NICE National Institute for Health and Care Excellence

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence

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Contents

Introduction

This guideline makes recommendations on the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and in young people aged 10–17 years.

This is one of three pieces of NICE guidance addressing alcohol-related problems and should be read in conjunction with:

- Alcohol-use disorders: preventing the development of hazardous and harmful drinking. NICE public health guidance 24 (2010). Public health guidance on the price, advertising and availability of alcohol, how best to detect alcohol misuse in and outside primary care, and brief interventions to manage it in these settings.
- Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications. NICE clinical guideline 100 (2010). A clinical guideline covering acute unplanned alcohol withdrawal including delirium tremens, alcohol-related liver damage, alcohol-related pancreatitis and management of Wernicke's encephalopathy.

Harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol. This could include psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis. In the longer term, harmful drinkers may go on to develop high blood pressure, cirrhosis, heart disease and some types of cancer, such as mouth, liver, bowel or breast cancer.

Alcohol dependence is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example, liver disease or depression caused by drinking). Alcohol dependence is also associated with increased criminal activity and domestic violence, and an increased rate of significant mental and physical disorders. Although alcohol dependence is defined in ICD-10 and DSM-IV in categorical terms for diagnostic and statistical purposes as being either present or absent, in reality dependence exists on a continuum of severity. However, it is helpful from a clinical perspective to subdivide dependence into categories of mild, moderate and severe. People with mild dependence (those scoring 15 or less on the Severity of Alcohol Dependence Questionnaire; SADQ) usually do not need assisted alcohol withdrawal. People with moderate dependence (with a SADQ score of between 15 and 30) usually need assisted alcohol withdrawal, which can typically be managed in a community setting unless there are other risks. People who are severely alcohol dependent (with a SADQ score of more than 30) will need assisted alcohol withdrawal, typically in an inpatient or

residential setting. In this guideline these definitions of severity are used to guide selection of appropriate interventions.

For convenience this guideline refers to harmful drinking and alcohol dependence as 'alcohol misuse'. When recommendations apply to both people who are dependent on alcohol and harmful drinkers, the terms 'person who misuses alcohol' or 'service user' are used unless the recommendation is specifically referring to either people who are dependent on alcohol or who are harmful drinkers.

Alcohol dependence affects 4% of people aged between 16 and 65 in England (6% of men and 2% of women), and over 24% of the English population (33% of men and 16% of women) consume alcohol in a way that is potentially or actually harmful to their health or well-being. Alcohol misuse is also an increasing problem in children and young people, with over 24,000 treated in the NHS for alcohol-related problems in 2008 and 2009.

Comorbid mental health disorders commonly include depression, anxiety disorders and drug misuse, some of which may remit with abstinence from alcohol but others may persist and need specific treatment. Physical comorbidities are common, including gastrointestinal disorders (in particular liver disease) and neurological and cardiovascular disease. In some people these comorbidities may remit on stopping or reducing alcohol consumption, but many experience long-term consequences of alcohol misuse that may significantly shorten their life.

Of the 1 million people aged between 16 and 65 who are alcohol dependent in England, only about 6% per year receive treatment. Reasons for this include the often long period between developing alcohol dependence and seeking help, and the limited availability of specialist alcohol treatment services in some parts of England. Additionally, alcohol misuse is under-identified by health and social care professionals, leading to missed opportunities to provide effective interventions.

Diagnosis is made on the basis of the symptoms and consequences of alcohol misuse outlined above. Simple biological measures such as liver function tests are poor indicators of the presence of harmful or dependent drinking. Diagnosis and assessment of the severity of alcohol misuse is important because it points to the treatment interventions required. Acute withdrawal from alcohol in the absence of medical management can be hazardous in people with severe alcohol dependence, as it may lead to seizures, delirium tremens and, in some instances, death.

Current practice across the country is varied and access to a range of assisted withdrawal and treatment services varies as a consequence. Services for assisted alcohol withdrawal vary considerably in intensity and there is a lack of structured intensive community-based assisted withdrawal programmes. Similarly, there is limited access to psychological interventions such as cognitive behavioural therapies specifically focused on alcohol misuse. In addition, when the alcohol misuse has been effectively treated, many people continue to experience problems in accessing services for comorbid mental and physical health problems. Despite the publication of the Models of Care for Alcohol by the Department of Health in 2007 (National Treatment Agency, 2007), alcohol service structures are poorly developed, with care pathways often ill defined. In order to address this last point the three pieces of NICE guidance are integrated into a care pathway.

This guideline will assume that prescribers will use a drug's summary of product characteristics (SPC) to inform their decisions for individual service users.

In this guideline, drug names are marked with a footnote if they do not have a UK marketing authorisation for the indication in question at the time of publication. Prescribers should check each drug's SPC for current licensed indications.

At the time of publication, no drug recommended in this guideline has a UK marketing authorisation for use in children and young people under the age of 18. However, in 2000, the Royal College of Paediatrics and Child Health issued a policy statement on the use of unlicensed medicines, or the use of licensed medicines for unlicensed applications, in children and young people. This states that such use is necessary in paediatric practice and that doctors are legally allowed to prescribe unlicensed medicines where there are no suitable alternatives and where the use is justified by a responsible body of professional opinion.

Person-centred care

This guideline offers best practice advice on the care of adults and young people with alcohol dependence or who are harmful drinkers.

Treatment and care should take into account people's needs and preferences. Service users should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If service users do not have the capacity to make decisions, healthcare professionals should follow the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act. In Wales, healthcare professionals should follow advice on consent from the Welsh Government.

If a service user is under 16, staff should follow the guidelines in the Department of Health's 'Seeking consent: working with children'.

Good communication between staff and service users is essential. It should be supported by evidence-based written information tailored to the service user's needs. Treatment and care, and the information service users are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

If the service user agrees, families and carers should have the opportunity to be involved in decisions about treatment and care. For young people under the age of 16, parents or guardians should be involved in decisions about treatment and care according to best practice.

Families and carers should also be given the information and support they need in their own right.

Care of young people in transition between paediatric and adult services should be planned and managed according to the best practice guidance described in 'Transition: getting it right for young people'.

Key priorities for implementation

Identification and assessment in all settings

- Staff working in services provided and funded by the NHS who care for people who potentially misuse alcohol should be competent to identify harmful drinking and alcohol dependence. They should be competent to initially assess the need for an intervention or, if they are not competent, they should refer people who misuse alcohol to a service that can provide an assessment of need.

