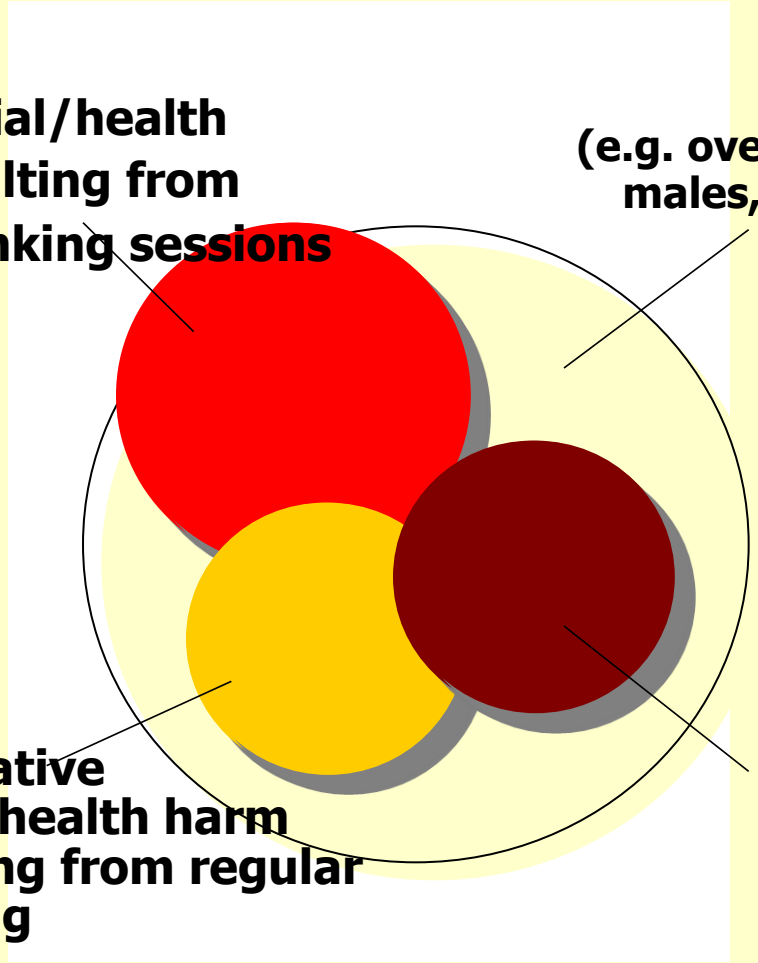
If alcohol treatment were evidence-based what would it look like?

