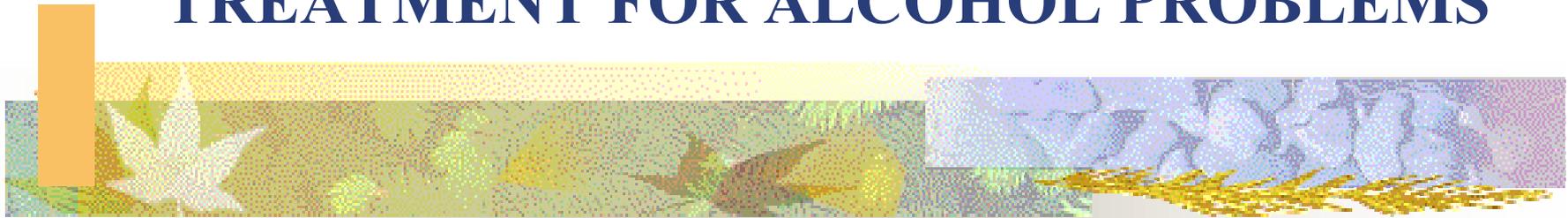


REVIEW OF THE EFFECTIVENESS OF TREATMENT FOR ALCOHOL PROBLEMS



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BACKGROUND

- In 1998 Raistrick & Heather completed a review of treatment effectiveness for the DH
- Asked to update this review for the MoCAM
- Professor Christine Godfrey asked to join authors to cover economic aspects
- A large amount of literature has appeared in the intervening 6 years and this meant a major revision of the earlier work
- This is a provisional presentation of conclusions from the Review



NATURE OF THE REVIEW

- **Not a systematic review**
- **Fortunately 3 systematic reviews of treatment for alcohol problems sponsored by foreign governments were published in 2003 and these are valuable sources for our review**
- **Also, many other recent reviews/ meta-analyses of specific topic areas**
- **To indicate the strength of the evidence upon which conclusions were based, the Review adopted the categories used by Lingford-Hughes *et al.* (2004)**



CATEGORIES OF EVIDENCE FOR CAUSAL RELATIONSHIPS AND TREATMENT

- Ia Evidence from meta-analysis of randomised controlled trials**
- Ib Evidence from at least one randomised controlled trial**
- IIa Evidence from at least one controlled study without randomisation**
- IIb Evidence from at least one other type of quasi-experimental study**
- III Evidence from non-experimental descriptive studies, such as comparative studies, correlational studies and case controlled studies**
- IV Evidence from expert committee reports or opinions and/or clinical experience of respected authorities**



CATEGORIES OF EVIDENCE FOR OBSERVATIONAL RELATIONSHIPS

- I Evidence from large representative population samples**
- II Evidence from small, well-designed but not necessarily representative samples**
- III Evidence from non-representative surveys, case reports**
- IV Evidence from expert committee reports or opinions and/or clinical experience of respected authorities**



CHAPTERS (1)

Executive Summary

Introduction

- 1) The Review Process**
- 2) Broadening the Base of Treatment**
- 3) Recent Evidence on Treatment Effectiveness**
- 4) Delivering Better Treatment**
- 5) Screening for Alcohol Problems**
- 6) Assessment and Measuring Treatment Outcomes**
- 7) Brief interventions**



CHAPTERS (2)

- 8) **Less Intensive Treatment**
 - 9) **Alcohol-focussed Specialist Treatment**
 - 10) **Non-alcohol-focussed specialist treatment**
 - 11) **Detoxification and Pharmacological Enhancements to Treatment**
 - 12) **Self-help and Mutual-aid**
 - 13) **Psychiatric Comorbidity**
 - 14) **Cost-effectiveness of Treatment**
 - 15) **The Treatment Journey in Context**
- References**



CHAPTER 2:

Broadening the Base of Treatment

- **A broadening of the base of treatment and interventions for alcohol misuse is needed to respond to the full range of alcohol-related harm that occurs. This broadened approach is aimed at:**
 - **(i) early intervention to prevent severe alcohol dependence,**
 - **(ii) secondary prevention of medical, psychological and social damage,**
 - **(iii) reduction of current levels of alcohol-related harm,**
 - **(iv) identification of alcohol misusers with serious problems who need specialised treatment.**

- **If successfully implemented, this broadening of the treatment response would be highly cost-effective and would be in the interests of both individual drinkers and society at large.**



CHAPTER 2:

A typology of alcohol misuse (1)

- A typology of alcohol misuse can assist thinking about the full range of services that are required and may be useful in planning and commissioning services:
 - i. hazardous drinkers;
 - ii. harmful drinkers;
 - iii. dependent drinking:
 - a) moderately-dependent drinking;
 - b) severely dependent drinking
 - iv. drinkers with complicated needs.

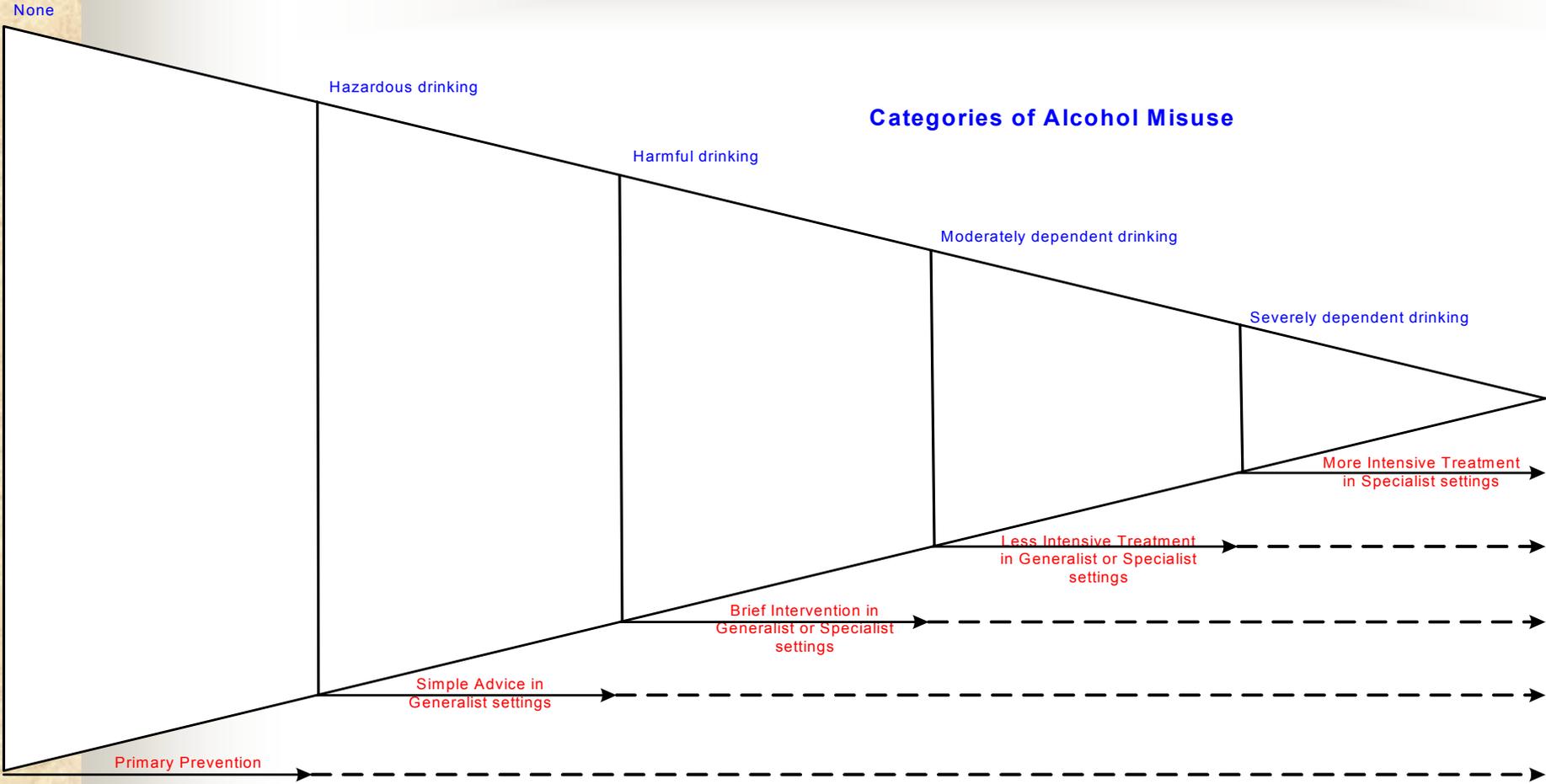


CHAPTER 2:

Typology of alcohol misusers (2)

- In general terms:
 - **primary prevention** is indicated for persons drinking at low-risk levels with no alcohol problems
 - **simple brief interventions (simple but structured advice of 5 mins or less)** in generalist settings is indicated for hazardous drinkers with no alcohol problems but levels of consumption that put them at specific risk for developing such problems
 - **extended brief interventions (structured therapy of 20-30 mins with repeat visits)** in generalist settings is indicated for harmful drinkers with levels of consumption that are already associated with problems
 - **less intensive treatment** in generalist or specialist settings is indicated for persons with moderate alcohol dependence
 - **intensive treatment** in specialist settings is indicated for persons with severe dependence
 - **special arrangements for treatment** are need for person with complicated alcohol problems

