

1. Health Economics studies for alcohol dependence and harmful alcohol use

1.1. Pharmacology

Study, year and country	Intervention details	Study population Setting Study design – data source	Study Type	Costs: description and values Outcomes: description and values	Results: Cost-effectiveness	Comments Internal validity (Yes/No/NA) Industry support
Annemans, 2000  Belgium	<u>Comparators:</u> Acamprosate  Versus  No pharmaceutical treatment	Population: weaned alcoholic patients  Setting: GP and specialist care  Source of clinical effectiveness data: Relapse rates: placebo-controlled prospective trial(n=448)Whitworth et al.1996;  Type of relapse & second line management: NEAT study unpublished data n=582 dependent patients,  Source of resource use estimates & costs: Belgian NEAT study[unpublished] and a cross-sectional study among GPs from the Belgian institute of Hygiene and Epidemiology (IHE)	Cost-Analysis – based on Markov model	<u>Costs:</u> Direct medical costs including hospital and ambulatory costs i.e. GP, psychiatry and psychologist/psychotherapy consultations, biochemistry tests and drug costs.  <u>Outcomes:</u> % patients remaining abstinent, preventing relapse  After 360 days on acamprosate= 18.3% After 360 days on placebo= 7.10%  After 720 days on acamprosate= 11.9% After 720 days on placebo= 4.9% Whitworth et al.1996	The total expected costs for the acamprosate strategy was equal to 211 986 BEF (5,255 Euros) over the period of 24 months, compared to 233 287 BEF (5783 Euro) for ‘no acamprosate’. It also results in reduction in relapses or a higher percentage of patients who remain abstinent. Therefore acamprosate dominates as it is cheaper and more effective.  Simple sensitivity analysis showed that the results were robust.	Perspective: Institute for Health Insurance Currency: Belgian Francs and Euros Cost year: 1997 Time horizon: 24 months Discounting: No Funded by : Unclear
Zarkin, 2008  USA	<u>Comparators:</u> 1) medical management(MM)+ placebo 2) MM+naltrexone 100mg/ day for	Population: patients with diagnosis of primary alcohol dependence(DSM-IV)  Setting: 11 US study sites	Cost effectiveness analysis	<u>Costs:</u> Direct medical costs  <u>Outcomes:</u> Incremental cost per percentage point increase in percentage of days abstinent, incremental cost per patient of avoiding	See attached table 2.  On the basis of the mean values of cost and effectiveness, 3 interventions were shown to be cost-effective options relative to the other interventions for all 3	Perspective: service provider Currency: US dollar Cost year: 2007 Time horizon: 16 weeks Discounting: NA Funded by : NIAAA

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	<p>16 weeks 3) MM+ Acamprosate 3g/day 4)MM+ placebo + combined behavioural intervention (CBI) 5) MM+ Acamprosate+naltrexone 6) MM+ naltrexone+CBI 7) MM+ acamprosate +CBI 8) MM+ naltrexone+acamprosate+CBI 9) CBI only</p>	<p>Source of clinical effectiveness data: COMBINE RCT n=1383</p> <p>Source of resource use estimates: COMBINE study data</p> <p>Source of unit costs: Federal supply schedule, co-ordinating centre data management system, 2005-Resource-Based Relative Value scale</p>		<p>heavy drinking, incremental cost per patient of achieving a good clinical outcome</p>	<p>outcomes: medical management (MM) with placebo (\$409 per patient), MM plus naltrexone therapy (\$671 per patient), and MM plus combined naltrexone and acamprosate therapy (\$1003 per patient).</p> <p>Author's conclusion: MM-naltrexone + acamprosate therapy may be a better choice, depending on whether the cost of the incremental increase in effectiveness is justified by the decision maker.</p>	
Slattery, 2003  Scotland	<p><u>Comparators:</u> Acamprosate (12 months)  Compared to  Placebo</p>	<p>Population: 45 yr old men and women who are alcohol dependent</p> <p>Setting: primary and secondary care (inpatient costs incl. in sensitivity analysis)</p> <p>Source of clinical effectiveness data: reported RCTs</p> <p>Source of resource use estimates: estimated from patient pathways provided by Alcohol and Drug Directorate South &amp; West</p> <p>Source of unit costs: Scottish health services costs and BNF</p>	<p>Cost effectiveness analysis based on adapted Schadlich and Brecht model (1998)</p>	<p><u>Costs:</u> drugs, GP, CPN and specialist consultations. Service user travel time.</p> <p>Costs of 7 disease endpoints also included: stroke, cancer, cirrhosis, alcoholic psychosis, chronic pancreatitis, Epilepsy and alcohol dependence syndrome</p> <p><u>Outcomes:</u> number of patients who have abstained or controlled drinking</p>	<p>Total intervention costs: £ 385 337</p> <p>Additional patients abstinent from standard: 84</p> <p>Cost per additional abstinent patient: £-822 (negative costs are cost saving)</p>	<p>Perspective: NHSScotland and patient Currency: UK Pound Cost year: 2002 Time horizon: 20 years Discounting: 6% per annum Funded by : HTBS</p>
Slattery, 2003	<p><u>Comparators:</u></p>	<p>Population: 45 yr old men and women who are</p>	<p>Cost effectiveness</p>	<p><u>Costs:</u> costs of drugs, laboratory tests, Medicals, key worker visits, GP</p>	<p>Total intervention costs: £ 380 526</p>	<p>Perspective: NHSScotland and patient</p>

