

Appendix 19: evidence tables for economic studies

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Health economics studies for alcohol dependence and harmful alcohol use

Pharmacology

Study ID (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 and colleagues, 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prospective trial (n = 448), Whitworth and colleagues (1996) Type of relapse and second line management: NEAT study (unpublished data), n = 582 dependent patients Source of resource-use estimates and costs: Belgian NEAT study (unpublished) and a cross-sectional study among GPs from the Belgian Institute of Hygiene and Epidemiology	Cost-analysis – based on Markov model	Costs: direct medical costs including hospital and ambulatory costs, that is GP, psychiatry and psychologist/psychotherapy consultations, biochemistry tests and drug costs Outcomes: percentage of 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 and colleagues (1996)	The total expected costs for the acamprosate strategy were equal to 211,986 Belgian Francs (€5,255) over the period of 24 months, compared to 233,287 Belgian Francs (€5783) for ‘no acamprosate’. It also results in reduction in relapses or a higher percentage of patients who remain abstinent. Therefore acamprosate dominates because 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 and colleagues, 2008 (US)	Comparators: (1) Medical management + placebo	Population: patients with diagnosis of primary alcohol dependence (DSM-IV)	Cost-effectiveness analysis	Costs: direct medical costs Outcomes: incremental cost per percentage point increase in percentage of	On the basis of the mean values of cost and effectiveness, three interventions were shown to be cost-effective options relative	Perspective: service provider Currency: US Dollar

Study ID (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
	<p>(2) Medical management + naltrexone 100 mg per day for 16 weeks</p> <p>(3) Medical management + acamprosate 3 g per day</p> <p>(4) Medical management + placebo + combined behavioural intervention</p> <p>(5) Medical management + acamprosate + naltrexone</p> <p>(6) Medical management + naltrexone + combined behavioural intervention</p> <p>(7) Medical management + acamprosate + combined behavioural intervention</p> <p>(8) Medical management + naltrexone + acamprosate + combined behavioural intervention</p> <p>(9) Combined behavioural intervention only</p>	<p>Setting: 11 US study sites</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>days abstinent, incremental cost per patient of avoiding heavy drinking, incremental cost per patient of achieving a good clinical outcome</p>	<p>to the other interventions for all three outcomes: medical management with placebo (\$409 per patient), medical management plus naltrexone therapy (\$671 per patient), and medical management plus combined naltrexone and acamprosate therapy (\$1,003 per patient)</p> <p>Author’s conclusion: medical management-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>	<p>Cost year: 2007</p> <p>Time horizon: 16 weeks</p> <p>Discounting: NA</p> <p>Funded by: NIAAA</p>

Study ID (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 and colleagues, 2003 (Scotland)	Comparators: acamprosate (12 months) compared with placebo	<p>Population: 45-year-old men and women who are alcohol dependent</p> <p>Setting: primary and secondary care (inpatient costs included 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 & West</p> <p>Source of unit costs: Scottish health service costs and BNF</p>	Cost-effectiveness analysis based on adapted Schadlich and Brecht (1998) model	<p>Costs: drugs, GP, CPN and specialist consultations. Service user travel time</p> <p>Costs of seven disease endpoints also included: stroke, cancer, cirrhosis, alcoholic psychosis, chronic pancreatitis, epilepsy and alcohol dependence syndrome</p> <p>Outcomes: 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: NHS Scotland 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: Health Technology Board for Scotland</p>
Slattery and colleagues, 2003 (Scotland)	Comparators: oral disulfiram (6 months) versus placebo	<p>Population: 45-year-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 of unsupervised treatment</p> <p>Source of resource-use estimates: estimated from patient pathways provided by Alcohol and</p>	Cost-effectiveness analysis based on adapted Schadlich and Brecht (1998) model	<p>Costs: costs of drugs, laboratory tests, medicals, key worker visits, GP consultations and visits to Alcohol Problems Treatment Unit. Service user travel time.</p> <p>Costs of seven disease endpoints also included: stroke, cancer, cirrhosis, alcoholic psychosis, chronic pancreatitis, epilepsy and alcohol dependence syndrome</p> <p>Outcomes: number of patients who have abstained or controlled drinking</p>	<p>Total intervention costs: £380,526</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>Perspective: NHS Scotland 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: Health Technology Board for Scotland</p>

