NATIONAL INSTITUTE FOR HEALTH AND   
CARE EXCELLENCE

Quality standards

Briefing paper: Alcohol-use disorders: diagnosis and management (update)

**Quality Standards Advisory Committee meeting**: 15 November 2022

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1. Introduction

This briefing paper presents a structured overview of potential quality improvement areas for alcohol use disorders: diagnosis and management. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

Recommendations selected from the key development source are included to help the committee in considering potential statements and measures.

* 1. Development source

The key development sources referenced in this briefing paper are:

[Alcohol-use disorders: prevention](https://www.nice.org.uk/guidance/ph24) (2010), NICE guideline PH24

[Alcohol-use disorders: diagnosis and management of physical complications](https://www.nice.org.uk/guidance/cg100) (2010, updated 2017) NICE guideline CG100

[Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence](https://www.nice.org.uk/guidance/cg115) (2011) NICE guideline CG115

1. Overview
   1. Focus of quality standard

The quality standard will cover identifying and supporting adults and young people (aged 10 and over) who may have an alcohol problem and caring for people with alcohol-related health problems, as well as support for their families and carers.

This quality standard will update and replace the existing [NICE quality standard for alcohol-use disorders: diagnosis and management](https://www.nice.org.uk/guidance/qs11) (QS11). The topic was identified for update following a review of quality standards in 2021. The review identified that there have been changes in commissioning and the areas for improvement.

* 1. Definition

Alcohol use disorders cover a range of conditions, including:

* Hazardous drinking (a pattern of alcohol consumption that increases someone's risk of harm)
* Harmful drinking (a pattern of alcohol consumption that is causing mental or physical damage)
* Alcohol dependence (behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use)
* Acute alcohol withdrawal (the physical and psychological symptoms that people can experience when they suddenly reduce the amount of alcohol they drink if they have previously been drinking excessively for prolonged periods of time)
* Wernicke's encephalopathy – caused by a severe thiamine deficiency and characterised by ocular motility disorders, ataxia, and confusion.
* Alcohol related liver disease
* Alcohol related acute and chronic pancreatitis
  1. Prevalence

The proportion of adults in England usually drinking at levels with an increased or higher risk of harm in 2017 was 28% of men and 14% of women. This decreased between 2011 and 2017 (from 34% of men, and from 18% of women).

* Drinking over 14 units a week was most common in ages 55 to 64, then declining in people aged 65 or older.
* There was variation by household income in the proportion of adults drinking at increased or higher risk of harm, and numbers were highest in higher income households. ([NHS Digital Statistics on alcohol 2019](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2019/part-4)).

[Public Health England](https://www.gov.uk/government/publications/alcohol-consumption-and-harm-during-the-covid-19-pandemic/monitoring-alcohol-consumption-and-harm-during-the-covid-19-pandemic-summary#changes-to-alcohol-consumption-in-2020) found that between March 2020 and March 2021, there was a 58.6% increase in the proportion of survey respondents drinking at increased risk and higher risk levels, and that the increase was aligned with timing of the COVID-19 pandemic.

[NHS Digital Smoking, Drinking and Drug Use among Young People in England](https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2021), 2021 shows that 9% of secondary school pupils in England in years 7 to 11 self-reported that they had drunk alcohol in the last week and 6% drinking at least once per week. 18% of those who drank in the last week were estimated to have drunk more than 15 units.

[NHS Digital Health Survey for England 2019](https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2019) in the section for adult’s health-related behaviours shows that in England, 57% of adults self-reported that they drank at levels which put them at lower risk of alcohol-related harm, that is, 14 units or less in the last week.

The estimated rate of adults with alcohol dependence in 2018/19 was 1.37% of the population of England. It was 1.38% in 2015/16 ([Public Health England (PHE) Alcohol dependence prevalence in England 2017, updated 2021](https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england)).

In 2019/20 there were an estimated 280,000 hospital admissions where the main reason for admission was attributable to alcohol. This is a 2% rise from 2018/19 and an 8% rise from 2016/17. Admissions rise with age to 55-64 and then fall. 65% of the patients were male.

In 2019/20 there were an estimated almost 980,000 admissions where the primary reason for hospital admission or a secondary diagnosis was linked to alcohol, a 4% rise from 2018/19. Representing 5.7% of all hospital admissions. 73% of patients were male ([NHS Digital Statistics on alcohol 2022](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2021/part-1)).

In 2020, there were 8,974 registered deaths from alcohol-specific causes in the UK, an increase of 18.6% from 2019. The rate of alcohol specific deaths was double for males compared to females. Although England still had the lowest rates among the constituent countries, it had an increase of 19.3%. ([Office for National Statistics Alcohol-specific deaths in the UK 2021](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2020))

* 1. Service delivery

76,740 adults started treatment for alcohol alone in drug and alcohol services between April 2020 and March 2021, a rise of 3% from the previous year. The COVID-19 pandemic meant that fewer people using services were able to access inpatient detoxification, and that testing for liver disease was greatly reduced. ([Office for Health Improvement and Disparities (OHID) Adult substance misuse treatment statistics 2021).](https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report)

41% (4,459) of young people entering treatment in drug and alcohol services reported having a problem with alcohol. Referral from social care services was the most common route for young people to get into specialist treatment services, higher than 2019/20 (25% compared with 18%). This represents a large fall in referrals from other sources, likely because of the COVID-19 pandemic ([OHID Young people’s substance misuse treatment statistics 2022](https://www.gov.uk/government/statistics/substance-misuse-treatment-for-young-people-statistics-2020-to-2021/young-peoples-substance-misuse-treatment-statistics-2020-to-2021-report)).

* 1. Resource impact

When the NICE guideline on alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115) was developed, it was expected to be cost saving due to the focus on increasing the role of community-based rehabilitation following medically aided alcohol withdrawal, over residential rehab.

However, CG115 published in 2011 and the health and care systems now face challenging circumstances. The committee will need to consider the ability of any new quality statements to be implemented within existing resources.

1. Summary of suggestions
   1. Responses

In total 13 registered stakeholders responded to the 2-week engagement exercise.

* 10 stakeholders suggested areas
* 3 stakeholders had no comments

7 specialist committee members suggested areas

The responses have been summarised in table 1 for further consideration by the committee.

Table 1 Summary of suggested quality improvement areas

| Area for improvement | Stakeholders |
| --- | --- |
| **Identification and referral**   * Screening and brief interventions * Referral to specialist alcohol services | CGL, KKL, NHSE, RCGP, RCPSY, SCM1, SCM4, SCM6, SCM7 |
| **Assessment in specialist alcohol services**   * Initial assessment * Comprehensive assessment | NHSE, RCPSY, SCM2, SCM3, SCM7 |
| **Assisted alcohol withdrawal** | CGL, KKL, POMH, RCGP, SCM2, SCM5, SCM7 |
| **Interventions after successful withdrawal**   * Psychological interventions and behavioural support * Medications for preventing relapse | CGL, SCM1, SCM3, SCM5, SCM7 |
| **Principles of care**   * Coordination of care * Information and advice * Families and carers | AA, ADFAM, CGL, DUK, RCGPSY, SCM2, SCM3, SCM4, SCM5, SCM7 |
| **Additional areas**   * Awareness of Alcohol Use Disorders * Training and staff understanding * Clinical leadership * Liver disease | ADFAM, RCPCH, SCM2, SCM4, SCM5, SCM6, SCM7 |

Abbreviations:

* AA, Alcoholics Anonymous
* ADFAM, Adfam on behalf of Alcohol and Families Alliance (AFA)
* CGL, Change Grow Live
* DUK, Dementia UK
* KKL, Kyowa Kirin Ltd
* NHSE, NHS England
* POMH, The Prescribing Observatory for Mental Health
* PTSDUK, Post Traumatic Stress Disorder UK
* RCGP, Royal College of General Practitioners
* RCPSY, Royal College of Psychiatrists
* SCM, Specialist Committee Member.

Full details of all the suggestions provided are given in appendix 1 for information.

1. Suggested improvement areas

Section 4 presents a summary of the suggested improvement areas, with provisional recommendations that may support statement development and information on current UK practice.

* 1. Identification and referral

### Screening and brief interventions

Stakeholders suggested that identification of hazardous and harmful drinking should be carried out opportunistically across health and social care as an embedded part of practice and should be followed by brief interventions where appropriate. They fed back that this should include screening for older people and people experiencing homelessness. Stakeholders highlighted that screening should be done using established screening tools such as AUDIT, or in some cases shorter screening tools such as FAST, and that screening should take place in settings where those in need of treatment are most likely to present.

#### Selected recommendations

NICE’s guideline on [Alcohol-use disorders: prevention](https://www.nice.org.uk/guidance/ph24) (PH24)

**Recommendation 7: screening young people aged 16 and 17 years**

* Complete a validated alcohol screening questionnaire with these young people. Alternatively, if they are judged to be competent enough, ask them to fill 1 in themselves. In most cases, [AUDIT](https://www.nice.org.uk/guidance/ph24/chapter/glossary#alcohol-use-disorders-identification-test-audit) (alcohol use disorders identification test) should be used. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, CRAFFT, SASQ or FAST). Screening tools should be appropriate to the setting. For instance, in an emergency department, FAST or the Paddington Alcohol Test (PAT) would be most appropriate. Use professional judgement as to whether to revise the AUDIT scores downwards when screening people under 18.
* Focus on key groups that may be at an increased risk of alcohol-related harm. This includes those:
  + who have had an accident or a minor injury
  + who regularly attend genito-urinary medicine (GUM) clinics or repeatedly seek emergency contraception
  + involved in crime or other antisocial behaviour
  + who truant on a regular basis
  + at risk of self-harm
  + who are looked after
  + involved with child safeguarding agencies.

**Recommendation 8: extended brief interventions with young people aged 16 and 17 years**

* Appropriately trained staff should offer the young person an extended brief intervention.

