Kliiniline küsimus nr 18

Kliiniline küsimus tekst

Kas kõigil alkoholi kuritarvitavatel ja alkoholisõltuvusega patsientidel, kellel on näidustatud ravi alustamine, tuleks ravisoostumuse parandamiseks kasutada järgmisi meetmeid (võrreldes mittekasutamisega):

- soovitud käitumise kinnitamine
- lähedaste kaasamine
- lühem teenusele saamise ooteaeg
- omaosalus teenuste saamisel
- regulaarne kontakt ravimeeskonnaga
- toetavad teenused

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

Ravijuhendid

Kokkuvõte tõendusmaterjali kvaliteedist

NICE (2011) kasutab oma soovitustes kahte terminit – ravi koordineerimine (*care coordination*) ja juhtumikorraldus (*case management*). Ravi koordineerimine kirjeldab indiviidi ravi raviepisoodi käigus. Ravikoordineerimine on limiteeritud kohustustega ning ei pruugi hõlmata otsest kontakti patsiendiga või kui siis ainult vähesel määral. Ravi koordineerimisel keskendutakse sellele, et kõik ravipaketi osad oleksid omavahel ühendatud ning toimuks aktiivne kommunikatsioon. Juhtumikorralduse all mõeldakse antud ravijuhendis palju keerulisemat ettevõtmist. Indiviidile on määratud individuaalne juhtumikorraldaja, kes vastutab indiviidi vajaduste põhjaliku hindamise eest ning raviplaani väljatöötamise eest koostöös kliendi enda ja teiste osapooltega (hõlmab perekonda, hooldajaid, teisi meekonna liikmeid ja asutusi kes vastutavad kliendi ravi eest). Juhtumi korraldaja viib tihtilugu läbi psühholoogilisi sekkumisi nagu motiveeriv intervjueerimine, et parandada ravisoostumust. Juhtumikorraldaja on vastutav tulemite monitoorimise ning raviplaanis vastavate muudatuste tegemise eest. **NICE (2011)** soovitab kasutada juhtumikorraldust (*case management*) kui sekkumist soodustamaks abstinentsi, vähendamaks alkoholi tarvitamist ning sellele lisaks parandamaks kliendi kaasatust ja ravisoostumust ning järelravi teenuste kasutamist. Juhtumikorraldus on liigtarvitajate jaoks efektiivne, kuid võrdlemisi intensiivne sekkumine. Seega peaks juhtumikorraldus olema suunitletud neile, kellele on mõõdukas või raske alkoholisõltuvus ning eriti neile kellel on varasemalt olnud rakusi teenustega kaasatuses ning risk ravi poolelijätmises.

Juhtumikorraldus (*case management*):

Juhtumikorralduse kohta leitud tõendusmaterjal on mõõduka kvaliteediga (hinnatud NICE 2011 koostajate poolt kasutades GRADE-i). Kolm randomiseeritud kontrollitud katset (*RCT*) ja kaks vaatlusuuringut (*observational studies*) võrdlesid juhtumikorraldust tavaraviga, nende uuringute andmeid kombineerides teostati metaanalüüs (vt LISA 1). **Ahles et al. (1983)** võrdlesid juhtumikorraldust tavaraviga (n=50). Uuringu tulemused näitasid, et neil indiviididel kes said intensiivset järelravi pikenes periood tagasilanguseni. Olenemata rühmast, need indiviidid kes

osalesid järelravis olid edukamad, mõõdetud alkoholi tarvitamise koguse järgi. **Conrad et al. (1998)** viisid läbi 5 aastat kestva prospektiivse sekkumisuuringu (n = 358, kodutud meessoost sõjaveteranid), kus võrreldi kahte tüüpi elamupõhist ravi (*residential inpatient care*). Sekkumisrühm sai juhtumiskorraldust ning kontrollrühm osales elamupõhises ravi programmis ilma juhtumikorralduseta. Sekkumisrühmas olid tähelepanuväärsed muutused meditsiiniliste, alhoholi, töö, ja majutuse mõõdikutes 2 aastase perioodi vältel. Ajatrendide uurimisel, selgus et need gruppidevahelised trendid tekivad ravi saamise aastal ning vähenevad jälgimisaja aasta käigus. Uurijad põhjendasid gruppidevaheliste erinevuste vähesust faktiga, et kontrollrühmas olevad uuritavad said programmiväliseid teenuseid. **Cox et al. (1998)** võrdlesid juhtumikorraldust tavaraviga 298 uuritava seas (81% meessoost). Uuringu tulemused ei näidanud statistiliselt olulist erinevust joomise sageduses, mõõdetud päevades millal tarbiti alkoholi viimase 30 päeva jooksul või keskmiselt joobes olnud päevades arvus 2 grupi vahel 6-, 9-või 12 kuuliseljälgimisajal. Gruppidevaheline statistiliselt oluline erinevus ilmnes 18 kuulisel jälgimisajal, juhtumikorralduse grupi kasuks. Jälgimisaja punktidel 6-, 12- ja 18 kuud esines gruppidevaheline erinevus juhtumiskorralduse kasuks, kui mõõdeti päevade arvu mil kasutati alkoholi pärast eelmist intervjuud. **Patterson et al. (1997)** võrdlesid 2 pruppi: kogukonna psühhiaatrilise õe lisamine 1 aastaseks järelraviks ja tavaravi gupp. Uuritavateks olid 127 meessoost valge nahavärviga indiviidi. Kõik uuritavad olid esmased ravile pöördujad ning viibisid statsionaarses raviasutuses 6 nädalat. Gruppidevahelisi erinevusi hinnati 5 aasta pärast. Grupis kes said järelravi kogukonna psühiaatria õega olid 36% saavutanud karskluse vs 6% tavaravi grupiga ($p < 0.001$). Indiviidid kes olid kogukonna psühiaatria õe grupis raporteerisid väiksema tõenäosusega enesekontrolli kaotust (blackouts) ($p < 0.05$) või hasartmängurlust ($p < 0.05$) samuti käisid nad suurema tõenäosusega haiglavastuvõttudel ($p < 0.0001$). **McLellan et al. (1999)** võrdlesid juhtumikorraldust tavaraviga. Tavaravi grupis said uuritavad 2 korda nädalas karsklusele orienteeritud grupinõustamist. Juhtumikorralduse grupis said uuritavad lisaks nõustamisprogrammile juhtumikorraldaja kes pakkus tuge majutuse otsimisel, meditsiinilise abi saamisel, juriidilist nõustamist ja lapsekasvatuse klasse. 6 kuulise jälgimisperioodi lõpus näitasid juhtumikorralduse grupis olevad patsiendid suurimaid muutusi alkoholi tarvitamises, meditsiinilises staatuses, töötamise staatuses, perekondlikkes suhetes ja juriidilises staatuses võrreldes tavaravi grupiga.

Tänu uuringute heterogeensusele, ei saanud osade RCT tulemusi metanalüüsi lisada, kuid sellest hoolimata lisavad nad teostatud meta-analüüsile väärtust: **Gilbert et al. (1988)** võrdlesid juhtumikorralduse, koduvisiidi ja tavaravi gruppi. Mõlemates aktiivsetes ravigruppides oli märgata vastuvõtule minemises langus, kui terapeut lõpetas aktiivse julgustamise teraapial osalemiseks. Joomise tulemites puudusid erinevused 3 grupi vahel. **Stout et al. (1999)** võrdlesid juhtumikorraldust tavaraviga alkoholisõltuvusega patsientide seas. 3 aastasel jälgimisaja punktil oli tugev alkoholi tarvitamise sagedus tavaravirühmas kaks korda kõrgem. Juhtumikorraldus pikendas ajalist perioodi tagasilanguseni ($p=0.05$) ning vähendas tagasilanguse raskust. **Chutuape et al. (2001)** uuringu tulemused näitasid, et patsiendid keda innustati ning pakuti eskorti teenusele või lihtsalt innustati järelravis osalema, osalesid ja lõpetasid järelravi suurema tõenäosusega kui need kes said tavaravi ($p<0.05$). **Sannibale et al. (2003)** teostatud uuring näitas et struktureeritud järelravi programm suurendas 4 korda osalemise hulka võrreldes mittesutruktureeritud järelravi programmiga (OR 4.3, 95% CI 1.7 to 11.2). Patsiendid kes osalised järelravis kogesid tagasilangust hiljem kui need kes ei osalenud. **Krupski et al. (2009)** leidsid, et järelraviteenuste programm, mis sisaldab juhtumikorralduse komponenti suurendab ravil olemise perioodi ning selle lõpetamise tõenäosust, samuti väheneb ravi enneaegse lõpetamise risk (HR = 0.58, $p <0.05$).

