

## Kliiniline küsimus nr 17

*Kas kõigil alkoholi kuritarvitavatel ja alkoholisõltuvusega patsientidel käitumise muutmiseks hinnata ravimotivatsiooni vs mitte hinnata:*

- ravi alustamisel
- raviplaani muutmisel
- tagasilanguse korral
- ravi lõpetamisel
- igal visiidil

Kriitilised tulemusnäitajad: *abstinents, tagasilangus, alkoholi tarvitamise vähenemine, patsiendi rahulolu, patsiendi elukvaliteet, ravisoostumus, ravi katkestamine mistahes põhjusel, juhuslik alkoholi tarvitamine*

## Ravijuhendid

### Kokkuvõte tõendusmaterjali kvaliteedist

Tõendusmaterjali kokkuvõtte koostamiseks vaadati läbi 12 alkoholisõltuvuse ja liigkasutamise ravijuhendit. Teemakohast infot sisaldas neist kuues ravijuhendis: SIGN2003, NICE2011, NSW2008, Australia2009, APA2006, SAMHSA2009. Lisaks üks süstemaatiline ülevaade.

Läbi vaadatud kirjanduses peetakse oluliseks motivatsiooni kui ühte teguritest, mis võib põhjustada ravi katkestamise ja tagasilanguse. Enamasti on soovitatud kaasata motivatsiooni hindamist patsiendi esialgsesse hindamisse ning kasutada võimalusel ravi käigus motivatsiooni tugevdavaid meetodeid. Ravijuhendites ei kajastata motivatsiooni hindamist raviplaani muutmisel.

#### SIGN2003

Tõendusmaterjal on hea kvaliteediga. Kaks süstemaatilist ülevaadet (Miller jt 2002, 361 kliinilist katset koondav; Dunn jt 2001, 29 kliinilise katse süstemaatiline ülevaade) ja üks ülevaade (Rollnick jt 1996) leiavad, et motivatsioon on oluline alkoholi liigtarbivate patsientide ravis ning seega tuleks ravis kasutada motiveerivat intervjuud. Seda eriti puhkudel, mil on vaja rakendada patseindil tavapärasest agressiivsemaid ravimeetodeid.

#### NICE2011

Tõendusmaterjal on hea kvaliteediga, põhinedes nii uuringutel kui raamatutel. Raistrick jt (2006) ülevaade rõhutab, et motivatsioon on väga oluline ravi valiku seisukohast ning kindlasti tuleks hinnata, millises motivatsiooni faasis patsient hetkel asub. Heather jt (1999) kliiniline uuring leidis, et patsientidel, kes asusid RCQ-TV küsimustiku alusel tegutsemise faasis, olid paremad ravitulemused. MoCAM (2006) juhis annab soovitusi, et motivatsioon peaks olema ühe komponendina patsiendi hindamises sees nii algses lühi-, kui ka hilisemas põhjalikumas hindamises. Miller ja Rollnick (2002) raamatus hoiatatakse, et patsiendi algne liigne küsitlemine võib omada hoopis negatiivset mõju ning et esialgne madal motivatsioon ei pruugi tingimata olla takistuseks edukaks raviks.

#### Austraalia2009

Tõendus on hea kvaliteediga ning põhineb kliinilistel- ja kohortuuringutel.

Cutler and Fishbain 2005: Projekt MATCH kasutas URICA skaalat ning leidis, et väga vähe tõendust on selle kohta, et motiveerituse faas võimaldaks ennustada ravitulemust. Ainult 3% ravitulemusest suudeti järelkontrollis omistada ravile. Tulemused näitasid, et ravi planeerimine vastavalt faasile ei olnud tulemuslik ning 3 erineva ravigrupi tulemused olid samad.

Callaghan jt (2007) näitasid, et vastupidiselt oodatule need patsiendid, kes liikusid motiveerituse faasis edasi tegutsemise faasi, ei omanud paremaid ravitulemusi, kui need, kes jäid ravi jooksul motiveerituse ettevalmistavatesse faasidesse.

Prospektiivne kohortuuring (Williams jt 2007) näitas, et suurem motiveeritus ei taganud paremaid tulemusi alkoholi tarbimise vähendamises. Sellest olulisemaks osutus hoopis patsiendi enesekindlus.

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West (2005) uuring kritiseerib taolist lähenemisviisi, kuna inimesed võivad muuta oma käitumist situatsioonidest lähtuvalt, mitte omades eelnevalt motivatsiooni selleks.

Heather jt (1996) uuring Austraalia patsientidel näitas, et vähem motiveeritud patsientidel andis paremaid ravitulemusi motiveeriv intervjuu, mitte oskuste põhine sekkumine. Samas ei olnud oskuste põhine sekkumine edukas ka motiveeritud patsientide seas.

Saitz jt (2007) haiglapatsientide uuring näitas, et motiveeriv intervjuu ei parandanud ravitulemusi sekkumisgrupis võrreldes tavaraviga, erinevused puudusid sekkumisgruppide vahel ka 3 kuu möödudes. Mõlemas grupis oli küll vaadeldav alkoholi tarbimise vähenemine, kuid tõenäoliselt oli see tänu üldisele skriinimisele ja antud tagasisidele.

#### NSW2008

Tõendusmaterjal on hea kvaliteediga ning antud soovitused tugeva tasemega, põhinedes nii kliinilistel uuringutel, süstemaatilistel ülevaadetel kui ka ravijuhenditel. Bien jt (1993) ülevaade soovib kasutada lühikest motiveerivat intervjuud erinevates tervishoiuasutustes. Shand jt (2003) juhend soovib kasutada motiveerivat intervjuud kõikides ravi ja hindamise faasides, soodustamaks revisoostumust.

Psychosocial Treatment	Level of Evidence for Use with Problematic Drug and Alcohol use	Strength of Recommendation for Use with Drug and Alcohol Clients
Brief Interventions	Level 1	★★★
Motivational Interviewing	Level 1	★★★
Contingency Management	Level 2	★★★
CBT	Level 1	★★★
Psychodynamic Approaches	Level 2	★★★
Emotional Regulation		
MBSR	Level 3b	★★
DBT	Level 2	★★★
ACT	Level 2	★★
Family Approaches		
Couple/Family Therapy	Level 3a	★★
SFBT	Level 4	★
Systemic Approaches	Nil	★
Narrative Approaches	Nil	★
Self-Help Groups	Level 2	★★
Self-Help	Level 1	★★★
Continuing Care	Level 2	★★★
Management of Crisis Situations	Level 4	★

#### APA2006

Ravijuhise poolt antud soovitused põhinevad suures osas eksperthinnangutel, ühel kohortuuringul (Domino jt 2005; 292 patsienti) ja ühel randomiseeritud kontrollitud uuringul. Alkoholisõltuvusega patsientide puhul on raviotsuse tegemiseks oluline hinnata ravimotivatsiooni ning kasutada ravi käigus motivatsiooni tugevdavaid strateegiaid. Connors (2002) randomiseeritud kontrollitud uuring 126 patsiendiga võrdles motiveerivat intervjuud (MI) ja rolli induktsiooni (*role induction*) kontrollgrupiga. MI gruppi kuulunutel esines vähem joomasööste võrreldes võrdlusgrupiga (nii ravi jooksul kui 12 kuud peale ravi). MI grupi liikmetel oli ka rohkem kainuse päevi (ravi ajal ja 3 kuud pärast), kuid see ei säilinud 12-kuulise jälgimisperioodi lõpuni.

### SAMHSA2009

Tõendusmaterjal on saadud ühest metaanalüüsist, väiksematest randomiseeritud kontrollitud uuringutest ja eksperthinnangutest.

Koeter ja kolleegid (2010) viisid läbi metaanalüüsi 11 kliinilisest uuringust (acamprosate=1128; platseebo=1177) ning leidsid, et patsiendi motivatsioon kainuseks mõjutab olulisel määral ravisoostumust ja parandab ravi efektiivsust. Seega on soovitatud varases ravi staadiumis kasutada motiveerivaid strateegiaid.

Randomiseeritud kontrollitud uuring 137 patsiendiga näitas, et motivatsiooni tugevdavad teraapiad koos platseeboga või medikamentoose raviga ei olnud efektiivsemad kui kognitiivne käitumisteraapia koos naltrexooniga (Baros jt 2007). Sama tulemuse said ka Davidson jt (2007) 149 patsiendiga randomiseeritud kontrollitud uuringus.

Andmebaaside otsingul saadud Brorson jt (2013) süstemaatiline ülevaade analüüsis 9 artiklit, kus oli käsitletud patsiendi motivatsiooni ning leidis vastuolulisi tulemusi. 5 koondatud uuringut, mis näitasid motivatsiooni olulisust, olid enamasti väikse valimiga ning kõrge väljalangemise määraga. Sarnase valimi suuruse ja väljalangemismääraga analüüsitud 4 artiklit aga seda olulisust ei kinnitanud.

