

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

**NICE guideline  
Draft for consultation, June 2010**

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## 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). Available from [www.nice.org.uk/guidance/PH24](http://www.nice.org.uk/guidance/PH24). 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). Available from [www.nice.org.uk/guidance/CG100](http://www.nice.org.uk/guidance/CG100). A clinical guideline covering acute unplanned alcohol withdrawal including delirium tremens, alcohol-related liver damage, alcohol-related pancreatitis and management of Wernicke's encephalopathy.

The care pathways in appendix D and E incorporate elements from both NICE guidelines above on case identification and possible diagnosis for adults, and withdrawal assessment.

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 30 or more) 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', and when recommendations apply to both people who are dependent on alcohol and harmful drinkers the term 'person who misuses alcohol' or 'service user' is 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, and over 26% of this population 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 disorders commonly include depression and anxiety disorders, 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

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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 work of the three NICE guidelines is integrated in the quick reference guide into a series of care pathways.

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

## Person-centred care

This guideline offers best practice advice on the care of adults and young people who are dependent on alcohol or 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, staff should follow the Department of Health's advice on consent (available from [www.dh.gov.uk/consent](http://www.dh.gov.uk/consent)) and the code of practice that accompanies the Mental Capacity Act (summary available from [www.publicguardian.gov.uk](http://www.publicguardian.gov.uk)). In Wales, healthcare professionals should follow advice on consent from the Welsh Assembly Government (available from [www.wales.nhs.uk/consent](http://www.wales.nhs.uk/consent)).

If a service user is under 16, staff should follow the guidelines in 'Seeking consent: working with children' (available from [www.dh.gov.uk](http://www.dh.gov.uk)).

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' (available from [www.dh.gov.uk](http://www.dh.gov.uk)).

## Key priorities for implementation

### Identification and assessment in all settings

- Staff working in services provided and funded by the NHS 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, to refer the service user to a service that can provide an assessment of need. [1.2.1.2]

### Assessment in specialist alcohol settings

- Consider a comprehensive assessment for all adults referred to specialist 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
  - 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. [1.2.2.4]

### 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
  - complex physical or psychiatric comorbidities

not responded to initial community-based interventions (see 1.3.1.2).  
[1.3.1.3]

- All interventions for people who misuse alcohol should be delivered by competent staff. 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 efficacy 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. [1.3.1.5]

### **Assessment and interventions for assisted alcohol withdrawal**

- For service users who typically drink over 15 units of alcohol per day, and/or who score more than 20 on the AUDIT, consider:
  - an assessment for and delivery of a community-based assisted withdrawal
  - a referral to specialist alcohol services for further assessment and management if there are safety concerns (see 1.3.2.3) about a community-based assisted withdrawal. [1.3.2.1]

### **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. [1.3.5.1]

### **Interventions for moderate and severe alcohol dependence**



- After a successful withdrawal consider offering oral naltrexone<sup>1</sup> or acamprostate 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 1.3.6). [1.3.7.1]

### **Assessment and interventions for children and young people who misuse alcohol**

- For children and young people aged 10 years and older 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. [1.3.9.7]

### **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. [1.3.10.1]

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<sup>1</sup> At the time of publication (June 2010), naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

# 1 Guidance

The following guidance is based on the best available evidence. The full guideline (insert web address) 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 is 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
- 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 and work effectively with 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.

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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 or carers can support the service user
- offer a carer's assessment of their caring, physical and mental health needs 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; pay proper attention to the service user's right to confidentiality.

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

- offer guided self-help, typically 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 individual 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
- typically 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 child's social network, education, mental health and own alcohol use
- be aware of and comply with the requirements of the Children Act (2004).

## 1.2 Identification and assessment

See appendix D to help with case identification and possible diagnosis of alcohol use disorders in adults, and as a supplement to the recommendations in this section. See appendix C for an explanation of the assessment levels for adults.