[LISA]

Lähedaste kaasamine:

Orford et al. (2005) poolt kogutud kvalitatiivsed andmed näitasid, et perekonna ja sõprade mõju aitasid soodustada muutusi alkoholi tarvitamise käitumises. Kaks sekkumisuuringut uurisid kaaslaste/partnerite kaasamist, ravisoostumuse/ravisosalemise prarandamises. **Barber (1996)** poolt läbi viidud sekkumisuuring näitas, et partneri kaasamine tugevalt alkoholi tarvitavate indiviidid ravisoostumuse parandamises on edukas. Uuring näitas, et ühepoolne sekkumine, millele viidatakse kui "Survele muutuda" (*pressure to change*) on edukas soodustamaks muutumist alkoholi tarvitavas partneris. **Miller et al. (1999)** poolt läbi viidud RCT käigus pakuti 130 kaaslasele/partnerile 3 einevat nõustamise vormi: AA poolt välja töötatud programm soodustamaks osalemist nende 12 sammulises programmis, Johnson instituudi programm, mis valmistab ette perekondlikuks sekkumiseks ning CRAFT mis õpetab koduseid käitumise muutuse soodustavaid oskusi. Enamus kaaslasi otsustab mitte läbi viia kodust perekondlikku sekkumist (70% siin uuringus), kuid need kes viisid nendes 75% alustas alkoholi tarvitav partner ravi. Kõiki sekkumisi seostati sarnaste positiivsete tulemustega alkoholi mitte tarvitava kaaslase paremas funktsioneerimises ning suhte üleüldises paranemises.

Lühem teenusele saamise ooteaeg:

Tõendusmaterjal, mis kirejdalb seost lühema teenusele saamise ooteaja ning parema ravisoostumuse vahel on madala kvaliteediga ning suhteliselt vananenud, koosnedes 1 kohort uuringust, 2 juht-kontroll uuringust ning 1 kvalitatiivse metoodikaga uuringust. **Bacchus (1999)** poolt osaliselt struktureeritud intervjuu käigus (n=42) kogutud andmed näitasid, et ⅓ patsientidest oleks soovinud raviprogrammi siseneda varem, et säilitada motivatsiooni raviks. **Leight et al. (1984)** uurisid ravist väljalangemist 172 uuritava seas, kes osalesid ambulatoorses alkoholiravi programmis. Faktorid, mis enim ennustasid ravist väljalangemist olid ajaline periood vastuvõttude vahel, eelnevad alkoholiga seotud seaduserikkumised, uimastite tarvitamine ja Michigani testi skoor. **Rees et al. (1984)** analüüsisid 101 patsiendi andmeid, kes suunati alkoholiravile. Uuringu tulemuste kohaselt ei pöördunud 46% suunatutest ravile. Need kes ravile ei pöördunud olid enamasti nooremad ning olid järjekorras pikemalt oodanud võrreldes ravile pöördunutega. **Rees (1985)** uuris patsientide uskumuste seost ravisoostumusega, kasutades Tervise Uskumuste Mudelit. Ravisoostumusega omasid tugevat seost patsiendi uskumus haiguse tõsidusest, ootused paranemisele, ning suhted tervishoiutöötajaga.

Phühhosotsiaalsed sekkumised:

Tugev tõendusmaterjal (hinnatud NSW poolt) näitab, et motiveeriv intervjueerimine parandab raviga kaasatust ning ravosoostumust **(Handmaker et al. 2002).** Tervishoiutöötajad saavad patsienti ravisse kaasata ning seal hoida kasutades motivatsiooi tõstvaid strateegiaid **(Miller & Rollnick 2002)**. Üks RCT, mis hõlmas 126 uuritavad, näitas et patsiendid kelle ravi soostumuse parandamiseks kasutati motiveerivat intervjueerimist käisid kohal rohkematel ravi sessioonidel ning neil oli vähem tugeva alkoholi tarbimisega päevi ravi ajal ja 12 kuud pärast ravi võrreldes tavaravi ja rolli induktsiooniga (*role induction*) **(Connors et al. 2002)**.

Soovitud käitumise kinnitamine pakub süsteemset stiimulite süsteemi, eesmärgiga muuta alkoholi tarbimine vähem atraktiivsemaks ning abstinents atraktiivseks. **NICE (2011)** toob välja 4 peamist meetodit: 1)kinkekaardi põhine kinnitamine (*Voucher-based reinforcement*) – liigtarvitamise häirega patsiendid saavad erinevates väärtustes kinkekaarte, vastutasuks negatiivse analüüsi tulemuse eest (nt uriiniproov). Kui analüüsi vastus on positiivne siis kinkekaarti ei saada. Kinkekaarti saab vahetada teenuste vastu, mis on kooskõlas alkoholi vaba elustiiliga. 2)auhinna põhine kinnitamine – liigtarvitamise häirega patsiendid saavad negatiivse analüüsi vatuse eest osa

võtta loosimisest, kus umbes pooltel piletitel on rahalised auhinnad (teised pooled sisaldavad teksti nt „hea töö“). 3)rahaline kinnitamine – liigtarvitamise häirega patsiendid saavad rahalise kompensatsiooni negatiivse tulemusega bioloogilise materjali analüüsi eest. 4)kliiniku privileegid – osalejad saavad kliiniku privileege, kui nad saavutavad tahetud tulemuse. Üks näide kliiniku privileegidest on koju kaasa võetav metadooni doos. Informatsioon, mis käib soovitud käitumise kinnitamise kohta on mõõduka kvaliteediga (hinnatud NICE 2011 poolt). Kolm RCT(vt. LISA 2) **(Petry et al 2000; Litt et al. 2007; Alessi et al. 2007)** käsitlesid soovitud käitumise kinnitamist. Ainult üks nendest **(Litt et al. 2007)** võrdles soovitud käitumise kinnitamise tehnikat kontrollrühmaga. Kaks uuringut **(Petry et al 2000; Alessi et al. 2007)** võrdlesid soovitud käitumise kinnitamist standardraviga (*TAU*) ning üks uuring võrdles soovitud käitumise kinnitamist teise aktiivse interventsiooniga. **Litt et al. (2007)** leidsid, et soovitud käitumise kinnitamine (koos võrgustiku toega) on efektiivsem strateegi võrreldes kontrollrühmaga pärast ravi lõppu ning 15 kuisel jälgimis perioodil. Rühmade vaheline erinevus kadus, pärast 15 kuud. Soovitud käitumise kinnitamine (koos võrgustiku toega) oli efektiivsem kui kontrollrühm vaadeldes alkoholi tarvitamise vähenemist 6-, 9- ja 21 kuisel jälgimisperioodil. Olulist erinevust ei täheldatud 12-, 15-, 18-, ja 27 kuisel jälgimisperioodi punktil. **Petry et al (2000), Alessi et al. (2007)** tulemused näitasid et soovitud käitumise kinnitamise lisamine tavaravile, ei andnud olulist positiivset efekti abstinentsi säilitamisel, vaadeldes pärast ravi lõppu. Soovitud käitumise kinnitamise lisamine tavaravile, vähendas tugeva joomise tagasilanguste arvu.

Mitmed nõrga kvaliteediga allikad näitavad et soovitud käitumise kinnitamine (*contingency management*) on efektiivne julgustamaks kliente jätkama ravimite võtmisega, vähendamaks alkoholi tarvitamist, abstinentsi säilitamiseks, ravisoostumuse parandamiseks ning julgustamaks ravikeskustes kohal käimist **(Higgins 1999; Petry 2002; Petry 2006)**.