### **Kokkuvõte ravijuhendites leiduvatest soovitustest**

#### SIGN2003

Tagasilanguse ennetamiseks on efektiivne kasutada motiveerivat intervjuud, mida viib läbi psühholoog.

Motiveeriva intervjuu tehnikat võiks kasutada esmatasandi arstiabis lühiajaliste sekkumiste puhul, kuna on näidatud, et see vähendab oluliselt alkoholi tarbimist.

Esmasel hindamisel vihasena näivate patsientide puhul on ravitulemus parem kasutades motiveerivat intervjuud.

#### NICE2011

Ravimeetodi valimiseks ja tulemuse saavutamiseks, on oluline mõista patsiendi motivatsiooni alkoholi tarbimise käitumise muutmiseks ja seda tuleks hinnata. Hindamiseks on loodud erinevaid meetodikaid, mis on reeglina seostatud muutuste tsüklitega (loodud Prochaska and DiClemente poolt 1983), mille patsient läbib (ja millises faasis ta parasjagu on). Muutuste toimumise faasis on: ravikaalumise eelne, ravikaalumise, tegutsemise ja säilitamise faas (Rastrick 2006).

Alkoholi liigtarvitavatel patsientidel saab ravimotivatsiooni hindamiseks kasutada küsimustikke - *Readiness to Change Questionnaire* (RCQ, RCQ-Treatment Version). RCQ on mõeldud ravi mitte otsivatele patsientidele. RCQ-TV küsimustik on mõeldud ravi otsivatele alkoholi liigtarvitavatele patsientidele. Heather ja kolleegid näitasid, et küsimustiku test-retest oli adekvaatne ( $R = 0.69$  kuni  $0.86$ ). Patsiendid, kes olid saanud eelnevalt ravi rohkem kui 6 kuud, olid suurema täenõususega tegutsemise faasis, kui need, kes olid saanud vähem või üldse mitte ravi ( $x^2 = 8.75$ ,  $p > 0.005$ ). Ka olid nende tulemused paremad järelkontrollis (Heather et al 1999).

On näidatud, et esialgne liigne info kogumine patsiendilt hinnangu andmiseks võib olla vastupidise efektiga, kuna algne madal motivatsioon ei ole tingimata takistuseks patsiendi hindamisel ja hilisemal ravisoostumusel (Miller & Rollnick, 2002).

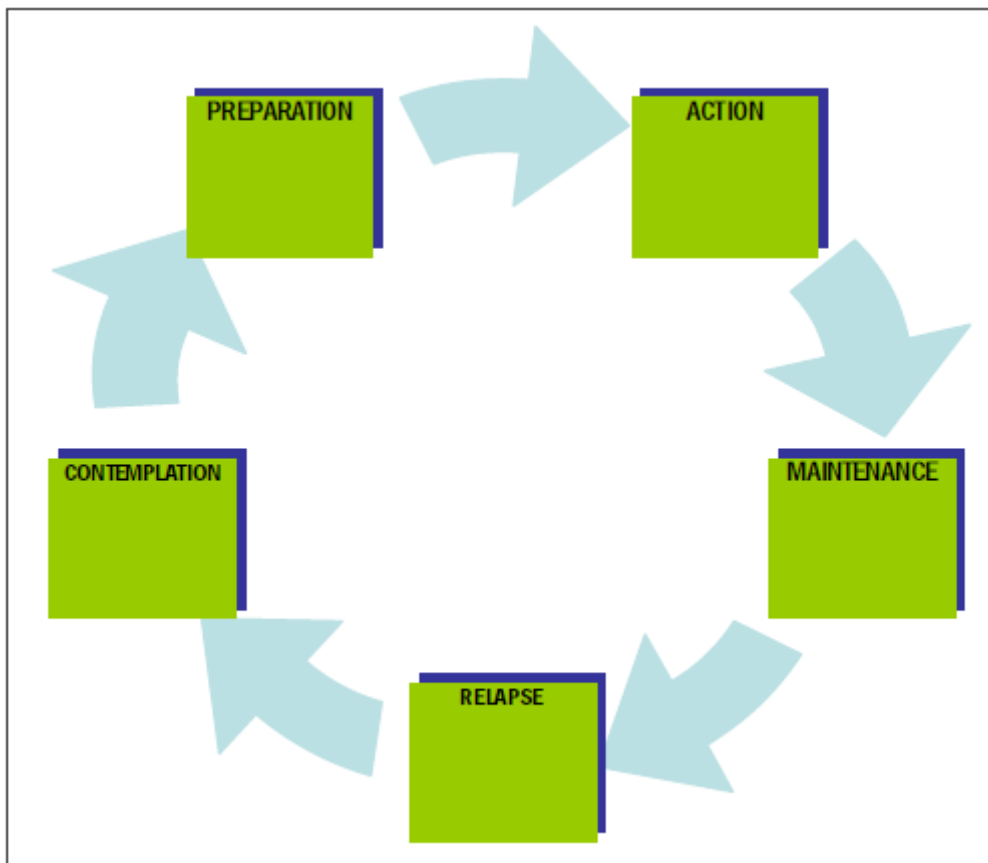
Patsiendi esmasel kokkupuutel spetsialistiga, tuleks hinnata alkoholi tarbimise ajalugu, kaasnevaid probleeme, riske, patsiendi valmisolekut ja motiveeritust raviks (*triage assessment*). Motiveeritust tuleks hinnata ka põhjalikul hindamisel (*comprehensive assessment*), mida viiakse läbi patsientidel, kel esineb komorbiidsusi, keskmine või tugev alkoholisõltuvus, risk endale või teiste tervisele (MoCAM; Department of Health, 2006a).

**Figure 4: Assessment levels**

Level 1: Case identification/diagnosis	Trained and competent staff in all services providing Tier 1 to 4 interventions
Level 2: Withdrawal assessment	Trained and competent staff in all services providing Tier 1 to 4 interventions
Level 3: Triage assessment	Trained and competent staff in all services providing Tier 2 to 4 interventions
Level 4: Comprehensive assessment	Trained and competent staff in all services providing Tier 3 to 4 interventions (and some Tier 2 interventions)

Austraalia2009

Patsiendi motiveeritus on oluline ennustaja ravitulemusele. Prochaska ja DiClemente alusel jagatakse motiveerituse tsükkel 5 faasiks:



*Design: Author*

Motiveerituse hindamiseks kasutatav vahend hindab neid 5 faasi. Erinevad uuringud (Cutler and Fishbain 2005, Callaghan et al. 2007, Williams et al. 2007, West 2005, Heather et al. 1996, Saitz et al. 2007) näitavad, et lisaks muutuse faasile, milles patsient on, omavad käitumise muutmisel olulist tähtsust ka teised faktorid (nt enesekindlus, sõpruskonna käitumine jne) ning neid tuleks igal patsiendi hindamisel arvesse võtta. Küll aga tuleks motiveerituse faasi arvesse võtta ravi planeerimisel (kavandades ravi nii, et olemasolevat motivatsiooni tõstetaks või säilitataks). Soovitus: Motiveeritust tuleks hinnata otseste küsimuste teel (nt URICA, RTCQ, SOCRATES), aga väljendatud motiveeritusel on vaid osaline mõju ravitulemusele.

Enne raviotsuse tegemist tuleks läbi viia kliiniline hindamine. Hinnata tuleks:

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- motiveeritust
- alkoholi tarbimise mustreid ja sõltuvuse raskust
- alkoholiga seotud kahjusid (nt tervis)
- perekondlikke faktoreid
- kognitiivset funktsioneerimist

Hindamine võib olla jaotatud mitme sessiooni peale ja peaks jätkuma kogu ravi vältel, mil mõõdetakse patsiendi edusamme ja võrreldakse neid seatud eesmärkidega.

#### NSW2008

Motivatsiooni hindamine peaks olema patsiendi esmase hindamise üks osa, kasutades selleks näiteks RCQ (readiness to change) skaalat.

Kui patsient tunneb, et edusammud on aeglased, võib väheneda tema motiveeritus. Seetõttu peaks patsiendi täieliku hindamise osas olema ettevaatlik ning keskenduma pigem seatud eesmärkide täitmisele.

Lühiajalistes sekkumistes võiks kasutada FRAMES lähenemist, kombineerides üldist nõustamist motiveeriva intervjuu tehnikatega: **F**eedback (risks, indicators, health status), **R**esponsibility (communicate choice to change), **A**dvice (importance of change, with permission), **M**enu (variety of change options - harm reduction), **E**mpathy (warm, non-judgmental, non-confronting), **S**elf-efficacy (optimism to attain chosen goals).

