NHS

National Treatment Agency
for Substance Misuse

A summary of the Review of the Effectiveness of Treatment for Alcohol Problems

Nick Heather, Duncan Raistrick and Christine Godfrey

The National Treatment Agency for Substance Misuse

The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001, to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

Treatment can reduce the harm caused by drug misuse to individuals' well-being, to public health and to community safety. The Home Office estimates that there are approximately 250,000–300,000 problematic drug misusers in England who require treatment.

The overall purpose of the NTA is to:

- Double the number of people in effective, well-managed treatment between 1998 and 2008
- Increase the percentage of those successfully completing or appropriately continuing treatment year-on-year.

In addition to its remit on drug treatment, the NTA is also commissioned to undertake specific work on alcohol treatment, including the development of Models of Care for Alcohol Misusers (DH, 2006) and commissioning the Review of the Effectiveness of Treatment for Alcohol Problems (NTA, 2006).

Reader information

Document purpose	To summarise the Review of the Effectiveness of Treatment for Alcohol Problems
Title	A Summary of the Review of the Effectiveness of Treatment for Alcohol Problems
Lead authors	Nick Heather, Duncan Raistrick and Christine Godfrey
Publication date	November 2006
Target audience	Managers, commissioners, providers, service users and key stakeholders in the provision of alcohol treatment services
Circulation list	See above
Description	A summary of the Review of the Effectiveness of Treatment for Alcohol Problems (NTA, 2006), to inform the commissioning and provision of local alcohol treatment systems in England
Cross reference	Review of the Effectiveness of Treatment for Alcohol Problems (NTA, 2006); Models of Care for Alcohol Misusers (DH, 2006); Alcohol Treatment Pathways: Guidance for Developing Local Integrated Care Pathways for Alcohol (NTA, 2006); Alcohol Harm Reduction Strategy for England (Prime Minister's Strategy Unit, 2004); Alcohol Misuse Interventions: Guidance on Developing a Local Programme of Improvement (DH, 2005); The Alcohol Needs Assessment Research Project (ANARP) (DH, 2005); Choosing Health: Making Healthy Choices Easier (DH, 2004).
Contact details	8th floor, Hercules House, Hercules Road, London SE1 7DU. Tel: 020 7261 8573. Fax: 020 7261 8883 Email: nta.enquiries@nta-nhs.org.uk Website: www.nta.nhs.uk
Gateway/ROCR approval	The NTA is a self-regulating agency in relation to Department of Health Gateway

The nature and purpose of this companion summary document

This summary document describes the chapter structure and gives a brief overview of the content of the extensive evidence-based expert review, the Review of the Effectiveness of Treatment for Alcohol Problems (NTA, 2006).

It is intended as a companion document. It sets out all of the conclusions of the review under the original chapter and section headings of the full report. The relevant codes (in Roman numerals) indicating the categories of evidence supporting each conclusion (summarised in table 1.1) are also maintained in this document.

While this companion provides ready access to all of the conclusions from the full review document, these are best fully understood by reference to the original chapters and sections, which have extensive and clear explanatory text for all of the conclusions.

It is anticipated that this companion document will assist in the discussion of the implications of the review and its conclusions for service delivery among a wide range of stakeholders. While the commissioners and providers of screening, assessment and care ought to be familiar with the full review, other stakeholders and partner organisations may find this companion document meets their needs.

Introductory section of the review

The introductory section introduces the authors, lists the content and gives information on the membership of the steering group for the project. In addition to the foreword by Baroness Massey of Darwen, chair of the National Treatment Agency for Substance Misuse, the authors identify ten key themes they consider a useful context within which to deliberate the detailed conclusions in later chapters.