**Recommendation 9: screening adults**

* NHS professionals should routinely carry out alcohol screening as an integral part of practice. For instance, discussions should take place during new patient registrations, when screening for other conditions and when managing chronic disease or carrying out a medicine review. These discussions should also take place when promoting sexual health, when seeing someone for an antenatal appointment and when treating minor injuries.
* Where screening everyone is not feasible or practicable, NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition. This includes people:
  + with relevant physical conditions (such as hypertension and gastrointestinal or liver disorders)
  + with relevant mental health problems (such as anxiety, depression or other mood disorders)
  + who have been assaulted
  + at risk of self-harm
  + who regularly experience accidents or minor traumas
  + who regularly attend GUM clinics or repeatedly seek emergency contraception.
* Non-NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and people who have alcohol-related problems. For example, this could include those:
  + at risk of self-harm
  + involved in crime or other antisocial behaviour
  + who have been assaulted
  + at risk of domestic abuse
  + whose children are involved with child safeguarding agencies
  + with drug problems.
* Complete a validated alcohol questionnaire with the adults being screened. Alternatively, if they are competent enough, ask them to fill 1 in themselves. Use AUDIT to decide whether to offer them a brief intervention (and, if so, what type) or whether to make a referral. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, SASQ or FAST). Screening tools should be appropriate to the setting. For instance, in an emergency department FAST or PAT would be most appropriate.
* Use professional judgement as to whether to revise the AUDIT scores downwards when screening:
  + women, including those who are, or are planning to become, pregnant
  + people aged 65 and over
  + people from some black and minority ethnic groups.  
      
    If in doubt, consult relevant specialists. Work on the basis that offering an intervention is less likely to cause harm than failing to act where there are concerns.

**Recommendation 10: brief advice for adults**

* Offer a session of structured brief advice on alcohol. If this cannot be offered immediately, offer an appointment as soon as possible thereafter.
* Use a recognised, evidence-based resource that is based on [FRAMES principles](https://www.nice.org.uk/guidance/ph24/chapter/glossary#frames) (feedback, responsibility, advice, menu, empathy, self-efficacy). It should take 5–15 minutes and should:
  + cover the potential harm caused by their level of drinking and reasons for changing the behaviour, including the health and wellbeing benefits
  + cover the barriers to change
  + outline practical strategies to help reduce alcohol consumption (to address the ‘menu’ component of FRAMES)
  + lead to a set of goals.
* Where there is an ongoing relationship with the patient or client, routinely monitor their progress in reducing their alcohol consumption to a low-risk level. Where required, offer an additional session of structured brief advice or, if there has been no response, offer an extended brief intervention.

**Recommendation 11: extended brief interventions for adults**

* Offer an extended brief intervention to help people address their alcohol use. This could take the form of motivational interviewing or motivational-enhancement therapy. Sessions should last from 20 to 30 minutes. They should aim to help people to reduce the amount they drink to low risk levels, reduce risk-taking behaviour as a result of drinking alcohol or to consider abstinence.

#### Current quality statements

NICE’s quality standard on [alcohol-use disorders: diagnosis and management](https://www.nice.org.uk/guidance/qs11) (QS11):

Statement 2

Health and social care staff opportunistically carry out screening and brief interventions for hazardous (increasing risk) and harmful (high-risk) drinking as an integral part of practice.

#### Current UK practice

In a [study of the completeness and validity of alcohol recording in general practice](https://bmjopen.bmj.com/content/9/11/e031537) based on the Clinical Practice Research Datalink in 2018 of around 1.8 million adult patients, under 10% had record of an AUDIT or FAST alcohol screening test score, and almost half had no recorded alcohol consumption data at all.

### Referral to specialist alcohol services

Stakeholders suggested that referral to specialist alcohol services should occur when appropriate from across the health and social care system, including emergency and crisis services where people with an alcohol use disorder are likely to present but may not currently be referred. They highlighted that the services referred to should be accessible, and that referral should occur in a timely manner and according to the person’s needs, to avoid gaps between seeking help and access to support. The [NHS England Commissioning for Quality and Innovation (CQUIN) Guidance for 2019 to 2020](https://www.england.nhs.uk/publication/commissioning-for-quality-and-innovation-cquin-guidance-for-2019-2020/) includes a goal of achieving screening on tobacco and alcohol use for 40 to 80% of people in inpatient settings, and brief advice delivered to 50-90%, an estimate of 60,000 alcohol users receiving brief advice.

#### Selected recommendations

NICE’s guideline on [Alcohol-use disorders: prevention](https://www.nice.org.uk/guidance/ph24) (PH24)

**Recommendation 8: extended brief interventions with young people aged 16 and 17 years**

* Provide information on local specialist addiction services to those who do not respond well to discussion but who want further help. Refer them to these services if this is what they want. Referral must be made to services that deal with young people.
* Give those who are actively seeking treatment for an alcohol problem a physical and mental assessment and offer, or refer them for, appropriate treatment and care.

**Recommendation 9: screening adults**

* Do not offer simple brief advice to anyone who may be dependent on alcohol. Instead, refer them for specialist treatment (see recommendation 12). If someone is reluctant to accept a referral, offer an extended brief intervention (see recommendation 11).

**Recommendation 12: referral**

Consider making a referral for specialist treatment if 1 or more of the following has occurred. They:

* show signs of moderate or severe [alcohol dependence](https://www.nice.org.uk/guidance/ph24/chapter/glossary#alcohol-dependence)
* have failed to benefit from structured brief advice and an extended brief intervention and wish to receive further help for an alcohol problem
* show signs of severe alcohol-related impairment or have a related co-morbid condition (for example, liver disease or alcohol-related mental health problems).

NICE’s guideline on [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence](https://www.nice.org.uk/guidance/CG115) (CG115):

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 ([high-risk drinking](https://www.nice.org.uk/guidance/ph24/chapter/8-Glossary#harmful-drinking-high-risk-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.

1.3.4.1 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 recommendation 1.3.4.5) about a community-based assisted withdrawal.

#### Current quality statements

NICE’s quality standard on [alcohol-use disorders: diagnosis and management](https://www.nice.org.uk/guidance/qs11) (QS11):

Statement 3

People who may benefit from specialist assessment or treatment for alcohol misuse are offered referral to specialist alcohol services and are able to access specialist alcohol treatment.

#### Current UK practice

In 2018, a [PHE inquiry into the fall in numbers of people in alcohol treatment](https://www.gov.uk/government/publications/alcohol-treatment-inquiry-summary-of-findings/phe-inquiry-into-the-fall-in-numbers-of-people-in-alcohol-treatment-findings#introduction) reported that the number of people accessing treatment had fallen between 2013-2014 and 2016-2017 despite high levels of unmet need and identified that financial pressures and service reconfiguration including reduction in capacity as major factors. [OHID adult substance misuse treatment statistics 2020 to 2021](https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report#people-starting-treatment-substances-age-and-referral-source) report that 21% of adults starting treatment for alcohol only substance misuse were referred by health and social care services, whereas 64% self-referred.

From 2018 to 2019 there were an estimated 602,391 adults with alcohol dependency in need of specialist treatment, a rise of 2.6% from the previous year. There were 107,428 people in treatment for alcohol (the total of alcohol only plus the non-opiate and alcohol groups) and based on these estimates, an estimated 82% of adults in need of specialist treatment for alcohol were not receiving it. ([OHID 2021).](https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report)

Issues for consideration

**For discussion:**

* What is the priority for improvement?
* What is the key action that will lead to improvement?
* Could we focus on a specific audience or setting?
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Assessment in specialist alcohol services

Initial assessment

Stakeholders suggested that there should be an initial assessment when a person first makes contact with a specialist alcohol service. They fed back that this would help initial elements of specialist care to begin earlier in the care pathway, without requiring a comprehensive assessment first, particularly where people are not in contact with a service for long enough to complete one. Stakeholders felt that homelessness should be assessed for in people with alcohol use disorders, and that their care needs should be met. They also highlighted that checking pregnancy status should be a part of assessment prior to making a decision about treatment. It was also suggested that alcohol withdrawal should be identified early by assessment in emergency services.

#### Selected recommendations

NICE’s guideline on [Alcohol-use disorders: diagnosis and management of physical complications](https://www.nice.org.uk/guidance/CG100) (CG100):

1.1.2.3 People in acute alcohol withdrawal should be assessed immediately on admission to hospital by a healthcare professional skilled in the management of alcohol withdrawal. **[2010]**

NICE’s guideline on [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence](https://www.nice.org.uk/guidance/CG115) (CG115):

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.

1.2.2.5 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

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.

#### Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

Comprehensive assessment

Stakeholders felt that people should be assessed for some key issues as part of their comprehensive assessment. They fed back that people with an alcohol use disorder should be assessed for cognitive impairment when they access acute hospital services, and that it is often an undetected issue.

#### Selected recommendations

NICE’s guideline on [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence](https://www.nice.org.uk/guidance/CG115) (CG115):

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.

1.3.7.4 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.

#### Current quality statements

NICE’s quality standard on [alcohol-use disorders: diagnosis and management](https://www.nice.org.uk/guidance/qs11) (QS11):

Statement 5

Adults accessing specialist alcohol services for alcohol misuse receive a comprehensive assessment that includes the use of validated measures.

Statement 6

Children and young people accessing specialist services for alcohol use receive a comprehensive assessment that includes the use of validated measures.

#### Current UK practice

[Alcohol Change UK](https://alcoholchange.org.uk/publication/alcohol-misuse-and-cognitive-impairment-in-older-people-an-exploratory-study#:~:text=Between%2050-80%25%20of%20individuals%20with%20chronic%20alcohol%20problems,and%20problem%20solving%20%28Bates%2C%20Buckman%2C%20%26%20Nguyen%2C%202013%29.) found in 2014 that there may be a significant amount of undiagnosed cognitive impairment in older people (aged 55 and over) attending substance misuse services.