Motiveerivat intervjuud võib kasutada kõikides ravi ja hindamise faasides, soodustamaks ravisoostumust.

Motiveerivat intervjuud tuleks kombineerida teiste psühhosotsiaalsete lähenemistega kvalifitseeritud tervishoiutöötaja poolt, et vähendada alkoholi liigtarvitamist.

#### APA2006

Mõistmine, millises motiveerituse faasis patsient asub, annab tervishoiutöötajale võimaluse otsustada, millised motiveerivad strateegiad võiksid antud patsiendi puhul olla kõige tulemuslikumad. Motiveeriva intervjuu üheks eesmärgiks on esile tuua patsiendi põhjused, miks soovitakse käitumist muuta ning aidata patsiendil liikuda läbi erinevate motiveerituste faaside.

Kuna sõltuvushäiretega patsiendid on sageli ambivalentsed oma sõltuvusest loobumisel, siis tuleks hinnata nende valmidust ravi ja antavaid soovitusi järgida. Sõltuvushäiretega patsiendid on vastuvõtlikud tagasilangusele erinevatel põhjustel (sotsiaalsed, majanduslikud jne). Seetõttu on oluline avalikult tunnustada patsiendi jõupingutusi ja edusamme, et motiveerida teda ravi jätkama, hoolimata tagasilangustest. Selleks võib kasutada motivatsiooni tugevdavaid strateegiaid. Ravisoostumisele aitavad kaasa ka jälgimisprogrammid (nt EAP-d ja *impaired-physician programs*).

#### SAMHSA2009

Enne ravi pakkumist tuleks hinnata patsiendi motivatsiooni alkoholi tarbimise käitumise muutmiseks. Tabelis 6-3 on toodud küsimused, mille alusel saab patsiendi motivatsiooni hinnata.

### **Exhibit 6-3** **Questions To Assess Patients'** **Readiness for Change**

In what ways are you concerned about your drinking?

How much does this concern you?

What are the reasons you see for making a change?

How do you feel about changing your drinking?

How ready are you to change your drinking?

What do you think will happen if you don't make a change?

What do you think you want to do about your drinking?

What do you think would work for you, if you needed to change?

Ravisoostumusel on oluline patsiendi ja tervishoiutöötaja vaheline side ning patsient peaks olema avatud ka teistele ravimeetoditele ja sekkumistele (nt psühhosotsiaalsed või kogukonna tugi). Kuigi psühhosotsiaalsed sekkumised vähendavad alkoholi tarbimise määra, on näidatud, et suur osa patsientidest alustavad uuesti alkoholi tarbimist esimese aasta jooksul.

Motivatsiooni olulisust on näidatud erinevates kliinilistes uuringutes, mis soovivad ravi algusest peale kasutada paremate ja püsivamate tulemuste saamiseks motiveerivaid strateegiaid. Mõned väiksemad uuringud on aga leidnud, et motiveerivatest strateegiatest olulisem on kognitiivse käitumisteraapia kasutamine koos medikamentoosse raviga.

#### **Ravijuhendite inglise keelsed tekstid:**

##### **SIGN2003**

Motivational interviewing and coping skills training for relapse prevention have been shown to be effective when delivered by psychologists.

Motivational interviewing (a non-judgemental interviewing style which avoids confrontation, helps the individual weigh up the pros and cons of change, and enhances self efficacy) is a style which is helpful in brief interventions. A systematic review showed that motivational interviewing has a significant effect on reducing alcohol consumption in the primary care setting. Research aiming to predict which patients will do better with which type of specialist treatments has given few leads. The GP.s decision where to refer a patient should be guided in large part by the patient.s choice. Some predictors however, have emerged: patients who are angry at the initial assessment appear to do better, in the short term, if given motivational interviewing

##### **NICE2011**

Raistrick and colleagues (2006) noted that 'an understanding of the service user's motivation to change drinking behaviour is a key to effective treatment and can be used to decide on the specific treatment offered'. A number of methods have been developed to aid the assessment of motivational status; these are usually linked to the cycle of change developed by Prochaska and DiClemente (1983) and are designed to site drinkers at specific stages within the cycle. The key

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stages of change are pre-contemplation (seemingly unaware of any problem), contemplation (aware and considering change), preparation (decision to change taken, planning what to do), action (doing it) and maintenance (working to secure the change).

Tools to measure motivation in people with alcohol misuse problems; these are the RCQ (Rollnick *et al.*, 1992) and the RCQ-TV. Test-retest reliability was adequate ( $R = 0.69$  to  $0.86$  across subscales). Participants who had been in treatment for more than 6 months or who had had any treatment were more likely to be in the action group than those treated for less than 6 months or those who had had no treatment ( $\chi^2 = 8.75$ ,  $p < 0.005$ ). Similarly, those initially assigned to the action group were more likely than those in the contemplation group to have a good outcome at follow-up. This result remained when reclassifying participants at follow-up (Heather *et al.*, 1999).

Indeed, there is evidence to suggest that a premature focus on information gathering and completion of the assessment process may have a negative impact on the engagement of the patient (Miller & Rollnick, 2002). Where this approach is adopted, there is some evidence to suggest that initial low levels of motivation are not necessarily a barrier to an effective assessment and the future uptake of treatment (Miller & Rollnick, 2002).

The triage assessment should include:

- alcohol use history
- co-occurring problems (medical, mental health, substance misuse, social and criminal)
- risk assessment
- readiness and motivation to change. (MoCAM; Department of Health, 2006a)

The comprehensive assessment should include assessment of motivation. However, a consideration of a patient's readiness and/or motivation for change is a vital part of assessment.

#### Australia 2009

There is only slim evidence of its ability to predict treatment outcome with alcohol dependent patients. Project MATCH assessed readiness to change using a subset of the University of Rhode Island Change Assessment (URICA) scale, and hypothesised that patients low in motivation would do better in the motivational enhancement therapy than in cognitive behaviour therapy. On an analysis of data, overall a median of only 3% of the drinking outcome at follow-up could be attributed to treatment; however the effect appeared to be present before most of the treatment had been delivered, with the zero treatment group showing the most improvement. The long-term results found that patient-treatment matching was unsuccessful and that the three treatments produced essentially the same results (Cutler and Fishbain 2005). Callaghan's additional analysis found that, contrary to expectations, the individuals who made a progressive stage transition to action-oriented stages did not manifest greater improvements in drinking than those remaining in preparatory stages (Callaghan *et al.* 2007). A similar effect, that greater readiness to change was not predictive of reduced alcohol consumption, was found in a prospective cohort study (Williams *et al.* 2007), where patient confidence in their ability to change was more predictive of a favourable outcome. Others have challenged the concept that well-defined 'stages' actually exist; West's criticism partly rests on the premise that people sometimes change their behaviour on strong situational determinants without any prior evidence of motivation (West 2005).

In an Australian study of brief interventions, heavy drinkers who were less ready to change did better with a brief motivational interviewing intervention than with a skills based intervention; however, those classified as ready to change did not do better in the skills-based intervention (Heather *et al.* 1996). In a more recent study of hospital patients, Saitz *et al.* found that brief motivational counselling did not reduce alcohol consumption significantly among the intervention group of heavy drinkers (1.8 drinks per day) compared to 'usual care' patients (2.6 drinks per day) at 12 months; neither did it reduce the need for alcohol assistance in the intervention group at 3 months. However, both groups reduced their drinking and this may be attributable to the screening and feedback process in itself (Saitz *et al.* 2007).

Results of these studies suggest that factors other than 'stage of change' (e.g. confidence, peer group behaviour) play an important part in behaviour change and must be considered in all

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assessments. However, treatment planning should take motivational state into account so as to maintain and enhance motivation to control excessive drinking.

Recommendation	Strength of recommendation	Level of evidence
3.12 Motivation to change should be assessed through direct questioning, although expressed motivation has only a moderate impact on treatment outcome	B	II

The areas for assessment include:

- motivation to change
- alcohol consumption pattern and severity of dependence
- alcohol-related harms (such as physical and psychological health problems, relationship problems, occupational problems and legal problems)
- family factors

Assessment continues throughout treatment as the patient's progress is measured against the treatment goals.cognitive functioning.

#### NSW2008

Drug and Alcohol services will likely have a core list of assessments to be administered to clients, and these should be used by the D&A professional in assessing a client's presenting condition. Usually, a comprehensive drug and alcohol assessment will include the following components: ■ Stages of change of drug and alcohol use (using scales such as the readiness to change scale).

If the client feels that little progress is being made, motivation to engage with treatment may decrease. As such, it is important to balance the need for a complete assessment with the overriding goal of engaging a client in drug and alcohol treatment.