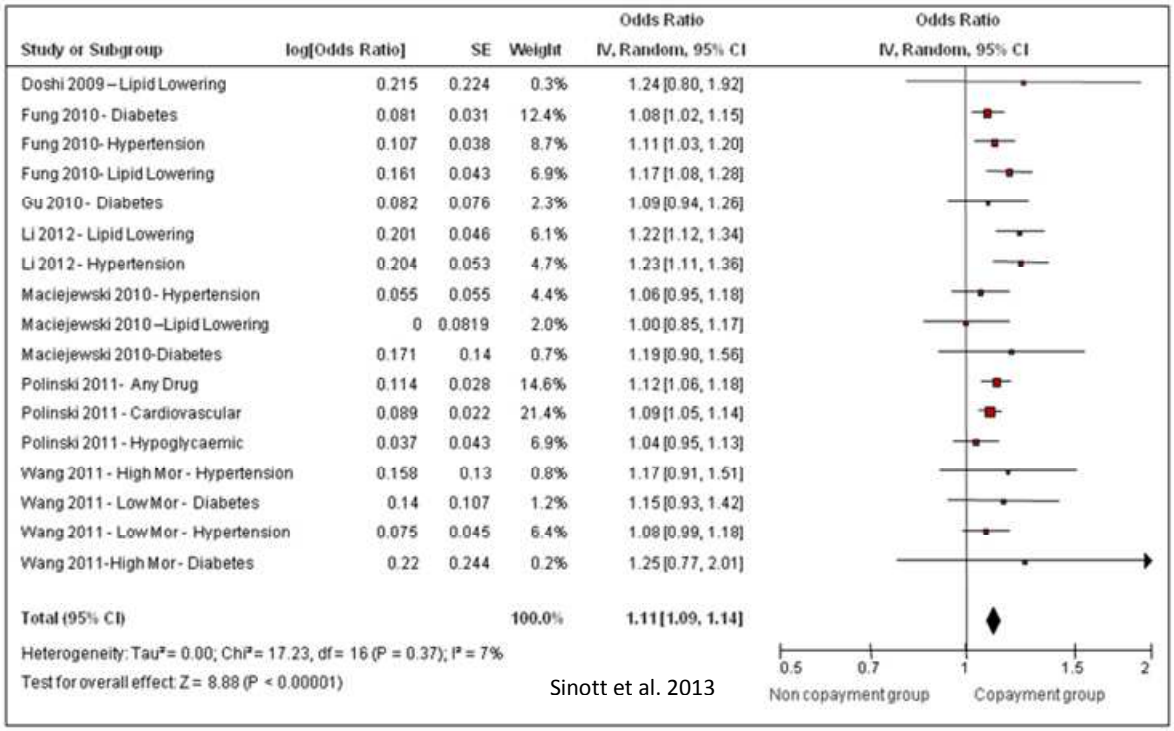
Farmakoteraapia:

Ravimite võtmise halvale ravisoostumusele võivad kaasa aidata järgmised tegurid: kõrvaltoimed, alkoholi liigtarvitamise ravimite võtmisega koos käiv stigma, kohese positiivse efekti puudumine, hirmud ravimite ohtuse ning kõrvaltoimete kohta **(O'Malley 1998; Kranzler et al. 2000)**. Üks randomiseeritud kontrollitud uuring hindas ravisoostumust parandava tehnika efektiivsust võrreldes tavaraviga, patsientide rühmas (n= 40) kellele määrati akamprosaat. Ravisoostumuse teraapia koosnes 6 individuaalsest sessioonist (kestvusega 60 min), kus dresseeriti uskumusi ravimite võtmise kohta, ambivalentsust, ravi positiivseid külgi, ravi jätkamist, tagasilanguste ennetamist, kasutades motiveerivat intervjueerimist ja kognitiivse käitumusliku teraapia tehnikaid. Uuringu tulemused näitasid, et osalemine 3 või rohkemas ravisoostumuse teraapia sessioonis parandas oluliselt ravisoostumust võtta akamprosaati ning parandas üldisi ravi tulemusi **(Reid et al. 2005)**. Ravi disulfiraamiga sobib enam indiviididele, kellel on sotsiaalse tugivõrgustiku (nt pere) tugi, kes aitavad teostada farmakoteraapia ravimisoostumuse järelvalvet **(Chick et al. 1992; Hughes and Cook 1997; Laaksonen et al. 2008)**. Kirjanduse ülevaade, mis hõlmas endas 13 kontrollitud ja 5 mittekontrollitud uuringut näitas, et järelvalvega disulfiraami tarvitamine vähendas joomist, ning parandas ravil püsimise määra võrreldes ilma järelvalveta manustamisega (**Brewer et al. 2000**). 2 mõõduka kvaliteediga uuringut on leidnud, et kohtu poolt määratud teraapi disulfiraamiga tõstab ravisoostumust **(Martin et al. 2004; Martin et al. 2005)**.

Omaosalus teenuste saamisel:

Mitte üheski läbivaadatud ravijuhendis ja preventsiooni juhendis ei käsitletud antud teemad. Seetõttu teostas sekretariaadi liige lisaotsingu. Otsingu tulemusena leiti üks süstemaatiline ülevaade ja meta analüüs. **Sinott et al. (2013)** poolt teostatud meta-analüüs käsitles uuritavaid, kellel oli riiklik ravikindlustus. Meta-analüüs haaras endasse 7 uuringut, uuritavate koguarv oli 199

996 inimest; 74 236 inimest omaosaluse grupis ja 125 760 mitteomaosaluse grupis. Ravisoostumust uuriti järgnevatele ravimitele: diabeet, hüpertensioon, lipiide alandav ravi, kardiovaskulaarsed ravimid, muud ravimid. Uuritavate keskmine vanus oli 71.75 aastat. Šansisuhe ravisoostumusele omaosaluse grupis versus mitteomaosaluse grupis oli 1.11 (95% CI 1.09-1.14; P = <0.00001). Meta analüüsi tulemused näitavad, et 11% tõusu šansis halvemale ravisoostumusele, kui on olemas omaosalus. Eelneva otsingu käigus leitud metanalüüs **Petry et al. (2012)** hõlmas 15 randomiseeritud uuringut ja 6 mitterandomiseeritud uuringut. Rahalisi stiimuleid rakendati avisoostumuse parandamiseks järgnevatele ravimitele: tuberkuloos, aine kuritarvitamine, HIV, hepatiit, skisofreenia ja insuldi ennetus. Uuringu tulemused näitasid, et rahalised stiimulid parandasid oluliselt ravisoostumust 0.77 (95% CI = 0.70–0.84), p < 0.001. Madalama kvaliteediga uuring varasemast otsingust **(Stein et al. 2000)** näitas et järelravil käimise tõenäosus vähenes oluliselt, kui suurenes ambulatoorne omaosalus (OR=0.97, p<0.05).



Sinott et al. 2013

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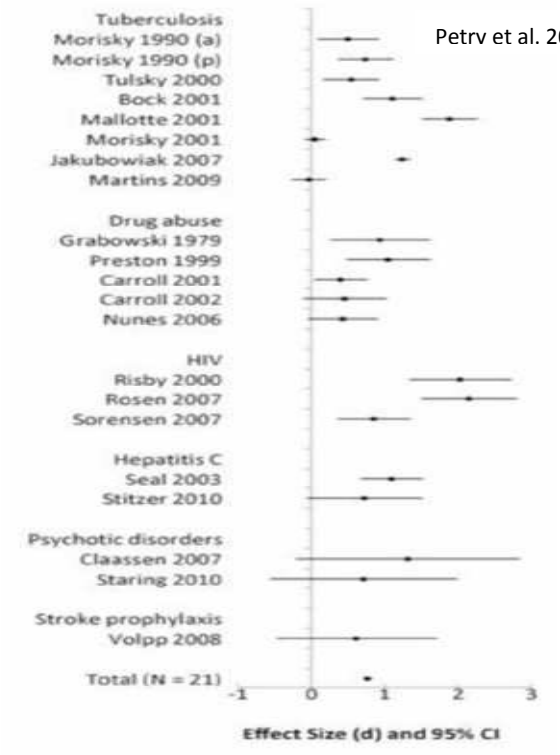

Petrv et al. 2012

Kokkuvõte ravijuhendites leiduvatest soovitustest

Antud küsimusele vastamiseks vaadati läbi 1 alkoholi liigtarvitamise preventsiooni juhend (USPSTF 2013) ja 10 ravijuhendit (BAP 2012, NICE 2011, SOOME 2010, NICE 2010a, AUSTRALIA 2009, SAMHSA 2009, WFSBP 2008, NSW 2008, APA 2006, SIGN 2003). Nendest 8 sisaldasid informatsiooni käesoleva küsimuse kohta (NICE 2011, Soome 2010, Australia 2009, SAMHSA 2009, WFSBP 2008, NSW 2008, APA 2006, SIGN 2003,). 2 ravijuhendis (BAP 2012, NICE 2010a) ja alkoholi liigtarvitamise preventsiooni juhendis (USPSTF 2013) käesoleva küsimuse kohta informatsiooni ei sisaldunud. Eelpool mainitud ravijuhenditest vaadati läbi teemaga seotud tõenduspõhised uuringud, millest kokkuvõtted on esitatud viidetes tabeli vormis.