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Scotland	Oral Disulfiram (6 months) vs. Placebo	<p>alcohol dependent</p> <p>Setting: primary and secondary care (inpatient costs incl. in sensitivity analysis)</p> <p>Source of clinical effectiveness data: reported RCTs of unsupervised treatment</p> <p>Source of resource use estimates: estimated from patient pathways provided by Alcohol and Drug Directorate South &amp; West</p> <p>Source of unit costs: Scottish health services costs and BNF</p>	analysis based on adapted Schadlich and Brecht model	<p>consultations and visits to Alcohol Problems treatment Unit. Service user travel time.</p> <p>Costs of 7 disease endpoints also included: stroke, cancer, cirrhosis, alcoholic psychosis, chronic pancreatitis, Epilepsy and alcohol dependence syndrome</p> <p><u>Outcomes:</u> number of patients who have abstained or controlled drinking</p>	<p>Additional patients abstinent from standard: 55</p> <p>Cost per additional abstinent patient: £1 521 (negative costs are cost saving)</p> <p>univariate sensitivity analysis revealed that effectiveness parameters had greatest impact on results. Higher disease costs increases the cost effectiveness per additional abstinent patient</p>	<p>Currency: UK Pound</p> <p>Cost year: 2002</p> <p>Time horizon: 20 years</p> <p>Discounting: 6% per annum</p> <p>Funded by : HTBS</p>
Slattery, 2003 Scotland	<p><u>Comparators:</u></p> <p>Naltrexone (6 months) Compared to Placebo</p>	<p>Population: 45 yr old men and women who are alcohol dependent</p> <p>Setting: primary and secondary care (inpatient costs incl. in sensitivity analysis)</p> <p>Source of clinical effectiveness data: reported RCTs</p> <p>Source of resource use estimates: estimated from patient pathways provided by Alcohol and Drug Directorate South &amp; West</p> <p>Source of unit costs: Scottish health services</p>	Cost effectiveness analysis based on adapted Schadlich and Brecht model	<p><u>Costs:</u> costs of drugs, key worker visits, GP and specialist consultations. Service user travel time.</p> <p>Costs of 7 disease endpoints also included: stroke, cancer, cirrhosis, alcoholic psychosis, chronic pancreatitis, Epilepsy and alcohol dependence syndrome</p> <p>Total intervention costs: £ 357 709</p> <p><u>Outcomes:</u> number of patients who have abstained or controlled drinking</p>	<p>A Total intervention costs: £ 357 709</p> <p>Additional patients abstinent from standard: 38</p> <p>Cost per additional abstinent patient: £4056 (negative costs are cost saving)</p> <p>univariate sensitivity analysis revealed that effectiveness parameters had greatest impact on results. Higher disease costs increases the cost effectiveness per additional abstinent patient</p>	<p>Perspective: NHSScotland and patient</p> <p>Currency: UK Pound</p> <p>Cost year: 2002</p> <p>Time horizon: 20 years</p> <p>Discounting: 6% per annum</p> <p>Funded by : HTBS</p>

