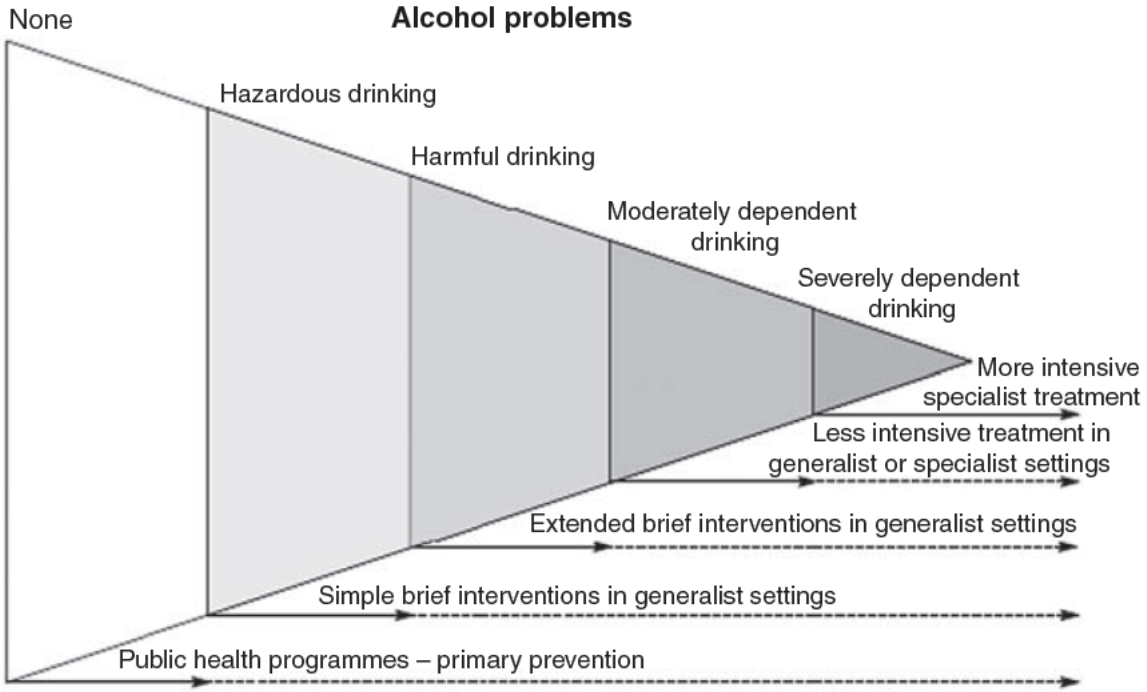
Interventi non farmacologici del Disturbo da Uso di Alcol

Valeria Zavan

ALCOHOL-USE DISORDERS

THE NICE GUIDELINE ON DIAGNOSIS, ASSESSMENT AND MANAGEMENT OF HARMFUL DRINKING AND ALCOHOL DEPENDENCE

Figure 3: A spectrum of responses to alcohol problems. Reproduced from a review of the effectiveness of treatment for alcohol problems (Raistrick *et al.*, 2006)



Text Box 2: Levels of care for addiction treatment (Mee-Lee *et al.*, *2001)*

Level I – Outpatient treatment
Level II – Intensive outpatient treatment/partial hospitalisation
Level III – Residential (medically-monitored) treatment
Level IV – Medically-managed intensive inpatient treatment

Primo capitolo – come indicare l'intervento

Ad ogni inquadramento diagnostico corrisponde un trattamento differente per qualità, intensità, durata, prognosi

In generale la valutazione viene fatta in funzione di consumo + (e/o) comportamenti

Esistono strumenti specifici:

- Chimico-tossicologici (consumo)
- **Sistemi diagnostici** (comportamenti)
- **Questionari standardizzati specifici per identificazione / identificazione precoce** (consumo + comportamenti) es. CIWA-AR per astinenza, AUDIT per consumo/comportamenti

OMS ICD-10

- **DEPENDENCE**
  AUDIT > 20
- **HARMFUL USE**
  (CONSUMO DANNOSO)
  AUDIT > 16
- **HAZARDOUS USE**
  (CONSUMO RISCHIOSO)
  AUDIT > 8

Rischio basso Consumo inferiore a 2 UA per maschi e 1 UA per femmine die

APA DSM-5

- **ADDICTION**
  (Alcohol Use Disorder)

Consumo e/o comportamento

Pattern di uso

- Continuativo
- A binge
- Atri pattern

AUDIT TEST

Leggere le domande come sono scritte. Iniziare il test Audit dicendo “Adesso le porrò alcune domande sull’uso di bevande alcoliche durante l’ultimo anno”. Spiegare cosa s’intende per “bevande alcoliche “ usando esempi pratici: 1 bicchiere di vino, 1 birra piccola o 1 superalcolico.

1) Con quale frequenza consumi bevande contenenti alcol?	a) Mai	0
	b) Meno di una volta al mese	1
	c) 1 volta al mese	2
	d) 1 volta a settimana	3
	e) Ogni giorno o quasi	4
2) Quante bevande alcoliche consumi in media in un giorno?	a) 1 o 2	0
	b) 3 o 4	1
	c) 5 o 6	2
	d) 7 o 9	3
	e) 10 o più	4
3) Con quale frequenza ti capita di bere sei o più bevande in una occasione?	a) Mai	0
	b) Meno di una volta al mese	1
	c) 1 volta al mese	2
	d) 1 volta a settimana	3
	e) Ogni giorno o quasi	4
4) Con quale frequenza, durante l’ultimo anno, ti sei accorto di non essere più in grado di bere una volta che avevi iniziato?	a) Mai	0
	b) Meno di una volta al mese	1
	c) 1 volta al mese	2
	d) 1 volta a settimana	3
	e) Ogni giorno o quasi	4
5) Con quale frequenza, durante l’ultimo anno, non sei riuscito a fare ciò che ci si aspettava da te a causa del bere?	a) Mai	0
	b) Meno di una volta al mese	1
	1 volta al mese	2
	olta a settimana	3
	iorno o quasi	4
6) Con quale frequenza, durante l’ultimo anno, hai avuto bisogno di bere di prima mattina per riprenderti dopo una bevuta pesante?	a) Mai	0
	b) Meno di una volta al mese	1
	c) 1 volta al mese	2
	d) 1 volta a settimana	3
	e) Ogni giorno o quasi	4
7) Con quale frequenza, durante l’ultimo anno, hai avuto sensi di colpa o rimorsi dopo aver bevuto?	a) Mai	0
	b) Meno di una volta al mese	1
	c) 1 volta al mese	2
	d) 1 volta a settimana	3
	e) Ogni giorno o quasi	4
8) Con quale frequenza, durante l’ultimo anno, non sei riuscito a ricordare quello che era successo la sera precedente perché avevi bevuto?	a) Mai	0
	b) Meno di una volta al mese	1
	c) 1 volta al mese	2
	d) 1 volta a settimana	3
	e) Ogni giorno o quasi	4
9) Ti sei fatto male o hai fatto male a qualcuno come risultato del bere?	a) No	0
	b) Sì, ma non nell’ultimo anno	2
	c) Sì, nell’ultimo anno	4
10) Un parente, un amico, un medico o altro operatore sanitario si è preoccupato del tuo bere o ti ha suggerito di smettere?	a) No	0
	b) Sì, ma non nell’ultimo anno	2
	c) Sì, nell’ultimo anno	4

Punteggio:

AUDIT-C donne >= 4 consumo rischioso/dannoso

AUDIT-C uomini >= 5 consumo rischioso/dannoso

< 8	**risultato negativo, nessun problema da segnalare**
8 – 15	**Consumo a rischio. Iniziali problemi alcol-correlati (infortuni o forti bevute occasionali) E’ importante parlarne con il proprio medico**
16-19	**Consumo dannoso/alcoldipendenza E’ importante rivolgersi al proprio medico**
>= 20	**Alcoldipendenza**