Assessment in specialist alcohol services

- Consider a comprehensive assessment for all adults referred to specialist services who score more than 15 on the Alcohol Use Disorders Identification Test (AUDIT). A comprehensive assessment should assess multiple areas of need, be structured in a clinical interview, use relevant and validated clinical tools (see 1.2.1.4), and cover the following areas:
    - alcohol use, including:
        - consumption: historical and recent patterns of drinking (using, for example, a retrospective drinking diary), and if possible, additional information (for example, from a family member or carer)
        - dependence (using, for example, SADQ or Leeds Dependence Questionnaire [LDQ])
        - alcohol-related problems (using, for example, Alcohol Problems Questionnaire [APQ])
    - other drug misuse, including over-the-counter medication
    - physical health problems
    - psychological and social problems
    - cognitive function (using, for example, the Mini-Mental State Examination [MMSE])
    - readiness and belief in ability to change.

General principles for all interventions

- Consider offering interventions to promote abstinence and prevent relapse as part of an intensive structured community-based intervention for people with moderate and severe alcohol dependence who have:
    - very limited social support (for example, they are living alone or have very little contact with family or friends) **or**
    - complex physical or psychiatric comorbidities **or**
    - not responded to initial community-based interventions (see1.3.1.2).
- All interventions for people who misuse alcohol should be delivered by appropriately trained and competent staff. Pharmacological interventions should be administered by specialist and competent staff[1]. Psychological interventions should be based on a relevant evidence-based treatment manual, which should guide the structure and duration of the intervention. Staff should consider using competence frameworks developed from the relevant treatment manuals and for all interventions should:
    - receive regular supervision from individuals competent in both the intervention and supervision
    - routinely use outcome measurements to make sure that the person who misuses alcohol is involved in reviewing the effectiveness of treatment
    - engage in monitoring and evaluation of treatment adherence and practice competence, for example, by using video and audio tapes and external audit and scrutiny if appropriate.

Interventions for harmful drinking and mild alcohol dependence

- For harmful drinkers and people with mild alcohol dependence, offer a psychological intervention (such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems and social networks.

Assessment for assisted alcohol withdrawal

- For service users who typically drink over 15 units of alcohol per day, and/or who score 20 or more on the AUDIT, consider offering:
    - an assessment for and delivery of a community-based assisted withdrawal, **or**
    - assessment and management in specialist alcohol services if there are safety concerns (see 1.3.4.5) about a community-based assisted withdrawal.

Interventions for moderate and severe alcohol dependence

- After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering acamprosate or oral naltrexone[a] in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol misuse (see section 1.3.3).

Assessment and interventions for children and young people who misuse alcohol

- For children and young people aged 10–17 years who misuse alcohol offer:
    - individual cognitive behavioural therapy for those with limited comorbidities and good social support
    - multicomponent programmes (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy) for those with significant comorbidities and/or limited social support.

Interventions for conditions comorbid with alcohol misuse

- For people who misuse alcohol and have comorbid depression or anxiety disorders, treat the alcohol misuse first as this may lead to significant improvement in the depression and anxiety. If depression or anxiety continues after 3 to 4 weeks of abstinence from alcohol, undertake an assessment of the depression or anxiety and consider referral and treatment in line with the relevant NICE guideline for the particular disorder[b].

[1] If a drug is used at a dose or for an application that does not have UK marketing authorisation, informed consent should be obtained and documented

[2] At the time of publication (February 2011), oral naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

[3] See Depression: the treatment and management of depression in adults' NICE clinical guideline 90 (2009) and 'Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care', NICE clinical guideline 113 (2011).

1 Guidance

The following guidance is based on the best available evidence. The full guideline gives details of the methods and the evidence used to develop the guidance.

1.1 Principles of care

1.1.1 Building a trusting relationship and providing information

1.1.1.1 When working with people who misuse alcohol:

- build a trusting relationship and work in a supportive, empathic and non-judgmental manner
- take into account that stigma and discrimination are often associated with alcohol misuse and that minimising the problem may be part of the service user's presentation
- make sure that discussions take place in settings in which confidentiality, privacy and dignity are respected.

1.1.1.2 When working with people who misuse alcohol:

- provide information appropriate to their level of understanding about the nature and treatment of alcohol misuse to support choice from a range of evidence-based treatments
- avoid clinical language without explanation
- make sure that comprehensive written information is available in an appropriate language or, for those who cannot use written text, in an accessible format
- provide independent interpreters (that is, someone who is not known to the service user) if needed.

1.1.2 Working with and supporting families and carers

1.1.2.1 Encourage families and carers to be involved in the treatment and care of people who misuse alcohol to help support and maintain positive change.

1.1.2.2 When families and carers are involved in supporting a person who misuses alcohol, discuss concerns about the impact of alcohol misuse on themselves and other family members, and:

- provide written and verbal information on alcohol misuse and its management, including how families and carers can support the service user
- offer a carer's assessment where necessary
- negotiate with the service user and their family or carer about the family or carer's involvement in their care and the sharing of information; make sure the service user's, family's and carer's right to confidentiality is respected.

1.1.2.3 When the needs of families and carers of people who misuse alcohol have been identified:

- offer guided self-help, usually consisting of a single session, with the provision of written materials
- provide information about, and facilitate contact with, support groups (such as self-help groups specifically focused on addressing the needs of families and carers).

1.1.2.4 If the families and carers of people who misuse alcohol have not benefited, or are not likely to benefit, from guided self-help and/or support groups and continue to have significant problems, consider offering family meetings. These should:

- provide information and education about alcohol misuse
- help to identify sources of stress related to alcohol misuse
- explore and promote effective coping behaviours
- usually consist of at least five weekly sessions.

1.1.2.5 All staff in contact with parents who misuse alcohol and who have care of or regular contact with their children, should:

- take account of the impact of the parent's drinking on the parent–child relationship and the child's development, education, mental and physical health, own alcohol use, safety, and social network
- be aware of and comply with the requirements of the Children Act (2004).

1.2 Identification and assessment

1.2.1 General principles

1.2.1.1 Make sure that assessment of risk is part of any assessment, that it informs the development of the overall care plan, and that it covers risk to self (including unplanned withdrawal, suicidality and neglect) and risk to others.

1.2.1.2 Staff working in services provided and funded by the NHS who care for people who potentially misuse alcohol should be competent to identify harmful drinking and alcohol dependence. They should be competent to initially assess the need for an intervention or, if they are not competent, they should refer people who misuse alcohol to a service that can provide an assessment of need.

