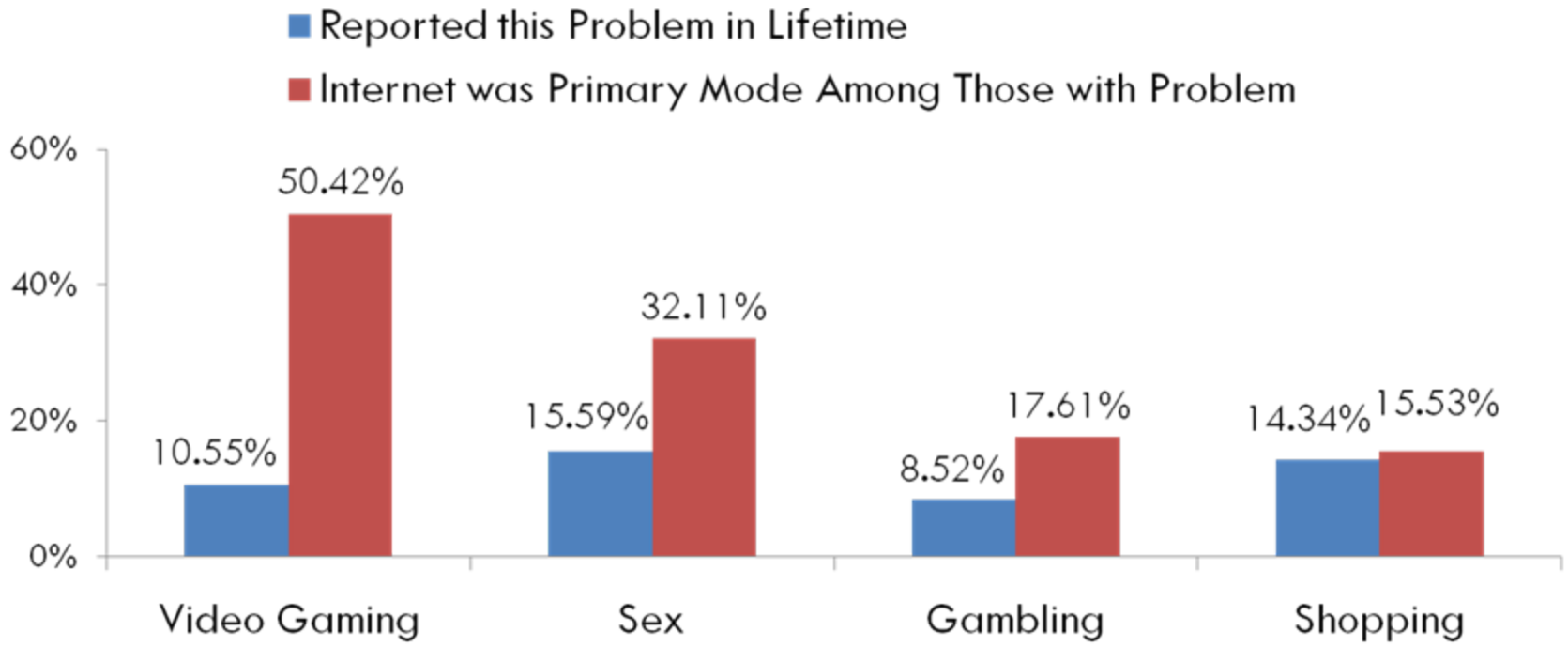


Lifetime and Past Year Self-Reported Problems



- Problems with work, tobacco, and eating were the most prevalent self-reported problems