Dr Jane Marshall

SSA Meeting: York

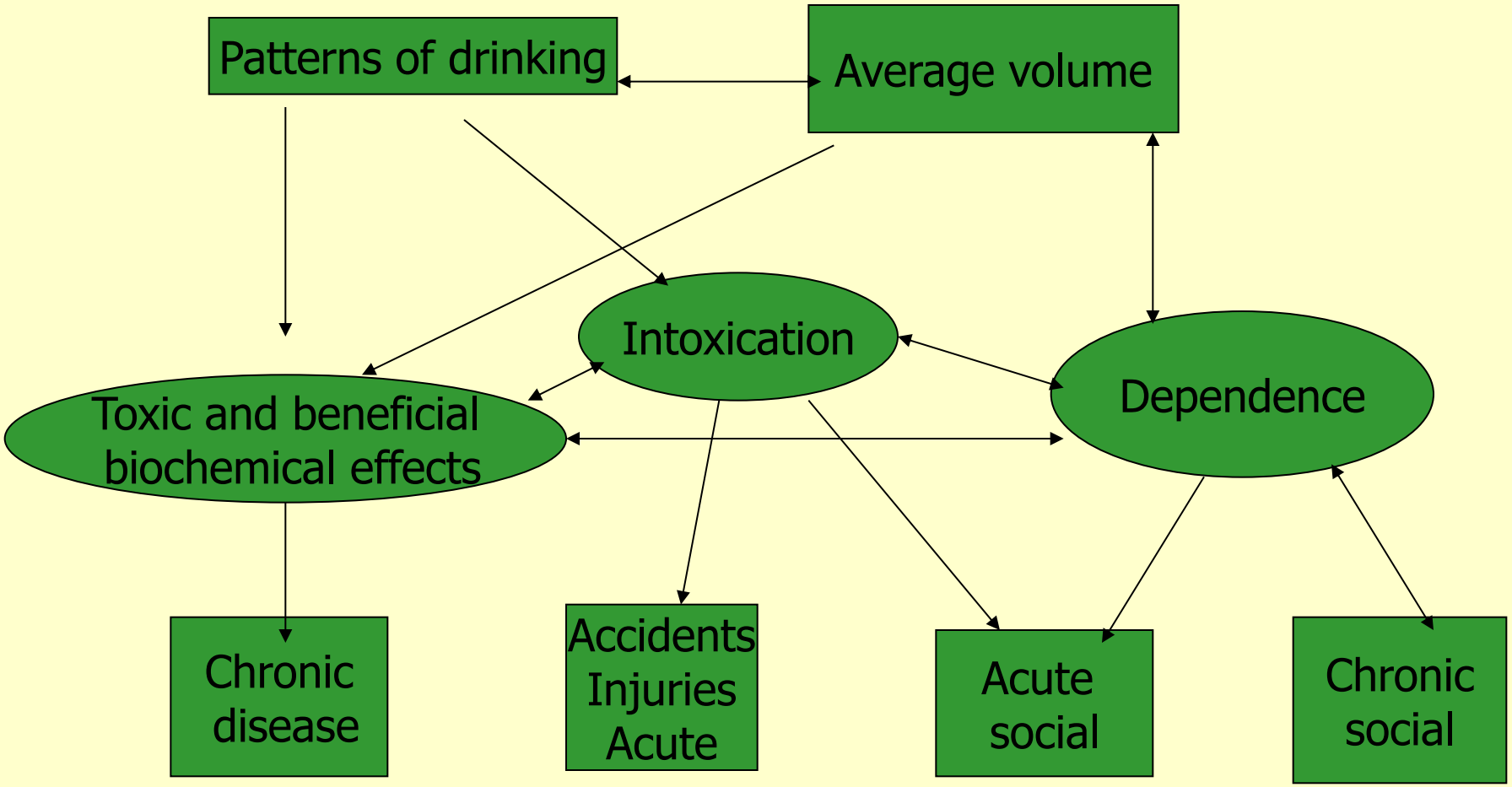
17th November 2005

RELATIONSHIP BETWEEN EXCESSIVE