Ten key themes

- Drinking takes place within a social context, which has a powerful influence on the amount and the patterns of drinking in the community. The effectiveness of prevention and control measures will modulate the total number of problem drinkers
- The majority of people, including dependent drinkers, move into and out of different patterns of drinking without recourse to professional treatment. Unassisted or natural recovery is often mediated through self-help, family and friends, and mutual aid groups
- Help-seeking is typically a consequence of experiencing prolonged alcohol-related problems and stress, notably related to health, relationships and finances, after attempts at unassisted behaviour change have failed
- Treatment effectiveness may be as much about how treatment is delivered as it is about what is delivered. With regard to the "what", the research evidence indicates that cognitive behavioural approaches to specialist treatment offer the best chances of success
- There is a choice of effective treatments to suit the variety of potential service users:
  - 7.1 million hazardous or harmful drinkers may benefit from brief interventions given by generic workers in almost any setting
  - 1.1 million dependent drinkers may benefit from more intensive treatment given by specialist workers
- Psychiatric co-morbidity is common among problem drinkers – up to ten per cent for severe mental illnesses, up to 50 per cent for personality disorders and up to 80 per cent for neurotic disorders. It is likely to make treatment more challenging and of longer duration
- Treatment for alcohol problems is cost-effective. Alcohol misuse has a high impact on health and social care systems, where major savings can be made. Drinking also places costs on the criminal justice system, especially with regard to public order. Overall, for every £1 spent on treatment, £5 is saved elsewhere
- Interventions of all kinds are only effective if delivered in accordance with their current descriptions of best practice and carried out by a competent practitioner. Assumptions drawn from the evidence are predicated on the availability of trained practitioners
- Stepped care is a rational approach to developing an integrated service model that makes best use of a finite resource. Stepped care can also be applied within an agency. The only proviso is that the steps,

which may involve a change of practitioner, are natural steps for service users

- The evidence base for the effectiveness of alcohol problems interventions is strong. The UK contribution is considerable and merits further financial support to research programmes.

Chapter 1: The review process

This chapter is the first of four scene-setters. It outlines the background to the review and how it fits with current alcohol policy. The chapter outlines the scope of the review and the rationale for the source material. It draws upon international work that is introduced and expanded in chapter three. It describes, in table 1, the categorisation of evidence used in the conclusions of the following chapters.

Chapter 2: Broadening the base of treatment and interventions

The second chapter sets out an overall perspective on treatment and interventions to reduce alcohol-related harm and considers ways in which the base of treatment for alcohol problems needs to be broadened from the traditional exclusive focus on "alcoholics".

Chapter 3: Recent evidence on treatment effectiveness

This third scene-setting chapter summarises the Mesa Grande project, which has been taken as the starting point of this section and three recent systemic reviews. Two large multi-centre trials of alcohol treatment, known as Project MATCH and UKATT, are also reviewed in depth.

Chapter 4: Delivering better treatment

This chapter is the last of the scene setters before the authors evaluate specific treatments and is the first where they estimate the strength of evidence. The issues considered are mainly about how to deliver treatment rather than what to deliver. The main topics covered are therapist characteristics, service user groups and settings in which to deliver services.

The therapist – conclusions

- Therapist characteristics account for around 10–50 per cent 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).

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.

Proposed 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.

Table 1a: Categories of evidence

Service user groups – conclusions

- 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 that benefit from ease of shared identity and the creation of a therapeutic alliance against generic services that offer greater choice and range of expertise (IV)
- Individuals from ethnic minorities tend to divide according to their degree of religious allegiance and there is a stronger case for novel ways of engaging ethnic minorities than for providing separate services (III)
- With the exception of women who have been abused, women do well with mainstream services provided co-morbidity needs are addressed (III).

The setting – conclusions

- The evidence base for determining the optimal treatment setting 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)
- There is a need to have residential treatment facilities for selected groups of service users (IIB).

Chapter 5: Screening for alcohol problems

Before reviewing treatments themselves, in this chapter the authors cover the topic of screening. They review commonly used screening tools, biological markers and clinical markers of alcohol misuse. Early detection is an essential element of broadening the base of treatment to detect problem drinkers before they become help-seekers.

Screening questionnaires – conclusions

- The AUDIT (Alcohol Use Disorders Identification Test) is a screening instrument of good sensitivity and specificity for detecting hazardous and harmful drinking among people not seeking treatment for alcohol problems (III)
- AUDIT is has been validated for use in a wide range of settings, populations and cultural groups and is in widespread use worldwide (II)
- AUDIT is superior to the MAST (Michigan Alcohol Screening Test) and CAGE (cut down, annoy, guilty, eye-opener) for the detection of hazardous and harmful drinking, although not necessarily in the detection of significant alcohol dependence (II)
- The AUDIT can be embedded in a general health questionnaire without loss of efficiency (III)
- The AUDIT should be considered as the screening instrument of first choice in community settings
- Shortened versions of the AUDIT can be used in very busy settings without undue loss of efficiency compared to the full AUDIT (III)
- The AUDIT-C (AUDIT – Consumption) is based on consumption items alone and is an efficient tool for the detection of hazardous drinking (II)
- The FAST (Fast Alcohol Screening Test) offers a rapid and efficient way of screening for hazardous and harmful alcohol consumption that can be used in a variety of settings (II).

