Kliiniline küsimus nr 23

Kas kõikide raviprotsessi koordineerimise meetodite kasutamine vs mitte kasutamine on tulemuslik alkoholitarvitamise häirega patsientide ravijärjepidevuse tagamiseks?

Kriitilised tulemusnäitajad:
abstinents, tagasilangus, alkoholi tarvitamise vähenemine, patsiendi rahulolu, patsiendi *elukvaliteet, kvaliteetselt elatud eluaastate lisandumine, haiguse/vaegurluse tõttu kaotatud päevade arv, ravisoostumus, ravi katkestamine mistahes põhjusel, osalemine ravijärgsetes programmides või ravijärgsete programmide lõpetanute arvu osakaal alustanutest, juhuslik alkoholi tarvitamine.*

Ravijuhendid

Kokkuvõte tõendusmaterjali kvaliteedist

Soovituse koostamiseks vaadati läbi 12 alkoholisõltuvuse ja liigkasutamise ravijuhendit. Teemakohast infot sisaldus neist kolmes: NICE2011, NSW2008, APA2006. Lisaks teostati artiklite otsing PubMed ja Medline andmebaasidest. Otsingusõnad olid järgmised: Vaadati läbi 26 artiklit, millest käesoleva ravijuhise jaoks oli käsitletud õiget populatsiooni ning mõõdetud relevantseid tulemusi viies.

NICE2011

Tõendusmaterjal on mõõduka või nõrga kvaliteediga, põhinedes väga vähestel randomiseeritud kontrollitud uuringutel, mille tulemused ei ole puulitavad, kuna tulemuste osas kasutatakse erinevaid mõõdikuid.

Juhtumikorraldus vs tavaravi

Tõendusmaterjal on mõõduka kvaliteediga. Uuringud hõlmavad 1262 patsienti. Soovituse koostamiseks on kasutatud 3 RCT ja 2 vaatlusuuringut (Ahles et al, 1983; Conrad et al, 1998; Cox et al, 1998; Mclellan et al, 1999; Patterson et al, 1997), mille tulemused on ühendatud ning soovituse tugevdamiseks on lisaks välja toodud veel nelja RCT tulemused (Chutuape et al, 2001; Gilbert, 1988; Krupski et al, 2009; Sannibale et al, 2003; Stout et al, 1999). Võrreldes tavaraviga, on juhtumikorraldus oluliselt parem tagasilanguse vältimiseks ning alkoholikoguse vähendamiseks. Alkoholi tarbimise sagedus ja teised kainuse mõõdikud, aga ei andnud olulisi erinevusi gruppide vahel. Viis metaanalüüsi jaoks lisatud uuringut näitasid kõik, et juhtumikorraldus on oluline tagamaks ravi lõpetamist ning järelravi edukust. Lisatud uuringutest ainult üks (Stout et al, 1999) leidis statistiliselt olulise tulemuse kõikides mõõdikutes. Negatiivsema poolena toob NICE´i ekspertide kogu välja juhtumikorralduse ohukoha, et kergema ja mõõduka sõltuvusega ning alkoholi kuritarvitavad patsiendid võivad selle süsteemi puhul jääda tähelepanuta, kuna kogu tähelepanu koondub eelkõige tugeva sõltuvusega patsientidele.

Assertive community treatment (ACT) vs tavaravi

Tõendusmaterjal on nõrga kvaliteediga ning põhineb ühel (Passetti et al, 2008) paralleelsete kohortidega mitte randomiseeritud pilootuuringul. Uuring leidis, et ACT parandas võrreldes tavaraviga meditsiiniliselt abistatud võõrutusravi ning järelravi järgimist ja lõpuni viimist.

Astmeline ravi

Tõendusmaterjal on nõrga kvaliteediga, kuna käsitletud uuringud ei defineerinud astmelist ravi sama moodi või käsitlesid veidi erinevat uuringurühma. 3 randomiseeritud kontrollitud uuringut, mis koondas 496 patsienti (Bischof et al., 2008; Breslin et al., 1999; Drummond et al., 2009), leidsid, et astmeline ravi on kasulik alkoholi ohtliku tarvitajate puhul (*hazardous drinker*), alkoholi sõltuvusega ja kuritarvitavate patsientide puhul erinevust ei nähtud.

NSW

Tõendusmaterjal on nõrga kvaliteediga, kuna põhineb enamasti ülevaadetel ning raportitel. Vähesed randomiseeritd kontrollitud uuringud hõlmavad väga väikeseid valimeid ning uuringupopulatsioon erineb kohati oluliselt käesoleva ravijuhendi jaoks olulisest populatsioonist.

Juhtumikorraldus

Dumaine et al (2003) metaanalüüsis leiti, et sotsiaaltöötajal on oluline roll ressursside omavahelisel ühendamisel, lisatoe pakkumisel patsiendile ja barjääride eemaldamisel, mis takistavad patsiendil ligipääsu erinevatele teenustele. Kõik uuringud metaanalüüsis käsitlesid uuritavatena vaimsete probleemidega patsiente, kellel on sõltuvusprobleemid.

662 patsienti hõlmav randomiseeritud kontrollitud uuring Saleh et al (2006) uuris kuluefektiivsust ning leidis, et juhtumikorraldus aitab luua usaldusväärset sidet patsiendi ja tervishoiutöötaja vahel ning vähendada seega vajatava ravi efektiivsust, kuid ei ole kuluefektiivne meetod võrreldes medikamentoosse raviga. 90 patsiendiga RCT (Noel et al, 2006) leidis, et juhtumikorraldus aitab küll paremini ravil püsida, kuid ei mõjuta lõpptulemusi ning et juhtumikorraldus saab olla efektiivne alles siis, kui programm on rakendatud usaldusväärselt.

Astmeline ravi

Breslin et al (1997) 212 patsiendiga uuringus püüdsid välja selgitada neid patsiente, kel on oht ravist hoolimata jätkata tarbimist. Uuring leidis, et astmeline ravi on hinnangute mudeli alusel sobiv neile, kes algselt ravile väga hästi ei reageeri (tulemina mõõdeti PDA-d, *percent days abstinent* ning DDD, *drinks per drinking day*).

Sobell et al (2000) ülevaade rõhutab, et astmeline ravi peab olema individuaalne, tõenduspõhine ning võimalikult vähe patsienti piirav (aga siiski piisavalt, et tagada ravi edukust).

APA 2006

Tõendusmaterjal on nõrga kvaliteediga. Uuringute asemel antakse pigem ülevaade ja defineeritakse juhtumikorraldust. Tõendumaterjalis on vaid üks suur 361 uuringut hõlmav metaanalüüs (Miller et al, 2002). Antud uuring leidis, et juhtumikorraldus on alkoholi liigtarvitajate puhul efektiivne, kuid see oli vaid üks paljudest uuritavatest alkoholi sõltuvusravi aspektidest (uuring ei keskendunud ainult sellele).

Süstemaatilised ülevaated

Lisaotsingul leitud artiklitest olid vaid vähesed relevantsed ning kuigi hea kvaliteediga, siis oli nende suurimaks puuduseks väiksed valimid (süstemaatilistes ülevaadetes vähe kaasatud uuringuid), mille tõttu isegi efekti ilmnemisel ei suudetud näidata selle statistilist olulisust. Seetõttu jääb ka nendest saadud tõenduse kvaliteet nõrgaks.

Astmelist ravi oli kajastatud kahes suures süstemaatilises ülevaates Berner et al (2008) ning Jaehne et al (2012). Jaehne et al tegid järelduse, et astmeline ravi on aega säästvam, kuid kummagi ülevaate tulemused ei näidanud astmelise ravi efektiivsust alkoholi liigtarbivatel patsientidel võrreldes tavaraviga. Reinhardt et al**.** (2008) suutsid oma analüüsis näidata, et naiste puhul siiski on astmelisel ravil efekt- naised näitasid suuremat langust alkoholi tarbimise koguses uuringu algusest kuni 12-kuu möödumiseni (35.5%, R^2=0.029). Meeste puhul aga efeki ei nähtud (9.6%, R2=0.001).

Juhtumikorralduse osas uuriti ühes randomiseeritud kontrollitud uuringus (Saitz et al, 2013) ning ühes ravi kvaliteeti hindavas uuringus (Theresa W. Kim et al, 2012) krooniliste haiguste manageerimise mudeli efektiivsust alkoholi sõltuvuse ravis. Saitz et al ei leidnud sekkumis- ja kontrollgrupi vahel erinevusi (kohandatud OR 0.84; 95% CI, 0.65-1.10; P=.21) kainuse säilitamisel 12-kuu jooksul. Theresa W. Kim et al leidsid, et ravi edukuse tagamiseks on oluline patsiendi poolt antud kvaliteedi hinnang ravile.