FIGURE 2.1 A Spectrum of Responses to Alcohol Misuse

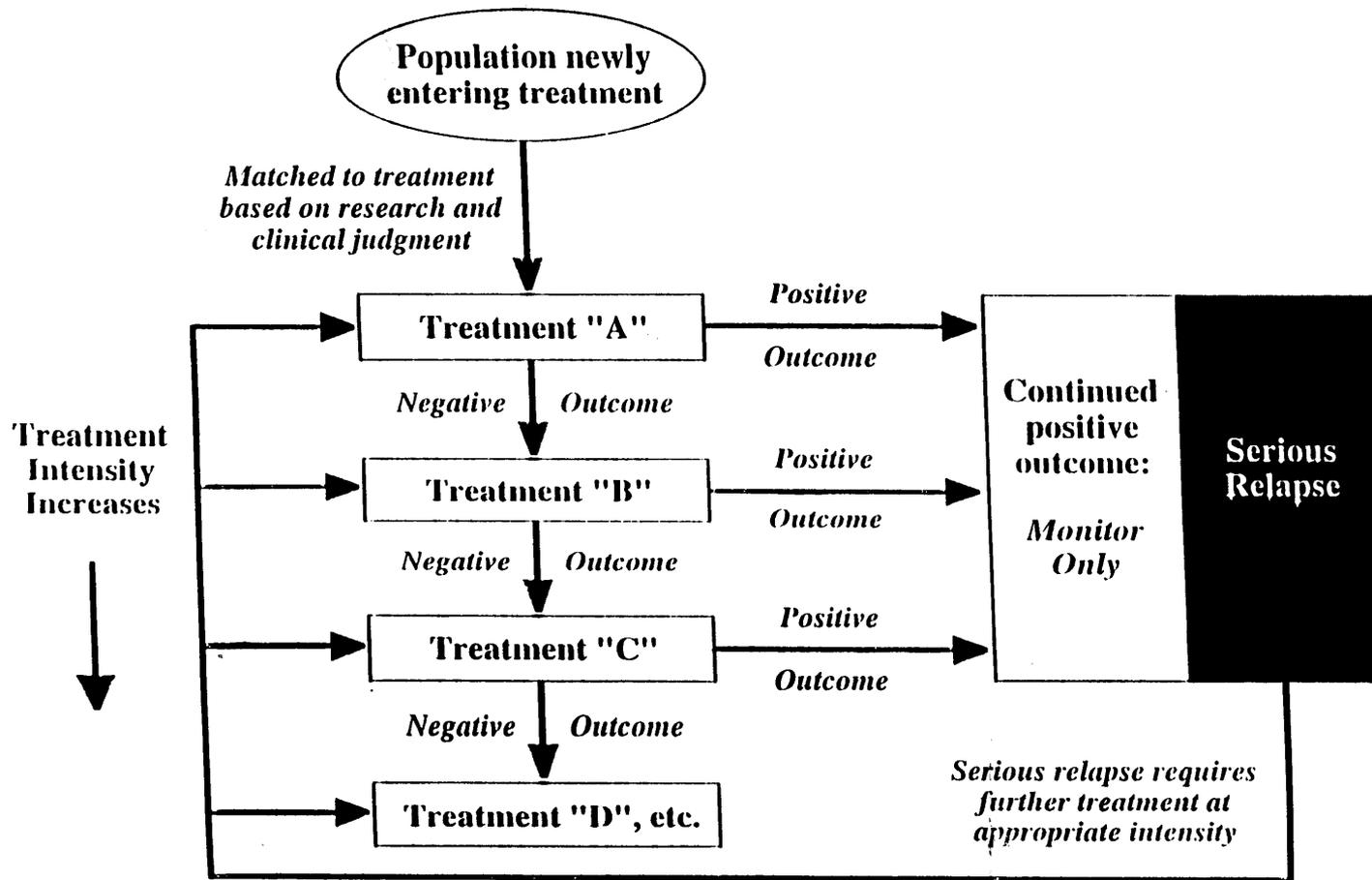


Adapted from Figure 9.1 in the Institute of Medicine [1990] report, p. 212. The triangle shown in Figure 2.1 represents the population of England, with the spectrum of alcohol misuse among the population shown along the upper side of the figure. Responses to these problems are shown along the lower side. The dotted lines in Figure 2.1 suggest that primary prevention, minimal intervention, brief intervention and less intensive treatment may have effects beyond their main target area. Although the figure is not drawn to scale, the prevalence in the population of each of the categories of alcohol problem is approximated by the area of the triangle occupied; most people have no alcohol problems, a very large number show hazardous drinking but no current problems, many show harmful drinking and less serious alcohol problems, some have moderate dependence and problems and a few have severe dependence or complicated alcohol problems.



CHAPTER 2: Other issues (1)

- **Treatment goals**
- **Including family and friends in treatment**
- **Service user choice**
- **Increasing accessibility and responsiveness of treatment services**
- **Stepped care**



STEPPED CARE MODEL OF TREATMENT FOR ALCOHOL PROBLEMS



CHAPTER 3:

Recent landmark evidence (*Mesa Grande*)

- A collection of recent publications was used to “triangulate” the conclusions of the Review.
