

Health Technology Assessment Advice 3: Prevention of relapse in alcohol dependence

Summary of recommendations

- NHS Boards, NHS Trusts and Alcohol Action Teams should take account of this Advice when preparing local strategies for those with alcohol dependence.
- The Health Technology Board for Scotland (HTBS) advises that the following psychosocial interventions should be available to all people with alcohol dependence who have undergone detoxification and are newly abstinent: Coping/Social Skills Training; Behavioural Self Control Training; Motivational Enhancement Therapy and Marital/Family Therapy.
- Two pharmacological interventions, acamprosate and supervised oral disulfiram, are recommended as treatment options for use in conjunction with psychosocial interventions.
- The recommended psychosocial interventions should be administered by appropriately trained and competent professionals using standardised protocols.
- Other psychosocial treatments are not recommended as their clinical effectiveness is unproven for alcohol dependence.
- Naltrexone is not recommended for routine use in alcohol dependence in NHSScotland.
- Health professionals should carefully consider the choice of treatments on an individual patient basis following discussion with patients about their needs, preferences and circumstances. These should be supported by information about the range of interventions.
- NHS specialist services should contact people who drop out of treatment to offer another appointment and make provision for continuing care.
- NHS specialist services should be aware of mutual help (Alcoholics Anonymous [AA]) and non-statutory agencies (Councils on Alcohol) operating in their area. Introduction to AA and non-statutory agencies should be part of the overall strategy.
- NHS Boards should ensure that their core services are of a uniformly acceptable standard and are accessible to all, considering the special service needs of subgroups.
- Long-term audit data should be collected for all psychosocial and pharmacological interventions to evaluate patient outcomes and resource consequences of using the therapies in various Scottish settings.
- In 2003, the Scottish Intercollegiate Guidelines Network (SIGN) will publish a guideline on the management of harmful drinking and alcohol dependence in primary care which will complement this Advice.

- 1. Introduction**
- 1.1 This Advice from HTBS is the outcome of a HTBS Health Technology Assessment (HTA) of interventions to prevent relapse in people with alcohol dependence. All HTAs address patients’ needs and preferences and organisational issues as well as clinical and cost effectiveness. *HTA Report 3, Section 2*
- 1.2 Treatment for alcohol dependence usually comprises two distinct stages: detoxification and prevention of relapse. This HTA focuses on the latter. Interventions used for the prevention of relapse can be either psychosocial or pharmacological. The assessment included analyses of the clinical and cost effectiveness of three pharmacological and four psychosocial interventions. *HTA Report 3, Section 3.2*
- 1.3 This Advice is based on critical appraisal and analysis of evidence published in scientific literature, evidence submitted by experts, professional groups, patient groups, manufacturers and other interested parties. An overview of the clinical and cost effectiveness is given in Section 4. The assessment process, evidence base, methodology, results and recommendations are described in detail in *Health Technology Assessment Report 3: Prevention of relapse in alcohol dependence*. To help users of this Advice locate additional information provided in the HTA report, relevant sections are referenced in the right-hand margin of this document. *HTA Report 3, Section 1.3*
- 1.4 HTBS Advice represents the evidence-based view of HTBS. Health professionals in NHSScotland should take account of what HTBS has advised and ensure that recommended drugs or treatments are made available to meet clinical need. However, this Advice does not override or replace the individual responsibility of health professionals to make appropriate decisions in the circumstances of each patient, in consultation with the patient and/or guardian or carer.
- 1.5 The HTA complements the SIGN guideline *The management of harmful drinking and alcohol dependence in primary care* to be published in 2003. *HTA Report 3, Section 2.1*

2. Advice 2.1 Recommended interventions

Psychosocial

- 2.1.1 Behavioural Self Control Training (BSCT), Motivational Enhancement Therapy (MET), Marital/Family Therapy and Coping/Social Skills Training are clinically and cost-effective psychosocial interventions and are recommended treatment options for the prevention of relapse in alcohol dependence. *HTA Report 3, Sections 5.5.1 and 7.14.6*
- 2.1.2 Brief Interventions are not recommended, as trials in alcohol-dependent people have failed to show any benefit. However, the SIGN guideline will recommend Brief Interventions for hazardous drinkers (a less severely affected group than those who are considered to be alcohol dependent). *HTA Report 3, Section 5.5.1.3*
- 2.1.3 Other psychosocial interventions are not recommended as their clinical effectiveness is unproven. *HTA Report 3, Section 5.5.1*

