PSYCHIATRIA ET NEUROLOGIA JAPONICA

Special Feature Article

Setting Treatment Goals for Alcohol Use Disorder According to the New Guideline for Substance Use Disorders

Yosuke YUMOTO, Susumu HIGUCHI
National Hospital Organization Kurihama Medical and Addiction Center
Psychiatria et Neurologia Japonica 123: 475-481, 2021

Abstract

The Japanese new diagnostic and treatment guideline for alcohol and drug use disorders was published in 2018, 15 years after the previous guideline had been first distributed in Japan. Among the substantial changes in the new guideline is the recommendation for goal setting in individuals with alcohol use disorder. Traditionally, almost all treatment facilities in Japan had prioritized the goal of abstinence, and moving toward a non-abstinent goal was regarded as a maltreatment for both therapists and clients. Numerous individuals with alcohol use disorder who were unwilling to maintain abstinence had been excluded from interventions provided at treatment facilities and health services. As such, we often lost opportunities to establish connections with individuals who wanted to solve their problems induced by alcohol use but who did not want to quit drinking. The new guideline suggests that the optimal goal is abstinence, but it accepts the choice of clients. Clients can adopt a strategy of reducing their alcohol consumption initially to prevent dropping out from treatment, especially in the cases where the client with alcohol use disorder has a severe symptom or comorbidities, faces serious family or social problems leading them to reject the goal of abstinence, or disagrees with the recommendation for abstinence. Moreover, individuals with mild symptoms of alcohol use disorder and without comorbidities can opt for a moderate drinking goal, except when they are required to set abstinence as their goal for any

specific reason. The possibility of applying a treatment goal that does not require only abstinence in individuals with alcohol use disorder had been discussed since the 1970s. Beginning in the 2000s, diagnostic and treatment guidelines for alcohol use disorder published in several countries began to adopt the new concepts of goal setting, such as reduced drinking and harm reduction. An advantage to accepting reduction as treatment goal for alcohol use disorder is that it decreases the resistance to visiting treatment facilities or accessing social health services among individuals with mild alcohol use disorder and those diagnosed as having harmful alcohol use. These individuals with mild alcohol use disorder tend to regard an abstinent goal as excessive for themselves and their alcohol habit as not requiring consultation. In addition, reduction in alcohol use has been shown to decrease problems induced by drinking, including physical and functional disabilities. Even in the case of individuals with severe alcohol use disorder or comorbidities complicated by their background, reduction in alcohol use can decrease health risks related to alcohol use and enable various interventions to be provided until these individuals can begin their preparation toward an abstinent goal. These advantages regarding the acceptance of reduction treatment should be considered in shaping attitudes toward alcohol use disorder. In line with these guidelines in other nations, the latest guideline published in Japan includes the concept that therapists should recognize individuals with alcohol use disorder as capable of choosing their treatment goal by themselves and as clients who should not be forced to take the singular route toward an abstinent goal based on the belief of therapists. The concept of reduction treatment goals should be spread among both therapists and clients in Japan. Increased interest in people's alcohol habit could contribute to preventing the harms induced by alcohol use.

Keywords: diagnostic and treatment guideline, alcohol use disorder, abstinence, harm reduction, reduction in alcohol consumption

Introduction

Guidelines for the Diagnosis and Treatment of Alcohol and Drug Dependence in Japan have not been updated since the "Guidelines for the Diagnosis and Treatment of Alcohol and Drug Related Disorders" were compiled in 2002 by the "Research Group on the Pathophysiology and Treatment of Alcohol and Drug Dependence" commissioned by the Ministry of Health, Labour and Welfare. In the less than 20

years since then, the guidelines have not been updated.

Also, in the less than 20 years since then, the diagnostic system has changed with the introduction of DSM-5, and new treatment principles, psychosocial interventions, and pharmacotherapy have emerged from new perspectives, increasing the diversity of treatment options in Japan. In addition, as a change in the legal system, the Basic Law on Alcohol and Health Disorders was enacted in 2014, and national measures against alcohol and health disorders are attracting attention. In 2016, a partial stay of execution system was introduced for drug use disorders, and medical professionals are required to disseminate knowledge about medical care and legal responses to people with drug use disorders. In addition, the health hazards and social problems caused by substance use disorders are attracting more attention in the press and public opinion, and their impact on the general population is increasing in magnitude. Therefore, education based on accurate knowledge from the medical field can help reduce stigma against people with substance use disorders and lower the hurdles to seeking medical consultation.