Screening instruments in various settings – conclusions

Antenatal clinics

- Both the T-ACE (tolerance, annoyed, cut down, eye-opener) and TWEAK (tolerance, worried, eye-opener, amnesia, k(c)ut down) are superior screening instruments for detecting alcohol misuse among pregnant women than the MAST or CAGE (III)
- The TWEAK seems to be more sensitive but less specific than the T-ACE (III).

A&E departments

- The FAST is a rapid and efficient screening tool for detecting alcohol misuse in the A&E setting (III)
- The PAT (Paddington Alcohol Test) has been developed to fit with the demands of very busy A&E departments and is a quick and efficient screening tool in this setting (III).

Biological markers – conclusions

- Laboratory markers are less sensitive in the detection of alcohol misuse in community settings than screening questionnaires (I)
- Laboratory markers can be useful for confirming self-reports, for providing motivational feedback on health status and in the monitoring of progress following treatment, but should be considered only as possible adjuncts to questionnaires in the screening process (III).

Clinical indicators – conclusions

- Clinical history and physical examination can be used to detect harmful drinking and practitioners should be aware of such indicators (III)
- Reliance on informal methods of screening may miss the majority of hazardous drinkers without obvious signs of alcohol-related harm (III).

Chapter 6: Assessment

Assessment and measuring treatment outcomes

Following on from screening, this chapter looks at the evidence that should be included in a comprehensive assessment and also reviews commonly used assessment tools. Treatments are only of value if they deliver useful outcomes. This chapter explores some of the problems of measuring outcomes.

Assessment tools – conclusions

- There are many instruments with good psychometric properties that can be combined to construct an assessment package; packages should also be suitable for outcome ratings (see chapter 15) (I)
- The CIDI (Composite International Diagnostic Interview) provides a thorough but time-consuming assessment with satisfactory reliability and validity for diagnosing alcohol dependence according to ICD-10 or DSM-IV criteria (II)
- Quantity-frequency (Q-F) measures of alcohol consumption can be used when time is limited but they are likely to be inaccurate to varying degrees (III)
- Retrospective drinking diaries offer the most reliable method of recording alcohol consumption in routine clinical practice, particularly using time-line follow-back (II)
- Several reliable and valid instruments exist for the measurement of alcohol dependence and one of these should be used in assessment (II)
- The APQ (Alcohol Problems Questionnaire) is the instrument of choice for the measurement of alcohol-related problems in the UK (II)
- The RCQ (Readiness to Change Questionnaire) and RCQ (TV) (RCQ – Treatment Version) provide brief methods of assessing a service user's stage of readiness to change drinking behaviour with moderately good psychometric properties (II)
- A collection of instruments are available for use in conjunction with cognitive behavioural therapy (II).

Routine follow-up – conclusions

- Routine evaluation of treatment outcomes is feasible but requires follow-up staff and access to statistical advice (II)
- Reporting clinically significant change is a strict test of outcome, which gives a good indication of improvement meaningful at an individual level (II)
- There is a logic to undertaking follow-ups three months and 12 months after entering treatment and then again annually (IV).

Outcome measurement tools – conclusions

- The reliability and validity of assessment packages have not been independently examined (except one meta-analysis on the ASI) and so the evidence to support standard assessment packages is weak (IV)
- The CDP (Council for Dependency Problems) family of instruments provide a lengthy but clinically useful and thorough assessment of alcohol problems. The reliability and validity have not been independently examined (IV)
- The ASI (Addiction Severity Index) is a widely-used, comprehensive assessment tool but reliability and validity have come into question. MAP (Maudsley Addiction Profile) or RESULT (Routine Evaluation of Substance Misuse Ladder of Treatments) are alternatives but have not been independently examined (IV)
- Measures that will be useful for routine clinical use can often be taken from major clinical trials (IV)

- There is ample scope to mix different scales to create an agency preferred package drawing on commonly used instruments (IV).

Chapter 7: Brief interventions

This chapter is the first of four specifically about core psychosocial treatments for alcohol misuse. The chapter describes the use of brief interventions in different populations and settings and starts with some clarification of terminology.

