Kliiniline küsimus nr 9

Kas kõigil alkoholi kuritarvitamise ja alkoholisõltuvusega patsientidel kasutada püsivama ravitulemuse saavutamiseks psühhosotsiaalseid sekkumisi vs mitte kasutada?

Kriitilised tulemusnäitajad: *abstinents, tagasilangus, alkoholi tarvitamise vähenemine, patsiendi rahulolu, patsiendi elukvaliteet, kvaliteetselt elatud eluaastate lisandumine, haiguse/vaegurluse tõttu kaotatud päevade arv, ravisoostumus, ravi katkestamine mistahes põhjusel, juhuslik alkoholi tarvitamine*

Ravijuhendid

Kokkuvõte tõendusmaterjali kvaliteedist:

Suurimat kasutust antud kokkuvõtte tegemisel leidsid NICE 2011 koostatud süstemaatilised ülevaated ning Austraalia ravijuhend "Guidelines for the treatment of alcohol problems". Lisaks on peaaegu kõik ravijuhendid kasutanud Project MATCH-i, Mesa Grande ning UKATT 2005a andmeid. Lisaks vaadati läbi 2 ennetustöö juhendit NICE 2010b ja USPSTF 2013. Järgnevalt on toodud psühhosotsiaalsed sekkumised teraapiate/sekkumiste kaupa.

Motiveerivad tehnikad (MT)

NICE 2011 on koostanud eraldi kõigi psühhosotsiaalsete sekkumiste kohta tõenduspõhised süstemaatilised ülevaated. MT/sekkumiste kohta on koostatud keskmise kvaliteediga randomiseeritud kontrollitud uuringutest süstemaatiline ülevaade (8 RCT uuringut, N=4209). Mitmes ravijuhendis on kasutatud soovituste tegemiseks William et al.2002 metodoloogilist ülevaadet („Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders", koosneb 361 CT-st, N=72052). Antud ülevaade puudutab kõiki enim kasutatavaid psühhosotsiaalseid sekkumisi. MT-sid kajastab ka meta-analüüs (Hettema et al. 2005, 31 randomiseeritud kontrollitud uuringut), mis leidis, et MT efektiivsus on sõltuvuses paljude faktoritega (läbiviija, kliendi profiil) ning raviefekt on sageli väike/mõõdukas. Vasilaki et al. 2006 (22 uuringut N=2767) meta-analüüs leidis, et motiveeriv intervjueerimine on efektiivne alkoholi koguste vähendamises liigtarvitamise korral (eriti esimesel kolmel kuul). Mitmes ravijuhendis kasutati randomiseeritud kontrollitud uuringut „Matching alcoholism treatments to client heterogeneity: Treatment main effects and matching effects on drinking during treatment" Project MATCH Research Group 1997,1998b, mis leidis, et motiveerival intervjueerimisel on abtsinentsile ning tarbitavate koguste vähendamisele kehvem mõju, kui näiteks kognitiiv-käitumuslikul teraapial. Samas alkoholi tarvitamise häirega patsientide puhul on efektiivsus KKT-l (sh toimetuleku treeningutega) ja motiveerival intervjueerimisel sama. UKATT 2005a („Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial", RCT, N=742) võrdles käitumuslikke/võrgustiku teraapiaid motiveerivate tehnikatega ning leidis, et efektiivsuse osas on meetodid võrdsed.

12 Sammu programm ehk AA

NICE 2011 koostatud süstemaatiline ülevaade antud sekkumisele põhines 6 randomiseeritud kontrollitud uuringul, N=2556, NICE hindab ülevaate kvaliteedi kõrgeks. Ülevaade ei leidnud suuri erinevusi 12SP ja teiste aktiivsete sekkumiste vahel säilitamaks abstinentsi, vähendamaks joomasööste (järelkontroll kuni aasta). 12SP oli oluliselt parem vähendamaks tarbitud alkoholi koguseid, kuid efekt oli leitav ainult poole aasta kontrollis, peale seda efekt kadus. Lisaks võrreldi direktiivset ja motiveerivat 12SP-d ning leiti, et esimene oli efektiivsem, kuid seda ainult joomasööstude osas. Teiste ravijuhendite soovitused põhinesid paljuski eelpool nimetatud projekt MATCH-il ning Mesa Grandel. Kiirete tulemuste saavutamiseks soovitab projekt MATCH 12 Sammu programmi.

Kognitiiv-käitumuslik teraapia (KKT) + variatsioonid

20 RCT uuringu põhjal koostatud NICE süstemaatiline ülevaade (N=3970). Tulemustest selgus, et KKT oli oluliselt efektiivsem vähendamaks joomasööstude episoode, kuid ei omanud olulist mõju vähendamaks päevade arvu, mil tarbiti alkoholi ning samuti ei vähendanud KKT (vs kontrollgrupp) tagasilanguste arvu. Võrreldes KKT-d teiste aktiivsete sekkumistega, ei leitud nendevahelisi olulisi erinevusi (abstinents, joomasööstude vähendamine, tarbitava alkoholi koguse hulga vähenemine). Erinevaid KKT formaate võrreldes, leidis NICE, et individuaalne KKT

lähenemine oli oluliselt efektiivsem abstinentsi tagamiseks kui kompleksne (packaged) KKT programm. Samas joomasöödstude vähendamisele ei täheldatud erinevusi. Toimetuleku teraapia (coping skills) ning teiste KKT vormide vahel ei täheldatud erinevusi. Tõenduspõhisus kõrge. Projekt MATCH soovitab kasutada KKT-d, kui on vaja kiiresti vähendada joomasööstude arvu ja muid alkoholiga seotud tagajärgi. Onken et al. 2005 leidis ülevaates, et KKT toime võib esineda ka peale aktiivse ravi lõppu. KKT eelpool kirjeldatud toimeid toetavad ka projekt MATCH ning Mesa Grande.

