THE ROLE OF THE CONTROLLED DRINKING GOAL IN THE RESPONSE TO ALCOHOL-RELATED HARM

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‘RESUMED NORMAL DRINKING’


• ‘The magnificent seven’ – paper caused huge furore

• But several findings of a similar nature had appeared during 1950s and more appeared during 1970s

• Davies’ findings later challenged by Griffith Edwards:
BEGINNINGS OF ‘CONTROLLED DRINKING TREATMENT’

- Participants were 70 ‘gamma’ alcoholics (ie, with loss of control, tremors, blackouts & DTs)
- Randomly allocated to CD-E, CD-C, ND-E, ND-C
- IBT consisted of 17 sessions that included videotaped replay of drunken behaviours, electrical avoidance conditioning, stimulus control training, problem-solving skills training and regulated drinking of alcohol
- Results showed that, at 1- and 2-year follow-ups, CD-E participants showed significantly higher number of ‘functioning well’ days (ie, both controlled drinking and abstinence) than CD-C
- At 3-year follow-up, CD-E participants showed higher number of abstinent days
FIRST STUDY OF CONTROLLED DRINKING TREATMENT IN UK


- 37 problem drinkers (low to moderate severity of dependence) randomly allocated to minimal treatment (3-4 sessions assessment and advice) or intensive treatment (individually tailored cognitive-behavioural, sessions ~9.1). Two groups followed up 15.5 months after treatment.

- The intensive group reduced consumption significantly more than the minimal group. The intensive group had a higher number of abstinent days in the month prior to follow-up and females had an increased number of abstinent days compared to men.

- Intensive controlled drinking treatment is more effective than minimal treatment intervention.
CONTROLLED DRINKING

Nick Heather and Ian Robertson
with a foreword by D.L. Davies

“This is an admirably complete summary of the state of our knowledge..., with important implications for the future of alcoholism treatment. It should be studied carefully by every professional involved in the treatment and prevention of alcohol problems.”

W.R. Miller, The Behavior Therapist
CONCLUSIONS FROM ‘CONTROLLED DRINKING’

• With regard to the CD goal, treatment services should diverge in two directions:

• (i) A move towards ‘brief, didactically-structured interventions carried out by non-specialist personnel in community settings;

• (ii) A move towards ‘specialist intensive treatment – which may in some cases require residential care – where certain more seriously handicapped alcoholics may be given various kinds of help including regulated drinking practice.’
CONTROLLED DRINKING FRAUD?

- Sobells cleared of fraud by 3 independent inquiries
- Mark Sobell winner of Jellinek Award in 2002 and Linda Sobell is a highly respected scientist in alcohol field
Percentages of nonproblem drinkers and abstainers at 4 years following treatment for three levels of alcohol dependence (from *The Rand Report*, Polich, Armor & Braiker, 1980)
WHY IS ABSTINENCE NECESSARY FOR THE RECOVERY OF SOME PROBLEM DRINKERS?

• Question asked over 20 years ago (Heather, N. & Robertson, I. [1983]. *British Journal of Addiction*, 78, 139-144.)

• Given that there is no upper limit of dependence at which CD becomes impossible but given too that the likelihood of successful CD decreases as a function of level of dependence, how do we explain why abstinence seems to be necessary for some problem drinkers’ recovery?

• In the disease theory, the need for abstinence had simply been regarded as self-evident without the need for explanation.

• The question forms part of “paradigm shift” from seeing problem drinking as an irreversible disease to seeing it as an (in principle) reversible behavioural disorder, ie, from ‘alcoholism’ to ‘problem drinking’.
Imagine you are a severely dependent problem drinker after many years of heavy drinking. How difficult would it be to go into a pub, surrounded by all the cues to associated with drinking, and just stick to a couple of pints?

There is also evidence that craving for alcohol is potentiated by the interoceptive effects of small quantities (i.e., the threshold effect).

If we assume that a change of lifestyle is essential for recovery from severe problems, then abstinence is much more likely to begin and maintain this process.

But these explanations, while intuitively or clinically appealing, do not amount to a scientific account and do not prove that CD is impossible for severely dependent individuals.
THE CONDITIONING THEORY OF DEPENDENCE

• Is it possible that advances in science of alcohol dependence and resulting treatment techniques could increase the level of dependence at which successful CD becomes likely?

• Assuming that craving is a classically conditioned response to interoceptive effects of alcohol, we developed Moderation-oriented Cue Exposure [MOCE] (i.e., cue exposure with response prevention in lab and real-life settings) and compared it with Behavioural Self-control Training [BSCT] in a randomised controlled trial (Heather, N. et al. [2000]. *Journal of Studies on Alcohol, 61*, 561-570.)

• We hypothesised a) that MOCE would be superior to BSCT; b) there would be an interaction between treatment type and level of dependence such that MOCE became relatively more effective as dependence increased.

• Neither hypothesis confirmed. This could be because of poor theory or incorrect application of good theory.

