Effectiveness of community psychosocial and pharmacological treatments for alcohol use disorder: A national observational cohort study in England

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Abstract

Background: This was a national English observational cohort study using administrative data to estimate the effectiveness of community pharmacological and psychosocial treatment for alcohol use disorder (AUD).

Methods: All adults commencing AUD treatment in the community reported to the National Drug Treatment Monitoring System (April 1 2014–March 31 2015; N = 52,499). Past 28-day admission drinking pattern included drinks per drinking day (DDD): 0 (‘Abstinent’), 1–15 (‘Low-High’), 16–30 (‘High-Extreme’) and over 30 DDD (‘Extreme’). The primary outcome was successful completion of treatment within 12 months of commencement with no re-presentation (SCNR) in the subsequent six months, analysed by multi-level, mixed effects, multivariable logistic regression.

Results: The majority reported DDD in the ‘Low-High’ (n = 17,698, 34%) and ‘High-Extreme’ (n = 21,383, 41%) range. Smaller proportions were categorised ‘Extreme’ (n = 7759, 15%) and ‘Abstinent’ (n = 5661, 11%). Three-fifths (58%) achieved SCNR. Predictors of SCNR were older age, black/minority ethnic group, employment, criminal justice system referral, and longer treatment exposure. Predictors of negative outcome were AUD treatment history, lower socio-economic status, housing problems, and ‘Extreme’ drinking at admission. In addition to psychosocial interventions, pharmacological interventions and recovery support increased the likelihood of SCNR. Pharmacological treatment was only beneficial for the ‘Low-High’ groups with recovery support.

Conclusions: Over half of all patients admitted for community AUD treatment in England are reported to successfully complete treatment within 12 months and are not re-admitted for further treatment in the following 6 months. Study findings underscore efforts to tailor AUD treatment to the severity of alcohol consumption and using recovery support.

1. Introduction

Reducing alcohol-related harms is a global public health priority (World Health Organisation, 2014). Alcohol consumption is linked to over 200 disease and injury conditions and is implicated as a cause in 3.8% of all global deaths (Rehm et al., 2009). Each year, 3.6% of the world’s population (15–64 years) meets diagnostic criteria for alcohol use disorder (AUD; American Psychiatric Association, 2013), and higher rates are estimated for Europe (5.5%) (Rehm et al., 2009). AUD is characterised as a chronic relapsing disorder, often associated with several presentations to treatment (Dennis et al., 2005).

Facilitating access to effective treatment is a key priority for most countries with developed healthcare systems. In the United Kingdom (UK), the National Institute for Health and Care Excellence (National Institute for Health and Clinical Excellence, 2011) guidelines have identified a range of formal, randomised controlled trial (RCT) supported psychosocial and pharmacological interventions for the management of AUD (see Donoghue et al., 2015; Jonas et al., 2014; Martin and Rehm, 2012).

In England, public treatment systems for alcohol-related problems...
are commissioned by local government authorities in accordance with NICE guidance. Most AUD treatment is offered by National Health Service (NHS) and third sector services in primary and secondary care community/outpatient settings. The latter is delivered by multi-disciplinary teams which typically include psychiatrists/physicians, psychiatric/general nurses, psychologists, social workers, and counsellors. There are also a small number of inpatient and residential programs provided by the NHS and third sector.

Psychosocial interventions, delivered individually or in a group format, variously apply motivational, cognitive, behavioural, psycho-dynamic, family, and social network methods. They provide access to general counselling, community support networks, and 12-step groups. They provide access to variously apply motivational, cognitive, behavioural, psychological, family, and social network methods. Therapeutic targets vary and include resolving ambivalence about change and improving recognition of, and control over, alcohol conditioned cues, urges and emotions. These interventions vary in duration from approximately 3–20 sessions according to the severity and complexity of the person’s AUD and the methods involved.

Pharmacological interventions are used to help patients withdraw from alcohol and to prevent relapse. Withdrawal regimens, usually incorporating benzodiazepine medications, are typically for 7–10 days. Specific medications targeting the brain’s reward and stress systems, including acamprosate, naltrexone, and nalmefene (Mason et al., 1999), help those who have stopped using alcohol maintain abstinence or prevent heavy drinking. These medications are usually provided for 6 months or longer with psychosocial support. In the context of continuing care, formal psychosocial and pharmacological interventions may be delivered concurrently or sequentially within specific episodes.