DRINKING, PROBLEMS AND DEPENDENCE

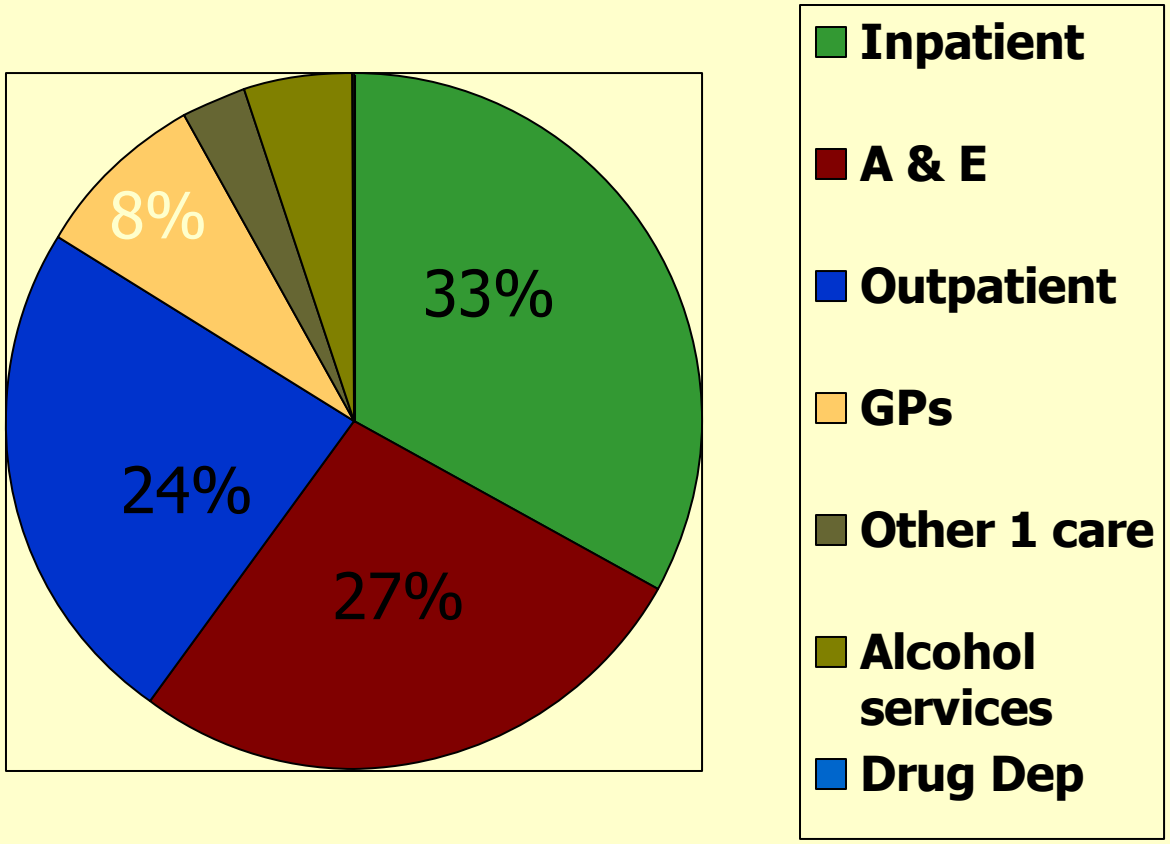


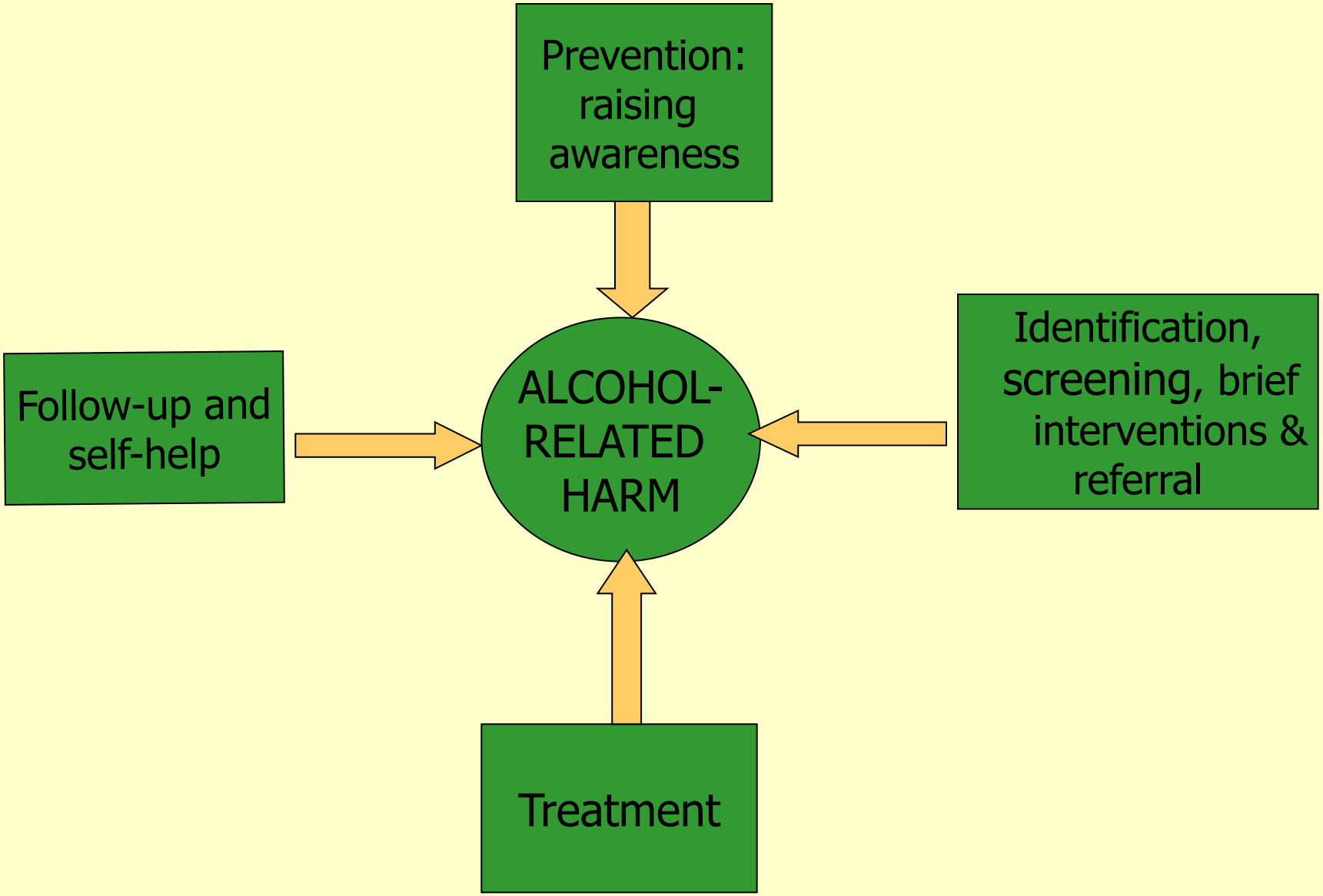
From: Chick et al (1997)