Pharmacological

- 2.1.4 Acamprosate and supervised oral disulfiram are treatment options recommended as adjuncts to psychosocial interventions. Naltrexone does not have a Marketing Authorisation for the treatment of alcohol dependence in the UK and is not recommended for routine use in NHSScotland. *HTA Report 3, Section 9.1.2*

Delivery

- 2.1.5 Alcohol services should aim to reduce the delay between detoxification and interventions for the prevention of relapse. This would be facilitated by joint working between specialist mental health services, primary care, social work addiction services and non-statutory agencies, as recommended by the Joint Futures Group. *HTA Report 3, Sections 5.9 and 8.1.2*
- 2.1.6 Acamprosate or supervised oral disulfiram should usually be initiated by a specialist service. The specialist service will: ensure that the patient meets the criteria for suitability; ensure the assessment of the motivation and ability of the patient to use the medication correctly; monitor efficacy; and ensure that adjunctive psychosocial treatment is organised. Usage should be in accordance with the Summary of Product Characteristics and reviewed regularly during the first 12 weeks after initiation of treatment, at which stage transfer of prescribing to the general practitioner (GP) may be appropriate, even though specialist care may continue (shared care). *HTA Report 3, Sections 3.2 and 8.2.2*

- 2.1.7 Introduction to AA and non-statutory agencies such as local Councils on Alcohol (Alcohol Focus Scotland) should be part of the overall strategy of specialist NHS services for the prevention of relapse. As with other psychosocial treatments, attendance is most likely to be beneficial if it is an informed voluntary decision. *HTA Report 3, Section 8.1.4*
- 2.1.8 People who are alcohol dependent should be informed about treatment choices. Their needs, preferences and social circumstances should be considered. As a result, the choice of interventions should be a shared decision between the health professional and the patient. *HTA Report 3, Section 6.7*
- 2.1.9 NHS specialist services should contact people who drop out of treatment programmes and offer them another appointment. *HTA Report 3, Section 6.5.8*
- 2.2 Communication with patients**
- 2.2.1 Health professionals should provide patient information, including leaflets, which should be used to support discussion between health professionals and patients about the most appropriate treatment option. *HTA Report 3, Section 6.9*
- 2.2.2 Written information about the range of available services should be readily accessible to people with alcohol problems, their families, carers and to health professionals, especially GPs. Alternative formats such as cartoons or audio-visual material should be used to support discussions with people who have low reading skills or poor concentration. Alcohol Action Teams could coordinate information requirements. *HTA Report 3, Section 6.9*
- 2.2.3 A regularly updated comprehensive directory of alcohol services and accommodation should be developed for the benefit of NHSScotland staff, patients and their families, friends and carers. *HTA Report 3, Section 8.4*
- 2.3 Organisation of alcohol services in Scotland**
- 2.3.1 Shorter, less intensive interventions (such as MET) might be provided first, following the principle of 'stepped' care, if the history suggests that such a relatively low intensity approach has not already failed. Non-response will indicate the need to move to more intensive treatment. *HTA Report 3, Section 8.2.1*

- 2.3.2 Recurrent relapse should not be a barrier to re-referral. If a particular intervention is unsuccessful for an individual, it is important to recognise that other treatments may be more suitable and to explore further options. *HTA Report 3, Sections 3.1.7 and 8.1.1*
- 2.3.3 Core services should provide the full spectrum of treatment options, including access to beds for inpatient or residential treatment. This could be facilitated by consolidation of services across Trusts and Boards provided that access is carefully considered. *HTA Report 3, Sections 8.1.2 and 8.1.3*
- 2.3.4 To ensure equity of access for the heterogeneous group of people with alcohol dependence, the provision and standard of alcohol services should be consistent throughout NHSScotland. Interventions should be carried out in accordance with standardised protocols by staff trained to agreed national standards. *HTA Report 3, Section 8.7*
- 2.3.5 Specialist NHS services should make provision for the continuing care of each individual. *HTA Report 3, Section 8.3*
- 2.3.6 Certain subgroups of people with alcohol dependence such as those in rural communities, young people, the homeless, those with comorbid mental health problems and those in the criminal justice system can encounter unique difficulties in accessing specialist services. Providers should make reasonable efforts to ensure that the needs of every alcohol-dependent person can be accommodated somewhere within the spectrum of service provision. *HTA Report 3, Section 8.1.2*
- 2.3.7 Providers should develop services for relatives, carers and dependants of people with alcohol dependence. *HTA Report 3, Section 8.1.2*
- 2.3.8 Joint training of staff from NHS and non-statutory services is recommended to help ensure that all staff are trained to uniform standards and equipped with the necessary skills to deliver the interventions recommended. *HTA Report 3, Section 8.6*

