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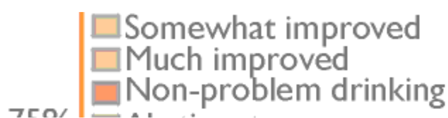
▶ Initial preference for drinking goal in the treatment of alcohol problems: II. Treatment outcomes.

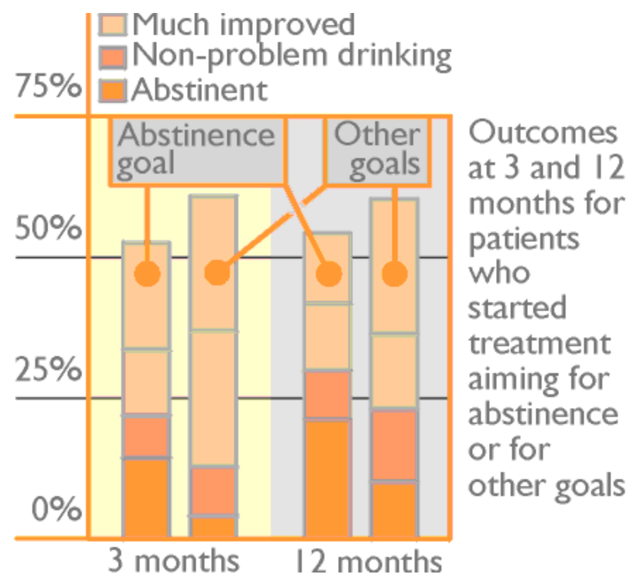
Adamson S.J., Heather N., Morton V. et al. Request reprint
Alcohol and Alcoholism: 2010, 45(2), p. 136–142.

Data from Britain's largest alcohol treatment trial is used to address possibly the most contentious issue in the field – whether services should offer moderation as well as abstinence goals to dependent clients. 'Let the patient choose' seems the general conclusion.

Abstract As documented in previous Findings analyses (1 2), the UKATT study recruited 742 patients seeking treatment for alcohol problems at seven specialist treatment services in England and Wales. Additional to other treatment elements like detoxification, they were randomly allocated either to three sessions of motivational enhancement therapy or eight of social behaviour and network therapy, each spread over eight to 12 weeks. Twelve months after therapy started, 85% of the participants who were still alive were re-interviewed. After both therapies, alcohol consumption over the past three months had fallen by 45% and other measures also improved to roughly equivalent degrees, nor were there the expected indications that certain types of patients would respond better to one therapy than the other.

The featured report examined the same dataset, not to search for differences in outcomes between the therapies, but between patients opting and not opting for abstinence as an initial treatment goal. An earlier report had documented differences at study entry between those who (according to the judgement of intake treatment staff) were probably aiming versus not aiming for abstinence. The caseload was fairly evenly split, 54% aiming for abstinence, 46% not. In general, abstinence-aiming clients were drinking more intensely and experiencing greater drink-related and other problems, and were more socially isolated, especially in their attempts to control their drinking.





This later report investigated whether treatment goals were related to drinking and drink-related problems three months after joining the study (shortly after the UKATT treatments had ended) and again at 12 months. As its primary yardstick of a successful outcome, the study adopted either total abstinence over the previous three months, or the total absence of drink-related problems as assessed by a questionnaire covering health, relationships, family, legal and financial issues. On this criterion, three months after joining the study patients judged as aiming for abstinence were significantly more likely to have been successful (22% v. 13%). Generally they did so by abstaining, while the successes among those not aiming for abstinence generally took the form of non-problem drinking. This difference in the type of successful outcome persisted to the 12-month follow-up, but by then the gap in the overall success rate had narrowed (30% v. 23%) to the point where it was no longer statistically significant ▶ *chart*. In line with this pattern, at both stages those aiming for abstinence actually were abstinent on significantly more days (at 12 months, 55% v. 43%). A measure of dependence on alcohol showed no difference between the groups at either stage.