1.2.1.3 When conducting an initial assessment, as well as assessing alcohol misuse, the severity of dependence and risk, consider the:

- extent of any associated health and social problems
- need for assisted alcohol withdrawal.

1.2.1.4 Use formal assessment tools to assess the nature and severity of alcohol misuse, including the:

- AUDIT for identification and as a routine outcome measure
- SADQ or LDQ for severity of dependence
- Clinical Institute Withdrawal Assessment of Alcohol Scale, revised (CIWA-Ar) for severity of withdrawal
- APQ for the nature and extent of the problems arising from alcohol misuse.

1.2.1.5 When assessing the severity of alcohol dependence and determining the need for assisted withdrawal, adjust the criteria for women, older people, children and young people[4], and people with established liver disease who may have problems with the metabolism of alcohol.

1.2.1.6 Staff responsible for assessing and managing assisted alcohol withdrawal (see 1.3.4) should be competent in the diagnosis and assessment of alcohol dependence and withdrawal symptoms and the use of drug regimens appropriate to the settings (for example, inpatient or community) in which the withdrawal is managed.

1.2.1.7 Staff treating people with alcohol dependence presenting with an acute unplanned alcohol withdrawal should refer to 'Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications' (NICE clinical guideline 100).

1.2.2 Assessment in specialist alcohol services

Treatment goals

1.2.2.1 In the initial assessment in specialist alcohol services of all people who misuse alcohol, agree the goal of treatment with the service user. Abstinence is the appropriate goal for most people with alcohol dependence, and people who misuse alcohol and have significant psychiatric or physical comorbidity (for example, depression or alcohol-related liver disease). When a service user prefers a goal of moderation but there are considerable risks, advise strongly that abstinence is most appropriate, but do not refuse treatment to service users who do not agree to a goal of abstinence.

1.2.2.2 For harmful drinking or mild dependence, without significant comorbidity, and if there is adequate social support, consider a moderate level of drinking as the goal of treatment unless the service user prefers abstinence or there are other reasons for advising abstinence.

1.2.2.3 For people with severe alcohol dependence, or those who misuse alcohol and have significant psychiatric or physical comorbidity, but who are unwilling to consider a goal of abstinence or engage in structured treatment, consider a

harm reduction programme of care. However, ultimately the service user should be encouraged to aim for a goal of abstinence.

1.2.2.4 When developing treatment goals, consider that some people who misuse alcohol may be required to abstain from alcohol as part of a court order or sentence.

Brief triage assessment

1.2.2.5 All adults who misuse alcohol who are referred to specialist alcohol services should have a brief triage assessment to assess:

- the pattern and severity of the alcohol misuse (using AUDIT) and severity of dependence (using SADQ)
- the need for urgent treatment including assisted withdrawal
- any associated risks to self or others
- the presence of any comorbidities or other factors that may need further specialist assessment or intervention.

Agree the initial treatment plan, taking into account the service user's preferences and outcomes of any previous treatment.

Comprehensive assessment

1.2.2.6 Consider a comprehensive assessment for all adults referred to specialist alcohol services who score more than 15 on the AUDIT. A comprehensive assessment should assess multiple areas of need, be structured in a clinical interview, use relevant and validated clinical tools (see 1.2.1.4), and cover the following areas:

- alcohol use, including:
  - consumption: historical and recent patterns of drinking (using, for example, a retrospective drinking diary), and if possible, additional information (for example, from a family member or carer)

  - dependence (using, for example, SADQ or LDQ)
  - alcohol-related problems (using, for example, APQ)
- other drug misuse, including over-the-counter medication
- physical health problems
- psychological and social problems
- cognitive function (using, for example, the Mini-Mental State Examination [MMSE])
- readiness and belief in ability to change.

1.2.2.7 Assess comorbid mental health problems as part of any comprehensive assessment, and throughout care for the alcohol misuse, because many comorbid problems (though not all) will improve with treatment for alcohol misuse. Use the assessment of comorbid mental health problems to inform the development of the overall care plan.

1.2.2.8 For service users whose comorbid mental health problems do not significantly improve after abstinence from alcohol (typically after 3–4 weeks), consider providing or referring for specific treatment (see the relevant NICE guideline for the particular disorder).

1.2.2.9 Consider measuring breath alcohol as part of the management of assisted withdrawal. However, breath alcohol should not usually be measured for routine assessment and monitoring in alcohol treatment programmes.

1.2.2.10 Consider blood tests to help identify physical health needs, but do not use blood tests routinely for the identification and diagnosis of alcohol use disorders.

1.2.2.11 Consider brief measures of cognitive functioning (for example, MMSE) to help with treatment planning. Formal measures of cognitive functioning should usually only be performed if impairment persists after a period of abstinence or a significant reduction in alcohol intake.

1.3 Interventions for alcohol misuse

1.3.1 General principles for all interventions

1.3.1.1 For all people who misuse alcohol, carry out a motivational intervention as part of the initial assessment. The intervention should contain the key elements of motivational interviewing including:

- helping people to recognise problems or potential problems related to their drinking
- helping to resolve ambivalence and encourage positive change and belief in the ability to change
- adopting a persuasive and supportive rather than an argumentative and confrontational position.

1.3.1.2 For all people who misuse alcohol, offer interventions to promote abstinence or moderate drinking as appropriate (see 1.2.2.1–1.2.2.4) and prevent relapse, in community-based settings.

1.3.1.3 Consider offering interventions to promote abstinence and prevent relapse as part of an intensive structured community-based intervention for people with moderate and severe alcohol dependence who have:

- very limited social support (for example, they are living alone or have very little contact with family or friends) **or**
- complex physical or psychiatric comorbidities **or**
- not responded to initial community-based interventions (see 1.3.1.2).

1.3.1.4 For people with alcohol dependence who are homeless, consider offering residential rehabilitation for a maximum of 3 months. Help the service user find stable accommodation before discharge.

1.3.1.5 All interventions for people who misuse alcohol should be delivered by appropriately trained and competent staff. Pharmacological interventions should be administered by specialist and competent staff[s]. Psychological

interventions should be based on a relevant evidence-based treatment manual, which should guide the structure and duration of the intervention. Staff should consider using competence frameworks developed from the relevant treatment manuals and for all interventions should:

- receive regular supervision from individuals competent in both the intervention and supervision
- routinely use outcome measurements to make sure that the person who misuses alcohol is involved in reviewing the effectiveness of treatment
- engage in monitoring and evaluation of treatment adherence and practice competence, for example, by using video and audio tapes and external audit and scrutiny if appropriate.

