

Volume Five: Interventions

Introduction

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As we saw in volume one, different societies have responded in very different ways to the use and problem use of drugs and alcohol. The papers in this volume are confined to relatively contemporary forms of intervention and, on the whole, to interventions emerging from and implemented within western industrialised societies. This has resulted, at least partly, from the emphasis placed on *evidence based* interventions, the proliferation of research studies aiming to provide evidence of efficacy and effectiveness and the growing impetus towards transference of intervention models and approaches globally. The choice of papers reflects the existing biases in research funding, the geographic source of research funding, research methods, and publication opportunities. (For a critique of the dominance of ‘evidence based practice’ and its impact on the knowledge base of policy and practice cf. Glasby and Beresford 2006; Holmes *et al.* 2006). The papers include discussion and examples of interventions which aim to prevent substance use or to prevent the onset of harmful use, interventions which aim to reduce the harms associated with substance use, and interventions which provide a treatment response. This collection does not include purely regulatory or criminal justice interventions as these approaches were included in other volumes. However, before turning to these mainstream approaches, two papers are included which remind us that there are many different ways of managing substance use and that, very often, there is no recourse to formal prevention or intervention programmes.

In the first paper, *Jilek 1994* presents a discussion of traditional non-western healing approaches to prevention and treatment. The approaches derive from religious traditions and from amalgamations of non-western traditional practices with Christian faith healing and culturally adapted mutual aid group approaches. Jilek defines *traditional healing* as ‘non-orthodox therapeutic practices based on indigenous cultural traditions and operating outside official health care systems’. Importantly, given the biases mentioned above, the approaches are not founded on ‘a positivist

system of logico-experimental science': rather they reflect and are validated by experience. The paper describes a range of approaches to the prevention and treatment of problem substance use from Asia (e.g. Hmong shamanic rituals), from North America (e.g. the Sweat Lodge), from Central and South America (e.g. *Espiritismo* – folk healing), and from southern Africa (syncretistic Afro-Christian cults). Jilek reminds us that even where there is access to modern health care, traditional practices survive and are often preferred, especially in treating psychosomatic and psychosocial aspects of health.

The second paper by *Klingeman, 2005*, a review of *self-change* research, challenges the belief that formal, professional treatment is necessary for recovery from problem substance use. Klingeman notes the considerable variations of meaning in the concept of *self-change* (or *natural recovery*) as used by clinicians, psychologists and sociologists, but what they have in common is the assumption that an unwanted condition can be overcome without professional help. Research indicates that only a small proportion of people resort to professional treatment: the majority recover or manage their substance use in other ways. For instance, some of the distancing techniques reported by users to manage their problems are noted by Klingeman; these include changing journeys to avoid pubs, imagining adverse effects, substituting other substances such as coffee or health products. However, processes of spontaneous recovery – which has some common features across addictive behaviours – have been neglected by research and this, Klingeman suggests, has important implications for treatment policy and practice (for an attempt to redress this cf Humphreys 2004). In conclusion, Klingeman argues for harmonisation of treatment programmes and interventions and provides some examples of ways in which the natural recovery process can be enhanced through interventions such as the provision of self-help materials (for a classic paper on natural recovery cf Vaillant and Milofsky 1984).

The following sections include papers which illustrate some of the major mainstream intervention approaches in prevention, harm reduction and treatment. It is a highly selected sample but, as with the two publications above, many of the papers provide

overviews of the emergence and development of different interventions and may open the door to further reading.

Prevention

The meaning of the term *prevention* has changed and broadened over time. Typically three main categories of prevention have been distinguished: primary prevention (to prevent the onset of a condition or problem), secondary prevention (to stop or delay the development of further problems or harm) and tertiary prevention (to arrest or delay progression – e.g. relapse prevention). However, as Starfield *et al.* (2008) have noted, the term is also applied to interventions to reduce risk factors and to prevent the emergence of predisposing social and environmental conditions. There is, as mentioned in volume 2, a very wide range of theories informing prevention and intervention approaches. Depending on the theory underpinning preventative activity, the target group may be the individual or the population as a whole or a particular group of people deemed to be *at risk* or it may be the environment within which the risk behaviour occurs. School based programmes or self-help leaflets, for instance, target individuals and aim to influence the individual's knowledge, attitudes, intentions or behaviour. Media awareness campaigns target populations nationally or in a particular geographical area or specific groups, such as women. Screening programmes aim to identify specific *at risk* groups or individuals. Changing the design of public bars or improving street lighting may target the environment to tackle alcohol related problems in the night time economy. While much policy emphasis in recent decades has focussed on individual lifestyles and aimed to change individual behaviour, a different interpretation of the public health perspective has emphasised the need for universal preventive measures aiming to reduce (or prevent) consumption and reduce risk at population level. Babor *et al.* (2010), for example, have argued that, in the case of alcohol, the evidence is in favour of universal measures such as increases in price and taxation and restrictions on availability. The authors claim that some of the more frequently implemented prevention approaches, such as education and public awareness campaigns, are less well evidenced.