Käitumuslikud teraapiad/sekkumised (behavioural interventions)

NICE koostas käitumuslike teraapiate efektiivsuse hindamiseks süstemaatilise ülevaate (koosnes 6 RCT keskmise kvaliteediga uuringust, N=527), milles võrdles teraapiat kontrollgrupi, teiste aktiivsete teraapiate ning muude käitumuslike teraapiate vormidega. Võrreldes käitumuslikke sekkumisi kontrollgrupiga, leidis NICE süstemaatiline ülevaade tõendeid positiivsest efektist alkoholi koguste vähendamisele ning kontrollitud alkoholi tarbimisele. Kuid efekt puudub abstinentsi tagamisele ning tagasilanguste vältimisele. Võrreldes teiste aktiivsete sekkumistega (nt paariteraapia) on käitumuslikud teraapiad vähem efektiivsed (abstinents). Alkoholi koguste vähendamise osas olid KKT ja käitumuslikud sekkumised võrdsed. Walters et al. 2000 (meta-analüüs, 17 RCT) uuris käitumusliku enesekontrolli teraapia efektiivsust ning leidis selle olevat efektiivsema vs sekkumiseta lähenemine, kuid vähem/võrdne teiste aktiivsete teraapiatega.

Keskkonna(võrgustiku)põhised teraapiad (Social network and environment-based therapies)

Keskkonnapõhiste teraapiate (social network and environment-based therapies) efektiivsust vaatles NICE 3 RCT (N=1058) uuringu põhjal. Kuid kuna uuringute koguhulk on väike, on ülevaate kvaliteet keskmine. Leiti, et abstinentsi saavutamiseks on keskkonnapõhised teraapiad kontrollgrupist oluliselt efektiivsemad, kuid nende toime ei olnud oluliselt parem kontrollgrupist hilisema alkoholi tarbimise osas. Teiste aktiivsete sekkumistega võrreldes olulisi erinevusi ei esinenud. Ka UKATT2005a on uuringus kajastanud keskkonnapõhiste teraapiate efektiivsust võrreldes motiveerivate tehnikatega ning ei leidnud olulisi erinevusi (vt üleval).

Paariteraapiad (sh käitumuslikud paariteraapiad)

NICE süstemaatiline ülevaade paariteraapiatest hõlmas kaheksat randomiseeritud kontrollitud uuringut, N=602. Tõenduse kvaliteet keskmine. Ei leitud erinevusi efektiivsuses lühiajalise abstinentsi saavutamisel erinevate paariteraapiate ja teiste aktiivsete sekkumiste (12SP, psühhoedukatsioon, nõustamine, KKT) vahel. 12 RCT uuringust koosnev meta-analüüs (Powers et al. 2008, N=754) toob välja, et paarisuhte olemasolul on käitumusliku paariteraapia kasutamine eelistatum KKT üle.

Nõustamine

Teemat puudutab viiest randomiseeritud kontrollitud (N=630) uuringust koosnev NICE ülevaade, millel tõenduspõhisus on keskmise kvaliteediga. Kuid nende tulemuste põhjal võib öelda, et nõustamise kasutamine ei oma eeliseid muude sekkumiste ja ka kontrollgrupi ees. Eraldi uuriti individuaalnõustamise ning grupiteraapia mõju alkoholsõltuvatele (”Motivational Intervention: An individual counsellind vs a group treatment approach for alcohol-dependent in-patients” John et al.2003, N=322) ning leiti, et abstinentsi saavutamise osas ei ole sekkumistel suuri erinevusi.

Psühhodünaamiline

NICE põhines oma soovitustes ühele randomiseeritud-kontrollitud uuringule (Sandhal et al.1998) KKT ja psühhodünaamilise teraapia kohta teostatud uuring (”Cognitive-behavioral therapy and psychodynamic psychotherapy: techniques, efficacy, and indications” Leichsenring et al. 2006) toob välja, et kuigi psühhodünaamilist lähenemist sobib kasutada motiveeritud ja koostöövalmis patsientidega, vajab antud teraapia tõenduspõhisuse tõstmiseks rohkem uuringuid.

Psühhoedukatsioon

NICE süstemaatilise ülevaate jaoks kasutati viite randomiseeritu-kontrollitud keskimise kvaliteediga uuringut, N=1312, milles ei leitud psühhoedukatsioonil eeliseid teiste sekkumiste ees (käitumuslik paariteraapia, multimodaalne ravi, 12SP, toimetulekuteraapia).

Lühisekkumised

6 hea kvaliteediga süstemaatilist ülevaadet (Ashenden et al., 1997, Ballesteros et al., 2004 a, Bertholet et al., 2005, Kaner et al. , 2007, Poikolainen, 1999, Whitlock et al., 2004) demonstreerisid, et lühinõustamised perearstiabis on efektiivsed vähendamaks alkoholi tarbimist 6 süstemaatilist ülevaadet (Ballesteros et al., 2004a; Bertholet et al., 2005; Whitlock et al.,

2004; Kaner et al ., 2007; Poikolainen,1999; Ballesteros et al. , 2004b) leidsid lühinõustamise olevat efektiivne vähendamaks alkoholi tarvitamist nii meeste kui naiste hulgas. 3 süstemaatilist ülevaadet (D' Onofrio & Degutis, 2002; Havard et al., 2008; Nilsen et al. , (2008) leidsid vähe tõendust lühinõustamisele erakorralises meditsiinis tuvastamaks alkoholi väärtarvitavaid patsiente. 2 süstemaatilist ülevaadet (Kaner et al ., 2007; Ballesteros et al ., 2004a) demonstreerisid pikendatud lühinõustamiste (2-7 sessiooni, 1 sessiooni pikkus 15-50min.) efektiivsust. 1 süstemaatiline ülevaade (Jonas et al., 2012) hindas lühinõustamise kasusid ja kahjusid täiskasvanutele ja noortele, kes väärtarvitasid alkoholi. Parim tõendus oli mitme kontaktiga lühinõustamisele. Peale lühinõustamist vähenes keskmiselt alkoholi tarbimine võrreldes algse tarbimisega 3.6 dringi võrra nädalas. Vt. Viited, Süstemaatilised ülevaated (lühinõustamise efektiivsus).

Kokkuvõte ravijuhendites leiduvatest soovitustest

Antud küsimusele vastamiseks vaadati läbi 10 ravijuhendit. Neist 9 sisaldasid informatsiooni psühhosotsiaalsete sekkumiste kohta. Üks (BAP 2012) keskendus ainult psühhosotsiaalsete sekkumiste ning farmakoloogilise ravi koostoimele. Lisaks 2 ennetustöö juhendit NICE 2010b ja USPSTF 2013. Järgenvalt on toodud psühhosotsiaalsed sekkumised teraapiate/sekkumiste kaupa.