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 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, to refer the service user to a service that can provide an assessment of need. **[KPI]**

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 withdrawal.

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

- Alcohol Use Disorders Identification Test (AUDIT) for identification and as a routine outcome measure
- Severity of Alcohol Dependence Questionnaire (SADQ) or Leeds Dependence Questionnaire (LDQ) for severity of dependence
- Clinical Institute Withdrawal Assessment of Alcohol Scale, revised (CIWA-Ar) for severity of withdrawal
- Alcohol Problems Questionnaire (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<sup>2</sup>, 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 1.3.2) 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 who are alcohol dependent 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 settings**

### ***Treatment goals***

1.2.2.1 In the initial assessment in specialist alcohol settings of all people who misuse alcohol, agree the goal of treatment with the service user. For harmful drinking and mild dependence the aim should be abstinence or a moderate level of drinking that is predetermined and agreed by both staff and the service user. For moderate and severe dependence or significant medical or psychiatric comorbidity the aim should be abstinence in the first instance.

1.2.2.2 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.

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<sup>2</sup> See section 1.3.9 for assessment of children and young people.

### ***Brief triage assessment***

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

- the history 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***

1.2.2.4 Consider a comprehensive assessment for all adults referred to specialist 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
- 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. **[KPI]**

1.2.2.5 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.

1.2.2.6 For service users whose comorbid 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).

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

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

1.2.2.9 Consider brief measures of cognitive functioning to help with treatment planning (for example, MMSE). Formal measures of cognitive functioning should typically 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
- 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) 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
- complex physical or psychiatric comorbidities
- not responded to initial community-based interventions (see 1.3.1.2). **[KPI]**

1.3.1.4 For people who are alcohol dependent and 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 competent staff. 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 efficacy 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. **[KPI]**

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 who misuse alcohol who are receiving an intervention:

- give information on the value and availability of community support networks and self-help groups (for example, Alcoholics Anonymous)
- help them to participate in these services, for example by arranging support to attend meetings.

### **1.3.2 Assessment and interventions for assisted alcohol withdrawal**

See appendix E, the care pathway for withdrawal assessment, to supplement the recommendations in this section. See section 1.3.9 for assessment for assisted withdrawal in children and young people.

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

- an assessment for and delivery of a community-based assisted withdrawal
- a referral to specialist alcohol services for further assessment and management if there are safety concerns (see 1.3.2.3) about a community-based assisted withdrawal. **[KPI]**

1.3.2.2 Service users who need assisted withdrawal should typically be offered a community-based programme. Community-based programmes should vary in intensity between:

- an outpatient-based programme in which contact between staff and the service user averages 2–4 meetings per week over a 3-week period, and
- an intensive community programme in which the service user may attend a day programme lasting between 4 and 7 days per week over a 3-week period.

1.3.2.3 Consider inpatient or residential assisted withdrawal if the 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 20 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)
  - a significant learning disability or cognitive impairment.

### **1.3.3 Drug regimens for assisted withdrawal**

1.3.3.1 When conducting community-based assisted withdrawal programmes, use fixed-dose medication regimens<sup>3</sup>.

1.3.3.2 Fixed-dose or symptom-triggered medication regimens<sup>4</sup> 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 safely.

1.3.3.3 Service users having assisted withdrawal in the community should be regularly medically monitored, at least on alternate days, and a family member or carer should preferably oversee the administration of medication. Adjust the dose if severe withdrawal symptoms or over-sedation occur; use the CIWA-Ar to monitor this.

1.3.3.4 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.

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<sup>3</sup> 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.

<sup>4</sup> 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 is given according to the service user's severity of withdrawal symptoms. Pharmacotherapy only continues as long as the service user is showing withdrawal symptoms.