Effectiveness of brief interventions in general – conclusions

- 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 interventions 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 interventions (IB)
- Brief interventions are effective in reducing alcohol-related problems among harmful drinkers (IIA), although more research would be useful
- There is some evidence that they are effective in reducing alcohol-related mortality, although more research is needed (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 moderately and severely dependent drinkers (IA) and such service users should be encouraged to attend specialist treatment services.

Brief interventions in primary healthcare – conclusions

- Opportunistic brief interventions delivered to hazardous and harmful drinkers in primary healthcare are effective in reducing alcohol consumption to low risk levels (IA)
- The public health impact of widespread implementation of brief interventions in primary healthcare is potentially very large (IB)
- NNT for alcohol brief interventions in primary healthcare is about eight and this compares favourably with advice to quit smoking (IA)
- Brief interventions in primary healthcare are equally effective among men and women (IA)
- Brief interventions in primary healthcare are effective among older adults (IB).

Brief interventions in the general hospital – conclusions

- Evidence for the effectiveness of brief interventions in the general hospital setting is inconclusive (IA)
- There is some evidence that excessive drinkers identified on general hospital wards who are not ready to change drinking behaviour do better with brief motivational interviewing than with brief skills-based counselling (IIA).

Brief interventions in A&E – conclusions

- Studies in both the UK and USA provide strong support for the effectiveness of brief interventions in A&E departments and linked services (IB)
- Brief interventions can reduce the workload of A&E departments (IB)
- Brief interventions may be especially useful in reducing alcohol-related harm among male patients and particularly among young men with alcohol-related injuries whom it may be difficult to recruit for intervention elsewhere (IB)
- There is some evidence that brief interventions in A&E services may reduce alcohol-related negative consequences without necessarily reducing overall levels of consumption (IB).

Brief interventions in other medical settings – conclusions

- There is some evidence that brief interventions are effective in producing short-term reductions in alcohol consumption among psychiatric patients with mid-range psychiatric disorders (IB)

- There is some evidence that brief interventions are effective in reducing the alcohol consumption of heavy drinking service users in needle exchange programmes (IB)
- There is no evidence as yet that brief interventions reduce alcohol consumption among pregnant women (IB)
- There is some evidence that brief interventions are effective among patients attending outpatient clinics for somatic disorders (IB)
- Scandinavian trials of intervention delivered as part of general population health screening programmes showed positive effects, though these interventions were more intensive than those normally considered "brief" (IB).

Brief interventions in educational establishments – conclusion

- Brief motivational interventions are effective in reducing levels of alcohol consumption and frequency of binge drinking among heavy-drinking college students (IB).

Brief interventions in other non-medical settings – conclusions

- Studies are needed of the effectiveness of brief interventions in social work settings (IV)
- Studies are needed of the effectiveness of brief interventions in various settings within the criminal justice system (IV)
- UK research is needed on the effectiveness of brief intervention in the workplace (IV).

Simple brief interventions – conclusion

- Simple brief interventions consisting of simple, structured advice are effective in reducing alcohol consumption and improving health status among hazardous and harmful drinkers encountered in healthcare settings (IB).

Extended brief interventions – conclusions

- There is mixed evidence on whether extended brief interventions in healthcare settings add anything to the effects of simple brief intervention, i.e., simple, structured advice (IA)
- The offer of extended brief intervention to some hazardous and harmful drinkers can be justified on pragmatic grounds (IA)
- There is some evidence that extended brief intervention is effective among male hazardous or harmful drinkers in the contemplation stage of change (IB).

Implementing brief interventions – conclusions

- Most healthcare professionals have yet to incorporate screening and brief interventions for hazardous and harmful drinking into 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 healthcare have been identified, including lack of time and lack of suitable reimbursement (I)
- Telemarketing appears to be the most cost-effective strategy for disseminating screening and brief intervention packages in primary healthcare (IB)
- Training and support can increase the implementation of screening and alcohol brief intervention in primary healthcare (IB)
- Training and support should be carefully adapted to meet the needs and attitudes of healthcare professionals (I)
- Research should focus on the effectiveness of brief interventions in real world conditions and on ways in which screening and intervention can be successfully implemented in healthcare settings (IV).