Nagu eelpool mainitud soovitab **NICE (2011)** kasutada juhtumikorraldust (*case management*) kui sekkumist soodustamaks abstinentsi, vähendamaks alkoholi tarvitamist, parandamaks kliendi kaasatust ja ravisoostumust ning järelravi teenuste kasutamist.

SIGN (2003) annab tugeva soovituse, et kõigile alkoholisõltuvusega patsientidele peaks olema kättesaadavad tagasilangust ennetavad teenused. Nõrgem soovitus antakse partneri kaasamisest, et soodustada patsiendi ravi alustamist.

[LISA]

SOOME (2010) ravi kesksed elemendid peaksid olema informatsiooni pakkumine, diskussioon, individuaalne-, grupi või pereteraapia. Eesmärgiks peaks olema ka farmakoteraapia ravisoostumus (mainitakse AA olemasolu). Kõige tavalisemaks psühhosotsiaalseks raviks on ”tavaline terapeutiline suhe”-> VIIDE PUUDUB

Australia (2009) ütleb, et kuigi alkoholsõltuvuse farmakoteraapia on hea ravisoostumusega patsientide seas efektiivne, on ravisoostumus alkoholisõltuvusega patsientide seas madal.

Australia (2009) soovitab järgmisi tegevusi farmakoteraapia ravisoostumuse parandamiseks:

1. Tuleks välja selgitada patsiendi mõtted ja mured, mis puudutavad ravimite võtmist ning kasutada kognitiivseid restruktureerimise tehnikaid, et aidata muuda ravimite võtmise kohta käivaid ebasoodsaid või kohanemist takistavaid mõtteid.

2. Tuleks patsiendile anda relistlik ülevaade, kuidas ravimite võtmine võiks teda aidata, mis on nende kõrvaltoimed ning ravimite võtmisega seostuvad riskid.

3. Motiveeriva intervjueerimise tehnikate kasutamine aitab patsiendil identifitseerida individuaalseid ravimite võtmisega kaasnevaid kulusid ja tulusid.

4. Patsiendile tuleks pakkuda koju kaasa võtmiseks ravimeid puututavat kirjalikku materjali.

5. Psühholoogilised sekkumised peaksid olema kooskõlas patsiedni poolt seatud eesmärkidega: mõned uuringud on näidanud, et toimetuleku oskuste treeningud (coping skills training) koos nalotreksooniga on efektiivsemad tagasilangustega kohanemisel, samas kui toetav teraapia (supportive therapy) on efektiivsem aitamaks patsientidel säilitada abstinetsi.

6. Patsientidega, kes ei pöördu vastuvõtule tuleks ühendust võtta

Akamprosaati peab võtma 3 korda päevas, mistõttu tuleb eriti tähelepanelik olla patsiendi ravisoostumuse suhtes. Ravimi kirjutajad saavad patsiendi ravisoostumuse parandamiseks aidata neil ravimi võtmist meenutada pakkudes välja viise nagu: kanda ”meeldetuletus” käevõru, panna äratuskell, välja kujundada rituaal tableti võtmisega, anda patsiendile spetsiaalne tabletikarp **(SAMHSA 2009)**. **SAMHSA (2009)** ütleb et tagasiside patsientide algsete analüüside ning nendega seotud terviseriskide kohta on mõjuvõimsad mõjutamaks patsiendi motivatsiooni ja ravisoostumust. Laboratsoorsed testid võimaldavad patsiendi seisundit monitoorida ja anda objektiivset tagasisidet. Teised võimalused patsiendi ravisoostumuse monitoorimiseks on: pidada arvet patsiendi vastuvõttudel käimise kohta, jälgida retseptide väljaostmist, monitoorida kas patsiendid peavad kinni kokkulepetest ravi eest maksmise kojta, küsides perioodilise staatuse raporteis ainete liigtarvitamise programmidest, pshühhiaatrilistest asutustes või teistest psühhosotsiaalsetest teraapia või tugigruppidest.

WFSBP (2008) ütleb, et peamine probleem disulfiraami raviga on kehv ravisoostumus. Enamus patsiendid jätavad ravi pooleli mõne kuu jooksul, seega tuleks julgustada järelvalve all teostatud ravi.

[LISA]

NSW (2008) soovitatakse kasutada ravisoostumuse parandamiseks motiveeriva intervjueerimise tehnikaid ja soovitud käitumuse kinnitamist.

APA (2006) ütleb, et patsienti saab ravisse haarata kasutades motiveerivaid strateegiaid ning julgustades patsienti osa võtmast eneseabi strateegiatest.

Ravijuhendite soovituste tekstid inglise keeles

NICE 2011

Case management (juhtumikorraldus):

- Care coordination should be part of the routine care of all service users in specialist alcohol services and should:

● be provided throughout the whole period of care, including aftercare

● be delivered by appropriately trained and competent staff working in specialist alcohol services

● include the coordination of assessment, interventions and monitoring of progress, and coordination with other agencies.

- Consider case management to increase engagement in treatment for people who have moderate to severe alcohol dependence and who are considered at risk of dropping out of treatment or who have a previous history of poor engagement. If case management is provided it should be throughout the whole period of care, including aftercare.

- Case management should be delivered in the context of Tier 3 interventions by staff who take responsibility for the overall coordination of care and should include:

● a comprehensive assessment of needs

● development of an individualised care plan in collaboration with the service user and relevant others (including families and carers and other staff involved in the service user's care)

● coordination of the care plan to deliver a seamless multiagency and integrated care pathway and maximisation of engagement, including the use of motivational interviewing approaches

● monitoring of the impact of interventions and revision of the care plan when necessary.

SIGN 2003

Access to relapse prevention treatments of established efficacy should be facilitated for

alcohol dependent patients (grade A)

The primary care team should help family members to use behavioural methods which will reinforce reduction of drinking and increase the likelihood that the drinker will seek help (grade C)

[LISA]

AUSTRALIA 2009

Medication compliance can be improved with use of adherence enhancing strategies.

Strength of recommendation: B Evidence level: Ia

SOOME 2010

Continuity of treatment, good cooperation, motivating and commitment of patients to treatment are important for all modes of psychosocial treatment and rehabilitation. Central elements of treatment include providing information, discussion, and individual, group, couple or family therapy. For example art, music or relaxation therapy or psychodrama can be used. Commitment to pharmaceutical treatment may also be the aim. In addition, self help and peer activity (AA group, A-kilta) are available. – The most common form of psychosocial treatment is an ”ordinary therapeutic relationship”: therapeutic, supportive interaction with aspects from various frames of reference. This is a common reference treatment in trials. ->VIIDE PUUDUB

WFSBP 2008

Poor adherence is a major problem with disulfiram treatment; most patients discontinue treatment within a few months. Therefore, the use of supervised disulfiram treatment has been advocated.

NSW 2008

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

Recommendation ★★★ * Contingency Management can be combined with other psychosocial approaches by suitably trained drug and alcohol professionals to reduce problematic drug and alcohol use.

*The recommendation is supported by at least Level 2 research and expert clinical opinion

APA 2006

Clinicians can optimize patient engagement and retention in treatment through the use of motivational enhancement strategies and by encouraging patients to actively partake in self-help strategies. Monitoring programs, such as EAPs and impaired-physician programs, can sometimes help patients adhere to treatment.

SAMHSA 2009

Because acamprosate must be taken three times per day, providers must pay particular attention to patient adherence. Providers can help patients adhere to the regimen by helping them develop ways to remember, such as wearing a “reminder” bracelet, setting a watch alarm, implementing a recovery-oriented ritual around taking the medication, or providing them with a special pillbox or blistercard pack.

[LISA]

Motivating patients for treatment and reinforcing progress. Providingfeedback about patients' initial test results, compared with norms, and the health risks associated with these results can be a powerful way to increase patients' motivation and adherence to treatment. Laboratory tests help healthcare providers objectively monitor patients' progress in treatment and provide patients with objective reinforcement by demonstrating biologic evidence of their improving health status.