Kokkuvõte ravijuhendites leiduvatest soovitustest

NICE2011

Ravi koordineerimine peaks olema rutiinne ravi osa ning peaks:

- olema pakutud kogu ravi vältel, ka järelravis

- olema pakutud spetsialistide poolt

- hõlmama hindamist, sekkumisi, edusammude monitoorimist ning koordineerimist teiste üksustega

- Juhtumikorraldust tuleks kaaluda mõõduka ja raske alkoholisõltuvusega patsientidel ning kellel on oht jätta ravi pooleli või kelle puhul on eelnevalt teada madal motiveeritus ravis osalemiseks. Juhtumikorralduse kasutamisel peaks see olema kättesaadav kogu ravi (ka järelravi) jooksul.

- Juhtumikorraldust peaksid pakkuma spetsialistid, kes peaksid võtma vastutuse kogu ravi koordineerimise eest. Juhtumikorralduse puhul tuleb hinnata patsiendi vajadusi ning luua individuaalne raviplaan koostöös teenuse saaja ja teiste osapooltega (ka pere). Raviplaani tuleb koordineerida ning monitoorida sekkumiste mõju ja vajadusel teha raviplaanis muudatusi.

Juhtumikorraldus vs tavaravi

Juhtumikorraldus aitas võrreldes tavaraviga säilitada kainust 6 kuu möödudes (efekt väike), kuid mitte 12 kuu möödudes. Olulist efekti oli näha 3, 4 ja 5 aasta möödudes, kusjuures efekt oli suurim 3 aasta möödudes ja langes sealt edasi järk-järgult (vaatlusuuring) (Patterson et al, 1997).

Alkoholi tarbimise sageduses (päevade arv, mil tarbiti) ei olnud juhtumikorralduse ja tavaravi vahel erinevusi 6, 9 ja 12 kuu mööduded. Erinevus juhtumikorralduse kasuks ilmnes 18 kuu möödudes. Uuring näitas, et kui võtta arvesse ainult alkoholi tarbimine peale viimast intervjuud, siis oli tarbimine väiksem juhtumikorralduse puhul (Cox et al, 1998).

Juhtumikorralduse, koduvisiitide ja tavaravi võrdluses ei olnud erinevusi alkoholi tarbimise osas. Juhtumikorralduse ja koduvisiidi puhul oli aga suurem ravi katkestamise määr koheselt, kui tervishoiutöötaja lõpetas patsiendi aktiivselt ravile kutsumise (Gilbert et al, 1988).

Patsiendi jälgimine (*case monitoring*) võrreldes tavaraviga aitab vähendada rohke alkoholi tarbimise päevi (3 aasta möödudes) ning pikendab aega relapsini (Stout et al, 1999).

Järelravi on edukam, kui ravi on struktureeritud ning patsiendid suunatakse ravile tervishoiutöötaja poolt (Chutuape et al, 2001; Sannibale et al, 2003).

Toetatud ravi (mis sisaldab ka juhtumikorraldust) tagab võrreldes tavaraviga pikema ravil püsimise (42,5 päeva pikem) ning vähendab oluliselt tõenäosust ravi katkestada (Krupski et al, 2009).

Table 7: Study information table for trials of case management

	Case management versus TAU
Total number of trials (total number of participants)	5 RCTs (N = 1262)
Study ID	(1) AHLES1983 (2) COX1998 (3) CONRAD1998 (4) MCLELLAN1999 (observational) (5) PATTERSON1997 (observational)
Baseline severity (mean [standard deviation; SD])	(1) 80% admitted to levels of drinking within the abusive range (2) Days of drinking (any alcohol use) in last 30 days: Case management: 23.6 (9.2) Control: 23 8 (9.1) (3) Days of alcohol use in past 30 days (mean): 18.4 for control group; 19.0 for experimental group (4) Whole sample on average reported 13.4 years of problem alcohol use (12.1) (5) Daily alcohol (units) (mean [SD]) CPN aftercare: 39.4 (18.3) Standard aftercare: 42.9 (16.6)
Length of follow-up	(1) 6- and 12-month (2) Assessed in 6-month intervals up to 2-year follow-up (3) 3, 6 and 9 months during enrolment and 12, 18 and 24 months after completion of treatment. (4) 6-month (5) Assessed at 1, 2, 3, 4 and 5 years post-treatment

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.

Assertive community treatment vs tavaravi

ACT-ravi pakub multidistsiplinaarne meeskond; ravi on mõeldud selgelt defineeritud grupile; ravivastutus jaguneb võrdselt kõigi meeskonnaliikmete vahel; meeskonnalikkmed ei suuna, vaid ravivad patsienti; ravi pakutakse kodus või tööl (võimalusel); ravi pakutakse ennast-läbisuruvalt nendele, kes ei ole koostöövalmid või on ravi osas vastumeelsed; ravimeid rõhutatakse kooskõlastatult

Kuna ACT on väljatöötatud vaimsete haiguste raviks, siis on vähe tõendusmaterjali, mis oleks uurinud ACT efektiivsust alkoholi liigtarbimise raviks. Passetti et al (2008) kohortuuring võrdles ACT-d (paindliku juurdepääsuga kliinik) tavaraviga (2 kogukonnaõde ja sotsiaaltöötajad). Uuring näitas, et paindliku ligipääsuga kliiniku teenuseid saavad patsiendid lõpetasid suurema täenäosusega võõrutusravi (χ^2 = 4.43 p = 0.05) ja jätkasid järelraviga (t = 2.61, p = 0.02), kui

tavaravi saanud. Alkoholi tarbimist uuringus ei vaadatud ning programmi lõpetamise osas kahe grupi vahel erinevusi polnud.

Astmeline ravi vs tavaravi (*stepped care*)

Astmeline ravi-kõige vähem piiravama ja kulukama ravi pakkumine; ise korrigeeruva mehhanismi kasutamine-kasutusel on monitoorimissüsteem, mis võimaldab näha kui patsiendile määratud esialgne ravimeetod ei sobi ning kasutusele tuleks võtta uus ja intensiivsem ravimeetod.

Breslin et al (1999) RCT uuring ei vastanud päris astmelise ravi kriteeriumitele. Uuring andis patsientidele 4 motiveerivat intervjuud ning jagas tulemuse alusel uuritavad 3 gruppi-need, kes ei reageerinud ravile peale esimest intervjuud, need kes ei reageerinud ravile (said asendussekkumisena ravi järgse arengu raporti) peale teist intervjuud (jõid rohkem kui 12 drinki nädalas intervjuude vahelisel ajal) ja ravile reageerinud. Esimesel grupil võrreldes teistega alkoholi tarbimise harjumused ei muutunud. Ravile reageerinud ja teise intervjuu järgselt mitte reageerinud otsisid hiljem abi samal määral. Uuringus nähtud efekt oli väike, kuna uuritavad olid vaid problemaatilised alkoholi tarbijad (mitte sõltuvustarbijad) ning ravile mitte reageerinute arengu raport ei olnud piisavalt agressiivne.

Bischof et al (2008) RCT võrdles kahte tüüpi astmelist ravi. Uuritavad jagati 3 gruppi-astmeline ravi (arvuti teel sekkumine+maksimum 3 nõustamist 1-, 3- ja 6-kuu möödudes), täisravi (lühikesed motiveerivad intervjuud, tagasiside arvuti teel), kontrollgrupp (tervisekäitumise infoleht). Lõpptulemusena vaadeldi tarbitud alkoholi kogust grammides järelkontrollis. Tulemused gruppide vahel oluliselt ei erinenud (R^2 change = 0.006, p = 0.124). Erinevus saadi vaid alkoholi väärtarbimise riskigrupis olevate uuritavate jaoks (R^2 change = 0.039, p = 0.036) võrreldes kontrollgrupiga. Erinevus puudus alkoholisõltuvusega ja joomasööstudega patsientide jaoks (vastavalt R^2 change = 0.002,p = 0.511 ja R^2 change = 0.000, p = 0.923).

Drummond et al (2009) RCT. Uuritavad said kas 3-astmelise ravi (käitumise muutumise nõustamine, 4 50-minutilist MET sessiooni, suunamine kogukonna võõrutusravi asutusse) või 5-minutilise nõustamise õe poolt. 6-kuu möödudes oli alkoholi tarbimine vähenenud mõlemas grupis, veidi enam oli astmelise ravi grupis vähenenud tarbitud alkoholi üldkogus ja drinkide arv ühe tarbismikorra jooksul (vastavalt: adjusted mean difference = 145.6, 95% CI, −101.7 to 392.9, effect size difference = 0.23; adjusted mean difference = 1.1, 95% CI, −0.9 to 3.1, effect size difference = 0.27). Aga need erinevused polnud statistiliselt olulised.

NSW2008

Juhtumikorraldus:

Raske uurida, kuna juhtumikorraldus on halvasti defineeritud ning seda kasutatakse mitte järjepidevalt, mistõttu on metoodika ja eesmärkide seadmine keeruline.

Probleemse alkoholitarbimise korral tuleks keskenduda patsiendi jaoks olulistele probleemidele, mis loob hea keskkonna raviks, kasutades näiteks ravi koordineerimist või juhtumiskorraldust (Lee et al, 2002).

Juhtumikorraldus soodustab positiivseid muutusi alkoholi kuritarvitavatel patsientidel, aidates neil luua usaldusväärne, tugev ja kestev side tervishoiutöötajaga. Arvatakse, et seetõttu aitab juhtumikorraldus vähendada vajatava ravi intensiivsust (Saleh et al, 2006).

