

DRUG & ALCOHOL FINDINGS *Hot topic*

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Should dependent drinkers always try for abstinence?

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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 into a box marked 'pointless debates', prioritising 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 what patients should be advised, but whether they 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 to the bitterest controversies ever seen in addiction treatment, while acknowledging that for patients, improvements short of either abstinence or controlled drinking (the non-abstinence alternative described below) may be worthwhile and the best that can be achieved at that point in time.

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** off the 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 alternate 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.

Gentlemanly start

The controversy dates back at least to a **1962 report** by British psychiatrist D. L. Davies on seven 'alcoholic' patients from south London's Maudsley Hospital said to have sustained controlled drinking. In 1994, collectively they **were judged** to have deceived a research-naïve 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 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.

For more see this **US account** and if you can this **British perspective** (turn to chapter four of the book). See also this **Effectiveness Bank analysis** of a recent UK study (the **background notes** are particularly informative) and this **recent review**.

This entry is based on **cell C4**, one of 25 cells in the **Alcohol Treatment Matrix**. 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.

That episode was relatively gentlemanly and limited to professional circles, but the following decade bitter disputes originating with US research literally hit the headlines and spread across TV networks, 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 holding out 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.

Sobells in the firing line

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 to 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 via not drinking at all. It seemed a clear vindication of an intervention based on seeing addiction as a 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.

...many drinkers will not accept interventions which presuppose abstinence

Their argument had been demonstrated in a [Canadian trial](#) which tried to randomly allocate drinkers to treatment aiming for abstinence or moderation. Most seemed to be drinking heavily enough to meet criteria for dependence but had yet to be severely affected by their drinking. Of the 35 allocated to abstinence, 23 either rejected it or expressed reservations, compared with 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.

A study which similarly allocated patients to receive either abstinence- or controlled drinking-oriented treatment (albeit on a smaller scale, 24 problem drinkers compared with 70 above) [found](#) that both abstinent and ‘asymptomatic’ (still drinking, but evidently free of alcohol-related problems and dependence) drinking outcomes occurred regardless of the drinking goals assigned.

Patient choice and shared decision-making

But, how do patients fare if they opt for (as opposed to being assigned) abstinence versus moderation as an initial treatment goal? The UKATT study – Britain's largest alcohol treatment trial – tested different forms of psychosocial therapy for 742 patients seeking treatment for alcohol problems at specialist treatment services in England and Wales. [According to a secondary analysis of the results](#), regardless of their initial choice, patients did equally well, and among those who at first wanted to stop drinking altogether, more 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 perhaps more enthusiastic about embracing moderation as a treatment goal in order to make treatment attractive to the (in various studies) 20–80% of dependent drinkers who prefer it. The review seemed to advocate shared decision-making (between patient and clinician) when selecting a treatment goal, with moderation as well as abstinence available, so the patient is engaged in making a positive choice rather than being 'told' what to do. This message was echoed in another [review](#) – in fact the first review to explicitly evaluate patient preferences for treatment goals and decision-making. It noted that nearly half of patients in three study groups preferred a reduction of alcohol consumption to a non-problematic amount, whereas 15% preferred to be completely abstinent; in contrast, two studies found that most patients preferred abstinence to moderate drinking. When patients with alcohol use disorders in one study were matched to their preferred treatments, no differences were found for number of drinking days and number of days intoxicated. However, in another study matched patients drank less over time than unmatched patients.

Shared decision-making has been [shown](#) to lead to patients becoming more independent and more able to stand up for themselves (reflected in their greater movement towards feelings of autonomy, control and extraversion). In practice, however, patient reliance on clinicians to help [navigate through](#) 'confusing and unpredictable' treatment pathways may undermine the ethos of shared decision-making, tipping the scales of power towards clinicians.

This UK-based study [identified](#) the need for treatment pathways to be more patient-friendly – better reflecting the capacity and capabilities of patients with alcohol dependence – and for health care professionals to support and build self-efficacy among patients (their belief in being able to succeed). It also highlighted some differences among patients, and between patients and clinicians, about the meaning of alcohol dependence and the treatment itself, with implications for shared decision-making. Among the 20 patients interviewed at alcohol treatment services in London, definitions of alcohol dependence varied widely – for some depending on volume or strength of alcohol consumed, and for others representing a need (as opposed to a want) to keep drinking – influencing their views about *what* and *who* treatment was for. Many saw 'cutting down' as an important step in being able to achieve abstinence and/or regain control of drinking – differing from their practitioners, who apparently tended to be supportive of cutting down only to the extent that it was a step towards abstinence, not a goal in itself. From the patient perspective, moderation could be both a means to an end, and the end in itself, problematising the mainstream clinical view of abstinence and drinking in moderation as mutually exclusive alternatives.