- L’ISS comunque raccomanda l’uso di AUDIT e da indicazioni sull’intervento in base ai punteggi di cut off (8 e 13):

- l’intervento informativo sotto gli 8
- l’intervento breve inteso a ridurre i consumi sotto i 13
- l’intervento breve inteso all’invio specialistico sopra i 13 punti

  - **l’intervento breve è la forma più semplice di intervento psico-sociale alcologico**
  - **è una forma di counselling specifica**
  - **è un intervento strutturato/semi strutturato descritto in manuali appositi**

Secondo capitolo - Gli interventi psicosociali nell'identificazione precoce

Basati fondamentalmente su varie tipologie di intervento breve finalizzato a dare informazioni e consigli e/o a favorire l'invio ai servizi specialistici in funzione della gravità della valutazione iniziale

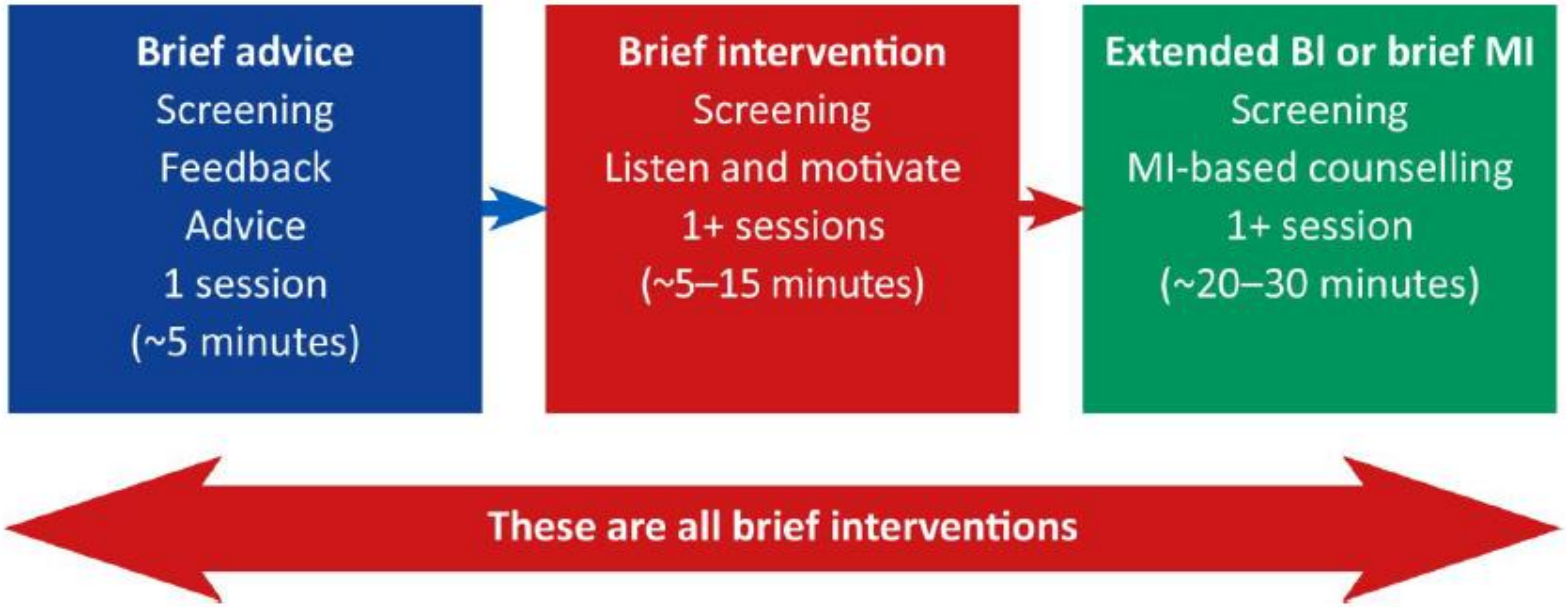
- **Sono interventi semi strutturati e/o manualizzati**
- **Di tipo sistematico od opportunistico in funzione del setting**
- **Fondati sostanzialmente sul feedback dopo somministrazione di AUDIT e/o CAGE**

Pensati per la popolazione generale possono essere attuati in un servizio specialistico in molti casi:

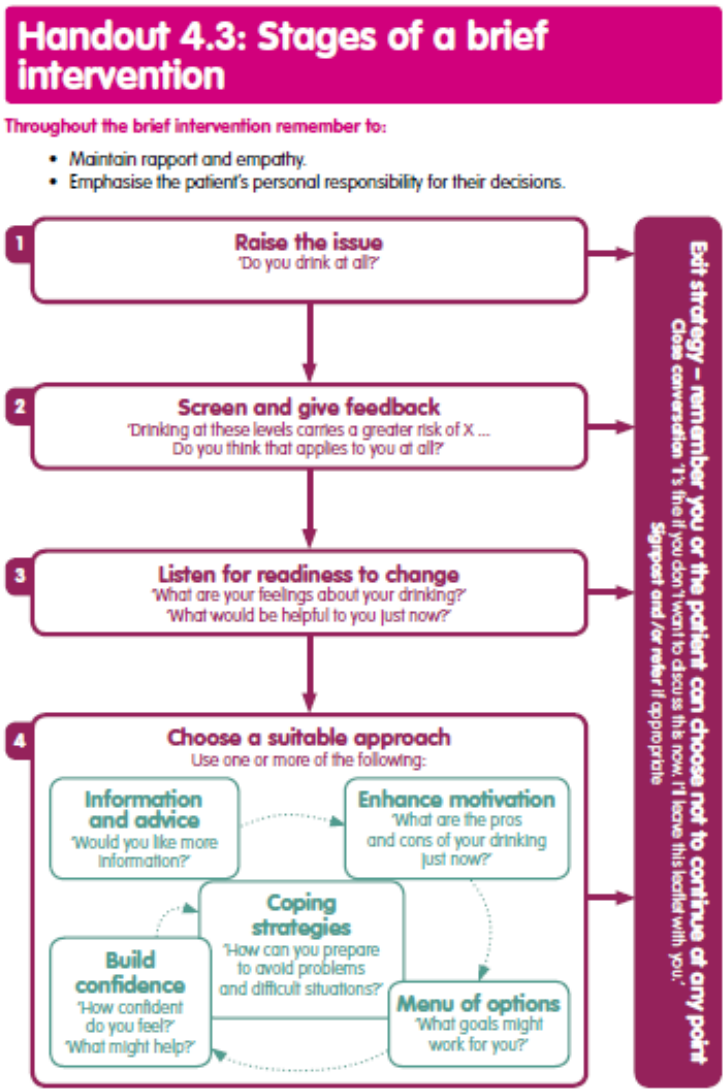
- **percorsi brevi mandatori** (es. visite per accertamenti CML / lavoratori, consulenze ospedaliere, consulenze altri servizi come consultori, prefetture…)
- Pz con altre diagnosi prevalenti ed **utilizzo di alcol eccedentario** senza criteri per DUA