Alcohol consumption, mechanisms, consequences

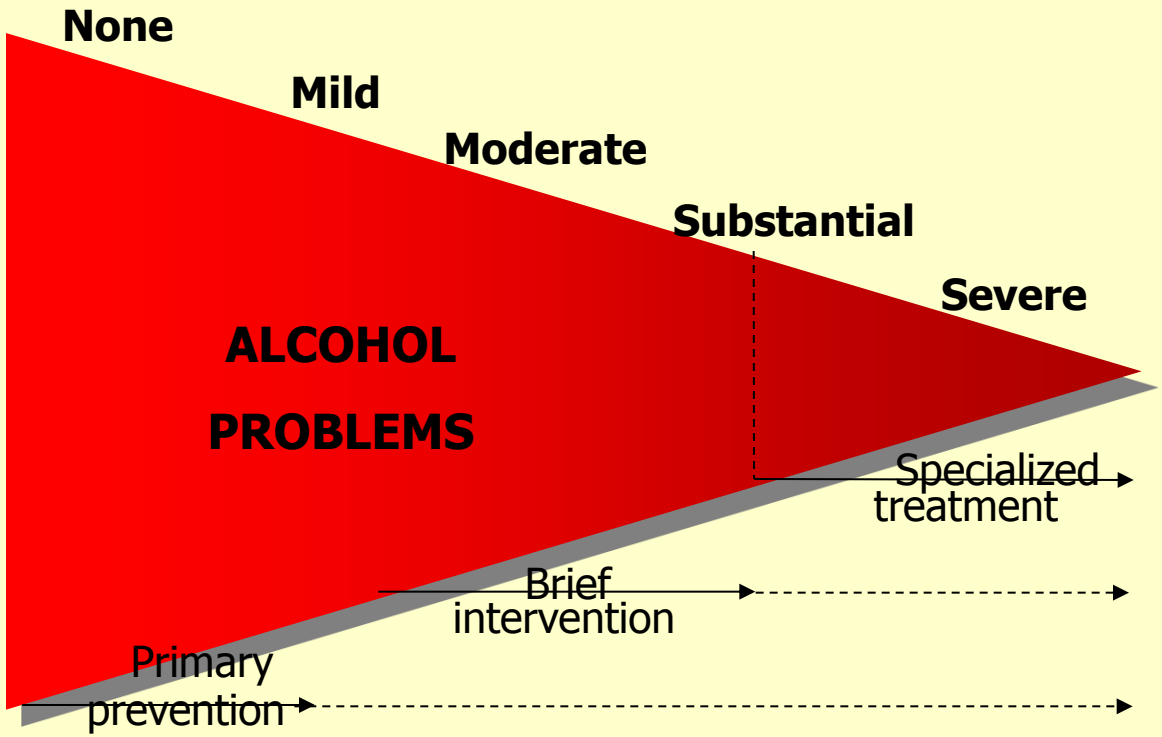


Alcohol misuse – cost breakdown £1.7 billion/yr



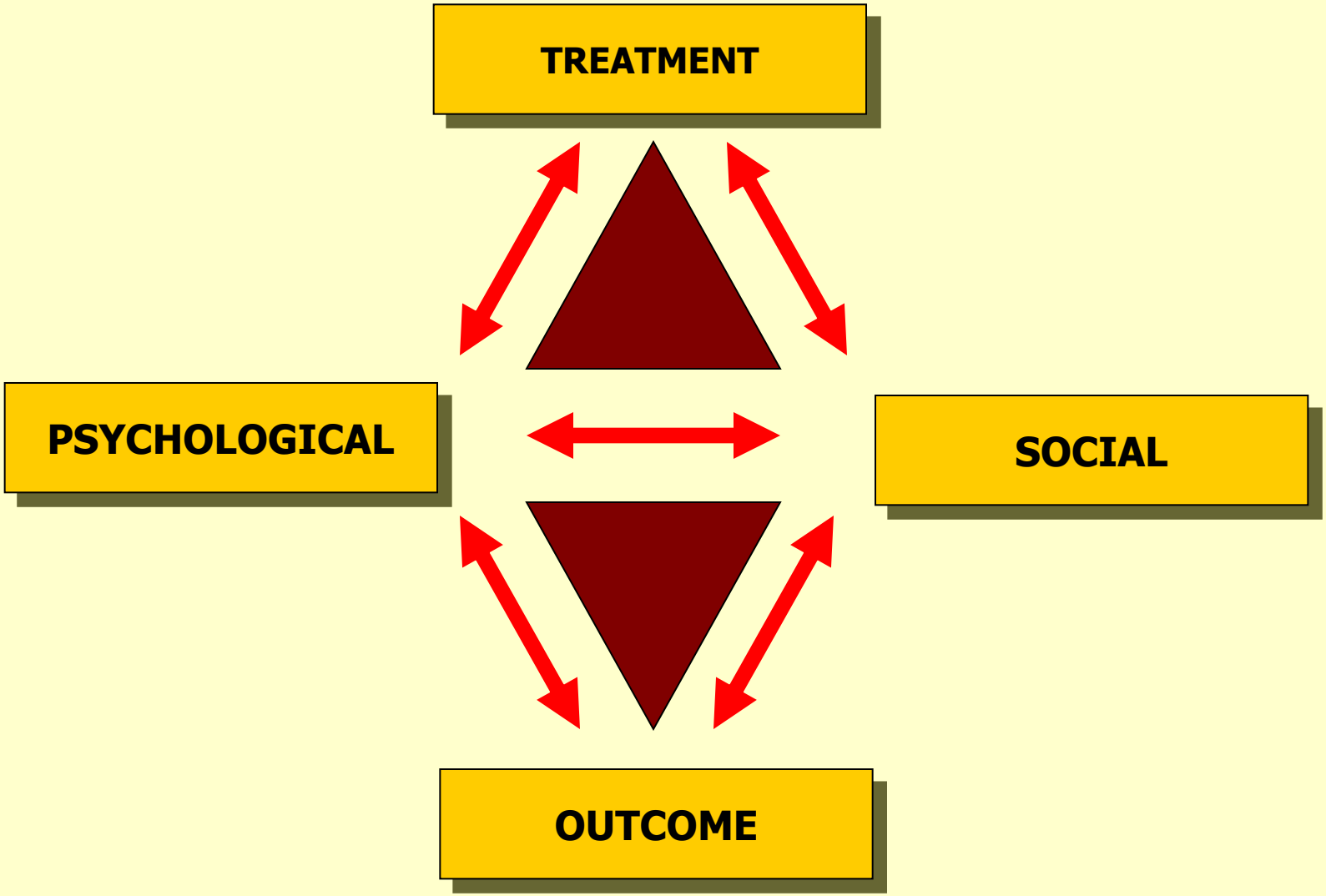

Prevention: raising awareness
Follow-up and self-help
ALCOHOL-RELATED HARM
Identification, screening, brief interventions & referral
Treatment

RELATIONSHIP BETWEEN THE SEVERITY OF ALCOHOL PROBLEMS AND THE TYPE OF INTERVENTION NEEDED



Institute of Medicine (1990)

EFFECTS OF TREATMENT, PSYCHOLOGICAL AND SOCIAL FACTORS UPON OUTCOME



Effective Treatments

- The context of treatment: behavioural change
- Psychosocial Interventions
- Pharmacological Interventions
- Long-term Outcomes

Behavioural Change

- Mental health professionals often assume that “change” occurs as a result of the service provided (counselling, advice etc)
- Individual strengths of the person are ignored
- People can “change” without treatment
- “Treatment” process should work on individual strengths to facilitate change

Psychosocial Interventions

- “Talking therapies” based on conceptual models of addiction
- Can be delivered on a 1:1 basis, in a group setting, or as part of a couple/family therapy approach
- Enhance the naturally occurring process of recovery

Psychosocial Interventions

- Elements of effective treatments
  - Build motivation
  - Enable behavioural change
  - Modify the social context

    - Raistrick and Tober 2004

Assessing Effectiveness

- Not easy to assess!
  - Treatment effects often less than the effects of therapist variables or changing social contexts (Raistrick & Tober, 2004)
  - Researchers do not always assess readiness to change or whether the change for which the patient is ready is matched to the treatment
  - Thus…common finding that all treatments deliver similar results

Psychosocial Interventions for Alcohol Use Disorders

- Evidence base
  - Mesa Grande project (Miller's Group, 1995; 1998; 2002)
  - UK Review of Effectiveness (Raistrick & Heather, 1998; 2005)
  - Swedish Health Technology Assessment (Berglund et al, 2003)
  - Health Technology Board of Scotland (2003)
  - Health Development Agency (2005)

Mesa Grande Project

- Ongoing systematic review summarising current evidence
- 2002 update: 361 randomised controlled trials were analysed and 87 treatments ranked
- Caveat: not clinically focused and remit very (?too) broad

Mesa Grande Ranking for Psychosocial Treatments

Miller and Wilbourne, 2002

- Brief Interventions
- Social Skills Training
- Community Reinforcement Approach
- Behaviour Contracting
- Behavioural Marital Therapy
- Case Management

Brief Interventions

- Targeted opportunistic screening
- Hazardous and harmful drinkers
- Very brief (minimal) intervention (simple advice, low intensity: 5-10 minutes)
- Brief counselling intervention (25-30 minutes)
- Cost effective
- Public health approach

Brief Interventions : the Evidence

- Effective in opportunistic samples with hazardous/harmful drinking (Moyer et al, 2002)
- Significant effect at follow-up for up to 2 years (Berglund et al, 2003)
- Longer-term effects less evident: booster sessions required (Fleming et al, 2002)
- Reduce alcohol-related problems and mortality

Brief Interventions in Primary Healthcare Settings: Advantages

- Primary care ideally placed for dealing with alcohol problems!
- Easily accessible
- GPs and other members of the team well-placed and respected
- Brief interventions effective in this setting
- Links with general hospital facilitated
- On-going support and monitoring possible