The most effective brief interventions will combine good general counselling skills with motivational interviewing techniques, using the FRAMES approach:

Elements of a brief intervention

**F**eedback (risks, indicators, health status)

**R**esponsibility (communicate choice to change)

**A**dvice (importance of change, with permission)

**M**enu (variety of change options - harm reduction)

**E**mpathy (warm, non-judgmental, non-confronting)

**S**elf-efficacy (optimism to attain chosen goals)

Motivational interviewing can be used in all phases of assessing and treating drug and alcohol clients to increase treatment engagement and adherence.

Motivational interviewing should be combined with other psychosocial approaches by suitably trained drug and alcohol professionals to reduce problematic drug and alcohol use.

#### APA2006

Understanding the patient's stage of readiness to change (precontemplation, contemplation, preparation, action, or maintenance stage) allows the clinician to determine what motivational strategies are most appropriate for the patient at that time. One of the goals of motivational interviewing is to elicit the patient's reasons for change and assist the patient in moving through the subsequent stages of change.

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Because individuals with substance use disorders are often ambivalent about giving up their substance use, it can be useful to monitor their attitudes about participating in treatment and adhering to specific recommendations. Supporting patients in their efforts to reduce or abstain from substance use positively reinforces their progress. Overt recognition of patient efforts and successes helps to motivate patients to remain in treatment despite setbacks. Clinicians can optimize patient engagement and retention in treatment through the use of motivational enhancement strategies. Monitoring programs, such as EAPs and impaired-physician programs, can sometimes help patients adhere to treatment.

#### SAMHSA2009

Before offering treatment for alcohol dependence, providers should assess patients' readiness to change drinking behavior. Through this assessment, patients and providers develop mutually agreeable intervention and treatment plans. Exhibit 6-3 provides questions that determine patients' readiness for change.

Regardless of patients' readiness to change, they should, at a minimum, be willing to be in a supportive relationship with their healthcare provider. In addition, patients should be willing to consider adjunctive options including specialty treatment, other independent psychosocial treatment providers, or forms of community support. A review of the literature suggests that although psychosocial interventions increase rates of abstinence and decrease alcohol consumption, a significant proportion of patients relapse to drinking within 1 year (Mason, 2005a)

Koeter and colleagues (2010) performed a meta-analysis of 11 clinical trials to determine the influence of early and late adherence to acamprosate on treatment attendance and duration of abstinence in the treatment of AUD. The authors examined data from 11 randomized controlled trials comparing acamprosate ( $n = 1,128$ ) with placebo ( $n = 1,177$ ) in studies published between 1985 and 2006. The meta-analysis confirms that nonadherence remains a serious problem; the early discontinuation of acamprosate may compromise the medication's effectiveness, because of its delayed onset of action. Conversely, treatment with disulfiram or oral naltrexone yields immediate pharmacological actions. The study confirmed that a person's motivation to become abstinent significantly affects treatment adherence and improves medication efficacy. Therefore, providing motivational interventions early in treatment can improve the likelihood of a person's adherence in taking medication, and thus the prospect of long-term abstinence.

This study evaluated outcomes for 137 randomized patients with alcohol dependence who completed 12 weeks of naltrexone or placebo, combined with either cognitive-behavioral therapy (CBT) or motivational enhancement therapy (MET). Patients treated with naltrexone and CBT showed more days of abstinence, less relapse to heavy drinking days, and fewer total drinks than the other groups (those receiving naltrexone plus MET or placebo plus psychotherapy). Baros et al., 2007

**Broad-spectrum treatment (BST).** A 3-month, randomized controlled trial explored whether a broad-spectrum CBT would be more effective than MET for patients who are alcohol dependent treated with naltrexone (Davidson, Gulliver, Longabaugh, Wirtz, & Swift, 2007). This initial trial suggests that, at least when combined with naltrexone, a second-generation CBT may have a meaningful clinical advantage over brief interventions such as MET (Davidson et al., 2007).

#### **Süsteematilised ülevaated**

Brorson jt (2013) süsteematilises ülevaates vaadeldi patsiendi motivatsiooni, kui ühte olulist tegurit, mis mõjutab sõltuvushäire ravi katkestamist. Süsteematilises ülevaates kasutatud artiklites käsitleti motivatsiooni kui tegurit 7% (9) leitud artiklites. 5 artiklit leidsid statistiliselt olulise seose. Kahes uuringus näidati, et madalam motivatsioon on seotud kõrgema ravi katkestamise tasemega. Kahes uuringus leiti seos kõrgema motivatsiooni ja kõrgema ravi katkestamise tasemega ning üks uuring leidis, et kõrge välimine motivatsioon (nt katseaeg) suurendab ravi katkestamise tõenäosust (seejuures sisemine motivatsioon ei andnud seost).

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Suurematest uuringutest käsitleti motivatsiooni kolmes, kahel juhul ei leitud seoseid motivatsiooni ja ravikatkestamise osas, üks uuring leidis positiivse seose motivatsiooni ja ravi katkestamise vahel.

**Table 2**  
Number of studies on specific risk factors and number of significant findings.

Variable	n analyzed	n sign.	Risk group	Studies, number in Table 1, significant in bold
Age	72	26	Older: 3 Younger: 23	<b>1, 3, 4, 6, 7, 9, 12, 14, 17, 18, 19, 23, 28, 32, 36, 37, 38, 44, 46, 49, 51, 53, 68, 73, 91, 101</b> 5, 10, 11, 15, 20, 24, 25, 29, 31, 33, 34, 39, 43, 47, 50, 52, 54, 55, 56, 58, 62, 66, 67, 71, 76, 79, 80, 83, 84, 87, 88, 93, 94, 95, 99, 100, 103, 107, 108, 112, 114, 115, 116, 117, 118, 121
Sex	64	10	Female: 5 Male: 5	<b>4, 11, 12, 28, 38, 55, 61, 80, 88, 109</b> 5, 6, 9, 10, 14, 15, 16, 17, 19, 20, 23, 24, 25, 27, 29, 31, 32, 33, 36, 37, 39, 40, 43, 47, 48, 49, 50, 51, 52, 53, 54, 56, 58, 62, 67, 74, 83, 84, 86, 87, 93, 94, 95, 96, 101, 103, 107, 108, 112, 114, 115, 116, 117, 121
Education	42	9	Low: 9 High: 0	<b>1, 19, 38, 51, 55, 62, 103, 112, 116</b> 5, 7, 11, 14, 23, 27, 28, 31, 34, 36, 40, 46, 47, 49, 50, 53, 54, 56, 58, 66, 71, 74, 76, 80, 83, 88, 93, 95, 100, 101, 114, 115, 118
Marital status	36	4	Single: 3 Separated: 1	<b>5, 17, 19, 55</b> 3, 4, 14, 23, 24, 25, 27, 28, 31, 34, 36, 38, 39, 40, 49, 58, 62, 71, 74, 76, 79, 87, 88, 93, 99, 100, 103, 107, 112, 115, 116, 117
Cognition	11	11		<b>7, 54, 62, 91, 102, 112, 115, 118, 120, 121, 122</b>
Motivation	9	5	Lower: 2 Higher: 3	<b>8, 40, 67, 93, 113</b> 7, 23, 31, 51

**Table 1**  
Key characteristics of included studies ordered by number of participants.

nmb	Author	n	Dropout rate (%)	Country
8	(J. F. Kelly & Moos, 2003)	2778	40.0	US
40	(ClaUS & Kindleberger, 2002)	260	40.0	US
67	(Callaghan et al., 2005)	130	55.4	Canada
93	(De Weert-Van Oene, Schippers, De Jong, & Schrijvers, 2001)	93	26.0	The Netherlands
113	(Dzialdowski, London, & Tilbury, 1998)	50	56.0	UK
7	(McKellar, Kelly, Harris, & Moos, 2006)	3649	12.0	US
23	(Marrero et al., 2005)	557	27.0	Puerto Rico
31	(Lin et al., 2013)	368	67.0	Taiwan