L'intervento breve per l'alcol è una forma di counseling orientato

Fig. 2. A continuum of brief interventions



WHO alcohol brief intervention training manual for primary care , 2017



Solleva il problema

Scrina e dai un feedback

Parla del cambiamento

Scegli un approccio gradito

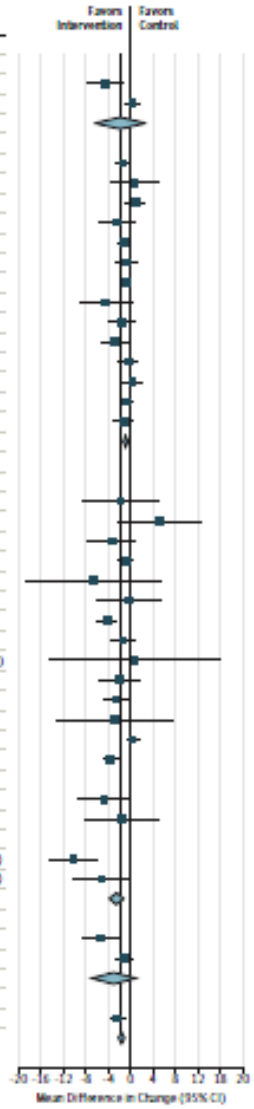
L'intervento breve implica, al di là delle modalità d'approccio:

1. **l'identificazione dell'uso rischioso di alcol**
2. **l'informazione del soggetto sugli svantaggi di tale uso**
3. **la motivazione del soggetto a cambiare l'abitudine alcolica**
4. **l'identificazione degli obiettivi personali**
5. **il dare istruzione su come raggiungerli**
6. **il monitorare nel tempo**

La sessione di un intervento breve può andare da pochi minuti ad un'ora ed essere singola o ripetuta nel tempo, secondo le singole necessità

Figure 4. Drinks per Week (Key Question 4a), Mean Difference in Change Between Alcohol Counseling Interventions and Control Groups, by Population

Source	Time Point, mo	Intervention: No. of Participants	Intervention: Mean Change From Baseline (SD)	Control: No. of Participants	Control: Mean Change From Baseline (SD)	Mean Difference in Change (95% CI)
Adolescents						
Haug et al,[92] 2017						
High-risk drinking	6	80	-7.9 (10.5)	74	-3.5 (8.8)	-4.41 (-7.46 to -1.36)
Medium-risk drinking	6	181	-0.9 (6.6)	142	-1.3 (5.0)	0.32 (-0.95 to 1.59)
Subtotal: I^2 = 87.2%; P = .005						-1.83 (-6.45 to 2.78)
Young adults						
Berthiaet et al,[71] 2015	6	338	-1.7 (7.8)	329	-0.4 (7.6)	-1.30 (-2.47 to -0.13)
Carey et al,[75] 2006	12	65	-3.6 (12.1)	59	-4.4 (11.6)	0.80 (-3.36 to 4.96)
Collins et al,[79] 2014	12	183	-1.8 (8.3)	173	-2.7 (7.8)	0.89 (-0.79 to 2.56)
Daeppen et al,[83] 2011	6	110	-1.5 (13.2)	125	0.8 (10.8)	-2.30 (-5.41 to 0.81)
Fleming et al,[87] 2010	12	493	-4.8 (9.5)	493	-3.6 (9.2)	-1.20 (-2.37 to -0.03)
LaBrie et al,[102] 2013	12	144	-2.2 (8.4)	143	-1.4 (9.0)	-0.80 (-2.82 to 1.22)
Larimer et al,[103] 2007	12	737	0.2 (7.2)	751	1 (6.3)	-0.83 (-1.52 to -0.14)
Leeman et al,[104] 2016	6	48	-1.7 (9.3)	42	2.7 (12.8)	-4.39 (-9.06 to 0.28)
Lewis et al,[105] 2014	6	119	-5.2 (10.1)	121	-3.7 (9.2)	-1.55 (-3.99 to 0.89)
Neighbors et al,[111] 2004	6	126	-3.6 (9.0)	126	-0.8 (9.5)	-2.80 (-5.08 to -0.52)
Neighbors et al,[113] 2016	6	177	-2.5 (8.7)	180	-2.1 (6.9)	-0.37 (-2.00 to 1.26)
Schaus et al,[125] 2009	12	181	-1.9 (7.4)	182	-2.3 (8.4)	0.40 (-1.23 to 2.03)
Turrisi et al,[129] 2009	10	278	3.6 (5.8)	305	4.4 (6.0)	-0.82 (-1.78 to 0.14)
Voogt et al,[133] 2014	6	456	0.7 (13.0)	451	1.9 (13.8)	-1.20 (-2.94 to 0.54)
Subtotal: I^2 = 10.9%; P = .33						-0.86 (-1.29 to -0.43)
Adults						
Aalto et al,[70] 2009						
Men	36	97	0.4 (19.1)	84	2.1 (25.4)	-1.71 (-8.34 to 4.91)
Women	36	37	4.8 (20.9)	39	-0.4 (10.6)	5.14 (-2.37 to 12.65)
Bischof et al,[72] 2008	12	131	-6.5 (18.6)	139	-3.2 (17.5)	-3.35 (-7.67 to 0.97)
Cunningham et al,[81] 2012	6	589	-0.5 (11.5)	589	0.3 (11.1)	-0.80 (-2.09 to 0.49)
Drummond et al,[84] 2009	6	39	-15.5 (30.4)	52	-9 (26.3)	-6.53 (-18.45 to 5.40)
Emmen et al,[85] 2005	6	61	5.7 (14.0)	62	5.9 (18.3)	-0.21 (-5.96 to 5.54)
Fleming et al,[88] 1997	12	392	-7.7 (11.8)	382	-3.5 (12.4)	-4.18 (-5.89 to -2.47)
Hansen et al,[91] 2012	12	476	NR	454	-5.5 (15.8)	-1.40 (-3.40 to 0.60)
Heather et al,[93] 1987	6	29	-8.4 (21.7)	32	-9.1 (37.7)	0.75 (-14.52 to 16.02)
Matzko et al,[106] 2001	12	73	-5.5 (11.3)	85	-3.6 (11.8)	-1.94 (-5.54 to 1.66)
Ockene et al,[114] 1999	12	235	-5.7 (11.3)	210	-3.2 (11.4)	-2.60 (-4.72 to -0.48)
Richmond et al,[120] 1995	12	66	-6.3 (26.2)	61	-3.5 (25.0)	-2.80 (-12.93 to 7.33)
Rose et al,[121] 2017	6	678	-0.5 (9.9)	685	-0.9 (10.0)	0.40 (-0.66 to 1.46)
Rubio et al,[123] 2010	12	371	-8.2 (9.3)	381	-4.7 (9.5)	-3.56 (-4.90 to -2.22)
Scott and Anderson,[127] 1991						
Men	12	80	-11.2 (13.9)	74	-6.6 (16)	-4.64 (-9.19 to 0.10)
Women	12	33	-11.6 (13.0)	39	-10 (15.2)	-1.60 (-8.14 to 4.94)
Wallace et al,[134] 1988						
Men	12	318	-18.2 (26.7)	322	-8.1 (28.7)	-10.10 (-14.40 to -5.80)
Women	12	130	-11.5 (18.2)	137	-6.3 (23.4)	-5.20 (-10.22 to -0.18)
Subtotal: I^2 = 69.7%; P < .001						-2.51 (-3.81 to -1.21)
Older adults						
Fleming et al,[90] 1999	12	87	-5.4 (7.3)	71	-0.1 (12.2)	-5.30 (-8.52 to -2.08)
Moore et al,[110] 2010	12	213	-5.7 (7.6)	294	-4.5 (7.9)	-1.21 (-2.58 to 0.16)
Subtotal: I^2 = 80.9%; P = .02						-2.98 (-6.96 to 0.99)
Postpartum women						
Fleming et al,[89] 2008	6	122	-3.6 (5.3)	113	-1.3 (5.0)	-2.28 (-3.59 to -0.96)
Overall: I^2 = 62.8%; P < .001						-1.59 (-2.15 to -1.03)



Weights are from random-effects analysis.