Mõned kohortuuringud on näidanud, et juhtumikorraldus tagab parema ravil püsimise, kuid ei anna paremaid lõpptulemusi alkoholi väärtarvitamisel (Noel et al, 2006).

Juhtumikorralduses on kasutatud 5 erinevat mudelit:

1. Maaklerluse mudel-juhtumikorraldaja vahendab tugiteenuseid lühiajaliselt. Parandab ligipääsu teenustele, aga ei paranda ravitulemusi

2. Üld/intensiivne mudel-parem ravijätkuvus, paremad esialgsed ravitulemused

3. ACT-parem vaimne tervis, tulemusi pole näidatud alkoholi sõltuvuse ravis

4. Kliiniline juhtumikorraldus- parem vaimne tervis, tulemusi pole näidatud alkoholi sõltuvuse ravis

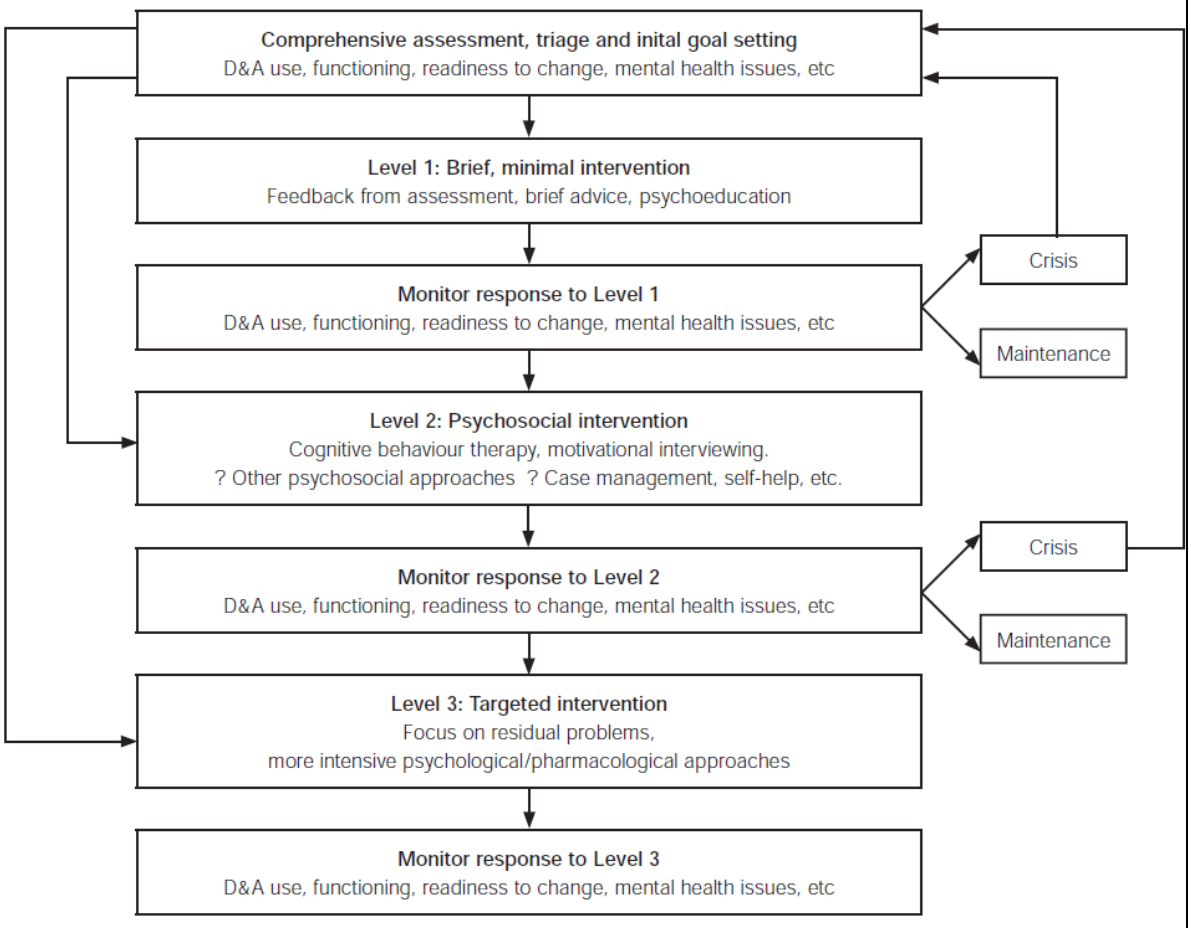
5. Tugevustel põhinev juhtumikorraldus- parem vaimne tervis, tulemusi pole näidatud alkoholi sõltuvuse ravis (Hesse et al, 2006)

Üld/intensiivne mudel kasutab 7 strateegiat, mis on ekspertide poolt enim soovitatud kui kõige efektiivsem juhtumikorralduse lähenemisviis: Patsiendi skriinimine ja hindamine, individuaalse raviplaani koostamine, raviplaani rakendamine ja ravi koordineerimine, spetsialisti vastuvõtule pääsemise kergendamine, juurdepääsu lihtsustamine teistele vajalikele teenustele (nt psühholoogiline abi), kogukonna teenustele ligipääsu lihtsustamine, kontakti ja toe säilitamine patsiendiga, progressi ja plaani tulemuste monitoorimine, individuaalse raviplaani revisioon (Case Management Sub-Committee, NSW Health Drug and Alcohol Council, 2005; Dumaine et al, 2003; Hall et al, 2002; Noel et al, 2006; Hesse et al, 2006).

<u>Astmeline ravi:</u>

Astmeline ravi annab võimaluse otsustada, millise raviga alustatakse ning millal vahetada see mõne muu või intensiivsema ravi vastu (intensiivse ravi kasuks otsustatakse alles siis, kui eelnev ravi ei ole piisavalt efektiivne). (N.H.D.a.A.A.H.W.A. Committee, editor. 2005; Sobell et al, 2000; Breslin et al, 1997; Schippers et al, 2002).

Astmelise raviga alustamise mudel:



APA2006

Juhtumikorralduse eesmärgiks on koordineerida ravi ja sotsiaalteenuseid, parandada patsiendi ravi jätkamist ja järelravi (Rockville, 1998). Juhtumikorraldus annab infot patsiendi diagnoosi ja ravi kohta ning hindab tema baasvajadusi, mille täitmine laseb patsiendil aktiivselt osaleda ravis (nt elukoht, transport jne). Lisaks pakuvad juhtumikorraldajad vajalikku stabiilsust ja mõistmist ning aitavad patsiendil järgid määratud raviskeemi. Juhtumikorralduse mudelite rohkus teeb nende uurimise aga keerukaks (McNeese-Smith et al, 1999; Graham et al, 1990). Sellest hoolimata näitavad uuringud, et alkoholi liigtarvitajate puhul on juhtumikorralduslikud sekkumised efektiivsed (Miller et al, 2002).

Juhtumikorraldus on väga oluline patsientide puhul, kel on vähe ressursse või, kes on vähese enesehoolitsus võimega mõne haiguse tõttu (Rockville, 1998).

Ravijuhendite inglise keelsed tekstid

NICE2011

Care coordination and case management

5.11.1.1 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.

5.11.1.2 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.

5.11.1.3 Case management should be delivered in the context of Tier 3 interventions15 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.

There was a significant difference in lapse (non-abstinence) at 6-month follow-up, in favour of case management, with a small effect size; however, this effect was not significant at 12-month follow-up. There was a significant difference favouring case management found at 3-, 4- and 5-year follow-up, with the largest effect size occurring at 3-year follow-up and decreasing to a moderate effect size at 4- and 5-year follow-up, respectively.

On measures of drinking frequency, when considering the number of days drinking any alcohol (in the last 30 days) or mean days of intoxication, there were no significant differences between case management or treatment as usual at either 6-, 9- or 12-month follow-up. Interestingly, there was a significant effect observed at 18-month follow-up.

A RCT comparing case management, a home visit andtreatment as usual for those with alcohol dependence. Both active treatment groups showed a decline in appointment keeping rates after the therapists stopped making active attempts to encourage the patient to attend therapy. On drinking outcomes, there were no significant differences between groups at any follow-up point.

A RCT comparing case monitoring versus treatment as usual for those with alcohol dependence. The results indicated a significant difference on percentage of days heavy drinking at 3-year follow-up, where the frequency of heavy drinking was twice as high in the controls as in the case monitored participants. In addition, survival analysis indicated that case monitoring was significantly better at prolonging time to lapse and relapse.

Transition from an assisted-withdrawal programme to aftercare-participants in the escort and incentive and incentive only conditions completed intake at aftercare more ($p \lrcorner 0.05$) than those receiving standard treatment. Comparing a structured aftercare programme with an unstructured aftercare programme, participants in either aftercare condition relapsed later than those who attended no aftercare programme; however, this significant difference did not emerge for time to lapse.