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		costs and BNF				
Schadlich, 1998  Germany	<u>Comparators:</u> Acamprosate  Placebo  +Standard care (routine counselling/ psychotherapy) in both	Population: Alcohol dependent patients who were abstinent for a min of 14 days and max of 28 days  Setting: Psychiatric outpatient clinics  Source of clinical effectiveness data: PRAMA study, secondary analysis of epidemiological data and official statistics, expert knowledge  Source of resource use estimates: retrospective analysis of hospital records, expert knowledge  Source of unit costs: statistics form National Association of Local Sickness Funds, \federal Statistical Office, Federal Association of Pension Funds	Cost effectiveness analysis	<u>Costs:</u> Direct medical costs  Treatment costs in Acamprosate arm= DM 7 333 131 and DM10 090 681 in the standard care group  <u>Outcomes:</u> proportion of abstinent alcoholics at the end of the medication-free follow-up period: 39.9% in the acamprosate group 17.3% in the placebo group  226 additional patients abstained form alcohol consumption in acamprosate group	Treatment costs were lower in the intervention arm compared to the placebo arm. 226 patients had abstained form alcohol consumption in the acamprosate arm. The cost effectiveness ratio of acamprosate was DM -2602. Acamprosate was the dominant treatment.  Acamprosate dominated standard care.  Base case results were robust to sensitivity analysis.	Perspective: German Healthcare system Currency: German DeutschMarks Cost year: 1995 Time horizon: 48 weeks and 48 weeks follow up Discounting: 5% annually Funded by : Lipha Arzneimittel
Rychlik, 2003  Germany	<u>Comparators:</u> Acamprosate  Standard care  All had some form of psychosocial rehabilitation programme	Population: patients who contacted their physicians and fulfilled DSM-IV criteria for alcohol dependence-prescribed detox and rehab  Setting: primary care centres that included GP and specialist care  Source of clinical effectiveness data: open label non-randomised cohort study n=814	Cost-effectiveness analysis	<u>Costs:</u> Direct medical costs incl. all physician visits, emergency treatments, diagnostic tests, lab tests, drugs, non-medical treatments, nursing, hospitalisation, cures and treatment of undesirable effects and side effects.  Costs in standard care arm 26% higher than Acamprosate arm  For the PPA population, abstinence rates after one year of treatment were significantly higher in the acamprosate cohort than in the standard care cohort (33.6 % and 21.1 % respectively, p < 0.001;	Acamprosate shown to dominate standard care as it is cheaper and more effective.	Perspective: Health insurance/social perspective Currency: Euro Cost year: not explicit, possibly 1998/1999 Time horizon: 12 months Discounting: NA Funded by : Merck KGaA

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		Source of resource use estimates& unit costs: collected alongside study & German outpatient standardised evaluation scale, and sums reimbursed by German health insurance		Wilcoxon test).  <u>Outcomes:</u> Abstinence rate over 12 month period  After 1 yr: 32.4% in Acamprosate cohort;20.4% in usual care cohort The total direct costs in the intervention group were € 1225 (ITT) and €1254 (PPA). The total direct comparator costs were € 1543 (ITT) and € 1592 (PPA).		
Palmer, 2000 Germany	<u>Comparators:</u> acamprosate as adjuvant therapy + standard counselling therapy  versus  standard counselling therapy alone	Population: detoxified alcoholic male patients (ave. age of 41). 80% with fatty liver, 15% with cirrhosis, 22% with pancreatitis, and 1% with alcoholic cardiomyopathy.  Setting: not reported  Source of clinical effectiveness data: Published literature + assumptions  Source of resource use estimates: published studies  Source of unit costs: German sources	Cost-effectiveness analysis Markov model	<u>Costs:</u> Direct medical costs incl. hospitalisations, rehabilitation costs, drug acquisition costs and psychosocial support  The cost of 48 weeks of acamprosate therapy was DM 2,177.  The discounted (and undiscounted) lifetime costs were DM 48,245 (DM 75,081) with adjuvant therapy and DM 49,907 (DM 76,942) with standard therapy.  <u>Outcomes:</u> number of life-years gained  The life expectancy from age 41 years increased from 14.60 to 15.90 years with adjuvant acamprosate over standard therapy. The resulting incremental, discounted life-years gained of adjuvant acamprosate over standard therapy were 0.52 (1.20 when undiscounted).	Adjuvant acamprosate therapy was shown to be the dominant strategy, as it was more effective and cheaper than standard therapy.	Perspective: Health insurance perspective Currency: German DeutschMarks (DEM) Cost year: 1996 Time horizon: Lifetime Discounting: 5% per annum Funded by : Lipha SA