JAMA | US Preventive Services Task Force | EVIDENCE REPORT

Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults

Updated Evidence Report and Systematic Review for the US Preventive Services Task Force

Elizabeth A. O'Connor, PhD; Leslie A. Perdue, MPH; Caitlyn A. Senger, MPH; Megan Rushkin, MPH; Carrie D. Patnode, PhD, MPH; Sarah I. Bean, MPH; Daniel E. Jonas, MD, MPH

JAMA. 2018;320(18):1910-1928. doi:10.1001/jama.2018.12086

OBJECTIVE To review literature on the effectiveness and harms of screening and counseling for unhealthy alcohol use to inform the US Preventive Services Task Force.

Do counseling interventions to reduce unhealthy alcohol use, with or without referral, reduce alcohol use or improve other risky behaviors in screen-detected persons?

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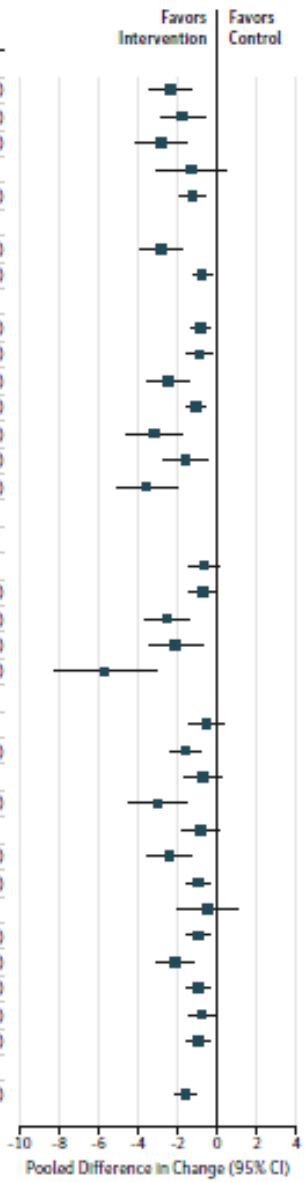
Figure 5. Subgroup and Sensitivity Analysis Results for Drinks per Week (Key Question 4a), Mean Difference in Change Between Alcohol Counseling Interventions and Control Groups, by Indicated Subgroup of Trials

Analysis	No. of Studies	I^2, %	Pooled Difference in Change (95% CI)
High applicability			
Primary care setting	21	70	-2.38 (-3.44 to -1.33)
Primary care in the United States	9	77	-1.75 (-2.88 to -0.61)
Primary care team involved, PC setting	16	68	-2.81 (-4.09 to -1.53)
Primary care team not involved, PC setting	5	65	-1.28 (-3.05 to 0.48)
United States	18	64	-1.27 (-1.91 to -0.62)
Comparison with previous review			
In previous review	15	68	-2.83 (-3.89 to -1.76)
Not in previous review	22	28	-0.77 (-1.24 to -0.30)
Heterogeneity: population, publication date			
Young adults	14	11	-0.86 (-1.29 to -0.43)
Young adults, excluding all-comers trials	12	24	-0.89 (-1.52 to -0.26)
Adults, excluding young adults	21	68	-2.49 (-3.53 to -1.45)
Published in 2007 or later	22	56	-1.07 (-1.58 to -0.57)
Published prior to 2007	15	43	-3.16 (-4.54 to -1.78)
Published in 2007 or later, non-young adults	8	72	-1.59 (-2.73 to -0.45)
Published prior to 2007, non-young adults	13	40	-3.56 (-5.11 to -2.02)
Heterogeneity: baseline severity			
Baseline drinks/wk			
0-7	4	41	-0.65 (-1.42 to 0.11)
>7-14	12	52	-0.75 (-1.47 to -0.02)
>14-21	9	56	-2.52 (-3.66 to -1.37)
>21-28	5	36	-2.10 (-3.41 to -0.78)
>28	7	11	-5.68 (-8.25 to -3.11)
Heterogeneity: intervention characteristics			
Single, very brief session	7	45	-0.56 (-1.40 to 0.28)
Single, brief session	8	0	-1.61 (-2.36 to -0.85)
Single, extended session	2	0	-0.74 (-1.68 to 0.20)
Multiple brief sessions	12	78	-3.02 (-4.49 to -1.56)
Multiple extended sessions	7	0	-0.83 (-1.79 to 0.13)
Multiple sessions	19	71	-2.44 (-3.56 to -1.33)
Single session	17	30	-0.95 (-1.49 to -0.40)
Multiple sessions, young adults only	2	59	-0.50 (-2.06 to 1.05)
Single session, young adults only	11	16	-0.95 (-1.55 to -0.35)
Direct contact (telephone, in-person)	24	68	-2.12 (-3.02 to -1.22)
No direct contact	13	38	-0.94 (-1.51 to -0.36)
Direct contact, young adult only	5	0	-0.77 (-1.42 to -0.12)
No direct contact, young adult only	9	24	-0.94 (-1.55 to -0.33)
Overall			
All included data	37	63	-1.59 (-2.15 to -1.03)



Health outcomes were sparsely reported and generally did not demonstrate group differences in effect.

There was no evidence that these interventions could be harmful.

Terzo capitolo – gli interventi psicosociali nei DUA

- Indicazioni di trattamento in funzione della gravità

Gli interventi post acuzie sono una combinazione di intervento psico-sociale associato spesso ad una farmacoterapia specifica anticraving
Lo scopo è di prevenire la ricaduta e l'intervento psicosociale è componente imprescindibile

La Prevenzione della Ricaduta è termine spesso utilizzato in modo generico, ma che sottende diversi modelli teorici sulla natura della ricaduta:

- *Come evento in un processo*
- *Come evento puntiforme progressivo ineluttabile*

- I due modelli se visti nell'ottica delle neuroscienze sono meno dissimili di quanto non possa apparire

- RP è in realtà molto specifico – il termine fa riferimento alle strategie CC

Psicosociale in Alcologia: lo stato dell'arte

Lancet 2016; 387: 988–98

Alcohol use disorders

Jason P Connor, Paul S Haber, Wayne D Hall

	Description	Level of evidence*
Cognitive behaviour therapy	This approach addresses cognitive, affective, and interpersonal triggers for alcohol use. It enhances drinking refusal self-efficacy† skills; identifies and modifies alcohol expectancies‡; improves problem-solving skills; and develops more effective coping strategies, including relaxation approaches.	High[20–24]
Motivational enhancement therapy	This therapy is a patient-centred approach that enhances motivation to change behaviour. It uses a collaborative therapeutic approach to assist patients to recognise and resolve ambivalence, and develop their own reasons to reduce or abstain from drinking. Key strategies include collaborative identification of the gap between the patient's present and desired health (ie, goal–status discrepancy), recognition of their resistance to change, avoidance of confrontational communication, and guided assessment of the pros and cons for change.	High[20–22]
Behavioural therapies based on conditioning	Cue exposure: repeated exposure to conditioned cues (eg, image or smell of alcohol, or associated emotion) can induce habituation or craving. Exposure to cues during treatment in the absence of drinking (with or without coping skill practice) is thought to reduce habituation. It is often combined with other cognitive therapy or skills. Contingency management: this approach introduces a tangible reinforcer, such as money or vouchers, to increase session attendance or abstinence. It is more suitable for inpatient and residential settings, and needs more translatable evidence.	Low;[23] Moderate[25,26]
12-step facilitation	This approach offers continuous mutual peer support, usually in the form of self-help groups run by Alcoholics Anonymous. Participation is free of charge. Participants need to "surrender to a higher power" to facilitate change. Some groups use a buddy system (a sponsor) to provide support between group meetings.	Mixed[21,22,27]

*Summary based on authors' narrative review of the highest level of evidence for each treatment. †Individuals' beliefs about their ability to refrain from drinking. ‡Individuals' expectations about the effects of alcohol consumption.