Chapter 8: Less intensive treatment

This chapter builds on the previous one by reviewing interventions that can still be considered brief but are clearly aimed at help-seekers and typically extend over a number of treatment sessions. These treatments are aimed at moderately dependent drinkers although in certain circumstances they can be offered to harmful drinkers.

A basic treatment scheme – conclusion

- A basic treatment scheme, consisting of three hours assessment and advice with male service users and their wives, is effective in reducing alcohol problems

among moderately-dependent, male alcohol misusers with intact marriages (IB).

Condensed cognitive-behavioural therapy – conclusion

- A condensed form of cognitive behavioural therapy (three sessions) is especially effective among female service users with a mild or moderate level of dependence (IB).

Brief conjoint therapy – conclusion

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

Motivational interviewing (MI) – conclusions

- The non-confrontational principles and style of 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 and its adaptations can be effective as a preparation for more intensive treatment of different kinds (IA)
- Standalone adaptations of MI are no more effective than other forms of psychosocial treatment but are usually less intensive and therefore potentially more cost-effective (IA).

Motivational enhancement therapy (MET) – conclusions

- MET is effective as a standalone specialist treatment for service users with moderate alcohol dependence provided the service user accepts a less-intensive treatment and there is an efficient follow-up system to check on progress (IB)
- For service users with severe dependence, and provided there are no sound reasons for immediately offering a more intensive form of treatment, MET should be considered as the first step in a stepped-care programme of care in specialist agencies (IA)
- MET seems especially effective for service users 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 (IB).

Training in motivational interviewing (MI) – conclusion

- 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-focused specialist treatment

This is the first of two chapters looking at the effectiveness of treatments most commonly used in specialist alcohol or addiction services. In this chapter, the authors consider the effectiveness of psychosocial treatments focused on the service user's drinking and alcohol-related problems. These treatments are mainly relevant to service users with moderate or severe alcohol dependence.

The community reinforcement approach (CRA) – conclusions

- The CRA is an effective treatment modality, particularly relevant to service users with severe alcohol dependence (IB)
- Supervised administration of disulfiram is an essential component of the full CRA (IB)
- The CRA has proved especially impressive with socially unstable and isolated service users with a poor prognosis for traditional forms of treatment, including those who have failed in treatment several times in the past (IB).

Social behaviour and network therapy (SBNT) – conclusion

- SBNT is an effective treatment for alcohol problems (IB).

Behavioural self-control training (BSCT) – conclusion

- BSCT is at present the most effective treatment modality available for service users considered suitable for a moderation goal (IA).

Behaviour contracting – conclusion

- Behaviour contracting is best thought of as a component of treatment rather than a standalone therapy (IV).

Coping and social skills training (CSST) – conclusions

- CSST is an effective treatment modality among moderately dependent alcohol misusers (IA)
- Specific treatment goals and methods can be tailored to the needs and preferences of the individual service user (IV)
- Social skills training may be especially beneficial to service users lacking social skills (IB)
- Service users with low psychiatric morbidity may benefit more from 12-Step facilitation therapy (see chapter 12) than CSST (IB)
- Service users high in anger may benefit more from motivational enhancement therapy (see chapter eight) than CSST (IB)
- Following detoxification, service users with severe dependence may benefit more from 12-Step facilitation therapy than from CSST (IB).

Cognitive behavioural marital therapy (CBMT) – conclusions

- CBMT is an effective treatment for service users with partners who, with the service user's agreement, are willing to be involved in the treatment process (IA)
- CBMT can be effective in reducing the service user's drinking problem and improving the interpersonal relationship (IA)
- CBMT seems to be superior to individual treatment among service users for whom it is suited and who agree to it (IB)
- Involving partners and families can make the initiation of treatment more likely and increase retention in treatment (IB)
- Service users with relatively intact relationships and moderate alcohol problems can benefit from a single session of behaviourally oriented conjoint therapy with their partners (IB).

Aversion therapy – conclusions

- Aversion therapy is not recommended for treatment practice (IV).

Cue exposure – conclusions

- CE shows promise as a treatment method, particularly when combined with coping skills or communication skills training and as part of a broader CBT programme (IB)
- There is insufficient evidence at present to justify the offer of CE as a standalone treatment (IV)
- There are no grounds for replacing behavioural self-control training by CE in moderation-oriented treatment (IB).

