Gerhard Bühringer Draft 01.02.2005

Towards a comprehensive treatment strategy: The role of specialist services

Seiten:	1
Zeichen (mit Leerzeichen)	31593
Zeichen (ohne Leerzeichen)	27009
Words:	4676

Introduction

The paper will present an overview on treatment in specialist services in Europe. Unfortunately we are confronted with two obstacles: (1) in contrary to the specialist treatment service for drug dependents (see European Monitoring Centre for Drug Dependence, 2003), we have no systematic data collection on the amount, type and quality of specialist services; (2) qualitative and/or selective overviews from the past years show an extremely high diversity of specialist services in terms of all relevant descriptive aspects, e. g. settings, patients, staff or type of interventions (see Klingemann, Takala and Hunt, 1992, WHO, 1993, Gossop, 1995; on a more general level Babor et al., 2003). For the information given in this paper one has to rely on two sources: (1) information based on publications like country reports and overviews about selected European countries. Incomplete information and lack of data comparability because of lacking descriptive standards are major problems of this approach; (2) the second source is scientific research about the relevance of major components of specialist treatment services, like treatment modality or duration of treatment. Problems of this approach are inconsistencies of outcome data and overrepresentation of studies from the United States respectively English language publications. It is often questioned if the specific cultural context of these studies from the U.S. or Australia are comparable with the variety of cultural conditions in European countries. In addition many of these studies have high exclusion criteria, so conclusions are difficult to generalize to the full spectrum of alcohol dependent clients in treatment. All together a rational and comprehensive description and analysis of specialist treatment services in Europe is limited.

The following five chapters each cover one major conclusion from the present situation of specialist services in Europe, based on the mentioned descriptive publications and the international scientific literature on treatment characteristics and outcome.

1. Specialist services are needed for the care of severe cases of alcohol related disorders, but are often not adequate linked with other professional and non-professional help options

1.1 Terminology

Specialist services are defined as facilities which have a special care focus for alcohol related disorders, partly within a broad range of substance use disorders. Services include one or more of the following options: information and counselling, medical treatment of alcohol related diseases (e. g. liver diseases) and the dependence syndrome (e. g. anti-craving-substances), psychological treatment (e. g. relapse prevention training) and social support (e. g. housing). Settings are either outpatient or inpatient, sometimes on a day care basis.

“Outpatient”, “inpatient” and “patient” are used as general terms for both medical and psychosocial settings to save space. But one has to keep in mind that these terms differ widely between settings and countries (e. g. ambulatory, residential or client).

1.2 The need for specialist services

Long term use of alcohol beverages beyond specified levels bears the risk to develop chronic disorders with negative consequences on the mental, somatic and social level. Family members and friends, self-help groups and professionals in the general health, educational and psychosocial care system are sources for advice to the individual to modify hazardous or harmful alcohol use patterns. But there are levels of alcohol related disorders where *advice* from general health care professionals will not lead to a subsequent change of the problematic behaviour. It is widely accepted, that specialist

services are needed for these cases. All European countries provide some type of specialist services for severe alcohol related disorders.

There are no clear cut criteria for the referral to either self-help groups, general health care or specialist services. Often an ICD-10 alcohol dependence diagnosis (F 10.2) will be used as a cut-off point for specialist services. But this working definition does not reflect the full range of expert opinions and administrative regulations in Europe. For instance, there are some recent arguments, that even severe alcohol dependent patients with no abstinence motivation might also be treated in the general health care – in the philosophy of harm reduction – to *reduce* alcohol consumption and related problems. On the other side even patients with the diagnosis "harmful use" (ICD-10.1) are treated in specialist services, because of a lack of expertise of modern types of early intervention or a lack of adequate working conditions in the general health care.

1.3 The relevance of specialist services

In the early decades of the last century treatment for alcohol problems was predominantly inpatient in Europe (mostly run by NGO´s outside the medical services). Treatment of this kind was only available for severe alcohol dependence. Beyond moderation or abstinence movement NGO´s there was no public alcohol policy in terms of prevention or early intervention, with the exception of Scandinavian countries. Even after World War II, the care system was nearly identical with specialist treatment services, and continued to be predominantly inpatient. There was also an increasing interest and utilisation of outpatient services, but predominantly for advice, motivation and preparation for inpatient care. Inpatient treatment had traditionally a higher relevance in the central and northern European countries. Taken all together, specialist services, with the preference of the inpatient version, was the treatment of choice until the Eighties and Nineties of the last century. And the patient of central concern was the dependent, long term alcohol user with severe somatic, mental and social disorders.