Table 1: **Non-pharmacological behavioural treatments**

Gli interventi motivazionali

Il CM riguarda il come impostare le conversazioni per fare in modo che le persone parlino del proprio cambiamento, partendo dai loro valori ed obiettivi personali. Si può scomporre in una ***componente tecnica (abilità) ed una componente relazionale (spirito)***

Il CM è una conversazione sul cambiamento

uno stile collaborativo di conversazione volto a rafforzare la motivazione e l'impegno al cambiamento di una persona

Gli interventi CC – la RP (Relapse Prevention)

Essenzialmente, quando gli individui provano a cambiare una iniziale battuta d'arresto (lapse) è altamente probabile.

Un possibile esito , di seguito, è un ritorno al modello di comportamento problematico precedente (relapse)

Un altro possibile esito è che l'individuo ritorni "in carreggiata", nella direzione del cambiamento positivo (prolapse)

Witkiewitz, Marlatt
Addictive Behavior, 2009

Basata su un framework cognitivo-comportamentale, la RP cerca di identificare le ***situazioni ad alto rischio*** nelle quali un individuo è vulnerabile di ricadere e di usare strategie di coping cognitive e comportamentali per prevenire ricadute future in situazioni simili

L'obiettivo principale della prevenzione della ricaduta (RP) è di analizzare il problema della ricaduta e di generare tecniche per prevenirla o gestirla

RP è strategia di **prevenzione indicata/selettiva** con due scopi specifici:

- prevenire una iniziale caduta e mantenere gli obiettivi del trattamento dell' astinenza o della riduzione del danno
- fornire il management della caduta se essa avviene, per prevenire una ulteriore ricaduta

L'obiettivo ultimo è di fornire le abilità per prevenire una ricaduta completa, a riguardo della situazione o di fattori di rischio incombente

Principi del Contingency Management

- CM-based treatments for SUDs originate in basic behavioral science, namely the operant-conditioning literature. Operant conditioning is a type of learning where the operant (ie, behavior) is maintained or modified via behavioral consequences (positive/negative reiforcement, positive/negative punishment).

- Grado del rinforzo
- Immediatezza del rinforzo
- importanza del rinforzo

} Delay discounting

- Dare un rinforzo tangibile ed immediato in presenza di un comportamento positivo/negativo verificabile

J Subst Abuse Treat. 2017 January ; 72: 10–18. doi:10.1016/j.jsat.2016.09.008.

Contingency management: New directions and remaining challenges for an evidence-based intervention

Carla J. Rash, PhD[1,*], Maxine Stitzer, PhD[2], and Jeremiah Weinstock, PhD[3]

Open Access Full Text Article REVIEW

A review of contingency management for the treatment of substance-use disorders: adaptation for underserved populations, use of experimental technologies, and personalized optimization strategies

Substance Abuse and Rehabilitation 2018:9 43–57

Highlights

- Contingency management (CM) is an efficacious intervention for substance use disorders.
- Clinical uptake is not commensurate with evidence for efficacy.
- CM is appropriate for and generalizable to a wide range of patient characteristics.
- Technology and designs sensitive to clinic constraints may further speed adoption efforts.

ETG urinario

Applicabilità migliorata con utilizzo tecnologia sperimentale:

Monitoraggio alcol trandermico
Monitoraggio via breathanalyzer e registrazione via cell
Monitoraggio aderenza via remoto etc…

Gruppi di Automutuoaiuto – Punti cardine DEI METODI

Alcolisti Anonimi – 12 Passi

Presupposto

malattia del corpo, della mente e dello spirito - progressiva e mortale

Gruppo – resp personale - autodeterminazione

ogni uno è libero di seguire il programma come meglio ritiene, l'unico presupposto per la frequenza è il desiderio di smettere

Metodo – 12 Passi

"Programma"

Unità (Tradizioni)

Servizio (Concetti)

3 legati

CAT

Presupposto

stile di vita

Gruppo - corresponsabilità

comunità multifamiliare

servitore-insegnante

Metodo - Hudolin

approccio ecologico-sociale ai problemi alcolcorrelati e complessi

tematiche sensibili da discutere e riformulare in chiave positiva

corretta ed aggiornata informazione sull'alcol e/o sugli altri problemi complessi

AA - Ingredienti attivi e meccanismi di azione

- aiuto al cambiamento del network sociale a supporto dell'astensione
- il sostegno all'autoefficacia e al recupero delle abilità di coping
- l'aiuto a mantenere la motivazione nel tempo
- Gestione degli stati emotivi negativi

l'effetto di AA sia da attribuirsi… «*primariamente ai cambiamenti del network sociale e all'aumento della auto-efficacia sociale all'astinenza,* e *nel ridurre gli stati emotivi negativi aumentato solo nei più compromessi dalla spiritualità/religiosità*»

Alcolisti Anonimi e i gruppi 12 Passi in generale sembrano avere un'efficacia che si estrinseca attraverso multipli meccanismi ed ingredienti attivi, che intervengono differentemente in diverse persone e nelle stesse persone in tempi differenti.

Similarità

- condividono i concetti generali di gruppo self-help, centrati sull'accoglienza, sull'atteggiamento empatico, sulla condivisione degli aspetti emotivi sia positivi che negativi finalizzati alla elaborazione ed al sostegno reciproco. Condividono perciò anche valori solidali come comprensione, amicizia, amore per e tra persone con esperienze dolorose simili.

- Entrambe rifuggono il termine trattamento come loro caratterizzazione, che viene invece demandato al sistema istituzionale, preferendo parlare rispettivamente di ***metodo*** per il recupero (recovery) e per la riabilitazione post-trattamento

- Per entrambi i tipi di gruppo la spiritualità costituisce elemento fondamentale seppure con le debite differenze.

- **Questo li distingue nettamente dai trattamenti professionali**

Linee guida internazionali

linee guida	farmacoterapia	tratt. Psicosociale	obiettivi del trattamento	intervento per gravità DUA	popolazioni speciali	donne	anziani	giovani	comorbili
AUSTRALIA	X	X	X	X	X	X	X	X	X
CANADA	?						X		
STATI UNITI	X		X	X	X	X			X
GERMANIA	X	X	X	X	X	X	X	X	X
FRANCIA	X		X	X	X	X	X	X	X
UK	X	X	X	X	X	X	X	X	X

Tutte le linee guida sono strutturate allo stesso modo e trattano gli stessi argomenti con quasi corrispondenti grade di raccomandazione

Tutti considerano il trattamento integrato il gold standard anche se con alcune differenze rispetto al momento di inserimento dell'intervento nel percorso in base a variabili come la gravità del DUA, l'età e la «tipologia» di persona affetta da DUA

Nel complesso i trattamenti farmacologici e psicosociali con grade A sono sempre gli stessi da diversi anni, anche se compaiono, in maniera piuttosto differenziata, interventi e raccomandazioni di grade inferiore specie quelli basati su letteratura ed «expert opinion»

Lasciano perciò poco spazio all'innovazione, in un momento storico poco incline all'investimento sulla ricerca

Delivering psychological interventions

1.3.3.3 **Cognitive behavioural therapies** focused on alcohol-related problems should usually consist of one 60-minute session per week for 12 weeks.

1.3.3.4 **Behavioural therapies focused on alcohol-related problems** should usually consist of one 60-minute session per week for 12 weeks.

1.3.3.5 **Social network and environment-based therapies focused on alcohol-related problems** should usually consist of eight 50-minute sessions over 12 weeks.