Clearly, adequate coverage of all the different facets of preventative intervention is not possible in this volume. Population based regulatory responses (such as taxation) have been included in other volumes (for example, Stockwell *et al.*, 1996, in volume 3; and Brand *et al.*, 2007, and Wagenaar *et al.* 2010, in volume 4). Here, we illustrate two main approaches, programmes delivered in school settings which target individual behaviour, and programmes which seek change at community level.

The provision of school-based programmes to influence substance use behaviour is a contentious topic. The conclusion emerging from past reviews and evaluations, that education on substance use is ineffective (e.g. Babor *et al.* 2010), has been challenged in more recent reviews and programme evaluations (e.g. Cuijpers 2002, Teesson *et al.* 2012; Midford *et al.* 2012; McKay *et al.* 2012: cf also Foxcroft and Tservadze 2012 in volume 3). The picture is obscured by the complexity of the programme evaluations which employ a wide range of outcome measures ranging from increased knowledge and awareness to behaviour change measures, the latter including, for example, delayed onset of drinking/smoking/other drug use, achieving abstinence, consuming less, fewer binge drinking sessions, reducing associated harms etc. Choice of realistic goals has been proposed as a necessary element of successful intervention (Midford *et al.*, 2012). Other research has attempted to identify successful elements of school based educational programmes, resulting in several menus of options to guide programme design. Summarising the conclusions from reviews, Van Der Krieft *et al.* (2009), for instance highlight that:

- programmes using interactive delivery methods are more effective
- programmes based on the ‘social influence model’ are the most effective
- focus on norms, commitment and intentions not to use are effective components
- the addition of community interventions increases the effects of school-based programmes
- the use of peer leaders may strengthen the effects, and
- adding life skills to programmes may strengthen the preventive effects.

As the list of options suggests, school based programmes can also be seen as part of a *multi-component approach* to prevention where intervention in the school setting is supported by, for instance, a family component, or a peer led component, or a community media component. These components have also received considerable research attention, also with mixed results (e.g. Mellanby *et al.*, 2000; Foxcroft and Tsertsvadze, 2011).

The paper by *Botvin and Griffin 2007* reviews school-based programmes to prevent alcohol, tobacco and other drug use. Botvin and Griffin start by sketching out the prevalence of substance use and misuse in the USA and internationally. They then provide an overview of the developmental transitions between early adolescence and young adulthood and highlight key factors associated with onset and progressive use of substances. Against this background, they discuss how prevention programmes can be guided by knowledge and understanding of developmental processes. The paper includes a brief outline of research on some common school-based prevention approaches (social resistance skills, normative education, and competence enhancement); it provides details of prevention programmes aimed at different age groups and concludes with a discussion on the characteristics of effective drug prevention programmes, (cf McAlaney *et al.*, 2011, for a fuller discussion of the *social norms approach* which has recently grown in popularity).

The issue of cultural transference of programmes has received increasing attention as major programmes are more frequently implemented in contexts which differ from the settings where they were developed and evaluated. Examples of discussion and accounts of adapting programmes can be found in McKay *et al.* 2012 (adapting an Australian programme to Ireland); Allen *et al.* 2007 (adapting a USA programme to the UK); and Karnell *et al.*, 2006 (adapting a USA programme to South Africa).

A different approach to prevention is illustrated in the paper by *Holder, 2000*. In discussing prevention activity which addresses the whole community, Holder makes an important distinction between the community as a *catchment area* – where different population groups or behaviour patterns are the target for interventions – and the community as an *interactive system*. In the latter case, action is directed towards changing the community structures that provide the context for harmful substance use. The problem, Holder suggests, is created by the system rather than the individual and preventive action must address the issues through changing local policies, tackling the supply rather than solely the demand for substances and influencing community processes. The systems theory underlying this approach is discussed, in this paper, in relation to alcohol and Holder provides a number of international examples of community level action to reduce alcohol-related problems. Typically, this approach involves *multi-component* programmes with each component of the programme designed to address the issue in a complementary fashion. For example, Holder describes the Community Trials Project, which consisted of five components and aimed to reduce alcohol-related injuries and death through promoting structural changes rather than changing individual behaviour. Holder concludes that:

The evidence from controlled prevention trials at the community level demonstrates the potential of theory-driven, community environmental approaches to reduce local alcohol problems. Community action projects are just that, projects that seek to address the total community system and are not limited to a specific target or service group. These are efforts to involve community leadership in designing and implementing and supporting approaches to reduce problems across the community in total.

