14.6 British trial bolsters case for investing in well-supervised alcohol treatment

Findings In a major British trial, an alcohol dependence therapy designed to improve on short motivational approaches did not result in greater benefits for the patients or cost savings for society, though both therapies were followed by substantial gains on both fronts.

The UK Alcohol Treatment Trial (UKATT) recruited 742 alcohol-dependent patients seeking treatment at seven substance misuse treatment services in England and Wales. They were randomly allocated to either three sessions of motivational enhancement therapy or eight of social behaviour and network therapy, each spread over eight to 12 weeks. The former was a familiar elaboration of motivational interviewing, the latter, a novel therapy integrating elements from other approaches and focused on building social networks supportive of positive change in the patient's drinking.

Twelve months after therapy started, 85% of the surviving participants (12 had died) were re-interviewed. Across both therapies, alcohol consumption over the past three months had fallen by 45%, mainly due to an increase in non-drinking days from about 30% to 46% ◤ study ❶. On each drinking day patients were drinking less but on average still very heavily. There had also been significant improvements in the severity of alcohol dependence, alcohol-related problems, and mental health symptoms.

Including training, as expected the longer therapy cost significantly more – £221 per patient compared to £129 ◤ study ❷. However, it also saved more in public sector resources, meaning that the net savings (though about £200 greater for social behaviour and network therapy) were not significantly different. When these savings were related to improvements in the patients' quality of life, neither therapy was definitely more cost-effective than the other.

This analysis was based on health (including further alcohol treatment), social care and criminal justice costs. In the last six months of the follow-up period these costs were much lower than in the six months before treatment. For each therapy, savings were roughly five times greater than the cost of the therapy. Most of the savings accrued to health and alcohol treatment services which 'saved' over twice the cost of the therapies.

In context The two therapies were broadly equivalent in reducing patients' alcohol problems, in how cost effectively they improved their quality of life, and in net savings in health, social and criminal justice costs. From conference presentations, it also seems that no type of patient did significantly better in one therapy than in the other, and that about 4 in 10 had clinically relevant remission in their drinking and no longer recorded elevated levels of dependence – essentially, were no longer dependent drinkers.

While in the trial to date the two therapies seem equivalent, this might not be the case in other circumstances or on a longer time scale. Instead of the intended difference between them of five sessions, in practice the difference averaged just two. The combined effects of patient-initiated pre-therapy drinking reductions, the assessments and help received before the UKATT therapies (including detoxification), the pharmacological treatments opted for by a substantial minority of patients, and of the extra treatment many sought and received, may have overwhelmed differences in the effectiveness of the therapies as actually delivered. Though the study kept exclusions to a minimum, an estimated 70% of clinic callers who might have joined the study did not do so, mainly because they refused consent. Among them may have been the types of clients who would have differentially benefited from the therapies. Also, as in other studies of similar therapies, a longer follow-up may reveal that social behaviour and network therapy was more able to sustain initial improvements.

Overall effectiveness too might differ in normal practice. Most patients seeking treatment did not enter the trial and it cannot be assumed that they would have benefited to the same degree. One of achievements of the trial is to demonstrate a training and supervision regime to which services can aspire which enthused and skilled through its training and continued to coach pre-selected therapists based on video recordings of sessions, probably elevating their performance above the norm.

The apparent good news in the study is that both therapies seemed effective and were followed by public sector cost savings. But how big these were, how far they were due to the UKATT therapies rather than the other elements of the treatment package, and whether they would have occurred even without treatment, cannot be determined. The headline '£5 savings for £1 spent on treatment' ratio assumes that the UKATT therapies were the sole cause of the savings rather than preparatory, concurrent and subsequent treatment, and the lack of economic data for the first six months after treatment entry is a major gap. While the study is well set up to compare the two treatments, its design does not adequately support estimates of absolute costs and savings. However, studies in other countries using different methodologies have also found treatment leads to net cost savings.

Relevant to the comparison between the two therapies, the US Project MATCH study found that motivational therapy (the programme used as the basis for the UKATT version) was not only cheaper than the alternatives but also led to lower post-treatment medical costs, making it the least costly option without any loss in overall effectiveness. The cost advantage of motivational therapy was concentrated among patients with a better initial prognosis in terms of either relatively low dependence, less severe psychiatric symptoms or a less pro-drinking social network. For patients with very severe psychiatric disturbance and/or a pro-drinking social circle, cognitive-behavioural therapy incurred the least costs.

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Equivalence of outcomes from a short and longer therapy raise the possibility that an even briefer therapies might also have been just as effective. In UKATT the motivational therapy was scheduled for three sessions, in Project MATCH, four. Some studies have found briefer (eg, one session) therapies as effective as longer or more intensive options, but these have generally excluded the most severely dependent and problematic drinkers, the clients most likely to benefit from extended treatment. A different way to compare alcohol treatments is to rank them in order of the solidity of the evidence for their effectiveness. One such ranking found that when studies are weighted to reflect the strength of the comparison treatment (which will also tend to emphasise studies of more severely dependent patients), more extended, behaviourally oriented therapies rank above brief approaches.

Practice implications For the UKATT research team, their findings imply that alcohol treatment commissioners can confidently invest in either of their two therapies providing similar training and supervision is part of the package. This study and others highlight the importance of insisting on and being prepared to fund not just initial training, but continued coaching incorporating feedback to therapists based on actual practice sessions. In the process, funders may reap cost savings for the broader public sector and in particular for the health service. However, assessing alcohol treatment primarily on this basis is as perverse as asking whether cancer treatment saves money – its role is to extend and improve the quality of life through the expenditure of public resources, not to save those resources.

Within the limits of problem severity tapped by the relevant studies, brief motivational approaches have the greatest backing as a safe and cost-effective starting point for one-to-one psychosocial therapy. More intensive therapies are still required for non-responders and for more problematic and dependent drinkers, and with these groups may save more in subsequent health care costs. Whatever their type, such therapies are not sufficient in themselves to constitute a treatment package. Neither in MATCH nor in UKATT were they the sole treatment ingredient. Many patients require and benefit from prior detoxification, self-help groups and pharmacotherapy, and many also need practical support and medical and psychiatric care.

Featured studies ❶ UKATT Research Team. "Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT)." *British Medical Journal*: 2005, 331 ❷ UKATT Research Team. "Cost effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT)." *British Medical Journal*: 2005, 331. Download both from www.bmj.com.

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