In the last decades, with a different speed and impact between the European countries, the concept of a national alcohol policy started to become an important issue, probably stimulated by a major publication on this topic (Edwards et al., 1994). In Germany, for example, the term "alcohol policy" (contrary to drug policy) was uncommon and no concept of a German alcohol policy existed at the time of publication of the German version of Edwards et. al (Edwards et al. 1997). Only recently some first aspects of a national alcohol policy have been published by the German government (Bundesministerium für Gesundheit und Soziale Sicherung, 2003).

Among others the concept of a national alcohol policy (1) broadened the view from the severe alcohol dependent patient to the wider concept of alcohol related disorders, (2) stimulated national efforts to estimate the size and type of population subgroups with different levels of treatment needs, (3) stressed the need for the implementation of prevention and early intervention activities for non-dependent alcohol problems, and finally (4) analysed much more critical than before the dominance of specialist, especially inpatient services and the scientific basis for many aspects of these services (e. g. type and duration of treatment). As a consequence from this new development, many traditional principles of specialist services were questioned, and parallel to the implementation of early intervention approaches in the general health care and better outpatient specialist services, the whole concept of "classical" inpatient treatment started a process of major "renovation". We observe today a much more careful process of allocating patients with alcohol disorders to early intervention approaches, specialist outpatient or inpatient services. But the progress of this development differs extremely between European countries.

1.4 The lack of cooperation

One major problem remains the lack of cooperation between outpatient and inpatient specialist facilities and – more general – between specialist and general educational, social and health care centres. Especially persons with hazardous or harmful alcohol use are inadequately screened, diagnosed and helped within their normal environment. The reasons are numerous: lack of knowledge and competence, doubts about the effectiveness of interventions, lack of time and interest, no financial support. Not until making a long and risky "alcohol career", persons receive adequate help, but often specialist care is needed then. On the other side specialist centres are not structural linked to general facilities in the different fields of society to provide the expertise which is needed for early identification and help.

2. Specialist services differ in many aspects

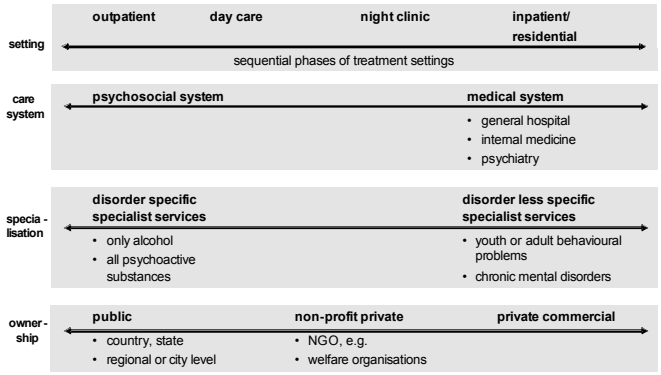
Even without a standardised survey about major characteristics of European specialist services it is obvious that they differ extremely between countries. This is true on a more general level for implementing a rational concept for early intervention services, specialist outpatient and inpatient services as well as for the progress to develop a national alcohol policy. But it is also true on a more specific level, as duration of treatment, treatment modalities, staff and staff education differ heavily in Europe.

2.1 Setting and ownership

Setting

Traditionally there was a dual system of specialist services with the dominance of inpatient settings and some outpatient services, the latter only with a preparatory function for inpatient treatment. At least in some countries more intensive day care programmes and "night clinics", where patients only stay over night, were implemented as additional options (Figure 1). Most recently new concepts have been tested with sequential phrases of treatment settings. That means, that on the basis of an individual analysis of alcohol related disorders in the specific case, patients are treated for certain aspects in different kinds of settings, according to a comprehensive treatment plan.