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Study, year and country	Intervention details	Study population Setting Study design - data source	Study Type	Costs: description and values Outcomes: description and values	Results: Cost-effectiveness	Comments Internal validity (Yes/No/NA) Industry support
Parrot, 2006  UK	<p><u>Comparators:</u> A detoxification service carried out at the Smithfield Centre in Manchester: open 24 hours a day*365 days. The 10-day detoxification service comprised a 22-bed facility staffed by mental health nurses with 24-hour support from a local GP.</p> <p>Versus  No treatment</p>	<p>Population: people dependent on alcohol requiring detoxification</p> <p>Setting: inpatient and outpatient clinics in NHS</p> <p>Source of clinical effectiveness data: single study</p> <p>Source of resource use estimates: costing was carried out on a sub-group of patients included in the effectiveness study</p> <p>Source of unit costs: Personal Social Service Research Unit, Home Office, HM Treasury and some published studies</p>	Cost-utility analysis and cost-effectiveness analysis.	<p><u>Costs:</u> Direct medical costs (also costs to criminal justice system and public/ social services)</p> <p><u>Outcomes:</u> QALYs in the cost-utility analysis, QALYs were calculated using the EQ-5D scores obtained by questionnaires given to the individuals who participated in the study.</p> <p>Unit of drink reduction per day or reduction in percentage of drinking days in the cost-effectiveness analysis.</p>	<p>In the cost-effectiveness analysis, the cost per unit reduction in alcohol was 1.87 in the Smithfield sample.</p> <p>The cost for a reduction of one drink per day was 92.75 at the Smithfield Centre.</p> <p>The cost per percentage point reduction in drinking was 30.71 at the Smithfield Centre.</p> <p>The cost per QALY gained was 65,454 (33,727 when considering only treatment costs) at the Smithfield Centre.</p> <p>No sensitivity analysis.</p>	<p>Perspective: Societal perspective Currency: UK pounds Cost year: 2003-04 Time horizon: 6 months Discounting: NA Funded by : None stated</p>
Pettinati et al. 1999 USA	<p><u>Comparators:</u> Inpatients vs. outpatient addiction treatment services - both services followed multimodal clinical approach based on 12-step programme of AA</p>	<p>Population: People with a DSM-III-R diagnosis of alcohol dependence and not dependent on any other substance</p> <p>Setting: Single US private, non-profit psychiatric hospital</p> <p>Source of clinical effectiveness data: Single study</p> <p>Source of resource use and unit cost estimates: Single study- weighted, cost-to-charge corrections applied</p>	Cost-effectiveness analysis	<p><u>Costs:</u> Direct treatment costs - educational and therapy sessions, AA support group attendances, family educational programmes</p> <p><u>Outcomes:</u> Probability of returning to significant drinking (3 or more alcoholic drinks in a sitting)</p>	<p>Average costs of successfully completing treatment: Inpatient: \$9,014 (SD \$2,986) Outpatient: \$1,420 (SD \$619)</p> <p>Cost-effectiveness ratio was calculated by dividing treatment costs by the probability of returning to significant drinking. For treatment responders, the inpatient:outpatient cost-effectiveness ratio was calculated for the 3-</p>	<p>Perspective: US health care provider Current: US \$ Cost year: Not reported Time horizon: 12 months Discounting: NA Funded by: National Institute on Alcohol Abuse and Alcoholism (US)</p>

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		to insurance billing charges			<p>month follow-up at 4.5:1, at the 6-month follow-up at 5.3:1, and at the 12-month follow-up at 5.6:1.</p> <p>No synthesis with clinical outcomes performed by authors.</p>	
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## Alcohol Use Disorders: Health economic evidence tables

### 2.1. Assessment & Service Delivery

Study, year and country	Intervention details	Study population Setting Study design - data source	Study Type	Costs: description and values Outcomes: description and values	Results: Cost-effectiveness	Comments Internal validity (Yes/No/NA) Industry support
Drummond et al., 2009  UK	<u>Comparators:</u> Stepped care – sequential series of interventions according to need and response after each successive step.  Minimal intervention - 5-min directive advice session	Population: Males aged 18+ with ICD-10 diagnosis of alcohol use disorder  Setting: Primary care  Source of clinical effectiveness data: single study  Source of resource use estimates: Study participants with 6-month follow-up data only  Source of unit costs: Personal Social Service Research Unit, Home Office and other published studies	Cost-utility analysis	<u>Costs:</u> interventions and training, other health care, social care, criminal justice services  <u>Outcomes:</u> QALYs - calculated using EQ-5D utility scores obtained from questionnaires completed by study participants	Intervention: Mean total costs were £5,692 at baseline and £2,534 at 6 months Mean QALY gain of 0.3849  Control: Mean total costs were £6,851 at baseline and £12,637 at 6 months Mean QALY gain of 0.3876  Probability of intervention being cost-effective at UK £20-30,000 threshold: 98%	Perspective: Societal perspective Currency: UK pounds Cost year: 2001 Time horizon: 6 months Discounting: NA Funded by : Wales Office for Research and Development
Parrott, 2006  UK	<u>Comparators:</u> A partial hospitalisation programme that was performed at Plummer Court, a NHS facility. Patients underwent 3-day inpatient detoxification, if required, followed by attendance at a day programme at the Newcastle	Population: people dependent on alcohol requiring detoxification  Setting: inpatient and outpatient clinics in NHS  Source of clinical effectiveness data: single study  Source of resource use estimates: costing was carried out on a sub-group of patients included in the	Cost-utility analysis and cost-effectiveness analysis.	<u>Costs:</u> Direct medical costs (also costs to criminal justice system and public/ social services)  <u>Outcomes:</u> QALYs in the cost-utility analysis, QALYs were calculated using the EQ-5D scores obtained by questionnaires given to the individuals who participated in the study.  Unit of drink reduction per day or reduction in percentage of drinking days in the cost-effectiveness analysis.	In the cost-effectiveness analysis, the cost per unit reduction in alcohol was 1.66 among patients admitted to Plummer Court.  The cost for a reduction of one drink per day was 22.56 at Plummer Court.  The cost per percentage point reduction in drinking was 45.06 at Plummer Court.  The cost per QALY gained	Perspective: Societal perspective Currency: UK pounds Cost year: 2003-04 Time horizon: 6 months Discounting: NA Funded by : none stated