Issues for consideration

**For discussion:**

* What is the priority for improvement?
* What is the key action that will lead to improvement?
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Assisted alcohol withdrawal

Stakeholders suggested that people needing medically assisted alcohol withdrawal receive specialist support, and that it is important for this to be done in an appropriate and well supported environment with appropriate specialist clinical expertise. Stakeholders reported that there can be variation in how criteria determining admission for medically assisted alcohol withdrawal is interpreted, and that there is ambiguity about when to adjust the threshold for certain vulnerable groups. They stated that those who are not admitted should still be given information on support available.

Stakeholders also suggested that signs of Wernicke’s encephalopathy should be routinely screened for in patients undergoing medically assisted alcohol withdrawal. They highlighted that thiamine should be prescribed for all people undergoing medically assisted alcohol withdrawal in an inpatient setting. Prescribing thiamine for all people with or suspected to have Wernicke’s encephalopathy, is an area for quality improvement as minimum prescribing durations of 5 days are not always met.

Stakeholders fed back that there is variation in current practice of community based assisted alcohol withdrawal, specifically in prescribing of benzodiazepine (chlordiazepoxide or diazepam) and Nalmefene. They also highlighted the role of Alcohol Care Teams in assisted withdrawal, and that there is inconsistency alongside resource concerns in arrangement of beds for inpatient acute withdrawal, as well as a need for well managed transfer back into community care.

#### Selected recommendations

NICE technology appraisal guidance on [Nalmefene for reducing alcohol consumption in people with alcohol dependence](https://www.nice.org.uk/guidance/ta325) (TA325)

NICE’s guideline on [Alcohol-use disorders: diagnosis and management of physical complications](https://www.nice.org.uk/guidance/CG100) (CG100):

1.1.1.1 For people in [acute alcohol withdrawal](https://www.nice.org.uk/guidance/cg100/chapter/recommendations#acute-alcohol-withdrawal-2) with, or who are assessed to be at high risk of developing, alcohol withdrawal seizures or delirium tremens, offer admission to hospital for [medically assisted alcohol withdrawal](https://www.nice.org.uk/guidance/cg100/chapter/recommendations#medically-assisted-alcohol-withdrawal). **[2010]**

1.1.1.2 For young people under 16 years who are in acute alcohol withdrawal, offer admission to hospital for physical and psychosocial assessment, in addition to medically assisted alcohol withdrawal. **[2010]**

1.1.1.3 For certain vulnerable people who are in acute alcohol withdrawal (for example, those who are frail, have cognitive impairment or multiple comorbidities, lack social support, have learning difficulties or are 16 or 17 years), consider a lower threshold for admission to hospital for medically assisted alcohol withdrawal. **[2010]**

1.2.1.1 Offer thiamine to people at high risk of developing, or with suspected, Wernicke’s encephalopathy. Thiamine should be given in doses toward the upper end of the ‘British national formulary’ range. It should be given orally or parenterally as described in recommendations 1.2.1.2 to 1.2.1.4. **[2010]**

1.2.1.2 Offer prophylactic oral thiamine to [harmful or dependent](https://www.nice.org.uk/guidance/cg100/chapter/recommendations#harmful-drinking-high-risk-drinking) drinkers:

* if they are [malnourished](https://www.nice.org.uk/guidance/cg100/chapter/recommendations#malnourishment) or at risk of malnourishment **or**
* if they have [decompensated liver disease](https://www.nice.org.uk/guidance/cg100/chapter/recommendations#decompensated-liver-disease)**or**
* if they are in acute withdrawal**or**
* before and during a planned [medically assisted alcohol withdrawal](https://www.nice.org.uk/guidance/cg100/chapter/recommendations#medically-assisted-alcohol-withdrawal). **[2010]**

1.2.1.4 Offer parenteral thiamine to people with suspected Wernicke’s encephalopathy. Maintain a high level of suspicion for the possibility of Wernicke’s encephalopathy, particularly if the person is intoxicated. Parenteral treatment should be given for a minimum of 5 days, unless Wernicke’s encephalopathy is excluded. Oral thiamine treatment should follow parenteral therapy. **[2010]**

NICE’s guideline on [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence](https://www.nice.org.uk/guidance/CG115) (CG115):

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 to 4 meetings per week over the first week.
* For people with mild to moderate dependence and complex needs, 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.  
    
  Examples of complex needs include psychiatric comorbidity, poor social support or homelessness.

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.

1.3.5.3 Prescribe and administer medication for assisted withdrawal within a standard clinical protocol. The preferred medication for assisted withdrawal is a benzodiazepine (chlordiazepoxide or diazepam). Prescribers should be aware of the [legislation on controlled drugs and driving: blood concentration limits](https://www.gov.uk/drug-safety-update/drugs-and-driving-blood-concentration-limits-to-be-set-for-certain-controlled-drugs-in-a-new-legal-offence) and advise patients accordingly.

#### Current quality statements

NICE’s quality standard on [alcohol-use disorders: diagnosis and management](https://www.nice.org.uk/guidance/qs11) (QS11):

Statement 8

People needing medically assisted alcohol withdrawal are offered treatment within the setting most appropriate to their age, the severity of alcohol dependence, their social support and the presence of any physical or psychiatric comorbidities.

Statement 9

People needing medically assisted alcohol withdrawal receive medication using drug regimens appropriate to the setting in which the withdrawal is managed in accordance with NICE guidance.

Statement 10

People with suspected, or at high risk of developing, Wernicke’s encephalopathy are offered thiamine in accordance with NICE guidance.

#### Current UK practice

Based on [NHS Digital Statistics on Alcohol](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2021) about 1 prescription item per 100,000 patients for the treatment of alcohol dependence was prescribed for Nalmefene in England in 2020/2021.

Issues for consideration

**For discussion:**

* What is the priority for improvement?
* What is the key action that will lead to improvement?
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Interventions after successful withdrawal

Psychological interventions and behavioural support

Stakeholders felt that people with alcohol use disorders should receive psychological interventions and that it would be useful to have clarity on which types should be offered, the intensity they should be offered at, and the appropriate delivery methods. They felt that this should also occur through assertive outreach teams where people, such as those with complex needs, are struggling with motivation in other services.

#### Selected recommendations

NICE’s guideline on [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence](https://www.nice.org.uk/guidance/CG115) (CG115):

1.3.3.1 For harmful drinkers ([high-risk drinkers](https://www.nice.org.uk/guidance/ph24/chapter/8-Glossary#harmful-drinking-high-risk-drinking)) 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 Offer behavioural couples therapy for harmful drinkers and people with mild alcohol dependence who have a regular partner who is willing to participate in treatment, unless there are indicators that the person is currently experiencing, or is a current perpetrator of, domestic abuse.

1.3.3.3 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] or oral naltrexone] 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).

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

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

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

1.3.3.7 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.

#### Current quality statements

NICE’s quality standard on [alcohol-use disorders: diagnosis and management](https://www.nice.org.uk/guidance/qs11) (QS11):

Statement 11

Adults who misuse alcohol are offered evidence-based psychological interventions, and those with alcohol dependence that is moderate or severe can in addition access relapse prevention medication in accordance with NICE guidance.

#### Current UK practice

[OHID](https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report#treatment-interventions) report that over 99% of adults accessing services for alcohol only treatment in 2020/2021 received a psychosocial intervention, with 98.4% doing so in a community setting and 3.5% doing so in an inpatient setting.

Medications for preventing relapse

Stakeholders raised that it was important to have clear pathways on, and access to medications including acamprosate, oral naltrexone and disulfiram, after successful withdrawal from alcohol in order to prevent relapse. They also felt that medications for preventing relapse are not fully utilised in practice, and that Alcohol Care Teams could have a role in ensuring prescribing happens at the right time in the care pathway.

#### Selected recommendations

NICE’s guideline on [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence](https://www.nice.org.uk/guidance/CG115) (CG115):

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.

1.3.6.1 After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering acamprosate or oral naltrexone] 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] 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] 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).

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]
* be stopped if drinking persists 4–6 weeks after starting the drug.

1.3.6.7 If using oral naltrexone, 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.

1.3.6.9 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.

1.3.7.9 After a careful review of the risks and benefits, specialists may consider offering acamprosate] or oral naltrexone] 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.

#### Current UK practice

Based on data for 2020/21 from [NHS Digital Statistics on Alcohol](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2021) about 208 prescription items per 100,000 patients were prescribed for acamprosate for the treatment of alcohol dependence, and 42 per 100,000 for disulfiram in England in 2020/2021. The total number of alcohol related prescription items has fallen by 15% since 2014/15.

Research by the [Institute of Alcohol Studies](https://www.ias.org.uk/2021/06/24/medicines-to-support-recovery-from-alcohol-are-they-being-used/) found that there is variation in prescribing of medications to prevent relapse, based on gender, ethnicity, age and location, and that the medications were not being considered as an initial treatment option.

Issues for consideration

**For discussion:**

* What is the priority for improvement?
* What is the key action that will lead to improvement?
* Could we focus on a specific audience or setting?
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Principles of care

Coordination of care

Stakeholders felt that people with alcohol use disorders should have their care coordinated, and that this should be done by a care coordinator and a case manager. They also suggested that those working with people who may have an alcohol problem are able to do so with a non-judgemental approach.

Stakeholders felt that meeting the needs of people who may have an alcohol problem and who also have physical health needs is an area for quality improvement. Stakeholders also felt that meeting the needs of people who may have an alcohol problem and who also have mental health needs, including depression and anxiety, is an area for quality improvement with a lack of integrated care in current practice. Suggestions included identifying need, ensuring access to and delivery of support, and delivering support as part of ongoing care through life. Furthermore, they highlighted that the needs of people with alcohol related dementia, and of those with neurodiversity, should be considered and they should be helped to access appropriate services.

#### Selected recommendations

1.1.1.1 NICE’s guideline on [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence](https://www.nice.org.uk/guidance/CG115) (CG115):

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.

1.2.2.7 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).

1.3.2.1 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.

1.3.7.2 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.