The authors cautioned that the superiority of overall outcome in the abstinence-goal group may not have been due to their choice of goal, but to their being more motivated to change their drinking. They also suggested that equally good outcomes on the measure of dependence indicates that patients aiming or not aiming for abstinence were equally satisfied with the changes they had made. Addressing the implications for practice, they advised that as a basis for negotiation, each client's personal drinking goals should routinely be discussed during initial assessments. Findings that patients who achieve success generally do so in ways concordant with their initial goals indicate that these goals should be taken seriously. Clinicians should also identify and support changes in goal as an unexceptional aspect of treatment which need not jeopardise good outcomes. As to which goal should be advocated, they say their findings do not support advising abstinence irrespective of the patient's preferences or problem severity, an insistence which might alienate or deter some patients. Where abstinence is the client's objective, the service should support it. Unless there are medical contraindications to continued drinking, similarly those opting for goals including lower risk drinking should also be supported if their choice is maintained after informed consideration of the alternative.

FINDINGS The report sees abstinence-aiming patients as achieving the best results

overall, but this judgement depends on how one draws the line between success and not success. Drawn differently, non-abstinence aiming patients did best. Also, while the study's success criterion accounted for the difficulties drinkers experienced with their drinking status, it did not do the same for abstainers. Several studies have found that the lives of people who aim for and/or achieve abstinence are not necessarily more satisfactory overall than those of patients who did not.

Neither this study nor most others support arguments that an exclusive abstinence or controlled drinking goal should be integral to treatment programmes for dependent drinkers, nor do they 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. Such findings are consistent with British guidance which warns against insisting on an abstinence gaol, while cautioning that generally this goal gives severely dependent patients the best chances of success. More below and fuller documentation in the background notes.

About the study

For details and corroboration of these comments ▸ background notes. Analyses like this which, after the data has been collected, divide up a study's participants in ways not intended in advance, in order to test propositions also not specified in advance, are best seen as suggesting that something might (or might not) be worth investigating further. Analysts give less weight to such findings than findings from studies explicitly designed to test a proposition specified in advance.

Though in the featured report some advantages associated with an abstinence goal were statistically significant, more striking was the similarity in the degree of success, regardless of this initial objective; details below.

The study chose a criterion which made abstinence successful by definition, no matter how the patient was faring in the rest of their life, but required drinkers to be free of associated difficulties. Yet in societies where not drinking at all is in statistical and social terms 'abnormal', and leisure and social activities often involve drinking and drinking venues, abstinence is not necessarily an unproblematic choice. This may be particularly the case among some former heavy drinkers whose social lives revolved around drink and drinkers, for whom drinking served psychological purposes, or who find sustaining abstinence a constant battle. As with controlled drinkers, on balance they will almost always be substantially better off than when drinking heavily, but there may still be some abstinence- (rather than drinking-) related deficits and difficulties in their lives.

Since abstinence was more common among those who aimed for it, this criterion favoured these patients, but still the differences were slight. Were the criterion changed to, at a minimum, appreciable problem reduction, then non-abstinence aiming patients would have been judged to have done slightly better. Also, slightly more (46% v. 40%) abstinence-aiming patients had unambiguously poor outcomes, either not appreciably improving or getting worse. Similarly, a less stringent criterion would have reversed the conclusion that abstinence-aiming patients generally achieved successful outcomes by doing what they had intended from the start.

Implications of other studies

Guidance on the importance of goal choice comes from a review which searched studies published from 1977–2005 for the most consistent predictors of successful treatment

outcomes. Choice of abstinence as a goal was one of the top five. On the basis of this review and further studies, it seems that while opting for abstinence is commonly associated with better drinking outcomes, this is by no means universal.

From the featured report and other British (1 2 3) and European studies, it also seems that even when abstinence-aiming patients do end up drinking less, this does not always mean their lives overall are more satisfactory than those of patients who did not opt for abstinence. The 'recovery' agenda in addiction treatment emphasising the overall wellbeing of the patient has most closely been associated with abstinence-oriented approaches. However, a focus on the patient's self-experienced quality of life now being advocated for treatment could as justifiably be seen as requiring flexibility in drinking goals. See next section for the British studies and turn to the background notes for more on reviews of the literature and selected overseas studies.