In response to these changes in medical care for substance use disorders and the demands of society, there was a need to revamp the guidelines to meet the current situation in Japan, including a new diagnostic system and new treatment methods. A guideline working group was formed by the Health and Labour Sciences Research "Study on the Provision of Comprehensive Medical Care for Alcoholism" (Higuchi Group), and a new guideline was developed. The guideline covers all aspects of substance use disorders, from basic responses to applied measures, so that it can be useful in all situations involving substance use disorders in daily clinical settings. The content is intended to be useful to a wide range of readers, including non-specialists and residents in substance use disorders, physicians involved in primary care and occupational health, and daily care providers.

This article focuses on the new perspective added to the treatment goals for alcohol use disorders, including reduction of alcohol consumption, as a result of the guideline update.

I. Structure of the New Guidelines

The new guidelines consist of the following four chapters 18).

A. "General Introduction" discusses the concept of addiction, diagnosis, and treatment of addiction in general, epidemiology, legal matters, and the skills required of supporters and the

basics of family support.

B. "Initial Response" describes the situations in which people with substance use disorders are most likely to come to the hospital, using case examples, and is intended for primary care physicians and residents who are mainly involved in the initial response.

C. "Problem-specific Response" divides the problems that people with substance use disorders are likely to have into four categories: I. Response by Severity of Substance Use Disorder, II. Social Problems, III. Physical Problems, and IV. Mental Problems, and explains how to respond to each problem separately.

D. In the "Reference Materials" section, information on medical institutions and recovery facilities is included as a list of social resources.

In particular, the section on "General Introduction" describes the setting of treatment goals, a point that has been renewed in the aforementioned new guideline.

The new guideline does not differ from the direction of conventional treatment goals in that the goal of treatment for alcohol dependence is, in principle, to achieve and maintain abstinence, but the new concept takes into account the "severity of dependence" and indicates the direction of treatment by treatment target. As with existing international guidelines, in cases where the difficulty in controlling drinking is severe or the background factors are complex, the goal of treatment should in principle be abstinence from alcohol, but if the patient does not agree to abstinence from alcohol, it is better to first try to persuade the patient and, if persuasion is unsuccessful, to avoid dropping out of treatment for that reason. One option is to start with the goal of reducing alcohol consumption, and if that does not work, to switch to abstinence. In the case of mild dependence and no clear comorbidities, reduction in alcohol consumption may also be a goal, unless the patient wants or has other circumstances that necessitate abstinence from alcohol. The guideline recommendations are listed in Table 1.

II. Historical Changes in Treatment Goals for Alcohol Use Disorders

The applicability of options other than "abstinence from alcohol" to treatment goals for alcohol use disorder is evident worldwide.

Looking back in history, the "craving for drinking" and "difficulty in controlling", which form the current concept of alcohol use disorder (addiction), were described by Rush, B. in 1784 10). Over time, recognition of alcoholism as a disease began to spread around the 1930s. According to the commentary on the philosophy of Alcoholics Anonymous (AA), which

came into existence in the late 1930s, a disease model of alcoholism was established that emphasized the goal of abstinence from alcohol, as seen in expressions such as "Alcoholism is progressive and never cured", "There is no return to the normal way of drinking", and "The only way to prevent the development of alcoholism is to abstain from alcohol in any form, even in very small amounts" 1).

Over time, since the days when abstinence from alcohol was considered the only direction, there have been many discussions and clinical studies on "controlled drinking vs. abstinence from alcohol". The results of the most well-known comparative study that sought a direction other than abstinence from alcohol were published by Sobell, M.B. et al. in 1973 19). According to this study, 70 alcoholics were divided into two groups, one with the goal of controlling drinking and the other with the goal of abstaining from alcohol consumption, and the effects of individualized behavioral therapy (IBT) based on operant conditioning theory were examined. During a one-year follow-up period, the group that received IBT functioned better on significantly more days than the control group in terms of emotional stability and job satisfaction, suggesting that even the goal of controlling drinking can be achieved with good results if training is conducted. In addition, a survey of alcoholics conducted by RAND Corporation in the U.S. since the early 1970s reported that among 758 alcoholics, 22% continued to drink moderately within 18 months after abstinence-centered treatment at a treatment facility, and 18% continued to drink without problems during the following 4 years 17), leading to the conclusion that some alcoholics can return to problem-free drinking.