Monitoring Adherence

Several means exist for a provider to monitor patients' compliance with treatment plans, including the following:

- Tracking patients' record of keeping (or not keeping) appointments for medication monitoring
- Monitoring prescription refills
- Noting whether patients are keeping agreements about payment for treatment
- Requesting periodic status reports from specialty substance abuse treatment programs, psychiatric referrals, and other psychosocial therapy or support.

Viited

Kokkuvõtte (abstract või kokkuvõtlikum info)	Viide kirjandusallikale
NICE 2011	
Aftercare to prevent relapse following alcohol treatment has not received adequate experimental investigation. The present study monitored alcohol intake of 50 patients following assignment to either an intensive aftercare recruitment procedure or regular clinic after-care. The results indicated that those who received the intensive aftercare procedure showed delayed relapse. In addition, regardless of group assignment those who attended aftercare had significantly more success as measured by alcohol intake. The implications of these results for the design of treatment and aftercare programs are discussed.	Ahles T. A, Schlundt D. G, Prue D. M, et al. Impact of aftercare arrangements on the maintenance of treatment success in abusive drinkers. Addictive Behaviors 1983; 8:53–58. RCT
Objective: The effectiveness of case-managed residential care (CMRC) in reducing substance abuse, increasing employment, decreasing homelessness, and improving health was examined. **Methods:** A five-year prospective experiment included 358 homeless addicted male veterans 3, 6, and 9 months during their enrollment and at 12, 18, and 24 months after the completion of the experimental case-managed residential care program. The customary control condition was a 21-day hospital program with referral to community services. **Results:** The experimental group averaged 3.4 months in transitional residential care with ongoing and follow-up case management for a total of up to 1 year of treatment. The experimental group showed significant improvement compared with the control group on the Medical, Alcohol, Employment, and Housing measures during the 2-year period. An examination of the time trends indicated that these group differences tended to occur during the treatment year, however, and to diminish during the follow-up year.	Conrad K. J, Hultman C. I, Pope A. R, et al. Case managed residential care for homeless addicted veterans: results of a true experiment. Medical Care 1998; 36:40–53. RCT
The objective of this study was to test whether an intensive case management intervention would be effective with a group of homeless chronic public inebriate clients. **Method:** Subjects (N = 298, 81% male) were interviewed at baseline, randomly assigned to treatment and control conditions and given follow-up interviews at 6-month intervals for 2 years. Case management services were provided for the duration of the project. Follow-up rates for the first three interviews averaged 82%. **Result:** Repeated measures MANCOVAs showed significant group differences favoring the case-managed group in all three areas targeted by the intervention:	Cox G. B, Walker D. R, Freng S. A, et al. Outcome of a controlled trial of the effectiveness of intensive case management for chronic public inebriates. Journal of Studies on Alcohol 1998; 59: 523–532. RCT

total income from public sources, nights spent in "own place" out of the previous 60 nights and days drinking out of the previous 30 days. The results held whether the three variables were analyzed jointly or separately and for alternative measures of drinking and homelessness. Although statistically significant, the group differences are generally not large.	
The aim of this study was to determine if community psychiatric nurse (CPN) aftercare for 1 year improved the 5-year outcome in patients following inpatient treatment for alcohol dependence. A 5-year follow-up study, observer blind, with non-random allocation of subjects to aftercare by CPN for 1 year or standard outpatient care, was used. Subjects had all received inpatient treatment for 6 weeks in a rural alcohol treatment unit. Subjects were traced and assessed in the community 5 years after the index admission. The participants consisted of 127 white male alcoholics. All were first admissions, who had been selected for inpatient treatment and who completed a 6-week inpatient stay. Seventy-three subjects received intensive aftercare by CPN for 1 year, 54 subjects received standard outpatient appointments not due to random allocation but because no CPN was available. Data were collected by semi-structured interview at entry to the trial, namely background epidemiological information, details of drinking history, previous hospital admission, educational, employment and criminal information. At 5-year follow-up, data on drinking status, use of other drugs, hospital admissions, criminal behaviour and gambling, attendance at self-help groups, relationships and employment were collected. Thirty-six per cent of the CPN aftercare group was completely abstinent during the 5 years after treatment compared to 6% of the standard aftercare group ($p < 0.001$). Subjects receiving CPN aftercare were less likely to report blackouts ($p < 0.05$) or gambling ($p < 0.05$). They were more likely to attend hospital meetings ($p < 0.0001$). CPN aftercare is an effective way of maximizing the effects of inpatient treatment. The effects endured for 5 years after treatment.	Patterson D. G, Macpherson J. & Brady N. M. Community psychiatric nurse aftercare for alcoholics: a five-year follow-up study. Addiction 1997; 92: 459–468. RCT
Past research on methods for actively engaging alcoholics in aftercare has been mixed with respect to the effects of such efforts on treatment outcome. The present study examined whether active follow-up methods do aid in engaging the alcoholic in treatment, whether such procedures improve treatment outcome and how much responsibility the therapist must be willing to assume in order to maintain the patient in treatment. Appointment keeping was significantly improved by a home-visit follow-up method in the first 6 months postdischarge (p less than .01). However, there was no one-to-one correspondence between improved therapy attendance and improved treatment outcome. When subjects were classified into treatment dropout and treatment completion groups, however, a treatment effect was achieved. The most intensive follow-up condition increased the probability of treatment completion, supporting to some degree the utility of aggressive follow-up. However, it was concluded that the cost of such procedures probably will limit their use since a significant economic variable (number of days hospitalized during the follow-up year) was not affected by type of aftercare.	Gilbert F. The effect of type of aftercare of follow-up on treatment outcome among alcoholics. Journal of Studies on Alcohol 1988; 49: 149–159.
There has been much research on and debate about the appropriate length of acute treatment for alcohol problems. In the United States, the lengthy and costly treatment programs of only a few years ago have been supplanted by ever-shorter and less intensive protocols, with little evidence that this trend will end soon. In this paper, we argue that, because of the chronic, recurrent nature of alcohol problems, an optimal system for delivering treatment services to alcoholics needs to focus on long-term engagement with clients. There is evidence from studies on research reactivity and telephone follow-up protocols that a low-intensity long-term protocol for maintaining contact with clients over time spans measured in years may result in better long-term clinical outcomes and reduced long-term health care utilization and costs. We describe a flexible long-term low-intensity follow-up protocol for alcohol abusers we call "case monitoring." This protocol is specifically designed to minimize long-term health-care use. We predict that such an intervention should be especially efficacious for women, persons with comorbid Axis I disorders, and persons lower in sociopathy. The design of a study to determine the clinical and health service effects of this intervention is also described.	Stout R, Rubin A, Zwick W, et al. Optimizing the cost-effectiveness of alcohol -treatment: a rationale for case monitoring. Addictive Behaviours 1999; 24:17–35.
This study examined methods for increasing transition of substance dependent patients from inpatient detoxification to outpatient aftercare. One hundred and	Chutuape M. A, Katz EC, Stitzer ML. Methods for enhancing