Figure 1: Differences in specialist services: setting and ownership



Type of care system

Specialised services are either located within a psychosocial system or within a medical system, either with specific wards in general hospitals, in internal medicine services, or most often in psychiatric facilities.

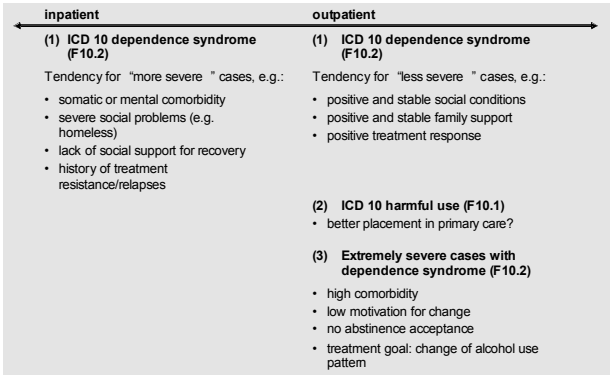
Intensity of specialisation
Some countries have specific services for substance use disorders, some even only for alcohol related disorders. Other countries treat alcohol problems within other specialist services, e. g. within facilities for youth or adult behaviour problems or with facilities for chronic mental disorders outside the psychiatry.

Ownership
In some countries specialist services are public owned (by very different public authorities), or they have a non profit private ownership (in some countries predominantly church-based welfare organisations) and others are private commercial companies. There are countries where one type of the ownership dominates and others where one can find all versions.

2.2 Patient and disorder profiles

In many countries there is no clear difference between patient characteristics, treated in outpatient or residential settings. Traditionally all patients in specialist services are characterised by the diagnosis of a dependence syndrome (F10.2); and there is at least a tendency to allocate patients to either inpatient or outpatient facilities according to the severity of alcohol-related disorders (Figure 2).

Figure 2: Differences in specialist services: patient and disorder profile s



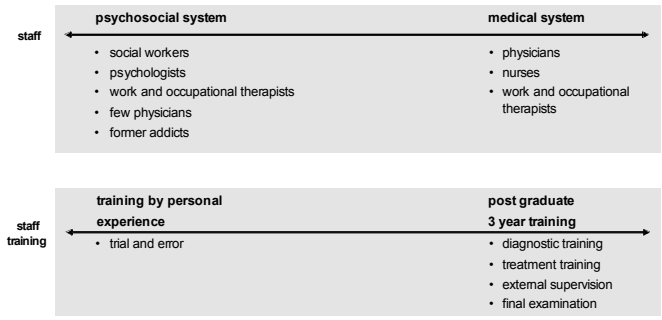
Outpatient facilities increasingly also treat patients with a diagnosis of harmful use (F10.1). It is questionable, if at least some of these patients would have been better treated in the general health care. The problem is, that in many countries this system is not prepared to treat patients with harmful alcohol use. Controversially discussed as a third group in outpatient treatment centres, are alcohol dependent patients with extremely severe additional disorders (comorbidity) and no motivation for abstinence. Under the concept of harm reduction some facilities try to reduce the negative consequences of dependent alcohol use without the primary goal of abstinence. At present, scientific evidence for this concept is unclear.

2.3 Staff and staff education

Type of professions
In accordance with the implementation of specialist facilities in either the psychosocial or in the medical system, professions of staff differ extremely (Figure 3). In the psychosocial system we have predominantly social workers, with a smaller group of psychologists, work and occupational therapists and very few (part time or external) physicians. In this system former addicts sometimes play a large role. In the medical system physicians and nurses dominate, in addition work and occupational therapist and usually few social workers and psychologists. There is no scientific evidence if a certain type of staff

composition is linked with more effective outcome. But in many cases, treatment in the medical system is more expensive.

Figure 3: Differences in specialist services: staff and staff education



Staff training

The qualification of staff in specialist services differ extremely in Europe. It can range from no training at all (experience based on "trial and error", Gossop, 1995) and a highly intensive post graduate diagnostic and treatment training with an external supervision and a final examination over a period of two or three years. In some countries standards are existing, e. g. imposed by financing organisations.