- 2.3.9 Measures should be in place to ensure that psychosocial treatments are delivered to consistently high standards over time. The delivery of these interventions should be as similar as possible to that which has been shown effective in clinical trials. As these have involved delivery by clinical psychologists, the skills of such professionals should be used at least in supervision of treatment delivery and in training in methods of delivery. *HTA Report 3, Sections 5.9 and 8.6*
- 2.3.10 The Plan for Action (Scottish Advisory Committee on Alcohol Misuse, 2002) requires each Alcohol Action Team to draw up, publish by April 2003, and subsequently implement, a local strategy covering at least three years. These strategies should take account of this Advice. *HTA Report 3, Section 3.9*
- 2.4 Audit**
- 2.4.1 An improved information collection system is required to ensure that the requirements of this Advice are fulfilled. Development of the National Alcohol and Information Resource (NAIR), currently being undertaken by the Information and Statistics Division, should take these requirements into account. *HTA Report 3, Section 8.4*
- 2.4.2 In order to assess the long-term clinical course of alcohol dependence following treatment in Scotland, measurement of simple, verifiable outcomes such as further detoxification over a period of, for example, five years would prove useful. Long-term treatment success rates in terms of abstinence or controlled drinking should be reported. *HTA Report 3, Section 9.2*
- 2.5 Further research**
- 2.5.1 More research is needed regarding the benefits of different settings for psychosocial interventions in order to determine the most effective and efficient approach to delivering the interventions. It has not been established whether group therapy is more effective than individual therapy, or whether an inpatient, outpatient or day unit setting is most conducive to treatment success. It is unclear if there is a correlation between the effectiveness of interventions and the length, frequency or intensity of treatment. In particular, the impact on effectiveness of multiple psychosocial treatments for one individual is not established. *HTA Report 3, Section 8.5*

2.5.2 Acamprosate (and naltrexone) have given unusually variable results in clinical trials in specialist settings (Section 4.6), with some trials having shown no treatment effect. Possible explanations have been suggested but these require corroboration by prospective studies. Given the variability of effect in specialist settings, any extrapolation to use in primary care requires new clinical trial evidence of effectiveness. *HTA Report 3, Section 9.1.2*

2.5.3 A trial of supervised oral disulfiram has shown a convincing reduction in drinking while on the drug but no study has demonstrated that this results in an increased likelihood of ongoing abstinence or controlled drinking. Such a study is needed to inform clinical practice. *HTA Report 3, Section 5.5.2.2*

3. Budget impact

3.1 Assuming a prevalence of 23 700 people with established alcohol dependence, 7820 people (one third of the total) may present for psychosocial therapy in a year. This is 2600 more people than the present estimated provision. Assuming that all of these will be offered, and accept, specific psychosocial treatment, there will be an incurred estimated cost of £0.94 million. *HTA Report 3, Section 8.9.1.2*

3.2 It is difficult to predict how many of these people will receive pharmacological as well as psychosocial interventions because the uptake will depend upon the outcome of a shared decision making process, and often as part of a step-wise treatment plan in the light of progress with non-pharmacological treatment. The cost per course for acamprosate is £520 per person and the cost per course of supervised oral disulfiram is £307 per person. *HTA Report 3, Section 8.9.1.2*

3.3 £0.9 million will provide continuing care for 7820 patients who have had therapy. *HTA Report 3, Section 8.9.1.0*

3.3 Whilst acknowledging the difficulties in providing a precise figure for total budget impact, it is estimated that the cost to NHSScotland of implementing the recommendations may be of the order of £2.5 million per annum. This global estimate comprises the following components: £0.94 million for additional psychosocial interventions, £0.9 million for continuing care, £0.4 million for additional staff training, audit and quality assurance services and patient information, and £0.21 million per annum for additional pharmacological treatments. The latter figure assumes that 20% of the additional 2600 people who have received psychosocial therapy will also receive medication, but the estimate is merely illustrative. *HTA Report 3, Section 8.9.1.0*