In developed healthcare systems, AUD treatment plans incorporate information on clinician history, patient preference, current clinical severity, case complexity, and service availability. In the UK, the National Institute for Health and Clinical Excellence (2011) guidelines are based on a delineation of treatment interventions according to level of consumption on a typical drinking day at assessment. People consuming ≤15 drinks per drinking day (DDD; one unit = 10 mL, containing 8 mg pure alcohol) are recommended for psychosocial interventions; those consuming 16–30 DDD should be assessed and are recommended for pharmacological treatment to assist withdrawal, coupled with appropriate psychosocial interventions; and for those consuming 30 DDD, there should be assessment for a 24-h medically supervised residential program.

Since 2005/06, the English National Drug Treatment Monitoring System (NDTMS; Public Health England, 2015b) has monitored access to treatment for drug use disorders and measuring associated outcomes. In 2008/09, NDTMS was enhanced to monitor outcomes from all public treatment services for AUD. Today, all operational public alcohol and drug treatment services who deliver treatment interventions report to the system and ~98% of patients consent to the use of their administrative and clinical data for local treatment system needs assessment and national research (Marsden et al., 2009, 2012; White et al., 2015; Willey et al., 2016).

A crucial question for alcohol policy and public accountability is whether public treatment services for AUD are effective. There has been remarkably little research on this question in the UK or overseas. For several reasons, routine effectiveness in the clinic may differ from results from RCTs and systematic reviews. Clinical trials conducted in this area typically involve specified treatment protocols, delivered within a single setting to patients categorised by a set threshold of severity (usually with criteria imposed to minimise risk of poor response; Witkiewitz et al., 2015). Such restrictions may not apply to the general treatment population, who present with a wide range of clinical severity and health and social complexities. Understanding those characteristics which predict treatment outcomes for this diverse population is critical for targeting services, facilitating prognosis, and improving treatment outcomes (Adamson et al., 2009).

There has been no national study to date on the clinical effectiveness of community AUD treatment services in the UK, with previous reports focusing on treatment provision (Brennan et al., 2005) and recidivism (Willey et al., 2016). For England, we report on the clinical outcomes for AUD associated with pharmacological and psychosocial interventions.

2. Methods

2.1. Design

This was an observational follow-up study of people accessing publicly-funded, community-based treatment for AUD in England. A report on the effectiveness of residential treatments is given elsewhere (Eastwood et al., in press). Data were collected from all community-based treatment agencies providing structured psychosocial and pharmacological interventions for AUD and reporting to NDTMS (Public Health England, 2015b). The study included all 152 upper-tier local authorities within England and all specialist AUD services within the National Health Service or third-sector reporting to the database. The study is reported according to the STROBE (and RECORD) guideline for cohort research (Benchimol et al., 2015).

2.2. Patient and treatment information

NDTMS records were accessed on patient-demographic, behavioural, clinical, and treatment outcome variables for each episode of treatment, including the dates of starting and finishing AUD interventions (Public Health England, 2015a,b). Reflecting national reporting standards (Public Health England, 2015b), and utilising a pre-existing variable in the database, individual treatment episodes were concatenated into ‘treatment journeys’, whereby multiple episodes (community-based or residential program) are subsumed under a single journey.

AUD intervention episodes were allocated to the same treatment journey if fewer than 21 days elapsed between the date of ending one intervention and the date of starting a subsequent one. In this way, a treatment journey for a patient could comprise a single intervention episode, concurrent episodes provided by more than one agency, or a continuing care package of consecutive episodes provided by one or more service providers.

2.3. Study cohort

The study population was adults (aged ≥18 years) who commenced community treatment for primary AUD between 1 April 2014 and 31 March 2015 (N = 54,354). Patients were not included in the study cohort if they: (1) reported problematic use of other substances at assessment, (2) had missing information on DDD at both triage and treatment admission, or (3) had missing information on clinical status at discharge were not considered for inclusion. Following removal of 1425 cases who were assessed but then received no treatment, the analysis cohort comprised 52,499 individuals.

Analyses were based on the patients’ first treatment journey during the period (hereafter ‘index journey’). The observation period commenced from the date of starting community-based structured treatment and ended either six months after the date of discharge from the index journey, if discharge occurred within 12 months of starting treatment, or 12 months after starting treatment if the patient was not yet discharged (the latter group was excluded from analysis of the primary outcome).

2.4. Outcome measure

A commonly used measure of treatment outcome is the proportion of patients treated who completed treatment successfully (i.e., discharge from treatment based on reduced alcohol use or abstinence,
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