1.3.3.6 **Behavioural couples therapy should be focused on alcohol-related problems and their impact on relationships**.
It should aim for abstinence, or a level of drinking predetermined and agreed by the therapist and the service user to be reasonable and safe. It should usually consist of one 60-minute session per week for 12 weeks.

National Collaborating Centre for Mental Health (Great Britain), National Institute for Health, & Clinical Excellence (Great Britain). (2011). Alcohol use disorders: The NICE guideline on the diagnosis, assessment and management of harmful drinking and alcohol dependence.

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence

NICE National Institute for Health and Care Excellence

Clinical guideline
Published: 23 February 2011
nice.org.uk/guidance/cg115

Interventions for harmful drinking and mild alcohol dependence

- **a psychological intervention focused specifically on alcohol-related cognitions, behaviour, problems and social networks**
- who have a regular partner **behavioural couples therapy**
- **who have not responded to psychological interventions alone, or who have specifically requested a pharmacological intervention acamprosate or oral naltrexone in combination with an individual psychological intervention or behavioural couples therapy**

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence

NICE National Institute for Health and Care Excellence

Clinical guideline
Published: 23 February 2011
nice.org.uk/guidance/cg115

Interventions for moderate and severe alcohol dependence

After a successful withdrawal consider offering

- **acamprosate or oral naltrexone + an individual psychological intervention** (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) **focused specifically on alcohol misuse**
- **consider offering acamprosate or oral naltrexone + behavioural couples therapy to service users who have a regular partner and whose partner is willing to participate in treatment**
- **consider offering disulfiram + a psychological intervention to service users who:**
  - **have a goal of abstinence but for whom acamprosate and oral naltrexone are not suitable or prefer disulfiram and understand the relative risks of taking the drug**

Assessment and interventions for children and young people who misuse alcohol

For children and young people aged 10–17 years who misuse alcohol offer:

– **individual cognitive behavioural therapy** for those with limited comorbidities and good social support

– **multicomponent programmes** (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy) for those with significant comorbidities and/or limited social support.

At the time of publication, no drug recommended in this guideline has a UK marketing authorisation for use in children and young people under the age of 18. However, in 2000, the Royal College of Paediatrics and Child Health issued a policy statement on the use of unlicensed medicines, or the use of licensed medicines for unlicensed applications, in children and young people. This states that such use is necessary in paediatric practice and that doctors are legally allowed to prescribe unlicensed medicines where there are no suitable alternatives and where the use is justified by a responsible body of professional opinion.

National Collaborating Centre for Mental Health (Great Britain), National Institute for Health, & Clinical Excellence (Great Britain). (2011). Alcohol use disorders: The NICE guideline on the diagnosis, assessment and management of harmful drinking and alcohol dependence.

Psychological and pharmacological interventions for person aged 10 to 17

- For all children and young people aged 10–17 years who misuse alcohol, the goal of treatment should usually be abstinence in the first instance.

- For children and young people who misuse alcohol offer:
- **individual cognitive behavioural therapy** for those with limited comorbidities and good social support

- **multicomponent programmes** (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy) for those with significant comorbidities and/or limited social support.

- After a careful review of the risks and benefits, specialists may consider offering acamprosate or oral naltrexone in combination with cognitive behavioural therapy to young people aged 16 and 17 years who have not engaged with or benefited from a multicomponent treatment programme

Psychological and pharmacological interventions for person aged 18 or over

For harmful drinkers (high-risk drinkers) and people with mild alcohol dependence, offer a psychological intervention (such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems and social networks.

After a successful withdrawal for people with moderate and severe alcohol dependence

- consider offering acamprosate or oral naltrexone in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol misuse.
- in combination with behavioural couples therapy to service users who have a regular partner and whose partner is willing to participate in treatment
- consider offering disulfiram in combination with a psychological intervention

National Collaborating Centre for Mental Health (Great Britain), National Institute for Health, & Clinical Excellence (Great Britain). (2011). Alcohol use disorders: The NICE guideline on the diagnosis, assessment and management of harmful drinking and alcohol dependence.

CLINICAL GUIDELINES

CNS Neuroscience & Therapeutics

Pharmacotherapy for Alcohol Dependence: The 2015 Recommendations of the French Alcohol Society, Issued in Partnership with the European Federation of Addiction Societies

Benjamin Rolland,[1,2] François Paille,[1,3] Claudine Gillet,[1,4] Alain Rigaud,[1,5,6] Romain Moirand,[1,7,8] Corine Dano,[1,9] Maurice Dematteis,[1,10] Karl Mann[11,12] & Henri-Jean Aubin[1,12,13]

CNS Neuroscience & Therapeutics 22 (2016) 25–37

Table 7 Recommendations issued on the management of treatment for alcohol dependence in specific populations, i.e., pregnant women, children and adolescents, elderly adults, and individuals with comorbid alcohol-related physical conditions or comorbid psychiatric and substance use disorders (question 16 of the GPRs)

#	Recommendation	Grade
16.2	Abstinence throughout pregnancy is recommended for any pregnant women	EC
16.4	If medically assisted withdrawal is necessary during pregnancy, using BZDs is recommended	B
16.5a	No treatments other than those for alcohol withdrawal should be initiated in pregnant or breastfeeding women	EC
16.5b	In the event of a pregnancy occurring in a patient obviously stabilized by a medication for supporting abstinence, the continuation of the drug should be considered on a case by-case basis, weighing up the benefit/risk ratio.	EC
16.5c	Disulfiram is an exception, and it should be always stopped during pregnancy, to the unknown risks on the fetus of the antabuse effect	EC
16.7a	Any adolescent with alcohol dependence under the age of 16 should undergo a pediatric psychiatric assessment	C
16.7b	In the case of alcohol dependence occurring under the age of 16, the objective of abstinence should be preferred	EC
16.7c	First line treatments to help maintain abstinence or reduce drinking are off-label, and should thus be considered on a case-by-case basis, after repeated failure of psychosocial measures alone.	EC
16.8a	In elderly patients with alcohol-dependence, it is preferable to conduct the detoxification process in a hospital setting	EC
16.8b	Short half-life benzodiazepines should be preferred for detoxification in elderly patients	B
16.8c	Initial doses of benzodiazepines should be reduced by 30 to 50% in elderly patients	EC
16.8d	Psychosocial support should be particularly emphasized in elderly patients with alcohol dependence	B
16.10	In patients with chronic alcohol-related physical disorders, a goal of abstinence is recommended	EC
16.11	Antidepressants or anxiolytic medication should be introduced only after reassessment of the psychiatric state, after 2–4 weeks of alcohol abstinence or low-risk use	B
16.12	A smoking cessation program should be systematically offered to smokers when they are giving up alcohol, in either a hospital or an outpatient setting	B

Each recommendation was graded from A to C using the methodological tool published by the Haute Autorité de Santé (HAS), i.e., the French High Authority for Health [14], according to the level of evidence of the studies on which the recommendation was based (see Table 1). EC = 'expert consensus', i.e., recommendations based on consensual expert opinion when no study was available; GPRs = 'good practice recommendations'.