Study ID (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
		Drug Directorate South & West Source of unit costs: Scottish health service costs and BNF				
Slattery and colleagues, 2003 (Scotland)	Comparators: naltrexone (6 months) compared with placebo	Population: 45-year-old men and women who are alcohol dependent Setting: primary and secondary care (inpatient costs included 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 service costs and BNF	Cost-effectiveness analysis based on adapted Schadlich and Brecht (1998) model	Costs: costs of drugs, key worker visits, GP and specialist consultations. Service user travel time. Costs of seven 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	Total intervention costs: £ 357,709 Additional patients abstinent from standard: 38 Cost per additional abstinent patient: £4,056 (negative costs are cost saving) Univariate sensitivity analysis revealed that effectiveness parameters had the greatest impact on results. Higher disease costs increase the cost effectiveness per additional abstinent patient	Perspective: NHS Scotland and patient Currency: UK Pounds Cost year: 2002 Time horizon: 20 years Discounting: 6% per annum Funded by: Health Technology Board for Scotland
Schadlich and Brecht, 1998 (Germany)	Comparators:acamprostate placebo + standard care (routine counselling/ psychotherapy) in both	Population: alcohol dependent patients who were abstinent for a minimum of 14 days and maximum of 28 days Setting: psychiatric outpatient clinics Source of clinical	Cost effectiveness analysis	Costs: direct medical costs Treatment costs in acamprostate arm = 7,333,131 DM and 10,090,681 DM in the standard care group Outcomes: proportion of abstinent alcoholics at the end of the medication-free follow-up period: 39.9% in the acamprostate group and 17.3% in the	Treatment costs were lower in the intervention arm compared to the placebo arm. 226 patients had abstained from alcohol consumption in the acamprostate arm. The cost effectiveness ratio of acamprostate was -2602 DM. Acamprostate was the dominant treatment	Perspective: German healthcare system Currency: Deutsche Marks Cost year: 1995 Time horizon: 48 weeks and 48 weeks follow-up

Study ID (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
		<p>effectiveness data: Prevention of Relapse with Acamprosate in the Management of Alcoholism study, secondary analysis of epidemiological data and official statistics, expert knowledge</p> <p>Source of resource-use estimates: retrospective analysis of hospital records, expert knowledge</p> <p>Source of unit costs: statistics from National Association of Local Sickness Funds, Federal Statistical Office, Federal Association of Pension Funds</p>		<p>placebo group</p> <p>226 additional patients abstained from alcohol consumption in acamprosate group</p>	<p>Acamprosate dominated standard care</p> <p>Base-case results were robust to sensitivity analysis</p>	<p>Discounting: 5% annually</p> <p>Funded by: Lipha Arzneimittel</p>
Rychlik and colleagues, 2003 (Germany)	<p>Comparators: acamprosate standard care</p> <p>All had some form of psychosocial rehabilitation programme</p>	<p>Population: patients who contacted their physicians and fulfilled DSM-IV criteria for alcohol dependence-prescribed detoxification and rehabilitation</p> <p>Setting: primary care centres that included GP and specialist care</p> <p>Source of clinical effectiveness data: open-label non-randomised cohort study n = 814</p> <p>Source of resource-use estimates and unit costs:</p>	<p>Cost-effectiveness analysis</p>	<p>Costs: direct medical costs including all physician visits, emergency treatments, diagnostic tests, lab tests, drugs, non-medical treatments, nursing, hospitalisation, cures and treatment of undesirable effects and side effects</p> <p>Costs in standard care arm 26% higher than acamprosate arm</p> <p>For the PPA population, abstinence rates after 1 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)</p> <p>Outcomes: abstinence rate over 12 month period</p>	<p>Acamprosate shown to dominate standard care because it is cheaper and more effective.</p>	<p>Perspective: health insurance/social perspective</p> <p>Currency: Euros</p> <p>Cost year: not explicit, possibly 1998/1999</p> <p>Time horizon: 12 months</p> <p>Discounting: NA</p> <p>Funded by: Merck KGaA</p>

