DRUG & ALCOHOL FINDINGS

Should dependent drinkers always try for abstinence?

Mike Ashton of Drug and Alcohol Findings on the milestones in the bitterest controversies ever seen in addiction treatment research.

The issue of whether dependent drinkers should always be advised to try for abstinence has been central to alcohol dependence and its treatment for decades. Far from receding in to a box marked 'pointless debates', abstinence as a treatment objective has recently returned to prominence as an essential component of influential visions of 'recovery'.

Not so long ago the issue in Britain and elsewhere was not just about advice, but whether alcoholics should actually be denied treatment until deterioration forced them to accept the need to stop drinking altogether and forever. Here we look at the milestones in this debate, subject of the bitterest controversies ever seen in addiction treatment, drawing on work done for the Alcohol Treatment Matrix.

Why such heat over a seemingly innocuous decision between patient and clinician on which form of reduced drinking to go for? In part it was generated by concerns on the one hand that allowing controlled drinking would let alcoholics (assumed to be unable to stop once they start) off the necessary hook of non-drinking and set them up to fail, and on the other that insisting on abstinence did nothing to improve outcomes, but did limit treatment to the minority of problem drinkers prepared to countenance a life without drink.

Behind this were alternative visions of dependence as a distinct category characterised by inevitable loss of control, or one end of a continuum of learnt behaviour, which even at its most extreme, can be replaced by learning to drink in moderation.

The controversy dates back at least to a 1962 report, *Normal drinking in recovered alcohol addicts*, by British psychiatrist D. L. Davies on seven 'alcoholic' patients from south London's Maudsley Hospital said to have sustained controlled drinking. In 1994 they were judged to have deceived a research-naive clinician. The basis for this reassessment was a 1985 paper documenting interviews with the patients and others and a (re)examination of records, to which the original author (he had died three years before) was unable to respond. The allegations came from the prestigious figure of Griffith Edwards, who later embraced normal drinking as a goal for many patients. But he maintained that (emphasis added) "abstinence is the *only* feasible objective" for those with a fully developed history of dependence. Among his criteria for identifying who should attempt which were those (see below) trialled by the Sobells in the USA.

That episode was relatively gentlemanly and limited to professional circles, but the following decade, bitter disputes originating within US research hit the headlines, in one case spawning legal proceedings. One major spat centred on a 1976 report from the Rand Corporation on new government alcoholism treatment centres. It found that fairly complete remission was the norm, that most patients achieved this without altogether stopping drinking, and that as many resumed normal drinking as sustained abstinence.

Aware of the storm their findings might provoke, the authors disavowed any intention to recommend alcoholics resume drinking. Nevertheless the storm broke, as suggesting the prospect of controlled drinking was likened to "playing Russian roulette with the lives of human beings". With striking prescience, the authors themselves felt the most important implication of their findings was that "the key ingredient in remission may be a client's decision to seek and remain in treatment rather than the specific nature of the treatment received" – an insight revisited decades later after another major US study – the Project MATCH trial, highlighted in cell A2 of the Alcohol Treatment Matrix.

One reason the Rand authors knew their findings might be controversial was the reaction three years before to an audacious and for the time methodologically advanced experiment conducted by husband and wife team Mark and Linda Sobell.

They had allocated hospitalised physically dependent alcoholics with what generally seemed a poor prognosis: either try for abstinence or for controlled drinking. The latter chosen principally on the basis that patients had asked for this, shown in the past they could manage it, and had a supportive environment to return to on discharge. Within each group, half were allocated to normal abstinence-oriented treatment and half to a radical procedure geared either to the abstinence or controlled-drinking goal to which the patient had been assigned. It entailed allowing patients to drink, showing them via videos how they looked when drunk, and training them how to manage or avoid what for them were situations conducive to drinking or over-consumption.

Over the last half of the follow-up year patients assigned to try for controlled drinking, and who had been trained how to manage this, spent nearly three quarters of the time out of hospital and prison and not drinking heavily, though all but four of the 40 continued to drink, the best results of all the patients. Those given the same treatment but selected for abstinence did almost as well, but many more

did so by not drinking at all.

It seemed a clear vindication of an intervention based on seeing addiction as learnt behaviour and of the judicious allocation of even physically dependent patients to try to learn moderation. Controlled-drinking patients had been selected partly because of their "sincere dissatisfaction with [Alcoholics Anonymous] and with traditional treatment modalities"; the study showed this rejection of US orthodoxy need not condemn them to the progressive deterioration predicted for untreated alcoholics.