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	service.  versus  No treatment	effectiveness study  Source of unit costs: Personal Social Service Research Unit, Home Office, HM Treasury and some published studies			was and 131,750 (90,375 when considering only treatment costs) at Plummer Court.	
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### 3.1. Psychology

Study, year and country	Intervention details	Study population Setting Study design – data source	Study Type	Costs: description and values Outcomes: description and values	Results: Cost-effectiveness	Comments Internal validity (Yes/No/NA) Industry support
Slattery, 2003  Scotland	<u>Comparators:</u>  Coping/Social skills training  Versus  Control intervention	Population: 45 yr old men and women who are alcohol dependent  Setting: primary and secondary care  Source of clinical effectiveness data: reported RCTs  Source of resource use estimates: Expert opinion, Annis et al. 19996  Source of unit costs: Scottish health services costs 2000/01	Cost effectiveness analysis based on adapted Schadlich and Brecht model	<u>Costs:</u> A cost per attendee was calculated based on the staff requirements, accommodation (non-residential i.e. hiring a hall), administration costs and manual. It also included patient travel costs and the costs of a consultation with a clinical psychologist. Total cost per person: £385.  Costs of 7 disease endpoints also included: stroke, cancer, cirrhosis, alcoholic psychosis, chronic pancreatitis, Epilepsy and alcohol dependence syndrome  Total intervention costs= 385 000/1000 people  <u>Outcomes:</u> : number of patients who have abstained or controlled drinking	Net health care savings over 20 years = -274 008 (negative costs are a cost saving)  The no. of additional patients abstinent = 122  The costs per additional abstinent patient = - 2252  Sensitivity analysis range = -4441 to 54923	Perspective: NHSScotland and patient Currency: UK Pounds Cost year: 2002 Time horizon: 20 years Discounting: 6% per annum Funded by : HTBS
Slattery, 2003  Scotland	<u>Comparators:</u>  BSCT  vs.  Control intervention	Population: 45 yr old men and women who are alcohol dependent  Setting: primary and secondary care  Source of clinical	Cost effectiveness analysis based on adapted Schadlich and Brecht model	<u>Costs:</u> A cost per attendee was calculated based on the staff requirements, accommodation (non-residential i.e. hiring a hall), administration costs and manual. It also included patient travel costs and the costs of a consultation with a clinical psychologist. Total cost per person: £385.	Net health care savings over 20 years = -80 452 (negative costs are a cost saving)  The no. of additional patients abstinent = 86	Perspective: NHSScotland and patient Currency: UK Pounds Cost year: 2002 Time horizon: 20 years Discounting: 6% per annum Funded by : HTBS