Study ID (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
		collected alongside study and German outpatient standardised evaluation scale, and sums reimbursed by German health insurance		After 1 year: 32.4% in acamprosate cohort; 20.4% in standard care cohort The total direct costs in the intervention group were €1,225 (ITT) and €1,254 (PPA). The total direct comparator costs were €1543 (ITT) and €1592 (PPA)		
Palmer and colleagues, 2000 (Germany)	Comparators: acamprosate as adjuvant therapy + standard counselling therapy versus standard counselling therapy alone	Population: detoxified alcoholic male patients (average age of 41 years). 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	Costs: direct medical costs including hospitalisations, rehabilitation costs, drug acquisition costs and psychosocial support The cost of 48 weeks of acamprosate therapy was 2,177 DM. The discounted (and undiscounted) lifetime costs were 48,245 DM (75,081 DM) with adjuvant therapy and 49,907 DM (76,942 DM) with standard therapy Outcomes: 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: Deutsche Marks Cost year: 1996 Time horizon: lifetime Discounting: 5% per annum Funded by: Lipha SA

Study ID (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 and colleagues, 2006 (UK)	<p>Comparators: a detoxification service carried out at the Smithfield Centre in Manchester: open 24 hours per day, 365 days per year. 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</p> <p>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>Costs: direct medical costs (also costs to criminal justice system and public/social services)</p> <p>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</p> <p>Units 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</p> <p>Currency: UK Pounds</p> <p>Cost year: 2003–04</p> <p>Time horizon: 6 months</p> <p>Discounting: NA</p> <p>Funded by: none stated</p>
Pettinati and colleagues, 1999 (US)	<p>Comparators: inpatients versus 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>Costs: direct treatment costs – educational and therapy sessions, AA support group attendances, family educational programmes</p> <p>Outcomes: probability of returning to significant drinking (three 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</p>	<p>Perspective: US healthcare provider</p> <p>Current: US Dollars</p> <p>Cost year: Not reported</p> <p>Tim horizon: 12 months</p> <p>Discounting: NA</p> <p>Funded by: NIAAA (US)</p>

		to insurance billing charges			<p>calculated for the 3-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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Assessment and service delivery

Study ID (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, 2009 (UK)	<p>Comparators: stepped care – sequential series of interventions according to need and response after each successive step</p> <p>Minimal intervention – 5-minute directive advice session</p>	<p>Population: males aged 18+ years with ICD-10 diagnosis of alcohol-use disorder</p> <p>Setting: primary care</p> <p>Source of clinical effectiveness data: single study</p> <p>Source of resource-use estimates: study participants with 6-month follow-up data only</p> <p>Source of unit costs: PSS Research Unit, Home Office and other published studies</p>	Cost-utility analysis	<p>Costs: interventions and training, other healthcare, social care, criminal justice services</p> <p>Outcomes: QALYs – calculated using EQ-5D utility scores obtained from questionnaires completed by study participants</p>	<p>Intervention: mean total costs were £5,692 at baseline and £2,534 at 6 months. Mean QALY gain of 0.3849</p> <p>Control: mean total costs were £6,851 at baseline and £12,637 at 6 months Mean QALY gain of 0.3876</p> <p>Probability of intervention being cost-effective at UK £20–30,000 threshold: 98%</p>	<p>Perspective: societal perspective</p> <p>Currency: UK Pounds</p> <p>Cost year: 2001</p> <p>Time horizon: 6 months</p> <p>Discounting: NA</p> <p>Funded by: Wales Office for Research and Development</p>
Parrott and colleagues, 2006 (UK)	<p>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</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</p>	Cost-utility analysis and cost-effectiveness analysis.	<p>Costs: direct medical costs (also costs to criminal justice system and public/social services)</p> <p>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.</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 1.66 among patients admitted to Plummer Court.</p> <p>The cost for a reduction of one drink per day was 22.56 at Plummer Court.</p> <p>The cost per percentage point reduction in drinking was 45.06 at Plummer Court.</p>	<p>Perspective: societal perspective</p> <p>Currency: UK Pounds</p> <p>Cost year: 2003–04</p> <p>Time horizon: 6 months</p> <p>Discounting: NA</p> <p>Funded by: none stated</p>

	day programme at the Newcastle service versus no treatment	carried out on a sub-group of patients included in the effectiveness study Source of unit costs: PSS Research Unit, Home Office, HM Treasury and some published studies			The cost per QALY gained was and 131,750 (90,375 when considering only treatment costs) at Plummer Court	
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Psychology