- 1.3.3.5 Prescribe and administer medication for assisted withdrawal within a standard clinical protocol. The preferred medication for assisted withdrawal in the community is a benzodiazepine (for example, chlordiazepoxide or diazepam). Gradually reduce the dose of the benzodiazepine over 7–10 days to avoid alcohol withdrawal recurring.
- 1.3.3.6 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 the dosages may need to exceed British National Formulary (BNF) guidelines to adequately control withdrawal (for example, for service users regularly drinking 60 units of alcohol per day or with an SADQ score of 60, an initial dose of approximately 60 mg chlordiazepoxide four times a day will usually be needed).
- 1.3.3.7 Be aware that benzodiazepine doses may need to be reduced for children and young people, older people, and people with liver impairment. For people with liver impairment, a short-acting benzodiazepine (for example, lorazepam) may be needed.
- 1.3.3.8 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. This is best managed with one benzodiazepine (for example, diazepam or chlordiazepoxide) rather than multiple benzodiazepines. The withdrawal regimen should be extended over 2–3 weeks depending on the severity of co-existing benzodiazepine dependence.
- 1.3.3.9 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<sup>5</sup>. Dispense for up to 2 days at a time.
- 1.3.3.10 Do not offer clomethiazole for community-based assisted withdrawal because of the risk of overdose and misuse.

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<sup>5</sup> When the drug is being taken by someone other than for whom it was prescribed.

- 1.3.3.11 For managing unplanned acute alcohol withdrawal and complications including delirium tremens and withdrawal-related seizures, refer to NICE clinical guideline 100 on diagnosis and clinical management of alcohol-related physical complications

### **1.3.4 Care coordination and case management**

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

- 1.3.4.1 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 staff within specialist alcohol services
  - include the coordination of assessment, interventions and monitoring of progress, and coordination with other agencies.
- 1.3.4.2 Offer case management to increase engagement in treatment for people who are moderately to severely alcohol dependent and who are considered at risk of dropping out of treatment or who have a previous history of poor engagement. Case management should be provided throughout the whole period of care, including aftercare.
- 1.3.4.3 Case management should be delivered in the context of Tier 3 interventions<sup>6</sup> 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 and individual 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.

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<sup>6</sup> See appendix C.

### **1.3.5 Interventions for harmful drinking and mild alcohol dependence**

- 1.3.5.1 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. **[KPI]**
- 1.3.5.2 For harmful drinkers or people with mild alcohol dependence, offer behavioural couples therapy to service users who have a regular partner and whose partner is willing to participate in treatment.
- 1.3.5.3 For harmful drinkers or people who are mildly dependent on alcohol and who have not responded to psychological interventions alone, or who have specifically requested a pharmacological intervention, consider offering acamprosate<sup>7</sup> or oral naltrexone<sup>8</sup> 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 1.3.8 for pharmacological interventions and 1.3.6 for psychological interventions).

### **1.3.6 Delivering psychological interventions**

- 1.3.6.1 Cognitive behavioural therapies focused on alcohol-related problems should typically consist of one 60-minute session per week for 12 weeks.
- 1.3.6.2 Behavioural therapies focused on alcohol-related problems should typically consist of one 60-minute session per week for 12 weeks.
- 1.3.6.3 Social network and environment-based therapies focused on alcohol-related problems should typically consist of eight 50-minute sessions over 12 weeks.
- 1.3.6.4 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

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<sup>7</sup> 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.

<sup>8</sup> At the time of publication (June 2010), naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

predetermined and agreed by the therapist and the service user to be reasonable and safe. It should typically consist of one 60-minute session per week for 12 weeks.

### **1.3.7 Interventions for moderate and severe alcohol dependence after successful withdrawal**

1.3.7.1 After a successful withdrawal consider offering oral naltrexone<sup>9</sup> or acamprosate 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 1.3.6). **[KPI]**

1.3.7.2 After a successful withdrawal consider offering oral naltrexone<sup>9</sup> or acamprosate 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 1.3.6).