ninety-six patients were randomly assigned to, (1) standard referral (standard); (2) standard referral with an incentive (incentive); or (3) staff escort from detoxification to aftercare with an incentive (escort+incentive). Incentives (worth US$13.00) were dispensed for completing aftercare intake procedures on the day of discharge from detoxification. More escort+incentive participants (76%) than those in the incentive (44%) or standard conditions (24%) completed intake. The escort+incentive procedure may be useful for improving transition from detoxification to aftercare.	transition of substance dependence patients from inpatient to outpatient treatment. Drug and Alcohol Dependence 2001; 61: 137–143.
The present study evaluated the impact of a structured aftercare programme following residential treatment for severe alcohol and/or heroin dependent clients. Over 17 months, 77 participants were recruited to the study and allocated randomly to either a structured aftercare (SA) programme or to unstructured aftercare (UA) of crisis counselling on request. Independent clinicians interviewed participants and collaterals, at 4-month (median) intervals, for 12 months following residential treatment. SA compared to UA was associated with a fourfold increase in aftercare attendance and one-third the rate of uncontrolled principal substance use at follow-up. Participants who attended either type of aftercare relapsed a median of 134 days later than those who attended no aftercare. Overall, 23% of monitored participants remained abstinent throughout, 21% maintained controlled substance use and 56% relapsed, within a median of 36 days following residential treatment. The only significant predictor of days to relapse, controlling for age, was pretreatment use of additional substances. Participants with pretreatment additional substance use relapsed a median of 192 days earlier than those who had used no other substances. The degree of agreement between participant self-reports and collateral reports was fair-to-moderate and moderate among collaterals. Intention-to-treat analyses revealed significant and clinically meaningful reductions in substance use in this sample of severely dependent residential treatment clients. The generalizability of these results is limited because of significant differences in age and presenting substance between the study sample and other clients admitted to the service during the study. This latter group of younger, male, heroin-dependent clients with polydrug use who refuse opioid pharmacotherapy, are more likely to drop out of treatment or relapse early following treatment and continue to present a challenge to treatment services.	Sannibale C, Hurkett P, van den Bossche E, et al. Aftercare attendance and post-treatment functioning of severely substance dependent residential treatment clients. Drug and Alcohol Review 2003; 22: 181–190.
The purpose of this study was to assess the impact of providing recovery support services to clients receiving publicly funded chemical dependency (CD) treatment through the Access to Recovery (ATR) Program in Washington State. Services included case management, transportation, housing, and medical. A comparison group composed of clients who received CD treatment only was constructed using a multistep procedure based on propensity scores and exact matching on specific variables. Outcomes were obtained from administrative data sources. Results indicated that ATR services were associated with a number of positive outcomes including increased length of stay in treatment, increased likelihood of completing treatment, and increased likelihood of becoming employed. The beneficial effects of ATR services on treatment retention were most pronounced when they were provided between 31 and 180 days after treatment began. The results reported here offer evidence for the value of ATR services.	Krupski A, Campbell K, Joesch J M, et al. Impact of access to recovery services on alcohol/drug treatment outcomes. Journal of Substance Abuse Treatment 2009; 37: 435–442.
This study evaluated the efficacy of a contingency management (CM) procedure that provided opportunities to win prizes as reinforcers. At intake to outpatient treatment, 42 alcohol-dependent veterans were randomly assigned to receive standard treatment or standard treatment plus CM, in which they earned the chance to win prizes for submitting negative Breathalyzer samples and completing steps toward treatment goals. Eighty-four percent of the CM participants were retained in treatment for an 8-week period compared with 22% of the standard treatment participants ($p < .001$). By the end of the treatment period, 69% of those receiving CM were still abstinent, but 61% of those receiving standard treatment had used alcohol ($p < .05$). These results support the efficacy of this CM procedure. Participants earned an average of $200 in prizes. This CM procedure may be suitable for use in standard treatment settings because prizes can be solicited from the community.	Petry N. M, Martin B, Cooney JL, et al. Give them prizes, and they will come: Contingency management for treatment of alcohol dependence. Journal of Consulting and Clinical Psychology 2000; 68:250–257.
The aim of this study was to determine whether a socially focused treatment can effect change in the patient's social network from one that reinforces drinking to one that reinforces sobriety. Alcohol dependent men and women (N = 210)	Litt MD, Kadden RM, Kabela-Cormier E, et al. Changing network support drinking: initial findings from the

recruited from the community were randomly assigned to 1 of 3 outpatient treatment conditions: network support (NS), network support + contingency management (NS + CM), or case management (CaseM; a control condition). Analysis of drinking rates for 186 participants at 15 months indicated a significant interaction effect of Treatment x Time, with both NS conditions yielding better outcomes than the CaseM condition. Analyses of social network variables at posttreatment indicated that the NS conditions did not reduce social support for drinking relative to the CaseM condition but did increase behavioral and attitudinal support for abstinence as well as Alcoholics Anonymous (AA) involvement. Both the NS variables and AA involvement variables were significantly correlated with drinking outcomes. These findings indicate that drinkers' social networks can be changed by a treatment that is specifically designed to do so, and that these changes contribute to improved drinking outcomes.	network support projects. Journal of Consulting and Clinical Psychology 2007;77: 229–242.
This study examined the feasibility and effectiveness of prize-based contingency management (CM) when incentives for attendance were administered in group therapy and incentives for abstinence were administered in individual meetings. Three community substance abuse treatment programs participated in this two-phase, crossover design study. Outpatients (N = 103) entering treatment who met diagnostic criteria for cocaine, opiate, and alcohol abuse or dependence were recruited. During the standard condition, participants received standard treatment and submitted breath and urine samples that were tested for alcohol, cocaine, and opiates twice weekly during Weeks 1-6 and once weekly during Weeks 7-12. During the CM condition, participants received the same standard treatment and sample and attendance monitoring, plus the opportunity to win prizes for negative samples and treatment attendance. Demographic information and substance abuse history were evaluated at intake, and posttreatment substance use (toxicology results and self-report) was evaluated at Month 6 and Month 9 follow-up interviews. Primary outcomes were weeks retained in treatment and longest duration of sustained abstinence (LDA). LDA was significantly greater in CM-condition participants, but weeks retained did not differ between groups. Rates of substance use were lower in CM participants at Month 9 but not at Month 6. This study suggests that it is feasible to deliver incentives for attendance in group therapy, but that further research is needed to understand the modest effects on attendance. Strengths and limitations of this study are discussed.	Alessi SM, Hanson T, Wieners M, et al. Low-cost contingency management in community clinics: delivering incentives partially in grouptherapy. Experimental and Clinical Psychopharmacology 2007; 15: 293–300.
Pole kättesaadav - raamat.	Orford J, Natera G, Copello A, *et al.* (2005) *Coping with Alcohol and Drug Problems: The Experiences of Family Members in Three Contrasting Cultures*. London: Taylor and Francis. Kvalitatsiivst metoodikat kasutatdes kogutud andmed.
Forty-two clients attending two specialist inpatient programmes for drug and alcohol dependence in South London participated in a semi-structured, researcher-administered interview about their treatment experiences. The quality of the therapeutic relationships with staff and other clients were amongst the most positive aspect of treatment described. Clients were generally enthusiastic about the content of the treatment programme and support services. Over one third of participants reported that they would have preferred to enter treatment sooner because there was an urgent need to maintain treatment motivation and receive acute medical care .Treatment dissatisfaction mostly centred on aspects of the programme regulations and physical environment. Concerns included: the physical comfort at the programme,shared personal space and a rule restricting visitors.	Bacchus L. Client perceptions of inpatient treatment: a qualitative account with implications for service delivery. *Drugs: Education, Prevention and Policy* 1999; *6*: 87–97. Kvalitatsiivst metoodikat kasutatdes kogutud andmed ?
SIGN 2003	
Treatment dropout was studied in 172 patients (40 women) of an outpatient alcoholism treatment program. The best predictors of dropout were the length of delay between appointments, and variables related to symptom levels such as the number of prior alcohol-related arrests, the use of illicit drugs and scores on	Leigh G, Ogborne AC, Cleland P. Factors associated with patient dropout from an outpatient alcoholism treatment service. J Stud Alcohol