**Viited ravijuhendites**

Kokkuvõtte (abstract või kokkuvõtlikum info)	Viide kirjandusallikale
<p><b>SIGN2003</b></p> <p><b>Aim</b> 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.</p> <p><b>Design</b> 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.</p> <p><b>Findings</b> 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.</p> <p><b>Conclusions</b> Treatment methods differ substantially in apparent efficacy. It would be sensible to consider these differences in designing and funding treatment programs.</p>	<p>Miller WR, Wilbourne PL. Mesa Grande: a methodological analysis of clinical trials for treatments for alcohol use disorders. <i>Addiction</i> 2002;97(3):265-77.</p>
<p>This paper describes the emergence of motivational interviewing in the addictions field, and the development of broader negotiating methods for use in medical consultations about behaviour change. It is argued that much of this material should be relevant to the treatment of obesity in brief medical consultations. It should be possible to encourage patients to be much more active in the consultation, and for practitioners to avoid some of the pitfalls of ineffective advice-giving. Four potentially relevant clinical strategies are described.</p>	<p>Rollnick S. Behaviour change in practice: targeting individuals. <i>Int J Obes Relat Metab Disord</i> 1996;20(Suppl 1):S22-6.</p>
<p><b>Aims.</b> To examine the effectiveness of brief behavioral interventions adapting the principles and techniques of Motivational Interviewing (MI) to four behavioral domains: substance abuse, smoking, HIV risk and diet/exercise. <b>Design.</b> We conducted a systematic review of 29 randomized trials of MI interventions. Data on methodological quality were extracted and tabulated. Between-group behavior change effect sizes and confidence intervals were calculated for each study. <b>Findings.</b> Due to varying intervention time lengths, targeted problem behaviors, settings and interventionists'</p>	<p>Dunn C, Deroo L, Rivara FP. The use of brief interventions adapted from motivational interviewing across behavioural domains: a systematic review. <i>Addiction</i> 2001;96(12):1725-42.</p>

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backgrounds and skill levels, outcomes were not combined meta-analytically. Sixty per cent of the 29 studies yielded at least one significant behavior change effect size. No significant association between length of follow-up time and magnitude of effect sizes was found across studies. There was substantial evidence that MI is an effective substance abuse intervention method when used by clinicians who are non-specialists in substance abuse treatment, particularly when enhancing entry to and engagement in more intensive substance abuse treatment treatment-as-usual. Data were inadequate to judge the effect of MI in the other domains. Client attribute-treatment interactions were understudied and the sparse and inconsistent findings revealed little about the mechanism by which MI works or for whom it works best. <b>Conclusion.</b> To determine more effectively how well MI works in domains other than substance abuse and for whom it works best in all domains, researchers should study MI with risk behaviors other than substance abuse, while examining both interactions and the theoretical components of MI.	
N/A	Matching Alcoholism Treatments to Client Group Heterogeneity: Project MATCH posttreatment drinking outcomes. J Stud Alcohol 1997;58(1):7-29.
N/A	Project MATCH secondary a priori hypotheses. Project MATCH Research Group. Addiction 1997;92(12):1671-98.
<b>NICE2011</b>	
N/A	Raistrick, D., Heather, N. & Godfrey, C. (2006) Review of the Effectiveness of Treatment for Alcohol Problems. London: National Treatment Agency for Substance Misuse.
N/A	Prochaska, J. O., DiClemente, C. C. (1983) Stages and processes of self-change of smoking: toward an integrative model of change. <i>Journal of Consulting and Clinical Psychology</i> , 51, 390–395.
A treatment version of the <i>Readiness to Change Questionnaire</i> (the RCQ[TV]) was developed among a sample of 263 clients attending treatment for alcohol problems. The psychometric properties of this new instrument were shown to be adequate for research and clinical purposes, although further work is needed to strengthen the internal consistency and test-retest reliability of the Contemplation scale. It was not found possible to include a Preparation or a Maintenance stage in the RCQ[TV] and subjects are therefore allocated to Precontemplation. Contemplation or Action stages of change. Significant relationships were found between allocated stage of change and level of alcohol consumption, items measuring motivation to change drinking habits, length of time in treatment and whether or not the subject has previously received treatment for an alcohol problem. Subjects allocated to the Contemplation stage at initial assessment were less likely to show a good treatment outcome at six months follow-up than those allocated to the Action stage, even after the effects of time in treatment were	Heather, N., Luce, A., Peck, D., et al. (1999) Development of a treatment version of the Readiness to Change Questionnaire. <i>Addiction Research</i> , 7, 63–83.

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<p>taken into account. Clinicians currently using the original RCQ in a treatment population should now use the RCQ[TV].</p>	
<p>N/A</p>	<p>Miller, W. R. &amp; Rollnick, S. (2002) <i>Motivational Interviewing: Preparing People for Change</i>, (2nd edn). New York, NY: Guilford Press.</p>
<p>Models of care for alcohol misusers (MoCAM) provides best practice guidance for local health organisations and their partners in delivering a planned and integrated local treatment system for adult alcohol misusers. It will be relevant to primary care trusts (PCTs) who will play a leading role, in partnership with other local agencies, to commission appropriate alcohol services. MoCAM is explicitly identified as a significant milestone towards achieving the second aim of the Alcohol harm reduction strategy for England<sup>2</sup> (2004), 'to better identify and treat alcohol misuse', and is a direct commitment in the Choosing Health<sup>3</sup> White Paper (2004).</p>	<p>(MoCAM; Department of Health, 2006a)</p>
<p><b>Australia 2009</b></p>	
<p><b>Background</b> Project MATCH was the largest and most expensive alcoholism treatment trial ever conducted. The results were disappointing. There were essentially no patient-treatment matches, and three very different treatments produced nearly identical outcomes. These results were interpreted post hoc as evidence that all three treatments were quite effective. We re-analyzed the data in order to estimate effectiveness in relation to quantity of treatment.</p> <p><b>Methods</b> This was a secondary analysis of data from a multisite clinical trial of alcohol dependent volunteers (N = 1726) who received outpatient psychosocial therapy. Analyses were confined to the primary outcome variables, percent days abstinent (PDA) and drinks per drinking day (DDD). Overall tests between treatment outcome and treatment quantity were conducted. Next, three specific groups were highlighted. One group consisted of those who dropped out immediately; the second were those who dropped out after receiving only one therapy session, and the third were those who attended 12 therapy sessions.</p> <p><b>Results</b> Overall, a median of only 3% of the drinking outcome at follow-up could be attributed to treatment. However this effect appeared to be present at week one before most of the treatment had been delivered. The zero treatment dropout group showed great improvement, achieving a mean of 72 percent days abstinent at follow-up. Effect size estimates showed that two-thirds to three-fourths of the improvement in the full treatment group was duplicated in the zero treatment group. Outcomes for the one session treatment group were worse than for the zero treatment group, suggesting a patient self selection effect. Nearly all the improvement in all groups had occurred by week one. The full treatment group had improved in PDA by 62% at week one, and the additional 11 therapy sessions added only another 4% improvement.</p> <p><b>Conclusion</b> The results suggest that current psychosocial treatments for alcoholism are not particularly effective. Untreated alcoholics in clinical trials show significant improvement. Most of the improvement which is interpreted as treatment effect is not due to treatment. Part of the remainder appears to be due to selection effects.</p>	<p>Cutler, RB and DA Fishbain 2005, Are alcoholism treatments effective? The project MATCH data. <i>BMC Public Health</i> 14 (5): 75.</p>
<p><b>Aims</b> To test two central assumptions of stage movement in the</p>	<p>Callaghan, RC, L Taylor and JA</p>