Study ID (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 and colleagues, 2003 (Scotland)	Comparators: coping-/social-skills training versus control intervention	Population: 45-year-old men and women who were alcohol dependent Setting: primary and secondary care Source of clinical effectiveness data: reported RCTs Source of resource-use estimates: expert opinion, Annis and colleagues (1996) Source of unit costs: Scottish health services costs 2000/01	Cost-effectiveness analysis based on adapted Schadlich and Brecht (1998) model	Costs: a cost per attendee was calculated based on the staff requirements, accommodation (non-residential, that is 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 seven disease endpoints also included: stroke, cancer, cirrhosis, alcoholic psychosis, chronic pancreatitis, epilepsy and alcohol dependence syndrome Total intervention costs = £385,000 per 1000 people Outcomes: number of patients who have abstained or controlled drinking	Net healthcare savings over 20 years = -£274,008 (negative costs are a cost saving) The number of additional patients abstinent = 122 The costs per additional abstinent patient = -£2,252 Sensitivity analysis range = -4,441 to 54,923	Perspective: NHS Scotland and patient Currency: UK Pounds Cost year: 2002 Time horizon: 20 years Discounting: 6% per annum Funded by: Health Technology Board for Scotland
Slattery and colleagues, 2003 (Scotland)	Comparators: BSCT versus control intervention	Population: 45-year-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 and	Cost-effectiveness analysis based on adapted Schadlich and Brecht (1998) model	Costs: a cost per attendee was calculated based on the staff requirements, accommodation (non-residential, that is 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 seven disease endpoints also included: stroke, cancer, cirrhosis, alcoholic psychosis, chronic pancreatitis, epilepsy and alcohol dependence syndrome Total intervention costs = £385,000 per 1000 people	Net healthcare savings over 20 years = -£80,452 (negative costs are a cost saving) The number of additional patients abstinent = 86 The costs per additional abstinent patient = -£936 Sensitivity analysis range = -3,467 to 146,018	Perspective: NHS Scotland and patient Currency: UK Pounds Cost year: 2002 Time horizon: 20 years Discounting: 6% per annum Funded by: Health Technology Board for Scotland

Study ID (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
		colleagues (1996) Source of unit costs: Scottish health services costs 2000/01		Outcomes: number of patients who have abstained or controlled drinking		
Slattery and colleagues, 2003 (Scotland)	Comparators: MET versus control intervention	Population: 45 year 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 and colleagues (1996) Source of unit costs: Scottish health services costs 2000/01	Cost-effectiveness analysis based on adapted Schadlich and Brecht (1996) model	Costs: a cost per attendee was calculated based on the staff requirements, accommodation (non-residential, that is 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 seven disease endpoints also included: stroke, cancer, cirrhosis, alcoholic psychosis, chronic pancreatitis, epilepsy and alcohol dependence syndrome Total intervention costs = £385,000 per 1000 people Outcomes: number of patients who have abstained or controlled drinking	Net healthcare savings over 20 years = -£151,723 (negative costs are a cost saving) The number of additional patients abstinent = 99 The costs per additional abstinent patient = -£1,531 Sensitivity analysis range = -3,256 to 68,964	Perspective: NHS Scotland and patient Currency: UK Pounds Cost year: 2002 Time horizon: 20 years Discounting: 6% per annum Funded by: Health Technology Board for Scotland
Slattery and colleagues, 2003 (Scotland)	Comparators: marital/family therapy versus control intervention	Population: 45 year 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	Cost-effectiveness analysis based on adapted Schadlich and Brecht (1996) model	Costs: a cost per attendee was calculated based on the staff requirements, accommodation (non-residential, that is 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 seven disease endpoints also included: stroke, cancer, cirrhosis, alcoholic psychosis, chronic pancreatitis, epilepsy and alcohol dependence syndrome Total intervention costs = £385,000 per 1000	Net healthcare savings over 20 years = -£183,795 (negative costs are a cost saving) The number of additional patients abstinent = 105 The costs per additional abstinent patient = -£1,759 Sensitivity analysis range = -3217 to 16,577	Perspective: NHS Scotland and patient Currency: UK Pounds Cost year: 2002 Time horizon: 20 years Discounting: 6% per annum Funded by: Health Technology Board for Scotland

