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Obstacles to the adoption of low risk drinking goals in the treatment of alcohol problems in the United States: A commentary

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Abstract
Although moderation and harm reduction approaches to the treatment of alcohol problems are accepted in many parts of the world, they continue to be rare in the US. A major reason for this state of affairs has to do with the way alcohol treatment services in the US developed, and in particular the creation of a group of paraprofessional counselors many of whom attributed their recovery to the 12-step philosophy. While it is unlikely that these counselors will offer moderation services, the provision of services to problem drinkers in primary care medical settings presents a promising alternative.

Keywords: *Alcohol, controlled drinking, moderation, treatment goal*

Introduction

Although moderation goals for individuals with alcohol problems has long been a controversial topic in the alcohol field in the USA (Marlatt, 1983; Sobell & Sobell, 1995), in other parts of the world moderation has become an accepted legitimate objective for some individuals (Rosenberg & Melville, 2005). This commentary is based on a presentation at a conference titled 'Controlled Drinking 30 Years On' (January, 2004) in Manchester, England. It offers possible explanations for the disparity in the way moderation goals are viewed in the USA and the UK, an issue that is clearly important but one that has not received much attention.

As discussed by others (Rosenberg, 1993; Saladin & Santa Ana, 2004), the disparity is not due to lack of research on moderation goals and outcomes,

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but rather to a lack of dissemination of research findings to clinical practice. However, whereas the gulf between research and practice usually relates to not adapting research procedures for use in community settings (Sobell, 1996), the present case is more complicated. Most importantly, many practitioners having a fervent belief in traditional concepts of alcohol problems, often crediting that approach with their own recovery (Pattison, Sobell, & Sobell, 1977). Because traditional concepts of alcohol problems do not allow for sustained moderation outcomes, the enormity of this impediment to moderation treatment cannot be overestimated.

Moderation: An evidential basis

The achievement of moderation outcomes and the use of moderation goals have been well researched and reviewed over the past 30 years and will not be reiterated in detail here (Heather & Robertson, 1983; Rosenberg, 1993; Saladin & Santa Ana, 2004). The collective literature, however, has yielded three conclusions that we put forth in 1995 and appear to have stood the test of time (Sobell & Sobell, 1995):

(1) Recoveries of individuals who have been severely dependent on alcohol predominantly involve abstinence.
(2) Recoveries of individuals who have not been severely dependent on alcohol predominantly involve reduced drinking.
(3) The association of outcome type and dependence severity appears to be independent of advice provided in treatment (Sobell & Sobell, 1995, p. 1149).

With respect to the last point, although therapists can offer advice, and clients may choose to follow that advice, in the end clients choose their own goals. In fact, the association between successful outcomes and dependence severity applies both to individuals in treatment and also to those who recover without treatment (Dawson et al., 2005; Sobell, Cunningham, & Sobell, 1996).

Additional support for moderation outcomes can be found in the way treatment success has been reported. For example, many outcomes are reported in the literature as reductions in drinking (Breslin, Sobell, Sobell, & Sobell, 1997). That is, change is reflected as improvement rather than total abstinence, using variables such as mean number of drinks per drinking day (Babor et al., 1994). Thus, although the goal is usually abstinence, published outcomes are reported in terms of harm reduction. For example, in a study of heavy drinking males who had diagnosed liver disease, Lieber, Weiss, Groszmann, Paronetto and Schenker (2003) reported that 'a monthly supportive visit to a team consisting of a medical nurse and a physician (gastroenterologist or hepatologist) was associated with a sustained decrease of alcohol consumption from an average of 16 drinks per day before enrollment to 2.5 drinks a day thereafter' (pp. 1761–1762). Reporting reduced drinking as an outcome category even for 'heavy daily drinkers' with diagnosed liver disease suggests that the failure to

more broadly consider low risk drinking as a goal or outcome of treatment is not empirically based.

Obstacles to acceptance of moderation goals

Until the 1970s when federal funding became available for alcohol research and treatment, scientists showed little interest in the alcohol field. It is not surprising, therefore, that prior to that time those who stepped forward to help were those who had alcohol problems themselves (Pattison et al., 1977). In a related regard, until the late 1960s nearly all alcohol treatment programs in the USA used a 12-step approach (Peele, 1989), represented largely by Alcoholics Anonymous (AA) and by the National Council on Alcoholism (NCA). Although AA was non-political, the NCA which included many AA members was politically active. In fact, the NCA became an early force in the field when the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was first established. The NIAAA was the first federally funded effort to counteract alcohol problems and with it came the first provision of federal funding for alcohol services.

