Towards a comprehensive treatment strategy: The role of specialist services

1. **Specialist services are needed for the care of severe case of alcohol related disorders, but are often not adequately linked with other professional and nonprofessional help options**

2. **Specialist services differ in many aspects**

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

4. **Scientific evidence requires improvements in major treatment aspects**

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

1. Specialist services are needed for the care of severe case of alcohol related disorders, but are often not adequately linked with other professional and nonprofessional help options

- traditional dominance of (inpatient) specialist services

- lack of cooperation with general services in the health, educational and social fields

- lack of early screening, diagnosis and help for persons with hazardous or harmful alcohol use in the “natural environment”

- tendency to refer alcohol use problems to specialist services too early

Conclusion

Lack of rational allocation of disorder profiles to services

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2. Specialist services differ in many aspects

- setting and ownership
  (e. g. out- vs. inpatient, psychosocial vs. medical system; degree of specialisation)

- patient and disorder profiles

- staff and staff education
  (training experience, supervision)

- treatment modalities
  (e. g. theoretical concept, type of treatment provision, intensity)

- financing and quality control
  (e. g. type and source of financing)

Conclusion
Many differences in Europe are historically founded but are not based on scientific evidence

3. 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 (Küfner & 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 & Künzel, (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 expensive and has a low impact.

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4. Scientific evidence requires improvements in major treatment aspects
4.1 Type of setting

What type of setting?

→ Some but not consistent evidence for superiority of day care or inpatient treatment *for certain specific cases* (Finney, Hahn & Moos, 1996)

outpatient ◄——————————————► **inpatient**

	patient factors	
	• serious medical conditions	not studied
	• serious mental disorders	(x)
	• negative social climate	(x)
	• low social stability (family, legal, work)	x
	• low social competence	x
	treatment factors	
lower	• intensity of treatment	higher
lower/none	• "respite"	higher

Conclusions

Inpatient treatment favourable for (1) high level of additional disorders (comorbidity) and (2) negative social environment/stability/competence

4. Scientific evidence requires improvements in major treatment aspects
4.2 Treatment modality

Do modalities differ in effectiveness?

→Behavioural treatments are likely to be more effective (Miller & Hester, 1986, Miller et al., 1995; Chambless & Ollendick, 2001; Miller & Wilbourne, 2002, Berglund & Johansson, 2003)

less effective (examples)	more effective (examples)
• marital/family, non behavioural	• brief intervention
• hypnosis	• social skills training
• milieu therapy	• motivational enhancement
• unspecified “standard” treatment	• community reinforcement approach
• relaxation training	• behaviour contracting
• confrontational counselling	• client-centred therapy
• psychotherapy	• relapse prevention
• general alcoholism counselling	• cognitive Therapy
	• marital/family therapy, behavioural

Conclusions

Behavioural treatments should be implemented

4. Scientific evidence requires improvements in major treatment aspects
4.3 Time in treatment

Does longer treatment lead to better treatment?

→ Inconsistent results

no effect ◄——————————————————► **positive effect**

- Miller and Hester, 1986

- Süß, 1995
- Sonntag und Künzel, 2000 (for a certain time frame)

Conclusions

- time in treatment is one, but not the dominant factor
- type and probably intensity of treatment are more relevant factors

4. Scientific evidence requires improvements in major treatment aspects
4.4 Treatment matching

Do specific patients profit from specific treatment?

→ Few results (McKay et al., 1992; Allen and Cadden, 1995; PRMG, 1997b, 1998b)

no outcome effect ◄——————————► **positive outcome effect**

- alcohol dependence
- social functioning
- self-efficacy
- readiness to change
- religious beliefs and background

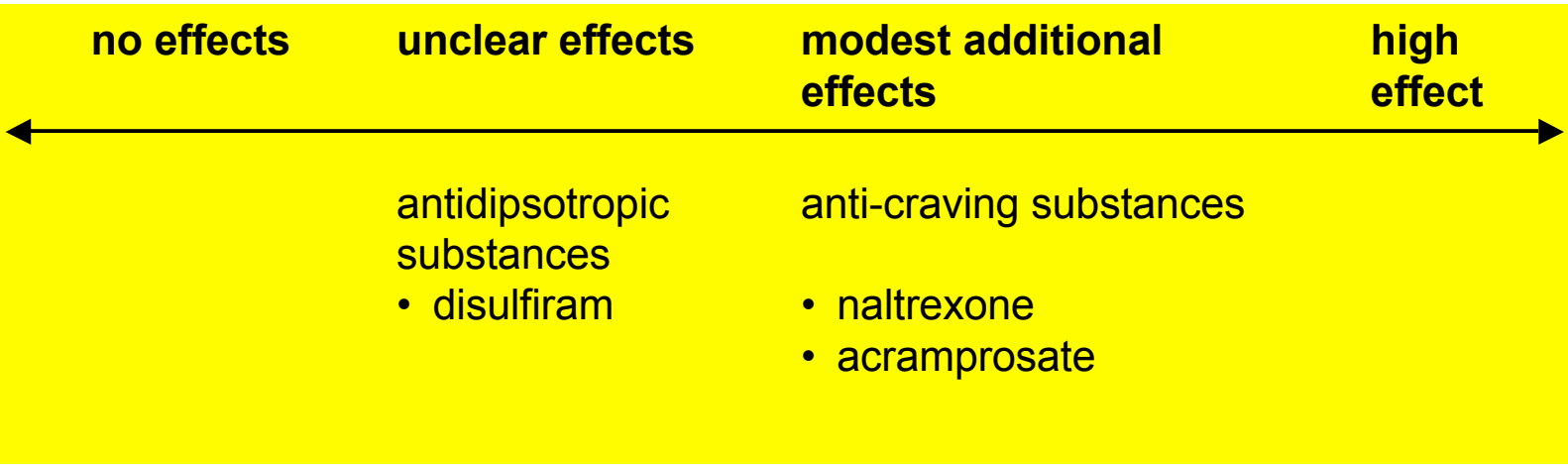
- severity of mental disorders (sociopathy)
- anger
- social support for drinking
- (dependence syndrome)

Conclusions

Few clinical relevant results for the allocation of patient and disorder characteristics to treatment options

4. Scientific evidence requires improvements in major treatment aspects
4.5 Pharmacological treatment

Does pharmacological treatment improve treatment outcome?
(as alternative or additional component)
→Modest additional effects for “anti-craving” substances



Conclusion
- anti-craving substances might improve treatment outcome
- not to be used as “stand-alone” intervention in severe cases

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

1. Close cooperation between general and specialist services

- targeted help options for hazardous, harmful and dependent alcohol use
- rational allocation of disorder profiles to adequate settings
- support and help as long as possible in the familiar setting
- close cooperation between general and specialist services

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

- rational allocation to outpatient, day care and inpatient treatment
- implementation of effective treatment modalities
- implementation of a continuous process of quality control and assurance