<p>Transtheoretical Model (TTM) <i>vis-à-vis</i> alcoholism recovery: (assumption 1) individuals making a forward transition to the action-oriented stages (i.e. preparation/action) will manifest relatively greater drinking improvements than their counterparts remaining in the pre-action stages (i.e. pre-contemplation, contemplation); and (assumption 2) individuals remaining in the pre-action stages across time will not demonstrate clinically relevant improvement in drinking outcomes.</p> <p><b>Design and setting</b> Secondary data analyses of data from Project MATCH, a large multi-site alcoholism treatment-matching study.</p> <p><b>Measurements</b> At baseline and 3 months post-treatment, the following variables were measured: stage-of-change (based on the University of Rhode Island Change Assessment measure and the most recent stage assignment algorithm), drinks per drinking day (DDD) and percentage days abstinent (PDA).</p> <p><b>Findings</b> Six of the eight tests of assumptions 1 and 2 failed to support the basic tenets of the TTM. Our study demonstrated that individuals making a progressive stage transition to the action-oriented stages (i.e. preparation/action) do not necessarily manifest greater improvements in drinking-related behavior than individuals remaining in the pre-action stages (i.e. pre-contemplation, contemplation), and that individuals remaining in the pre-action stages over time actually do manifest statistically significant and clinically important improvements in drinking-related behavior.</p> <p><b>Conclusions</b> Our findings challenge not only the criterion validity associated with stage movement in the TTM account of alcoholism recovery, but also recent TTM-based substance abuse treatment approaches which systematically promote forward stage transition as a primary clinical goal and marker of therapeutic success.</p>	<p>Cunningham 2007, Does progressive stage transition mean getting better? A test of the Transtheoretical Model in alcoholism recovery. <i>Addiction</i> 102(10): 1588-1596.</p>
<p><b>Background:</b> Assessing readiness to change is recommended as part of brief interventions for patients with unhealthy alcohol use. However, the utility and predictive validity of readiness measures have not been well established.</p> <p><b>Methods:</b> In a prospective cohort study, we assessed primary care patients with unhealthy alcohol use (past-month drinking of risky amounts, or any amount and an affirmative response to CAGE alcohol screening questionnaire) and reassessed them 6 months later. At study entry, we assessed readiness to change using 1 multi-item measure of stage of change, and 5 single-item measures (readiness per se, importance of changing, confidence in ability to change, intention to cut down, intention to abstain). Outcomes included alcohol consumption and alcohol-related consequences. Multivariable regression models were fit for each measure of readiness and each outcome.</p> <p><b>Results:</b> Of 312 patients with unhealthy alcohol use, 228 (73%) were assessed at study entry and 6 months later and had complete data. Among readiness measures, only confidence and intention to abstain (1 point changes on single-item measures) were associated with consumption 6 months later: less heavy episodic drinking [adjusted odds ratio (AOR) 0.88, 95% CI 0.80–0.98 and AOR 0.79, 0.64–0.98, respectively], and less drinking of risky amounts (AOR 0.89, 0.79–1.00 and AOR 0.78, 0.62–0.98, respectively). Intention to abstain was also associated with more abstinence (AOR 1.43, 1.09–1.88). Single-item measures of readiness, importance, and intention to cut down were significantly associated with higher odds of alcohol consequences. Greater confidence (single item) was associated with a lower odds of any consequences (AOR 0.88, 0.79–0.98).</p> <p><b>Conclusions:</b> Greater readiness, as measured by several brief</p>	<p>Williams, EC, Horton NJ, Samet JH et al. 2007, Do brief measures of readiness to change predict alcohol consumption and consequences in primary care patients with unhealthy alcohol use? <i>Alcohol Clin Expe Res</i> 31(3): 428-435.</p>

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<p>assessments, was associated with more consequences and was not predictive of consumption. However, assessing confidence in the ability to change one's alcohol use may have a role in predicting subsequent decreases in both consumption and consequences in primary care patients.</p>	
<p>The Transtheoretical Model of behaviour change, known to many as the Stages of Change (SOC) model, states that with regard to chronic behaviour patterns such as smoking, individuals can be characterized as belonging to one of five or six 'stages'. Stage definitions vary from behaviour to behaviour and across different versions of the model but in the case of smoking: 'precontemplation' involves an individual not thinking about stopping for at least 6 months; 'contemplation' involves an individual planning to stop between 31 days and 6 months, or less than 31 days if they have not tried to quit for 24 hours in the past year; 'preparation' involves the individual having tried to stop for 24 hours in the past year and planning to stop within 30 days (it has been accepted by the proponents of the model that having tried to stop should perhaps be dropped from this stage definition); 'action' involves the individual having stopped for between 0 and 6 months; 'maintenance' involves the individual having stopped for more than 6 months. In some versions of the model there is also a 'termination' stage in which the individual has permanently adopted the new behaviour pattern.</p>	<p>West, R 2005, Time for a change: putting the Transtheoretical (Stages of Change) Model to rest. <i>Addiction</i> 100: 1036-1037.</p>
<p>Although the prevalence of heavy alcohol consumption among patients of general hospitals is well documented, no study has yet reported an effect of counselling on the ward in reducing the level of consumption among such patients after discharge. This study was designed to evaluate brief counselling to reduce alcohol consumption among male heavy drinkers identified on general hospital wards. Male patients were screened on wards of four teaching hospitals in Sydney, Australia. Identified heavy drinkers (<math>n = 174</math>) showing predominantly low levels of alcohol dependence were allocated to one of two forms of brief counselling (skills-based counselling or brief motivational interviewing) or to a non-intervention control group. Blind follow-up for 123 patients (71%) was carried out approximately 6 months after discharge from hospital and self-reports of alcohol consumption were compared with collateral sources of information. Patients who received counselling showed a significantly greater mean reduction in a quantity-frequency measure of weekly alcohol consumption than controls but there were no significant differences in reduced consumption between the two intervention groups. However, patients who were deemed "not ready to change" showed greater reductions if they had received brief motivational interviewing than if they had received skills-based counselling. The implications of these findings for counselling male in-patients to reduce alcohol consumption are discussed.</p>	<p>Heather, N, Rollnick S, Bell A et al. 1996, Effects of brief counselling among male heavy drinkers identified on general hospital wards. <i>Drug Alcohol Rev</i> 15(1): 29-38.</p>
<p><b>Background:</b> The efficacy of brief intervention in reducing alcohol consumption is well established for selected outpatients but not for medical inpatients.  <b>Objective:</b> To determine whether brief intervention improves alcohol outcomes in medical inpatients who were identified by screening as having unhealthy alcohol use.  <b>Design:</b> Randomized, controlled trial.  <b>Setting:</b> Medical service of an urban hospital.  <b>Patients:</b> 341 medical inpatients who were drinking risky amounts of alcohol (defined for eligibility as <math>&gt;14</math> drinks/wk or <math>\geq 5</math> drinks/occasion for men and <math>&gt;11</math> drinks/wk or <math>\geq 4</math> drinks/occasion for women and persons <math>\geq 66</math> y); 77% had</p>	<p>Saitz, R, Palfai TP, Cheng DM et al. 2007, Brief intervention for medical inpatients with unhealthy alcohol use: a randomized, controlled trial. <i>Ann Int Med</i> 146(3): 167-176.</p>

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<p>alcohol dependence as determined by the Composite International Diagnostic Interview Alcohol Module.</p> <p><b>Intervention:</b> A 30-minute session of motivational counseling given by trained counselors during a patient's hospitalization (<math>n = 172</math>) versus usual care (<math>n = 169</math>).</p> <p><b>Measurements:</b> Self-reported primary outcomes were receipt of alcohol assistance (for example, alcohol disorders specialty treatment) by 3 months in dependent drinkers and change in the mean number of drinks per day from enrollment to 12 months in all patients.</p> <p><b>Results:</b> The intervention was not significantly associated with receipt of alcohol assistance by 3 months among alcohol-dependent patients (adjusted proportions receiving assistance, 49% for the intervention group and 44% for the control group; intervention-control difference, 5% [95% CI, -8% to 19%]) or with drinks per day at 12 months among all patients (adjusted mean decreases, 1.5 for patients who received the intervention and 3.1 for patients who received usual care; adjusted mean group difference, -1.5 [CI, -3.7 to 0.6]). There was no significant interaction between the intervention and alcohol dependence in statistical models predicting drinks per day (<math>P = 0.24</math>).</p> <p><b>Limitations:</b> Baseline imbalances existed between randomized groups. Patients who received usual care were assessed and advised that they could discuss their drinking with their physicians.</p> <p><b>Conclusions:</b> Brief intervention is insufficient for linking medical inpatients with treatment for alcohol dependence and for changing alcohol consumption. Medical inpatients with unhealthy alcohol use require more extensive, tailored alcohol interventions.</p>	
<b>NSW2008</b>	
<p>Excessive drinkers (141) identified in medical settings who were not seeking help for an alcohol problem completed a questionnaire based on Prochaska and DiClemente's stages of change model. Principal components analysis revealed a clear factor structure corresponding to the 'precontemplation', 'contemplation' and 'action' stages of change. On this basis, a 12-item 'Readiness to change' questionnaire was developed with satisfactory psychometric properties. As predicted, scale scores on adjacent stages of change showed significantly higher inter-correlations than scores on non-adjacent stages. Concurrent validation by comparison with subjects' choices of cartoons depicting each of the stages of change and with screening questions regarding aspects of drinking behaviour was moderate to very good. The questionnaire provides a short and convenient measure of readiness to change which may be used in conjunction with brief, opportunistic interventions with excessive drinkers.</p>	<p>Rollnick, S., et al. 'Development of a Short "Readiness to Change Questionnaire" for use in Brief, Opportunistic Interventions Among Excessive Drinkers'. <i>British Journal of Addiction</i> 1992; 87: p743-754.</p>
<p>This review covers the major treatments currently available for treating alcohol use disorders. We have included screening and assessment as a critical component of the treatment process. The evidence on treatment setting, brief and early intervention with problem drinkers is reviewed. The review also covers pharmacotherapies for alcohol dependence, a range of psychosocial interventions, motivational interviewing, cognitive behavioural, behavioural couples and family therapy and self-directed treatment resources such as mutual support</p>	<p>Shand, F., et al., <i>the Treatment of Alcohol Problems: a Review of the Evidence</i>. 2003, Canberra: Australian Commonwealth Department of Health and Ageing.</p>