1.3.1.6 All interventions for people who misuse alcohol should be the subject of routine outcome monitoring. This should be used to inform decisions about continuation of both psychological and pharmacological treatments. If there are signs of deterioration or no indications of improvement, consider stopping the current treatment and review the care plan.

1.3.1.7 For all people seeking help for alcohol misuse:

- give information on the value and availability of community support networks and self-help groups (for example, Alcoholics Anonymous or SMART Recovery) **and**
- help them to participate in community support networks and self-help groups by encouraging them to go to meetings and arranging support so that they can attend.

1.3.2 Care coordination and case management

Care coordination is the routine coordination by any staff involved in the care and treatment of a person who misuses alcohol. Case management is a more intensive process concerned with delivering all aspects of care, including assessment, treatment, monitoring and follow-up.

1.3.2.1 Care coordination should be part of the routine care of all service users in specialist alcohol services and should:

- be provided throughout the whole period of care, including aftercare
- be delivered by appropriately trained and competent staff working in specialist alcohol services
- include the coordination of assessment, interventions and monitoring of progress, and coordination with other agencies.

1.3.2.2 Consider case management to increase engagement in treatment for people who have moderate to severe alcohol dependence and who are considered at risk of dropping out of treatment or who have a previous history of poor engagement. If case management is provided it should be throughout the whole period of care, including aftercare.

1.3.2.3 Case management should be delivered in the context of Tier 3 interventions by staff who take responsibility for the overall coordination of care and should include:

- a comprehensive assessment of needs
- development of an individualised care plan in collaboration with the service user and relevant others (including families and carers and other staff involved in the service user's care)
- coordination of the care plan to deliver a seamless multiagency and integrated care pathway and maximisation of engagement, including the use of motivational interviewing approaches
- monitoring of the impact of interventions and revision of the care plan when necessary.

1.3.3 Interventions for harmful drinking and mild alcohol dependence

1.3.3.1 For harmful drinkers and people with mild alcohol dependence, offer a psychological intervention (such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems and social networks.

1.3.3.2 For harmful drinkers and people with mild alcohol dependence who have a regular partner who is willing to participate in treatment, offer behavioural couples therapy.

For harmful drinkers and people with mild alcohol dependence who have not responded to psychological interventions alone, or who have specifically requested a pharmacological intervention, consider offering acamprosate[a] or oral naltrexone[a] in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) or behavioural couples therapy (see section 1.3.6 for pharmacological interventions).

Delivering psychological interventions

1.3.3.3 Cognitive behavioural therapies focused on alcohol-related problems should usually consist of one 60-minute session per week for 12 weeks.

1.3.3.4 Behavioural therapies focused on alcohol-related problems should usually consist of one 60-minute session per week for 12 weeks.

1.3.3.5 Social network and environment-based therapies focused on alcohol-related problems should usually consist of eight 50-minute sessions over 12 weeks.

1.3.3.6 Behavioural couples therapy should be focused on alcohol-related problems and their impact on relationships. It should aim for abstinence, or a level of drinking predetermined and agreed by the therapist and the service user to be reasonable and safe. It should usually consist of one 60-minute session per week for 12 weeks.

1.3.4 Assessment and interventions for assisted alcohol withdrawal

See section 1.3.7 for assessment for assisted withdrawal in children and young people.

1.3.4.1 For service users who typically drink over 15 units of alcohol per day and/or who score 20 or more on the AUDIT, consider offering:

- an assessment for and delivery of a community-based assisted withdrawal, **or**

- assessment and management in specialist alcohol services if there are safety concerns (see 1.3.4.5) about a community-based assisted withdrawal.

1.3.4.2 Service users who need assisted withdrawal should usually be offered a community-based programme, which should vary in intensity according to the severity of the dependence, available social support and the presence of comorbidities.

- For people with mild to moderate dependence, offer an outpatient-based assisted withdrawal programme in which contact between staff and the service user averages 2–4 meetings per week over the first week.
- For people with mild to moderate dependence and complex needs[s], or severe dependence, offer an intensive community programme following assisted withdrawal in which the service user may attend a day programme lasting between 4 and 7 days per week over a 3-week period.

1.3.4.3 Outpatient-based community assisted withdrawal programmes should consist of a drug regimen (see 1.3.5) and psychosocial support including motivational interviewing (see 1.3.1.1).

1.3.4.4 Intensive community programmes following assisted withdrawal should consist of a drug regimen (see 1.3.6) supported by psychological interventions including individual treatments (see 1.3.6), group treatments, psychoeducational interventions, help to attend self-help groups, family and carer support and involvement, and case management (see 1.3.2.2).

1.3.4.5 Consider inpatient or residential assisted withdrawal if a service user meets one or more of the following criteria. They:

- drink over 30 units of alcohol per day
- have a score of more than 30 on the SADQ
- have a history of epilepsy, or experience of withdrawal-related seizures or delirium tremens during previous assisted withdrawal programmes
- need concurrent withdrawal from alcohol and benzodiazepines

- regularly drink between 15 and 30 units of alcohol per day and have:
  - significant psychiatric or physical comorbidities (for example, chronic severe depression, psychosis, malnutrition, congestive cardiac failure, unstable angina, chronic liver disease) **or**
  - a significant learning disability or cognitive impairment.

1.3.4.6 Consider a lower threshold for inpatient or residential assisted withdrawal in vulnerable groups, for example, homeless and older people.

1.3.5 Drug regimens for assisted withdrawal

1.3.5.1 When conducting community-based assisted withdrawal programmes, use fixed-dose medication regimens[9].

1.3.5.2 Fixed-dose or symptom-triggered medication regimens[10] can be used in assisted withdrawal programmes in inpatient or residential settings. If a symptom-triggered regimen is used, all staff should be competent in monitoring symptoms effectively and the unit should have sufficient resources to allow them to do so frequently and safely.

1.3.5.3 Prescribe and administer medication for assisted withdrawal within a standard clinical protocol. The preferred medication for assisted withdrawal is a benzodiazepine (chlordiazepoxide or diazepam).

1.3.5.4 In a fixed-dose regimen, titrate the initial dose of medication to the severity of alcohol dependence and/or regular daily level of alcohol consumption. In severe alcohol dependence higher doses will be required to adequately control withdrawal and should be prescribed according to the SPC. Make sure there is adequate supervision if high doses are administered. Gradually reduce the dose of the benzodiazepine over 7–10 days to avoid alcohol withdrawal recurring.