Table 6. Children and adolescents (references marked with S can be found in the suppl. material)

Recommendations	Grades
Motivational interviewing (MI) shall be offered to adolescents after alcohol intoxication for short-term reduction of alcohol consumption and risky alcohol consumption. MI is not effective regarding long-term reduction of alcohol consumption Level of evidence (LoE): 1a References: (S2, S16, S21, S24, S26, S29)	A
Brief interventions can be offered to adolescents with alcohol use disorders LoE: 5 References: (S24)	O
Cognitive behavioural therapy shall be offered for the treatment of children and adolescents with alcohol use disorders LoE: 1a References: (S3, S4, S6, S10, S11, S12, S14, S18, S20, S25, S27, S28)	A
Multi-systemic therapy (MST), short-term family therapy, functional family therapy, and resource-oriented family therapy can be offered for the treatment of children and adolescents with alcohol use disorders LoE: 1a References: (S1, S4, S5, S7, S13, S14, S20, S21, S23, S25)	O
Multi-dimensional family therapy should be offered for the treatment of children and adolescents with alcohol use disorders LoE: 1a References: (S1, S4, S14, S15, S20, S21, S25)	B
Integrative family and cognitive behavioural therapy should be offered for the treatment of children and adolescents with alcohol use disorders LoE: 1a References: (S1, S4, S13, S20, S21, S25)	B
Family members shall be included in the treatment of children and adolescents with alcohol use disorders LoE: 1a References: (S1, S21, S22, S28, S30)	A
In-patient therapies should be offered to children and adolescents with alcohol withdrawal syndrome. Somatic symptoms should be considered and psychosocial support offered LoE: n.a. References: (S19)	CCP
Educational support for families of children and adolescents with alcohol use disorders can be offered as part of the treatment plan LoE: n.a. References: (S7, S21)	CCP
During in-patient treatment, children and adolescents with alcohol use disorders should have the possibility to attend clinic schools LoE: n.a.	CCP
Regarding relapse prevention with acamprosate or naltrexone, no treatment recommendations can be given for adolescents with alcohol use disorders LoE: n.a. References: (S18, S20)	CCP
In cases of indication for methylphenidate, treatment of ADHD administration should be doubled-checked if alcohol use disorders coexist. Medication should be carefully planned and monitored LoE: n.a.	CCP
The setting for the treatment of children and adolescents with alcohol use disorders should be chosen based on the following questions: – How strong is the need for a safe environment? – How strong is the motivation of the adolescent and her/his family to actively participate in the treatment? – How strong is the need for structure and clear boundaries? – Are there any additional medical or psychiatric symptoms and related risks? – Are specific treatment settings for adolescents available? – Are there any preferences for treatment in certain settings and are there treatment failures in the past in less restrictive/intensive settings? LoE: 4 References: (S18)	B

Mann, K., Batra, A., Fauth-Bühler, M., & Hoch, E. (2017). German guidelines on screening, diagnosis and treatment of alcohol use disorders. *European addiction research*, *23*(1), 45-60.

Summary

• There is strong support for the efficacy of motivational interviewing as a treatment intervention.

•There is also sufficient support for the efficacy of cognitive behavioural treatment approaches, such as behavioural self-management, coping skills training, cue exposure and behavioural couples therapy, although there are variations in effectiveness across studies, settings and providers.

•However, there is less evidence for contingency management and residential rehabilitation programs and no sufficient evidence for solution-focused approaches, mindfulness-based stress reduction, psychodynamic, narrative therapy or other counselling techniques for use in treatment of alcohol problems at his stage.

•There is little evidence that patient-treatment matching is effective as a technique to reduce alcohol consumption.

National Collaborating Centre for Mental Health (Great Britain), National Institute for Health, & Clinical Excellence (Great Britain). (2011). Alcohol use disorders: The NICE guideline on the diagnosis, assessment and management of harmful drinking and alcohol dependence.

JAMA Network Open

Original Investigation | Psychiatry

Combined Pharmacotherapy and Cognitive Behavioral Therapy for Adults With Alcohol or Substance Use Disorders
A Systematic Review and Meta-analysis

Lara A. Ray, PhD; Lindsay R. Meredith, MA; Brian D. Kiluk, PhD; Justin Walthers, BA; Kathleen M. Carroll, PhD; Molly Magill, PhD

JAMA Network Open. 2020;3(6):e208279. doi:10.1001/jamanetworkopen.2020.8279

Question **Is cognitive behavioral therapy associated with improved outcomes for alcohol and other substance use disorders in the context of pharmacotherapy for addiction?**

Findings This systemic review and meta-analysis including 30 studies found that combined cognitive behavioral therapy and pharmacotherapy was associated **with increased benefit compared with usual care and pharmacotherapy**. Cognitive behavioral therapy did not perform better than another evidence-based modality in this context or as an add-on to combined usual care and pharmacotherapy.

CONCLUSIONS AND RELEVANCE

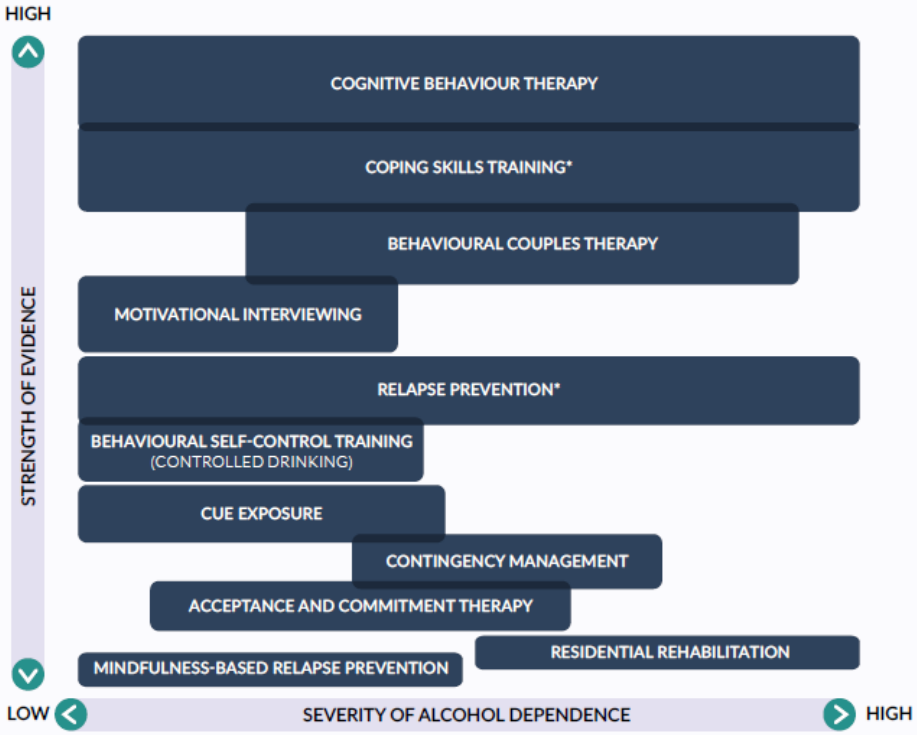
The present study supports ***the efficacy of combined CBT and pharmacotherapy*** compared with usual care and pharmacotherapy. ***Cognitive behavioral therapy did not perform better than another evidence-based modality*** (eg, motivational enhancement therapy, contingency management) in this context or as an add-on to combined usual care and pharmacotherapy. **These findings suggest that best practices in addiction treatment should include pharmacotherapy plus CBT or another evidence-based therapy, rather than usual clinical management or nonspecific counseling services**.

50% degli studi su alcol
Si conferma effetto dodo

CONCURRENT PSYCHOSOCIAL INTERVENTIONS

Although combining psychosocial and pharmacologic treatments for AUD could be more efficacious than either treatment alone, few studies have examined the effect of varying the intensity of the psychosocial treatment. Therefore, definitive recommendations on the optimal combinations are not possible.

FIGURE 9.1. Diagrammatic summary of evidence for psychosocial interventions.



Note: Box height reflects number of studies with alcohol-dependent populations. *Intervention is a core component of Cognitive Behaviour Therapy.