• In either case, conclusion is that BSCT should not be replaced as standard method of treatment aimed at goal of CD.
INCENTIVE-SENSITIZATION THEORY


1) potentially addictive drugs share the ability to alter brain organisation;

2) the brain systems that are altered include those normally involved in the process of incentive motivation and reward;

3) the critical neuroadaptations for addiction render these brain reward systems hypersensitive (“sensitized”) to drugs and drug-associated stimuli;

4) the brain systems that are sensitized do not mediate the pleasurable or euphoric effects of drugs (drug “liking”), but instead they mediate a subcomponent of reward termed incentive salience (drug “wanting”);

5) sensitization is long-lasting.
THEORY OFINTRAPERSONAL BARGAINING


• Proposes a constant process of intrapersonal bargaining between short-term and long-term interests in the control of behaviour and between present and future selves.

• Abstinence provides a “bright line” for the implementation and evaluation of “personal rules”, whereas “moderation” does not.

• CD goal must be backed by unequivocal definition of acceptable drinking.
FOUR USES OF THE CD GOAL

1. Among the non-treatment-seeking population of hazardous and harmful drinkers
2. Among socio-economically deprived individuals who are unlikely to achieve either abstinence or harmfree drinking
3. Among treatment-seeking clients with low to moderate degrees of dependence
4. Among treatment-seeking clients with moderate to severe dependence
THE NON-TREATMENT-SEEKING POPULATION

- CD goal now accepted as part of opportunistic brief interventions delivered by generalists (e.g. GPs, probation officers, etc.)
- Work of Sanchez-Craig and others shows that advocacy of abstinence counterproductive among low dependence individuals
- Main advantage is obviously to increase accessibility and impact of brief interventions
- Although CD explicitly referred to in 1st report of brief interventions in general medical practice, reduced drinking after brief intervention no longer seen in this way
THE SOCIO-ECONOMICALLY DEPRIVED POPULATION

• Typically homeless individuals with little to gain from either abstinence or harmfree drinking
• Goal described by Mansell Pattison in 1970s as “attenuated drinking” – not “controlled drinking” in any meaningful sense
• This is “harm reduction” in true sense of term
LOW TO MODERATE DEPENDENCE CLIENTS SEEKING TREATMENT

• CD goal not controversial here in theory but proportions of clientele directed to CD in different countries will vary
• In UK surveys show that roughly 25% of treatment agency clientele on average directed to CD
• But this may have increased recently – see UKATT findings
MODERATE TO SEVERE DEPENDENCE
CLIENTS SEEKING TREATMENT

- Conventional cut-points for deciding whether or not to recommend CD – SADQ < 31; ICS2 < 25
- Two RCTs have shown that Moderation-oriented cue exposure (MOCE) does not improve on standard CD method (BSCT), though Sitharathan et al. reported different findings
- Thus, if a CD method exists that enables more severely dependent clients to benefit, it has not been discovered yet
ALCOHOL PROBLEMS

A Spectrum of Responses to Alcohol Problems
THREE TYPES OF PROBLEM DRINKER

• 1) Excessive drinkers with no or few alcohol-related problems and low levels of dependence (30% of males; 15% of females)

• 2) Those with definite alcohol-related problems but only moderate levels of dependence (8% of males; 4% of females)

• 3) Those with definite alcohol-related problems and severe dependence (2% of males; 0.5% of females)
THREE CLASSES OF TREATMENT/INTERVENTION

I: “brief interventions” in generalist settings

- Opportunistic interventions at the level of primary health care and other generalist settings among those not seeking help for alcohol problems (Type 1 problem drinkers)
- Consist of very brief information and advice (e.g. the 5 min simple feedback and advice used in WHO trial of brief intervention in primary care)
- Usually aimed at a goal of moderate (“safe”) drinking
- In this context, to recommend abstinence can be seen as harmful because:
  - likely to deter people from admitting problem, seeking help or acting on advice
  - less likely to produce successful outcomes
THREE CLASSES OF TREATMENT/INTERVENTION
II: brief treatment in generalist or specialist settings

• Briefer forms of treatment in specialist alcohol agencies or generalist services among treatment-seekers with moderately severe problems (Type 2 problem drinkers). “Shared care” could be used here
• Consist mainly of condensed forms of regular treatment (e.g. 3 hrs. of conjoint assessment and counselling as used by Orford & Edwards [1977] or 4 sessions Motivational Enhancement Therapy as used in Project MATCH
• Aimed at a goal of total abstinence or moderate drinking
• Choice of goal is a clinical decision based on level of dependence, severity and nature of problems, client preference and a range of other factors
THREE CLASSES OF TREATMENT/INTERVENTION

III: intensive treatment in specialist settings

• More intensive forms of treatment in specialist alcohol agencies among treatment-seekers with severe dependence and problems, including comorbidity and complex needs (Type 3 problem drinkers)

• Consist mainly of relatively prolonged forms of regular treatment (e.g. 12 sessions of cognitive-behavioural therapy as used in Project MATCH)