MINIMAL INTERVENTIONS

MEN		CONSUMPTION			CONSUMPTION CHANGE	
	No.	Initial	6/12	12/12	After 6/12	After12/12
Treatment Group	318	62.2	46.7	44.0	-15.5	-18.2
Controls	322	63.7	55.5	55.6	- 8.2	- 8.1

$p < 0.001$ at 6 months and 12 months

21% Reduction in alcohol consumption amongst men receiving brief intervention

Wallace et al, 1988

Brief Interventions in Primary Healthcare Settings: the Evidence

- Equally effective in men and women (Ballesteros et al, 2004)
- Effective among older adults (>65 years); Fleming et al, 1999
- Extended BIs effective in women, not men (Poikolainen, 1999)
- NNT = 8 (Moyer et al, 2002)

Brief Interventions in Primary Healthcare Settings: the Evidence

- Evidence suggests that it may be possible to increase engagement of GPs in screening and giving advice for hazardous and harmful drinking (Anderson et al, 2004)
- Evidence suggests that use of bibliotherapy is effective in decreasing at-risk and harmful drinking, esp. in those seeking help (Apodaca and Miller, 2003)

Primary Healthcare Setting

- Pole position on treatment grid
- Easily accessible
- Opportunistic and patient-led interventions (GPs and practice nurses..and others)
- Possibility for follow-up
- Critical need for links with community alcohol teams (statutory and voluntary sectors)

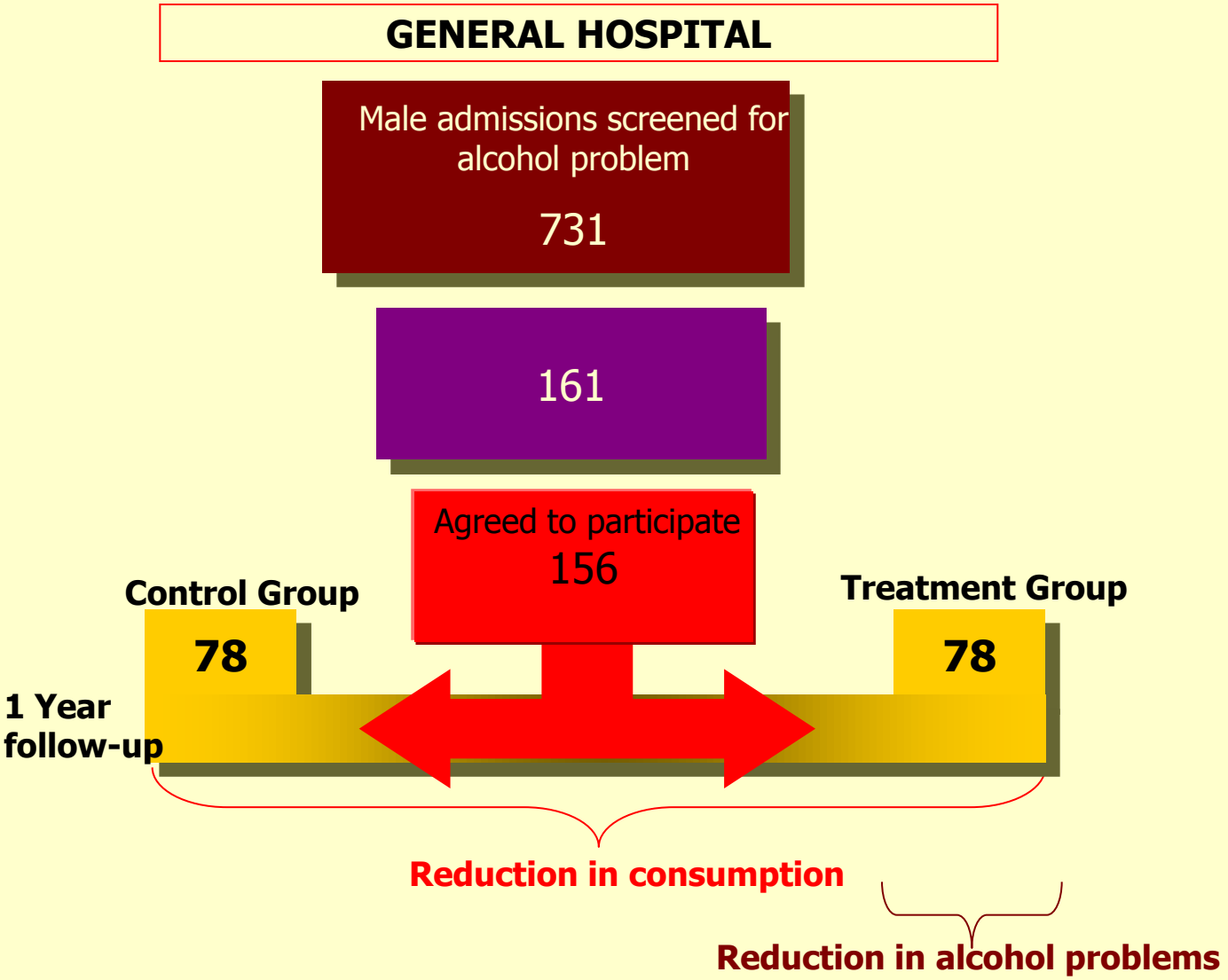
The General Hospital

- Appropriate setting for BIs
- High numbers of excessive drinkers
- One meta-analysis unduly pessimistic (Emmen et al, 2004)
- Chick et al's (1985) study showed reduction in alcohol-related harm at 1-year follow-up

Primary Healthcare Setting

- Liaison with:
  - A&E Departments
  - The general hospital
  - Community psychiatry services
  - Community alcohol services
  - The police
  - Probation service
  - Community pharmacies

MINIMAL INTERVENTIONS



Chick et al (1989) BMJ 290, 965 - 967

The Accident & Emergency Department

- Pragmatic study in a London A&E dept: referral for BI associated with short-term reduction in alcohol consumption (Crawford et al, 2004)
- Studies from UK and US support effectiveness of BIs in A&E settings
- (certainly reduce workloads in A&E depts!)