Study ID (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
		opinion, Annis and colleagues (1996) Source of unit costs: Scottish health services costs 2000/01		people Outcomes: number of patients who have abstained or controlled drinking		
UKATT Research Team, 2005 (UK)	Comparators: MET versus SNBT	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 and 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 GP for home visit and in-surgery consultation, a prescription, a home visit by a CPN, a detoxification episode in primary care, rehabilitation and consultation in an alcohol agency, social service contact and court attendance Outcomes: QALYs, 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 SNBT 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. MET 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:
Mortimer and Segal, 2005 (Australia)	Comparators: MOCE versus 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	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	BSCT dominated MOCE (cheaper and more effective) The cost per QALY gained was estimated at AU\$2,145 in a predominantly male population with moderate dependence.	Perspective: Department of Health and Ageing Currency: Australian Dollars Cost year: 2003 Time horizon: lifetime Discounting: 5% Funded by: Australian

Study ID (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
		<p>effectiveness data: Heather and colleagues (2000)</p> <p>Source of resource-use estimates: estimated prospectively from study</p> <p>Source of unit costs: Australian healthcare costs sources, Medicare Benefits Schedule</p>		<p>Outcomes: mean DDD; mean PDA</p> <p>Measures of benefit: cost per changer and cost per QALY</p> <p>Utility data sourced from: Stouthard and colleagues (1997)</p>		Government and Monash University
Mortimer and Segal, 2005 (Australia)	<p>Comparators: MET</p> <p>versus</p> <p>no further counselling after initial assessment</p>	<p>Population: mild to moderately dependent drinkers aged 15-59 years</p> <p>Setting: outpatient</p> <p>Source of clinical effectiveness data: Sellman and colleagues (2001)</p> <p>Source of resource-use estimates: costs have been taken from the intervention undertaken by Sellman and colleagues (2001), from the methods described in the published paper</p> <p>Source of unit costs: Australian healthcare costs sources</p>	Cost-effectiveness analysis and cost-utility analysis	<p>Costs: 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</p> <p>Outcomes: for the cost-effectiveness analysis between-group comparison the key outcome: percentage drinking within national guidelines for the duration of the trial</p> <p>QALYs</p> <p>Utility data sourced from Stouthard and colleagues (1997)</p>	<p>The incremental cost per changer = -AU\$26.5 per changer; MET dominates no further counselling</p> <p>In the cost utility analysis: MET is estimated to deliver 0.116 QALYs gained per completer as compared to no further counseling</p> <p>The incremental cost per completer of MET as compared to no further counselling was estimated at AU\$389 and was assumed to reflect the incremental cost over the entire evaluation period. The cost per QALY gained is estimated at AU\$3,366</p>	<p>Perspective: Department of Health and Ageing</p> <p>Currency: Australian Dollars</p> <p>Cost year: 2003</p> <p>Time horizon: lifetime</p> <p>Discounting: 5%</p> <p>Funded by: Australian Government and Monash University</p>