Relapse prevention (RP) – conclusions

- RP denotes a set of treatment principles and techniques that should be incorporated in all specialist treatments for alcohol problems in a variety of treatment settings (IV)
- There is good evidence for the effectiveness of the specific RP treatment programme first described by Marlatt and Gordon (1985) (IA)
- RP can improve psychosocial functioning in addition to alcohol problems (IA).

Aftercare – conclusions

- Planned and structured aftercare is effective in improving outcome following the initial treatment episode among service users with more severe alcohol problems (IB)
- Among various forms of aftercare described in the literature, there is no evidence as yet that any one is more effective than others (IB)
- Aftercare may not be effective with service users showing less severe problems owing to the good prognosis of such service users without aftercare (IB).

Extended case monitoring (ECM) – conclusions

- Findings of one trial are promising regarding the effectiveness and cost-effectiveness of ECM (IB).

Chapter 10: Non-alcohol focused specialist treatment

This chapter complements the previous one on specialist treatment. The authors explain that they thought it important, in principle, to make the distinction between treatments directly addressing alcohol problems and those having a less direct approach, although they note that in practice there is much overlap. The main topics covered are coping skills, counselling, family work, and complementary therapies.

Families and significant others – conclusions

- Families and friends benefit from involvement in treatment, whether or not it is alcohol focused (IB)
- The strongest evidence available supports the use of cognitive behavioural couple and family therapies (IB)
- Coping skills training for the spouse or partner of problem drinkers is effective (II)
- Family interventions require suitably trained staff but they can be delivered in a variety of settings, including primary care (IIB).

Social skills training – conclusions

- The effectiveness of social skills training may have been overestimated because early studies made comparisons against treatments that were less effective than now (III)
- Social skills training can be matched to need, whether this is very specific in individuals who otherwise function well or for individuals scoring high on sociopathy (III)
- Care planning for relapse prevention might be expected to include an assessment of social skills deficits (IV).

Counselling – conclusions

- Rogerian methods of counselling are less about specific therapies and more about how to deliver therapy, or to optimise therapist characteristics (IV)
- Client-centred therapy is effective but less so than a specific structured therapy that is equally well delivered (IB).

Self-esteem and complementary therapies – conclusions

- Self-esteem continues to hold interest as a concept of relevance to addictions but there are a lack of specific self-esteem therapies (IV)
- Complementary therapies are best thought of as having a general feelgood effect that helps to build the therapeutic alliance (IV).

Chapter 11: Detoxification and pharmacological enhancements to treatment

This chapter looks at pharmacotherapies and their interaction with the psychosocial interventions discussed in chapters 7–10. The pharmacotherapies are categorised as detoxification, relapse prevention and nutritional.

Detoxification – conclusions

- Chlordiazepoxide is the drug of choice for uncomplicated detoxification. Diazepam is an acceptable alternative (IB)
- Preparation is important to build service user confidence and maximise the benefits from each detoxification episode (III)
- Home detoxification, as compared to centre-based detoxification, is relatively expensive but in rural areas, at least, may be the best option (IV)
- Detoxification with complications, such as physical or mental illness, should be managed with guidance from an addiction specialist (III)
- Detoxification is usually straightforward but monitoring is important to pick up the approximate five per cent of service users who progress to experience complications (II)
- Post-detoxification is a time of heightened risk as well as opportunity (III).

Medications for relapse prevention – conclusions

Sensitising agents

- Disulfiram taken supervised is an effective component of relapse prevention strategies (IA)

- Service users who drink on top of disulfiram without causing a disulfiram-ethanol reaction should be offered 400mg, then 600mg and an alcohol challenge; there is a significant risk of toxicity at higher doses (III).

Anti-craving medications

- Both naltrexone and acamprosate show minor positive effects in relapse prevention when used in conjunction with psychosocial interventions (IA)
- Naltrexone is most clearly indicated to help individuals who have lapsed or "slipped" and acamprosate is best suited to supporting abstinence among those who fear craving will lead to a lapse (III)
- There is considerable variation in outcomes, suggesting trial methodologies or treatment delivery are an important influence on outcome (IA)
- There are too few studies to compare naltrexone against acamprosate.

Nutritional supplements – conclusions

- High dose parenteral thiamine is an effective treatment for Wernicke's encephalopathy (I)
- Consideration should be given, as a harm reduction measure, to prescribing vitamin supplements at any stage of change where nutritional deficiencies are likely (IV).