- The *Mesa Grande* (Miller, Wilbourne & Hettema, 2003)
 - Despite the methodological shortcomings of the “box-score” method, the *Mesa Grande* was used to give a rough indication of the comparative effectiveness of different treatment modalities based on accumulated evidence in the research literature
 - Quantitative meta-analysis is a more methodologically sound way of synthesising research evidence than the box-score method but is not free of problems



CHAPTER 3:

Recent landmark evidence (Three recent systematic reviews)

- **Three systematic reviews commissioned by national governments and published in 2003:**
 - *Scottish Health Technology Assessment report (Slattery et al., 2003)*
 - *Evidence-based review for the Swedish Council on Technology Assessment (Berglund et al., 2003)*
 - *Review prepared for the National Alcohol Strategy in Australia (Shand et al., 2003a)*



CHAPTER 3:

Recent landmark evidence (Project MATCH [1])

- **Direct implications for clinical practice:**
 - **levels of psychiatric severity, network support for drinking and client anger should be considered when assigning clients to outpatient treatment;**
 - **level of alcohol dependence should be considered when assigning clients to aftercare treatment (i.e., following detoxification);**
 - **apart from these factors, treatment providers need not take into account the client characteristics examined in the project when deciding a client's best treatment from among those studied in Project MATCH.**