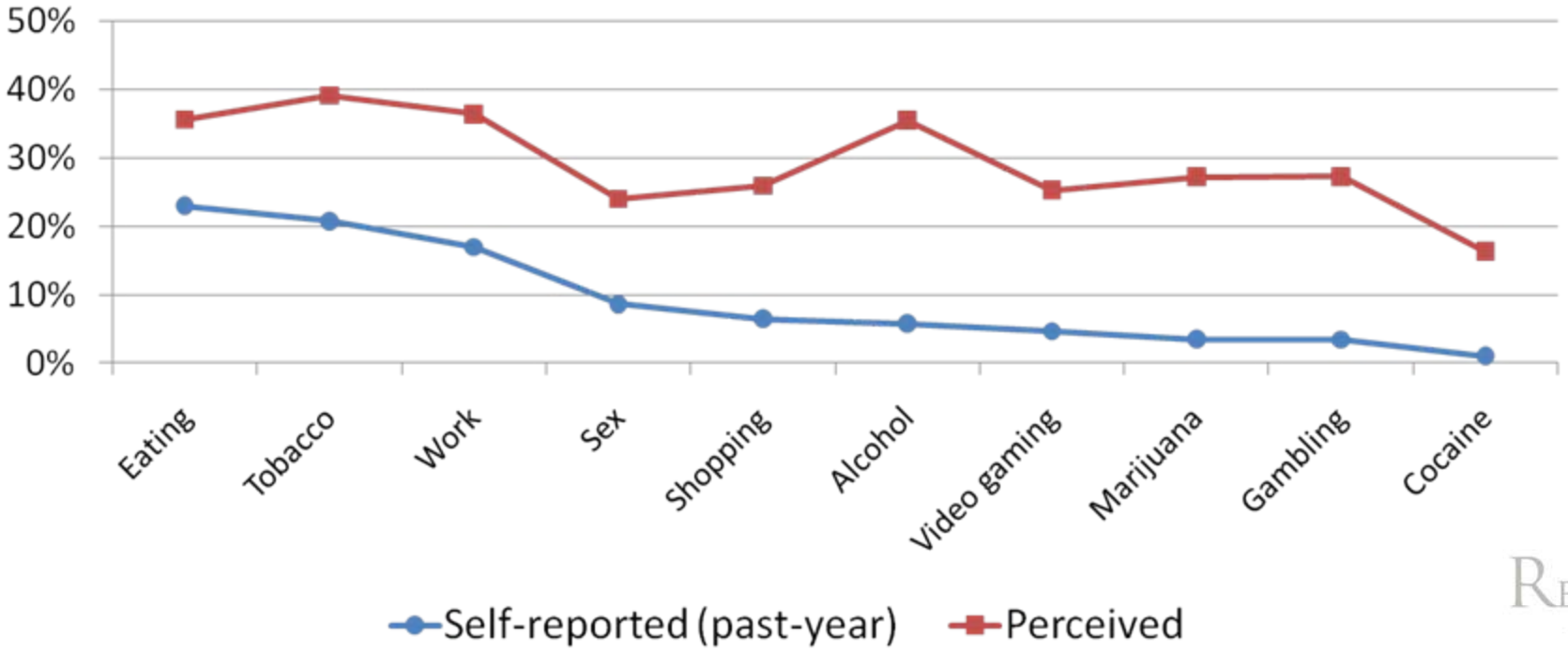
Internet as the Primary Mode of Problem Behaviour



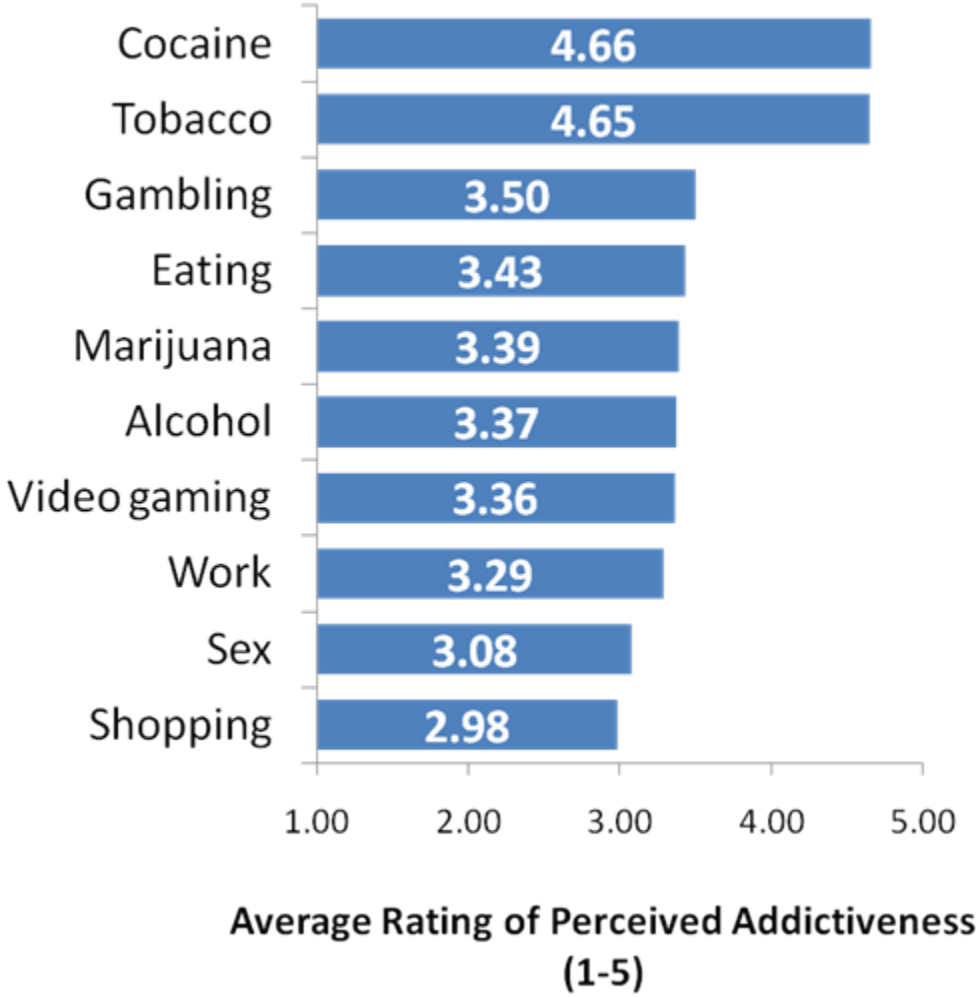
- Among those reporting a problem, half of those with a video gaming problem and one third of those with a sex problem used the internet primarily

