Health Economics Evidence Tables

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	Comparators: 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placebo-controlled prospective trial(n=448)Whitworth et al.1996; Type of relapse & second line management: NEAT study unpublished data n=582 dependent patients, Source of resource use estimates & costs: Belgian NEAT study[unpublished] and a cross-sectional study among GPs from the Belgian institute of Hygiene and Epidemiology (IHE)	Cost-Analysis – based on Markov model	Costs: Direct medical costs including hospital and ambulatory costs i.e. GP, psychiatry and psychologist/psychotherapy consultations, biochemistry tests and drug costs. Outcomes: % 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

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**
Mortimer, 2005 Australia	<u>Comparators:</u> Naltrexone + counselling versus Placebo + counselling	Population: detoxified patients with a history of severe alcohol dependence. Setting: inpatient and outpatient Source of clinical effectiveness data: Streeton and Whelon, 2001 meta-analysis Source of resource use estimates: based on description in 1 study included in the meta-analysis. Chick et al. 2000 Source of unit costs: not mentioned – Australian health care costs sources	Cost-effectiveness analysis	<u>Costs:</u> direct medical costs including: cost of screening, assessment, drugs, laboratory work-up. Cost <u>Outcomes:</u> QALYs Utility data sourced from: Stouthard et al. (1997) Returning problem drinkers to safe consumption pattern = 0.110 annual QALY gain Returning dependent drinkers to safe consumption pattern = 0.330 annual QALY gain	Naltrexone + counselling is estimated to deliver 0.0528 QALYs gained per completer at an incremental cost per completer of 685 AUD as compared to placebo + counselling. The cost per QALY gained for the naltrexone + counselling vs. placebo + counselling comparison is estimated at 12 966 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

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
Zarkin, 2008 USA	<u>Comparators:</u> 1) medical management(MM)+ placebo 2) MM+naltrexone 100mg/day for 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	Population: patients with diagnosis of primary alcohol dependence(DSM-IV) Setting: 11 US study sites Source of clinical effectiveness data: COMBINE RCT n=1383 Source of resource use estimates: COMBINE study data Source of unit costs: Federal supply schedule, co-ordinating centre data management system, 2005-Resource-Based Relative Value scale	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 heavy drinking, incremental cost per patient of achieving a good clinical outcome	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 outcomes: medical management (MM) with placebo ($409 per patient), MMplus naltrexone therapy ($671 per patient), and MM plus combined naltrexone and acamprosate therapy ($1003 per patient). 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.	Perspective: service provider Currency: US dollar Cost year: 2007 Time horizon: 16 weeks Discounting: NA Funded by : NIAAA

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	Comparators: Acamprosate (12 months) Compared to Placebo	Population: 45 yr old men and women who are alcohol dependent Setting: primary and secondary care (inpatient costs incl. in sensitivity analysis) Source of clinical effectiveness data: reported RCTs Source of resource use estimates: estimated from patient pathways provided by Alcohol and Drug Directorate South & West Source of unit costs: Scottish health services costs and BNF	Cost effectiveness analysis based on adapted Schadlich and Brecht model (1998)	Costs: drugs, GP, CPN and specialist consultations. Service user travel time. Costs of 7 disease endpoints also included: stroke, cancer, cirrhosis, alcoholic psychosis, chronic pancreatitis, Epilepsy and alcohol dependence syndrome Outcomes: number of patients who have abstained or controlled drinking	Total intervention costs: £ 385 337 Additional patients abstinent from standard: 84 Cost per additional abstinent patient: £-822 (negative costs are cost saving)	Perspective: NHSScotland and patient Currency: UK Pound Cost year: 2002 Time horizon: 20 years Discounting: 6% per annum Funded by : HTBS

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	Comparators: Oral Disulfiram (6 months) vs. Placebo	Population: 45 yr old men and women who are alcohol dependent Setting: primary and secondary care (inpatient costs incl. in sensitivity analysis) Source of clinical effectiveness data: reported RCTs of unsupervised treatment Source of resource use estimates: estimated from patient pathways provided by Alcohol and Drug Directorate South & West Source of unit costs: Scottish health services costs and BNF	Cost effectiveness analysis based on adapted Schadlich and Brecht model	Costs: costs of drugs, laboratory tests, Medicals, key worker visits, GP consultations and visits to Alcohol Problems treatment Unit. Service user travel time. Costs of 7 disease endpoints also included: stroke, cancer, cirrhosis, alcoholic psychosis, chronic pancreatitis, Epilepsy and alcohol dependence syndrome Outcomes: number of patients who have abstained or controlled drinking	Total intervention costs: £ 380 526 Additional patients abstinent from standard: 55 Cost per additional abstinent patient: £1 521 (negative costs are cost saving) univariate sensitivity analysis revealed that effectiveness parameters had greatest impact on results. Higher disease costs increases the cost effectiveness per additional abstinent patient	Perspective: NHSScotland and patient Currency: UK Pound Cost year: 2002 Time horizon: 20 years Discounting: 6% per annum Funded by : HTBS

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

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
Schadlich, 1998 Germany	Comparators: 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	Costs: Direct medical costs Treatment costs in Acamprosate arm= DM 7 333 131 and DM10 090 681 in the standard care group Outcomes: 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