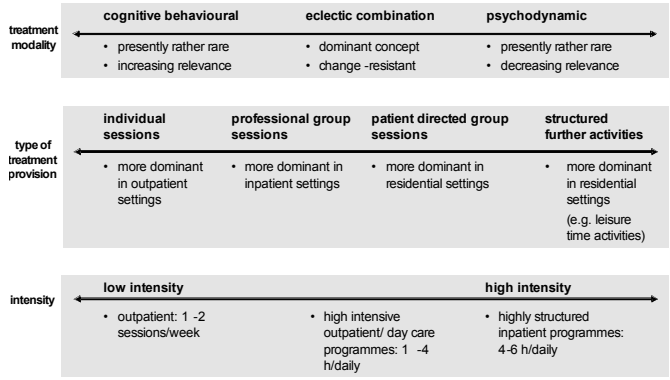
2.4 Treatment modalities

A major area of differences between treatment facilities in European countries are the type of treatment modality (treatment components or techniques) and other treatment related characteristics.

Treatment modalities

The traditional dominant concept in outpatient and inpatient services can be characterised by an eclectic combination of different treatment components, staff members with different types of alcohol specific training and a highly change-resistant treatment philosophy (Figure 4). There are few treatment facilities with a specific psychodynamic treatment concept, which seemed to have a decreasing relevance on an European prospective. On the other side there are also very few programmes with a strict cognitive behavioural approach. But it seems, that the proportion of this type of treatment modality increases in the last decades, probably influenced by publications on the scientific evidence for different treatment modalities.

Figure 4: Differences in specialist services: treatment modalities



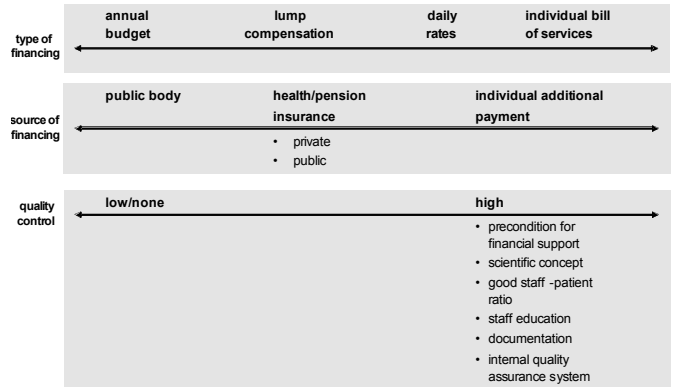
Type of treatment provision
Between and within treatment modalities we find a high variation of the type of treatment provision, e. g. in terms of individual sessions and professional or patient directed group sessions.

Intensity of treatment provision
Naturally outpatient facilities have a much lower intensity of treatment than inpatient programs. But especially high intensive outpatient/day care programmes can compete with residential treatment in the intensity of services, but on a lower cost basis.

2.5 Financing and quality control

Specialist treatment services are financed under a wide variety of concepts. On the one extreme, we have the annual budget for the whole facility, on the other extreme the individual bill for every specific service for a single client (e. g. for every individual or group session) (Figure 5). Lump compensations and daily rates are in between this groups.

Figure 5: Differences in specialist services: financing and quality contro l



Sources of financing
Again we have large differences between European countries. The cost might be funded directly by different types of public bodies, by health or pension insurances on a private or public base or by the individual patients themselves (total or additional payment).

Quality control
Very few treatment facilities have a well developed concept of quality control and quality improvement, including components like scientific concept, a good patient-staff–ratio, basic staff education and a system of continued education, a treatment documentation system and an overall internal quality assessment system. But there is an increasing pressure by financing organisations on the facilities to implement such a system.

3. Well designed specialist treatment services are effective, but expensive and have only low impact

3.1 Effectiveness

There is enough evidence that treatment will lead to better outcomes than no treatment (e. g. Timko et al., 2000, Moyer et al., 2002). From large multi-site treatment studies, narrative literature reviews and meta-analyses (e. g. Polich et al., 1981; Küfner & Feuerlein, 1989; Süß, 1995; PMRG, 1997 a, 1998 a; Sonntag & Künzel, 2000) we have also enough evidence that specialist treatment has a high and stable effectiveness

(Figure 6): over periods of about 3 – 4 years after treatment abstinence rates range between 30% and 60%. Results seem to be significantly better in Europe than in the US (meta analysis of Süß, 1995: 45% vs 31%), but with clearly longer treatment duration (14.7 vs 4.3 weeks).