Motiveerivad tehnikad: NICE 2011 soovitab kõigile alkoholi liigtarvitajatele rakendada motiveerivaid tehnikaid esmase hindamise raames. Lisaks toob NICE välja, et motiveerivaid tehnikaid kasutades on võimalik vähendada tarbitavaid alkoholi koguseid joomasööstude korral, kuid antud toime ei ole pikaajaline. Motiveerivate tehnikate ja teiste aktiivsete sekkumiste vahel ei ole abstinentsi säilitamisel suuri erinevusi. SIGN 2003 mainib motiveerivat intervjueerimist kui tagasilanguse ennetamise tööriista, samuti mainib Austraalia 2009 motiveerivat intervjueerimist kui ühte mitmest empiiriliselt kasutatavast vahendist, kuid peab üldist raviefekti väikseks (võrreldes kontrollgrupiga) ning soovitab MT kasutada kas eraldiseisva meetodina (vs sekkumiseta) või siis lisana teistele meetoditele ravi alguse ambivalentsusega tegelemiseks. NSW 2008 soovitab kasutada MI-d kõikides ravietappides tõstmaks koostööd ning ravil püsimist. Ka APA 2006 soovitab alkoholi tarvitamisega häirega patsientidele muude sekkumiste hulgas kasutada motiveerivaid tehnikaid ning toob välja, et MT on sageli sama efektiivne kui 12SP ja KKT.

12 Sammu programmid/asutused ehk AA

NICE süstemaatiline ülevaade ei leidnud märkimisväärset erinevust 12SP ja teiste aktiivsete sekkumiste vahel (nii abstinensi säilitamine kui ka joomasööstu episoodide vähendamises) 1 aasta jooksul. Kuid 12SP oli oluliselt efektiivsem vähendamaks tarbitava alkoholi koguseid. Austraalia 2009 soovitab 12SP-i abstinentsi/tarbitavate koguste vähendamiseks (MATCH 1997;1998b). APA 2006 soovitab võimalusel patsiente 12SP ja teistesse eneseabi gruppidesse suunata. SIGN 2003 soovitab kõiki alkoholsõltuvusega patsiente suunata osalema AA kohtumistel. Sama leiab ka Soome 2010. MATCH projekt leidis, et 12SP põhine järelravi oli efektiivsem kui KKT ambulatoorsetele patsientidele, kellel ei esinenud muid psühhiaatrilisi sümptomeid ning oli võrdse efektiga psühhiaatriliste sümptomite olemasolul. Enamus analüüsitud ravijuhenditest (APA 2006, WFSBP 2008, Soome 2010, Austraalia 2009, SIGN 2003, Nice 2011) soovitavad patsienti teavitada võimalustest liituda lähipiirkonnas tegutsevate AA gruppidega (jm 12SP).

Kognitiiv-käitumuslik teraapia

NICE 2011 soovitab alkoholi kuritarvitamise ning mõõduka alkoholisõltuvuse korral kasutada KKT-d, mis on efektiivne vähendamaks joomasööstude episoode võrreldes ravi mitte saanutega. Teiste aktiivsete sekkumistega (12SP, käitumuslik teraapia, MT, toimetulekuteraapia, nõustamine) võrreldes olulisi erinevusi efektiivsuse osas ei ole (NICE). Austraalia 2009 soovitab samuti KKT-d ja toob välja KKT mõnedes uuringutes ilmnenud kestva efekti ning mõju ka peale ravi lõppu. UKATT 2005a põhjal leiti, et KKT on sama efektiivne kui MT vähendamaks alkoholi tarbimist alkoholsõltuvusega patsientidel. Erinevate KKT formaatide vahel on leitud individuaalsel lähenemisel suurem efekt olevat kui kompleksetel (packaged) KKT programmidel, kuid seda ainult abstinentsi säilitamiseks (NICE 2011). Austraalia 2009 soovitab toimetuleku treeninguid (coping skills) inimestele, kellel on vähesed/ puuduvad oskused abstinentsi säilitamiseks.

Käitumuslikud teraapiad/sekkumised (behavioural interventions)

Võrreldes käitumuslikke sekkumisi kontrollgrupiga, leidis NICE süstemaatiline ülevaade tõendeid positiivsest efektist alkoholi koguste vähendamisele ning kontrollitud alkoholi tarbimisele. Kuid efekt puudub abstinentsi tagamisele ning tagasilanguste vältimisele. Võrreldes teiste aktiivsete

sekkumistega (nt paariteraapia) on käitumuslikud teraapiad vähem efektiivsed (abstinents). Alkoholi koguste vähendamise osas olid KKT ja käitumuslikud sekkumised võrdsed. SIGN 2003 kutsub üles alkoholsõltuvaid patsiente osalema kätiumuslikel enesekontrolli treeningutel. Samamoodi toob välja käitumusliku enesekontrolli teraapia kasutamisvõimaluse Austraalia 2009, seda eriti alkoholsõltuvuseta patsientidele (või nõrk sõltuvus).

Keskkonna(võrgustiku)põhised teraapiad (social network and environment-based therapies)

NICE 2011 soovitab alkoholi kuritarvitamise ning mõõduka sõltuvuse korral lisada farmakoloogilisse ravisse muu hulgas ka keskkonnapõhiseid teraapiaid kui eelnev psühhosotsiaalne sekkumine ei ole osutunud efektiivseks. Eraldiseisvalt kasutades on keskkonnapõhised teraapiad oluliselt efektiivsemad vs ravita jätmine, kuid muude sekkumiste ees eeliseid ei oma. Eraldi uuris motiveerivate tehnikate ning keskkonnapõhiste teraapiate effektiivsust UKATT2005a, kuid olulisi erinevusi raviefektiivsuses ei leitud.

Paariteraapiad (sh käitumuslikud paariteraapiad)

Lühiajaliselt ei erine paariteraapiad teistest sekkumistest abstinentsi saavutamise poolest (NICE süstemaatiline ülevaade). Paariteraapia efektiivsus(abstinents) ilmneb 12kuu järelkontrollis, kuid kaob pikemaajaliselt. Seevastu vähendab paariteraapia kasutamine joomasööstude episoode. Omavahel käitumuslikke paariteraapiaid muude paariteraapiatega võrreldes ei ilmnenud olulisi erinevusi (nii abstinentsile, kui ka joomasööstude vähendamisele). Samuti võrreldi intensiivset ja lühiteraapiat ning leiti, et lühiteraapia oli lühiajaliselt effektiivsem abstinentsi saavutamiseks. Samuti ei olnud intensiivsel teraapial eeliseid joomasööstude vähendamise ees. Kokkuvõtvalt soovitab NICE kerge sõltuvuse/kuritarvitamise ning osavõtliku elukaaslase olemasolul käitumuslikku paariteraapiat. Ka Austraalia 2009 soovitab paarisuhte olemasolul kasutada käitumuslikku paariteraapiat. Samas NSW 2008 hindab olemasolevat tõenduspõhist materjali liiga väheseks andmaks konkreetseid soovitusi.