Just as with Davies' research at the Maudsley, a later follow-up of the same patients cast doubt on the validity of the findings, and led one of the authors to publicly (in the *New York Times*) allege scientific fraud. The Sobells were cleared by an investigation set up by their employers and by one commissioned by a committee of the US Congress, and their research (though sharing some of the flaws characteristic of the time) was judged fairly presented.

In 1995 (and again in 2011) the Sobells revisited controlled drinking as a treatment objective in an editorial for the *Addiction* journal, which attracted eight commentaries. It accepted that "Recoveries of individuals who have been severely dependent on alcohol predominantly involve abstinence", possibly because poor social support and lack of a stake in society in the form of a career and a job tend to go along with severity of dependence. Beyond this minority, they argued that reducing alcohol-related harm across the population demanded acceptance of the moderation goal, because many (especially less or non-dependent) drinkers simply will not accept interventions which presuppose abstinence.

Their argument had been demonstrated by a Canadian trial which tried to randomly allocate drinkers (most of whom seemed to be drinking heavily enough to meet criteria for dependence but had yet to be severely affected by their drinking) to treatment aiming for abstinence or moderation. Of the 35 allocated to abstinence, 23 either rejected it or expressed reservations, *but just five of the 35 allocated to controlled drinking.* That was at the start of treatment. After it had ended the picture was the same; whatever goal had been impressed on them by their clinicians, most in the end chose to drink moderately.

Skipping other important studies in Britain and elsewhere (for which see these Findings notes) we come up to date with Britain's largest alcohol treatment trial, the UKATT study of psychosocial therapy for 742 patients seeking treatment for alcohol problems at specialist treatment services in England and Wales. I'm not looking at the main findings, but a secondary analysis of how patients fared depending on whether they had opted for abstinence as an initial treatment goal.

From our analysis you will see that regardless of their initial choice, patients did about equally well, and that even among those who at first wanted to stop drinking altogether, more later substantially reduced their drink-related problems while continuing to drink, than did so by abstaining.

UKATT was among the studies assessed in a recent European review whose conclusions were largely in line with others from North America. Though they were perhaps more enthusiastic about embracing moderation as a treatment goal, in order to make treatment attractive to the 20 to 80 per cent of dependent drinkers who preferred this goal.

The review seems to advocate shared decision-making when selecting a treatment goal, with moderation as well as abstinence on the table, so the patient makes a positive choice rather than being 'told' what to do. Incidentally, a Dutch study showed that shared decision-making can be systematised, and that as a result, in relation to life in general, patients feel more able to make their own decisions. They are more in control and less submissive – possibly portending a more stable shift away from a dependent mind-set than could be achieved by less explicit shared decision-making.

What seems mainstream contemporary opinion was enshrined in alcohol treatment guidance published in 2006 by the Department of Health and National Treatment Agency for Substance Misuse. It stressed that goal choice should not exclude drinkers from support or treatment, but did see abstinence as "the preferred goal for many problem drinkers with moderate to severe levels of alcohol dependence, particularly…whose organs have already been severely damaged through alcohol use, and perhaps for those who have previously attempted to moderate… without success".

Even for these drinkers, if abstinence is not acceptable, moderation is better than nothing, and may lead to abstinence. We know from research that no matter how physically dependent, moderation is feasible for some, especially when there are sufficient supports in the patient's life.

But the more severe the dependence, the more likely abstinence is to be the suitable strategy. On how the decision should be made, in relation to care planning in general, the guidance sees patient choice as not just an entitlement, but a strategy which improves the chances that the treatment approach will succeed because "it has been selected and committed to by the individual".

This is how Drug and Alcohol Findings summed up the evidence: "Treatment programmes for dependent drinkers should not be predicated on either abstinence or controlled drinking goals but offer both. Nor does the literature offer much support for requiring or imposing goals in the face of the patient's wishes. In general it seems that (perhaps especially after a little time in treatment) patients themselves gravitate towards what for them are feasible and suitable goals, without services having to risk alienating them by insisting on a currently unfavoured goal".

Click here for an extended web version of this article. For fuller accounts see this US analysis and if you can this British perspective (turn to chapter four of the book). See also this Findings analysis of a recent UK study (the background notes are particularly informative) and this recent review.
This article is based on cell C4, one of 25 cells in the Alcohol Treatment Matrix constructed by Drug and Alcohol Findings for the Substance Misuse Skills Consortium. This and the corresponding Drug Treatment Matrix map treatment sectors and influences which might affect impact, and for each sub-territory (a cell) list the most important UK-relevant research, reviews and guidance.