The impact of recovery support services (including case management) provided through an access to recovery programme in the US for clients undergoing substance-misuse treatment. In comparison with standard care the ATR programme was associated with increased length of stay in treatment and completion of treatment (42.5 days longer). Further, multivariate survival analysis indicated the risk of ending treatment was significantly lower (hazard ratio = 0.58, $p \lrcorner 0.05$) among the ATR clients.

ACT-care is provided by a multidisciplinary team (usually involving a psychiatrist with dedicated sessions); care is exclusively provided for a defined group of people (those with severe and chronic problem); team members share responsibility for clients, so that several members may work with the same client, and members do not have individual caseloads (unlike case management); the team attempts to provide all psychiatric and social care for each service user, rather than making referrals to other agencies; care is provided at home or in the workplace, as far as possible; treatment and care are offered assertively to individuals who are uncooperative or reluctant ('assertive outreach'); medication concordance is emphasised.

Passetti and colleagues (2008) conducted a parallel cohort trial comparing a flexible access clinic (based on ACT principles) with a usual care clinic. Treatment as usual (usual care clinic) consisted of two specialist alcohol community nurses and social workers. Medical cover was provided by a consultant, an associate specialist and a junior doctor. Care coordinators had a relatively large caseload and there was limited integration of health and social care staff, along with less community-based assessments and case discussions. The trial found that participants in the flexible access clinic were significantly more likely to complete withdrawal (Pearson's Chi square test, $\chi^2 = 4.43$ $p = 0.05$) and enter an aftercare programme earlier (Student's t-test, $t = 2.61$, $p = 0.02$). No significant difference between the two groups was found on completion of assessment and drinking outcomes were not measured.

Breslin and colleagues (1999) evaluated a stepped-care model (but which the GDG considered might be more accurately described as an evaluation of sequenced as opposed to stepped care14) for harmful drinkers, with the initial treatment consisting of four sessions of motivationally-based outpatient treatment. The design split participants into treatment responders and nonresponders, with treatment non-responders defined as those having consumed more than 12 drinks per week between assessment and the third session of the intervention. There was also a third group of non-responders who did not respond to initial treatment, but received a supplemental intervention consisting of post-treatment progress reports. A repeated measures ANOVA indicated a significant effect of time for percent days abstinent (PDA), $F (2,116) = 35.89$, $p \lrcorner 0.0001$, for all groups) and for DDD, $F (2,115) = 26.91$, $p \lrcorner 0.0001$. F results from follow-up contracts revealed that those who received a supplemental intervention showed no additional improvements on drinking outcome measures in comparison with those who did not receive a supplemental intervention (no significant differences on PDA or DDD). Furthermore, treatment responders and non-responders sought additional help at the same rate. It should be noted that this intervention was aimed at problem drinkers and not at severely dependent drinkers. Furthermore, it is possible that the lack of effect in this study was due to the 'intensity' of the 'stepped' intervention, as it only consisted of a progress report.

Bischof and colleagues (2008) compared two types of 'stepped-care' interventions. The 'stepped-care' group received a computerised feedback programme after assessment and a maximum of three brief counselling sessions delivered by telephone, lasting 30 to 40 minutes each. The counselling was delivered based on the success of the previous intervention, the computerised feedback programme. The control group received a booklet on health behaviour. An OLS regression analysis indicated that there was no significant difference overall, in terms of efficacy of the intervention ($R2$ change $= 0.006$, $p = 0.124$). A significant difference was found for at risk/alcohol misuse at 12-month follow-up ($R2$ change $= 0.039$, $p = 0.036$), but not for alcohol dependence ($R2$ change $= 0.002$, $p = 0.511$) or heavy episodic driving ($R2$ change $= 0.000$, $p = 0.923$). Thus stepped-care and full-care groups did not differ on drinking outcomes, but when compared with the control group the intervention showed small to medium effect size for at-risk drinkers only.

Drummond and colleagues (2009) conducted an RCT pilot study to evaluate a stepped-care intervention in primary care primarily for hazardous and harmful drinkers. Participants received either a three-stage stepped-care intervention or 5 minutes of brief advice delivered by a practice nurse. Participants in the stepped-care intervention received a single session of behaviour change counselling (delivered by a practice nurse), four 50-minute sessions of MET. At 6-month follow-up, there was a reduction on drinking outcome measures in both groups and a slight trend favouring the stepped-care intervention for total alcohol consumed (adjusted mean difference = 145.6, 95% CI, −101.7 to 392.9, effect size difference = 0.23) and drinks per drinking day (adjusted mean difference = 1.1, 95% CI, −0.9 to 3.1, effect size difference = 0.27). These differences were not significant.

NSW2008

Marsh and Dale (2) highlight the importance of focusing psychosocial treatments for problematic drug and alcohol use on issues that are important to the client. In the short term, this may involve addressing very practical concerns for the client such as housing, economic, legal or social problems, and adopting a 'case management' or care co-ordination approach to treatment (226).

Addressing these pressing issues for the client presents the D&A professional with an ideal opportunity to build strong rapport and engagement, potentially setting the scene for psychosocial and other treatment strategies.

Case management is thought to encourage positive changes in the drug and alcohol client by enabling them to form a trusting, strong, and enduring relationship with a D&A professional. Over the longer term, by co-ordinating care for the client and organising ongoing support services, case management is thought to reduce the intensity with which drug and alcohol treatment will be required.

A few cohort studies do exist to suggest that case management is associated with increased retention in treatment (Level 3-b evidence, 229), but this has not been directly related to improved drug and alcohol use outcomes.

Five models of case management have generally been used for drug and alcohol clients (7, 230):

1. Brokerage Model (brief approach whereby case workers 'broker' support services within one-two sessions; no evidence for effectiveness on retention in treatment or drug and alcohol outcomes, but associated with increased access to drug and alcohol services)

2. Generalist/Intensive Model (Level 3-b evidence for effectiveness on retention in treatment, preliminary evidence for improved drug and alcohol outcomes)

3. Assertive Community Treatment Model (Level 2 evidence for effectiveness on mental health outcomes, but no drug and alcohol studies to date)

4. Clinical Case Management (Level 2 evidence for effectiveness on mental health outcomes, but no drug and alcohol studies to date)

5. Strengths-Based Case Management (Level 2 evidence for effectiveness on mental health outcomes, but no drug and alcohol studies to date).

The Generalist/Intensive

model uses the seven strategies most commonly suggested by experts in the case management area as the most effective case management approach (Level 3-b evidence, 53, 128, 229, 230).

Recommendation (★★)

Core activities in Generalist/Intensive Case Management should include (53, 128, 227, 229, 230):

■ Screening and assessment of individual clients including assessment across all factors relating to the client's presentation

■ Development of comprehensive, individual treatment or care plans

■ Co-ordination of treatment or care plan implementation

■ Facilitation of access to specialist treatment for substance use disorders

■ Facilitation of access to other health services including mental health, hepatology, emergency etc as required

■ Facilitation of access to a broad range of community services

■ Maintenance of contact with and support for the individual client

■ Monitoring progress and outcome across the care plan

■ Review and revision of individual care plans.

Stepped-care

In the stepped care approach to treatment, a set of empirically-based guidelines determine what treatment to start with and when to progress to an additional or more intensive treatment (30-32). The principle of Stepped Care as outlined by Schippers (32) states that "a more intensive or different form of care or treatment is offered only when a less intensive form has been insufficient". For drug and alcohol treatment, this would involve monitoring the results of interventions and changing the intervention in some way if the outcome in relation to treatment goals was poor (8).

APA2006

The goals of case management interventions are to provide advocacy and coordination of care and social services and to improve patient adherence to prescribed treatment and follow-up care (76). Case management initially provides psychoeducation about the patient's diagnosis and treatment as well as assessment and stabilization of basic necessities required for the individual to actively participate in treatment (e.g., housing, utilities, income, health insurance, transportation). Beyond this, case managers aid individuals in maintaining stability and understanding and adhering to prescribed treatment. The variability in case management models has complicated research on the effectiveness of this approach (77, 78). Nevertheless, studies show that case management interventions are effective for individuals with an alcohol use disorder (79).

This is particularly important for patients lacking resources or the capacity for self-care because of a psychiatric or medical disorder. Case management services are aimed at such coordination of care (125).

Süstemaatilised ülevaated

Astmeline ravi

Berner et al (2008) viisid läbi kirjandusotsingu, uurimaks astmelist ravi, mille üks osa oleks psühhoteraapia. Kirjandusotsingu käigus saadi 2 artiklit (Breslin et al,1998; Sobell et al, 2000), mis käsitlesid astmelist ravi seoses alkoholismiga. Kumbki uuringutest ei leidnud, et astmelise ravi mudel oleks efektiivne alkoholi sõltuvusega patsientide ravis.

Samuti esitati artiklis PREDICT uuringu tulemusi. Uuringu esimeses faasis said patsiendid alkoholi himu vähendavaid ravimeid (acamrosate vs naltrexone vs platseebo) ning teises faasis need, kel toimus relaps ühe aasta jooksul, randomiseeriti edasi kahte gruppi-ühed, kes jätkavad sama raviga ning teised, kes lisaks medikamentoossele ravile said alkoholismi spetsiifilist psühhoteraapiat. 173 relapseerunud patsiendist jätkas teises faasis 97. Medikamentoosse ravi grupis oli ravi lõpetajate määr 50%, medikamentoosse+psühhoteraapia grupis 30%.