Psühhodünaamiline lähenemine

NSW 2008 soovitab psühhodünaamilist teraapiat kasutada ainult kvalifitseeritud ning kogenud spetsialistidel ning patsientidega, kes on valmis tegelema lisaks alkoholi probleemidele ka muude teemadega. NICE 2011, WFSBP 2008, APA 2006, Soome 2010 on psühhodünaamiliste teraapiate kasutamise osas ootaval seisukohal ning tuginedes hetkel kättesaadavatele tõenduspõhistele uuringutele ning eriti nende vähesusele, ei saa konkreetseid psühhodünaamilisi sekkumisi soosivaid soovitusi teha.

Psühhoedukatsioon

Psühhoedukatsioon ei oma eeliseid teiste sekkumiste ees. Samuti leidis Hettema et al.2005, et psühhoedukatsioon on vähem efektiivne kui motiveeriv intervjueerimine. Ka Mesa Grande ei toeta psühhoedukatsiooni meetodeid.

Mindfulness

Ei ole piisavalt tõenduspõhist informatsiooni (NICE, NSW 2008).

Lühinõustamine

SIGN 2003 ei soovita kasutada lühisekkumist/nõustamist alkoholsõltuvatele patsientidele madala efektiivsuse tõttu (Moyer et.al 2002). Küll aga alkoholi kuritarvitajatele (SIGN 2003, Austraalia 2009). NSW 2008 soovitab kasutada lühisekkumisi rutiinselt kõigile alkoholiprobleemidega patsientidele. Kõige põhjalikumalt on skriiningujärgset lühinõustamist analüüsinud 2 ennetustöö juhendit NICE 2010b ja USPSTF 2013. Mõlemad juhendid soovitavad ohustava ja riskantse alkoholi tarvitamise korral lühinõustamist. NICE 2010b soovitab esmalt anda lühikest tagasisidet patsiendi alkoholitarvitamise kohta põhinedes FRAMES (feedback, responsibility, advice, menu, empathy, self-efficacy) printsiibile. Isikutel, kelle puhul lühike tagasiside ei ole piisav, tuleb rakendada pikemat (extended) lühinõustamist, mis sisaldab motiveerivat intervjuud ja kestab 20-30 minutit. USPSTF 2013 soovitab lühikest mitme kontaktiga lühinõustamist, millele on leitud kõige suurem efektiivsus. USPSTF 2013 leidis, et lühinõustamised perearstiabis muudavad ohustava ja riskitasemega alkoholi tarvitavate isikute joomiskäitumist vähenemise suunas: väheneb nädalane tarbitav alkoholikogus, järgitakse pikemalt soovitatavaid alkoholi tarvitamise limiite.

Astmeline lähenemine (Stepped care):

Astmelise lähenemise korral algab sekkumine vähem intensiivsemalt intensiivsemale. Enim edastab astmelise sekkumise kohta informatsiooni Austraalia 2009, mis toob küll välja, et

tõenduspõhist materjali astmelisele lähenemisele on vähe, kuid sellele vaatamata on meetod võetud laialdaselt kasutusele.

Ravijuhendite soovituste tekstid (inglise keeles):

NICE 2011: *For harmful drinkers and people with mild alcohol dependence, offer a psychological intervention (such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems and social networks. For harmful drinkers and people with mild alcohol dependence who have a regular partner who is willing to participate in treatment, offer behavioural couples therapy.*

SIGN 2003: *Alcohol dependent patients should be encouraged to attend Alcoholics Anonymous. Behavioural Self Control Training (BSCT), Motivational Enhancement Therapy (MET), Marital/Family Therapy and Coping/Social Skills Training are clinically and cost effective psychosocial interventions and are recommended treatment options for the prevention of relapse in alcohol dependence. Motivational interviewing and coping skills training for relapse prevention have been shown to be effective when delivered by psychologists. Among psychosocial treatments, strongest evidence of efficacy was found for brief interventions, social skills training, the community reinforcement approach, behavior contracting, behavioral marital therapy and case management.*

Austraalia 2009: *Motivational interviewing approaches can be used as a first-line or stand-alone treatment, or as an adjunct to other treatment modalities in addressing patient's ambivalence to change their drinking or other behaviours. Behavioural self-management (controlled drinking program) can be recommended as a treatment strategy for people with no or low level dependence and for when patient and clinician agree that moderation is an appropriate goal. The behavioural self-management approach (also called controlled drinking programs) teaches people to reduce their alcohol consumption, and is suitable for people at the less severe end of the dependence spectrum. Coping skills training is recommended for people who appear to lack the relevant skills to achieve and remain abstinent. Behavioural couples' therapy, which focuses on drinking behaviour as the problem, can improve drinking outcomes following treatment and should be delivered by an appropriately trained clinician.*

Soome 2010: *Psychosocial treatment is more effective than leaving the patient untreated. In moderately severe dependence, various forms of treatment would appear to give on the whole equally good results. Couple and family therapy appear to be more effective than individual therapy alone. The twelve-step programme would appear to produce more total abstinence but otherwise the results do not appear to differ essentially from those of conventional psychosocial treatments. Psychodynamic therapies do not appear to be very useful. So far, no criteria exist for choosing the most appropriate form of treatment for alcohol abuse.*

WFSBP 2008: *Nonetheless, comprehensive reviews of treatment studies reveal that, generally speaking, alcohol treatment is more effective than no treatment. Interventions that have been found to be effective include strategies aimed at the enhancement of motivation for recovery, CBT, including broad spectrum treatment with a CBT focus and other related forms, 12-step treatment, various forms of family, social network, and marital therapy, and social competence training. It is difficult to demonstrate the superiority of one active approach to alcohol treatment over another.*

NSW 2008: *Psychosocial treatments are considered to be thefoundation of drug and alcohol treatment, especially for substances where pharmacological treatments have not been sufficiently evaluated. Motivational interviewing can be used in all phases of assessing and treating drug and alcohol clients to increase treatment engagement and adherence. Brief, opportunistic interventions, using the frames approach, should be used routinely in all clients with problematic drug and alcohol use across a range of settings by specialist and generalist drug and alcohol professionals. CBT should be used with all drug and alcohol clients to improve psychosocial outcomes, reduce problematic drug and alcohol use, and reduce risk of relapse. D&A professionals should be aware of local 12-Step groups and provide this information to interested clients.*