Harm reduction

Programmes which are labelled as ‘prevention’ very often include objectives to avoid or reduce associated harm, so that the boundaries between prevention and harm reduction become blurred. The concept of *harm reduction* has been applied in different – and contested – ways. The terms *harm reduction*, *risk reduction* and *harm*

minimisation are often used interchangeably but, Strang (1993:5) argues, these concepts are quite distinct. *Risk*, Strang suggests, ‘relates to the possibility that an event might occur; *harm* might be seen as the event itself or as relating to the event’. *Harm reduction*, can be operationalised through policies or programmes, for example, whereas *harm minimisation* is an end point to be aimed for. (cf also Riley and O’Hare ., 2000 for a fuller discussion of the emergence and definition of *harm reduction*). Stronach (2003: 31) identified five key elements that should underpin policies and interventions for alcohol harm reduction. These are applicable to other substances:

- Harm reduction is a complementary strategy alongside supply control and demand reduction.
- Its key focus is on outcomes rather than actual behaviours *per se*.
- It is realistic and recognises that the substance will continue to be used and will continue to create problems for some individuals and some communities.
- Harm reduction is non-judgemental about the use of the substance and is focussed on reducing the problems that arise.
- It is pragmatic – it does not seek to pursue policies or strategies that are unachievable or likely to create more harm than good.

The next five papers illustrate different aspects of harm reduction interventions and provide an introduction to the debates which surround this approach.

Stockwell, Single, Hawks and Rehm, 1997, present the argument, in the case of alcohol, for policy approaches which focus on reducing the harm associated with consumption rather than policies which aim to reduce total consumption. They recommend that greater efforts be made to measure and monitor hazardous or harmful drinking patterns. This, they suggest, will help to assemble appropriate evidence to mount effective prevention strategies. The potential for identifying and addressing harmful drinking patterns and its justification in clinical and population health terms is discussed by *Heather, 2012*. Heather argues that it is possible to screen for harmful

or hazardous drinking patterns and to offer brief advice to individuals who are not necessarily seeking help for their drinking. He documents the evidence in favour of this approach (tracing the origins back to a smoking intervention in the 1970s) and considers the arguments for universal or targeted screening and intervention. He also examines the potential for screening and brief intervention (SBI) to have an impact at population level, coming to the conclusion that, at the present time, such an effect is unlikely. This does not negate the usefulness of the approach and there is increasing use of SBI in different settings. (cf, for example, Dhital *et al.* 2013; Kaner *et al.* 2013; Coulton *et al.* 2012; Hermansson *et al.* 2010).

A broader overview of harm reduction strategies for alcohol, tobacco and other drugs is presented by Ritter and Cameron 2006, who look at the evidence for efficacy and effectiveness. As they note, harm reduction ‘is a very inclusive notion; it can readily accommodate a vast array of drug interventions and drug types’. In this paper, they focus on interventions that reduce harms but which do not aim to or operate through use reduction. With regards to alcohol, they examine research on harm reduction aimed at injury and violence, road accidents (drink driving) and social harms. With regards to tobacco, they look at efforts to make tobacco products safer and to reduce the risks to non-smokers. Harm reduction interventions for illicit drugs focus on the harm associated with injecting, the association with blood borne viruses and the risk of overdose and other injection-related harms. They point out that the illegal status of drugs is also a source of harm and that reducing these harms requires changes in regulatory systems. As well as reviewing the evidence on specific interventions, the authors comment on harm reduction as an overarching policy approach and conclude that, despite the fact that not all the evidence is positive and that there are problems of data interpretation, the data point to the effectiveness of harm reduction as a policy approach.