1.3.5.5 When managing alcohol withdrawal in the community, avoid giving people who misuse alcohol large quantities of medication to take home to prevent overdose or diversion[11]. Prescribe for installment dispensing, with no more than 2 days' medication supplied at any time.

1.3.5.6 In a community-based assisted withdrawal programme, monitor the service user every other day during assisted withdrawal. A family member or carer should preferably oversee the administration of medication. Adjust the dose if severe withdrawal symptoms or over-sedation occur.

1.3.5.7 Do not offer clomethiazole for community-based assisted withdrawal because of the risk of overdose and misuse.

1.3.5.8 For service users having assisted withdrawal, particularly those who are more severely alcohol dependent or those undergoing a symptom-triggered regimen, consider using a formal measure of withdrawal symptoms such as the CIWA-Ar.

1.3.5.9 Be aware that benzodiazepine doses may need to be reduced for children and young people[12], older people, and people with liver impairment (see 1.3.5.10).

1.3.5.10 If benzodiazepines are used for people with liver impairment, consider one requiring limited liver metabolism (for example, lorazepam); start with a reduced dose and monitor liver function carefully. Avoid using benzodiazepines for people with severe liver impairment.

1.3.5.11 When managing withdrawal from co-existing benzodiazepine and alcohol dependence increase the dose of benzodiazepine medication used for withdrawal. Calculate the initial daily dose based on the requirements for alcohol withdrawal plus the equivalent regularly used daily dose of benzodiazepine[13]. This is best managed with one benzodiazepine (chlordiazepoxide or diazepam) rather than multiple benzodiazepines. Inpatient withdrawal regimens should last for 2–3 weeks or longer, depending on the severity of co-existing benzodiazepine dependence. When withdrawal is managed in the community, and/or where there is a high level of benzodiazepine dependence, the regimen should last for longer than 3 weeks, tailored to the service user's symptoms and discomfort.

1.3.5.12 For managing unplanned acute alcohol withdrawal and complications including delirium tremens and withdrawal-related seizures, refer to NICE clinical guideline 100.

1.3.6 Interventions for moderate and severe alcohol dependence after successful withdrawal

1.3.6.1 After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering acamprosate or oral naltrexone[7] in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol misuse (see section 1.3.3).

1.3.6.2 After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering acamprosate or oral naltrexone[7] in combination with behavioural couples therapy to service users who have a regular partner and whose partner is willing to participate in treatment (see section 1.3.3).

1.3.6.3 After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering disulfiram[14] in combination with a psychological intervention to service users who:

- have a goal of abstinence but for whom acamprosate and oral naltrexone are not suitable, **or**
- prefer disulfiram and understand the relative risks of taking the drug (see 1.3.6.12).

Delivering pharmacological interventions

1.3.6.4 Before starting treatment with acamprosate, oral naltrexone[17] or disulfiram, conduct a comprehensive medical assessment (baseline urea and electrolytes and liver function tests including gamma glutamyl transferase [GGT]). In particular, consider any contraindications or cautions (see the SPC), and discuss these with the service user.

Acamprosate

1.3.6.5 If using acamprosate, start treatment as soon as possible after assisted withdrawal. Usually prescribe at a dose of 1998 mg (666 mg three times a day) unless the service user weighs less than 60 kg, and then a maximum of 1332 mg should be prescribed per day. Acamprosate should:

- usually be prescribed for up to 6 months, or longer for those benefiting from the drug who want to continue with it[15]
- be stopped if drinking persists 4–6 weeks after starting the drug.

1.3.6.6 Service users taking acamprosate should stay under supervision, at least monthly, for 6 months, and at reduced but regular intervals if the drug is continued after 6 months. Do not use blood tests routinely, but consider them to monitor for recovery of liver function and as a motivational aid for service users to show improvement.

Naltrexone

1.3.6.7 If using oral naltrexone[7], start treatment after assisted withdrawal. Start prescribing at a dose of 25 mg per day and aim for a maintenance dose of 50 mg per day. Draw the service user's attention to the information card that is issued with oral naltrexone about its impact on opioid-based analgesics. Oral naltrexone should:

- usually be prescribed for up to 6 months, or longer for those benefiting from the drug who want to continue with it
- be stopped if drinking persists 4–6 weeks after starting the drug.

1.3.6.8 Service users taking oral naltrexone[7] should stay under supervision, at least monthly, for 6 months, and at reduced but regular intervals if the drug is continued after 6 months. Do not use blood tests routinely, but consider them for older people, for people with obesity, for monitoring recovery of liver function and as a motivational aid for service users to show improvement. If the service user feels unwell advise them to stop the oral naltrexone immediately.

Disulfiram

1.3.6.9 If using disulfiram, start treatment at least 24 hours after the last alcoholic drink consumed. Usually prescribe at a dose of 200 mg per day. For service users who continue to drink, if a dose of 200 mg (taken regularly for at least 1 week)

does not cause a sufficiently unpleasant reaction to deter drinking, consider increasing the dose in consultation with the service user.

1.3.6.10 Before starting treatment with disulfiram, test liver function, urea and electrolytes to assess for liver or renal impairment. Check the SPC for warnings and contraindications in pregnancy and in the following conditions: a history of severe mental illness, stroke, heart disease or hypertension.

1.3.6.11 Make sure that service users taking disulfiram:

- stay under supervision, at least every 2 weeks for the first 2 months, then monthly for the following 4 months
- if possible, have a family member or carer, who is properly informed about the use of disulfiram, oversee the administration of the drug
- are medically monitored at least every 6 months after the initial 6 months of treatment and monitoring.

1.3.6.12 Warn service users taking disulfiram, and their families and carers, about:

- the interaction between disulfiram and alcohol (which may also be found in food, perfume, aerosol sprays and so on), the symptoms of which may include flushing, nausea, palpitations and, more seriously, arrhythmias, hypotension and collapse
- the rapid and unpredictable onset of the rare complication of hepatotoxicity; advise service users that if they feel unwell or develop a fever or jaundice that they should stop taking disulfiram and seek urgent medical attention.

Drugs not to be routinely used for the treatment of alcohol misuse

1.3.6.13 Do not use antidepressants (including selective serotonin reuptake inhibitors [SSRIs]) routinely for the treatment of alcohol misuse alone.

1.3.6.14 Do not use gammahydroxybutyrate (GHB) for the treatment of alcohol misuse.

1.3.6.15 Benzodiazepines should only be used for managing alcohol withdrawal and not as ongoing treatment for alcohol dependence.