According to a 2004 paper by Cox, W.M., et al. and others, long-term treatment outcome results for controlled and moderate drinking, such as these, indicate that a significant number of problem drinkers in and out of treatment are capable of moderate drinking, as many have indicated since the 1980s. They argue that the debate about controlled drinking is no longer about whether to accept its existence as a treatment goal, but rather about the background and characteristics of problem drinkers who are capable of achieving moderate drinking 3). The applicability of moderate drinking as a treatment goal includes low levels of dependence 6) and the absence of serious problems caused by drinking 20).

III. Response to Guidelines of each Country

The application of treatment options other than abstinence from alcohol has

been reflected in treatment guidelines for alcohol use disorders in various regions of the world. The first guideline in the world to express acceptance of reduced drinking for alcoholics who do not wish to abstain from alcohol was probably the National Institute on Alcohol Abuse and Alcoholism (NIAAA) Clinical Guide, published in 2005. The text states, "Abstinence is the safest path for most people with alcohol use disorders. However, it is best to work with the patient in goal setting. Some patients may not accept abstinence as a goal in the early stages. If the alcoholic agrees to reduce his or her alcohol consumption sufficiently, it would be best to set a goal of reducing alcohol consumption while demonstrating that abstinence is the best path 14). The guidelines issued by the Australian Government Department of Health and Ageing in 2009 also state that "Abstinence is the most ideal goal for those with severe alcohol dependence and certain levels of comorbidity. On the other hand, these patients may be hesitant to abstain from alcohol and should be persuaded, including suggestions for moderate drinking, toward eventual abstinence.", being similar to the NIAAA guide 5).

Subsequently, the 2011 National Institute for Health and Care Excellence (NICE) guidelines for the treatment of alcohol use disorders in the U.K. modified the above guidelines, recommending that the patient's goals should be agreed at the initial assessment stage 13). According to the NICE guidelines, "For most alcoholics, abstinence from alcohol is an appropriate goal. If there is no harmful drinking or mild dependence, no specific complications, adequate social support, and the patient chooses to reduce alcohol consumption, this desire should be considered. A Harm Reduction Program should be considered for those with severe alcohol dependence or mental or physical comorbidities that make them unsuitable for abstinence. However, abstinence as the ultimate goal should be recommended." It states that while abstinence is the best option, for those who are mildly ill and have no comorbidities or complicating factors, maintaining the goal of alcohol reduction is an option that can be adopted in accordance with the patient's wishes. It also emphasizes the application of harm reduction to severely ill patients 13). The above NICE guideline policy has also been adopted in the alcohol use disorder guidelines of other countries, such as France and Germany. While these guidelines state that abstinence from alcohol is the safest treatment goal for alcohol dependence, they also demonstrate that the approach of reducing alcohol consumption can also

be a treatment option for alcohol dependence.

Thus, it is safe to say that there is a worldwide trend toward the inclusion of options other than abstinence, such as "controlled drinking," "reduced drinking," and "moderate drinking," as options.

IV. Advantages of Adopting Options Other than Alcohol Abstinence

We have discussed the expansion of treatment options other than abstinence for alcohol use disorders. What are the benefits of doing so?

One is the effect on improving the treatment gap. The small number of people who seek medical care for alcohol-related problems is on the same level as in other countries around the world, and it has been pointed out that this is low. In Japan, the number of lifetime alcoholics is estimated to be 1.07 million 16), while the number of alcoholics who seek medical care is about 40,000 according to the Ministry of Health, Labour and Welfare Patient Survey (2011), suggesting that there is a significant number of people who meet the diagnosis of alcoholism but do not seek medical care. The treatment gap is the same worldwide. The WHO survey on the treatment gap in Europe shows that the percentage of people who need treatment but do not receive it is as high as 92% for alcohol abuse/dependence, which is higher than for other mental disorders 9) (Figure).