Kirjanduse ja PREDICT uuringu tulemused ei näidanud astmelise ravi efektiivsust alkoholi liigtarbivatel patsientidel (küll aga depressiooni ja obsessiiv-kompulsiivhäirega patsientidel).

Jaehne et al (2012) süstemaatiline ülevaade, mis hõlmab 5 artiklit astmelise ravi käsitlusest seoses alkoholi liigtarbimisega. 2 nendest on ravijuhendites juba käsitletud (Breslin et al, 1998; Drummond et al, 2009). Ülevaates käsitletud artikkel **Borsari et al.** (2007) viis uuringu läbi 43 tudengi seas, kes suunati lühinõustamisele. 4 nädala möödudes randomiseeritud nõustamisele mitte vastanud kahte gruppi-kontrollgrupp ja lühikene motiveeriv sekkumine. 10 nädala möödudes ei olnud astmelist ravi saanute ja kontrollgrupi vahel erinevusi joomasööstude arvus, drinkide arvus nädalas, vere alkoholitasemes (YAAPST skoor). **Bischof et al.** (2008) randomiseeris 408 alkoholi tarbimise riskikäitumisega patsienti 3 gruppi-tavaravi lühisekkumisega (arvuti teel sekkumine+neli 30-minutilist sekkumist telefoni teel, mis

maksimaalselt vastaks astmelise ravi mahule), astmeline ravi (arvuti teel sekkumine+kolm 40-minutilist sekkumist telefoni teel, esimese astme ravile reageerinutele edasist ravi ei rakendatud) ning kontrollgruppi (ei saanud mingit ravi). Astmelise ravi grupp sai nõustamist nii kaua, kuniks näitasid langust tarbimises ja kõrget motiveeritust muutuse säilitamiseks. Mõlemad sekkumisgrupid said tagasisidet arvuti teel.
Tulemused näitasid, et astmelise ravi sekkumised alkoholi riskitarbijatele on aega säästvad ja sama efektiivsed kui tavaravi, vähendamaks alkoholi tarbimist. Astmelise ravi nõustamine (mis tagas tulemuse) võttis umbes 50% vähem aega kui tavaravi grupis (rahaline kokkuhoid 20 eurot ühe nõustatud patsiendi kohta). Huvitava tulemusena nähti, et suur osa riskitarbijatest reageeris juba esimese astme (arvuti teel pakutud) nõustamisele. Võrreldes kontrollgrupiga vähendasid mõlemad sekkumisgrupid oma alkoholi tarbimist. Täpsemad tulemused on toodud alljärgnevas tabelis:

Table 2
Differences in main outcome between intervention and control group (CG)

Variable	CG	Intervention	*p*
Gram alcohol per day follow-up			
Overall (n = 139/269)	34.9 (48.9)	35.7 (48.1)	.883[a]
Alcohol dependence (n = 36/88)	62.1 (82.9)	61.7 (71.2)	.471[a]
Abuse or at-risk (n = 63/108)	33.0 (23.3)	28.7 (25.8)	.096[a]
Heavy episodic drinking only (n = 40/73)	13.5 (17.1)	14.7 (12.8)	.222[a]
Difference gram alcohol per day baseline to follow-up (M; S.D.)			
Overall (n = 139/269)	−6.3 (35.1)	−12.6 (37.7)	.048[a]
Alcohol dependence (n = 36/88)	−18.4 (57.5)	−16.9 (54.9)	.617[a]
Abuse and/or at-risk (n = 63/108)	−3.7 (24.3)	−17.9 (29.3)	.002[a]
Heavy episodic drinking only (n = 40/73)	0.34 (15.8)	0.46 (11.6)	.283[a]
Binge criteria at follow-up (%)			
Alcohol dependence (n = 36/88)	50.0	54.5	.694[b]
Abuse and/or at-risk (n = 63/108)	41.3	25.0	.039[b]
Heavy episodic drinking only (n = 40/73)	27.5	32.9	.672[b]
Help-seeking at follow-up (%)			
Alcohol dependence (n = 36/88)	11.1	19.3	.307[b]
Abuse and/or at-risk (n = 63/108)	1.6	3.7	.653[b]

[a] Mann–Whitney U-test.
[b] χ^2-test.

Reinhardt et al. (2008) uurisid soolisi erinevusi astmelises ravis. Kasutades samu andmeid, mis Bischof et al, leiti, et kombineerides mõlemad sekkumisgrupid, näitasid naised suuremat langust alkoholi tarbimise koguses uuringu algusest kuni 12-kuu möödumiseni (35.5%, R^2=0.029). Meeste puhul aga efeki ei nähtud (9.6%, R2=0.001). Ravi esimesele etapile astmelises ravis reageeris rohkem naisi (40%), kui mehi (24,4%), kuid see erinevus ei olnud statistiliselt oluline (p=.089). Hilisemates etapides efekti ei nähtud.

Juhtumikorraldus

Saitz et al (2013) uurisid randomiseeritud kontrollitud uuringus krooniliste haiguste manageerimise mudeli sobivust (CCM, chronic care management) alkoholi sõltuvuse ravi ja ravitulemuste parandamiseks. Patsiendid randomiseeriti saama CCM (282) või mitte saama ehk kontrollgruppi (281). CCM hõlmas esmatasandi arsti poolt koordineeritud pikaaegset ravi, motivatsiooni tõstvat teraapiat, relapsi ennetamise nõustamist, meditsiinilist-, sõltuvus- ja psühhiaatrilist ravi, sotsiaaltöötaja abi ning suunamisi. Sekkumisgrupp pidi tegema kaks 90-minutilist visiiti kliinikusse, 3-4 päevaste vahedega, mil neid hinnati psühhiaatriliselt, tarbimiskäitumise alaselt ja meditsiiniliselt. Nende külastuste eesmärgiks oli suurendada patsientide ravijärgivust. Vastavalt hinnatud seisundile, said sekkumisgrupi patsiendid vajalikku ravi. Lisaks said nad 4 sessiooni motiveerivat nõustamist sotsiaaltöötaja poolt. Esmatasandi kohtumine ning suunamine eriarstile ja abigruppidesse toimus arvestades patsiendi soove ja

vajadusi. Vajadusel määrati ka medikamentoosset ravi. Järelravi pakuti jälgimisaja jooksul (kliiniku külastamised, telefoni kontaktid, suunamised eriarstile, *drop-in care*, *24-hour pager access*). Kontrollgrupile määrati kohtumine esmatasandi tervishoiutöötajaga ning neile anti nimekiri võimalikest ravidest koos telefoninumbritega, et vajadusel korraldada nõustamist. Patsientidele maksti uuringus osalemise eest rahalist kompensatsiooni. Peamise tulemina mõõdeti 30-päevalist ise-raporteeritud kainust.
Peamise tulemuse (kainus) osas ei olnud sekkumisgrupi (44%) ja kontrollgrupi (42%) vahel erinevusi 12-kuu möödudes (kohandatud OR 0.84; 95% CI, 0.65-1.10; P=.21). Erinevused puudusid ka teistes tulemites (sõltuvuse tugevus, elukvaliteet jne). Ainsa erinevuse leiti SIP-2R mõõdikus (alkoholiga seotud probleemid), mille tulemused olid paremad sekkumisgrupis (keskmine skoor 10.4 vs 13.1 12-kuu möödumisel; IRR=0.85; 95%, CI=0.72-1.00; P=.048).
Alkoholisõltuvusega patsientidel krooniliste haiguste manageerimise mudel ei andnud paremaid tulemusi kainuse säilitamises 12-kuu jooksul, võrreldes esmataasandi raviga.
Theresa W. Kim et al (2012) uurisid samuti krooniliste haiguste manageerimise mudeli kasutamist alkoholi sõltuvuse ravis. Nende uuring keskendus eelkõige CCM kvaliteedi (külastuste arv ja enesehinnanguline kvaliteet-*Patient Assessment of Chronic Illness Care* (PACIC)) mõju hindamisele sõltuvusravi edukuses. Peamiste tulemustena saadi, et kliiniku külastamiste arv ei olnud seotud ravitulemustega, küll aga parandas sõltuvuse tugevust ja kainust enesehinnanguline ravi kavliteet (ükskõik millises raviasutuses).