Self-Reported and Perceived Problem Prevalence

- Perceptions of the percentage of adults who experienced each problem in the past year were consistently higher than self-reported past year problems



Perceived Addictiveness

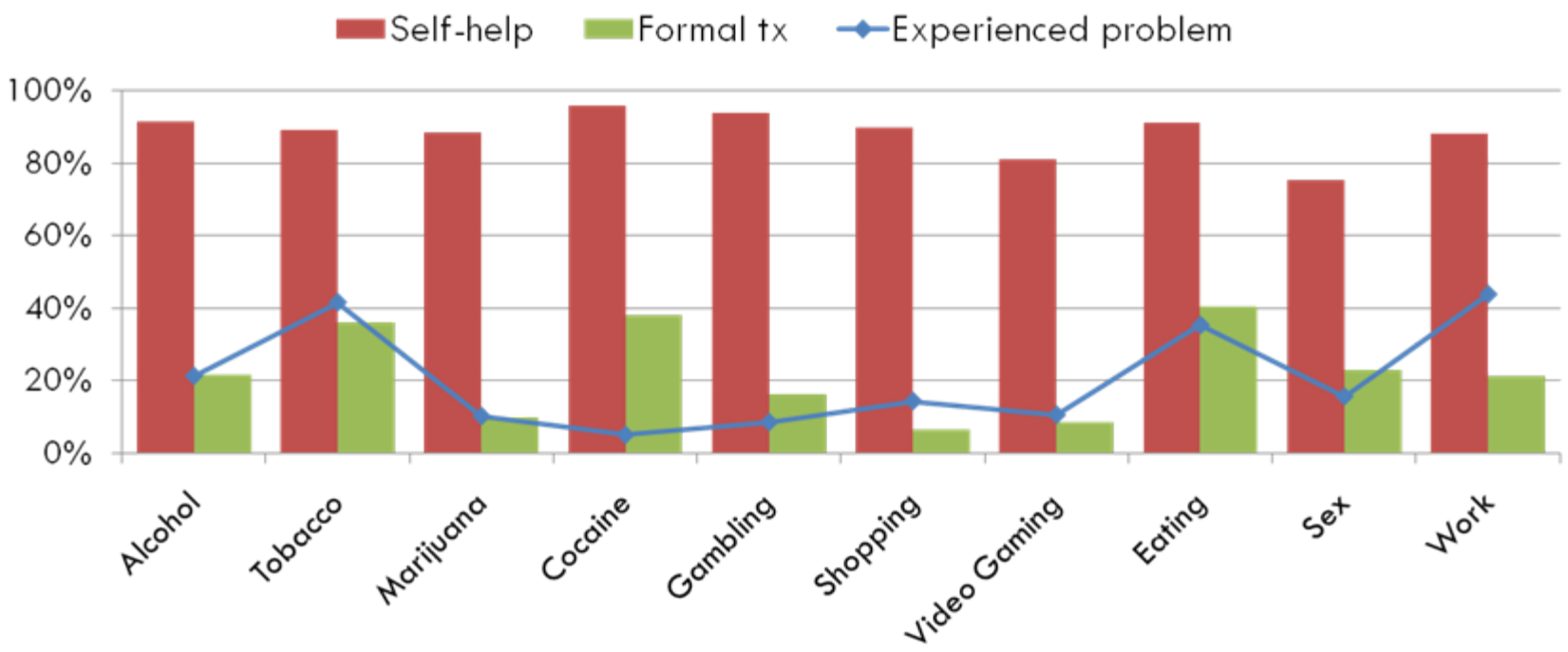


- Online participants rated the problem behaviours as moderately addictive
- Cocaine and tobacco were viewed as the most addictive and shopping, the least addictive