Figure 6: Well designed specialist services are effective but expensive and have only low impact

Is any (specialist) treatment better than no treatment?			
☿ Yes (Timko et al., 2000; Moyer et al.,2002)			
Overall effectiveness of specialist treatment		1 year	3-4 years
• MEAT (K üfner & Feuerlein , 1989)	inpatient	53%	66%
• Rand Report (Polich et al., 1981)			28%
• Süß (1995)	inpatient	29%	25%
• Match (PMRG, 1997a; 1998a)	outpatient	19%	29%
• Sonntag & K ünzel, (2000)	inpatient	53%	
Costs (Germany; Pension Insurance, 2002)			
• outpatient			≈ 2.000 €
• inpatient			≈ 9.300 €
Impact			
• 2 – 4 % or less of F 10.1 / F 10.2			
Conclusions			
Specialist treatment for alcohol dependents is effective but exp ensive and has a low impact.			

3.2 Costs

Specialist services result in high costs: in 2002 the German Pension Insurance BfA, which finances specialist inpatient and outpatient treatment for alcohol dependence, calculated about 9,300 € for inpatient (average duration: 94 days, average daily rate: 99 €) and about 2,000 € for outpatient treatment. Data from the BfA support the cost-effectiveness of this type of specialist treatment: 5 years after treatment, 47% have been employed for the full period and 26% at times (and pay contributions for their pension), 79% needed no additional specialist treatment (personal communication). But in spite of their effectiveness and efficiency, specialist services in general are more and more confronted with two questions: (1) Can we increase effectiveness and reduce costs by implementing evidence-based treatment modalities and by improving other aspects of treatment settings (e. g. time in treatment)? (2) Can we reduce costs without loosing effectiveness by better allocating groups of alcohol related disorders to adequate treatment services, either to specialist outpatient instead of inpatient treatment or to the general health care instead of specialist services?

But one has to keep in mind, that general health care is not always cheaper than specialist services. Even early intervention strategies for hazardous or harmful use (F 10.1), which go beyond a simple advice and follow up control, might be more expensive in a private, profit oriented doctor's practice than in a non profit ambulant psycho-social facility, without the high system costs of medical services. But costs are only one aspect: patients in early problem stages often prefer a treatment in familiar settings and avoid the referral to specialist centres for "addicts".

3.3 Impact

Specialist treatment for severe alcohol related disorders is effective and probably also cost-effective, but has a low impact. 2% - 4% or less of the population with either F 10.1 or F 10.2 diagnosis will be treated in specialist services annually. Most countries will not be able to increase specialist services. This means that this type of service should be restricted to the most severe cases and that general services have to take more responsibility in the field.

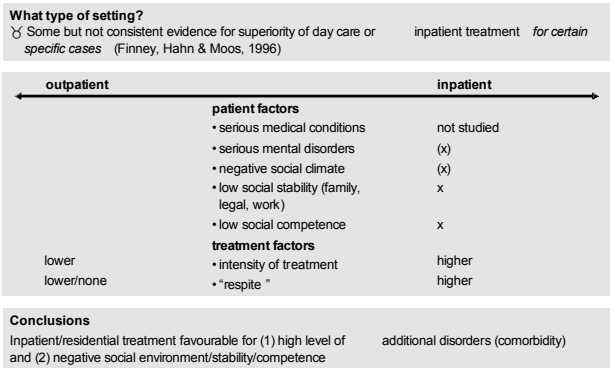
4. Scientific evidence requires improvements in major treatment aspects