1.3.7.3 After a successful withdrawal consider offering disulfiram in combination with a psychological intervention to service users who:

- want to achieve abstinence but for whom oral naltrexone and acamprosate are not suitable, **or**
- have specified a preference for disulfiram and understand the relative risks of taking the drug (see 1.3.8.9).

### **1.3.8 Delivering pharmacological interventions**

1.3.8.1 Before starting treatment with acamprosate, naltrexone<sup>9</sup> or disulfiram, undertake a comprehensive medical assessment (baseline urea and electrolytes and liver function tests including gamma glutamyl transpeptidase [GGT]). In particular, consider any contraindications or cautions (see the SPC or BNF).

#### ***Acamprosate***

1.3.8.2 If using acamprosate, start treatment as soon as possible after assisted withdrawal and typically prescribe at a dose of 2 g (666 mg three times a day) unless the service user weighs less than 60 kg, and then a maximum of 1.332 mg should be prescribed per day. Acamprosate should:

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<sup>9</sup> At the time of publication (June 2010), naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

- typically be prescribed for up to 12 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.

1.3.8.3 Service users taking acamprosate should stay under medical supervision, at least monthly, for 6 months. Do not use blood tests routinely, but consider them to monitor for liver recovery and as a motivational aid for service users to show improvement.

***Naltrexone***

1.3.8.4 If using oral naltrexone,<sup>10</sup> start treatment after assisted withdrawal and typically prescribe at a dose of 50 mg per day. Provide the service user with an information card about oral naltrexone and its impact on opioid-based analgesics, as part of a comprehensive medical assessment before prescribing. Oral naltrexone should:

- typically be prescribed for up to 12 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.

1.3.8.5 Service users taking oral naltrexone<sup>10</sup> should stay under medical supervision, at least monthly, for 6 months. Do not use blood tests routinely, but consider them to monitor for liver recovery 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***

1.3.8.6 If using disulfiram, start treatment at least 24 hours after the last alcoholic drink consumed. Typically prescribe at a dose of 200 mg per day.

1.3.8.7 Before starting treatment with disulfiram, carry out liver function tests, or urea and electrolyte tests, to assess for liver or renal impairment.

1.3.8.8 Make sure that service users taking disulfiram:

- stay under medical supervision, at least every 2 weeks for the first 2 months, then monthly for the following 4 months
- have a family member or carer oversee the administration of the drug.

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<sup>10</sup> At the time of publication (June 2010), naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

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

- the potential interaction between disulfiram and alcohol, and that alcohol may also be included in food, perfume, aerosol sprays and so on
- 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***

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

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

**1.3.9 Assessment and interventions for children and young people who misuse alcohol**

***Assessment and referral***

1.3.9.1 If alcohol misuse is identified as a potential problem in children and young people aged 10 years and older, conduct an initial brief assessment to assess:

- the duration and severity of the alcohol misuse (the threshold on the AUDIT for referral and intervention should be lower for young people aged 10–16 on the basis 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.

1.3.9.2 Refer all children and young people aged 10 years and older who misuse alcohol to a specialist child and adolescent mental health service (CAMHS) for a comprehensive assessment of their needs.



1.3.9.3 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]<sup>13</sup> or the Teen Addiction Severity Index [T-ASI]<sup>14</sup>), 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
- formulation of a care plan and risk management plan.

#### **Assisted withdrawal**

1.3.9.4 Offer inpatient care to children and young people aged 10 years and older who need assisted withdrawal.

1.3.9.5 Base assisted withdrawal for children and young people aged 10 years and older on the recommendations for adults in this guideline (see 1.3.3) and in NICE clinical guideline 100. Adjust drug regimens to take account of age, height and body mass, and development of the child or young person.

#### **Promoting abstinence and preventing relapse**

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

- 1.3.9.7 For children and young people aged 10 years and older 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. **[KPI]**
- 1.3.9.8 After a careful review of the risks and benefits, specialists may consider offering acamprosate or oral naltrexone<sup>11</sup> in combination with cognitive behavioural therapy to young people aged between 16 and 18 years who have not engaged with or benefited from a multicomponent treatment programme.