Chapter 12: Self-help and mutual aid

Having covered formal treatment methods in previous chapters, the authors turn to how alcohol misusers can help themselves to recover from their problems without the aid of formal treatment. The chapter is divided into separate sections on individual self-help and on collective mutual-aid.

Individual self-help – conclusions

- Self-help manuals based on cognitive behavioural principles are an effective and 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 a personalised and motivationally based type of intervention.

Computer and web-based self-help programmes – conclusions

- A computer-based form of behavioural self-control training is effective among alcohol misusers suitable for a moderation goal (IB)
- An internet-based assessment and brief intervention program has short-term beneficial effects among university students (IB)
- Further development and evaluation of internet-based programmes for alcohol misusers is needed (IV).

Collective mutual-aid – conclusions

- 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)
- Coercive referral to AA is ineffective (IA)
- Al-Anon and Alateen are effective in providing emotional support to families of AA members (IIB).

12-Step facilitation therapy (TSF) – conclusions

- TSF is an effective form of treatment for alcohol problems (IA)
- Based on research in the USA, TSF and referral to AA is best suited to:
  - Service users in outpatient treatment with low psychiatric severity
  - Service users in outpatient treatment with high social network support for drinking
  - Service users with high levels of alcohol dependence who have undergone detoxification (IA).
- To facilitate successful affiliation among service users referred to AA, treatment providers should familiarise

themselves with the philosophy, organisation and therapeutic methods of AA (IV).

12-Step residential treatment – conclusion

- 12-Step residential treatment confers no added benefit compared with other forms of treatment and is less cost-effective than outpatient treatment (IA).

Other mutual-aid groups – conclusions

- 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 members of Secular Organizations for Sobriety with serious alcohol problems show good outcomes, although this cannot be definitely attributed to the effects of the group (III)
- SMART Recovery (Self Management and Recovery Training) offers a scientifically based form of mutual aid, but its effectiveness has not been studied (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 mutual aid groups (IV)
- Research is needed on the effectiveness of non-12-Step mutual aid groups (IV).

Chapter 13: Psychiatric co-morbidity

The authors note that most of the interventions described in chapters 4–12 will be helpful to people with mental health problems, albeit they may need to be used in modified form. This chapter covers the prevalence of co-morbidity, its impact, some evidence on integrated treatment and a consideration of service models.

The validity of co-morbidity diagnoses – conclusions

- Broadly speaking, diagnostic systems are reliable for both Axis I and Axis II disorders when used correctly (IIA)
- Some diagnostic categories, notably personality disorders, are subject to greater variation than others (IIA)
- It should be expected that some symptom clusters will be artefacts of substance use and co-vary. Particular caution should be exercised with regard to diagnosing depression and anxiety (IIA)
- Validity depends on having staff skilled in diagnostics and using comparable diagnostic systems (III).

Estimates of the prevalence of co-morbidity – conclusions

- Co-morbidity is common among problem drinkers: up to ten per cent for severe mental illness, up to 50 per cent for personality disorder and up to 80 per cent for neurotic disorders (I)
- Both Axis I and Axis II disorders are commonly thought of as part and parcel of substance misuse, implying that service users are not given a diagnosis or adequate treatment (III)
- Co-morbidity is so common as to be the norm and it follows that practitioners in both mental health teams and addiction teams need to be competent at delivering integrated treatment (III).

The importance of co-morbidity – conclusions

- Co-morbidity is associated with high levels of use of health and social care services (IIA)
- Misuse of alcohol and other drugs exacerbates psychiatric symptomatology (IIA)
- Misuse of alcohol and other drugs is associated with poor compliance with mental illness treatment (IIA)
- Alcohol misuse is associated with high rates of completed suicide (IA)
- Severe and enduring mental illness requires specialist practitioners with competencies in psychiatric co-morbidity (IV).

Symptoms versus diagnoses of anxiety, depression and insomnia – conclusions

- Prescribing of antidepressants and anxiolytics is generally not indicated during periods of drinking or withdrawal – ideally reassess after two weeks abstinence (IIA)
- Judicious and short-term use of hypnotics may be helpful where insomnia is identified as a cue for continued drinking (IIA)

- Neurotic disorders such as depression, anxiety spectrum disorders and obsessive compulsive disorders may emerge post-detoxification (IIA)
- The evidence is insufficient to guide specific treatment plans for co-morbidity of neurotic disorders. Optimal use of treatments is best defined by experienced clinicians (III).