The traditional type of specialist inpatient treatment could be characterised as a very long-term intervention (in Germany in the Sixties and Eighties 6 months and longer), an eclectic combination of treatment concepts without components of modern (cognitive) behavioural therapies, a low intensity of specific therapy sessions and a high relevance of unspecific leisure time and occupational activities. Scientific evidence questioned many of these major characteristics. As a consequence some facilities have implemented a more evidence-based treatment philosophy. But “tradition” plays a very important role, especially in specialist inpatient services. This is understandable if one keeps in mind, that in most European countries the whole concept of alcohol dependence treatment and the whole service system was implemented in the early 20th century by engaged laymen and NGO´s. But this long tradition also obstructed for many years the implementation of modern treatment philosophies and concepts. Therefore the pressure for improvements in this field often come from external forces, especially from financing bodies. It is still very difficult to overcome this resistance in treatment facilities without having a long term concept, economic support for the implementation of evidence based treatment components and also a good external and internal system of quality control and quality improvement. The following chapters present a brief overview on evidence for major treatment characteristics.

4.1 Type of setting

The need for inpatient treatment is obvious for certain disorder and patient profiles like severe somatic or mental comorbidity or homelessness. In addition inpatient or at least day care treatment is superior for cases with low social stability (family, legal situation, work), low social competences, probably also with a negative social climate (heavy drinking environment) and for cases with the need for high treatment intensity and a “respite” (consolidation of treatment efforts for the patient and the patient’s family) (Finney, Hahn & Moos, 1996; Figure 7).

Figure 7: Scientific evidence: type of setting

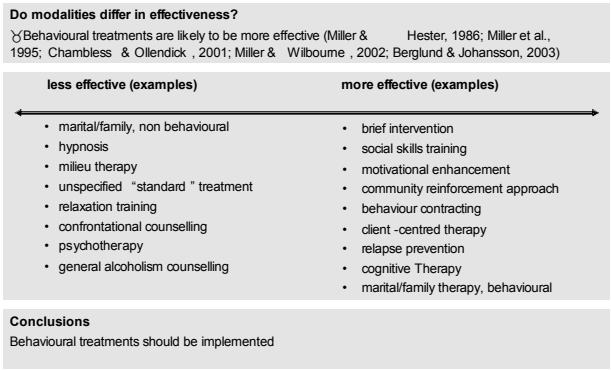


4.2 Treatment modality

Treatment modalities differ in effectiveness: a well based finding since the meta-analyses of Miller and colleagues (Miller and Hester, 1986; Miller et al., 1995; Miller and Wilbourne, 2002) and other groups (e. g. Chamblers and Ollendick, 2001; Berglund and Johansson, 2003). In general (cognitive) behavioural intervention techniques are more effective than unspecific counselling and other similar approaches (Figure 8). Effective modalities share the following characteristics (Miller and Wilbourne, 2002):

- Support of motivation for change (motivational enhancement, contracts, contingency management)
- Support of patient's activation to cope with alcohol problems (self management skills, coping skills, relapse prevention, self-efficacy)
- Social support (social competence skills)

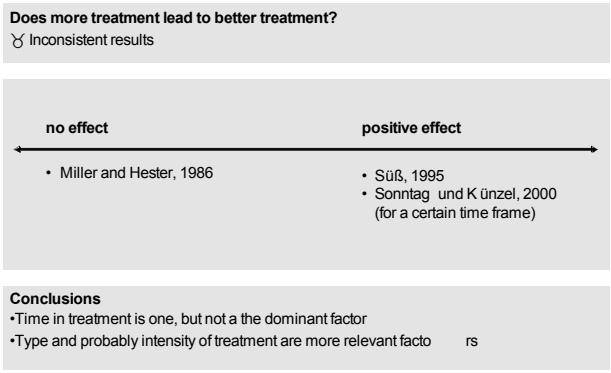
Figure 8: Scientific evidence: treatment modality



4.3 Time in treatment

Results are not consistent to answer the question if time in treatment has an impact on treatment outcome. US studies doubt a significant relation (e. g. Miller and Hesler, 1986), some European studies are in favour of a positive impact (e. g. Süß, 1995; Sonntag and Künzel, 2000), at least for a certain time frame (Figure 9). Probably the dominance of short treatment periods in the U. S. do not provide enough statistical variance for detecting significant effects.