Table 5
Multivariable associations of three measures of high quality CDM care and addiction outcomes.[a]

Variable	Abstinence		Lower alcohol addiction severity	
	Global *p*-value	AOR (95% CI)	Global *p*-value	AOR (95% CI)
Engagement with CDM clinic care[b]				
Yes	.2	0.94 (0.61, 1.43)	.8	1.08 (0.64, 1.82)
No		0.76 (0.56, 1.03)		0.94 (0.69, 1.27)
Control		1		1
PACIC-CDM clinic (tertiles)[c]				
Highest	.1	1.71 (1.00, 2.94)	.2	1.22 (0.69, 2.13)
Middle		1.19 (0.69, 2.03)		0.78 (0.46, 1.35)
Lowest		1		1
PACIC-any (tertiles)[e]				
Highest	.0005[f]	1.99 (1.34, 2.95)	.02[g]	1.24 (0.81, 1.88)
Middle		1.13 (0.76, 1.68)		0.73 (0.49, 1.10)
Lowest		1		1

Ravijuhendite viited

Kokkuvõtte (abstract või kokkuvõtlikum info)	**Viide kirjandusallikale**
NICE2011	
The aim of this study was to determine if community psychiatric none (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,	Patterson, D. G., Macpherson, J. & Brady, N. M. (1997) Community psychiatric nurse aftercare for alcoholics: a five-year follow-up study. Addiction, 92, 459–468.

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> O.OOJ). 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.	
OBJECTIVE: 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. The primary goals of the case management were to improve the financial and residential stability of the clients and to reduce their use of alcohol. **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%. **RESULTS**: Repeated measures MANCOVAs showed significant group differences favoring the case-managed group in all three areas targeted by the intervention: 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. **CONCLUSIONS**: The results indicate that case management had a beneficial effect on the clients receiving it. This effect may have been the result of an increase in services received by the case-managed clients.	Cox, G. B., Walker, D. R., Freng, S. A., et al. (1998) Outcome of a controlled trial of the effectiveness of intensive case management for chronic public inebriates. Journal of Studies on Alcohol, 59, 523–532.
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. (1988) The effect of type of aftercare of follow-up on treatment outcome among alcoholics. Journal of Studies on Alcohol, 49, 149–159.
N/A	Stout, R., Rubin, A., Zwick, W., et al. (1999) Optimizing the cost-effectiveness of alcohol -treatment: a rationale for case monitoring. Addictive Behaviours, 24, 17–35.
This study examined methods for increasing transition of substance dependent patients from inpatient detoxification to	Chutuape, M. A., Katz, E. C. & Stitzer, M. L. (2001) Methods

outpatient aftercare. One hundred and 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.	for enhancing transition of substance dependence patients from inpatient to outpatient treatment. Drug and Alcohol Dependence, 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. (2003) Aftercare attendance and post-treatment functioning of severely substance dependent residential treatment clients. Drug and Alcohol Review, 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. (2009) Impact of access to recovery services on alcohol/drug treatment outcomes. Journal of Substance Abuse Treatment, 37, 435–442.
Aims: Assertive approaches to treatment, which are becoming established for individuals with severe and enduring mental	Passetti, F., Jones, G., Chawla, K., et al. (2008) Pilot study of

illness, may also be beneficial for engaging alcohol-dependent individuals without severe psychiatric co-morbidity, but so far there has been little research on this. This pilot study looked at the feasibility and potential benefits of introducing assertive community methods into the treatment of alcohol-dependent individuals with a history of poor engagement. **Methods**: Non-randomized parallel cohort study comparing a Flexible Access Clinic employing assertive community treatment methods with the Usual Care Clinic. Participants were individuals re-referred to our service after they had previously disengaged from treatment. **Results**: Patients receiving assertive treatment attended assessment a mean of 14 days earlier than those receiving treatment as usual. Treatment at the Flexible Access Clinic was associated with significantly higher rates of completing assisted alcohol withdrawal (35% versus 26%) and entering an aftercare placement (23% versus 14%). Aftercare was entered significantly earlier in the Flexible Access Clinic group (93 days versus 125 days). **Conclusions**: These promising results point to the feasibility and potential efficacy of assertive community treatment methods for alcohol dependence, and the need for a randomized controlled trial of effectiveness and cost effectiveness.	assertive community treatment methods to engage alcohol-dependent individuals. Alcohol and Alcoholism, 43, 451–455.
The present study evaluated a stepped-care model for the treatment of problem drinkers; those not severely dependent on alcohol. The initial treatment consisted of a motivationally based, four-session outpatient treatment. Based on previous research, treatment nonresponders were defined as having consumed more than 12 drinks per week between the assessment and third session. Six-month follow-up interviews were conducted on three groups of problem drinkers: (1) those who responded to the initial intervention (n=67); (2) those who did not respond to the initial treatment (n=36); and (3) those who did not respond to the initial treatment and received a supplemental intervention (n=33). The last two groups were used to evaluate whether providing treatment nonresponders with an additional "step" would improve treatment outcomes. The primary dependent measures were posttreatment percent days abstinent and posttreatment drinks per drinking day. Results suggested that: (1) within treatment drinking can help identify treatment nonresponse in stepped-care models; (2) the supplemental intervention did not influence posttreatment drinking; (3) treatment responders and nonresponders sought additional help at the same rate. The present study is the first study on stepped care for alcohol treatment and provides a methodology for evaluating stepped interventions. Recommendations for future research in this area include more attention to assessing the needs of treatment nonresponders and help seeking behavior of both responders and nonresponders after an initial intervention.	Breslin, F. C., Sobell, M., Sobell, L., et al. (1999) Problem drinkers: evaluation of a stepped-care approach. Journal of Substance Abuse, 10, 217–232.
Background Brief interventions for problem drinking in medical settings are effective but rarely conducted, mainly due to insufficient time. A stepped care approach (starting with a very brief intervention and intensifying efforts in case of no success) could save resources and enlarge effectiveness; however, research is lacking. The present study compares a full care brief intervention for patients with at-risk drinking, alcohol abuse or dependence with a stepped care approach in a randomized controlled trial. **Methods** Participants were proactively recruited from general practices in two northern German cities. In total, 10,803 screenings were conducted (refusal rate: 5%). Alcohol use disorders according to DSM-IV were assessed with the Munich-Composite International Diagnostic Interview (M-CIDI). Eligible participants were	Bischof, G., Grothues, J., Reinhardt, S., et al. (2008). Evaluation of a telephone-based stepped care intervention for alcohol-related disorders: a randomised controlled trial. Drug and Alcohol Dependence, 93, 244–251.

randomly assigned to one of three conditions: (1) stepped care (SC): a computerized intervention plus up to three 40-min telephone-based interventions depending on the success of the previous intervention; (2) full-care (FC): a computerized intervention plus a fixed number of four 30-min telephone-based interventions that equals the maximum of the stepped care intervention; (3) an untreated control group (CG). Counseling effort in the intervention conditions and quantity/frequency of drinking were assessed at 12-month follow-up. **Results** SC participants received roughly half of the amount of intervention in minutes compared to FC participants. Both groups did not differ in drinking outcomes. Compared to CG, intervention showed small to medium effect size for at-risk drinkers. Conclusions Study results reveal that a stepped care approach can be expected to increase cost-effectiveness of brief interventions for individuals with at-risk drinking.	
N/A	Drummond, C. (2009) Treatment services for alcohol use disorders. In The New Oxford Textbook of Psychiatry (eds M. Gelder, N. Andreasen, J. Lopez-Ibor, et al.), 2nd edn. Oxford: Oxford University Press.
NSW2008	
N/A	NSW Health, Stepped Care in drug and alcohol treatment: Discussion Paper, N.H.D.a.A.A.H.W.A. Committee, editor. 2005: Sydney.
A stepped care approach to treatment decisions for alcohol problems consists of the application of decision rules derived from practice in other areas of health care. The treatment used should be (a) individualized, (b) consistent with the research literature and supported by clinical judgment, and (c) least restrictive but still likely to be successful. Used in this way, stepped care emphasizes serving the needs of clients efficiently but without sacrificing quality of care. Issues concerning stepped care are discussed, and the application of a stepped care approach to alcohol treatment services is described.	Sobell, M.B., et al. 'Stepped Care as a Heuristic Approach to the Treatment of Alcohol Problems'. Journal of Consulting and Clinical Psychology 2000; 68(4): p573-579.
Aims. Cost containment, a central issue in current health planning, encourages the use of brief interventions. Although brief interventions for problem drinkers have proved successful, a portion of such individuals do not change their alcohol use during treatment. **Design**. Repeated measures design (pre-treatment, within-treatment and 6 months post-treatment). **Setting and participants**. To identify individuals at risk for continued problem drinking, predictors of post-treatment drinking were examined for 212 problem drinkers who presented for treatment in an outpatient treatment clinic. **Intervention**. All participants completed a brief cognitive behavioral motivational intervention. **Measurements**. At the pre-treatment assessment demographic, drinking pattern, severity of dependence and other cognitive variables (e.g. self-efficacy, goal choice) were collected. Within-treatment, drinking pattern and cognitive variables such as self-efficacy and goal choice were again measured. **Findings**. Regression analyses showed that therapist prognosis ratings contributed significantly to the prediction of outcome even when pre-treatment variables were controlled. However, when within-treatment variables were included in the prediction, variables	Breslin, F.C. 'Toward a Stepped Care Approach to Treating Problem Drinkers: the Predictive Utility of Within-Treatment Variables and Therapist Prognostic ratings'. Addiction 1997; 92(11): p1479-1489.