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<p>groups. Interventions for at-risk groups (indigenous people, pregnant women, older people, adolescents and the cognitively impaired) are discussed. Finally, the impact of psychological and physical comorbidity and polysubstance use upon treatment outcomes is reviewed. The focus of the review is on evidence that has emerged since the previous literature review, The Treatment of Alcohol Problems: a Review of the Evidence (Shand et al. 2003). Developments since that time include a significant volume of research into brief interventions, as well as more clinical trials in the use of acamprosate and naltrexone in relapse prevention.</p>	
<p>Relatively brief interventions have consistently been found to be effective in reducing alcohol consumption or achieving treatment referral of problem drinkers. To date, the literature includes at least a dozen randomized trials of brief referral or retention procedures, and 32 controlled studies of brief interventions targeting drinking behavior, enrolling over 6000 problem drinkers in both health care and treatment settings across 14 nations. These studies indicate that brief interventions are more effective than no counseling, and often as effective as more extensive treatment. The outcome literature is reviewed, and common motivational elements of effective brief interventions are described. There is encouraging evidence that the course of harmful alcohol use can be effectively altered by well-designed intervention strategies which are feasible within relatively brief-contact contexts such as primary health care settings and employee assistance programs. Implications for future research and practice are considered.</p>	<p>Bien, T.H., et al. 'Brief Interventions for Alcohol Problems: a Review'. <i>Addiction</i> 1993; 88(3): p315-335.</p>
<p><b>APA2006</b></p>	
<p>N/A</p>	<p>US Department of Health and Human Services: Enhancing Motivation for Change in Substance Abuse Treatment: Treatment Improvement Protocol (TIP) Series No. 35. DHHS Publication (SMA) 99-3354. Rockville, Md, Substance Abuse and Mental Health Services Administration, 1999</p>
<p>N/A</p>	<p>Miller WR, Rollnick S: Motivational Interviewing: Preparing People for Change, 2nd ed. New York, Guilford, 2002</p>
<p>OBJECTIVE: To estimate the effect of Employee Assistance Program (EAP) use on healthcare utilization as measured by health claims. DATA SOURCES: A unique data set that combines individual-level information on EAP utilization, demographic information, and health insurance claims from 1991 to 1995 for all employees of a large midwestern employer. STUDY DESIGN: Using "fixed-effect" econometric models that control for unobserved differences between individuals' propensities to use healthcare resources and the EAP, we perform our analyses in two steps. First, for those employees who visited the EAP, we test whether post-EAP claims differ from pre-EAP claims. Second, we combine claims data of individuals who went to an EAP with those of individuals who did not use an EAP to test whether differences in utilization exist between EAP users and nonusers. DATA COLLECTION METHODS: From the EAP we obtained the date of first EAP contact for all employees who used the service, and from the company's human resources department we</p>	<p>Zarkin GA, Bray JW, Qi J: The effect of employee assistance programs use on healthcare utilization. <i>Health Serv Res</i> 2000; 35:77-100</p>

<p>obtained limited demographic data on all employees. We obtained healthcare utilization claims data on all employees and their dependents from the company's two healthcare plans: a fee-for-service (FFS) plan and a health maintenance organization (HMO) plan. <b>PRINCIPAL FINDINGS:</b> We found that going to an EAP substantially increases both the probability of an alcohol, drug abuse, or mental health (ADM) claim and the number of ADM claims in the same quarter as EAP contact. The increased probability of an ADM claim persists for approximately 11 quarters after the initial contact, while the increased ADM charges persist for approximately six quarters after the initial EAP contact. <b>CONCLUSIONS:</b> Our results strongly suggest that the EAP is able to identify behavioral and other health problems that may affect workplace performance and prompt EAP users to access ADM and other healthcare. Consistent with the stated goals of many EAPs, including the one examined in this study, this process should improve individuals' health, family functioning, and workplace performance.</p>	
<p><b>Context</b> Substance use disorders among physicians are important and persistent problems. Considerable debate exists over whether use of major opioids, especially among anesthesiologists, is associated with a higher relapse rate compared with alcohol and nonopioids. Moreover, the risk factors for relapse with current treatment and monitoring strategies are unknown.</p> <p><b>Objective</b> To test the hypothesis that chemically dependent health care professionals using a major opioid (eg, fentanyl, sufentanil, morphine, meperidine) as drug of choice are at higher risk of relapse.</p> <p><b>Design, Setting, and Participants</b> Retrospective cohort study of 292 health care professionals enrolled in the Washington Physicians Health Program, an independent posttreatment monitoring program, followed up between January 1, 1991, and December 31, 2001.</p> <p><b>Main Outcome Measure</b> Factors associated with relapse, defined as the resumption of substance use after initial diagnosis and completion of primary treatment for chemical dependency.</p> <p><b>Results</b> Twenty-five percent (74 of 292 individuals) had at least 1 relapse. A family history of a substance use disorder increased the risk of relapse (hazard ratio [HR], 2.29; 95% confidence interval [CI], 1.44-3.64). The use of a major opioid increased the risk of relapse significantly in the presence of a coexisting psychiatric disorder (HR, 5.79; 95% CI, 2.89-11.42) but not in the absence of a coexisting psychiatric disorder (HR, 0.85; 95% CI, 0.33-2.17). The presence of all 3 factors—major opioid use, dual diagnosis, and family history—markedly increased the risk of relapse (HR, 13.25; 95% CI, 5.22-33.59). The risk of subsequent relapses increased after the first relapse (HR, 1.69; 95% CI, 1.13-2.53).</p> <p><b>Conclusions</b> The risk of relapse with substance use was increased in health care professionals who used a major opioid or had a coexisting psychiatric illness or a family history of a substance use disorder. The presence of more than 1 of these risk factors and previous relapse further increased the likelihood of relapse. These observations should be considered in monitoring the recovery of health care professionals. The prevalence of chemical dependency (excluding nicotine) among physicians has been estimated to be 10% to 15%, similar to that in the general population. Following completion of primary treatment, recovery is best achieved through continuing group therapy and regular attendance at mutual help groups. Because of the proclivity to relapse, ongoing monitoring can help ensure sustained remission of individuals occupying safety-</p>	<p>Domino KB, Hornbein TF, Polissar NL, Renner G, Johnson J, Alberti S, Hanks L: Risk factors for relapse in health care professionals with substance use disorders. JAMA 2005; 293:1453-1460</p>

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<p>sensitive positions. Monitoring methods have changed over the past decade and now include frequent contact for behavioral assessment, random urine testing with observed micturition, and workplace surveillance. Treatment programs estimate that up to 70% of health care professionals successfully return to medical practice.</p> <p>Data on the incidence of relapse and risk factors contributing to the likelihood of relapse after initial treatment for substance use are lacking. Virtually every study of chemical dependency among health care professionals has had relatively short follow-ups, limitations in statistical methods or analyses, and variable intensity of monitoring.</p> <p>Among health care professionals, anesthesiologists appear to be at somewhat higher risk. They are overrepresented in drug treatment programs relative to their proportion among medical specialties. With their hands-on access to many potent addicting drugs, they have a predilection for parenteral opioids and nearly 3 times the risk of drug-related death than general internal medicine physicians.</p> <p>We examined 11 years of outcome data from the Washington Physicians Health Program (WPHP), a posttreatment program monitoring health care professionals with substance use disorders. We sought in particular to identify factors that might predispose individuals to relapse. In addition, we examined whether those who self-administered potent opioids might be more at risk of relapse (and perhaps death) than users of other drugs.</p>	
<p>In this study, 126 clients (87 men, 39 women) entering outpatient alcoholism treatment were assigned randomly to 1 of 3 preparatory conditions: a role induction (RI) session, a motivational interview (MI) session, or a no-preparatory session control group (CG). Clients assigned to the MI preparatory condition attended more treatment sessions and had fewer heavy drinking days during and 12 months after treatment relative to CG clients. Clients assigned to MI, relative to CG clients, also had more abstinent days during treatment and during the first 3 months posttreatment, although this difference was not maintained through the remainder of the 12-month follow-up period. Clients assigned to the RI condition showed no significant advantage over those in the CG condition. (PsycINFO Database Record (c) 2012 APA, all rights reserved)</p>	<p>Connors GJ, Walitzer KS, Dermen KH: Preparing clients for alcoholism treatment: effects on treatment participation and outcomes. <i>J Consult Clin Psychol</i> 2002; 70:1161–1169</p>
<p>Employee assistance programs (EAPs) are widely available to assist employees with a variety of problems. This research examined factors related to utilization and outcome by individuals with addictive behaviors (ABs) versus other problem areas. The specific aims of this study were to evaluate referral source and treatment outcome by gender and presenting problem. The sample included 3890 men and women who attended the EAP for a variety of concerns. Men were less likely than women to self-refer and more likely to be mandated to the EAP. Men were also much more likely to present with ABs. Relative to clients presenting with other issues, individuals with ABs were less likely to self-refer, have their problems resolved in the EAP, and were seen for fewer sessions. These results suggest that EAPs may be well suited for implementation of brief interventions (BIs) that have been empirically supported in other contexts.</p>	<p>Chan KK, Neighbors C, Marlatt GA: Treating addictive behaviors in the employee assistance program: implications for brief interventions. <i>Addict Behav</i> 2004; 29:1883–1887</p>
<b>SAMHSA2009</b>	
<p>Acamprosate is indicated for the maintenance of abstinence from alcohol in patients with alcohol dependence who are abstinent at treatment initiation in combination with psychosocial support.</p>	<p>Mason, B. J. (2005a). Acamprosate in the treatment of alcohol dependence. <i>Expert</i></p>