1.3.7 Special considerations for children and young people who misuse alcohol

Assessment and referral of children and young people

1.3.7.1 If alcohol misuse is identified as a potential problem, with potential physical, psychological, educational or social consequences, in children and young people aged 10–17 years, conduct an initial brief assessment to assess:

- the duration and severity of the alcohol misuse (the standard adult threshold on the AUDIT for referral and intervention should be lowered for young people aged 10–16 years because of the more harmful effects of a given level of alcohol consumption in this population)
- any associated health and social problems
- the potential need for assisted withdrawal.

1.3.7.2 Refer all children and young people aged 10–15 years to a specialist child and adolescent mental health service (CAMHS) for a comprehensive assessment of their needs, if their alcohol misuse is associated with physical, psychological, educational and social problems and/or comorbid drug misuse.

1.3.7.3 When considering referral to CAMHS for young people aged 16–17 years who misuse alcohol, use the same referral criteria as for adults (see section 1.2.2).

1.3.7.4 A comprehensive assessment for children and young people (supported if possible by additional information from a parent or carer) should assess multiple areas of need, be structured around a clinical interview using a validated clinical tool (such as the Adolescent Diagnostic Interview [ADI] or the Teen Addiction Severity Index [T-ASI]), and cover the following areas:

- consumption, dependence features and patterns of drinking
- comorbid substance misuse (consumption and dependence features) and associated problems
- mental and physical health problems

- peer relationships and social and family functioning
- developmental and cognitive needs, and educational attainment and attendance
- history of abuse and trauma
- risk to self and others
- readiness to change and belief in the ability to change
- obtaining consent to treatment
- developing a care plan and risk management plan.

Assisted withdrawal in children and young people

1.3.7.5 Offer inpatient care to children and young people aged 10–17 years who need assisted withdrawal.

1.3.7.6 Base assisted withdrawal for children and young people aged 10–17 years on the recommendations for adults (see 1.3.5) and in NICE clinical guideline 100. Consult the SPC and adjust drug regimens to take account of age, height and body mass, and stage of development of the child or young person[16].

Promoting abstinence and preventing relapse in children and young people

1.3.7.7 For all children and young people aged 10–17 years who misuse alcohol, the goal of treatment should usually be abstinence in the first instance.

1.3.7.8 For children and young people aged 10–17 years who misuse alcohol offer:

- individual cognitive behavioural therapy for those with limited comorbidities and good social support
- multicomponent programmes (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy) for those with significant comorbidities and/or limited social support.

1.3.7.9 After a careful review of the risks and benefits, specialists may consider offering acamprosate[15] or oral naltrexone[7] in combination with cognitive behavioural therapy to young people aged 16 and 17 years who have not engaged with or benefited from a multicomponent treatment programme.

Delivering psychological and psychosocial interventions for children and young people

1.3.7.10 Multidimensional family therapy should usually consist of 12–15 family-focused structured treatment sessions over 12 weeks. There should be a strong emphasis on care coordination and, if necessary, crisis management. As well as family sessions, individual interventions may be provided for both the child or young person and the parents. The intervention should aim to improve:

- alcohol and drug misuse
- the child or young person's educational and social behaviour
- parental well-being and parenting skills
- relationships with the wider social system.

1.3.7.11 Brief strategic family therapy should usually consist of fortnightly meetings over 3 months. It should focus on:

- engaging and supporting the family
- using the support of the wider social and educational system
- identifying maladaptive family interactions
- promoting new and more adaptive family interactions.

1.3.7.12 Functional family therapy should be conducted over 3 months by health or social care staff. It should focus on improving interactions within the family, including:

- engaging and motivating the family in treatment (enhancing perception that change is possible, positive reframing and establishing a positive alliance)

- problem solving and behaviour change through parent training and communication training
- promoting generalisation of change in specific behaviours to broader contexts, both within the family and the community (such as schools).

1.3.7.13 Multisystemic therapy should be provided over 3–6 months by a dedicated member of staff with a low caseload (typically between three and six cases). It should:

- focus specifically on problem-solving approaches with the family
- use the resources of peer groups, schools and the wider community.

1.3.8 Interventions for conditions comorbid with alcohol misuse

1.3.8.1 For people who misuse alcohol and have comorbid depression or anxiety disorders, treat the alcohol misuse first as this may lead to significant improvement in the depression and anxiety. If depression or anxiety continues after 3 to 4 weeks of abstinence from alcohol, assess the depression or anxiety and consider referral and treatment in line with the relevant NICE guideline for the particular disorder[17].

1.3.8.2 Refer people who misuse alcohol and have a significant comorbid mental health disorder, and those assessed to be at high risk of suicide, to a psychiatrist to make sure that effective assessment, treatment and risk-management plans are in place.

1.3.8.3 For the treatment of comorbid mental health disorders refer to the relevant NICE guideline for the particular disorder, and:

- for alcohol misuse comorbid with opioid misuse actively treat both conditions; take into account the increased risk of mortality with taking alcohol and opioids together[18]
- for alcohol misuse comorbid with stimulant, cannabis[19] or benzodiazepine misuse actively treat both conditions.

  Service users who have been dependent on alcohol will need to be abstinent, or

have very significantly reduced their drinking, to benefit from psychological interventions for comorbid mental health disorders.

1.3.8.4 For comorbid alcohol and nicotine dependence, encourage service users to stop smoking and refer to 'Brief interventions and referral for smoking cessation in primary care and other settings' (NICE public health guidance 1).

Wernicke-Korsakoff syndrome

1.3.8.5 Follow the recommendations in NICE clinical guideline 100 on thiamine for people at high risk of developing, or with suspected, Wernicke's encephalopathy. In addition, offer parenteral thiamine followed by oral thiamine to prevent Wernicke-Korsakoff syndrome in people who are entering planned assisted alcohol withdrawal in specialist inpatient alcohol services or prison settings and who are malnourished or at risk of malnourishment (for example, people who are homeless) or have decompensated liver disease.

1.3.8.6 For people with Wernicke-Korsakoff syndrome, offer long-term placement in:

- supported independent living for those with mild cognitive impairment
- supported 24-hour care for those with moderate or severe cognitive impairment.

In both settings the environment should be adapted for people with cognitive impairment and support should be provided to help service users maintain abstinence from alcohol.

[4] See section 1.3.7 for assessment of children and young people.

[5] If a drug is used at a dose or for an application that does not have UK marketing authorisation, informed consent should be obtained and documented.