CHAPTER 3:

Recent landmark evidence (Project MATCH [2])

- With regard to main effects of treatment, the major implications of Project MATCH results were:
 - 12-step facilitation programmes in general are effective;
 - *Motivational Enhancement Therapy (MET)* is as effective as the more intensive treatments studied in the project (*Cognitive-behavioural Coping Skills Therapy/12-step Facilitation Therapy*)
- Project MATCH suggested the importance in treatment provision of:
 - high standards of therapist training;
 - rigorous quality assurance in treatment delivery;
 - manualised treatment protocols.



CHAPTER 3:

Recent landmark evidence (UKATT[1])

- **Both Social Behaviour and Network Therapy (SBNT) and Motivational Enhancement Therapy (MET) produced improvements in drinking and general functioning but there were no significant differences in effectiveness between them.**
- **The effectiveness of MET was confirmed by UKATT results. The effectiveness of SBNT was shown by UKATT results.**
- **At the present state of knowledge, there is no best treatment or “treatment of choice” for alcohol problems. There is a range of treatments of proven effectiveness, including MET and SBNT.**



CHAPTER 3:

Recent landmark evidence (UKATT[2])

- **In the absence of clear indications of client characteristics that can be used to guide selection of treatments, this selection must be based on grounds other than research evidence.**
- **Unless there are good grounds to offer clients more intensive treatments as a first resort, MET should be considered for use as the initial step in a stepped-care programme within a specialist agency.**



CHAPTER 4: Delivering better treatment (1)

- **Outcome of treatment is variable and factors other than treatment method itself have a powerful effect on outcomes.**

- **The therapist**
 - **Therapist characteristics account for between 10-50% of the outcome variance (Ia)**
 - **Treatment fidelity and competent delivery are important elements of a successful outcome – (IIa)**
 - **Building a therapeutic alliance between service user and therapist is important – (Ib)**



CHAPTER 4: Delivering better treatment (2)

■ The service user

- There is a large number of possible user groups based on demographic, social, political and other factors, including gender, sexual orientation, professional affiliation, comorbidity diagnosis, homelessness, age, ethnicity, religion and legal status
- All services should aspire to be ethno-culturally competent as might be appropriate to their particular locality (IV)
- There is a trade-off between providing services for special groups, which benefit from ease of shared identity and the creation of a therapeutic alliance, and generic services which offer greater choice and range of expertise (IV)



CHAPTER 4: Delivering better treatment (3)

■ The treatment setting

- A local integrated treatment system needs to deliver treatment in a variety of settings, including the home, workplace, general and psychiatric hospitals, primary care, hostels and community-based treatment agencies. Selection of setting will depend on a number of factors, including service user choice, safety, opportunism, accessibility, availability of treatment and cost
- The evidence base on treatment settings is weak because treatment has usually been delivered in what has been considered the safest and, to a lesser extent, cheapest setting; service user choice may change these considerations (IV)
- In effectiveness terms, there is an association between social and psychological damage and the need for more intensive treatment settings (III)



CHAPTER 7:

Brief interventions (1)

- Brief interventions are carried out in community settings and are delivered by non-specialist personnel, such as general medical practitioners and other primary health care staff, hospital physicians and nurses, social workers, probation officers and other generalist professionals
- Brief interventions are directed at hazardous and harmful drinkers who are not complaining about or seeking help for an alcohol problem (Types 1 and 2 alcohol misuse) and who have to be identified by *opportunistic* screening or some other identification process
- Two kinds of opportunistic brief interventions can be distinguished: *simple* and *extended* brief intervention



CHAPTER 7: Brief interventions (2)