• Usually aimed at a goal of total abstinence

• Recommendation of moderation goal would only be made in exceptional circumstances, e.g. strong client preference for moderation
TREATMENT

Initial Preference for Drinking Goal in the Treatment of Alcohol Problems: I. Baseline Differences Between Abstinence and Non-Abstinence Groups

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Abstract — Aims: To compare baseline characteristics of clients initially preferring abstinence with those preferring non-abstinence at the screening stage of a randomized controlled trial of treatment for alcohol problems (UKATT) and to identify predictors of goal preference from client characteristics present before the preference was stated. Methods: From discussions with clients entering the trial (N = 742), screeners noted whether clients were aiming for abstinence ‘probably yes’ or ‘probably no’. Differences between the two groups thus formed were explored by univariate comparisons among client characteristics recorded at baseline assessment and by logistic regression analysis with pre-existing characteristics as independent variables. Results: Across all UKATT sites, 54.3% of clients expressed a preference for abstinence and 45.7% for non-abstinence. In univariate comparisons, clients preferring abstinence were significantly (P < 0.01) more likely to: (i) be female, (ii) be unemployed, (iii) report drinking more heavily but less frequently, (iv) have been detoxified in the 2 weeks prior to assessment, (v) report more alcohol problems, (vi) be in the action stage of change, (vii) report greater negative expectancies of drinking, (viii) report greater mental and physical ill-health, (ix) report less social support for drinking and (x) be more confident of their ability to resist heavy drinking in tempting situations. In the logistic regression model, the strongest predictors of goal preference were gender, drinking pattern, recent detoxification and social support for drinking. Conclusion: The implications of these findings for service delivery are best considered in conjunction with findings from a companion paper reporting treatment outcomes associated with each goal preference.
TREATMENT

Initial Preference for Drinking Goal in the Treatment of Alcohol Problems: II. Treatment Outcomes

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Abstract — Aims: To compare treatment outcomes between clients preferring abstinence and those preferring non-abstinence at the screening stage of a randomized controlled trial of treatment for alcohol problems (the United Kingdom Alcohol Treatment Trial) and to interpret any differential outcome in light of baseline differences between goal preference groups outlined in an accompanying paper. Methods: Outcomes at 3 and 12 months’ follow-up were recorded both in categorical terms (abstinence/non-problem drinking/much improved/somewhat improved/same/worse) and on continuous measures (percent days abstinent, drinks per drinking day/dependence score). Results: Clients initially stating a preference for abstinence showed a better outcome than those stating a preference for non-abstinence. This superior outcome was clearer at 3 months’ follow-up but still evident at 12 months’ follow-up. The better outcome consisted almost entirely in a greater frequency of abstinent days, with only a modest benefit in drinking intensity for goal abstainers that disappeared when baseline covariates of goal preference were controlled for. Type of successful outcome (abstinence/non-problem drinking) was related to initial goal preference, with clients preferring abstinence more likely to obtain an abstenent outcome and those preferring non-abstinence a non-problem drinking outcome. Conclusion: The client’s personal drinking goals should be discussed in assessment at treatment entry and as a basis for negotiation. Clinicians should be prepared to identify and support goal change as an unexceptional part of the treatment process that need not jeopardize good outcome.
OTHER ISSUES

- Mutual aid groups
  - Moderation Management
  - Not SMART Recovery

- Computer/ Internet-based programmes
  - Work of Reid Hester on computer versions of BSCT
  - Online self-help programmes (eg, Down Your Drink in UK)
  - e-health interventions & web-based support groups

- Nalmefene – 2 RCTs claim evidence of a small but clinically significant reduction in the number of heavy drinking days
DRINKING GOAL RECOMMENDATIONS (1)

- Goal choice is an essentially clinical decision, depending on the unique characteristics and preferences of the individual client.
- Acceptance of a client’s choice of drinking goal is more likely to result in a successful outcome.
- All other things considered, the CD goal should be reserved for clients with less severe dependence.
- The main advantage of recommending the CD goal to suitable clients is that more may be attracted into treatment who might be deterred by the prospect of lifelong abstinence.
• Specific drinking targets should be negotiated with each client but moderation can be defined for treatment purposes in terms of levels of low-risk consumption recommended by medical authorities.

• There are special circumstances in which the moderation goal is contra-indicated irrespective of level of dependence and where the abstinence goal should be preferred: liver damage; other medical problems that may be exacerbated by continued drinking; taking certain medications; pregnancy or an intention to become pregnant.
If a client has failed to achieve a goal of stable moderate drinking, the clinician should advise them to aim for abstinence. Conversely, if there have been failed attempts at abstinence, a moderation goal should be considered.

Some clients may be thought very unlikely to be able to sustain either abstinence or moderate drinking without problems, mainly because quality of life is so impoverished that a change in drinking offers few incentives. For these clients a harm-reduction approach should be adopted in which precedence is given to modest gains in health, work and social relationships over radical changes in drinking behaviour.