APA 2006: *Psychosocial treatments found effective for some patients with an alcohol use disorder include MET (Motivational Enhancement Therapy), CBT, behavioral therapies, TSF, marital and family therapies, group therapies, and psychodynamic therapy/IPT. Recommending that patients participate in self-help groups, such as Alcoholics Anonymous (AA), is often helpful.*

Ravijuhendid

The management of harmful drinking and alcohol dependence in primary care, a national clinical guideline, Scottish Intercollegiate Guidelines Network, 2003	SIGN 2003
Treatment of Alcohol Abuse, Current Care Guideline**,** The Finnish Medical Society Duodecim and the Finnish Society of Addiction Medicine,2010	Soome 2010
NSW Health Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines, 2008	NSW 2008
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Incorporating Alcohol Pharmacotherapies Into Medical Practice . Treatment Improvement Protocol (TIP) Series, Substance Abuse and Mental Health Services Administration, 2009.	SAMHSA 2009
Practice Guideline For The Treatment of Patients With Substance Use Disorders, 2nd Edition, American Psychiatric Association, 2006	APA 2006
Alcohol-Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence, National Institute for Health & Clinical Excellence, 2011	NICE 2011
World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Substance Use and Related Disorders, Part 1: Alcoholism, 2008	WFSBP 2008
Evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from The British Association for Psychopharmacology,2012	BAP 2012

Lühinõustamise efektiivsuse süstemaatilised ülevaated vt. EvSu 1.

NICE 2011 süstemaatilised ülevaated

	Motivational versus minimal intervention control	Motivational versus other active intervention
K (total N)	3 RCTs (N = 433)	6 RCTs (N = 3818)
Study ID	(1) HESTER2005 (2) ROSENBLUM2005b (3) SELLMAN2001	(1) DAVIDSON2007 (2) MATCH1997 (3) SELLMAN2001 (4) SHAKESHAFT2002 (5) SOBELL2002 (6) UKATT2005
Diagnosis	(1) AUDIT score 8+ (2) DSM alcohol dependent/abuse (3) DSM alcohol dependent	(1) DSM alcohol dependent (2) DSM alcohol dependent/abuse (3) DSM alcohol dependent (4)–(5) Not reported (6) DSM alcohol dependent/abuse
Baseline severity	(1) DDD: approximately 7 (2) Not reported (3) Mild/moderate dependence Unequivocal heavy drinking more than six times (in 6 months prior to treatment): 90.2%	(4) PDA: approximately 30%, percent days heavy drinking: approximately 63% (5) PDA: approximately 30%, DDD: approximately 16 (6) Unequivocal heavy drinking six or more times in 6 months prior to treatment: 90.2% (1) Weekly Australian units per week: approximately 32 units (2) Number of drinking days per week: approximately 5.5 days, DDD: approximately 5 (3) PDA: 29.5%, number of DDD: 26.8 drinks
Number of	Range: 1 to 12 sessions	Range: 1 to 12 sessions
Length of	Range: 1 to 6 weeks	Range: 1 to 12 weeks
Length of	Range: 1 month to 5 years	Range: 6 months to 5 years
Setting	(1) Computer-based intervention (2) Homeless soup-kitchen (3) Outpatient treatment centre	(1) Outpatient treatment centre (2) Clinical research unit (3)–(4) Outpatient treatment centre (5) Mail information (6) Outpatient treatment centre
Treatment goal	(1) Abstinence or drinking reduction/moderation (2) Drinking reduction/moderation (3) Not explicitly stated	(1)–(2) Abstinence or drinking reduction/moderation (3)–(5) Not explicitly stated (6) Abstinence or drinking reduction/moderation
Country	(1)–(2) US (3) New Zealand	(1)–(2) US (3) New Zealand (4) Australia (5) US (6) UK

	TSF versus other active intervention	**Different formats of TSF**
K (total N)	5 RCTs (N = 1221)	2 RCTs (N = 456)
Study ID	(4) EASTON2007 (5) FALSSTEWART2005 (6) FALSSTWEART2006 (7) MATCH1997 (8) WALITZER2009	(7) TIMKO2007 (8) WALITZER2009
Diagnosis	(1)–(2) DSM alcohol dependent (3)–(4) DSM IV alcohol dependent/abuse (5) Not reported	(1)–(2) Not reported
Baseline severity	(4) Approximately 19 years of alcohol use, alcohol use in past 28 days: approximately 6 days (5) Percent days heavy drinking: 56 to 59% across treatment groups (6) PDA: 40 to 44% across treatment groups (7) PDA: approximately 30, DDD: approximately 16 drinks (8) PDA: 35.4%, percent days heavy drinking: 32.7%	(4) ASI alcohol score: approximately 0.28 (5) PDA: 35.4%, percent days heavy drinking: 32.7%
Number of sessions	Range: 12 to 32 sessions	(4) 1 session (5) 12 sessions in which TSF was in addition to other treatment
Length of	12 weeks	Unclear
Length of	Range: 3 to 15 months	Range: 3 to 12 months
Setting	(1)–(3) Outpatient treatment centre (7) Clinical research unit (8) Outpatient treatment centre	(1)–(2) Outpatient treatment centre
Treatment goal	(4) Drinking reduction/moderation (5) Not explicitly stated (6) Abstinence (7) Abstinence or drinking reduction/moderation (8) Not explicitly stated	(1)–(2) Not explicitly stated
Country	(1)–(5) US	(1)–(2) US

	Cognitive behavioural therapies versus TAU or control	**Cognitive behavioural therapies versus other active intervention**	**Different formats of cognitive behavioural therapies**
K (total N)	3 RCTs (N = 450)	13 RCTs (N = 2956)	6 RCTs (N = 771)
Study ID	(1) BURTSCHEIDT2001 (2) MONTI1993 (3) ROSENBLUM2005B	(1) CONNORS2001 (2) DAVIDSON2007 (3) EASTON2007 (4) ERIKSEN1986B (5) LAM2009 (6) LITT2003 (7) MATCH1997 (8) MORGENSTERN2007 (9) SANDAHL1998 (10) SHAKESHAFT2002 (11) SITHARTHAN1997 (12) VEDEL2008 (13) WALITZER2009	(1) BURTSCHEIDT2001 (2) MARQUES2001 (3) CONNORS2001 (4) LITT2009 (5) MONTI1990 (6) ROSENBLUM2005A
Diagnosis	(1)–(2) DSM alcohol dependent (3) Not reported	(1)–(3) DSM alcohol dependent (4) Not reported (5)–(8) DSM alcohol dependent/abuse (9) DSM alcohol dependent (10) Not reported (11) Not reported (12) DSM alcohol dependent/abuse (13) Not reported	(1)–(3) DSM/ICD alcohol dependent (4) DSM alcohol dependent/abuse (5) DSM/ICD alcohol dependent (6) DSM alcohol dependent/abuse