1.3.8.2 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
* for alcohol misuse comorbid with stimulant, cannabis 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.  
    
  See the NICE guidelines on [drug misuse in over 16s: opioid detoxification](https://www.nice.org.uk/guidance/cg52) and [drug misuse in over 16s: psychosocial interventions](https://www.nice.org.uk/guidance/cg51).

#### Current quality statements

NICE’s quality standard on [patient experience in adult NHS services](https://www.nice.org.uk/guidance/qs15) (QS15):

People using adult NHS services experience coordinated care with clear and accurate information exchange between relevant health and social care professionals. **[2012]**

#### Current UK practice

[UKHSA](https://ukhsa.blog.gov.uk/2020/11/17/alcohol-dependence-and-mental-health/) report that about a quarter of people who are dependent on alcohol in England are likely to be receiving mental health medication. [OHID](https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report#mental-health) report that 64% of people starting alcohol only treatment said they had a mental health need.

Information and advice

Stakeholders suggested that people seeking help for an alcohol problem should be given information that can help them. This includes information on the value of community support networks and how to access them both when initially seeking support and after successful withdrawal, and advice on avoiding sudden reduction in alcohol intake when alcohol dependent but not admitted to hospital. They felt that people should be fully informed about their own care, including treatment choices and available interventions, and being involved in agreeing goals related to their drinking.

#### Selected recommendations

NICE’s guideline on [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence](https://www.nice.org.uk/guidance/CG115) (CG115):

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.

1.2.2.1 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.

1.3.1.7 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.

#### Current practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience

Families and carers

Stakeholders felt that families and carers of people who may have an alcohol problem should be offered information, proactively told of the support available to them and how to access it, as well as having their own needs identified.

#### Selected recommendations

NICE’s guideline on [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence](https://www.nice.org.uk/guidance/CG115) (CG115):

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 (see [NICE’s guideline on supporting adult carers](https://www.nice.org.uk/guidance/ng150))
* 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.

#### Current quality statements

NICE’s quality standard on [alcohol-use disorders: diagnosis and management](https://www.nice.org.uk/guidance/qs11) (QS11):

Statement 7

Families and carers of people who misuse alcohol have their own needs identified, including those associated with risk of harm, and are offered information and support.

NICE’s quality standard on [supporting adult carers](https://www.nice.org.uk/guidance/qs200) (QS200)

Statement 1

Carers are identified by health and social care organisations and encouraged to recognise their role and rights.

Statement 3

Carers having a carer’s assessment are given the opportunity to discuss what matters most to them, including their own health, wellbeing and social care needs, and work, education, or training.

#### Current practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

Issues for consideration

**For discussion:**

* What is the priority for improvement?
* What is the key action that will lead to improvement?
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Additional areas

### Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However, they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or need further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the Advisory Committee meeting.

Table 2 Summary of information available for additional areas

| Suggested area for improvement | Within remit of NICE QS | In scope | Guideline recs | Relevant  existing QS |
| --- | --- | --- | --- | --- |
| Awareness of Alcohol Use Disorders | No | No | No | No |
| Training and staff understanding | No | No | Yes | No |
| Clinical leadership | Yes | Yes | No | No |
| Liver Disease | Yes | Yes | Yes | Yes |

### Awareness of alcohol use disorders

Stakeholders felt awareness of the impact of alcohol use disorders on families and interpersonal relationships is needed amongst the general population.

This area has not been progressed because it is beyond the scope of this quality standard.

### Training and staff understanding

Alcohol awareness training for staff was suggested as an area of quality improvement.

This suggestion has not been progressed. Quality statements focus on actions that demonstrate high quality care or support, not the training that enables the actions to take place. The committee should consider which parts of care and support would be improved by increased training. Training may be referred to in the audience descriptors.

### Clinical leadership

Clinical leadership for management of alcohol-use disorders was suggested as an area of quality improvement.

This suggestion has not been progressed, as the source guidance does not contain relevant recommendations.

### Liver disease

Stakeholders suggested that people with an alcohol use disorder and decompensated liver disease should be promptly seen by a liver specialist. This is already covered in the existing NICE quality standard on [liver disease (QS152)](https://www.nice.org.uk/guidance/qs152).

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# Appendix 1: Suggestions from registered stakeholders