The above papers provide a good picture of the range of harm reduction interventions, of the debates surrounding the concept and its application, and of the evidence for efficacy and effectiveness. A specific example of one approach - needle and syringe exchange schemes (NSP) – is provided in the paper by Stöver and Nelles, 2003. Given

the prevalence of injecting drug use in prisons, Stöver and Nelles highlight the relevance of NSP to prison populations. Harm reduction measures, predominantly needle exchange projects, they argue, have been resisted and poorly developed in European prisons. The authors give examples of prison based needle exchange programmes in several European countries and summarise the results from evaluations of eleven projects in three countries. As the authors suggest, syringe exchange schemes in prison remains a 'hot topic', subject to political decisions and strategies and, although evaluations and experiences are encouraging, they remain 'a somewhat exotic' harm reduction approach in the prison setting. (For a review of needle exchange programmes in Switzerland, Germany and Spain which reached similar conclusions about effectiveness cf Dolan *et al.* 2003). This paper by Stöver and Nelles draws attention to the contentious nature of harm reduction as a goal and of needle exchange as a specific approach. It also shows how acceptability of an approach may be contingent on the nature of the target group and on the setting in which the intervention is implemented.

As with the issues arising in the cross-cultural transfer of educational programmes, the transfer of harm reduction approaches and interventions across nations raises serious challenges. In 2010, the World Health Organisation (WHO) published a strategy to halt and reverse the HIV epidemic among people who inject drugs in Asia and the Pacific. The strategy document reports a varied response to the HIV epidemic among drug injectors and comments that efforts so far have not halted the spread of HIV or provided an adequate response to new problems such as co-infection with hepatitis C. Of the eleven countries in Asia with drug-related HIV epidemics, none, at the time, offered comprehensive harm reduction services. (There are some signs of change however: for example, the governments of Vietnam and China have introduced NSPs and China, Indonesia and Iran have expanded opioid substitution for heroin dependence). The lack of facilities in prisons was noted in particular. Barriers to the implementation of harm reduction services arising from lack of co-ordination between law enforcement and health approaches are highlighted. However, resistance to harm reduction approaches is by no means confined to developing or transitional countries. Wodak and Cooney (2006: 779) point to the United States, a country with a high incidence and prevalence of HIV, where adoption of needle exchange

programmes 'has been late and implementation slow because of explicit rejection of harm reduction and strong support for a zero tolerance approach to drugs'. (However here too there are signs of change - the Obama administration recommended removal of the federal ban on funding for syringe exchange services).

In Europe some countries have developed supervised injecting facilities in response to concerns about marginalised drug users and open drug scenes. Hedrich 2004 provides an account and description of consumption rooms – supervised locations where drug users can inject. Designed to reduce harms to the user and to the public, they have however aroused fierce controversy at international as well as national level.

Treatment

The provision of treatment for problem substance use through the medium of formal, professional services, often as part of health care, criminal justice or welfare systems, is a relatively new phenomenon. The papers in this volume provide accounts of some major developments in treatment and illustrate how research has shifted knowledge and understanding regarding key aspects of treatment such as its duration, intensity, location and goals.

In 1967, Edwards *et al.* published the results of a controlled trial in which male patients presenting for alcohol problems at a hospital clinic were randomly assigned to receive either in-patient or out-patient care. A year later, there were no significant differences between the two groups. In another classic paper, *Edwards et al., 1977*, reported a controlled trial which provided patients at a hospital alcohol clinic with either treatment as usual – several months of in and out-patient care – or one counselling session. When patients were followed up twelve months later, there was no significant difference in outcomes between the two groups. By showing that minimal treatment intervention could be as effective as a more intensive treatment regimen, the research paved the way for further work to explore the effectiveness and cost effectiveness of less intensive care. Similarly, research was underway which questioned the necessity of an abstinence goal for heavy, and even dependent, drinkers. Early studies such as Davies' (1962) follow up of 93 'alcoholics' challenged

the generally accepted view that no alcoholic could ever return to 'normal' drinking and opened the flood gates to much controversy, revealing a divide between 'scientific' and 'belief' based views of alcohol problems and treatment goals, (cf Edwards 1985 for a re-assessment of Davies' findings). The paper by *Sobell and Sobell, 1995*, reviews the evidence and the debate over what came to be known as *controlled drinking*. The paper considers why controversy gradually waned. Three main developments are discussed: the growth of epidemiological studies which identified a large number of people with low severity alcohol problems; introduction of the *alcohol dependence syndrome* concept; and consideration of alcohol as a public health concern. Research on the moderation of drinking thus became integrated into a broader model of alcohol problems, the drinking population was broken down into different categories and people with less severe problems became the focus of attention for moderation research. (We can see here the beginnings of trends which were to develop into screening and brief intervention approaches and lead to more differentiated interventions. Heather and Robinson, 1983, give an account of the shift towards a *problem drinking* approach). These classic studies provide examples of how standard treatment approaches are questioned, refined and changed over time. They illustrate how a shift took place from hospital based, mainly psychiatric, treatment to a greater range and variety of treatment approaches provided in the community by a wider group of professionals.