Other Medical Settings

- Psychiatric in-patients settings (Hulse and Tait, 2002)
- Ante-natal clinics (Chang et al, 1999)
- Medical OPD clinics

Non-medical settings

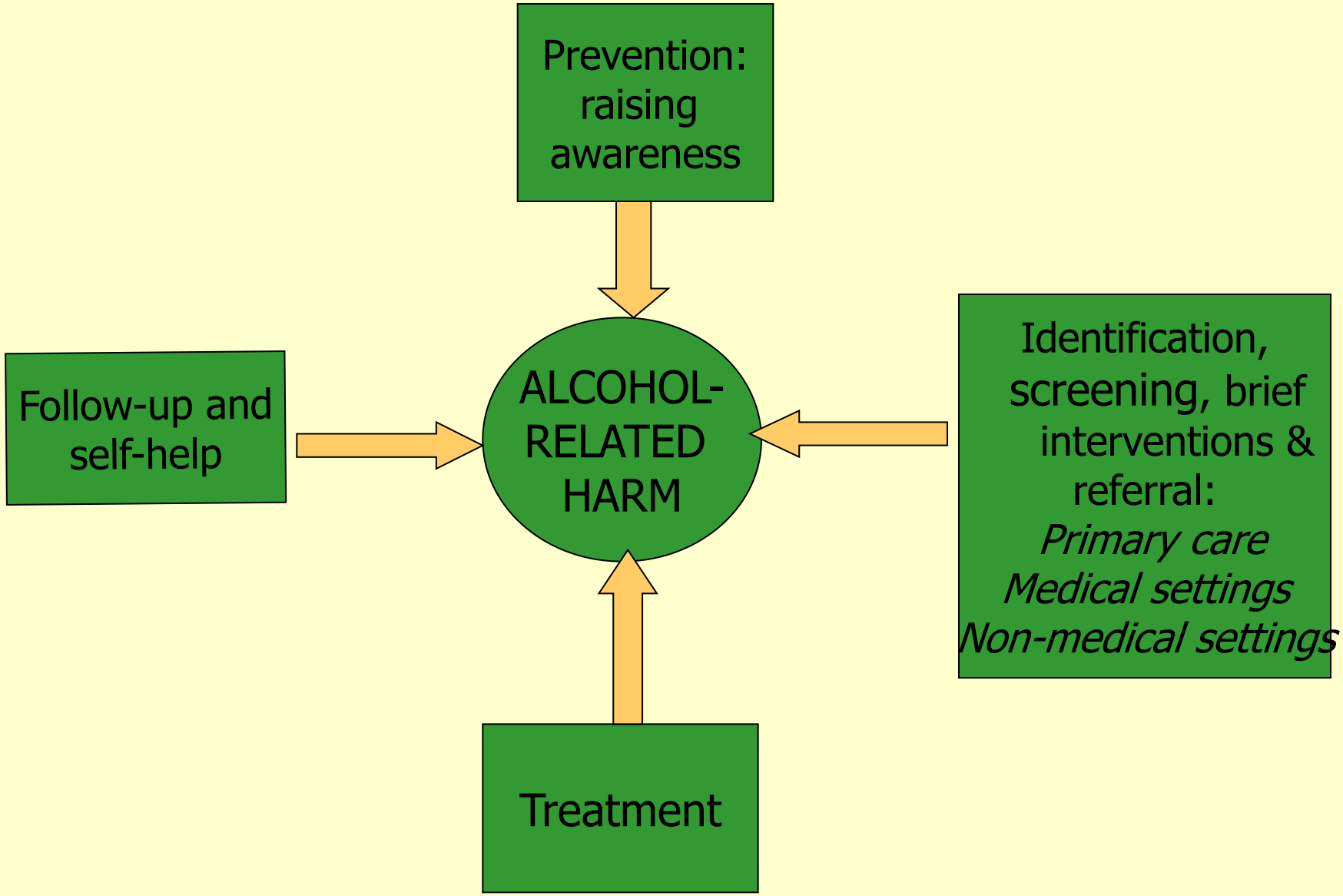
- Potential setting for which research evidence is lacking (Heather and Mason, 1999)
  - Prisons
  - Probation service
  - Drink-driving offenders
  - Workplace
  - Social work settings

Implementing Brief Interventions

- Health professionals don't
- Barriers (Kaner et al, 1999)
  - Lack of time/training/appropriate materials
  - Little support/reimbursement from government
  - Don't feel competent/confident
  - Negative attitudes

How to Support Primary Care

- Tele-marketing most cost-effective means of disseminating BI programmes in primary care (Kaner et al, 1999)
- Training and support are required
- But training and support do not improve attitudes! (Anderson et al, 2004)
- Need for training programmes to be tailored to needs and attitudes of PHC professionals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Primary care
Medical settings
Non-medical settings
Treatment

UK Effectiveness Review

Raistrick and Heather, 2005

- Commissioned by Dept of Health in 1997
- Sets out evidence base
- Recommendations for organisation of a comprehensive UK alcohol treatment service
- Evidence for efficacy of continuing care
- “Stepped care” model

UK Effectiveness Review

Raistrick and Heather, 2005

- Social Skills Training
- Community Reinforcement Approach
- Aversion Therapy
- Cognitive Behavioural Therapy
- Behavioural Self-Control Training