Figure 9: Scientific evidence: time in treatment

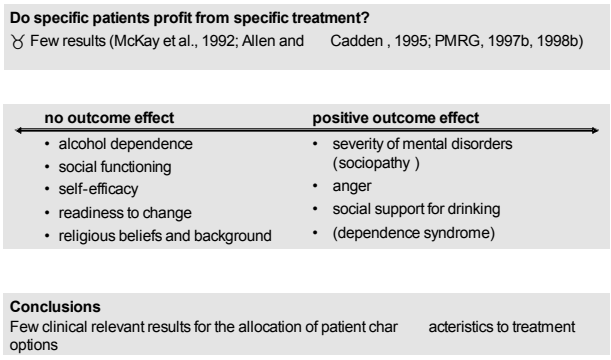


4.4 Treatment matching

It seems obvious that cases with specific patient or problem profiles might benefit from specific treatment modalities (in addition to more general allocation procedures to general or specialist, outpatient or inpatient services). But up to now research results on matching guidelines are not very promising (e. g. PMRG, 1997b, 1998 b; Figure 10): very few sociodemographic, personality, psychological or alcohol use related factors can be used for the allocation of specific treatment modalities or techniques. E. g. patients with an anti-social personality disorder do better with coping skills techniques than with

interactional approaches (Allen and Cadden, 1995). But research in this field is still in an early stage.

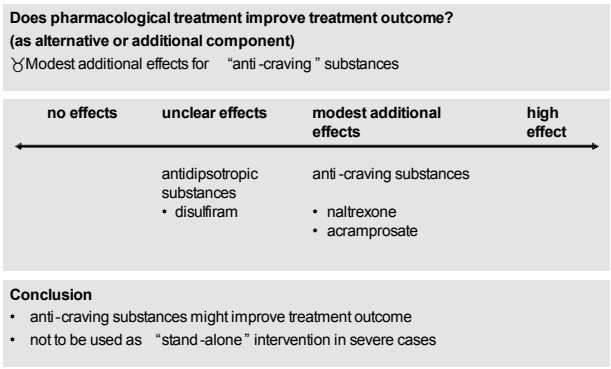
Figure 10: Scientific evidence: treatment and matching



4.5 Pharmacological treatment

The search for a simple, safe and effective pharmacological agents to treat alcohol dependence was not very effective up to now. Anti craving substances (e. g. acramprosate or naltrexone) and substances to produce a highly unpleasant reaction after alcohol use (e. g. disulfiram) have modest additional effects, especially for highly motivated patients (Figure 11). In general they should combined with other interventions.

Figure 11: Scientific evidence: pharmacological treatment



5. The challenge to specialist services: cooperation and quality improvement

Up to now European countries progressed differently on the way to implement a national public health concept for the prevention and reduction of alcohol related disorders in terms of (1) evidence based policy and intervention strategies (2) rational allocation of non specialist and specialist services to patient needs in different stages of alcohol related disorders. But all countries still have a long way to go in this process, and we need all efforts to stimulate a continuous process of quality assessment on the national, regional, local and facility level. Based on the present situation of alcohol specialist services in Europe and the scientific evidence for this type of facility, the following recommendations for the future development of specialist services can be derived.

5.1 Close cooperation between general and specialist services

Within a public health oriented national and European alcohol policy targeted help options should be available for different groups of persons with hazardous, harmful or

dependent alcohol use and additional mental, social or somatic disorders and problems. Within such a concept cases should receive adequate help (as a general term for all types of information, advice and interventions) in their “national environment”, e. g. in normal educational, social and general health care services. Specialist services should maintain close cooperation with these non specialist agencies to support the staff in early screening, diagnosis and intervention for cases with hazardous or harmful use. As long as possible these cases should be helped in their familiar settings.

5.2 Implementation of evidence based and cost-effective interventions for specialist services

Specialist services are needed for severe cases with alcohol related disorders. Based on scientific evidence many improvements of treatment aspects should be implemented, e. g. in the field of:

- Rational allocation to outpatient, day care and inpatient treatment
- Implementation of effective treatment modalities
- Shortening extremely long inpatient treatment
- Implementing the knowledge on treatment matching
- Implementing pharmacological treatment options when indicated as a additional component.

It will be a major challenge for the future of specialist services to start a continuous process of quality assurance.

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