- Effectiveness of opportunistic brief interventions in general
- Opportunistic brief interventions, of various forms and delivered in a variety of settings, are effective in reducing alcohol consumption among hazardous and harmful drinkers to low risk levels (Ia)
- Effects of brief intervention persist for periods up to two years after intervention and perhaps as long as four years (Ib)
- Booster sessions may be necessary to maintain the effect for longer periods of time, although more research is needed on the longevity of the effects of brief intervention (Ib)
- Brief interventions are effective in reducing alcohol-related problems among harmful drinkers (IIa)
- There is some evidence that brief interventions are effective in reducing alcohol-related mortality, although more research is needed here (Ia)
- There is no evidence that opportunistic brief interventions are effective among people with more severe alcohol problems and levels of dependence, i.e., among Types 3 and 4 alcohol misusers (Ia)



CHAPTER 7:

Brief interventions (3)

■ Simple brief intervention

- “Minimal” intervention consisting of 5 minutes simple but structured advice is effective in reducing alcohol consumption and improving health status among hazardous and harmful drinkers encountered in health care settings **(Ib)**

■ Extended brief intervention

- Based on principles and methods described by Rollnick, Mason & Butler (1999)
- There is mixed evidence on whether extended brief intervention in health care settings adds anything to the effects of simple advice **(Ia)**
- The offer of extended brief intervention to some hazardous and harmful drinkers can be justified on pragmatic grounds **(IV)**



CHAPTER 7:

Brief interventions (4)

- **Implementing brief interventions**
- **Most health care professionals have yet to incorporate screening and brief interventions for hazardous and harmful drinking in their routine practices (III)**
- **GPs in particular tend to miss most hazardous and harmful drinkers presenting to their practices (I)**
- **Specific barriers to the implementation of screening and alcohol brief interventions in primary health care have been identified, including lack of time and lack of suitable reimbursement (I)**
- **Training and support can increase the implementation of screening and alcohol brief intervention in primary health care (Ib)**
- **Training and support should be carefully adapted to meet the needs and attitudes of health care professionals (I)**
- **Research should focus on the effectiveness of brief interventions in real-world conditions and on ways in which screening and brief interventions can be successfully implemented in health care settings (IV)**



CHAPTER 8:

Less intensive treatment (1)

- **Less intensive treatments are delivered by specialist workers in alcohol treatment agencies or by generalists who take a special interest in the treatment of alcohol problems. They are of shorter duration or lower intensity and cheaper to deliver than conventional intensive treatments**
- **Less intensive treatment is mainly intended for Type 3 alcohol misuse, often as the initial step in a stepped care programme in specialist services. They are also suitable for Type 2 harmful drinkers who have not benefited from brief counselling and will accept referral for relatively more intensive intervention**
- **Failure to offer less intensive treatment in appropriate circumstances represents a waste of resources that could be directed towards providing treatment to a greater number of clients and ensuring that those who do need more attention are properly catered for**



CHAPTER 8: Less intensive treatment (2)

■ Basic treatment scheme

- A basic treatment scheme described by Edwards and Orford (1977) and consisting of three hours assessment and advice with the client and wife is effective in reducing alcohol problems among male alcohol misusers with intact marriages (Ib)

Condensed cognitive-behaviour therapy

- A condensed form of cognitive-behaviour therapy is especially effective among female clients (Ib)

Brief conjoint therapy

- A single session of conjoint marital therapy is effective among socially stable alcohol misusers with moderate alcohol problems and relatively intact marriages (Ib)



CHAPTER 8:

Less intensive treatment (3)

- **Motivational interviewing**
- The non-confrontational principles and style of motivational interviewing (MI) should inform the conduct of specialist treatments for alcohol problems **(Ib)**
- MI increases the effectiveness of more extensive psychosocial treatment **(Ia)**
- While there is no evidence at present of long-term effects, MI or its adaptations can be effective as a preparation for more intensive treatment of different kinds **(Ia)**
- Stand-alone adaptations of MI are no more effective than other forms of psychosocial treatment but are usually less intensive and therefore presumably more cost-effective **(Ia)**



CHAPTER 8:

Less intensive treatment (4)