### **Delivering psychological and psychosocial interventions**

- 1.3.9.9 Multidimensional family therapy should typically consist of 12–15 family-focused structured treatment sessions over 12 weeks. There should be a strong emphasis on case 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.
- 1.3.9.10 Brief strategic family therapy should typically 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.

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<sup>11</sup> At the time of publication (June 2010), naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

1.3.9.11 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).

1.3.9.12 Multisystemic therapy should be provided over 3–6 months by a dedicated member of staff with a low caseload. It should:

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

### **1.3.10 Interventions for conditions comorbid with alcohol misuse**

1.3.10.1 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, undertake an assessment of the depression or anxiety and consider referral and treatment in line with the relevant NICE guideline for the particular disorder. **[KPI]**

1.3.10.2 Refer people who misuse alcohol and have a significant comorbid mental 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.

1.3.10.3 For the treatment of comorbid mental health disorders refer to the relevant NICE guideline for the particular disorder and be aware that:

- for alcohol misuse comorbid with opioid, cocaine or benzodiazepine misuse both conditions should be actively treated.
- service users who have been dependent on alcohol will need to be abstinent, or have very significantly reduced their drinking, to benefit from a psychological intervention for comorbid mental health disorders.

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

**Wernicke-Korsakoff syndrome**

1.3.10.5 Consider using thiamine to prevent Wernicke-Korsakoff syndrome (see NICE clinical guideline 100) in service users who:

- are undergoing assisted withdrawal
- have alcohol-related liver disease
- are malnourished or at risk of malnourishment
- are homeless.

1.3.10.6 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.

## 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 from <http://www.nice.org.uk/guidance/index.jsp?action=download&o=43683>.

### 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 ([www.nice.org.uk/guidelinesprocess](http://www.nice.org.uk/guidelinesprocess)). A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' (fourth edition, published 2009), is available from NICE publications (phone 0845 003 7783 or email [publications@nice.org.uk](mailto:publications@nice.org.uk) and quote reference N1739).

## 3 Implementation

NICE has developed tools to help organisations implement this guidance (see [www.nice.org.uk/CGXX](http://www.nice.org.uk/CGXX)).

## **4 Research recommendations**

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

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 (e.g. 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 (e.g. 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:

- a) 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)

- b) a purpose designed suite of measures to assess their reliability and validity in characterising the nature and the severity of the alcohol misuse in children and young people and which also determines 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 to 18 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 for children and young people with alcohol-related problems in the NHS.

### ***4.3 Is acupuncture compared with usual care effective in reducing alcohol consumption?***

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 (e.g. acamprosate or naltrexone) and psychological treatments (e.g. 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 for people who misuse alcohol in the NHS.

#### ***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 in order 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 is wasteful of 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 who are moderately and severely dependent on alcohol and 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 are moderately and severely dependent on alcohol 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 in order 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 the provision of such care. 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 who are dependent on alcohol, which medication is most likely to improve concordance 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-compliance/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 (e.g. 3 months) and longer-term (e.g. 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 is 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 service users who are eligible in the UK healthcare system. Overall, the results of these studies will have important implications for the provision of pharmacological treatment for alcohol misuse in the NHS.

## 5 Other versions of this guideline

### 5.1 Full guideline

The full guideline, 'Alcohol dependence and harmful use: 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, and is available from our website

([www.nice.org.uk/guidance/CG\[XX\]/FullGuidance](http://www.nice.org.uk/guidance/CG[XX]/FullGuidance)). **Note: these details will apply to the published full guideline.**

### 5.2 Quick reference guide

A quick reference guide for healthcare professionals is available from

[www.nice.org.uk/guidance/CG\[XX\]/QuickRefGuide](http://www.nice.org.uk/guidance/CG[XX]/QuickRefGuide)