Baseline severity	(1) Not reported (2) ADS score: 20.7 SMAST* score: 9.97 DDD: 12.1 drinks, PDA: 47%	(1) Percentage of sample severe dependence: 8.3% Percentage of sample moderate dependence: 66% Percentage of sample mild dependence: 18.1% (2) PDA: approximately 30% Percentage days heavy drinking: approximately 63% (3) Approximately 19 years of alcohol	(1) Not reported (2) Number of drinking days in last 90 days: 49 Number of heavy drinking days in last 90 days : 34.5 Number of problem drinking days in last 90 days: 16.5 Mean weekly consumption: 36.5 drinks SADD** score abstinence/moderate

	Cognitive behavioural therapies versus TAU or control	**Cognitive behavioural therapies versus other active intervention**	**Different formats of cognitive behavioural therapies**
		(11) SADQ-C score: 18.81 Impaired Control Questionnaire (ICQ) score: 13.05 CDSES score: 35.93 Drinking days per month: 20.2 days Consumption per occasion: 8.82 drinks (12) 62% alcohol dependent 50% drank seven or more units 57% drank daily or nearly daily (13) PDA: 35.4% Percentage of days heavy drinking: 32.7%	Number of possible DDD: 11 drinks Number of actual DDD: 17 drinks Percentage possible drinking days in which heavy drinking: 45% (6) Number of days abstinent in past 30 days: 14 days ASI alcohol score: approximately 0.47
Number of sessions	Range: 6 to 26 sessions	Range: 6 to 26 sessions	Range: 12 to 23 sessions
Length of treatment	Range: 2 weeks to 6 months	Range: 10 weeks to 6 months	Range: 6 to 10 weeks
Length of follow-up	Range: 0 to 6 months	Range: 3 to 18 months	Range: 3 to 18 months

Setting	(1) Outpatient treatment centre (2) Inpatient (3) Homeless soup-kitchen	(1)–(3) Not reported (4) Inpatient (5) Not reported	(1)–(2) Outpatient treatment centre (3) Outpatient research unit (4) Outpatient treatment centre
		(6) Outpatient research unit (7)–(12) Not reported (13) Outpatient treatment centre	(5) Inpatient (6) Outpatient research unit
Treatment goal	(1)–(3) Not explicitly stated	(1) Drinking reduction/moderation (2) Abstinence or drinking reduction/moderation (3) Drinking reduction/moderation (4) Abstinence or drinking reduction/moderation (5)–	(1)–(2) Not explicitly stated (3) Drinking reduction/moderation (4)–(6) Not explicitly stated
Country	(1) Germany (2)–(3) US	(1)–(3) US (4) Norway (5)–(8) US (9) Sweden (10)–(11) Australia (12) Netherlands (13) US	(1) Germany (2) Brazil (3)–(6) US

	Behavioural therapies versus control/TAU	**Behavioural therapies versus other active intervention**	**Different formats of behavioural therapy**
K (total N)	2 RCTs (N = 134)	4 RCTs (N = 3420)	2 RCTs (N = 199)
Study ID	(9) ALDEN1988 (10) MONTI1993	(9) ALDEN1988 (10) KAVANAGH2006 (11) SITHARTHAN1997 (12) WALITZER2004	(9) HEATHER2000 (10) KAVANAGH2006
Diagnosis	(6) Not reported (7) DSM alcohol dependent	(6) Not reported (7) DSM alcohol dependent (8) Not reported (9) 85% had low level alcohol dependence and 15% had moderate levels	(9) Not reported (10) DSM alcohol dependent
Baseline severity	(9) Consuming >84 standard ethanol units per week (10) ADS score: 20.7 SMAST score: 9.97 DDD: 12.1; abstinent days: 47%; heavy drinking days: 45%	(4) Consuming >84 standard ethanol units per week (5) SADQ-C score: approximately 13.7 AUDIT score: approximately 28 Weekly alcohol consump- tion: approximately 37 (6) SADQ-C score: 18.81 ICQ score: 13.05 CDSES* score: 35.93 Drinking days per month: 20.2; consumption per occasion: 8.82 (7) ADS score: 8.4 Abstinent days/month: 11.0; Frequency of more than six drinks per drinking period per month: 5.1	(3) SADQ-C score: 18.7 APQ score: 10.1 DDD: 19.96; abstinent days: 19.14% (4) SADQ-C score: approximately 13.7 AUDIT score: approximately 28 Weekly alcohol consumption: approximately 37
Number of	Range: 6 to 12	Range: 6 to 12	8 sessions
Length of	Range: 6 to 12 weeks	Range: 6 to 12 weeks	8 weeks
Length of	Range: 6 to 24 months	Range: 3 to 12 months	Range: 3 to 12 months
Setting	(7) Outpatient clinical research unit (8) Inpatient VA medical centre	(1)–(4) Outpatient clinical research unit	(1)–(2) Outpatient clinical research unit
Treatment goal	(4) Drinking reduction/ moderation (5) Not explicitly stated	(1)–(4) Drinking reduction/ moderation	(1)–(2) Drinking reduction/moderation
Country	(7) Canada (8) US	(1)–(3) Australia (4) US	(1) UK (2) Australia

	Social network and environment-based therapies versus control	Social network and environment-based therapies versus other active intervention
K (total N)	1 RCT (N = 210)	2 RCTs (N = 989)
Study ID	LITT2007	(11) LEIGH2009 (12) UKATT2005
Diagnosis	DSM alcohol dependent/ abuse	(13) Not reported (14) DSM alcohol dependent/abuse
Baseline severity	Drinking days in past 3 months: 72% Prior treatment for alcohol dependence: 1.3	(11) Outpatient alcoholics drinking 5.5 days per week Drinks per week: Range 73 to 89 (12) Days abstinent: 29.5% per month Number of drinks per drinking day: 26.8
Number of	12 sessions	8 sessions
Length of	12 weeks	Range: 8 to 16 weeks
Length of	6- to 27-month	Range: 1- to 12-month
Setting	Outpatient treatment centre	(1)–(2) Outpatient treatment centre
Treatment goal	Not explicitly stated	(1)–(2) Abstinence or drinking reduction/moderation
Country	US	(8) Canada (9) UK