| **ID** | **Stakeholder** | **Suggested key area for quality improvement** | **Why is this a key area for quality improvement?** | **Supporting information** |
| --- | --- | --- | --- | --- |
| **Identification and referral: Screening and brief interventions** | | | | |
| 1 | Change Grow Live | Identifying and supporting those who are at increased risk of alcohol-related illness | National Statistics for England estimate 82% of adults in need of specialist treatment for alcohol are not receiving it.  Over 10 million people in England consume alcohol at levels above the UK CMO’s low-risk drinking guidelines and increase their risk of alcohol-related ill health.  Alcohol is a causal factor in more than 60 medical conditions. In 2016-17 in England there were almost 340,000 hospital-admissions where an alcohol-related condition was a primary diagnosis. 5% of inpatients in secondary care may be alcohol-dependent and pathways for referral from secondary care to specialist services are needed.  FibroScan has a role in assessing liver fibrosis/cirrhosis in people who misuse alcohol and may become more available in community settings. Reference to the potential role of FibroScan in improving monitoring of liver health and earlier referral to a specialist in future guidance may be beneficial. | National Statistics for England (Adult substance misuse treatment statistics 2020 to 2021: report – GOV.UK (www.gov.uk))  Alcohol: applying All Our Health [Alcohol: applying All Our Health – GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/alcohol-applying-all-our-health/alcohol-applying-all-our-health)  Developing pathways for referring patients from secondary care to specialist alcohol treatment Developing pathways for referring patients from secondary care to specialist alcohol treatment – GOV.UK (www.gov.uk)  NICE MIB216 [Overview | FibroScan for assessing liver fibrosis and cirrhosis in primary care | Advice | NICE](https://www.nice.org.uk/advice/mib216) |
| 2 | Kyowa Kirin Ltd | Opportunities for Screening and Brief Interventions | We have identified the need to ensure that screening for at risk alcohol use is conducted in the older person, independent to the age segmentation as currently expressed for younger adult and paediatric patient groups.  A worldwide increase in life expectancy equates to a global rise in absolute numbers of older people with alcohol use disorders.[5]  Alcohol misuse in older people has increased significantly over the past 20 years. An estimated 1 in 5 older men and 1 in 10 older women are drinking at harmful levels.[6] Recent published statistics show that in 2018-19 there were 358,000 hospital admissions primarily related to alcohol misuse of which, nearly 1/3rd (28%) were in 65+ age group.[7]  Alcohol misuse can remain undetected with clinical presentations such as falls and injuries, and in favour of other primary age-related diagnosis. Delirium and dementia may mistakenly be attributed as an assumptive diagnosis of older age, when at risk alcohol use, or alcohol-related dementia could occur as differential diagnosis, and present as either a contributory or confounding factor to cognitive decline. Indeed, Wernicke’s encephalopathy can also cause a change in gait (ataxia), which may contribute to falls. Features of Wernicke’s encephalopathy are considered reversable when the condition is promptly identified and treated. One or more of the three diagnostic criteria of the classic triad, ophthalmoplegia, ataxia, and cognitive impairment/decline, are not always apparent when making, or excluding, a diagnosis of Wernicke’s, and may not present at all. Caine’s criteria, a validated diagnostic tool, increased diagnostic sensitivity vs. the classic triad from 22% to 85% by introducing dietary deficiencies as a diagnostic criterion.[8]  When mis- or underdiagnosed, and therefore left untreated, Wernicke’s can lead to the permanent sequelae and cognitive decline of Korsakoff’s syndrome.[2],[9].  It is therefore imperative that all health and social care professionals likely to come into contact with the older population, are familiar with an appropriate validated alcohol screening tool: particularly in this vulnerable population who, when drinking at risk even when considered functional with no external signs, could potentiate risk of falls; decompensated liver (with or without the presence of natural age-related hepatic shrinkage); or, cognitive impairment/decline.  The World Health Organisation (WHO) developed the Alcohol Use Disorders Identification Test (AUDIT), a 10-item screening questionnaire for detecting hazardous, harmful, and dependent drinking.[10] A validated (n=143; mean age 71) abbreviated version of AUDIT-C,[11] is utilised frequently and in many throughout UK primary and secondary care to identify the at-risk alcohol user. The authors conclude that AUDIT-C performed well in identifying unhealthy drinking among older people.  Other screening tools available for the older person include the CAGE questionnaire,[12] and the Short Michigan Alcoholism Screening Test (SMAST-G).[13] NICE Public Health Guidelines contain details of other tools and measures for alcohol use disorders.[14]  In consideration to the above, we recommend additions to the Statement 2 section: ‘Process’, as follows:  **Process:**  Proportion of people aged 65 years and over, and those aged below 65 with frailty that indicates a physiological age of 65 years and over, in the locally defined target population who receive alcohol screening.  Numerator – the number of people in the denominator receiving alcohol screening.  Denominator – the number of people aged 65 years and over, and those aged below 65 with frailty that indicates a physiological age of 65 years and over, in the locally defined target population for alcohol screening. | 1. NICE Clinical Guideline CG100 – Full Guidance – June 2010 (April 2017 update) 2. Thomson AD, Marshall EJ, & Bell DB. Time to Act on the Inadequate Management of Wernicke’s Encephalopathy in the UK. Alcohol. 2013;48(1):4-8 3. Thomson AD, Cook C, Touquet R, et al. The Royal College of Physicians Report on Alcohol: Guidelines for Managing Wernicke’s Encephalopathy in the Accident and Emergency Department. Alcohol Alcohol. 2002;37(6):513-521 4. NICE Clinical Guideline CG100 - - Alcohol-use disorders: diagnosis and management of physical complications. NICE guideline CG100 (June 2010, updated April 2017), recommendations 1.2.1.1, 1.2.1.2, 1.2.1.3 and 1.2.1.4 5. O’Connell H, Chin A, Cunningham C, Lawlor B. Alcohol use disorders in elderly people–redefining an age-old problem in old age BMJ 2003; 327 :664 6. <https://www>.rcpsych.ac.uk/mental-health/problems-disorders/alcohol-and-olderpeople 7. <https://digital.nhs.uk/data-and-information/publications/statistical/statistics-onalcohol/2020/part-1> 8. Caine D, Halliday GM, Kril JJ, Harper CG. 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(1998) Brief screening for alcohol problems in the elderly populations using the Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G). Alcohol Clin Exp Res 22(Suppl):131A. 14. <https://www>.nice.org.uk/guidance/ph24/resources/alcoholuse-disorders-prevention-pdf-1996237007557 (Accessed 22 September 2022) |
| 3 | Royal College of General Practitioners | Health and social care staff **across boundaries** opportunistically carry out screening and brief interventions for hazardous (increasing risk) and harmful (high-risk) drinking as an integral part of practice. **These are documented in a retrievable format across systems.** (from 2011) | Would be useful to build on this if felt to be important. We believe that so many staff are identifying or wanting to intervene as an integral part of clinical care when busy. A clear standard – across all health and care staff – with a good option for brief interventions training (like VBA for smoking from National Centre for Smoking Cessation Training – hence indicator is they are trained (% in organisations; and % recording in clinical environments should be incentivised. |  |
| 4 | Royal College of Psychiatrists | Screening and Brief Intervention carried out as an integral part of practice | Performance on Alcohol Brief Interventions is not routinely collected in England, but there is research evidence, that the number is low and has fallen. (O’Donnell et al doi:10.1111/add.14778) | <https://onlinelibrary.wiley.com/doi/epdf/10.1111/add.14778>  There is evidence from other countries, including Scotland, that a planned implementation programme with training and support, target setting and monitoring, financial incentives for Primary Care increases ABI delivery  <https://doi.org/10.1093/eurpub/cky181>  <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-015-1527-6> |
| 5 | Royal College of Psychiatrists | Assess for alcohol use disorder in people presenting with drug poisonings. | Alcohol was mentioned on the death certificate in 894 out of 4859 deaths related to drug poisoning in England and Wales (2021 registrations). This included drug misuse deaths. | The most recent ONS report on drug poisoning deaths showed that these were at the highest number since records began in 1993.  [Deaths related to drug poisoning in England and Wales – Office for National Statistics (ons.gov.uk)](https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2021registrations)  There is a government 10 year plan that outlines the need for supporting people obtaining drug treatment into long term recovery from alcohol problems.  From harm to hope: A 10-year drugs plan to cut crime and save lives – GOV.UK (www.gov.uk) |
| 6 | SCM1 | Homelessness and access to alcohol support services | Homelessness charities including CRISIS have identified that homeless patients struggle to access primary care and related services due to a lack of identification/address/significant other | National homelessness data  <http://drugsandhousing.co.uk/homeanddrycrisis.pdf>  <https://www>.mungos.org/app/uploads/2020/01/StM\_Knocked\_Back\_DA\_Summary\_Report\_Final\_Sp\_2901.pdf |
| 7 | SCM1 | Access to drug and alcohol services to those aged 65+ | National audits from NHS hospitals and Alcohol liaison services have identified that the drinking population are aged between 40-70 and then 70+ who access their services. | National hospital data  <https://digital>.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2020/part-1  <https://www.webmd.com/healthy-aging/what-to-know-about-alcohol-as-you-get-older>  <https://alcohol>.org/faq/do-alcohol-effects-differ/ |
| 8 | SCM6 | Key area for quality improvement 2  Early identification of those drinking at increasing risk | Prevention has been placed at the heart of the NHS 10-year plan. With respect to alcohol, therefore, much of the focus should be on the early identification and treatment of high-risk drinkers.  NICE [PH 24] recommend that NHS professionals should routinely carry out alcohol screening as an integral part of practice. The NCEPOD report (2013) found that this was not happening and recommended that all patients presenting to hospital services should be screened for drinking at increasing risk, in order that opportunities for identification and assessment of harmful drinking and/or alcohol dependence would not be missed. Those with high-risk drinking should be referred on to alcohol support services.  Both recommended that objective screening tools are used. Ideally, AUDIT should be used to decide whether to offer a brief intervention or whether to make a referral. Abbreviated version (such as AUDIT-C, AUDIT-PC, SASQ or FAST) are validated for when time is limited. Screening tools should be appropriate to the setting. | 1. Alcohol Use Disorder: Prevention [PH24], NICE 2010 |
| 9 | SCM7 | Current QS statement 2 requires revision – the inclusion of ‘identification and referral of possible alcohol dependence’. | Alcohol screening and brief intervention strategies have not achieved the scalability previously envisaged. Whilst this remains an appropriate strategy the incorporation of identification for the detection of possible alcohol dependence targets the large proportion of those in need of treatment who fail to access treatment (i.e. >80%), who are most proportionately more likely to present to mental health services, criminal justice services, liver services, emergency departments and within homeless populations. The impact of these high-need high cost individuals is across these services, their families and communities. In practice, those service areas using the AUDIT screening tool employ algorithms for local referral/signposting of specialist services for those either 16/20 or more (this is included in Statement 3, but broadening the identification of possibly alcohol dependence among health and social care staff is important to the early detection of clinical need). Recent studies have examined the utility of short screening tools (AUDIT-C, FAST) in a variety of settings and has utility within health and social care services. Additionally, we are seeing the emergence of ACT in hospitals increasing the identification AUD in hospital admissions. |  |