For printed copies, phone NICE publications on 0845 003 7783 or email

publications@nice.org.uk (quote reference number N[XXXX]). **Note: these details will apply when the guideline is published.**

### 5.3 'Understanding NICE guidance'

A summary for patients and carers ('Understanding NICE guidance') is available from

[www.nice.org.uk/guidance/CG\[XX\]/PublicInfo](http://www.nice.org.uk/guidance/CG[XX]/PublicInfo)

For printed copies, phone NICE publications on 0845 003 7783 or email

publications@nice.org.uk (quote reference number N[XXXX]). **Note: these details will apply when the guideline is published.**

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

- Alcohol use disorders: diagnosis and clinical management of alcohol-related physical complications. NICE clinical guideline 100. Available from [www.nice.org.uk/guidance/CG100](http://www.nice.org.uk/guidance/CG100)
- Alcohol use disorders: preventing the development of hazardous and harmful drinking. NICE public health guidance 24. Available from [www.nice.org.uk/guidance/PH24](http://www.nice.org.uk/guidance/PH24)
- Depression: the treatment and management of depression in adults. NICE clinical guideline 90 (2009). Available from: [www.nice.org.uk/guidance/CG90](http://www.nice.org.uk/guidance/CG90)
- Interventions in schools to prevent and reduce alcohol use among children and young people. NICE public health guidance 7 (2007). Available from [www.nice.org.uk/guidance/PH7](http://www.nice.org.uk/guidance/PH7)
- Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. NICE public health intervention guidance 4 (2007). Available from [www.nice.org.uk/guidance/PHI4](http://www.nice.org.uk/guidance/PHI4)
- Varenicline for smoking cessation. NICE technology appraisal guidance 123 (2007). Available from: [www.nice.org.uk/guidance/TA123](http://www.nice.org.uk/guidance/TA123)
- Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. NICE clinical guideline 22 (2007). Available from: [www.nice.org.uk/guidance/CG22](http://www.nice.org.uk/guidance/CG22) [generalised anxiety disorder is currently being updated]
- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007). Available from: [www.nice.org.uk/guidance/CG51](http://www.nice.org.uk/guidance/CG51)
- Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007). Available from: [www.nice.org.uk/guidance/CG52](http://www.nice.org.uk/guidance/CG52)
- Brief interventions and referral for smoking cessation in primary care and other settings. NICE public health intervention guidance 1 (2006). Available from: [www.nice.org.uk/guidance/PHI1](http://www.nice.org.uk/guidance/PHI1)

## **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**

### **Professor Colin Drummond (Chair, Guideline Development Group)**

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### **Dr Edward Day**

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Lay member and Retired Alcohol Treatment Agency CEO

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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.