The following US study suggests that practitioners may be less inclined to support moderation as the treatment goal among patients with more severe drinking problems. The web-based survey of 913 addiction professionals [revealed](#) that the extent to which clinicians are supportive of non-abstinence goals is likely to depend on whether the patient is deemed to have alcohol problems or to be alcohol dependent. Where over half of respondents reported non-abstinent drinking patterns to be acceptable as intermediate (58%) and final (51%) outcome goals for people with alcohol problems, considerably fewer rated this as acceptable for clients with alcohol dependence (28% and 16%). As well as the severity of the problem drinking, their evaluations of the acceptability of non-abstinence goals were informed by patients' health problems (86% deemed 'very important'), number of previous treatment episodes (70%), presence of mental health disorders (68%), age (67%) and emotional stability (65%). Yet overall, the researchers concluded that "individuals with alcohol and drug problems who avoid treatment because they are ambivalent about abstinence should know that – depending on the severity of their condition, the finality of their nonabstinence goal, and their drug of choice – their interest in moderating their consumption will be acceptable to many clinicians, especially those working in outpatient and independent practice settings".

Contemporary guidance

While patients may be ambivalent about abstinence as a treatment goal, the policy context means that practitioners are unlikely to be. Alcohol treatment services in the UK, for example, are [advised](#) by the National Institute for Health and Care Excellence (NICE) to guide drinkers at

the more severe end of the continuum of alcohol use disorders towards one treatment goal – this being abstinence:

In the initial assessment in specialist alcohol services of all people who misuse alcohol, agree the goal of treatment with the service user. Abstinence is the appropriate goal for most people with alcohol dependence, and people who misuse alcohol and have significant psychiatric or physical comorbidity (for example, depression or alcohol-related liver disease). When a service user prefers a goal of moderation but there are considerable risks, advise strongly that abstinence is most appropriate, but do not refuse treatment to service users who do not agree to a goal of abstinence.

For harmful drinking or mild dependence, without significant comorbidity, and if there is adequate social support, consider a moderate level of drinking as the goal of treatment unless the service user prefers abstinence or there are other reasons for advising abstinence.

For people with severe alcohol dependence, or those who misuse alcohol and have significant psychiatric or physical comorbidity, but who are unwilling to consider a goal of abstinence or engage in structured treatment, consider a harm reduction programme of care. However, ultimately the service user should be encouraged to aim for a goal of abstinence.

Before NICE had pronounced on treatment goals, in 2006 the Department of Health and National Treatment Agency for Substance Misuse had issued [guidance](#) for England which promoted a similar strategy – 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, it continued, 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 for some feasible, 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”.

And beyond the binary framed above, are the end goals and intermediate successes which may fall short of abstinence and controlled drinking but nonetheless have a material impact on the quality of client’s lives. Professor Nick Heather notes this in his [discussion](#) about the role of controlled drinking and harm reduction in response to alcohol-related problems. He writes that outcomes such as ‘drinking but improved’ should not be dismissed by alcohol professionals, but “recognised and hailed as a major achievement”.

Where the elimination of harm via abstinence is (perhaps for the time being) not possible, harm reduction should be the goal, said the NICE guidance above. Yet, what harm reduction means in relation to problem drinking is [not always clear](#). In the US, controlled drinking is synonymous with harm reduction, because like needle exchange programmes, controlled drinking does not require abstinence as a prerequisite for treatment. In Europe on the other hand, the working definitions tend to emphasise decreasing harm from consumption, for example through measures to reduce drink-driving, rather than decreasing consumption itself (which could be more accurately described as ‘use reduction’). If what we’re talking about more specifically is reducing drinking to a level (unique to each individual) that reduces or eliminates the harm they experience, this may involve “hard and painful work”, which might not be clear at the outset if patients are presented with abstinence versus moderation as their choice.

Conceptions of alcohol use problems have changed in recent years. The American Psychiatric Association, for example, previously [classified](#) alcohol abuse and alcohol dependence as two distinct disorders in its Diagnostic and Statistical Manual of Mental Disorders, but in 2013 integrated these into a single ‘alcohol use disorder’, acknowledging a spectrum of experiences and symptoms within this ranging from mild, to moderate, to severe. This reimagining of drinking problems as a continuum throws up new questions about whether there can be a concrete point at which abstinence can become the preferable or only acceptable treatment goal.

[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".

Thanks for their comments on this entry in draft to Dr Peter Rice, Chair of the Scottish Health Action on Alcohol Problems (SHAAP). Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 24 January 2017. First uploaded 06 March 2011

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