While many people who fit the diagnosis of alcoholism are considered to benefit from treatment, what are the reasons why they do not seek treatment? It has been reported that "about half of those who do not seek treatment want to continue drinking" 11). Therefore, it is hoped that presenting alcohol use disorder patients with the option of reducing their alcohol consumption will facilitate access to treatment for many people who have not yet made up their minds to abstain from alcohol use. This is an opportunity to interact with people who would have been excluded from treatment in the past, when it was said that "treatment begins when a person is ready to get sober. "

V. Items Expected to Improve with Reduced Alcohol Consumption

The effect of reduced alcohol consumption is evident from the association between alcohol consumption and mortality. There is a J-curve argument for this, in which mortality is lower among those with a small drinking habit, and the existence of the J-curve continues to be tested, including adjustment for confounding factors. A systematic analysis of alcohol-related deaths and disability adjusted life years (DALYs) due to drinking in

195 countries and regions worldwide published in the Lancet in 2018 concluded that the amount of alcohol consumed that minimizes the health consequences of drinking is zero 4). In any case, numerous studies have commonly pointed out that the mortality rate increases in proportion to the amount of alcohol consumed above a certain level.

In a study using the WHO risk classification by alcohol intake (Table 2), there was no difference in utilization of medical services or medical costs between a low-risk drinking group (men: 1-40 g, women: 1-20 g) and abstinence group at 6 months after treatment for persons with alcohol use disorder 7). Furthermore, the low-risk drinking group and abstinence group had less mental, family, and social problems than the heavy drinkers, and the low-risk drinking group, like the abstinence group, had a good psychosocial status that could be maintained for 9 years 8).

Furthermore, there is a large body of evidence that reducing alcohol consumption improves various alcohol-related disorders. A review of 63 studies discussing interventions involving reduced alcohol consumption cited the benefits of reduced alcohol consumption in a variety of settings, including reduced alcohol-related injuries, improved blood pressure, weight loss, slowing the progression of alcohol-induced liver fibrosis, improved depression and anxiety, and improved physical and mental quality of life 2).

VI. Harm Reduction Perspective

Harm reduction is defined as "the reduction of the adverse health, social, and economic effects of substance use without necessarily reducing the amount of the substance used" and is a concept developed from a drug policy perspective. The use of harm reduction for alcohol use has been discussed in the literature. For example, Marlatt, G.A., et al. recognize the existence of alcohol reduction as one of the specific initiatives of harm reduction, arguing that harm reduction can be viewed as an alternative to abstinence and includes alcohol reduction as an effective and important treatment target 12). Other literature also acknowledges that "harm reduction does not = anti-alcoholism" and that while abstinence is ideal for reducing alcohol harm, for those who drink or will drink in the future, harm reduction provides a balanced perspective and practical skills to reduce alcohol harm that abstinence (zero tolerance) cannot provide 15). While acknowledging that abstinence is best, the authors recommend the use of harm reduction as a complementary role, not a concept at odds with abstinence.

Conclusion

The trend toward recognizing the diversity of treatment goals for alcohol use disorders is a direction that should be accepted based on the guidelines of various countries and their merits. It is hoped that new guidelines including this point will be utilized in Japan to lower the barriers to intervention for people with alcohol use disorders, and that options other than the direction of abstinence will play a role in supporting areas that cannot be covered by abstinence treatment.

Yosuke Yumoto: Lecture fee Otsuka Pharmaceutical Co.

Susumu Higuchi: Lecture fee Otsuka Pharmaceutical Co., Research funds and grants, etc., Suntory Holdings Ltd.

References

1) AA Grapevine: This is A. A.: An introduction to the A. A. Recovery Program. Alcoholics Anonymous World Services, Inc, New York, 2017

2) Charlet, K., Heinz, A.: Harm reduction: a systematic review on effects of alcohol reduction on physical and mental symptoms. Addict Biol, 22 (5); 1119-1159, 2017

3) Cox, W. M., Rosenberg, H., Hodgins, C. H. A., et al.: United Kingdom and United States healthcare providers' recommendations of abstinence versus controlled drinking. Alcohol Alcohol, 39 (2); 130-134, 2004

4) GBD 2016 Alcohol Collaborations: Alcohol use and burden for 195 countries and territories, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. Lancet, 392 (10152); 1015-1035, 2018

5) Haber, P., Lintzeris, N., Proude, E., et al.: Guidelines for the Treatment of Alcohol Problems. University of Sydney, Sydney, 2009

6) Heather, N., Raistrick, D., Godfrey, C.: Review of the Effectiveness of Treatment for Alcohol Problems. National Treatment Agency for Substance Misuse. London, 2006

7) Kline-Simon, A. H., Falk, D. E., Litten, R. Z., et al.: Posttreatment low-risk drinking as a predictor of future drinking and problem outcomes among individuals with alcohol use disorders. Alcohol Clin Exp Res, 37 (Suppl 1); E373-383, 2013