Beliefs about Program Causes

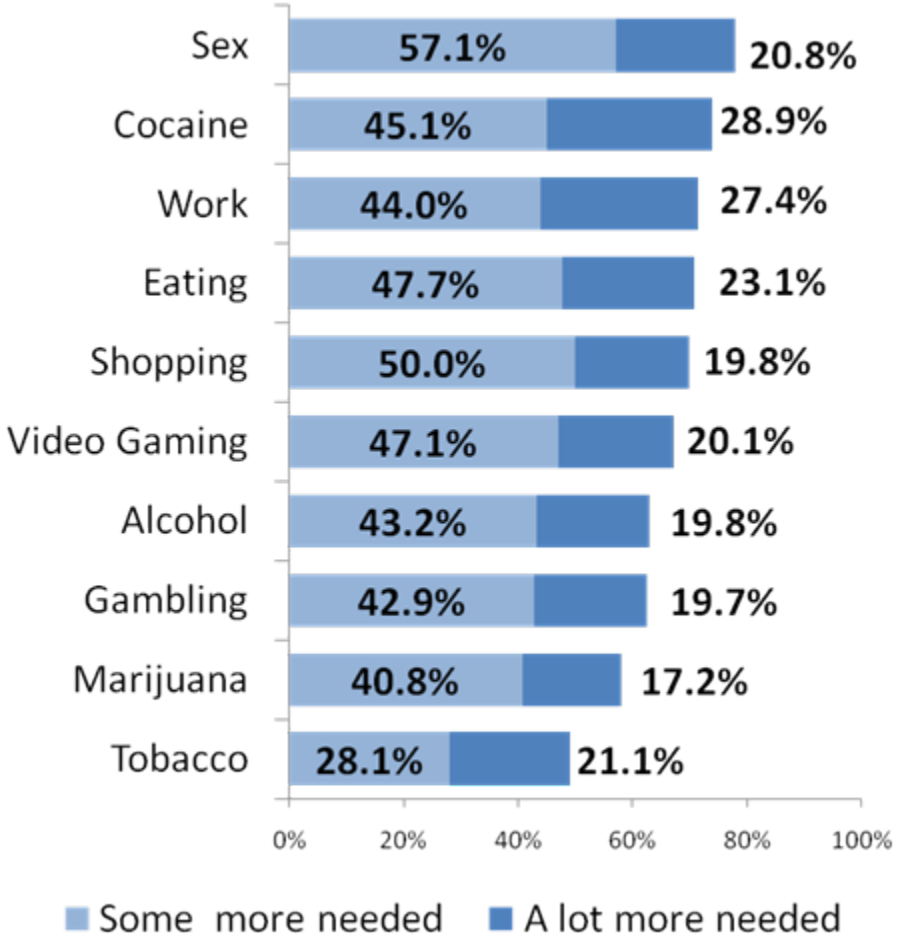
- Online survey participants were asked to rate the likelihood that one of the 10 problem behaviours was caused by six possible sources
- Alcohol problems and eating problems were more strongly attributed to genetic problems compared to the other problem behaviours
- Problems related to sex, alcohol, eating, and cocaine were more strongly attributed to childhood trauma than were other problem behaviours

Use of Self-Help or Formal Treatment Among Those with Self-Reported Problem



- Respondents who had experienced a problem were much more likely to report trying to change on their own than going to a formal treatment program

Adequacy of Available Treatment



- Most participants felt that Alberta needs some more services for people with addictive behaviour problems
- The greatest agreement that more treatment is needed was found for sex, cocaine, and work problems

Summary of AAS Findings

In a population-based sample of 4000 Alberta adults (and confirmed in a second sample of 2000):

- About 80% reported experiencing a lifetime problem with at least one of 10 target behaviours (work, tobacco, eating, alcohol, sex, shopping, video gaming, marijuana, gambling, cocaine; rank-ordered).

Summary of AAS Findings

- Internet use was the most frequent mode of engaging in addictive behaviour among respondents who reported a video gaming problem.

- Almost one-third of those who indicated that they had a sex problem reported that they engaged in this activity primarily over the Internet.

Thank You!

- The research partners gratefully acknowledge the support of the Norlien Foundation
- We appreciate the institutional support provided for the A-SMARTS from Alberta Health Services, and in particular, Kathy Huebert and Laurie Beverley

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