▶ Treatment seeking and subsequent 1-year drinking outcomes among treatment clients in Sweden and the U.S.A.: a cross-cultural comparison.

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Detailed examination of how differing welfare and treatment systems and understandings of dependence affect the alcohol caseloads of substance use treatment services in Sweden and the USA and how they fare in the year after starting treatment; reveals differences and similarities in what 'success' consists of and what seems to promote it.

Summary This paper compares alcohol-dependent patients entering treatment in Sweden and the USA, countries with relatively well resourced treatment services but different health and social welfare systems for responding to problem drinking.

In keeping with Sweden's intent to provide for the basic needs of its citizens, treatment is publicly financed. US treatment services are financed mainly through private and public health insurance, self-pay, and other public funds. Though both countries share strong temperance traditions, the primary goals and expectations of treatment have been framed somewhat differently in the two countries. Alcohol misuse in Sweden has traditionally been viewed and handled as more of a social than a health problem, and though treatment focuses on alcohol misuse, it does so in the context of promoting social reintegration. Stronger influences in the USA are the concept of dependence as a disease, Alcoholics Anonymous (AA) ideology, and the belief that abstinence is essential.

To contrast these systems, parallel studies were conducted which recruited alcohol dependent adults entering treatment in 2000 to 2002 in the Stockholm area, and between 1995 and 1996 in one county in California. They were interviewed by researchers and followed up over the phone a year later. In Sweden 997 were interviewed of whom of whom 635 could be followed up, in the USA, 501 and 384. In both cases the more severe drinkers with fewer social resources were less likely to be followed up.

Main findings

The Swedish sample included fewer women (26% v. 38%). Also, many more patients were aged 50 or over (44% v.16%), they were less likely to be well educated, and more likely to have social networks comprised mostly of substance abusers (25% v. 11%). More of the US sample were aiming for abstinence (84% v. 54%) and more had attended AA and similar groups (91% v. 64%), though fewer had previously been in treatment (74% v. 87%). The US sample too were on average drinking more heavily and had more severe psychiatric problems and problems with drugs other than alcohol.

At treatment entry 62% of the Swedish sample felt considerably or extremely bothered by their drinking problems falling to 26% a year later. More of the US sample started treatment feeling that way (91%) but the figure fell to near the same level (29%). At the start 75% of the US patients but 62% in Sweden felt treatment was very important to them. During the following year, nearly two thirds (63%) of the Swedish patients had drunk heavily (five or more drinks – 60g alcohol – on a single occasion) but less than half (46%) in California. Among the remainder, moderate drinking was slightly more common in Sweden, abstinence in the USA.

In both countries, patients who had started treatment aiming for abstinence rather than some other drinking gaol were a year later less likely to be drinking heavily and more likely to be abstinent or drinking moderately. In Sweden the same was true of being younger and having mainly non-abusers among one's social network. Instead, in the USA being a woman was the only other feature which made heavy drinking less likely than either abstinence or moderate drinking.

Other variables were associated *either* with being more likely to have drunk moderately than heavily, or more likely have abstained than drunk heavily, but not both or not both in the same way. Among these, in Sweden previous treatment for drinking problems and starting treatment with greater psychiatric problems meant patients were more likely to have been moderate than heavy drinkers over the follow-up year, but less likely to have been abstainers than heavy drinkers. In the USA the same features meant patients were both more likely (but not always to a statistically significant degree) to be abstainers and more likely to be moderate drinkers.

The authors' conclusions

In both countries, three characteristics of the individuals were associated with moderate drinking after starting treatment; being a woman, younger age, and having an abstinence goal. More generally, characteristics often associated with lower problem severity and greater social resources were predictive of moderate drinking but not abstinence.

Factors differently associated with outcomes in the two countries may reflect true cultural differences. For example, having more non-substance abusing associates was related to moderate drinking and abstinence in Sweden, but not in the USA. Moreover, having severe psychiatric problems was associated with abstinence rather than heavy drinking in the US sample, while in Sweden having more severe psychiatric problems was most strongly associated with moderate drinking.

For Swedish providers, the main clinical implication relates to the social network findings, suggesting that efforts be directed to countering the influence of networks dominated by other problem drinkers and/or drugtakers.

The fact that the US sample exhibited greater problem severity at the start of treatment may be related to Sweden's social welfare system being more accessible, and its alcohol treatment services pervading this system in ways which mean they 'capture' a greater range of problem drinkers.

It was expected that greater integration of services in Sweden would mean problem drinkers had better post-treatment drinking outcomes, but this was not the case. Instead, after a year significantly fewer US clients were heavy drinkers and more were abstainers.

FINDINGS The researchers had expected Sweden's more integrated and rounded alcohol treatment system to produce better drinking outcomes, but the reverse was the case, more of the Swedish sample in parallel studies drinking heavily the year after starting treatment. It could just be the idiosyncrasies of the samples, each drawn from a single area in the countries. But there seems more to this puzzle. Entry to the US system was more restricted, meaning the caseload was more extreme and more felt very bothered by their drinking and in need of treatment. Perhaps they had what for them were better reasons to stop drinking heavily, while more of the Swedes were persuaded in to treatment by the country's enveloping welfare system when they did not feel it was needed. The criterion for heavy drinking embraced a once in a while mini-binge; perhaps the Swedes, less attached to abstinence, did not think this meant treatment had failed.

An earlier report drawing on the same studies, but including patients with drug problems as well those with alcohol problems, focused on

attendance at mutual aid groups. Generally the US sample, although somewhat younger and with seemingly better social supports (eg, more educated, more likely to be married/cohabitating), reported greater problem severity in more life areas than the Swedish clients. The reason may have been dual use of alcohol and drugs in the USA, or less access to social welfare benefits and services. In both countries nearly two thirds of the clients had been encouraged to seek treatment by family, friends and acquaintances. A striking difference, however, was that Swedish clients were three times more likely to have been encouraged by staff in medical, social, or psychiatric services, perhaps the result of a more integrated public system for social and health service provision.

According to this report, in the year after starting treatment twice as many of the US patients had attended mutual aid groups (72% for both men and women, versus in Sweden 32% of men and 37% of women), but within each country neither sex was significantly more likely to attend than the other. In Sweden, attending mutual aid groups in the year after starting treatment was associated with abstinence as a treatment goal, perceived need for treatment, treatment being suggested by work colleagues, and prior mutual-aid attendance. In the USA the picture was similar. These factors were applicable to men and women, but another was not: in both countries, women with a network of trusted friends to talk to about personal problems were more likely than other women to attend mutual aid groups, not the case for men.

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