Swedish (SBU) Health Technology Assessment

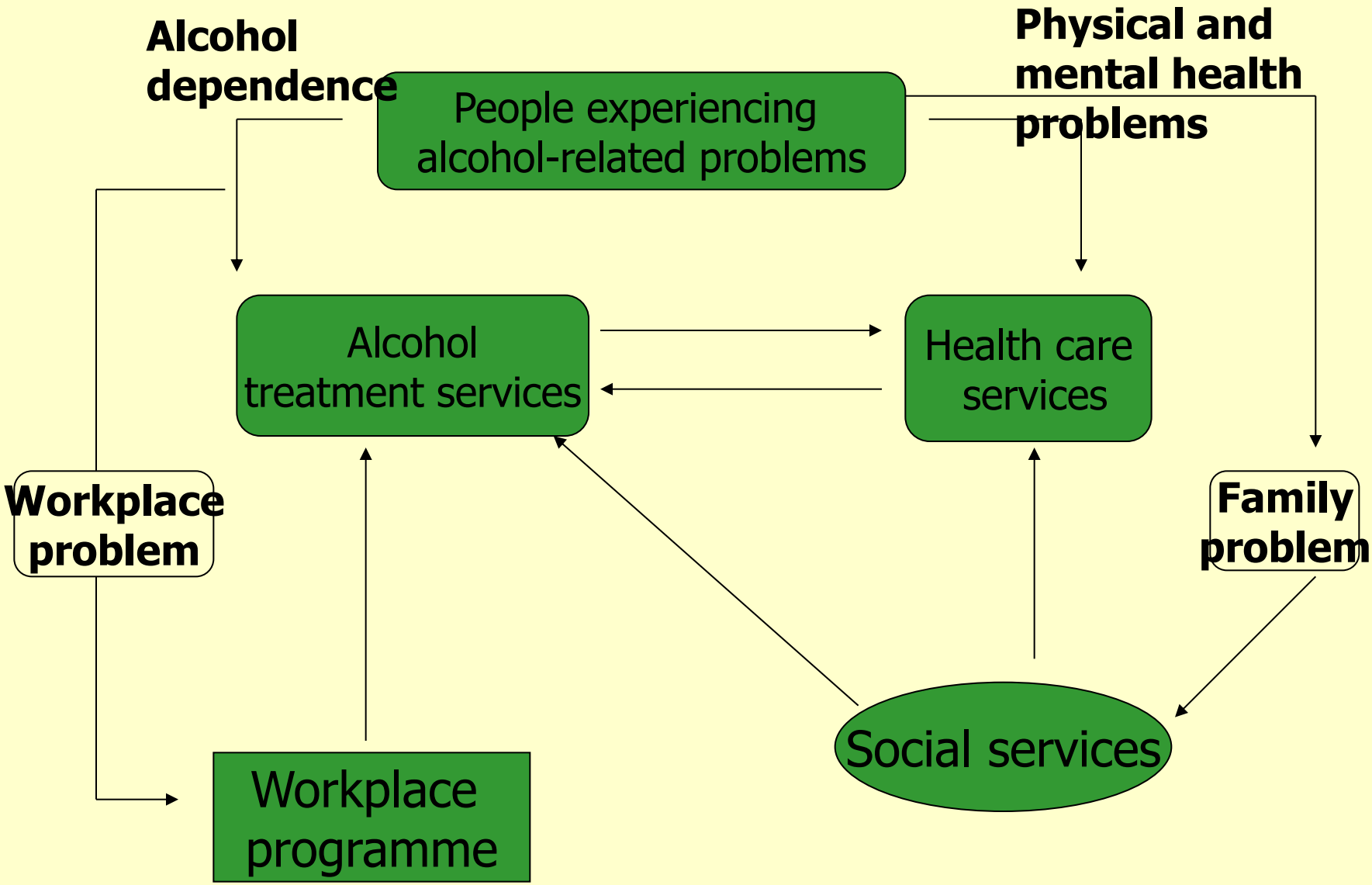
- Systematic review of treatments for alcohol and other addictive substances (2001)
- 139 studies initially analysed
- 25 more added for English version (2003)
- **Treatment shown to be effective**
- Specific* treatment better than standard treatment
  - (* theoretical base, trained therapists, manual guided)

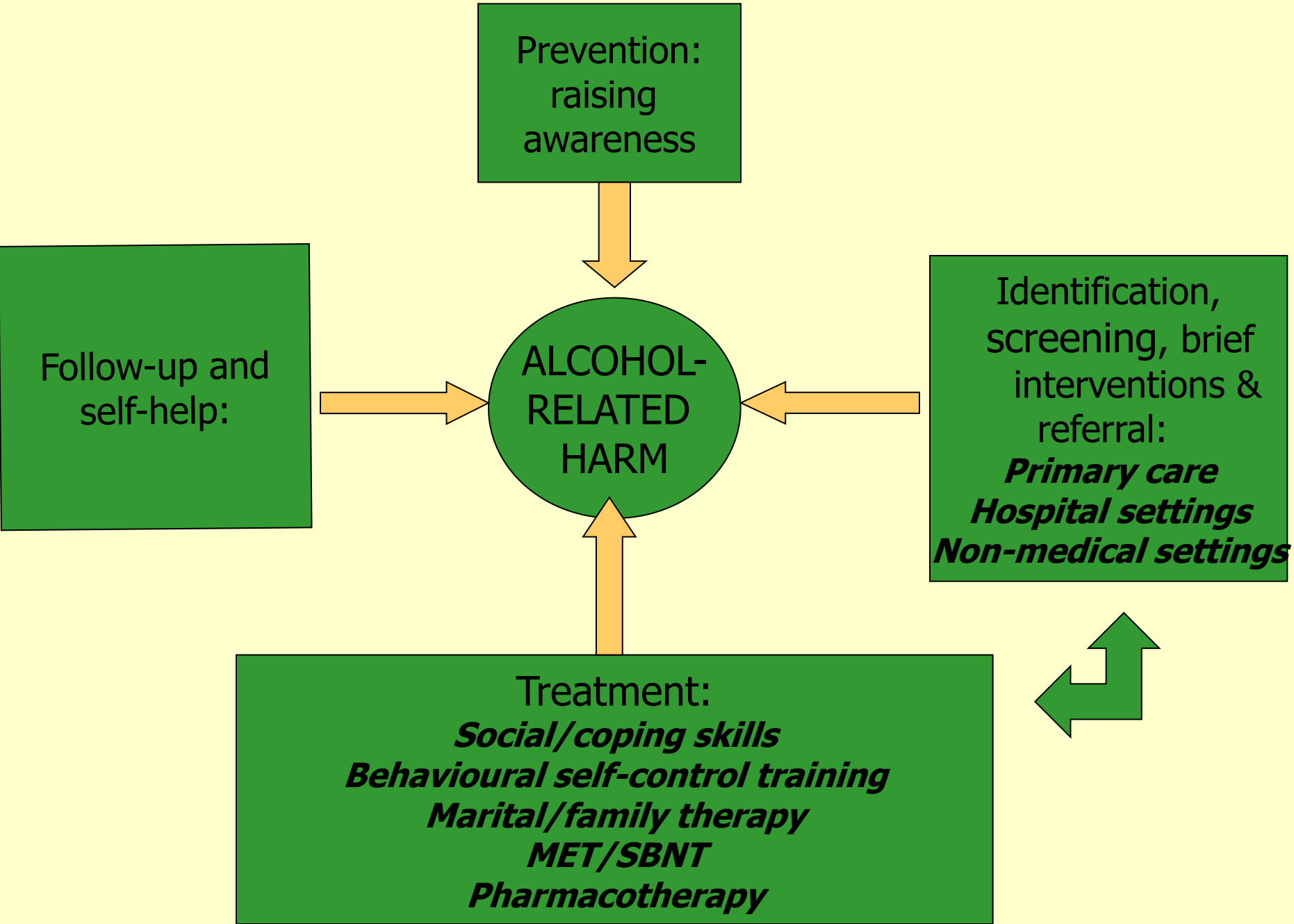
Swedish Health Technology Assessment: Alcohol