Abstraktid

Aims: (1) To examine whether or not motivational interviewing (MI) is more efficacious than no intervention in reducing alcohol consumption; (2) to examine whether or not MI is as efficacious as other interventions. Method: A literature search followed by a meta-analytic review of randomized control trials of MI interventions. Aggregated between-group effect sizes and confidence intervals were calculated for each study. Results: Literature search revealed 22 relevant studies, of which nine compared brief MI with no treatment, and met methodological criteria for inclusion. In these, the aggregate effect size was 0.18 (95% C.I. 0.07, 0.29), but was greater 0.60 (95% C.I. 0.36, 0.83) when, in a post-hoc analysis, the follow-up period was three months or less. Its efficacy also increased when dependent drinkers were excluded. There were nine studies meeting methodological criteria for inclusion which compared brief MI with another treatment (one of a diverse set of interventions), yielding an aggregate effect size of 0.43(95% C.I. 0.17, 0.70). The literature review pointed to several factors which may influence MI's long-term efficacy effectiveness of MI. Conclusions: Brief MI is effective. Future studies should focus on possible predictors of efficacy such as gender, age, employment status, marital status, mental health, initialexpectations, readiness to change, and whether the population is drawn from treatment-seeking or non-treatment-seeking populations.Also, the components of MI should be compared to determine which are most responsible for maintaining long-term changes.	Vasilaki, EI, SG Hosier and WM Cox 2006, The efficacy of motivational interviewing as a brief intervention for excessive drinking: a meta-analytic review. Alcohol Alcohol 41(3): 328-335.
Reviewed 17 studies that employed a randomized control design to investigate the efficacy of behavioral self-control training for problem drinking. A meta-analysis of these 17 studies show that behavioral self-control training was superior to no intervention and alternative non abstinence-oriented interventions in reducing both alcohol consumption and problematic drinking. The results of this meta-analysis also favor behavioral self-control training over traditional abstinence-oriented treatment, but the effect size fell short of statistical significance. Additional analyses found self-control training to be equally effective for use with alcohol dependent and problem-drinking Ss and for follow-ups spanning several mo to several yrs. The implications of these results for interventions with alcohol-abusing clients are discussed.	Walters, GD 2000, Behavioral Self-Control Training for Problem Drinkers:A Meta- Analysis of Randomized Control Studies. *Behav Ther* 31: 135—149.

Motivational interviewing (MI) is a client-centered, directive therapeutic style to enhance readiness for change by helping clients explore and resolve ambivalence. An evolution of Rogers's person-centered counseling approach, MI elicits the client's own motivations for change. The rapidly growing evidence base for MI is summarized in a new meta-analysis of 72 clinical trials spanning a range of target problems. The average short-term between-group effect size of MI was 0.77, decreasing to 0.30 at follow-ups to one year. Observed effect sizes of MI were larger with ethnic minority populations, and when the practice of MI was not manual-guided. The highly variable effectiveness of MI across providers, populations, target problems, and settings suggests a need to understand and specify how MI exerts its effects. Progress toward a theory of MI is described, as is research on how clinicians develop proficiency in this method.	Hettema, J, Steele J and R Miller 2005, Motivational interviewing. Ann Rev Clin Psychol 1: 91-111.
Objective - To compare the effectiveness of social behaviour and network therapy, a new treatment for alcohol problems, with that of the proved motivational enhancement therapy. Design Pragmatic randomised trial. Setting - Seven treatment sites around Birmingham, Cardiff, and Leeds. Participants 742 clients with alcohol problems; 689 (93.0%) were interviewed at three months and 617 (83.2%) at 12 months. Interventions Social behaviour and network therapy and motivational enhancement therapy. Main outcome measures Changes in alcohol consumption, alcohol dependence, and alcohol related problems over 12 months. Results Both groups reported substantial reductions in alcohol consumption, dependence, and problems, and better mental health related quality of life over 12 months. Between groups we found only one significant difference in outcome, probably due to chance: the social network group showed significantly better physical health at three months. Non-significant differences at 12 months in the motivational group relative to the social network group included: the number of drinks consumed per drinking day had decreased by an extra 1.1 (95% confidence interval − 1.0 to 3.2); scores on the Leeds dependence questionnaire had improved by an extra 0.6 (− 0.7 to 2.0); scores on the alcohol problems questionnaire had improved by an extra 0.5 (− 0.4 to 1.4); but the number of days abstinent from drinking had increased by 1.2% less (− 4.5% to 6.9%). Conclusion- The novel social behaviour and network therapy for alcohol problems did not differ significantly in effectiveness from the proved motivational enhancement therapy.	UKATT Research Team (2005) Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT). British Medical Journal, 331, 541–545
This study reports 3-year outcomes for clients who had been treated in the five outpatient sites of Project MATCH, a multisite clinical trial designed to test a priori client treatment matching hypotheses. The main purpose of this study was to characterize the status of the matching hypotheses at the 3-year follow-up. This entailed investigating which matching findings were sustained or even strengthened across the 3-year study period, and whether any hypotheses that were not supported earlier eventually emerged at 3 years, or conversely, whether matching findings discerned earlier dissipated at this later time. This research also examines the prognostic effects of the client matching attributes, characterizes the overall outcomes at 37 to 39 months, and explores differential effects of the three treatments at extended follow-up. With regard to the matching effects, client anger demonstrated the most consistent interaction in the trial, with significant matching effects evident at both the 1-year and 3-year follow-ups. As predicted, clients high in anger fared better in Motivational Enhancement Therapy (MET) than in the other two MATCH treatments: Cognitive-Behavioral Therapy (CBT) and Twelve-Step Facilitation (TSF). Among subjects in the highest third of the anger variable, clients treated in MET had on average 76.4% abstinent days, whereas their counterparts in the other two treatments (CBT and TSF) had on average 66% abstinent days. Conversely, clients low in anger performed better after treatment in CBT and TSF than in MET. Significant matching effects for the support for drinking variable emerged in the 3-year outcome analysis, such that clients whose social networks were more supportive of drinking derived greater benefit from TSF treatment than from MET. Among subjects in the highest third of the support for drinking variable, TSF participants were abstinent	Project MATCH Research Group (1997) Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. Journal of Studies on Alcohol, 58, 7–29