4. Overview of clinical and cost effectiveness

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| 4.1 | Untreated alcohol dependence results in levels of drinking which substantially increase the risk of dying and diseases such as stroke, cirrhosis of the liver, brain damage and several forms of cancer. Consequently alcohol dependence is associated with substantially increased mortality and morbidity. | <i>HTA Report 3, Section 3.5</i> |
| 4.2 | In addition to the associated increase in mortality and morbidity, alcohol dependence can lead to a wide range of psychological and social problems, all of which place a significant burden on the workload of the NHS. | <i>HTA Report 3, Section 3.1</i> |
| 4.3 | Overall, BSCT, MET, Marital/Family Therapy and Coping/Social Skills Training are of benefit in preventing relapse in alcohol dependence. | <i>HTA Report 3, Section 5.5.1</i> |
| 4.4 | There is evidence that acamprosate, supervised oral disulfiram or naltrexone is of clinical benefit when given individually in addition to psychosocial therapies. | <i>HTA Report 3, Section 5.5.2</i> |
| 4.5 | For both psychosocial and pharmacological interventions, there is a paucity of convincing long-term clinical effectiveness data. | <i>HTA Report 3, Section 9.2</i> |
| 4.6 | The benefit obtained from acamprosate and naltrexone varied between clinical studies more than would be expected by chance. This suggests that their effects may vary with conditions of use and that extrapolation to settings dissimilar from the studies cannot be justified. | <i>HTA Report 3, Section 9.1.2</i> |
| 4.7 | The economic evaluation shows that the four psychosocial therapies, and acamprosate and naltrexone (when combined with effective psychosocial therapies) are all cost effective. Furthermore, providing the four psychosocial therapies and acamprosate yield savings to NHSScotland as a result of avoided disease-related costs. The cost effectiveness of supervised oral disulfiram could not be assessed as the outcome of abstinence or controlled drinking has not been reported in a well-conducted trial. | <i>HTA Report 3, Section 7.14.6</i> |

- 4.8 Results of clinical studies emphasise that even the most effective interventions will fail in the majority of patients and alternative approaches will be needed. This, together with other HTA evidence, suggests that treatment should be individualised and flexible, taking account of patients' expectations, needs, preferences and social circumstances with the understanding that these may change. *HTA Report 3, Sections 5.6.1 and 6.7*
- 4.9 There is currently considerable variation in the provision of alcohol services throughout NHSScotland, leaving some areas without access to what should be considered core services for people with alcohol dependence. *HTA Report 3, Sections 3.18.1 and 8.8*
- 4.10 Few psychosocial interventions are delivered according to standardised protocols and effectiveness may be affected by factors such as setting, duration of treatment and personal qualities of the therapist. *HTA Report 3, Section 9.1.2*

5. Review As HTBS chooses broad topics for HTAs, it is likely that new evidence will emerge which bears on the specific recommendations on an ongoing basis. Rather than having a fixed review period, HTBS, in conjunction with experts, will determine the importance of new evidence and produce report addenda in which the evidence is analysed and any alteration to the recommendations is explained. If a major change is required, the HTA report, HTBS Advice, and Understanding HTBS Advice will be rewritten.

6. Further information

- *Health Technology Assessment Report 3: Prevention of relapse in alcohol dependence*
- *Understanding HTBS Advice: Prevention of relapse in alcohol dependence*
- *Scottish Intercollegiate Guidelines Network (SIGN). The management of harmful drinking and alcohol dependence in primary care. Edinburgh: SIGN; due to be published in 2003*
- All HTBS documents are available in a variety of formats on request and from the HTBS website, www.htbs.co.uk

Health Technology Board for Scotland

HTBS works to improve Scotland's health by providing evidence-based advice to NHSScotland. It evaluates the value for money of new and existing health technologies such as medicines, devices, clinical procedures and healthcare settings.

HTBS:

- conducts Health Technology Assessments, which is an open and inclusive process that takes account of medical, ethical, social, and economic impacts of using health technologies
- provides Comments on NICE Guidance, identifying differences that affect the suitability of the English and Welsh Guidance for Scotland
- supports the Scottish Medicines Consortium which provides advice on new medicines at the time of market launch.

In January 2003, HTBS will become part of a new body called **NHS Quality Improvement Scotland** which will aim to contribute to the highest quality of patient care in NHSScotland by promoting best practice in clinical care and ensuring effective clinical governance.

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