the Michigan Alcoholism Screening Test. Of lesser importance, but in line with previous findings, were sociodemographic variables such as age, the level of social stability and the presence of dependents at home. No personality variables were found to be relevant. It is suggested that treatment programs can improve attendance by reducing the delay with which services are offered and by changing certain characteristics of treatment personnel.	1984;45:359-62.
The investigation set out to examine the extent of problems of low compliance at an alcoholism clinic, to investigate some variables that might differentiate referral failures and initial clinic attenders as well as categories of patients who attend for treatment, and to generate hypotheses concerning these differences as a means of developing a compliance-enhancement strategy. Information, including sociodemographic and personality variables, patient self-reports of drinking behaviour, self-perceptions of their need for help and of drinking problem severity, and therapist ratings of drinking problem severity, was gathered on one hundred referrals to a clinic for new patients. Results showed that 46% of patients were referral failures and that, in comparison with attenders, the former group had both waited longer for the initial appointment and were younger. Few variables differentiated the categories of attenders. A greater proportion of those remaining in treatment contact for longer than a month rated the change in their drinking problem over the previous year as 'worse' and more of them had been arrested for public drunkenness. Those who made five or more clinic visits had waited a shorter time for their initial appointment, and a greater proportion rated the effects of their drinking on their work as 'serious' and the change in their social life as 'worse' than patients who had made fewer visits. The findings suggest that variables related to personal perceptions of drinking problems offer a better account of compliance behaviour than the sociodemographic variables which have been the focus of previous research	Rees DW, Beech HR, Hore BD. Some factors associated with compliance in the treatment of alcoholism. Alcohol Alcohol 1984;19:303-7.
This study examined the health beliefs and attitudes of patients seen in an alcoholism treatment clinic and investigated the relationship between these beliefs and attitudes and patient compliance as defined by length of time in treatment contact. Results showed that health beliefs and attitudes measured at the onset of treatment were predictive of patient adherence to treatment. Elements of the Health Belief Model found to be strongly associated with compliance included patients' perceived severity of their drinking problem, their expectations of improvement by remaining in treatment, and their levels of satisfaction with aspects of the doctor-patient relationship during the initial visit. The Health Belief Model offers a fruitful approach to understanding patients' compliance with alcoholism treatment and indicates possible areas for intervention to improve adherence.	Rees DW. Health beliefs and compliance with alcoholism treatment. J Stud Alcohol 1985;46:517-24.
This article reports on a controlled field experiment into the effectiveness of a brief unilateral intervention for the partners of heavy drinkers. Forty-five women and 3 men whose partners were both dependent on alcohol and highly resistant to change were randomly allocated to 4 experimental conditions: (a) unilateral intervention on an individual basis, (b) unilateral intervention within a group, (c) a no-treatment waiting list, and (d) traditional Al-Anon groups. Results revealed that both forms of the umlateral intervention, which is referred to as Pressures to Change, were successful in promoting change in the drinker, whereas neither of the alternatives was. However, only when Pressures to Change was offered on an individual basis did the client her- or himself report reductions in personal problems. Similar reductions were also reported by Al-Anon participants. Individual Pressures to Change was also the only intervention to produce improvements in marital consensus. The need for longitudinal research into partner interventions is identified.	Barber JG, Gilbertson R. An experimental study of brief unilateral intervention for the partners of heavy drinkers. Res Soc Work Pract 1996;6:325-36. controlled field experiment
In a randomized clinical trial, 130 concerned significant others (CSOs) were offered 1 of 3 different counseling approaches: (a) an Al-Anon facilitation therapy designed to encourage involvement in the 12-step program, (b) a Johnson Institute intervention to prepare for a confrontational family meeting, or (c) a community reinforcement and family training (CRAFT) approach teaching behavior change skills to use at home. All were manual-guided, with 12 hr of contact. Follow-up interviews continued for 12 months, with 94% completed. The CRAFT approach was more effective in engaging initially unmotivated problem drinkers in treatment (64%) as compared with the more commonly practiced Al-	Miller WR, Meyers RJ, Tonigan JS. Engaging the unmotivated in treatment for alcohol problems: a comparison of three strategies for intervention through family members. J Consult Clin Psychol 1999;67:688-97. RCT

Anon (13%) and Johnson interventions (30%). Two previously reported aspects of the Johnson intervention were replicated: that most CSOs decide not to go through with the family confrontation (70% in this study) and that among those who do, most (75%) succeed in getting the drinker into treatment. All 3 approaches were associated with similar improvement in CSO functioning and relationship quality. Overall treatment engagement rates were higher for CSOs who were parents than for spouses. On average, treatment engagement occurred after 4 to 6 sessions.	
AUSTRALIA 2009	
Chick, J, Gough K, Falkowski W et al. Disulfiram treatment of alcoholism. Br J Psychiatry 1992;161: 84–89. Hughes, J and C Cook. The efficacy of disulfiram: a review of outcome studies. Addiction 1997; 92: 381–395. Laaksonen, E, Koski-Jannes A, Salaspuro M et al. A randomized, multicentre, open-label, comparative trial of disulfiram, naltrexone and acamprosate in the treatment of alcohol dependence. Alcohol Alcohol 2008;43: 53-61. Myrick, H and RF Anton. Treatment of Alcohol Withdrawal. Alcohol Health Res World 1998;22:38-43 O'Malley, S 1998, Naltrexone And Alcoholism Treatment: Treatment Improvement Protocol (TIP). Rockville, MD.	
AUSTRALIA 2009; NSW 2008	
Objective: This study sought to evaluate the effectiveness of compliance therapy in increasing adherence to pharmacological treatment for alcohol dependence. **Method:** Forty subjects were randomly allocated to receive usual medical care (n = 20) or usual medical care plus compliance therapy (n = 20). All subjects were prescribed acamprosate (Campral) for 4 months. Subjects were volunteers treated at a hospital-based outpatient drug and alcohol treatment service, and were men and women who were 18-65 years old and with a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, diagnosis of alcohol dependence. All subjects received usual medical care consisting of seven medical reviews (duration = 15 minutes) over 4 months. Compliance therapy consisted of four to six individual sessions (duration = 60 minutes) in which beliefs about medication side effects, ambivalence, the benefits of treatment, treatment maintenance and relapse prevention were addressed and explored with motivational interviewing and cognitive behavior therapy techniques. **Results**: The outcome variables were number of days taking acamprosate, days to first drink, days to first relapse (more than five drinks) and days to first extended relapse (greater than 2 consecutive days of more than five drinks). Intention-to-treat analyses showed little difference between the two groups in the outcome drinking measures. Nevertheless, the per-protocol analyses revealed that participation in three or more sessions of compliance therapy significantly increased adherence to acamprosate and improved overall treatment outcomes.	Reid, SC, Teesson M, Sannibale C et al. The efficacy of compliance therapy in pharmacotherapy for alcohol dependence: a randomized controlled trial. J Stud Alcohol 2005;66: 833-41. RCT
WFSBP 2008	
When taken in an adequate dose, disulfiram usually deters the drinking of alcohol by the threat or experience of an unpleasant reaction. However, unless its consumption is carefully supervised by a third party as part of the formal or implied therapeutic contract, it is usually discontinued and the deterrent effect is therefore lost. In most studies, disulfiram administration has not been supervised and most reviews fail to stress the crucial importance of supervision. Unsupervised disulfiram has little or no specific effect. We have therefore reviewed all published clinical studies in which there was evidence that attempts had been made to ensure that disulfiram administration was directly supervised at least once a week. We found 13 controlled and 5 uncontrolled studies. All but one study reported positive findings, which were usually both statistically and clinically significant in controlled evaluations. In the sole exception, involving 'skid-row alcoholics', it seems that adequate supervision was not achieved. In general, the better the supervision, the better the outcome. Provided that attention is paid to the details of supervision and that supervisors are given appropriate training, supervised disulfiram is a simple and effective addition to psychosocial treatment programmes. Compared with unsupervised disulfiram or no disulfiram control groups, it reduces drinking, prolongs remissions, improves treatment retention and facilitates compliance with psychosocial interventions such as community reinforcement, marital and network therapies. The supervisor may be a health professional, workmate, probation officer or hostel worker but is usually a family member. Treatment	Brewer C, Meyers RJ, Johnsen J. Does disulfiram help to prevent relapse in alcohol abuse? CNS Drugs 2000; 5:329–341.

should probably continue for a minimum of 12 months. Supervised disulfiram appears to be more effective than supervised naltrexone and may be more effective than unsupervised acamprosate. The crucial importance of supervising the consumption of disulfiram has been overlooked or minimised by many reviewers.	
NSW 2008	
Handmaker N. et al. 'Motivational Interviewing in the Treatment of Dual Disorders', in Motivational Interviewing: preparing People for Change (second edition), W.R. Miller and S. Rollnick, editors. 2002, the Guildford Press: New York. Petry, N.M. 'Contingency Management in Addiction Treatment'. Psychiatric Times 2002; 19 Higgins ST. et al. 'Contingency Management: Incentives for Sobriety'. Alcohol Research and Health 1999; 23:p122-127. Petry NM. 'Contingency Management in Treatments'. British Journal of Psychiatry 2006; 189:97-98.	
APA 2006	
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.	Connors GJ, Walitzer KS, Dermen KH: Preparing clients for alcoholism treatment: effects on treatment participation and outcomes. J Consult Clin Psychol 2002; 70:1161–1169 [A–] RCT
SAMHSA 2009	
Martin B, Clapp L, Alfers J, Beresford T P. Adherence to court-ordered disulfiram at fifteen months: A naturalistic study. Journal of Substance Abuse Treatment 2004; 26: 233–236. Martin B, Mangum L, Beresford T P. Use of court-ordered supervised disulfiram therapy at DVA Medical Centers in the United States. American Journal on Addictions 2005; 14,:208–212.	