| **Identification and referral: Referral to specialist alcohol services** | | | | |
| 10 | NHS England | Key area for quality improvement 1  Alcohol Care Teams (ACT’s) to be considered specialist services.  ACT’s provide clinical advice to staff, support patients with alcohol use disorder and dependence within Acute Trusts and refer patients into community pathways. | This proposed standard is linked to the current NICE clinical guidance (CG100) and NICE Quality Standards (QS11). ACT’s will draw together the required elements of best practice for hospital-based services, into overarching liaison services, which can drive hospital wide improvement to clinical care and patient outcomes.  Between March 2020 and March 2021, there was [a 58.6% increase](https://analytics.phe.gov.uk/apps/covid-19-indirect-effects/) in people reporting that they are drinking at increasing and higher-risk levels(increasing risk >14 units per week, higher risk > 50 units p.w. (men), >35 units p.w. (women) [(PHE, 2021).](https://www.gov.uk/government/publications/alcohol-consumption-and-harm-during-the-covid-19-pandemic)  Alongside this, Alcohol related liver disease (ARLD) deaths increased by 21% during the year of the pandemic, marking the highest levels ever recorded. This is against a backdrop of liver mortality rates in England increasing by 43% between 2001 and 2019.  Using funding from the NHS Long Term Plan, Alcohol Care Teams are being established across the country where alcohol harm is most prevalent. A previous NICE QIPP case study has demonstrated that ACT’s are effective, efficient and improve patient outcomes (link).  The establishment and development of ACT’s is supported by the NHS, Royal College of Psychiatrists, OHID and wider system partners. | [**Alcohol Care Teams: Core Service Descriptor**](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/11/ACT-core-service-descriptor-051119.pdf) – This resource has been jointly developed by NHS England and Public Health England, based on the evidence for effectiveness of alcohol care teams in acute hospital settings.  [**Clinical Competencies for the Care of Hospitalized Patients with Alcohol Use Disorders**](https://academic.oup.com/alcalc/article/55/4/395/5823511) **–** Drawing on the existing published resources, an expert panel reached consensus on the core clinical competencies required for ACT’s in caring for hospitalised patients with alcohol use disorders; aimed at developing a standard for clinical competencies across different ACT’s.  To support wider implementation and drive improvements in quality of care, linked to ACTs, the Royal College of Psychiatrists has been commissioned to delivery an [Alcohol Care Team Improvement and Optimisation Network (ACTION)](https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/alcohol-care-team-innovation-optimisation-network?searchTerms=ACTION) to develop a community of practice and deliver consistency in clinical care across ACTs |
| 11 | Royal College of General Practitioners | Across system methods are agreed and undertaken to identify, code and refer to more specialist processes when appropriate people with alcohol use related problems. | Many turn up to out of hours, emergency department, crisis team , social care, ambulance services, counselling lines– but are not referred into appropriate services. Often highlighting of the relevant problems is not seen in clinical reports from these settings – hence repeated incidents prior to more proactive care taking place. |  |
| 12 | Royal College of General Practitioners | People who may benefit from specialist assessment or treatment for alcohol misuse are offered referral to specialist alcohol services and are able to access specialist alcohol treatment **in a timely fashion according to their needs**.  **(adapted from 2011)** | Many people at a point when they seek help are invited to continue consuming alcohol for weeks or months prior to being able to access specialist support. With the increase in alcohol consumption during COVID19 the problems are likely to increase and there is a well recognised cost to people and society in failing to address alcohol misuse. |  |
| 13 | Royal College of Psychiatrists | Statements 4, 5 ,6, 7 and 11 on staff competence, assessment quality and Psychological interventions for children, adults and families in the current QS11 | The considerable unmet need for alcohol treatment services documented by PHE shows that most people with alcohol dependence do not receive any intervention. |  |
| 14 | Royal College of Psychiatrists | People who may benefit from alcohol treatment are referred to accessible services | Public Health England reported on the decline in numbers accessing alcohol treatment in 2018.  <https://www.gov.uk/government/publications/alcohol-treatment-inquiry-summary-of-findings/phe-inquiry-into-the-fall-in-numbers-of-people-in-alcohol-treatment-findings> | The PHE report describes a number of factors which may contribute to the fall and steps for improvement. |
| 15 | SCM4 | People with alcohol use disorders are provided with specialist alcohol services support and treatment | Without specialist support and treatment people can receive inappropriate support that can lengthen the period of harmful drinking and associated heath problems. Alcohol use disorders requires awareness and competence to be able to treat and support what is a complex disorder | QS 11 – statement 3, 5 and 8  CG 100 (2017) – 1.2.2 and 1.3 (esp. 1.3.4.1 and 1.3.4.2 and 1.3.4.5) |
| 16 | SCM7 | Since the development of these NICE guidelines and quality standards, there have been considerable changes in the specialist service provision. The applicability of these QS in the development of hospital-based alcohol care teams (ACT) needs to be considered. | Over the last 5-10 years the community prevalence of alcohol dependence among adults in England has remained static (approximately 1.4%; circa 600,000 individuals), whereas the proportion accessing specialist community treatment has fallen to approximately 76,000 per annum – suggesting 12.7% of those in need of treatment are accessing specialist alcohol treatment providers. Over the same period national statistics have reported an increase in wholly alcohol attributable hospital admissions (AAHA) (including harmful drinking and alcohol dependence), as well as increases in partially AAHA. There is a significant negative correlation providing strong evidence of an association between the fall in specialist treatment access and rise in non-specialist admissions. Recent studies have identified the significant underreporting of hospital admissions involving harmful drinking and alcohol dependence estimated to be 20% and 10% respectively. The NHS long term plan (2019) has committed to the development of ACT in more than 50 hospitals in England. This new model of hospital based specialist alcohol services provides an important role in the identification and engagement of unmet and high need service users – **we need to ensure these revised QS adequately consider these specialist alcohol services and the requirements of those likely to be identified.**  Those admitted often experience high levels complexity (e.g. coexisting mental health problems, numerous acute/chronic medical conditions and are likely to experience disproportionate health inequalities), frequency of admission, have multiple and competing priorities and have limited previous specialist treatment exposure.  **Emphasis on tailored goals that supports positive contacts and community engagement may have importance for these cohorts.** These suggestions fit with the NICE CG115 regarding use of goals for drinking behaviour. | Alcohol dependence prevalence in England <https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england>  Specialist Treatment statistics: <https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report#treatment-outcomes>  Alcohol related hospital admissions: <https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2021/part-1>  Phillips et al (2021) [https ://doi.org/10.1093/alcalc/agaa086](https://doi.org/10.1093/alcalc/agaa086)  Roberts, E., et al. “The prevalence of wholly attributable alcohol conditions in the United Kingdom hospital system: a systematic review, meta‐analysis and meta‐regression.” Addiction 114.10 (2019) : 1726-1737.  Phillips T, Coulton S, Drummond C (2019) Burden of alcohol disorders on emergency department attendances and hospital admissions in England. Alcohol Alcohol 54:516–24. Doi:10.1093/alcalc/agz055 |
| **Assessment in specialist alcohol services: Initial assessment** | | | | |
| 17 | NHS England | Key area for quality improvement 3 | General comment | Although the two guidance documents that this relates to don't exclude pregnancy, there is a limited focus on pregnancy which perhaps limits specification of a particular standard, especially recognising there is a separate fetal alcohol disorder QS.  The only additional suggestion based on a review of the guidance content would be ensuring enquiry about/checking of pregnancy status before prescribing for withdrawal or dependence.    However, it might be that there are more pressing priorities for quality improvement. |
| 18 | Royal College of Psychiatrists | Assess for homelessness in people with alcohol use disorders and ensure their care needs are met. | Alcohol has been persistently identified as an important reason for death in studies of populations experiencing homelessness.  Ivers JH, Zgaga L, O’Donoghue-Hynes B, Heary A, Gallwey B, Barry J. Five-year standardised mortality ratios in a cohort of homeless people in Dublin. BMJ open. 2019 ;9(1):e023010.  Roncarati, J.S., Baggett, T.P., O’Connell, J.J., Hwang, S.W., Cook, E.F., Krieger, N. and Sorensen, G., 2018. Mortality among unsheltered homeless adults in Boston, Massachusetts, 2000-2009. JAMA internal medicine, 178(9), pp.1242-1248.  Hassanally K, Asaria M. Homeless mortality data from East London. London journal of primary care. 2018 4;10(4):99-102. | Recommendations of care for people experiencing homelessness, NICE guideline [NG214] are outlined below.  Recommendation 1.3.2  Homelessness multidisciplinary teams should act as expert teams, providing and coordinating care across outreach, primary, secondary and emergency care, social care and housing services.  Recommendation 1.3.9  In areas assessed as not needing a full-time homelessness multidisciplinary team because of low numbers of people experiencing homelessness, establish links with multidisciplinary teams in nearby areas and designate homelessness leads in all relevant mainstream services, for example, in primary, secondary and emergency care, palliative care and in adult and child social services.  [Recommendations | Integrated health and social care for people experiencing homelessness | Guidance | NICE](https://www.nice.org.uk/guidance/ng214/chapter/Recommendations#general-principles) |
| 19 | SCM7 | NICE previously stated, and placed emphasis on, a brief triage assessment should be undertaken when an individual first contacts a specialist alcohol service…with the aim of developing an initial plan of care” and assessment of risk. It is important to consider initial/triage assessment as a QS statement  Statement 5 currently relates to comprehensive assessment, which for those with complexity and is a process, not a single event. | Inclusion of triage or initial assessment emphasises a number of key elements important to individuals with AUD and practice across the field:   * Initial risk assessment is prioritised within * A recognition that initial care (i.e. MAW) can proceed earlier in the care pathway, for example with hospital and community services * Recognises that whilst comprehensive assessment is important this should not be a barrier to commencing treatment – treatment can commence after initial assessment   Helps to recognise specialist services such as ACT have an important role in carrying out initial/triage assessments but due to the acuity of patients and the short lengths of stay may not be able to complete a comprehensive assessment – but attempt facilitation of this in collaboration with community based services. |  |
| **Assessment in specialist alcohol services: Comprehensive assessment** | | | | |
| 20 | Royal College of Psychiatrists | Assessment for cognitive impairment in patients with alcohol use disorder attending acute hospitals. | A group in Liverpool used a Montreal Cognitive Assessment Tool score of ≤23 as a screening tool for impaired cognition. They excluded patients with acute conditions ( such as illicit drug use) and patients with long term conditions (such as Alzheimer’s disease). They focused on a high risk cohort ( frequent admissions or concerns expressed about cognition). The study took place over a year.  The prevalence rate for impaired cognition for this group attending an acute hospital was 36.1%. The authors described this as a “hidden problem” that is “often misunderstood in clinical care”.  Thompson A, Richardson P, Pirmohamed M, Owens L. Alcohol-related brain injury: An unrecognized problem in acute medicine. Alcohol. 2020 Nov 1;88:49-53. | Recommendation for Alcohol-use disorders: diagnosis and management of physical complications Clinical guideline [CG100] are outlined below.  Recommendation 1.1.1.3  For certain vulnerable people who are in acute alcohol withdrawal (for example, those who are frail, have cognitive impairment or multiple comorbidities, lack social support, have learning difficulties or are 16 or 17 years), consider a lower threshold for admission to hospital for medically assisted alcohol withdrawal.  The implication of this recommendation is that there needs to be a recent assessment of cognition in this group.  <https://www.nice.org.uk/guidance/cg100/chapter/Recommendations> |