**NICE to add**

**[Name; style = Unnumbered bold heading]**

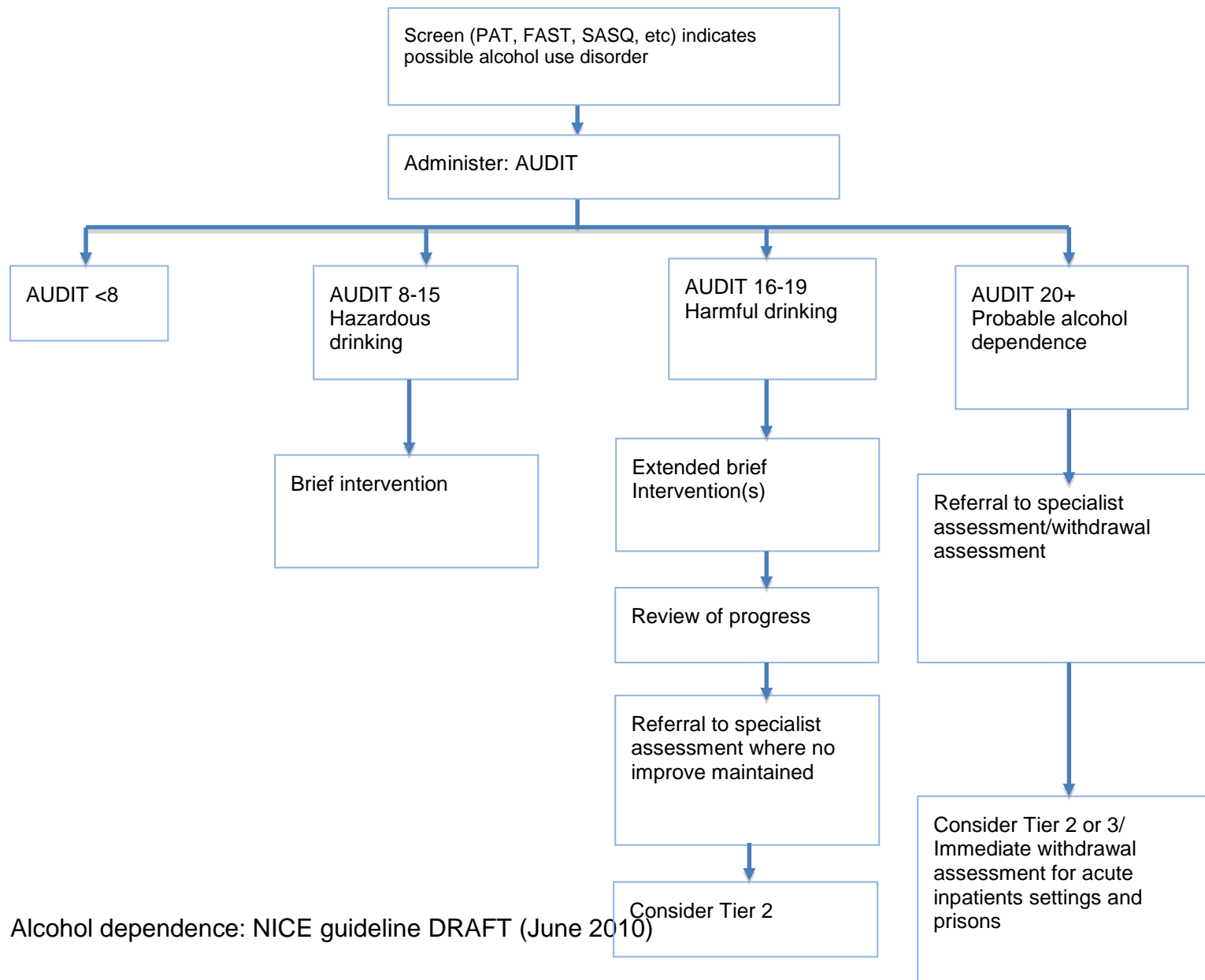
[job title and location; style = NICE normal]

## Appendix C: Assessment levels for adults<sup>12</sup>

<b>Level 1:</b> <b>Case identification/diagnosis</b>	Carried out by: Trained staff in all Tiers 1-4
<b>Level 2:</b> <b>Withdrawal assessment</b>	Carried out by: Trained staff in all Tiers 1-4
<b>Level 3:</b> <b>Triage assessment</b>	Carried out by: Trained staff in Tiers 2-4
<b>Level 4:</b> <b>Comprehensive assessment</b>	Carried out by: Trained staff in Tiers 3 & 4 and some Tier 2 services

<sup>12</sup> Adapted from Department of Health (2006) *Models of Care for Alcohol Misusers*. National Treatment Agency, London. [http://www.nta.nhs.uk/publications/documents/nta\\_modelsofcare\\_alcohol\\_2006\\_mocam.pdf](http://www.nta.nhs.uk/publications/documents/nta_modelsofcare_alcohol_2006_mocam.pdf)

## Appendix D: Care pathway - case identification and possible diagnosis for adults



## Appendix E: Care pathway: withdrawal assessment