[6] Note that the evidence for acamprosate in the treatment of harmful drinkers and people who are mildly alcohol dependent is less robust than that for naltrexone. At the time of publication (February 2011), acamprosate did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

[7] At the time of publication (February 2011), oral naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

[8] For example, psychiatric comorbidity, poor social support or homelessness.

[9] A fixed-dose regimen involves starting treatment with a standard dose, not defined by the level of alcohol withdrawal, and reducing the dose to zero over 7–10 days according to a standard protocol.

[10] A symptom-triggered approach involves tailoring the drug regimen according to the severity of withdrawal and any complications. The service user is monitored on a regular basis and pharmacotherapy only continues as long as the service user is showing withdrawal symptoms.

[11] When the drug is being taken by someone other than for whom it was prescribed.

[12] At the time of publication (February 2011), benzodiazepines did not have UK marketing authorisation for use in children and young people under 18. Informed consent should be obtained and documented.

[13] At the time of publication (February 2011), benzodiazepines did not have UK marketing authorisation for this indication or for use in children and young people under 18. Informed consent should be obtained and documented. This should be done in line with normal standards of care for patients who may lack capacity (or see NHS Wales) or in line with normal standards in emergency care.

[14] All prescribers should consult the SPC for a full description of the contraindications and the special considerations of the use of disulfiram.

[15] At the time of publication (February 2011), acamprosate did not have UK marketing authorisation for use longer than 12 months. Informed consent should be obtained and documented.

[16] If a drug does not have UK marketing authorisation for use in children and young people under 18, informed consent should be obtained and documented.

[17] See 'Depression: the treatment and management of depression in adults', NICE clinical guideline 90 (2009) and 'Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care', NICE clinical guideline 113 (2011).

[18] See 'Drug misuse: opioid detoxification', NICE clinical guideline 52 (2007).

[19] See 'Drug misuse: psychosocial interventions'. NICE clinical guideline 51 (2007).

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guideline is available – click on 'How this guidance was produced'.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to develop this guideline. The Centre established a Guideline Development Group (see appendix A), which reviewed the evidence and developed the recommendations. An independent Guideline Review Panel oversaw the development of the guideline (see appendix B).

There is more information about how NICE clinical guidelines are developed on the NICE website. A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' is available.

3 Implementation

NICE has developed tools to help organisations implement this guidance.

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

4.1 Is contingency management effective in reducing alcohol consumption in people who misuse alcohol compared with standard care?

This question should be answered using a randomised controlled design that reports short-and medium-term outcomes (including cost-effectiveness outcomes) of at least 18 months' duration. Particular attention should be paid to the reproducibility of the treatment model and training and supervision of those providing the intervention to ensure that the results are robust and generalisable. The outcomes chosen should reflect both observer and service user-rated assessments of improvement and the acceptability of the intervention. The study needs to be large enough to determine the presence or absence of clinically important effects, and mediators and moderators of response should be investigated.

Why this is important

Psychological interventions are an important therapeutic option for people with alcohol-related problems. However, even with the most effective current treatment (for example, cognitive behavioural therapies and social network and environment-based therapies), the effects are modest at best and the treatments are not effective for everyone. Contingency management has a considerable and compelling evidence base in the treatment of substance misuse (for example, opioid misuse) but there is only a limited, if promising, evidence base for contingency management in the treatment of alcohol-related problems. The results of this research will have important implications for the provision of psychological treatment for alcohol misuse in the NHS.

4.2 What methods are most effective for assessing and diagnosing the presence and severity of alcohol misuse in children and young people?

This question should be answered in a programme of research that uses a cross-sectional cohort design testing:

- the sensitivity and specificity of a purpose-designed suite of screening and case identification measures of alcohol misuse against a diagnostic gold standard (DSM-IV or ICD-10)
- the reliability and validity of a purpose-designed suite in characterising the nature and the severity of the alcohol misuse in children and young people and their predictive validity in identifying the most effective treatment when compared with current best practice.

  Particular attention should be paid to the feasibility of the measures in routine care and the training required to obtain satisfactory levels of accuracy and predictive validity. The programme needs to be large enough to encompass the age range (10–17 years) and the comorbidity that often accompanies alcohol misuse in children and young people.

Why this is important

Alcohol misuse is an increasingly common problem in children and young people. However, diagnostic instruments are poorly developed or not available for children and young people. In adults there is a range of diagnostic and assessment tools (with reasonable sensitivity and specificity, and reliability and validity) that are recommended for routine use in the NHS to both assess the severity of the alcohol misuse and to guide treatment decisions. No similar well-developed measures exist for children and young people, with the result that problems are missed and/or inappropriate treatment is offered. The results of this study will have important implications for the identification and the provision of effective treatment in the NHS for children and young people with alcohol-related problems.

4.3 Is acupuncture effective in reducing alcohol consumption compared with standard care?

This question should be answered using a randomised controlled design that reports short-and medium-term outcomes (including cost-effectiveness outcomes) of at least 12 months' duration. Particular attention should be paid to the reproducibility of the treatment model and training and supervision of those providing the intervention to ensure that the results are robust and generalisable. The outcomes chosen should reflect both observer and service user-rated assessments of improvement and the acceptability of the treatment. The study needs to be large enough to determine the presence or absence of clinically important effects, and mediators and moderators of response should be investigated.

Why this is important

Non-pharmacological treatments are an important therapeutic option for people with alcohol-related problems. There is an evidence base for acupuncture in reducing craving but not alcohol consumption in a number of small trials. The evidence for pharmacological treatments (for example, acamprosate or naltrexone) and psychological treatments (for example, cognitive behavioural therapies and social network and environment-based therapies) is modest at best and the treatments are not effective for everyone. Anecdotal evidence suggests that acupuncture, like psychological treatment, is valued by service users both in alcohol misuse and substance misuse services (although the evidence base for effectiveness is weak). The results of this study will have important implications for increased treatment choice in the NHS for people who misuse alcohol.

4.4 For which service users who are moderately and severely dependent on alcohol is an assertive community treatment model a clinically and cost-effective intervention compared with standard care?

This question should be answered using a randomised controlled design in which participants are stratified for severity and complexity of presenting problems. It should report short- and medium-term outcomes (including cost-effectiveness outcomes) of at least 18 months' duration. Particular attention should be paid to the reproducibility of the treatment model and training and supervision of those providing the intervention to ensure that the results are robust and

generalisable. The outcomes chosen should reflect both observer and service user-rated assessments of improvement (including personal and social functioning) and the acceptability of the intervention. The study needs to be large enough to determine the presence or absence of clinically important effects, and mediators and moderators of response should be investigated.