| 21 | SCM2 | 1.1.1.1 For people in [acute alcohol withdrawal](https://www.nice.org.uk/guidance/cg100/chapter/recommendations#acute-alcohol-withdrawal-2) with, or who are assessed to be at high risk of developing, alcohol withdrawal seizures or delirium tremens, offer admission to hospital for [medically assisted alcohol withdrawal](https://www.nice.org.uk/guidance/cg100/chapter/recommendations#medically-assisted-alcohol-withdrawal). **[2010]** | The criteria here is interpreted in very different ways depending on the on duty staff. Same patient will receive different treatment (“if” they get assessed) depending on who’s on shift and their knowledge of conducting proper assessments. Also vital to ensure those who are not admitted are given sign posting to both local services- but more importantly peer based recovery services/community based/mutual aid groups in the interim and are advised of safe home withdrawal detox (i.e. if their not dependant enough to be admitted, then surely some advice could be given at this stage for safe home reduction?) | Personal lived experience.  -Personal experience of working with/for a community based alcohol/peer based recovery group (carers, parents, patients, etc).  -Dame Carol Black report on drugs (of which alcohol is a drug): [Review of drugs part two: prevention, treatment, and recovery - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery) |
| 22 | SCM2 | 1.1.1.3 For certain vulnerable people who are in acute alcohol withdrawal (for example, those who are frail, have cognitive impairment or multiple comorbidities, lack social support, have learning difficulties or are 16 or 17 years), consider a lower threshold for admission to hospital for medically assisted alcohol withdrawal. **[2010]** | In regards to this area; I’d like to challenge the criteria or better understand what is meant by “certain vulnerable people” – Generally, if a person is unwell enough to consider attending hospital due to alcohol related withdrawal symptoms, I argue and suggest the view point that it is difficult to discount anybody and a framework/measurable test/assessment should/could be developed to consider this. Lacking social support is often a given by this stage and the vulnerable element of it is also often implied (unless proved otherwise). At the very least I think this wording needs reviewing or developing to ensure vulnerable people aren’t being discounted or stigmatised. The argument I’m making is linked closely with mental capacity – long term abuse of alcohol that leads to alcohol dependency can often be mislabelled as a choice when in reality deep rooted trauma/complex contributing factors have led to this set of circumstances including shame, lack of knowledge and understanding of what they are suffering with and no clear route to better well being as well as compromised brain function/capacity to think clearly (hence continuing to drink/despite serious social/personal and physical/mental health consequences that are obvious to others yet do not stop the individual consuming more alcohol. So at what point are these people considered to have capacity? | Personal lived experience.  -Personal experience of working with/for a community based alcohol/peer based recovery group (carers, parents, patients, etc).  --Dame Carol Black report on drugs (of which alcohol is a drug): [Review of drugs part two: prevention, treatment, and recovery - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery) -[Alcohol and inequalities | Alcohol Change UK](https://alcoholchange.org.uk/policy/policy-insights/alcohol-and-inequalities)  -[Alcohol and capacity (localgovernmentlawyer.co.uk)](https://www.localgovernmentlawyer.co.uk/adult-social-care/307-adult-care-features/44485-alcohol-and-capacity)  -[Challenging drug and alcohol stigma | NHS inform](https://www.nhsinform.scot/campaigns/challenging-drug-and-alcohol-stigma/) |
| 23 | SCM3 | Early identification and management of alcohol withdrawal in Emergency Departments | Although EDs have protocols in place for the management of alcohol withdrawal, their effectiveness depends upon instituting treatment as soon as possible after withdrawal symptoms begin.  In a very busy department, with waits beyond 6 hours, the onset of alcohol withdrawal can go unnoticed, and treatment may not be commenced until the individual is already in advanced withdrawal. | NICE Clinical Guideline CG100 states that “People in acute alcohol withdrawal should be assessed immediately on admission to hospital by a healthcare professional skilled in the management of alcohol withdrawal.” **[2010]**  Although this relates in the guidance to patients admitted for the sole purpose of MMAW, it is equally important in those in hospital for other reasons where alcohol withdrawal may develop as a complicating factor.  It is important to instigate appropriate management of withdrawal as soon as possible to prevent progression to DTs, Wernicke’s and seizures.  Melson J, Kane M, Mooney R, Mcwilliams J, Horton T. Improving alcohol withdrawal outcomes in acute care. Perm J. 2014 Spring;18(2):e141-5. doi: 10.7812/TPP/13-099. PMID: 24867561; PMCID: PMC4022573. |
| 24 | SCM3 | Early identification and assessment of cognitive impairment in inpatients on acute hospital wards | Patients admitted to acute hospitals with a history of alcohol withdrawal may present with features of ARBD that are worsened as a result of unmanaged/inadequately managed withdrawal. Due to the nature of the cognitive impairment in ARBD and a lack of awareness amongst staff, this may not be picked up (ARBIAS, 2009) and, as a result, not considered in relation to suitability of discharge destination. Patients may, therefore, be discharged to unsafe environments leading to rapid deterioration and readmission. | An initial identification of patients who may be presenting with features of ARBD can be easily made following the process adopted by Wilson and colleagues (2012). Such patients can then be referred for more formalised assessment looking at levels of cognitive function and capacity to make decisions about health, social care and accommodation. (Welsh Government Substance Misuse Treatment Framework: Diagnosis, Treatment and Support for Alcohol Related Brain Damage; 2021). |
| **Assisted alcohol withdrawal** | | | | |
| 25 | Change Grow Live | Standard approach to community-based assisted alcohol withdrawal | Current NICE CG115 guidance recommends chlordiazepoxide/diazepam – chlordiazepoxide identified as potential mutagen, there is a gap in the guidance where chlordiazepoxide may not be suitable.  Nalmefene’s place within the NICE CG115 guidelines for reducing alcohol consumption should be determined as currently it sits in standalone guidance NICE TA325.  People who live alone may not have a family member or carer (as stated in NICE CG115) to oversee medication administration. | NICE CG115 [Overview | Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence | Guidance | NICE](https://www.nice.org.uk/guidance/cg115)  UKTIS update Librium [Librium SPC Updates Opinion Statement (medicinesinpregnancy.org)](https://www.medicinesinpregnancy.org/bumps/monographs/Librium-SPC-Updates-Opinion-Statement/)  NICE TA325 [Overview | Nalmefene for reducing alcohol consumption in people with alcohol dependence | Guidance | NICE](https://www.nice.org.uk/guidance/ta325) |
| 26 | Kyowa Kirin Ltd | Wernicke’s encephalopathy | We are aware that local clinical guidelines across UK in the hospital acute setting align with NICE CG100 [1] to recommend a high index of suspicion for Wernicke’s encephalopathy and a low threshold for treatment, for the at risk (of harmful or hazardous) alcohol use population. When Wernicke’s encephalopathy is suspected however, we note that the NICE CG100 guidance of parenteral thiamine to be administered at a minimum duration of 5 days is not consistently met. Due to the aetiology of disease, Wernicke’s encephalopathy is considered a medical emergency, and prompt and adequate treatment is critical to ensure opportunity is given to prevent exacerbation to the more permanent sequalae and cognitive decline of Korsakoff’s syndrome.[2]  The clinical consequences of not treating Wernicke’s encephalopathy promptly or adequately are significant for those patients suspected of having this debilitating disease. This may be fatal in up to 20% of patients and in those who survive, lead to the more permanent sequalae of alcohol related brain damage as seen in Korsakoff’s syndrome, 25% of whom require long term institutional care [3].  For this reason, we recommend that the minimum duration of treatment with parenteral thiamine for a minimum of 5 days be included into the quality standard.  From the Standing Committee’s full NICE CG100 recommendations:[1]  ‘…Due to the need for rapid absorption of thiamine in patients that are suspected of having Wernicke’s encephalopathy the oral route of administration was felt to be inadequate. It was noted that blood thiamine levels fall rapidly after administration so the treatment should be given more than once a day. Due to the concern of long term brain injury, it was felt *that patients with even a low index of suspicion for Wernicke’s encephalopathy* should be treated with parenteral thiamine...’  The term Wernicke-Korsakoff’s syndrome does not differentiate between a presumptive diagnosis of Wernicke’s encephalopathy (suspected Wernicke’s encephalopathy), actual diagnosis of Wernicke’s encephalopathy, or the exacerbation to full blown Korsakoff’s syndrome, where symptoms of Wernicke’s encephalopathy have progressed to permanent cognitive decline requiring longer term interventions that include institutional care.[3]  With consideration to the above, we recommended additions to the Statement 10 sections: ‘Outcome’; and, ‘What the quality statement means for each audience’, as follows:  Proportion of people misusing alcohol who, on following the NICE CG100 risk criteria, are suspected to have Wernicke’s encephalopathy  Numerator – the number of people in the denominator who, on following the NICE CG100 risk criteria, are suspected to have Wernicke’s encephalopathy  Denominator – the number of people misusing alcohol.  **Outcome**  Proportion of people misusing alcohol who have Wernicke’s encephalopathy or Wernicke-Korsakoff syndrome.  Numerator – the number of people in the denominator who have Wernicke’s encephalopathy or Wernicke-Korsakoff syndrome.  Denominator – the number of people misusing alcohol.  Proportion of people misusing alcohol who have confirmed Korsakoff’s syndrome.  Numerator – the number of people in the denominator who have confirmed Korsakoff’s syndrome.  Denominator – the number of people misusing alcohol.  **What the quality statement means for each audience**  Service providers ensure that systems are in place to provide thiamine in accordance with NICE guidance to people with suspected, or at high risk of developing, Wernicke's encephalopathy  As NICE CG100, service providers ensure that parenteral thiamine is administered at the upper end of the BNF dose range (NICE CG100 1.2.1.1), and for a minimum duration of 5 days, unless Wernicke’s is excluded. (NICE CG100 1.2.1.4)  Source guidance  Alcohol-use disorders: diagnosis and management of physical complications. NICE guideline CG100 (2010, updated 2017), recommendations 1.2.1.1, 1.2.1.2, 1.2.1.3 and 1.2.1.4 | 1. NICE Clinical Guideline CG100 - Full Guidance - June 2010 (April 2017 update) 2. Thomson AD, Marshall EJ, & Bell DB. Time to Act on the Inadequate Management of Wernicke’s Encephalopathy in the UK. Alcohol. 2013;48(1):4-8 3. Thomson AD, Cook C, Touquet R, et al. The Royal College of Physicians Report on Alcohol: Guidelines for Managing Wernicke’s Encephalopathy in the Accident and Emergency Department. Alcohol Alcohol. 2002;37(6):513-521 4. NICE Clinical Guideline CG100 - - Alcohol-use disorders: diagnosis and management of physical complications. NICE guideline CG100 (June 2010, updated April 2017), recommendations 1.2.1.1, 1.2.1.2, 1.2.1.3 and 1.2.1.4 5. O'Connell H, Chin A, Cunningham C, Lawlor B. 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Duncan Stewart, Catherine Hewitt, Jim McCambridge, Exploratory Validation Study of the Individual AUDIT-C Items among Older People, Alcohol and Alcoholism, Volume 56, Issue 3, May 2021, Pages 258–265 12. Stewart D, Oslin DW. Recognition and treatment of late-life addictions in medical settings. J Clin Geropsychol. 2001;7(2):145–58 13. Blow FC, Gillespie BW, Barry KL, et al. (1998) Brief screening for alcohol problems in the elderly populations using the Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G). Alcohol Clin Exp Res 22(Suppl):131A. 14. https://www.nice.org.uk/guidance/ph24/resources/alcoholuse-disorders-prevention-pdf-1996237007557 (Accessed 22 September 2022) |
