Prevention of relapse in alcohol dependence; HTA Advice 3: Prevention of relapse in alcohol dependence; Understanding HTBS Advice: Prevention of relapse in alcohol dependance

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Record Status
This is a bibliographic record of a published health technology assessment from a member of INAHTA. No evaluation of the quality of this assessment has been made for the HTA database.

Citation

Authors' objectives
The objectives of this health technology assessment were to answer the following questions:

1. Which treatment or combination of treatments (pharmacological and psychosocial) will yield the maximum maintenance of recovery amongst the population of those with alcohol dependence who have undergone detoxification?

2. What is the most effective and efficient approach to delivering the individual interventions (or combination of interventions) taking into account the different risk groups, locations, durations of treatment, etc?

Authors' conclusions
1. The following treatments are recommended because they are clinically effective and cost-effective: Coping Skills; Behavioural Self Control Training; Motivational Interviewing; Marital/Family Therapy. Suitably trained and competent professionals should administer them using standardized protocols.

2. Other therapies are less effective and are not recommended. In particular, Brief Interventions are not effective for people with established alcohol dependence. The Classical Relapse Prevention model of treatment is also unproven.

3. Specialist services must make themselves aware of non-NHS agencies (such as Councils on Alcohol and Alcoholics Anonymous) operating in their area and co-ordinate their approach, making this information available to individuals within their care. Informing people about these agencies should be part of the overall relapse prevention strategy.

4. Disulfiram (given under supervision) and acamprosate are recommended as options for treatment in addition to talking therapies. Acamprosate is the most cost effective. As these medicines work differently and have different side effects the choice of treatment should be considered carefully on an individual patient basis.

5. Naltrexone is not recommended because it does not have Marketing Authorisation in the UK for this use and is not as cost effective as acamprosate.

6. Specialist unit protocols should be available for all treatment options to ensure standardised and consistent treatment. Clear patient information leaflets should be available for each intervention.

7. Patients value group and one-to-one therapies. Certain people - such as young people, the homeless and those with other mental health problems - have special service needs and providers should ensure services are responsive and accessible to all.

8. Collection of longer-term audit data, evaluating patient outcome and resource consequences of alcohol relapse, in various Scottish settings, is needed to refine further these recommendations. Additionally, better information on the number of people in Scotland who are alcohol dependent and who would benefit from such services, and the availability
of resources to meet these demands, is needed.

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INAHTA brief and checklist

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