- Motivational Enhancement Therapy
- Motivational Enhancement Therapy (MET) is effective as a stand-alone specialist treatment for clients with moderate alcohol dependence provided the client accepts a less intensive treatment and there is an efficient follow-up system to check on progress **(1a)**
- For clients with severe dependence, and provided there are no sound reasons for immediately offering a more intensive form of treatment, MET should be considered as first step in a stepped-care programme of care in specialist agencies **(1a)**
- MET seems especially effective for clients showing a high level of anger at entry to treatment and possibly for those with low levels of readiness to change, although more research is needed to confirm this latter suggestion **(1b)**



CHAPTER 8:

Less intensive treatment (5)

- **Training in motivational interviewing**
 - **Clinicians should not offer MI and MET without having received appropriate training and having achieved a required level of competence, although research is proceeding on the most efficient ways this training should be delivered (Ib)**



CHAPTER 9:

Alcohol-focussed specialist treatments (1)

- This category consists of psycho-social (i.e., non-drug) treatments focussed on the client's drinking and alcohol-related problems. These treatments are relevant to Types 3 and 4 alcohol misuse.
- While not ignoring issues of general adjustment, the alcohol-focussed perspective is most relevant to clients whose main difficulties are judged to be consequences of excessive drinking or are exacerbated by drinking.
- Effective treatments in this category show a great deal of overlap in the specific methods they use, come under the broad heading of *cognitive-behavioural therapy* (CBT) and have their foundations in social-cognitive learning theory and experimental psychology.



CHAPTER 9:

Alcohol-focussed specialist treatments: effective modalities

- **Community Reinforcement Approach**
- **Behavioural Self-control Training**
- **Coping/ Social Skills Training**
- **Cognitive-behavioural Marital Therapy**
- **Relapse prevention**
- **Aftercare**
- **Extended case monitoring**



CHAPTER 12

Self-help and mutual-aid (1)

■ Individual self-help

- Self-help manuals based on cognitive-behavioural principles are an effective and highly cost-effective adjunct or alternative to formal treatment among alcohol misusers with mild to moderate dependence (**Ib**).
- Self-help manuals or correspondence courses can be effective when delivered through the post to media-recruited alcohol misusers (**Ib**).
- Community-level mail interventions as part of a public health approach show promise (**Ib**) but more research is needed on the effectiveness of this approach.



CHAPTER 12

Self-help and mutual-aid (2)

- Computer and web-based self-help programmes
- A computer-based form of BSCT is effective among alcohol misusers suitable for a moderation goal (**Ib**).
- A web-based assessment and brief intervention programme has short-term beneficial effects among university students (**Ib**).
- Further development and evaluation of web-based programmes for alcohol misusers is needed (**IV**).



CHAPTER 12

Self-help and mutual-aid (3)

■ Alcoholics Anonymous

- Alcoholics Anonymous (AA) appears to be effective for those alcohol misusers who are suited to it and who attend meetings regularly **(IIa)**.
- AA is a highly cost-effective means of reducing alcohol-related harm **(II)**
- Not all alcohol misusers find the AA approach acceptable **(II)**.
- Coerced referral to AA is ineffective **(Ia)**.
- *Alanon* and *Alateen* are effective in providing emotional support to families of AA members **(IIb)**.



CHAPTER 12

Self-help and mutual-aid (4)

- Other mutual-aid groups
- *Women for Sobriety* is attractive to some women with serious alcohol problems and many members show good outcomes, although this cannot definitely be attributed to the effects of the group (III).
- Many *Secular Organisations for Sobriety* members with serious alcohol problems show good outcomes, although this cannot be definitely attributed to the effects of the group (III).
- *SMART Recovery* offers a scientifically-based form of mutual-aid but nothing is known of its effectiveness (IV).
- *Moderation Management* attracts alcohol misusers with relatively mild alcohol problems who wish to aim for moderation and many members show reductions in alcohol-related harm (III).
- Treatment providers should encourage and support the development of non-12-step alternative mutual-aid groups to AA (IV).
- Research is needed on the effectiveness of non-12-step mutual-aid groups (IV).