16.1% more days than MET participants. At the lower end of this variable, difference in percent days abstinent between MET and TSF was 3%, with MET clients having more abstinent days. A significant matching effect for psychiatric severity that appeared in the first year posttreatment was not observed after 3 years. Of the 21 client attributes used in testing the matching hypotheses, 11 had prognostic value at 3 years. Among these, readiness-to-change and self-efficacy emerged as the strongest predictors of long-term drinking outcome. With regard to the overall outcomes, the reductions in drinking that were observed in the first year after treatment were sustained over the 3-year follow-up period: almost 30% of the subjects were totally abstinent in months 37 to 39, whereas those who did report drinking nevertheless remained abstinent an average of two-thirds of the time. As in the 1-year follow-up, there were few differences among the three treatments, although TSF continued to show a possible slight advantage.	
Aim - A 3-year update with 59 new controlled trials is provided for the ongoing Mesa Grande project reviewing clinical trials of treatments for alcohol use disorders. The project summarizes the current evidence for various treatment approaches, weighting findings differentially according to the methodological strength of each study. Design - The review includes 361 controlled studies that (1) evaluated at least one treatment for alcohol use disorders, (2) compared it with an alternative condition (such as a control group, a placebo, a brief intervention or an alternative treatment), (3) used a procedure designed to create equivalent groups before treatment and (4) reported at least one outcome measure of drinking or alcohol-related consequences. Studies were rated by two reviewers on 12 methodological criteria, and outcome logic was analyzed for the specific treatment modalities tested. Findings - Methodological quality of studies was significantly but modestly correlated with the reporting of a specific effect of treatment. Among psychosocial treatments, strongest evidence of efficacy was found for brief interventions, social skills training, the community reinforcement approach, behavior contracting, behavioral marital therapy and case management. For the first time, two pharmacotherapies also appeared among the most strongly supported approaches: opiate antagonists (naltrexone, nalmefene) and acamprosate. Least supported were methods designed to educate, confront, shock or foster insight regarding the nature and causes of alcoholism. Conclusions - Treatment methods differ substantially in apparent efficacy. It would be sensible to consider these differences in designing and funding treatment programs.	Miller, W. R. & Wilbourne, P. L. (2002) Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders. Addiction, 97, 265–277.
Alcohol dependence treatment may include medications, behavioral therapies, or both. It is unknown how combining these treatments may impact their effectiveness, especially in the context of primary care and other nonspecialty settings. Objectives - To evaluate the efficacy of medication, behavioral therapies, and their combinations for treatment of alcohol dependence and to evaluate placebo effect on overall outcome. Design, Setting, and Participants. Randomized controlled trial conducted January 2001-January 2004 among 1383 recently alcohol-abstinent volunteers (median age, 44 years) from 11 US academic sites with Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, diagnoses of primary alcohol dependence. Interventions - Eight groups of patients received medical management with 16 weeks of naltrexone (100 mg/d) or acamprosate (3 g/d), both, and/or both placebos, with or without a combined behavioral intervention (CBI). A ninth group received CBI only (no pills). Patients were also evaluated for up to 1 year after treatment. Main Outcome Measures Percent days abstinent from alcohol and time to first heavy drinking day. Results - All groups showed substantial reduction in drinking. During treatment, patients receiving naltrexone plus medical management (n=302), CBI plus medical management and placebos (n=305), or both naltrexone and CBI plus medical management	Anton, R. F., O'Malley, S. S., Ciraulo, D. A., et al. (2006) Combined pharmacotherapies and behavioral interventions for alcohol dependence. The Journal of the American Medical Association, 295, 2003–2017

(n=309) had higher percent days abstinent (80.6, 79.2, and 77.1, respectively) than the 75.1 in those receiving placebos and medical management only (n=305), a significant naltrexonebehavioral intervention interaction (P=.009). Naltrexone also reduced risk of a heavy drinking day (hazard ratio, 0.72; 97.5% CI, 0.53-0.98; P=.02) over time, most evident in those receiving medical management but not CBI. Acamprosate showed no significant effect on drinking vs placebo, either by itself or with any combination of naltrexone, CBI, or both. During treatment, those receiving CBI without pills or medical management (n=157) had lower percent days abstinent (66.6) than those receiving placebo plus medical management alone (n=153) or placebo plus medical management and CBI (n=156) (73.8 and 79.8, respectively; P.001). One year after treatment, these between-group effects were similar but no longer significant. Conclusions - Patients receiving medical management with naltrexone, CBI, or both fared better on drinking outcomes, whereas acamprosate showed no evidence of efficacy, with or without CBI. No combination produced better efficacy than naltrexone or CBI alone in the presence of medical management. Placebo pills and meeting with a health care professional had a positive effect above that of CBI during treatment. Naltrexone with medical management could be delivered in health care settings, thus serving alcohol-dependent patients who might otherwise not receive treatment.	
Aims: The present study aimed to evaluate whether individual counselling for alcohol-dependent patients in three sessions is as effective as a 2-week group treatment programme as part of an in-patient stay in a psychiatric hospital which was to foster motivation to seek further help and to strengthen the motivation to stay sober. Of particular importance was the external validity of the results, i.e. a 'normal' intake load of in-patients in detoxification and a wide variety of motivation to stop drinking were to be investigated. Methods: Subjects eligible for the study were all patients with alcohol problems admitted to a psychiatric hospital, but without psychosis, as the main diagnosis, and with a maximum of 10 detoxification treatments in the past. A randomized-controlled trial was conducted with 161 alcohol-dependent in-patients who received three individual counselling sessions on their ward in addition to detoxification treatment and 161 in-patients who received 2 weeks of in-patient treatment and four out-patient group sessions in addition to detoxification. Both interventions followed the principles and strategies of motivational interviewing. Results: Six months after intervention, group-treatment patients showed a higher rate of participation in self-help groups; however, this difference had disappeared 12 months after treatment. The abstinence rate among the former patients did not differ between the two intervention groups. Conclusion: Group treatment may lead to a higher rate of participation in self-help groups, but does not increase the abstinence rate 6 months after treatment.	John, U., Veltrup, C., Driessen, M., et al. (2003) Motivational intervention: an individual counselling vs. a group treatment approach for alcohol-dependent inpatients. Alcohol and Alcoholism, 38, 263–269

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