Although alcohol treatment is the subject of the studies discussed above, similar questions have been raised regarding the goals and methods of treatment for drug addiction. Three papers included in this volume consider substitution treatment. The substitution of illegal opiates with prescribed opiate derivatives or prescription heroin has been seen as addressing several aims: to retain the user in treatment and, therefore, offer a greater chance of recovery; to reduce crime associated with drug use; and to improve general health and social integration. The papers illustrate how these therapies have been extremely controversial and their implementation subject to political considerations as much as to the strength of evidence for their effectiveness.

At the time *Dole and Nyswander, 1965*, were writing, in countries where formal treatment was available, it was generally under psychiatric or medical supervision and abstinence was the desired goal. There was a lack of convincing evidence for previous approaches to maintenance treatment through narcotic dispensaries which had existed in the early 20th century in the USA. (. Hubbard 1920 gives an account of a New York dispensary and the reasons for its closure; and Edwards, 1965, considers the relevance of the American experience of treatment to the British context, commenting on narcotic clinics and on questions of maintenance dose). Dole and Nyswander describe a research study in which 22 male patients, following a period of hospitalised detoxification and stabilisation, were provided with methadone maintenance at daily outpatient attendance and, finally, allowed a degree of freedom to take home methadone for weekend use. The study was important in opening up issues around dosage and in providing credible evidence for the value of methadone maintenance. The story is taken up by *Jaffe and O’Keeffe, 2003*, who document the history of methadone maintenance treatment, noting the hostility and scepticism with which the approach was viewed in the early years (influenced by Anslinger’s vision, cf Kinder and Walker, 1986, in volume 1). Issues of diversion of methadone, iatrogenic methadone addiction, and accidental overdoses were arguments marshalled against the use of methadone (issues which remain pertinent to current debates on substitution treatment). Eventually, in the USA, new regulations were passed in 1972 which set the future framework for the use of methadone and similar opioid agonist drugs in the treatment of heroin addiction. Jaffe and O’Keeffe describe the continuing critiques and changes to the framework and to the regulatory agencies and, importantly, the struggle to reduce the burden of regulatory constraints on clinical judgement over the following thirty years. The introduction in the 1990s of buprenorphine (a partial opioid agonist) and the changes in regulations and regulatory agencies which followed illustrate the influence of political contexts and stakeholder interests and beliefs in determining drug treatment options.

In response to the needs of heroin users who were unable to benefit from opioid maintenance therapy, a few countries began experimental implementation of *heroin assisted treatment* (HAT). *Fischer, Oviedo-Joekes, Blanken et al., 2007*, describe these experimental projects in Canada, Germany, The Netherlands, Spain, Switzerland

(where the first study took place in 1994), and the UK.. They note the socio-political controversy around HAT (especially injection) and highlight the resistance to this treatment approach in most countries. The authors conclude that HAT is feasible, effective and safe as a therapeutic option but that, given the political resistance and the expansion and diversification of oral opioid maintenance therapies, HAT should be a 'last resort' option for users who have failed to benefit from other approaches. They suggest that rather than conducting new effectiveness studies, evidence based guidelines are required to assist matching addict profiles and needs to existing treatment options.

As these papers have indicated, treatment approaches changed rapidly in the second half of the 20th century as research and experimental approaches began to examine and question existing therapies and assumptions and as techniques and treatment options expanded. Another development which had a profound effect on treatment theories and the range of available treatment options was the increasing involvement and influence of clinical psychologists. The next three papers provide examples of approaches derived from psychological theory and insights.

In their book, from which the excerpt in this volume is taken, *Beck et al., 1993*, discuss a variety of cognitive models of addiction and suggest that cognitive therapies can be compatible with other treatment approaches. Cognitive therapy, the authors argue, has an emphasis on: identification and modification of beliefs which exacerbate craving; amelioration of negative affective states; teaching patients how to apply cognitive and behavioural skills and techniques; and helping patients go beyond abstinence and adopt new lifestyles. The excerpt in this volume details the therapeutic processes and techniques needed in delivering the approach.