such as within treatment drinking eliminated the predictive utility of therapist prognosis ratings. This pattern held for both percentage of days abstinent and drinks per drinking day at a 6-month follow-up. **Conclusions**. It is suggested that a stepped care approach based on prediction models that include clients' within-treatment response can be applied to the treatment of problem drinkers who show little initial response to treatment.	
The Dutch substance abuse treatment system is in the middle of a major reorganization. The goal is to improve outcomes by redesigning all major primary treatment processes and by implementing a system of regular monitoring and feedback of clinical outcome data. The new program includes implementing standardized psychosocial behavior-oriented treatment modalities and a stepped-care patient placement algorithm in a core–shell organizational model. This article outlines the new program and presents its objectives, developmental stages, and current status.	Schippers, G.M., et al. 'Reforming Dutch Substance Abuse Treatment Services' Addictive Behaviours 2002; 27(6): p995-1007.
Objective: A quantitative analysis of 15 empirical studies is conducted to determine effective interventions with the dually diagnosed. **Method**: Client and practitioner characteristics, types of interventions, and treatment effectiveness are examined through meta-analytic techniques. **Results**: (a) Age of client was positively correlated with effect size, (b) there were no statistically significant correlations between practitioner training or practitioner-to-client ratio and effect size, (c) intensive case management was associated with the greatest effect size, and (d) a small positive effect size was found for standard aftercare with outpatient psychoeducational treatment groups. **Conclusions**: Social work practice implications, based on the results of the quantitative analysis and trends identified in the studies, are that there is a unique role for practitioners in advocating for linkage of resources, additional supports for clients, and the dismantling of barriers that impede resource access.	Dumaine, M.L., 'Meta-Analysis of Interventions with Co-occurring Disorders of Severe Mental Illness and Substance Abuse: Implications for Social Work Practice'. Research on Social Work Practice 2003; 13: p142-165.
This article describes the development of an innovative approach to case management for rural clients in drug abuse treatment. This innovative approach is discussed in the context of the broader field of case management—including social casework, public health, nursing, modern case management, and managed care. Because case management has been defined in many different ways, making comparisons of programs and models is difficult. The article presents an expanded set of criteria for comparing case management models. The Iowa Case Management model is compared with these other models across several dimensions. This article also describes the philosophy and goals of the Iowa model, as well as key activities in which clients and case managers participate. The authors discuss implications for practice and issues related to evaluation of case management.	Hall, J.A., et al. 'Iowa Case Management: Innovative Social Casework'. Social Work 2002; 47(2): p132-141.
Objective: The purpose of this study, which is part of a larger clinical trial, was to examine the cost-effectiveness of case management for individuals treated for substance abuse in a residential setting. **Method**: Clients who agreed to participate were randomly assigned to one of four study groups. Two groups received face-to-face case management and one telecommunication case management, and the fourth was the control group. **Results**: Using a ratio of cost to days free from substance abuse, the case management groups were less cost-effective than the control group at 3 months, 6 months, and 12 months. The telecommunication case management was least cost-effective of the three case management conditions. **Conclusion**: Results from the analysis revealed case management is not cost-effective as a supplement to traditional	Saleh, S.S., et al. 'Cost-Effectiveness of Case Management in Substance Abuse Treatment'. Research on Social Work Practice 2006; 16: p38-47.

drug treatment over a 12-month follow-up period.	
N/A	Lee, N., et al., 'Psychosocial Interventions for Clients on Methadone and Buprenorphine Maintenance', in PSI Project Report. 2002.
N/A	NSW Health, Position Paper on Case Management in the Nsw Health Drug and Alcohol Program. 2005, NSW Health (DAC05-03 4.3 (Tab 14): Case Management Sub-Committee, NSW Health Drug and Alcohol Council.
Establishing the efficacy of case management in substance abuse treatment has been confounded by the lack of attention given to assessing the fidelity of case management implementation. The current study measured the fidelity of case management implementation and used fidelity information to examine the impact of therapeutic case management on attrition in an adolescent, outpatient, group, substance abuse treatment program. Ninety adolescent women enrolled in substance abuse treatment were randomly assigned to receive or to not receive case management. Treatment fidelity was measured using the Case Management Quality Inventory. Cox regression analyses revealed that higher fidelity of case management implementation predicted a decreased risk of dropping out of the substance abuse treatment program (RR = −11.21, $p < 0.02$). Higher proportions of total case management time spent on case management core functions predicted a decreased risk of dropping out of treatment (RR = 4.32, $p < 0.03$). This study confirms that programs need to first demonstrate that the case management model has been implemented faithfully before its efficacy in reducing attrition in the substance abuse treatment program can be fairly evaluated. It also suggests that core case management functions may have a greater influence on attrition in substance abuse treatment than does intensity.	Noel, P.E. 'The Impact of Therapeutic Case Management on Participation in Adolescent Substance Abuse Treatment'. The American Journal of Drug and Alcohol Abuse 2006; 32: p311-327.
N/A	Hesse, M., et al. 'Case Management for Substance Use Disorders (Protocol)'. Cochrane Database of Systematic Reviews 2006; 4 (Article No. CD006265): p1-7.
APA2006	
N/A	Center for Substance Abuse Treatment: Comprehensive Case Management for Substance Abuse Treatment Improvement Protocol (TIP) Series No. 27. DHHS Publication (SMA) 98-3222. Rockville, MD, US Department of Health and Human Services, 1998.
Case management has been used to link clients and the service system, but is loosely defined and poorly understood. The aims of this study were to describe the use and purposes of case management within substance abuse treatment programs, and also the structures and processes for providing case management services. A descriptive survey was done, with 50	McNeese-Smith DK: Case management within substance abuse treatment programs in Los Angeles County. Care Manag J 1999; 1:10–18.

program directors of 134 treatment programs (with 205 case managers), in Los Angeles County. Results showed that 80% of directors reported they use case management. Half of the programs use case management both before and after discharge, and 72% provide case management to all clients. Case managers' most important roles are to develop treatment plans and prevent relapse during treatment, and 60% of directors indicate the case managers in their programs are also counselors. Case managers perform numerous roles of coordination and advocacy. Eighty percent of case managers follow the care of the client during treatment and 32% of directors reported a case load of 1-10, while 26% reported a case load of 11-20. The professional background of case managers varies from chemical dependence professional to social worker or nurse. Twenty percent of program directors plan to increase case management in the future.	
The need for case management in addictions treatment systems has been recognized for at least 10 years. As more attention is paid to developing this treatment component and as more data are available concerning the implementation of case management in addictions, it is becoming apparent that there is a lack of consensus concerning who should provide case management and how it should be defined. This paper reviews sources of variability of case management services identified in the mental health field and discusses the implications for the development of case management in addictions programs.	Graham K, Timney CB: Case management in addictions treatment. J Subst Abuse Treat 1990; 7:181–188.
Aim A 3-year update with 59 new controlled trials is provided for the ongoing Mesa Grande project reviewing clinical trials of treatments for alcohol use disorders. The project summarizes the current evidence for various treatment approaches, weighting findings differentially according to the methodological strength of each study. **Design** The review includes 361 controlled studies that (1) evaluated at least one treatment for alcohol use disorders, (2) compared it with an alternative condition (such as a control group, a placebo, a brief intervention or an alternative treatment), (3) used a procedure designed to create equivalent groups before treatment and (4) reported at least one outcome measure of drinking or alcohol-related consequences. Studies were rated by two reviewers on 12 methodological criteria, and outcome logic was analyzed for the specific treatment modalities tested. **Findings** Methodological quality of studies was significantly but modestly correlated with the reporting of a specific effect of treatment. Among psychosocial treatments, strongest evidence of efficacy was found for brief interventions, social skills training, the community reinforcement approach, behavior contracting, behavioral marital therapy and case management. For the first time, two pharmacotherapies also appeared among the most strongly supported approaches: opiate antagonists (naltrexone, nalmefene) and acamprosate. Least supported were methods designed to educate, confront, shock or foster insight regarding the nature and causes of alcoholism. **Conclusions** Treatment methods differ substantially in apparent efficacy. It would be sensible to consider these differences in designing and funding treatment programs.	Miller WR, Wilbourne PL: Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders. Addiction 2002; 97:265–277.