When alcohol treatment services started to be supported by federal block grants to states, a workforce was needed to provide the services. For several reasons, health care professionals did not choose alcohol counseling as their profession. Rather, there developed a large group of 'recovering' alcohol counselors whose training, related to their personal recovery, was based on the then dominant Minnesota model (Cook, 1988). While the history of this large grassroots treatment industry has been documented elsewhere (Peele, 1989), what is noteworthy is that the development of the treatment industry coincided with the development of credentialing programs to provide counselors with legitimacy and credibility.

Although in most helping professions training is evidence-based and licensure is contingent on passing an evidence-based examination, the alcohol field has departed markedly from this model. As in many fields, there already existed an entrenched group of practitioners when credentialing was first introduced. However, unlike other professions, most of these practitioners had not been trained through professional schools. Rather than working to reshape the orientation of counselors to be consistent with the research literature, training embodied the traditional model of alcohol treatment (Pattison et al., 1977). For example, in the state of Illinois, the Illinois Alcoholism Counselor Certification Board (IACCB), in a 1985 statement explaining why it had changed the name of its certification system from alcoholism counselor to addictions counselor stated the following: 'The change was made because . . . IACCB wants to ensure that the accepted philosophy and practice of the profession of alcoholism counseling was applied to other additions counseling. That essential philosophy, simply stated, is: Alcoholism/addictions is a disease that requires abstinence for recovery, and family members are affected by this disease' (IACCB Action. Newsletter. Illinois Alcoholism Counselor Certification Board, Inc., 1985, 35, p. 2).

The result of this accommodation was that in the early 1990s a survey of 450 private-sector alcohol and chemical dependency programs in the US found that more than 93% were based on a 12-step model of treatment (Peele 1998). Although recent research suggests that treatment orientation may not be an important factor with regard to treatment outcomes (Allen et al., 1997), what is important is that in the US there developed a large and influential body of treatment providers whose allegiance was not only to a particular view but also at the level of strong personal beliefs associated with their personal recovery. Central to their recovery were the beliefs that they had lost the ability to control their drinking, that they must be forever abstinent, and that they must have faith that a higher power would help them because their 'own willpower has been defeated by alcoholism' (Nowinski, Baker, & Carroll, 1992, p. 2).

Given this context, it should not be surprising that moderation has not been embraced by an establishment that defines the disorder as based on powerlessness over alcohol and a key symptom of the disorder as denial that one has lost control over drinking (Pattison et al., 1977). Consequently, a factor that continues to hinder moderation goals has been that counselors invested in a 12-step model will be philosophically unlikely to adopt moderation approaches.

Despite the foregoing, the alcohol field has been evolving. For example, while 28-day inpatient treatments were once the predominant approach in the USA, outpatient treatment is now the accepted standard of care (McCaul & Furst, 1994). Interestingly, the main reason for this change was the lack of evidence that costly inpatient treatment was superior to outpatient services. As insurance companies became aware of this reality, and faced with serious needs for cost containment, insurers stopped inpatient funding ('HMOs Push Cheaper', 1996).

For the foregoing reasons, current alcohol treatment service providers in the USA are unlikely to offer moderation goals. However, some progress is occurring in other arenas. For example, a limited number of service providers in the USA now offer moderation services (http://www.behaviortherapy.com/moderat.htm#therapists). Also, Moderation Management, on a small scale at present, provides a self-help moderation alternative (Rotgers, Kern, & Hoeltzel, 2002). Further, as part of an increasing emphasis on health promotion and preventive services there has developed a data base supporting the provision of drinking reduction services in primary care health settings (Fleming & Manwell, 1999). Such approaches have many advantages. Although problem drinkers are unlikely to enter traditional treatment programs (Sobell & Sobell, 1993), a large majority will see their physicians at least annually (Kahan, 1996; National Center for Health Statistics, 2000). The focus in such programs has been on brief motivation interventions aimed at drinking reduction (Fleming & Maxwell, 1999).

When viewed as part of a stepped care model of health service delivery (Sobell & Sobell, 2000) moderation approaches are a reasonable first step for use with those who have no known medical or social (e.g. court order) contraindications to drinking. While this is a far cry from offering harm reduction services for more severe drinkers (harm reduction from the standpoint that reduced drinking will be associated with fewer consequences and less morbidity and mortality), it has the

potential to benefit a huge number of problem drinkers. Moreover, if such services do become commonplace, that could have an important effect on traditional providers by making salient that a large market exists for alternative services. Nevertheless, although change is on the horizon, widespread acceptance of moderation and harm reduction approaches in the US will be slow in coming.

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