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
Rychlik, 2003 Germany	Comparators: Acamprosate Standard care All had some form of psychosocial rehabilitation programmme	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 Source of resource use estimates& unit costs: collected alongside study &German outpatient standardised evaluation scale, and sums reimbursed by German health insurance	Cost-effectiveness analysis	Costs: Direct medical costs incl. all physician visits, emergency treatments, diagnostic tests, lab tests, drugs, non-medical treatments, nursing, hospitialisation, 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, $p < 0.001$; Wilcoxon test). Outcomes: 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).	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

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**
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

2) 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**
Parrot, 2006 UK	Comparators: 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. Versus No treatment	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 effectiveness study Source of unit costs: Personal Social Service Research Unit, Home Office, HM Treasury and some published studies	Cost-utility analysis and cost-effectiveness analysis.	Costs: Direct medical costs (also costs to criminal justice system and public/social services) Outcomes: 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 1.87 in the Smithfield sample. The cost for a reduction of one drink per day was 92.75 at the Smithfield Centre. The cost per percentage point reduction in drinking was 30.71 at the Smithfield Centre. The cost per QALY gained was 65,454 (33,727 when considering only treatment costs) at the Smithfield Centre. No sensitivity analysis.	Perspective: Societal perspective Currency: UK pounds Cost year: 2003-04 Time horizon: 6 months Discounting: NA Funded by : None stated

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	Comparators: 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	Costs: interventions and training, other health care, social care, criminal justice services Outcomes: 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

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
Parrott, 2006 UK	Comparators: 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 service. versus No treatment	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 effectiveness study Source of unit costs: Personal Social Service Research Unit, Home Office, HM Treasury and some published studies	Cost-utility analysis and cost-effectiveness analysis.	Costs: Direct medical costs (also costs to criminal justice system and public/social services) Outcomes: 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 was and 131,750 (90,375 when considering only treatment costs) at Plummer Court.	Perspective: Societal perspective Currency: UK pounds Cost year: 2003-04 Time horizon: 6 months Discounting: NA Funded by : none stated

3) 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

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> BSCT vs. 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 = -80 452 (negative costs are a cost saving) The no. of additional patients abstinent = 86 The costs per additional abstinent patient =-936 Sensitivity analysis range = -3467 to 146 018	Perspective: NHSScotland and patient Currency: UK Pounds Cost year: 2002 Time horizon: 20 years Discounting: 6% per annum Funded by : HTBS

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	Comparators: MET 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	Costs: 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 Outcomes: number of patients who have abstained or controlled drinking	Net health care savings over 20 years = -151 723 (negative costs are a cost saving) The no. of additional patients abstinent =99 The costs per additional abstinent patient = -1531 Sensitivity analysis range = -3256 to 68 964	Perspective: NHSScotland and patient Currency: UK Pounds Cost year: 2002 Time horizon: 20 years Discounting: 6% per annum Funded by : HTBS

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> Marital/Family Therapy 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. 1996 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 = -183 795 (negative costs are a cost saving) The no. of additional patients abstinent = 105 The costs per additional abstinent patient = -1 759 Sensitivity analysis range = -3217 to 16 577	Perspective: NHSScotland and patient Currency: UK Pounds Cost year: 2002 Time horizon: 20 years Discounting: 6% per annum Funded by : HTBS

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
UKATT Research team, 2005. UK	Comparators: Motivational enhancement therapy Versus Social behaviour and network therapy	Population: People who would normally seek treatment for alcohol problems at a British treatment site. Setting: outpatient: treatment sites around Birmingham, Cardiff and Leeds Source of clinical effectiveness data: UKATT RCT Source of resource use estimates & Source of unit costs:: national, government sources, UKATT trial and another UK trial	Cost-effective analysis	Costs: 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 Outcomes: 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.	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). An incremental analysis was performed. Motivational enhancement therapy had an incremental cost-effectiveness ratio of 18,230 in comparison with social therapy.	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:

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**
Mortimer, 2005 Australia	Comparators: Moderation-oriented cue exposure (MOCE) vs. Behavioural self-control training (BSCT) Emphasis on controlled drinking	Population: Patients with mild to moderate dependence seeking help for alcohol problems with a preference for moderation rather than abstinence Setting: outpatient Source of clinical effectiveness data: Heather et al., 2000 Source of resource use estimates: estimated prospectively from study Source of unit costs: Australian health care costs sources, MBS	Cost-effectiveness analysis and cost utility analysis – based on Markov model	Costs: 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. Outcomes: 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)	BSCT dominated MOCE (cheaper but more effective). The cost per QALY gained was estimated at 2145 AUD in a predominantly male population with moderate dependence.	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

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**
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

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
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 vs. No further counselling after initial assessment and feedback/ education	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 study Source of unit costs: Australian health care costs sources, MBS	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 consumption pattern = 0.110 annual QALY gain Returning dependent drinkers to safe consumption pattern = 0.330 annual QALY gain	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 NFC dominating the NDRL.	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

4) 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	Comparators: CBT 12 week manual based outpatient program Vs. CBT + naltrexone	Population with alcohol dependence (DSM-IV) Setting: outpatient hospital based Source of clinical effectiveness data: Source of resource use estimates: Drug Abuse Treatment Cost Analysis Program Source of unit costs: DATCAP	Costing analysis	Costs: Personnel costs, supplies and materials, equipment, contracted services, buildings and facilities and misc, resources and treatment failure. Outcomes: Costs per 100 successful treatment completions Successful treatment = alcohol abstinence over 12 week program and attending all 8 sessions SF-6D utility scores estimated from SF-36 questionnaire	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.	Perspective: Not stated Currency: Australian Dollars Cost year: not stated Time horizon: not specifically stated:12 weeks Discounting: not stated Funded by : non-industry