8) Kline-Simon, A. H., Litten, R. Z., Weisner, C. M., et al.: Posttreatment low-risk drinking as a predictor of future drinking and problem outcomes among individuals with alcohol use disorders: a 9-year follow-up. Alcohol Clin Exp Res, 41 (3); 653-658, 2017

9) Kohn, R., Saxena, S., Levav, I., et al.: The treatment gap in mental health

care. Bull World Health Organ, 82 (11); 858-866, 2004
10) Mann, K., Hermann, D., Heinz, A.: One hundred years of alcoholism: the Twentieth Century. Alcohol Alcohol, 35 (1); 10-15, 2000
11) Mann, K., Aubin, H. J., Witkiewitz, K.: Reduced drinking in alcohol dependence treatment, what is the evidence? Eur Addict Res, 23 (5); 219-230, 2017
12) Marlatt, G. A., Larimer, M. E., Witkiewitz, K., et al.: Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors. Guilford Press, New York, p.69-121, 1998
13) National Institute for Health and Care Excellence: Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. National Institute for Health and Care Excellence, Leicester, 2011
14) National Institute of Alcohol Abuse and Alcoholism: Helping Patients Who Drink Too Much: A Clinician's Guide. National Institutes of Health. U. S. Department of Health and Human Services, Washington, D. C., 2005
15) Neighbors, C., Larimer, M. E., Lostutter, T. W., et al.: Harm reduction and individually focused alcohol prevention. Int J Drug Policy, 17 (4); 304-309, 2006
16) 尾崎米厚, 樋口 進, 神田秀幸ほか: WHO 世界戦略を踏まえたアルコールの有害使用対策に関する総合的研究平成 25 年度総括研究報告書(厚生労働科学研究費補助金疾病・障害対策研究分野循環器疾患・糖尿病等生活習慣病対策総合研究事業). 2014
17) Polich, J. M., Armor, D. J., Braiker, H. B.: The Course of Alcoholism: Four Years After Treatment. John Wiley & Sons Inc, Santa Monica, 1981
18) 新アルコール・薬物使用障害の診断治療ガイドライン作成委員会監, 樋口 進, 齋藤利和ほか編: 新アルコール・薬物使用障害の診断治療ガイドライン. 新興医学出版社, 東京, 2018
19) Sobell, M. B., Sobell, L. C.: Alcoholics treated by individualized behavior therapy: one year treatment outcome. Behav Res Ther, 11 (4); 599-618, 1973
20) Sobell, M. B., Sobell, L. C.: Controlled drinking after 25 years: how important was the great debate? Addiction, 90 (9); 1149-1153, 1995

表 1　アルコール依存症の治療目標に関する推奨事項

・アルコール依存症の治療目標は，原則的に断酒の達成とその継続である．
・重症のアルコール依存症や，明確な身体的・精神的合併症を有する場合，または，深刻な家族・社会的問題を有する場合には，治療目標は断酒とすべきである．
・上記のようなケースであっても，患者が断酒に応じない場合には，まず説得を試みる．もし，説得がうまくいかない場合でも，そのために治療からドロップアウトする事態は避ける．一つの選択肢として，まず飲酒量低減を目標として，うまくいかなければ断酒に切り替える方法もある．
・軽症の依存症*1で明確な合併症を有しないケースでは，患者が断酒を望む場合や断酒を必要とするその他の事情がない限り，飲酒量低減も目標になりうる．
・理想的には，男性では 1 日平均 40 g 以下の飲酒，女性では平均 20 g 以下の飲酒が飲酒量低減の目安になる*2．
・上記目安にかかわらず，飲酒量の低下は，飲酒に関係した健康障害や社会・家族問題の軽減につながる．

*1 依存症の重症度に関する統一的見解はない．ICD-10 の診断項目を満たした数や AUDIT の点数などが参考になる．
*2 この目安は，厚生労働省による第二次健康日本 21 の「生活習慣病のリスクを上げる飲酒」の基準をもとに作成した．
（文献 18 より一部改変して引用）

Table 1: Recommendations on treatment goals for alcoholism

・The goal of treatment for alcohol dependence is, in principle, to achieve and maintain abstinence.

・In cases of severe alcohol dependence, cases with definite physical or mental complications, or cases with serious family or social problems, the goal of treatment should be abstinence.