Süstemaatilised ülevaated

Kokkuvõte süstemaatilistest ülevaadetest

Sekretariaadi liikme poolt teostatud uuring (omaosalus teenuste saamisel)
(((cost[Title/Abstract] AND sharing[Title/Abstract]) OR copayments[Title/Abstract]) OR "Cost Sharing"[Mesh]) AND (adherence[Title/Abstract] OR compliance[Title/Abstract]) AND ("loattrfull text"[sb] AND "2004/10/22"[PDat] : "2014/10/19"[PDat] AND "humans"[MeSH Terms] AND English[lang] AND "adult"[MeSH Terms])

Viited

Kokkuvõtte (abstract või kokkuvõtlikum info)	Viide kirjandusallikale
Introduction: Copayments are intended to decrease third party expenditure on pharmaceuticals, particularly those regarded as less essential. However, copayments are associated with decreased use of all medicines. Publicly insured populations encompass some vulnerable patient groups such as older individuals and low income groups, who may be especially susceptible to medication non-adherence when required to pay. Non-adherence has potential consequences of increased morbidity and costs elsewhere in the system. **Objective:** To quantify the risk of non-adherence to prescribed medicines in publicly insured populations exposed to copayments. **Methods:** The population of interest consisted of cohorts who received public health insurance. The intervention was the introduction of, or an increase, in copayment. The outcome was non-adherence to medications, evaluated using objective measures. Eight electronic databases and the grey literature were	Sinnott SJ, Buckley C, O'Riordan D, Bradley C, Whelton H. The effect of copayments for prescriptions on adherence to prescription medicines in publicly insured populations; a systematic review and meta-analysis. PLoS One 2013;8: e64914. SYSTEMATIC REVIEW + META ANALYSIS

systematically searched for relevant articles, along with hand searches of references in review articles and the included studies. Studies were quality appraised using modified EPOC and EHPPH checklists. A random effects model was used to generate the meta-analysis in RevMan v5.1. Statistical heterogeneity was assessed using the I(2) test; p>0.1 indicated a lack of heterogeneity. **Results:** Seven out of 41 studies met the inclusion criteria. Five studies contributed more than 1 result to the meta-analysis. The meta-analysis included 199,996 people overall; 74,236 people in the copayment group and 125,760 people in the non-copayment group. Average age was 71.75 years. In the copayment group, (verses the non-copayment group), the odds ratio for non-adherence was 1.11 (95% CI 1.09-1.14; P = <0.00001). An acceptable level of heterogeneity at I(2) = 7%, (p = 0.37) was observed.	
Background—Financial reinforcement interventions based on behavioral economic principles are being increasingly applied in health care settings, and this study examined the use of financial reinforcers for enhancing adherence to medications. **Methods**—Electronic databases and bibliographies of relevant references were searched, and a meta-analysis of identified trials was conducted. The variability in effect size and the impact of potential moderators (study design, duration of intervention, magnitude of reinforcement, and frequency of reinforcement) on effect size were examined. **Results**—Fifteen randomized studies and 6 non-randomized studies examined the efficacy of financial reinforcement interventions for medication adherence. Financial reinforcers were applied for adherence to medications for tuberculosis, substance abuse, HIV, hepatitis, schizophrenia, and stroke prevention. Reinforcement interventions significantly improved adherence relative to control conditions with an overall effect size of 0.77 (95% CI = 0.70–0.84), p < .001. Nonrandomized studies had a larger average effect size than randomized studies, but the effect size of randomized studies remained significant at 0.44 (95% CI = 0.35–0.53), p < .001. Interventions that were longer in duration, provided average reinforcement of ≥$50/week, and reinforced patients at least weekly resulted in larger effect sizes than those that were shorter, provided lower reinforcers, and reinforced patients less frequently.	Petry NM, Rash CJ, Byrne S, Ashraf S,White WB. Financial reinforcers for improving medication adherence: Findings from a meta-analysis. Am J Med 2012;125: 888–896. META ANALYSIS
Objective: The study examined the rate and duration of outpatient substance abuse treatment following inpatient detoxification under managed care. **Methods:** Seven years of claims data from a large behavioral health care carve-out plan were used to identify patients. Rates and duration of formal substance abuse treatment following detoxification were calculated, and regression models were used to explore factors that may affect participation in treatment. **Results:** Seventy-nine percent of the detoxification patients received formal substance abuse treatment, the majority within the week following discharge. Formal follow-up care lasted an average of ten weeks, with visits occurring on average about once a week. When other variables likely to influence participation in substance abuse treatment were controlled for, the level of outpatient copayments significantly affected the rate of participation in treatment.	Stein B, Orlando M, Sturm R. The Effect of Copayments on Drug and Alcohol Treatment Following Inpatient Detoxification Under Managed Care. Psychiatric Services 2000; 51: 195–198.

[LISA]

Table 8: Case management versus TAU

Outcome or subgroup	K	Total N	Statistics	Effect (95% CI)	Quality of the evidence (GRADE)
Lapse (non-abstinence)					
At 6-month follow-up	1	36	RR (M-H, Random, 95% CI)	0.27 (0.11,0.65)	⊕⊕⊕○ MODERATE
At 12-month follow-up (RCT)	1	36	RR (M-H, Random, 95% CI)	0.75 (0.52,1.08)	⊕⊕⊕○ MODERATE
At 2-year follow-up (non-RCT)	1	122	RR (M-H, Random, 95% CI)	0.88 (0.69,1.12)	⊕○○○ VERY LOW
At 3-year follow-up	1	122	RR (M-H, Random, 95% CI)	0.68 (0.53,0.85)	⊕○○○ VERY LOW
At 4-year follow-up	1	122	RR (M-H, Random, 95% CI)	0.57 (0.45,0.73)	⊕○○○ VERY LOW
At 5-year follow-up	1	122	RR (M-H, Random, 95% CI)	0.49 (0.37,0.63)	⊕○○○ VERY LOW
Drinking frequency					
Mean days of alcohol intoxication (non-RCT)	1	537	SMD (IV, Random, 95% CI)	–0.07 (–0.25,0.11)	⊕⊕○○ LOW
Days any alcohol use at 6-month follow-up	2	551	SMD (IV, Random, 95% CI)	–0.10 (–0.40,0.20)	⊕⊕⊕⊕ HIGH
Days using alcohol since last interview at 6-month follow-up	1	193	SMD (IV, Random, 95% CI)	–0.34 (–0.63,-0.05)	⊕⊕⊕⊕ HIGH
Days drinking any alcohol in last 30 days at 9-month follow-up	1	358	SMD (IV, Random, 95% CI)	–0.13 (–0.34,0.08)	⊕⊕⊕⊕ HIGH
Days drinking any alcohol in last 30 days at 12-month follow-up	1	193	SMD (IV, Random, 95% CI)	–0.21 (–0.49,0.08)	⊕⊕⊕⊕ HIGH
Days using any alcohol since last interview at 12-month follow-up	1	193	SMD (IV, Random, 95% CI)	–0.30 (–0.59,–0.01)	⊕⊕⊕⊕ HIGH
Days drinking any alcohol in last 30 days at 18-month follow-up	1	193	SMD (IV, Random, 95% CI)	–0.33 (–0.62,–0.05)	⊕⊕⊕⊕ HIGH
Days using alcohol since last interview at 18-month follow-up	1	193	SMD (IV, Random, 95% CI)	–0.49 (–0.78,–0.20)	⊕⊕⊕⊕ HIGH

Note. M-H = Mantel-Haenszel estimate; IV = inverse variance.

[LISA]

Table 53: Summary of study characteristics for contingency management

	Contingency management versus control	Contingency management versus TAU	Contingency management versus other active intervention
K (total N)	1 RCTs (N = 139)	2 RCTs (N = 145)	1 RCTs (N = 141)
Study ID	LITT2007	(1) ALESSI2007 (2) PETRY2000	LITT2007
Diagnosis	DSM alcohol dependent/abuse	(1) DSM alcohol dependent/abuse (2) DSM alcohol dependent	DSM alcohol dependent/abuse
Baseline severity	Drinking days in past 3 months: 72%	(2) Years of alcohol dependence: 23.5 years	Drinking days in past 3 months: 72%
Number of sessions	12 sessions	(1) Rewards for negative sample and attendance (2) Rewards for negative sample	12 sessions
Length of treatment	12 weeks	(1)–(2) Not applicable	12 weeks
Length of follow-up	27 months	Range: Post-treatment only	27 months
Setting	Outpatient treatment centre	(1)–(2) Outpatient treatment centre	Outpatient treatment centre
Treatment goal	Not explicitly stated	(1)–(2) Abstinence	Not explicitly stated
Country	US	(1)–(2) US	US