## Alcohol Use Disorders: Health economic evidence tables

		<p>effectiveness data: reported RCTs</p> <p>Source of resource use estimates: Expert opinion, Annis et al. 19996</p> <p>Source of unit costs: Scottish health services costs 2000/01</p>		<p>Costs of 7 disease endpoints also included: stroke, cancer, cirrhosis, alcoholic psychosis, chronic pancreatitis, Epilepsy and alcohol dependence syndrome</p> <p>Total intervention costs= 385 000/1000 people</p> <p><u>Outcomes:</u> : number of patients who have abstained or controlled drinking</p>	<p>The costs per additional abstinent patient =-936</p> <p>Sensitivity analysis range = -3467 to 146 018</p>	
Slattery, 2003  Scotland	<p><u>Comparators:</u></p> <p>MET</p> <p>Versus</p> <p>Control Intervention</p>	<p>Population: 45 yr old men and women who are alcohol dependent</p> <p>Setting: primary and secondary care</p> <p>Source of clinical effectiveness data: reported RCTs</p> <p>Source of resource use estimates: Expert opinion, Annis et al. 19996</p> <p>Source of unit costs: Scottish health services costs 2000/01</p>	<p>Cost effectiveness analysis based on adapted Schadlich and Brecht model</p>	<p><u>Costs:</u></p> <p>A cost per attendee was calculated based on the staff requirements, accommodation (non-residential i.e. hiring a hall), administration costs and manual. It also included patient travel costs and the costs of a consultation with a clinical psychologist. Total cost per person: £385.</p> <p>Costs of 7 disease endpoints also included: stroke, cancer, cirrhosis, alcoholic psychosis, chronic pancreatitis, Epilepsy and alcohol dependence syndrome</p> <p>Total intervention costs= 385 000/1000 people</p> <p><u>Outcomes:</u> number of patients who have abstained or controlled drinking</p>	<p>Net health care savings over 20 years = -151 723 (negative costs are a cost saving)</p> <p>The no. of additional patients abstinent =99</p> <p>The costs per additional abstinent patient = -1531</p> <p>Sensitivity analysis range = -3256 to 68 964</p>	<p>Perspective: NHSScotland and patient</p> <p>Currency: UK Pounds</p> <p>Cost year: 2002</p> <p>Time horizon: 20 years</p> <p>Discounting: 6% per annum</p> <p>Funded by : HTBS</p>
Slattery, 2003  Scotland	<p><u>Comparators:</u></p> <p>Marital/Family Therapy</p> <p>Versus</p> <p>Control Intervention</p>	<p>Population: 45 yr old men and women who are alcohol dependent</p> <p>Setting: primary and secondary care</p> <p>Source of clinical effectiveness data: reported RCTs</p> <p>Source of resource use estimates: Expert opinion,</p>	<p>Cost effectiveness analysis based on adapted Schadlich and Brecht model</p>	<p><u>Costs:</u></p> <p>A cost per attendee was calculated based on the staff requirements, accommodation (non-residential i.e. hiring a hall), administration costs and manual. It also included patient travel costs and the costs of a consultation with a clinical psychologist. Total cost per person: £385.</p> <p>Costs of 7 disease endpoints also included: stroke, cancer, cirrhosis, alcoholic psychosis, chronic pancreatitis, Epilepsy and alcohol dependence syndrome</p>	<p>Net health care savings over 20 years = -183 795 (negative costs are a cost saving)</p> <p>The no. of additional patients abstinent = 105</p> <p>The costs per additional abstinent patient = -1 759</p> <p>Sensitivity analysis range = -3217 to 16 577</p>	<p>Perspective: NHSScotland and patient</p> <p>Currency: UK Pounds</p> <p>Cost year: 2002</p> <p>Time horizon: 20 years</p> <p>Discounting: 6% per annum</p> <p>Funded by : HTBS</p>

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		<p>Annis et al. 1996</p> <p>Source of unit costs: Scottish health services costs 2000/01</p>		<p>Total intervention costs= 385 000/1000 people</p> <p><u>Outcomes:</u> : number of patients who have abstained or controlled drinking</p>		
<p>UKATT Research team, 2005. UK</p>	<p><u>Comparators:</u> Motivational enhancement therapy</p> <p>Versus</p> <p>Social behaviour and network therapy</p>	<p>Population: People who would normally seek treatment for alcohol problems at a British treatment site.</p> <p>Setting: outpatient: treatment sites around Birmingham, Cardiff and Leeds</p> <p>Source of clinical effectiveness data: UKATT RCT</p> <p>Source of resource use estimates &amp; Source of unit costs:: national, government sources, UKATT trial and another UK trial</p>	<p>Cost-effective analysis</p>	<p><u>Costs:</u> treatment costs; costs of hospitalisation, a hospital day visit, a hospital outpatient visit, a general practitioner for home visit and in-surgery consultation, a prescription, a home visit by a community psychiatric nurse, a detoxification episode in primary care, rehabilitation and consultation in an alcohol agency, social service contact and court attendance</p> <p><u>Outcomes:</u> Quality-adjusted life-years (QALYs). These were assessed using the EQ-5D questionnaire that was completed by clients at baseline and at 3 and 12 months. The QALYs were calculated using UK population norms for the evaluation of health states and linear interpolation to identify the areas under the QALY curve.</p>	<p>Incremental QALYs were reported. After adjusting for baseline differences in the analysis, the social network therapy group achieved 0.0113 QALYs less than the motivational group, but the difference was not statistically significant (bias corrected 95% CI: 0.0532 fewer to 0.0235 more).</p> <p>An incremental analysis was performed. Motivational enhancement therapy had an incremental cost-effectiveness ratio of 18,230 in comparison with social therapy.</p>	<p>Perspective: Unclear, but healthcare costs and costs to criminal justice system included Currency: UK Pounds Cost year: 2000/01 Time horizon: 12 months Discounting: NA Funded by:</p>
<p>Mortimer, 2005 Australia</p>	<p>Comparators: Moderation-oriented cue exposure (MOCE)</p> <p>vs.</p> <p>Behavioural self-control training (BSCT) Emphasis on controlled drinking</p>	<p>Population: Patients with mild to moderate dependence seeking help for alcohol problems with a preference for moderation rather than abstinence</p> <p>Setting: outpatient</p> <p>Source of clinical effectiveness data: Heather et al., 2000</p>	<p>Cost-effectiveness analysis and cost utility analysis - based on Markov model</p>	<p><u>Costs:</u> Research costs were not mentioned in the effectiveness study. The cost that is estimated is the cost to run this program in Australia currently. Costs incurred purely as a result of research activity, rather than in the administration of the intervention, were excluded. The following was included: Clinical psychologist and psychiatric nurse training and trainee (Clinical psychologist), consumables, lab investigations, phone calls, treatment sessions.</p> <p><u>Outcomes:</u></p>	<p>BSCT dominated MOCE (cheaper but more effective).</p> <p>The cost per QALY gained was estimated at 2145 AUD in a predominantly male population with moderate dependence.</p>	<p>Perspective: department of health and Ageing Currency: Australian Dollars Cost year: 2003 Time horizon: life time Discounting: 5% Funded by : Australian Government and Monash University</p>