Süstemaatiliste ülevaadete viited

Kokkuvõtte (abstract või kokkuvõtlikum info)	**Viide kirjandusallikale**
Aims: To provide an overview over empirical evidence regarding	Berner M, Günzler C, Frick K,

stepped care approaches that include psychotherapies. To present own preliminary study results in alcohol dependent patients. **Methods**: Publications were searched in the databases Medline, PsycINFO and the internet search engine Google Scholar. Inclusion criteria were psychosocial treatment and psychiatric disorders. Our own study consists of two steps. In step 1 patients receive anti-craving medication or placebo and Medical Management (MM). After a relapse to heavy drinking patients can step up and after randomization they either continue with the same treatment or they receive additional alcoholism specifi c psychotherapy (ASP). **Results**: Evidence suggests that stepped care might be effi cacious in patients with obsessive-compulsive behavior and depression. There is no evidence for effi cacy in problem drinkers. Results of our own study show that the completer rate in MM alone is higher than in ASP with MM, but there are no signifi cant differences concerning age, sex and disease severity between completer and non-completer in both study arms. **Conclusions**: Further research with regard to stepped care in alcohol dependent patients is needed. An introduction of the psychotherapy at earlier stages might be sensible.	Kriston L, Loessl B, Brück R, Gann H, Batra A, Mann K: Finding the ideal place for a psychotherapeutic intervention in a stepped care approach – a brief overview of the literature and preliminary results from the Project PREDICT Int. J. Methods Psychiatr. Res. 17(S1): S60–S64 (2008)
Of particular interest in the psychosocial treatment of addictions is determining how much therapy is required to bring about behaviour change. Stepped care approaches, where non responders to a less intensive therapy receive a more intensive intervention, aim to only provide intensive assistance to those who need it, thereby allocating therapeutic resources more efficiently. This paper provides a systematic review of stepped care models involving different levels of psychosocial intervention for the treatment of alcohol use disorders and smoking cessation. Five publications on alcohol and three on smoking were included in the review. Due to the heterogeneity of outcome measures, participant characteristics and interventions, a narrative review format was employed. Overall, little evidence was found to suggest that stepping up non-responders to more intensive therapy improved outcomes, a finding that could partially be attributed to a lack of power to find significant effects. In one study, the application of a stepped care approach was found to reduce treatment costs compared with usual care. There was some evidence that the greater differentiation between the intensity of the interventions offered at each step, the better the outcome. Further research is needed to evaluate the efficacy of stepped care approaches to providing psychosocial treatment, employing larger samples and/or consistent definitions of the nature of the interventions offered at each step, and assessing treatment response in a timely manner.	Andreas Jaehne, Barbara Loessl, Katrin Frick, Michael Berner, Gary Hulse, James Balmford. The Efficacy of Stepped Care Models Involving Psychosocial Treatment of Alcohol Use Disorders and Nicotine Dependence: A Systematic Review of the Literature. Current Drug Abuse Reviews, 2012, 5, 41-51
In the past decade, colleges and universities have seen a large increase in the number of students referred for the violation of alcohol policies. Stepped care assigns individuals to different levels of care according to treatment response, thereby maximizing efficiency. This pilot study implemented stepped care with students mandated to attend an alcohol program at a private northeastern university. High retention rates and participant satisfaction ratings suggest the promise of implementing stepped care with this population. Considerations for future applications of stepped care with mandated students are discussed.	Borsari B, O'Leary Tevyaw T, Barnett NP, Kahler CW, Monti PM. Stepped care for mandated college students. A pilot study. Am J Addict 2007; 16: 131-7.
Background: Brief interventions for problem drinking in medical settings are effective but rarely conducted, mainly due to insufficient time. A stepped care approach (starting with a very brief intervention and intensifying efforts in case of no success) could save resources and enlarge effectiveness; however,	Bischof G, Grothues JM, Reinhardt S, Meyer C, John U, Rumpf HJ. Evaluation of a telephone-based stepped care intervention for alcohol-related

research is lacking. The present study compares a full care brief intervention for patients with at-risk drinking, alcohol abuse or dependence with a stepped care approach in a randomized controlled trial. **Methods**: Participants were proactively recruited from general practices in two northern German cities. In total, 10,803 screenings were conducted (refusal rate: 5%). Alcohol use disorders according to DSM-IV were assessed with the Munich-Composite International Diagnostic Interview (M-CIDI). Eligible participants were randomly assigned to one of three conditions: (1) stepped care (SC): a computerized intervention plus up to three 40-min telephone-based interventions depending on the success of the previous intervention; (2) full-care (FC): a computerized intervention plus a fixed number of four 30-min telephone-based interventions that equals the maximum of the stepped care intervention; (3) an untreated control group (CG). Counseling effort in the intervention conditions and quantity/frequency of drinking were assessed at 12-month follow-up. **Results**: SC participants received roughly half of the amount of intervention in minutes compared to FC participants. Both groups did not differ in drinking outcomes. Compared to CG, intervention showed small to medium effect size for at-risk drinkers. Conclusions: Study results reveal that a stepped care approach can be expected to increase cost-effectiveness of brief interventions for individuals with at-risk drinking.	disorders, a randomized controlled trial. Drug Alcohol Depend 2008; 93(3): 244-51.
Aim: To analyse gender differences in the efficacy of stepped care brief interventions for general practice patients with alcohol problems. **Methods**: Data are part of "Stepped Interventions for Problem Drinkers," in which 10,803 patients from 85 general practitioners were screened using alcohol related questionnaires; 408 patients were randomized (32% were female) to a control (booklet only) or two different intervention groups: stepped care (feedback, manual, and up to three counselling sessions depending on the success of the previous intervention) and fixed care (four sessions). Response rate for the 12 months follow-up was 91.7%. **Results**: Regression analysis revealed a significant effect size only in women (P = 0.039). After excluding alcohol dependents and binge drinkers, an effect size (R2) of 0.031 (P = 0.050) in women and an effect size (R2) of 0.069 (P = 0.057) in men was obtained. Among the patients in stepped care who, by the first assessment point, had reduced drinking to within safe-drinking limits, there was a tendency for females to have achieved this more often than males (40% vs. 24%; P = 0.089). **Conclusions**: In a heterogeneous sample, the intervention was only effective for women. Women tended to profit more from the first, less intensive intervention than men. When analysis was limited to those reporting "at risk" average daily consumption and "alcohol abuse," the gender differences in efficacy appeared to be less, but the study was not sufficiently powered to affirm that.	Reinhardt S, Bischof G, Grothues J, John U, Meyer C, Rumpf HJ. Gender differences in the efficacy of brief interventions with a stepped care approach in general pratice patients with alcoholrelated disorders. Alcohol Alcohol 2008; 43(3): 334-40.
IMPORTANCE People with substance dependence have health consequences, high health care utilization, and frequent comorbidity but often receive poor-quality care. Chronic care management (CCM) has been proposed as an approach to improve care and outcomes. **OBJECTIVE** To determine whether CCM for alcohol and other drug dependence improves substance use outcomes compared with usual primary care. **DESIGN, SETTING, AND PARTICIPANTS** The AHEAD study, a randomized trial conducted among 563 people with alcohol and other drug dependence at a Boston, Massachusetts, hospital-based primary care practice. Participants were recruited from September 2006 to September 2008 from a freestanding residential detoxification unit and referrals from an urban	Richard Saitz, Debbie M. Cheng, Michael Winter, Theresa W. Kim, Seville M. Meli, Don Allensworth-Davies, Christine A. Lloyd-Travaglini, Jeffrey H. Samet, Chronic Care. Management for Dependence on Alcohol and Other Drugs The AHEAD Randomized Trial. JAMA. 2013;310(11):1156-1167. doi:10.1001/jama.2013.277609

teaching hospital and advertisements; 95%completed 12-month follow-up. **INTERVENTIONS** Participants were randomized to receive CCM (n=282) or no CCM (n=281). Chronic care management included longitudinal care coordinated with a primary care clinician; motivational enhancement therapy; relapse prevention counseling; and on-site medical, addiction, and psychiatric treatment, social work assistance, and referrals (including mutual help). The no CCM (control) group received a primary care appointment and a list of treatment resources including a telephone number to arrange counseling. **MAIN OUTCOMES AND MEASURES** The primary outcomewas self-reported abstinence from opioids, stimulants, or heavy drinking. Biomarkers were secondary outcomes. **RESULTS** There was no significant difference in abstinence from opioids, stimulants, or heavy drinking between the CCM (44%) and control (42%) groups (adjusted odds ratio, 0.84; 95% CI, 0.65-1.10; P=.21). No significant differences were found for secondary outcomes of addiction severity, health-related quality of life, or drug problems. No subgroup effects were found except among those with alcohol dependence, in whom CCM was associated with fewer alcohol problems (mean score, 10 vs 13; incidence rate ratio, 0.85; 95%CI, 0.72-1.00; P=.048). **CONCLUSIONS AND RELEVANCE** Among persons with alcohol and other drug dependence, CCM compared with a primary care appointment but no CCM did not increase self-reported abstinence over 12 months. Whether more intensive or longer-duration CCM is effective requires further investigation.	
We examined the effect of the quality of primary care-based chronic disease management (CDM) for alcohol and/or other drug (AOD) dependence on addiction outcomes. We assessed quality using (1) a visit frequency based measure and (2) a self-reported assessment measuring alignment with the chronic care model. The visit frequency based measure had no significant association with addiction outcomes. The self-reported measure of care—when care was at a CDM clinic—was associated with lower drug addiction severity. The selfreported assessment of care from any healthcare source (CDM clinic or elsewhere) was associated with lower alcohol addiction severity and abstinence. These findings suggest that high quality CDM for AOD dependence may improve addiction outcomes. Quality measures based upon alignment with the chronic care model may better capture features of effective CDM care than a visit frequency measure.	Theresa W. Kim, Richard Saitz, Debbie M. Cheng, Michael R. Winter, Julie Witas, Jeffrey H. Samet. Effect of quality chronic disease management for alcohol and drug dependence on addiction outcomes. Journal of Substance Abuse Treatment 43 (2012) 389–396.

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