It's a puzzle: why is longer treatment better for drug users but not for drinkers?

Reading the last issue of FINDINGS I was struck by the divide between recommendations for optimum treatment duration for users of alcohol compared to other drugs.

In the NTORS article there seemed to be a clear overarching theme that retaining drug users in treatment was linked to positive outcomes,[1] a theme echoed strongly in Philip Bean's article on coerced treatment which quoted evidence suggesting that "Length of exposure to treatment ... powerfully predicts [success] no matter what the treatment setting".[2]

In the very same edition, "How brief can you get?", dealing with interventions for alcohol users, espoused the long accepted view that "More treatment input does not always equate to better treatment outcomes".[3]

I am, of course, simplifying the divide between the two positions. The articles relating to drug treatment made it clear that duration is not the only factor, while that on brief interventions for alcohol users states, "there is no research justification for denying intensive support to drinkers with severe alcohol ... problems".

However, the divide is marked enough to be of great interest and has led me to ponder the reasons behind it. One possibility is that alcohol users who present for treatment are seen as having less entrenched and severe difficulties. Although some people do present in the early stage of their drinking careers (as do drug users), the three studies featured in the brief interventions review ensured that their subjects were heavy and dependent drinkers.

I would be interested to hear other readers' opinions on this issue, particularly how they interpret the evidence base in relation to problem users of *both* alcohol and other drugs – particularly relevant given that the alcohol use outcomes in NTORS (and the US equivalent DATOS) seems to be among the most questionable and disappointing.

Colin Bradbury

Research, Outcome Monitoring and Evaluation Manager, Alcohol and Drug Services, 87 Oldham Street, Manchester M4 1LW.

1. Ashton M. ANTORS.@ Drug and Alcohol Findings: 1999, 2, p. 16B22.
2. Bean P. APressure pays.@ *Drug and Alcohol Findings*: 1999, 2, p. 4B7.
3. Drummond C., et al. AHow brief can you get?@ Drug and Alcohol Findings: 1999, 2, p. 23B29.

AHow brief can you get?@ author replies

In his letter prompted partly my FINDINGS article on brief interventions for drinkers,[1] Colin Bradbury has highlighted both a gap in the literature and provided an opportunity to address some common misinterpretations of the research evidence.

Drug evidence patchy

As Colin points out, in the alcohol field brief motivational interventions have been widely studied and there is good evidence for their efficacy, but there has been very little similar research in relation to drug misusers,[2] yet there is no evidence to suggest that problem drinkers presenting for treatment have less severe or entrenched problems than drug misusers.

One study found that after a brief motivational intervention methadone maintenance patients had fewer drug-related problems and a greater commitment to abstinence (compared to an educational control condition), but no differences were seen on some outcomes, including severity of opioid dependence.[3] Two studies have found benefits of a brief intervention for long-term benzodiazepine users, including up to a two-thirds reduction in drug use.[4 5]

As in the alcohol field, the evidence from randomised controlled trials (such as it is) is somewhat mixed in relation whether more intensive counselling interventions are more effective than less intensive interventions for treatment-seeking illicit drug users. With some exceptions, there is no clear advantage for more intensive psychotherapy. However, compared to the alcohol field the research base is underdeveloped and none of the studies was conducted in the UK, so the findings may not apply here.

In the context of methadone maintenance treatment, a comparison of two more intensive, structured therapies (cognitive behavioural and supportive expressive psychotherapy) against basic drug counselling found that at 12-months follow-up they produced better outcomes in terms of drug use, criminality, employment and psychological symptoms; more psychotherapy appeared better than less.[6]

However, a later study by the same group matched supportive expressive psychotherapy and drug counselling for intensity in terms of the time input by the therapists, yet still found an advantage for the more structured therapy.[7] In other words, the differences seen in the earlier study could have been due to the *type* of therapy rather than its intensity. Consistent with this interpretation, another study found no advantage for intensive individual psychotherapy over ›low contact‹ counselling[8] and another no difference between twice weekly cognitive behavioural sessions and a more intensive five day a week day programme.[9]

One randomised controlled trial involving methadone maintenance clients did find that at six-month follow-up more intensive psychotherapy was associated with better outcomes.[10] Three intensities were tested from minimal input to an Aextended@ behavioural intervention incorporating additional Aprofessional and vocational services@. However, it is unclear whether the results were solely due to the intensities of the treatments, or also/instead to their relative quality.