・Even in these cases, if the patient refuses to abstain from alcohol, the first step is to try to persuade him or her to do so. If persuasion is unsuccessful, the patient should not drop out of treatment for that reason. One option is to start with the goal of reducing alcohol consumption, and if that does not work, to switch to abstinence.

・In cases of mild dependence*1 with no obvious complications, reduction in alcohol consumption can be a goal unless the patient wants to stop drinking or there are other circumstances that require abstinence.

・Ideally, the goal should be to reduce alcohol consumption to an average of 40 g or less per day for men and 20 g or less per day for women*2.

・Regardless of the above guidelines, a reduction in alcohol consumption will lead to a reduction in health problems and social and family problems related to alcohol consumption.

*1 There is no unified view on the severity of dependence, and the number of ICD-10 diagnostic items met or the AUDIT score can be used as a reference.

*2 This guideline was developed based on the criteria for "alcohol consumption that increases the risk of lifestyle-related diseases" in the Second Healthy Japan 21 by the Ministry of Health, Labour and Welfare.

(Cited with some modifications from Ref. 18)

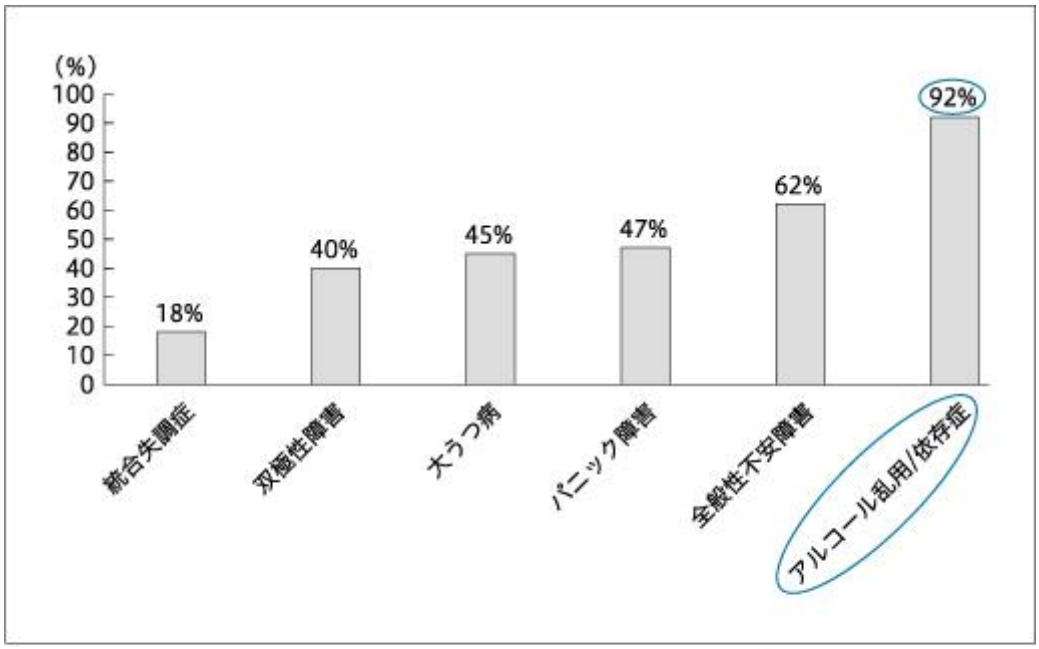

図　WHO Europe region の精神疾患治療ギャップ

治療ギャップ：疾患の治療を必要としている人の数と実際に治療を受けている人の数の差.

（文献 9 より作成）

Figure: WHO Europe Region Mental Illness Treatment Gap

Treatment gap: the difference between the number of people in need of treatment for a disease and the number of people actually receiving treatment.

(Compiled from Ref. 9)

表 2　アルコール摂取量によるリスク分類（WHO）

DRL	男性	女性
低リスク	1～40 g	1～20 g
中リスク	41～60 g	21～40 g
高リスク	61～100 g	41～60 g
超高リスク	101 g～	61 g～

DRL：Drinking Risk Level

Table 2: Risk classification by alcohol intake (WHO)

DRL / Male / Female

Low risk 1-40 g, 1-20 g

Intermediate risk 41-60 g, 21-40 g

High risk 61-100 g, 41-60 g

Very high risk 101 g~ 61 g~

DRL: Drinking Risk Level