TABLE 10.1. Currently available first-line medications for managing relapse prevention in AUD

NALTREXONE

COSTS
PBS FUNDED
~$40, PER MONTH

INDICATIONS
- Patients with moderate- severe AUD
- Possibly more effective in reducing heavy drinking

CONTRAINDICATIONS AND/OR PRECAUTIONS
- Use of opioids (precipitated withdrawal)
- Liver failure/ hepatitis (hepatotoxicity)
- Liver function test (ALAT) 3-5 times above the normal limit
- Pregnancy/ lactation
- Renal impairment

ACAMPROSATE

COSTS
PBS FUNDED
~$40, PER MONTH

INDICATIONS
- Patients with moderate- severe AUD
- Possibly more effective for abstinence
- Capacity to adhere to medication regime.

CONTRAINDICATIONS AND/OR PRECAUTIONS
- Pregnancy/ lactation
- Renal impairment
- Severe liver failure (Childs Pugh classification C).

DISULFIRAM

COSTS
NOT PBS FUNDED
~$80-90, PER MONTH

INDICATIONS
- Patients with moderate- severe AUD
- Patients with goal of abstinence (disulfiram-ethanol reaction)
- Willingness to be supervised in the daily dosing of medication (e.g. family, pharmacy)

CONTRAINDICATIONS AND/OR PRECAUTIONS
- Cardio-vascular disease
- Pulmonary disease
- Liver failure/ hepatitis (hepatotoxicity)
- Renal impairment
- Psychosis (monitor psychotic symptoms in patients with risk of psychosis)

Haber PS, Riordan BC (2021). Guidelines for the Treatment of Alcohol Problems (4th edition).

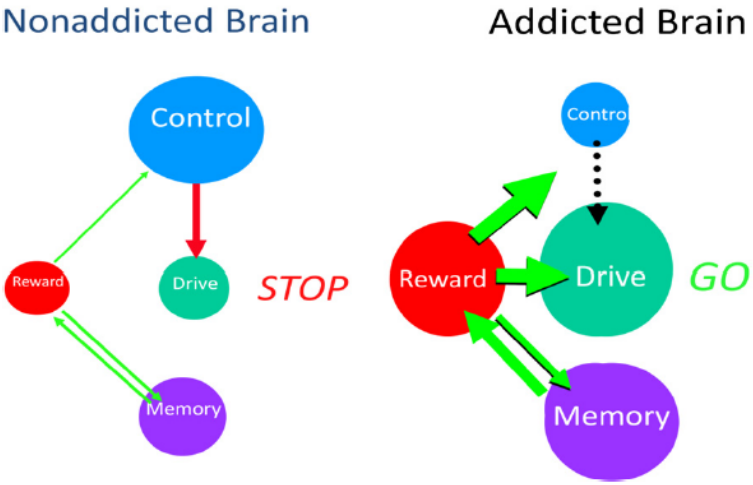
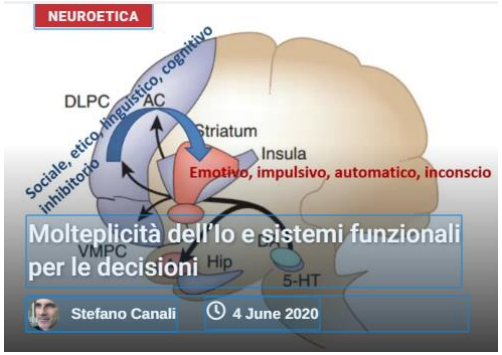
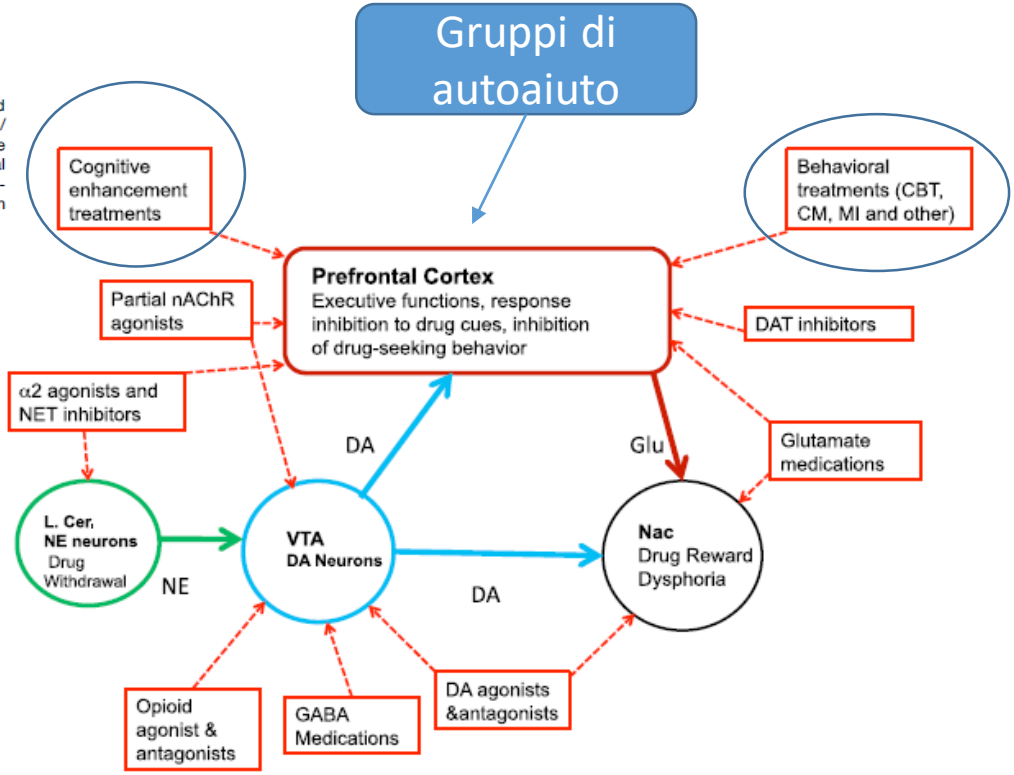


Figure 1. Model Proposing a Network of Four Circuits Involved with Addiction: Reward, Motivation/Drive, Memory, and Control
These circuits work together and change with experience. Each is linked to an important concept: reward (value of positive and negative reinforcers), drive (incentive motivation), memory (learned associations/conditioning), and control (conflict resolution). During addiction, the enhanced value of the drug in the reward, motivation, and memory circuits overcomes the inhibitory control exerted by the prefrontal cortex, thereby favoring a positive-feedback loop initiated by the consumption of the drug and perpetuated by the enhanced activation of the motivation/drive and memory circuits (reprinted with permission [Volkow et al., 2003]).



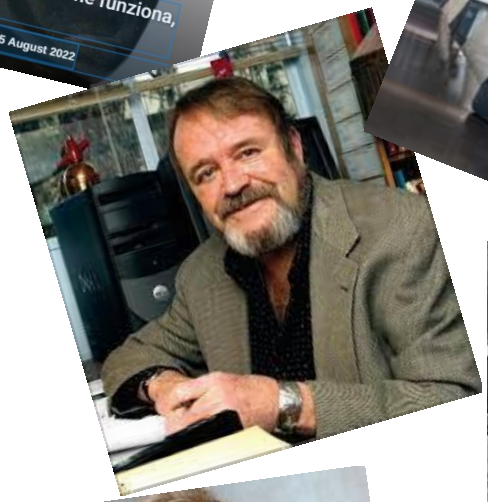
Azioni su:
Autocontrollo
Disregolazione emotiva
Sconto temporale…

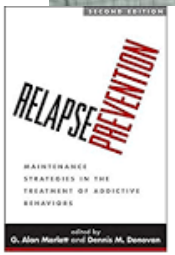


Neuron 69, February 24, 2011 ©2011 Elsevier Inc.

PSICOATTIVO

HOME | MANIFESTO | STORIA | FILOSOFIA | NEUROETICA | SCIENZE | MOSTRA | CHI SIAMO | CONTATTI





★★★★½ 36

• *Grazie per l'attenzione….*