One common misinterpretation of the research evidence is to assume that variation in treatment *compliance* can be used to test treatment *intensity*. In both NTORS and DATOS clients retained in treatment for longer were self-selecting rather than being randomised to treatments of different intensity or duration. Better outcomes among those who stayed longer could be accounted for by, say, their greater motivation or better prognosis rather than the intensity of treatment. This is why randomised trials are so important: they ensure that as far as possible patients in the different samples are reasonably well matched in terms of important factors predictive of outcome, including motivation.

Another common misconception, highlighted in our FINDINGS article[11] and in earlier reviews,[12 13] is that brief alcohol intervention and intensive treatment studies are comparable. Typically (though not exclusively) brief intervention studies involve minimally dependent, early stage excessive drinkers, identified through a screening programmes; intensive treatment studies typically involve patients seeking treatment for severe alcohol dependence.

Intensive treatment studies typically exclude more complex, problematic patients. so we cannot assume that the results will generalise to the wider treatment population.

For both these reasons the existing evidence base does not support denying intensive treatment to people with severe or complex alcohol problems. The same appears to be true of drug misuse.

There is definitely a need for more research on the effectiveness of brief interventions for illicit drug misusers. As is often the case, the absence of evidence may be due to the absence of research rather than the ineffectiveness of the interventions. As they have for alcohol misuse, brief interventions may yet find an important place in the overall treatment response to illicit drug use.

Colin Drummond

Psychiatrist specialising in alcohol treatment at St George's Hospital in London and co-author of AHow brief can you get?@ in FINDINGS issue 2.

---

1. Drummond C., *et al.* AHow brief can you get?@ *Drug and Alcohol Findings*: 1999, 2, p. 23B29.

2.Heather N. AInterpreting the evidence on brief interventions for excessive drinkers: the need for caution.@ *Alcohol and Alcoholism*: 1995, 3, p. 287B296.

3. Saunders B., *et al.* AThe impact of a brief motivational intervention with opiate users attending a methadone programme.@ *Addiction*: 1995, 90, p. 415B424.

4. Cormack M.A., *et al.* AEvaluation of an easy, cost effective strategy for cutting benzodiazepine use in general practice.@ *British Journal of General Practice*: 1994, 44, p. 5B8.

5. Bashir K., *et al.* AControlled evaluation of brief intervention by general practitioners to reduce chronic use of benzodiazepines.@ *British Journal of General Practice*: 1994, 44, p. 408B412.

6. Woody G.E., *et al.* APsychotherapy for opiate addicts: does it help?@ *Archives of General Psychiatry*: 1983, 40, p. 639B645.

7. Woody G.E., *et al.* (APsychotherapy in community methadone programs: a validation study.@ *American Journal of Psychiatry*: 1995, 152, p. 1302B1308.

8. Rounsaville B.J., *et al.* AShort-term interpersonal psychotherapy in methadone maintained opiate addicts.@ *Archives of General Psychiatry:* 1983, 40, p. 629B636.

9. Avants S.K., *et al.* ADay treatment versus enhanced standard methadone services for opioid dependent patients: a comparison of clinical efficacy and cost.2 *American Journal of Psychiatry*: 1999, 156, p. 27B33.

10. McLellan A.T., *et al.* AThe effects of psychosocial services in substance abuse treatment.@ *Journal of the American Medical Association:* 1993, 269, p. 1953B1959.

11. Drummond C., *et al*, 1999, op cit.

12. Heather N., 1995, op cit.

13. Drummond D.C. AAlcohol interventions: do the best things come in small packages?@ *Addiction*: 1997, 92, p. 375B379.