Study ID (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 and Segal, 2005 (Australia)	<p>Comparators: NDRL (subjects talked about anything they wanted, with no attempt to steer towards alcohol problem). Four sessions over 6 weeks</p> <p>versus</p> <p>no further counselling after initial assessment and feedback/education</p>	<p>Population: mild to moderately dependent drinkers aged 15 to 59 years</p> <p>Setting: outpatient</p> <p>Source of clinical effectiveness data: Sellman and colleagues (2001)</p> <p>Source of resource-use estimates: estimated prospectively from the study</p> <p>Source of unit costs: Australian healthcare costs sources, Medicare Benefits Schedule</p>	Cost-utility analysis based on a Markov model	<p>Costs: 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</p> <p>Outcomes: QALYs</p> <p>Utility data sourced from: Stouthard and colleagues (1997)</p> <p>Returning problem drinkers to safe consumption pattern = 0.110 annual QALY gain</p> <p>Returning dependent drinkers to safe consumption pattern = 0.330 annual QALY gain</p>	<p>The Markov model was also used to estimate QALYs gained per person for NRDL compared to no further counselling</p> <p>The NDRL was inferior to the no further counselling based on the proportion remaining within national guidelines at 6-months follow-up. Given that the NDRL is also more costly than the no further counselling; the modelled cost-utility analysis has the no further counselling dominating the NDRL</p>	<p>Perspective: Department of Health and Ageing</p> <p>Currency: Australian Dollars</p> <p>Cost year: 2003</p> <p>Time horizon: lifetime</p> <p>Discounting: 5%</p> <p>Funded by: Australian Government and Monash University</p>
Holder and colleagues, 2000 (US)	<p>Comparators: 12-session CBT</p> <p>versus</p> <p>4-session MET</p> <p>versus</p> <p>12-session TSF</p>	<p>Population: adult patients with alcohol-dependency symptoms</p> <p>Setting: inpatient, outpatient and aftercare settings</p> <p>Source of clinical effectiveness data: Project MATCH RCT (Project MATCH Research Group, 1997 and 1998)</p> <p>Source of resource-use and cost estimates:</p>	Cost-analysis	<p>Costs: direct healthcare costs - treatments, inpatient care and outpatient care</p> <p>Total monthly mean costs (post-treatment):</p> <p>CBT: \$186</p> <p>MET: \$176</p> <p>TSF: \$225</p>	<p>No formal incremental analysis presented by authors.</p> <p>Authors concluded that MET had potential for health-care cost savings after matching patients in each group for clinical prognosis</p>	<p>Perspective: Healthcare payer (US)</p> <p>Currency: US Dollars</p> <p>Cost year: 1982-84</p> <p>Time horizon: 3 years</p> <p>Discounting: Not reported</p> <p>Funded by: National Institute on Alcohol and Alcoholism (US)</p>

Study ID (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
		taken from 279 of 430 Project MATCH participants				
Fals-Stewart and colleagues, 2005 (US)	<p>Comparators: BRT - 18 scheduled sessions over 12 weeks</p> <p>versus</p> <p>S-BCT - 24 sessions over 12 weeks</p> <p>versus</p> <p>IBT - 18 scheduled sessions over 12 weeks</p> <p>versus</p> <p>PACT - 18 scheduled sessions over 12 weeks</p>	<p>Population: male partner (within couple) met DSM-IV criteria for alcohol dependence and have alcohol as their primary substance of abuse</p> <p>Setting: outpatient</p> <p>Source of clinical effectiveness data: single RCT</p> <p>Source of resource-use and cost estimates: 100 couples</p>	Cost-effectiveness analysis	<p>Costs: treatment programme expenditures (for example, counsellor time, equipment); patient travel time</p> <p>Total mean treatment costs: BRT: \$897 (SD \$312) S-BCT: \$1,294 (SD \$321) IBT: \$840 (SD \$200) PACT: \$884 (SD \$297)</p> <p>Outcomes: percentage of days of heavy drinking- change from baseline to 12 months</p>	<p>Authors calculated mean change in percentage of days of heavy drinking over 12 months divided by mean cost of treatment delivery (in \$100 units) - higher ratios indicate greater cost-effectiveness</p> <p>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)</p>	<p>Perspective: societal</p> <p>Currency: US Dollars</p> <p>Cost year: Not reported</p> <p>Time horizon: 12 months</p> <p>Discounting: N/A</p> <p>Funded by: National Institute on Alcohol Abuse and Alcoholism</p>

Combination (psychology and pharmacology)

Study ID (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 and colleagues, 2009 (Australia)	Comparators: CBT 12-week manual based outpatient program versus 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: Drug Abuse Treatment Cost Analysis Program	Costing analysis	Costs: personnel costs, supplies and materials, equipment, contracted services, buildings and facilities and miscellaneous, 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