Why this is important

Many people, in particular those with severe problems and complex comorbidities, do not benefit from treatment and/or lose contact with services. This leads to poor outcomes and wastes resources. Assertive community treatment models have been shown to be effective in retaining people in treatment in those with serious mental illness and who misuse alcohol and drugs but the evidence for an impact on outcomes is not proven. A number of small pilot studies suggest that an assertive community approach can bring benefit in both service retention and clinical outcomes in alcohol misuse. Given the high morbidity and mortality associated with chronic severe alcohol dependence the results of this study will have important implications for the structure and provision of alcohol services in the NHS.

4.5 For people with moderate and severe alcohol dependence who have significant comorbid problems, is an intensive residential rehabilitation programme clinically and cost effective when compared with intensive community-based care?

This question should be answered using a prospective cohort study of all people who have moderate and severe alcohol dependence entering residential and intensive community rehabilitation programmes in a purposive sample of alcohol treatment services in the UK. It should report short- and medium-term outcomes (including cost-effectiveness outcomes) of at least 18 months' duration. Particular attention should be paid to the characterisation of the treatment environment and the nature of the interventions provided to inform the analysis of moderators and mediators of treatment effect. The outcomes chosen should reflect both observer and service user-rated assessments of improvement (including personal and social functioning) and the acceptability of the intervention. The study needs to be large enough to determine the presence or absence of clinically important effects, and mediators and moderators of response should be investigated. A cohort study has been chosen as the most appropriate

design as previous studies in this area that have attempted to randomise participants to residential or community care have been unable to recruit clinically representative populations.

Why this is important

Many people, in particular those with severe problems and complex comorbidities, do not benefit from treatment and/or lose contact with services. One common approach is to offer intensive residential rehabilitation and current policy favours this. However, the research on the effectiveness of residential rehabilitation is uncertain with a suggestion that intensive community services may be as effective. The interpretation of this research is limited by the fact that many of the more severely ill people are not entered into the clinical trials because some clinicians are unsure of the safety of the community setting. However, clinical opinion is divided on the benefits of residential rehabilitation, with some suggesting that those who benefit are a motivated and self-selected group who may do just as well with intensive community treatment, which is currently limited in availability. Given the costs associated with residential treatment and the uncertainty about outcomes, the results of this study will have important implications for the cost effectiveness and provision of alcohol services in the NHS.

4.6 For people with alcohol dependence, which medication is most likely to improve adherence and thereby promote abstinence and prevent relapse?

This question should be answered by: a) an initial development phase in which a series of qualitative and quantitative reasons for non-adherence/discontinuing drugs used in the treatment of alcohol are explored; b) a series of pilot trials of novel interventions developed to address the problems identified in (a) undertaken to support the design of a series of definitive trials; c) a (series of) definitive trial(s) of the interventions that were successfully piloted in (b) using a randomised controlled design that reports short-term (for example, 3 months) and longer-term (for example, 18 months) outcomes. The outcomes chosen should reflect both observer and service user-rated assessments of improvement and the acceptability of the intervention. Each individual study needs to be large enough to determine the presence or absence of clinically important effects, and mediators and moderators of response should be investigated.

Why this is important

Rates of attrition in trials of drugs to promote abstinence and prevent relapse in alcohol dependence are high (often over 65%), yet despite this the interventions are still clinically and cost effective. Retaining more service users in treatment could further significantly improve outcomes for people who misuse alcohol and ensure increased effectiveness in the use of health service resources. The outcome of these studies may also help improve clinical confidence in the use of effective medications (such as acamprosate and naltrexone), which despite their cost effectiveness are currently offered to only a minority of eligible NHS service users. Overall, the results of these studies will have important implications for the provision of pharmacological treatment in the NHS for alcohol misuse.

5 Other versions of this guideline

5.1 Full guideline

The full guideline, Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health.

5.2 Information for the public

NICE has produced information for the public explaining this guideline.

We encourage NHS and voluntary sector organisations to use text from this booklet in their own information about alcohol dependence.

6 Related NICE guidance

Published

- Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care. NICE clinical guideline 113 (2011).
- Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. NICE clinical guideline 110 (2010).
- Alcohol use disorders: diagnosis and clinical management of alcohol-related physical complications. NICE clinical guideline 100 (2010).
- Alcohol use disorders: preventing the development of hazardous and harmful drinking. NICE public health guidance 24 (2010).
- Depression: the treatment and management of depression in adults. NICE clinical guideline 90 (2009).
- Interventions in schools to prevent and reduce alcohol use among children and young people. NICE public health guidance 7 (2007).
- Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. NICE public health intervention guidance 4 (2007).
- Varenicline for smoking cessation. NICE technology appraisal guidance 123 (2007).
- Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007).
- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007).
- Brief interventions and referral for smoking cessation in primary care and other settings. NICE public health intervention guidance 1 (2006)

7 Updating the guideline

NICE clinical guidelines are updated so that recommendations take into account important new information. New evidence is checked 3 years after publication, and healthcare professionals and patients are asked for their views; we use this information to decide whether all or part of a guideline needs updating. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations. Please see our website for information about updating the guideline.

Appendix A: The Guideline Development Group and National Collaborating Centre

Guideline Development Group

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Lay member and retired Alcohol Treatment Agency CEO

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Guideline Development Manager, National Collaborating Centre for Mental Health (2008 to 2010)

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Appendix B: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

Peter Robb (Chair)
Consultant ENT Surgeon, Epsom General Hospital, Surrey

Greg Rogers
General Practitioner, Kent

Catherine Arkley
Chief Executive, Children's Liver Disease Foundation

Aomesh Bhatt
Director of Regulatory and Medical Affairs UK, Ireland, Scandinavian Region, Reckitt Benckiser (UK) Ltd

Changes after publication

October 2014: The wording of the final bullet in recommendation 1.3.4.5 has been corrected to make it clear that inpatient or residential assisted withdrawal should be considered for people who regularly drink between 15 and 30 units (not between 15 and 20 units) of alcohol per day, if they also have the additional complicating features mentioned in the recommendation.

About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guideline was developed by the National Collaborating Centre for Mental Health. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in The guidelines manual.

The recommendations from this guideline have been incorporated into a NICE Pathway. We have produced information for the public explaining this guideline. Tools to help you put the guideline into practice and information about the evidence it is based on are also available.

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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