The concept of personality disorder – conclusions

- Personality disorder is a diagnosis of inclusion, albeit with risks of misdiagnosis, that points to treatment (I)
- Personality disorder is a diagnosis of inclusion requiring specialist practitioners with competencies in psychiatric co-morbidity (IV)
- Pharmacotherapy has a limited place in treatment, whereas there is evidence to support the use of structured psychotherapies (III).

Integrated treatment for co-morbidity – conclusions

- Cognitive behavioural techniques offer a flexible approach for the treatment of co-morbidity, including both Axis I and Axis II disorders (II)
- Involvement of social support systems, particularly family and friends, is important for people with co-morbidity problems (II)
- Pharmacotherapies designed to reduce craving and drinking can be used safely with individuals suffering from a psychotic illness, albeit that due caution must be exercised (III)
- People with mental illness require specialist practitioners with competencies in psychiatric co-morbidity (IV).

Service models – conclusions

- There is insufficient evidence to support any particular service model; however, there is theoretical and anecdotal evidence to favour either an integrated or shared care approach (IV)
- There is a need to configure services and construct care pathways in such a way that people with co-morbidity are not excluded from treatment and are not moved from one agency to another (III).

Chapter 14: Cost-effectiveness of treatment

The previous chapters have considered the effectiveness of treatment without regard to economic costs and benefits. In this chapter, the authors turn to the crucial question of the cost-effectiveness of treatment and its relevance to the provision of treatment for alcohol problems in England.

Economic benefits of alcohol treatment – conclusions

- Evidence-based alcohol treatment in the UK could result in net savings of £5 for every £1 spent for the public sector (IB)
- Providing effective treatment is likely to reduce significantly the social costs relating to alcohol as well as increase individual social welfare (IB)
- Healthcare costs may increase in the short term for drinkers who have not accessed healthcare services prior to alcohol treatment (II).

Cost-effectiveness of brief interventions – conclusions

- Brief interventions delivered opportunistically are cost-effective compared to no interventions (IIA)
- Brief interventions in a hospital setting may be cost neutral but achieve health gains for the population (IIB).

Intensive treatments in different settings – conclusions

- Outpatient care is more cost-effective than residential or inpatient care, although inpatient or residential facilities are still required for some service users (IB)
- Time-limiting residential programmes can result in a more cost-effective intervention (II).

Psychosocial treatments – conclusions

- Psychosocial interventions can be delivered at a reasonable cost, will have wider social cost savings and achieve reductions in drinking and alcohol problems (IB)
- Savings for the public sector are comparable to treatment for problem drug users (III)

- Problem drinkers have low health-related quality of life compared to others of the same age (I).

Pharmacotherapies – conclusion

- Phamacotherapies can reduce longer-term health costs of problem drinkers (IIA).

Comparisons of psychosocial and pharmacotherapies – conclusions

- Evidence from the literature can be combined with local cost data to model cost-effectiveness and demonstrate the value of evidence-based approaches (II)
- Alcohol treatments are highly cost-effective in comparison with other healthcare interventions (IB).

Chapter 15: The treatment journey in context

The authors summarise this chapter as follows: "Many individuals move out of problem drinking without the assistance of formal treatment, but rather by responding to support and direction from family and friends or responding to self appraisal of the problem drinking. People with the more severe problems are more likely to act to achieve stable abstinence, which confers long-term benefits, compared to those moving in and out of problem drinking episodes. Public health and preventive measures act as modulators of alcohol consumption which, taken with local cultures, determine the overall prevalence of problem drinking."

To summarise, there are many influences on an individual's drinking and treatment is one of them. Directly or indirectly, treatment probably accounts for around one-third of all improvements made.

National Treatment Agency for Substance Misuse
8th floor, Hercules House, Hercules Road, London SE1 7DU
Tel 020 7261 8573
Fax 020 7261 8883
Email: nta.enquiries@nta-nhs.org.uk
Website: www.nta.nhs.uk

Publications
All NTA publications can be downloaded from www.nta.nhs.uk. To order additional copies of this report, complete the online order form at www.nta.nhs.uk. Alternatively, email nta@prolog.uk.com or telephone 08701 555 455 and quote product code ALCOHOL3