<p>Acamprosate is a synthetic taurine analogue that seems to act centrally to restore the normal activity of glutamatergic neurotransmission altered by chronic alcohol exposure. Over the past 15 years, the safety and efficacy of acamprosate for alcohol dependence have been well established in multiple double-blind, placebo-controlled trials. Overall, acamprosate has been consistently associated with greater beneficial effects on measures of alcohol abstinence compared with placebo. Specifically, patients treated with acamprosate achieve greater rates of complete abstinence, longer times to first drink and/or increased duration of cumulative abstinence when compared with placebo. Acamprosate received approval by the US FDA for the treatment of alcohol dependence in July 2004 and is currently prescribed in 28 countries.</p>	<p><i>Opinion on Pharmacotherapy</i>, 6, 2103–2115.</p>
<p><b>Background</b> The aim of this study is to assess the influence of early and late compliance of acamprosate on attendance and abstinence duration in the treatment of alcohol dependence.</p> <p><b>Methods</b> Individual patient data of 2,305 patients from 11 randomized controlled trials comparing acamprosate (<math>n = 1,128</math>) with placebo (<math>n = 1,177</math>) were used to predict early and late compliance and to study the effect of early and late compliance on attendance and abstinence duration using regression analysis and structural equation modeling.</p> <p><b>Results</b> Early compliance was predicted by baseline motivation to become fully abstinent and baseline abstinence (<math>R^2 = .26</math>); late compliance was predicted by early compliance (<math>R^2 = .13</math>); treatment discontinuation was predicted by young age, marital status, compliance, and treatment condition (<math>R^2 = .26</math>); and abstinence duration was predicted by motivation to become fully abstinent early compliance and the interaction of early compliance and treatment condition (<math>R^2 = .27</math>). Structural equation modeling showed that abstinence duration was significantly associated with motivation at baseline, late compliance, and treatment condition (Goodness of Fit Index [GFI] <math>\chi^2/df = 1.56</math>; Parsimonious Goodness of Fit Index [PGFI] = 0.69).</p> <p><b>Conclusions</b> Motivation to become fully abstinent and abstinence at the start of treatment are important for early compliance. Early compliance in turn predicts late compliance. Late compliance, in combination with motivation to become fully abstinent, and treatment condition (acamprosate vs. placebo) predict duration of abstinence. This suggests that motivational interventions directed toward full abstinence motivation and abstinence at the start of treatment are crucial for both compliance with acamprosate and successful treatment outcome.</p>	<p>Koeter, M. W. J., Van den Brink, W., &amp; Leher, P. (2010). Effect of early and late adherence on the effectiveness of acamprosate in the treatment of alcohol dependence. <i>Journal of Substance Abuse Treatment</i>, 39(3), 218–226.</p>
<p><b>Background:</b> Compliance with medication in pharmacotherapy trials of alcoholism has been shown to be equal to, or more, important than in other areas of medicine. Research has suggested that naltrexone's effectiveness can be greatly influenced by the compliance of participants in clinical trials. Presently, we compare 2 compliance measurement methods [urine riboflavin and medication event monitoring system (MEMS)] used simultaneously to evaluate naltrexone's efficacy and the impact of compliance on the size of observable treatment effects.</p> <p><b>Methods:</b> One hundred and thirty-seven of 160 randomized alcoholic patients completed 12-weeks (84 days) of naltrexone or placebo and cognitive behavioral therapy (CBT) or motivational</p>	<p>Baros, A. M., Latham, P. K., Moak, D. H., Voronin, K., &amp; Anton, R. F. (2007). What role does measuring medication compliance play in evaluating the efficacy of naltrexone? <i>Alcoholism: Clinical and Experimental Research</i>, 31(4), 596–603.</p>

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<p>enhancement therapy (MET). Urine riboflavin was determined during study weeks 2, 6, and 12. The MEMS provided a detailed computerized record of when a participant opened their medication bottle throughout the trial. Baseline predictors of MEMS (80% openings) and urine riboflavin (<math>\geq 1,500</math> ng/mL by fluorimetry) compliance were examined. The effects of the treatments in the compliant participants defined by one, the other, or both methods were compared and contrasted with a previously reported intent-to-treat analysis where compliance was not taken into account.</p> <p><b>Results:</b> Age was predictive of compliance. 105 participants were deemed compliant via urine riboflavin criteria, 87 via MEMS, and 77 when both criteria were met, with no significant differences between treatment groups. The most compliant participants showed a significant medication by therapy interaction. Those treated with naltrexone/CBT showed more abstinence days (<math>p &lt; 0.03</math>), less heavy drinking days (<math>p &lt; 0.03</math>) and less total drinks (<math>p &lt; 0.03</math>) than the other groups. The effect size of this interaction increased from about 0.2 in the intent-to-treat analysis, to about 0.4 to 0.5 in the compliant group analyses, with little difference between compliance measurement methods.</p>	
<p><b>Objective:</b> The current study investigated the treatment effectiveness, during treatment, of a second-generation cognitive-behavioral therapy for alcoholism broad-spectrum treatment (BST) compared with motivational-enhancement therapy (MET), when both were offered in conjunction with a therapeutic dose of naltrexone (Revia). <b>Method:</b> One hundred forty-nine alcohol-dependent patients completed a 3-month randomized, controlled trial of BST and naltrexone versus MET and naltrexone. <b>Results:</b> Patients receiving BST had a significantly higher percentage of days abstinent than patients receiving MET. The superior effect of BST is particularly strong in interaction with support for drinking, suggesting that the advantage of BST is worth the additional cost for patients whose psychosocial networks are supportive of continued drinking. This effect remains significant when controlling for pretreatment percentage of days abstinent. <b>Conclusions:</b> In aggregate, these findings suggest that it is either the combination of naltrexone and BST or the unique properties of BST that account for BST's superiority to MET and naltrexone. The results of this initial phase of the trial suggest that a second-generation cognitive-behavioral therapy such as BST may have a meaningful clinical advantage over brief interventions such as MET, at least when combined with naltrexone.</p>	<p>Davidson, D., Gulliver, S. B., Longabaugh, R., Wirtz, P. W., &amp; Swift, R. (2007). Building better cognitive-behavioral therapy: Is broad-spectrum treatment more effective than motivational-enhancement therapy for alcohol-dependent patients treated with naltrexone? <i>Journal of Studies on Alcohol and Drugs</i>, 68(2), 238–247.</p>

#### Viited (Süsteematilised ülevaated)

Kokkuvõtte (abstract või kokkuvõtlikum info)	Viide kirjandusallikale
<p>Completion of addiction treatment is one of the most consistent factors associated with a favorable treatment outcome. Unfortunately, it is more common for a patient to drop-out of addiction treatment than to complete the treatment. To prevent drop-out, risk factors must be identified. This box-score review focuses on studies investigating the risk factors associated with drop-out from addiction treatment published in peer-reviewed journals from 1992 to 2013. A total of <b>122 studies</b> involving <b>199,331 participants</b> met the inclusion criteria. Contrary to recommendations from previous reviews, 91% of the included</p>	<p>Drop-out from addiction treatment: A systematic review of risk factors Hanne H. Brorson, Espen Ajo Arnevik, Kim Rand-Hendriksen, Fanny Duckert</p>

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<p>studies focused primarily on enduring patient factors, mainly demographics. The most consistent risk factors across the different study designs, samples, and measurement methods were cognitive deficits, low treatment alliance, personality disorder, and younger age. With the exception of younger age, none of the demographic factors emerged as consistent risk factors. Further research on the relationship between simple demographic factors and drop-out risk is of limited value. However, little is known about the potential risk factors related to treatment programs and to the treatment processes. Based on the review, clinical recommendations include assessing cognitive functioning and personality disorders at baseline and continuous monitoring of treatment alliance.</p>	
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