Miller 1996 recounts the start of his work on motivational interviewing ('more a *style* of therapy than a set of particular techniques') leading to the development of the FRAMES elements of counselling and brief intervention (feedback, responsibility, advice, menu, empathy). He documents the line of research which has established motivational interviewing as a prominent technique within the substance use field and

broadened its application to programmes targeting a wider variety of problems. Motivational interviewing is one of the key aspects of the stages of change model (discussed in volume 2) employed to help the client move from one stage to another. But, how discrete are the stages? *D'Sylva et al., 2012*, describe the stages of change from pre-contemplation to contemplation to action to maintenance – although it is acknowledged that the process is not necessarily linear or uni-directional. They report the findings from a study which examined the usefulness of the stages of change model with a group of Australian prisoners. The results lead the authors to question the usefulness of a ‘stages of change’ approach and suggest other models including a *states of change* alternative in which stages can run concurrently.

Compulsory incarceration in treatment centres for lengthy periods of time, common in some countries, has been criticised by the World Health Organisation (WHO 2010). However, forms of *coercive treatment* have become more common. For instance, treatment as an alternative to prison is an option meted out by drug courts (predominantly in the United States). But is coercive treatment effective? Schaub *et al* (2011:246) consider *quasi-compulsory treatment* (QCT) which they define “as substance abuse/dependence therapy that is motivated, ordered, or supervised by the criminal justice system but that takes place outside of prisons”. Their study of QCT in five European countries concluded that “predictors of treatment retention were generally quite similar under both quasi-compulsory and voluntary treatment. More specifically, perceived medical pressure was of higher relevance than the often-believed legal pressure for predicting treatment retention in quasi-compulsory treatment”. (p 257). *Ashby et al., 2010*, examined the use of alcohol treatment requirements (ATR) meted out to dependent drinkers as part of a community sentence in the UK. As with coercive approaches to addressing drug related crime (for example, in the UK, Drug Treatment and Testing Orders and Drug Rehabilitation Requirements) the ATR aims at rehabilitation. In considering their findings, the authors raise an issue which is implicit in much of the treatment studies included in this volume: in assessing the success of an intervention, what are the appropriate treatment outcomes and impact? Outcomes, as *Ashby et al.* note, might include engaging in treatment, reducing alcohol intake, improving health and social functioning, and/or reducing threats to society. As the authors point out, the evidence

regarding the effectiveness of coercive treatment to change behaviour is unclear. They conclude that, 'Whilst debates and research around the ethics and implementation of coercive treatment remain important it seems that there is evidence that the ATR opens up a new pathway to identify and engage with individuals who have dependent, hazardous and harmful drinking patterns'.

With a wide range of treatment options to choose from, it seems sensible to ask whether patients could be matched to different treatment modes. *Project Match Research Group, 1997*, considered the 'matching hypothesis' which states that clients who are appropriately matched to treatments will show better outcomes than those who are unmatched or mismatched. The objective was to determine if subgroups of alcohol dependent clients would respond differently to three different types of treatment: cognitive behavioural coping skills therapy, motivational enhancement therapy, and twelve step facilitation therapy. This large-scale, randomized, clinical trial found that, with the exception of psychiatric severity, there was no convincing evidence of major treatment matching effects for the three approaches in the trial. However, they did find that, 'the striking differences in drinking by clients from pre-treatment levels to all follow-up points suggest that participation in any of these treatments will be associated with substantial and sustained changes in drinking'. Project MATCH did not have a no-treatment control group but the conclusion that treatment is better than no treatment has generally been supported by research. The final paper in this volume by *McLellan et al, 1982*, indicates the long standing concern with issues of treatment effectiveness for problem use of both alcohol and drugs. This classic paper describes a study to examine treatment effectiveness for 879 male patients admitted to hospital for alcohol or drug use problems and to investigate to what extent any improvements were due to treatment. At six month follow up, both alcohol and drug users showed improvements in several outcome measures, especially in the target behaviours of alcohol and drug use. Comparing the treatment sample with a sample of patients who had received shorter term treatment, the study findings supported the conclusion that positive effects were due to the treatment received.

Conclusion

The papers in this volume provide a glimpse of the many and varied responses to problem substance use which have been adopted over the past fifty years or so and illustrate the factors which have led to changes in prevention, harm reduction and treatment interventions. While new approaches and techniques have resulted from research evidence, many approaches have proved to be controversial and the papers in this volume have shown the extent to which decisions are often politically determined. The controversial nature of issues in the drug and alcohol field and the continuing emergence of new trends in drug use and responses to drug and alcohol use are the focus of the papers in volume six.

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