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		Source of resource use estimates: estimated prospectively from study  Source of unit costs: Australian health care costs sources, MBS		Mean drinks per drinking day (DDD); Mean percent days abstinent (PDA)  Measures of benefit: Cost per changer And cost per QALY  Utility data sourced from: Stouthard et al. (1997)		
Mortimer, 2005 Australia	<u>Comparators:</u>  Motivational enhancement therapy (MET).  vs.  No further counselling after initial assessment	Population: Mild to moderately dependent drinkers Aged 15–59 years  Setting: outpatient  Source of clinical effectiveness data: Sellman et al., 2001  Source of resource use estimates: Costs have been taken from the intervention undertaken by Sellman et al, from the methods described in the published paper  Source of unit costs: Australian health care costs sources	Cost-effectiveness analysis and cost-utility analysis	<u>Costs:</u> direct costs which included the cost of clinical psychologist training including trainer (clinical psychologist) fees, session fees, consumables, assessment, feedback sessions, lab investigations and information booklets.  <u>Outcomes:</u> For the CEA between-group comparison the key outcome: percentage drinking within national guidelines for the duration of the trial  QALYs  Utility data sourced from Stouthard et al. (1997)	The incremental cost per changer = -26.5 \$/changer , MET dominates NFC  In the CUA: MET is estimated to deliver 0.116 QALYs gained per completer as compared to NFC. The incremental cost per completer of MET as compared to NFC was estimated at 389 AUD and was assumed to reflect the incremental cost over the entire evaluation period. The cost per QALY gained is estimated at 3,366 AUD	Perspective: department of health and Ageing Currency: Australian Dollars Cost year: 2003 Time horizon: life time Discounting: 5% Funded by : Australian Government and Monash University
Mortimer, 2005 Australia	<u>Comparators:</u>  Non-directive reflective listening (NDRL). NDRL subjects talked about anything they wanted, with no attempt to steer towards alcohol problem Four sessions over 6 weeks	Population: Mild to moderately dependent drinkers Aged 15–59 years  Setting: outpatient  Source of clinical effectiveness data: Sellman et al., 2001  Source of resource use estimates: estimated prospectively from the	Cost-utility analysis based on a Markov model	<u>Costs:</u> direct costs which included the cost of clinical psychologist training including trainer (clinical psychologist) fees, session fees, consumables, assessment, feedback sessions, lab investigations and information booklets  <u>Outcomes:</u> QALYs  Utility data sourced from: Stouthard et al. (1997)  Returning problem drinkers to safe	The Markov model was also used to estimate QALYs gained per person for NRDL compared to NFC. The NDRL was inferior to the NFC based on the proportion remaining within national guidelines at 6-months follow-up. Given that the NDRL is also more costly than the NFC; the modelled cost-utility analysis has the	Perspective: department of health and Ageing Currency: Australian Dollars Cost year: 2003 Time horizon: life time Discounting: 5% Funded by : Australian Government and Monash University