- Coping/social skills training
- Behavioural Self-Control Training
- Marital/Family Therapy
- Motivational Enhancement Therapy

Health Technology Board for Scotland (2003)

- Assessed psychosocial interventions to prevent relapse in people with alcohol dependence
- Identified 4 broadly defined treatments with proven effectiveness
  - Coping/Social Skills Training
  - Behavioural Self Control Training
  - Marital/Family Therapy
  - Motivational Enhancement Therapy


Alcohol dependence
People experiencing alcohol-related problems
Physical and mental health problems
Alcohol treatment services
Health care services
Workplace problem
Family problem
Social services
Workplace programme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ALCOHOL-RELATED HARM
Identification, screening, brief interventions & referral:
Primary care
Hospital settings
Non-medical settings
Treatment:
Social/coping skills
Behavioural self-control training
Marital/family therapy
MET/SBNT
Pharmacotherapy

Project MATCH

- 1726 subjects with AUDs:
  - Randomly allocated to Motivational Enhancement Therapy (MET), Cognitive-behavioral coping skills therapy (CBT) or 12-step facilitation (TSF)
  - No major differences between groups at 1-year follow-up
    - ⇑ in abstinence days from 20-30% to 80-90%
    - ⇓ in drinks per drinking day from 12-20 to 1-4

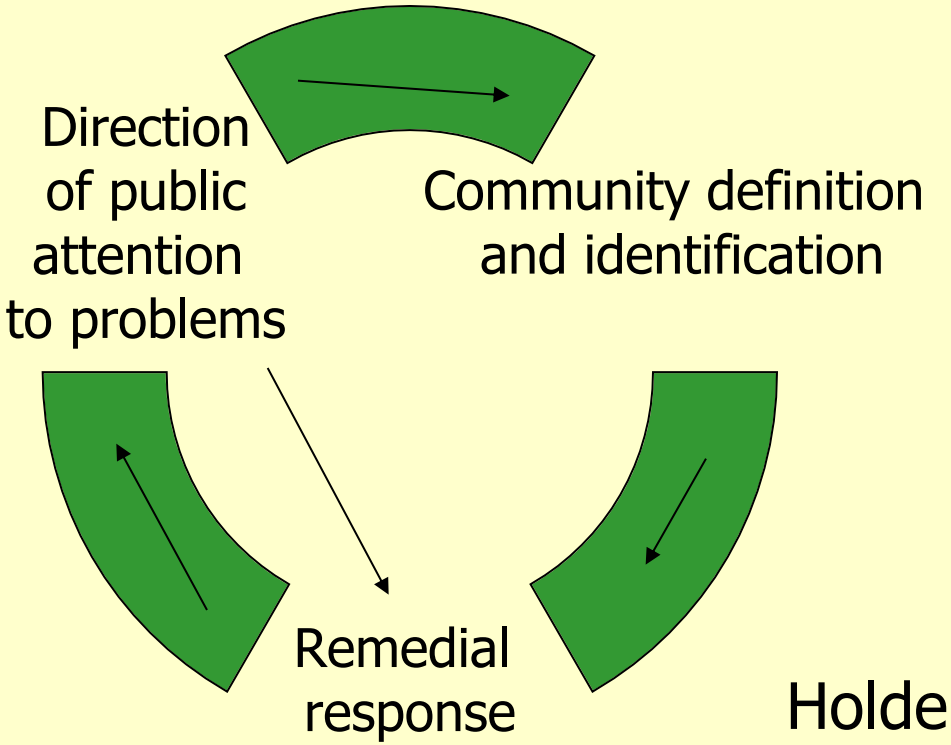
UKATT

- 742 people with alcohol problems:
  - Randomly allocated to MET or SB&NT
  - Pragmatic trial
  - No major difference between groups at 12-month follow-up
    - ↓ alcohol consumption and problems
    - ↓ dependence
    - ↑ mental health QOL

Issues about which communities are concerned

- Drinking and young people
- Drinking and driving
- Alcohol dependence
- Drinking at the workplace
- Accidental injuries and deaths resulting from alcohol use
- Violence resulting from alcohol use

The social, economic and health consequences subsystem



Holder, 1998

Remedial response

- Provision of social and health services
- Demand strongly related to alcohol use
  - A & E; hospital admission
  - Arrest referral workers in police stations
  - Brief interventions (all settings)
  - Better access to treatment
  - Effective treatment
- If deaths/injuries caused by alcohol increase then community concern will increase