Findings in Britain

The support patients receive in achieving controlled drinking or abstinence goals, the optimism they and their associates feel and express about being able to implement these goals, the availability of post-treatment relapse prevention options geared to these goals such as mutual aid groups, and therefore the sustainability of these recovery options, are all likely to be heavily dependent on the local drinking culture and the positions taken by treatment staff and services on the desirability and feasibility of these goals. In turn this environment is likely to affect the extent to which patients adopt controlled drinking or abstinence goals. For UK clinicians, this places a premium on studies conducted in Britain.

Before the featured study, there seem to have been four British studies (described more fully in the background notes), all conducted at NHS hospital inpatient alcohol treatment units: two at the same Liverpool unit (1 2) and another (1 2) at a different unit in the city. Like the featured report, all four found that choice of goal was meaningful in the sense that successful outcomes generally took a corresponding form. The three Liverpool studies also agreed that overall success rates in eliminating risky drinking were similar whether or not abstinence was chosen. Another study in Northampton found that opting for abstinence was more likely to be followed by non-problem drinking, but did not report whether lesser degrees of improvement were also more common among these patients.

Conclusions reached by reviewers

Several North American experts (1 2 3) have recently reviewed studies on goal choice in alcohol dependence treatment, concerned that the dominant abstinence-orientation of their services might unnecessarily restrict access to treatment and limit what counts as success. Their views are separately summarised in the background notes.

Among the points they made are that this dominance is partly due to concern that acknowledging the feasibility of controlled drinking for previously dependent drinkers would undermine patients' commitment to abstinence, leading them to try controlled drinking solutions they were unable to sustain. This concern seems supported by studies which have found abstinence to be a more stable post-treatment drinking pattern than controlled drinking, and less likely to transition to problem drinking (see for example 1 2). However, such findings do not mean that patients who opt for or (even if only for a time) achieve non-problem drinking, would have done better had the service insisted on

an abstinence goal; many may simply have rejected or quickly dropped out of treatment, failing to benefit at all. Reviewers also identified an understandable 'play safe' mentality among treatment staff, who are unwilling to advocate a non-abstinence gaol for an individual in the absence of any definitive indication from the research of who would be able to sustain controlled drinking. In response it has been argued that research suggests there is no added harm in patients trying moderation as opposed to abstinence, so the balance of clinical advantage lies in widening treatment access by permitting choice.

Reviewers also generally agree that drinking goals change during treatment and need to be regularly re-evaluated, leading if required to corresponding changes to the treatment programme. To avoid premature drop-out, one Swedish centre implemented such a re-evaluation schedule and found more patients started and stayed in treatment. The evaluation of this initiative found that over two years 44% of patients changed between abstinence and controlled drinking goals, with no apparent detriment to their recovery.

Who does best with which goal?

While insufficient to determine individual treatment, research does indicate that *in general* successful non-abstinent outcomes are associated with younger and female patients, those who are relatively socially integrated and psychologically stable, less severely alcohol dependent, and who strongly believe in their ability to moderate their drinking. Goals short of abstinence are contraindicated by certain medical or psychological conditions exacerbated by continued drinking, or when medicines interact dangerously with alcohol. Moderation is less likely to be sustained by patients who have repeatedly been unable to maintain reduced-risk drinking or have a history of severe alcohol withdrawal symptoms. Such patients who nevertheless will not accept an abstinence goal may be persuaded to try this for a trial period, or agree to revert to an abstinence goal if reduced drinking is not working out. Some authorities recommend that if controlled drinking is chosen, patients should be encouraged to be specific about their intended limits so the goal is clear, meaning it will also be clear when this option is not working out.

British guidance

This advice based on research and expert opinion is consistent with alcohol treatment guidance published in 2006 by England's Department of Health and National Treatment Agency for Substance Misuse, quoted more fully in the background notes. It stressed that drinkers who opt for moderation or even decline to set change goals should not be excluded from services, while recognising that abstinence will be the preferred goal for many of the more heavily dependent drinkers. The guidance observed that moderation or controlled drinking is more acceptable to some (especially less dependent) drinkers, and is worth pursuing for patients who would normally be advised to abstain but currently find this unacceptable, and may offer a stepping-stone to abstinence.

Thanks for their comments on this entry in draft to Nick Heather of Northumbria University and Trevor McCarthy. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 23 March 2010

▶ Background notes

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