## Alcohol Use Disorders: Health economic evidence tables

	vs.  No further counselling after initial assessment and feedback/ education	study  Source of unit costs: Australian health care costs sources, MBS		consumption pattern = 0.110 annual QALY gain Returning dependent drinkers to safe consumption pattern = 0.330 annual QALY gain	NFC dominating the NDRL.	
Holder, 2000 USA	<u>Comparators:</u>  12-session CBT vs. 4-session MET vs. 12-session twelve-Step facilitation (TSF)	Population: Adult patients with alcohol dependency symptoms  Setting: Inpatient, Outpatient and Aftercare settings  Source of clinical effectiveness data: Project MATCH RCT (Project MATCH Research Group, 1997; 1998)  Source of resource use and cost estimates: taken from 279 of 430 Project MATCH participants	Cost-analysis	<u>Costs:</u> Direct health care costs - treatments, inpatient care and outpatient care  Total Monthly Mean Costs (Post-treatment): CBT: \$186 MET: \$176 TSF: \$225	No formal incremental analysis presented by authors.  Authors concluded that MET had potential for health-care cost savings after matching patients in each group for clinical prognosis	Perspective: Health care payer (US) Currency: US \$ Cost year: 1982-84 Time horizon: 3 years Discounting: Not reported Funded by: National Institute on Alcohol and Alcoholism (US)
Fals-Stewart, 2005 USA	<u>Comparators:</u>  Brief relationship therapy (BRT) - 18 scheduled sessions over 12 weeks vs. Standard behavioural couples therapy (S-BCT) - 24 sessions over 12 weeks vs. Individual-based treatment (IBT) - 18 scheduled sessions over 12 weeks vs.	Population: Male partner (within couple) met DSM-IV criteria for alcohol dependence and have alcohol as their primary substance of abuse  Setting: Outpatient  Source of clinical effectiveness data: Single RCT  Source of resource use and cost estimates: 100 couples	Cost-effectiveness analysis	<u>Costs:</u> Treatment programme expenditures (e.g. counsellor time, equipment); patient travel time  Total Mean Treatment Costs: BRT: \$897 (SD \$312) S-BCT: \$1,294 (SD \$321) IBT: \$840 (SD \$200) PACT: \$884 (SD \$297)  <u>Outcomes:</u> Percentage of Days of Heavy Drinking (PDHD) - change from baseline to 12 months	Authors calculated mean change in PDHD over 12 months divided by mean cost of treatment delivery (in \$100 units) - higher ratios indicate greater cost-effectiveness  Mean ratios: BRT: 4.61 (SD 1.54) S-BCT: 3.30 (SD 1.61) IBT: 3.68 (SD 1.59) PACT: 3.48 (SD 1.70)	Perspective: Societal Currency: US \$ Cost year: Not reported Time horizon: 12 months Discounting: N/A Funded by: National Institute on Alcohol Abuse and Alcoholism

## Alcohol Use Disorders: Health economic evidence tables

	Psychoeducational attention control treatment (PACT) - 18 scheduled sessions over 12 weeks					
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### 4.1. Combination (Psychology and Pharmacology)

Study, year and country	Intervention details	Study population Setting Study design - data source	Study Type	Costs: description and values Outcomes: description and values	Results: Cost-effectiveness	Comments Internal validity (Yes/No/NA) Industry support
Walters 2009. Australia	<p><u>Comparators:</u></p> <p>CBT 12 week manual based outpatient program</p> <p>Vs.</p> <p>CBT + naltrexone</p>	<p>Population with alcohol dependence (DSM-IV)</p> <p>Setting: outpatient hospital based</p> <p>Source of clinical effectiveness data:</p> <p>Source of resource use estimates: Drug Abuse Treatment Cost Analysis Program</p> <p>Source of unit costs: DATCAP</p>	Costing analysis	<p><u>Costs:</u> Personnel costs, supplies and materials, equipment, contracted services, buildings and facilities and misc, resources and treatment failure.</p> <p><u>Outcomes:</u></p> <p>Costs per 100 successful treatment completions</p> <p>Successful treatment = alcohol abstinence over 12 week program and attending all 8 sessions</p> <p>SF-6D utility scores estimated from SF-36 questionnaire</p>	Adjunctive pharmacotherapy (CBT +naltrexone) was 54% more expensive than CBT alone. There were no differences between groups on a preference-based health measure (SF-6D). The dominant choice was CBT +naltrexone based on modest economic advantages and significant efficiencies in the numbers needed to treat.	<p>Perspective: Not stated</p> <p>Currency: Australian Dollars</p> <p>Cost year: not stated</p> <p>Time horizon: not specifically stated:12 weeks</p> <p>Discounting: not stated</p> <p>Funded by : non-industry</p>