| 27 | The Prescribing Observatory for Mental Health (POMH) | Commissioners should be aware that MAAW commonly occurs in acute adult psychiatric inpatient settings and should therefore ensure when commissioning these services that the appropriate clinical expertise is available to provide safe and effective care for patients requiring this intervention. | In a large audit sample of patients who underwent medically assisted alcohol withdrawal (MAAW) in an acute adult psychiatric ward (n=908) or specialist alcohol ward (n=347), the quality of assessment and care planning was poorer when an addictions psychiatrist (specialist) was not involved in a patient’s care. This was found for documentation of drinking history, screening blood tests to detect alcohol-related damage, measurement of breath alcohol, screening for Wernicke’s encephalopathy, prescription of thiamine, initiation of medication for relapse prevention and referral to continuing support following discharge. | (Prescribing Observatory for Mental Health [2021]. Topic 14c. Prescribing for substance misuse: alcohol detoxification in adult mental health inpatient services. Prescribing Observatory for Mental Health, CCQI 379 [data on file]) |
| 28 | The Prescribing Observatory for Mental Health (POMH) | All patients who undergo medically assisted withdrawal from alcohol (MAAW) should be screened for the emergence of signs/symptoms of Wernicke’s encephalopathy. | This is essential to detect emerging neurological complications during MAAW.  This is consistent with recommendation 1.2.1.4 in CG100 that clinicians should ‘…..maintain a high level of suspicion for the possibility of Wernicke’s encephalopathy….’ | In this large audit sample of patients who underwent MAAW in an acute adult psychiatric ward, only one in five was screened for all 3 signs/symptoms of Wernicke’s encephalopathy and there was no documented record of any screening at all for this condition for one patient in two. This limits the ability to detect an emerging serious neurological condition and therefore to intervene in a timely manner.  (Prescribing Observatory for Mental Health [2021]. Topic 14c. Prescribing for substance misuse: alcohol detoxification in adult mental health inpatient services. Prescribing Observatory for Mental Health, CCQI 379 [data on file]) |
| 29 | The Prescribing Observatory for Mental Health (POMH) | Thiamine should be prescribed for all patients undergoing MAAW in an inpatient setting. | This is essential to prevent harm directly attributable to MAAW  This is consistent with recommendation 1.2.11 in CG100 that ‘thiamine should be offered to people at high risk of developing, or with suspected Wernicke’s encephalopathy’. | In this large audit sample of patients who underwent MAAW in an acute adult psychiatric ward only two patients out of every five were prescribed parenteral thiamine and almost one patient in 5 were not prescribed thiamine by any route  (Prescribing Observatory for Mental Health [2021]. Topic 14c. Prescribing for substance misuse: alcohol detoxification in adult mental health inpatient services. Prescribing Observatory for Mental Health, CCQI 379 [data on file]) |
| 30 | Royal College of General Practitioners | People needing medically assisted alcohol withdrawal are offered **specialist** treatment, **with support,**  within the setting most appropriate to their age, the severity of alcohol dependence, their social support and the presence of any physical or psychiatric comorbidities.  **(adapted from 2011)** | This is a specialist area where often intensive specialist support required and feel that it should be emphasised that medically assisted alcohol withdrawal is not best undertaken in a generalist poorly supported environment. |  |
| 31 | SCM2 | **Research Area: 1 Admission to hospital for acute alcohol withdrawal**  What is the clinical and cost effectiveness of admitting people who attend hospital in mild or moderate acute alcohol withdrawal for unplanned medically assisted alcohol withdrawal compared with no admission and a planned medically assisted alcohol withdrawal with regard to the outcome of long-term abstinence? | This is a good question. I don’t know if it’s been researched yet albeit I would suggest an area for researching to include the introduction of peer led lived experience interventions at both the acute stage (while admitted and throughout detox) as well as at the point a patient is turned away/back into the community (i.e. proper introduction to mutual aid/named contacts/peer led lived experience rather than traditional services). | Personal lived experience.  -Personal experience of working with/for a community based alcohol/peer based recovery group (carers, parents, patients, etc).  --Dame Carol Black report on drugs (of which alcohol is a drug): [Review of drugs part two: prevention, treatment, and recovery - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery) -BMJ Article on Patient Led Research: [P025 OSHI (open source healing initiative): an example of patient-led innovation in liver services | Gut (bmj.com)](https://gut.bmj.com/content/70/Suppl_3/A22.2) . |
| 32 | SCM5 | Assisted Alcohol withdrawals  This is more about the pathways and options being provided across the stakeholder community within geography.  Ensuring that there are Quality Inpatient Acute Beds with a pathway of accessing these in place. I would go further to add in the role of Alcohol Care teams and ensuring that there is a transition from acute inpatient back out to community.  Ensure that the environment ie the workforce competence ( can be captured in above ). | CG100 1.1.1.1  There is a recurrent experience nationally that at service level there is an inconsistency in the ability to arrange acute in hospital admission for management of alcohol withdrawal- which is often precipitated due to an acute medical need ( secondary symptoms or other co morbid conditions ). There is often a need to have 1:1 discussions on a case by case basis, reliant on the engagement of individual professionals .  In these scenarios there is also the common findings that an acute alcohol assisted withdrawal is “ started “ for a number of days in hospital with a discharge plan that has to be rapidly co ordinated between in hospital and community services ( again on a 1:1 basis ) and not always with the support of specialist people or pathways ( eg ACT ).  The opportunity to encourage the quality standard of these practically needed pathways that work across providers/stakeholders/roles/sectors ( a systems approach ) is paramount to be able to deliver meaningful healthcare.  If there is an ability to utilise local data to identify the demand of such places so that services are able to strategically manage their responses. With an expectation that there are clear management plans with ability to complete alcohol detoxification and manage aftercare in a seamless approach. |  |
| 33 | SCM7 | Revision of Statement 8: | 1. Two key issues need review/amendment under this QS statement. 2. Since publication of the NICE guidelines and QS11 there has been a dramatic reduction in specialist, inpatient beds/services for MAW. Therefore, the current criteria set out on page 43/72 should be continued but it needs to be acknowledged that increasing waiting times are likely. This is because the underlying community prevalence has not changed and the increasing numbers of individuals with alcohol dependence (i.e. via ACTs) is likely to increase demand. Previous studies have demonstrated that early access to MAW improves engagement and outcomes and reducing the delay between initial contact and treatment improves engagement. Issues of equality and diversity exist as those with moderate alcohol dependence compared to those with severe/complex dependence are likely to access treatment far earlier. 3. The emergence of ACT has identified a clinical pathway issue that relates to the setting for medically assisted alcohol withdrawal – setting. Emerging clinical practice identifies changes of setting during MAW (i.e. acute ward to mental health ward, acute ward and community setting) – this was not covered in the NICE guidance but the safety and appropriateness of these decisions need to be emphasised in the future QS. | NICE CG115 Full Guideline  Care Quality Commission (2019) Brief guide: substance misuse services –detoxification or withdrawal from drugs or alcohol. Care Quality Commission  PHE (Developing pathways for referring patients from secondary care to specialist alcohol treatment. <https://www.gov.uk/government/publications/developing-pathways-for-alcohol-treatment/developing-pathways-for-referring-patients-from-secondary-care-to-specialist-alcohol-treatment> |
| 34 | SCM7 | Use of metrics to assess outcomes for MAW: | The NICE guidance priorities those with probable alcohol dependence are referred to specialist services for treatment. This is because AUDIT with a cut score of 20 is used. Previous studies of national data suggest 60-67% of those commencing treatment may require access to MAW in the community or inpatient due to their severity of alcohol dependence (i.e. moderate, severe or complex), yet only a small proportion appear to access these interventions. Whilst analysing these data might be difficult assessment of outcomes should possibly include:  the proportion in need of MAW accessing these interventions in the community/inpatient (as previously reported in early NDTMS reports)  waiting time for MAW  proportion completing MAW  Care of patients within the acute sector reveals that 20% of those admitted and experiencing Alcohol Withdrawal are readmitted within 30days  Reporting readmission within 30days and self-discharge rates might help support improvements | Brennan, A., Buykx, P., Pryce, R. E., Jones, A., Hill-McManus, D., Stone, T., . . . Drummond, C. (2016). An evidence-based model for estimating requirements for specialist alcohol treatment capacity in England: The Specialist Treatment for Alcohol Model (STreAM) Version 1.0. Final report to DH Policy Research Programme, PR-R4-0512-12002, October 2016. Retrieved from https://www.sheffield.ac.uk/polopoly\_fs/1.693424!/file/STreAMReportFinalOct2016.pdf  Brennan, A., Hill-McManus, D., Stone, T., Buykx, P., Ally, A., Pryce, R. E., ... & Drummond, C. (2019). Modeling the potential impact of changing access rates to specialist treatment for alcohol dependence for local authorities in England: The Specialist Treatment for Alcohol Model (STreAM). Journal of Studies on Alcohol and Drugs, Supplement, (s18), 96-109.  Phillips, T., Coleman, R., & Coulton, S. (2022) Predictors of 30-day readmissions among adults treated for alcohol withdrawal in acute hospitals in England. Alcoholism: Clinical and Experimental Research, Vol. 46 (S1), 283A |
| **Interventions after successful withdrawal: Psychological interventions and behavioural support** | | | | |
| 35 | SCM3 | Promote development of assertive outreach teams | Motivation to change is a complex topic in alcohol dependence and ‘poor motivation’ is often used as a reason to discharge individuals from services. However, neuroadaptive changes to the brain’s reward circuitry underlie this phenomenon and, therefore, it can be argued that, especially in those with complex needs, a more assertive approach to engagement is warranted. | Blackwood R, Wolstenholme A, Kimergård A, Fincham-Campbell S, Khadjesari Z, Coulton S, Byford S, Deluca P, Jennings S, Currell E, Dunne J, O'Toole J, Winnington J, Finch E, Drummond C. Assertive outreach treatment versus care as usual for the treatment of high-need, high-cost alcohol related frequent attenders: study protocol for a randomised controlled trial. BMC Public Health. 2020 Mar 14;20(1):332. doi: 10.1186/s12889-020-8437-y. PMID: 32171278; PMCID: PMC7071678. |
| 36 | SCM5 | Psychological Interventions  This comes up regularly within the Drug and Alcohol sector and maybe related to the changing workforce and providers within this sector. The NICE guidance are clear with the types/intensity/ to be offered.  Recognition that support; motivation ; tools that enable change in behaviour and ability to address any triggers/ trauma are paramount. | Any update on Contingency management ( as part of the research request from last QS ?)- which could be included in this section?  Quality hour interventions CBT ( 1.3.3.3.3.) as examples of what should be expected from services.  There are now online provision ( eg BreakingFree online)- are we able to make comments about the NON face to face psychological interventions which are either still delivered by people ( eg DrinkCoach ) or within a ( AI ie non person interaction) platform reliant on the individual engagement? |  |
| **Interventions after successful withdrawal: Medication for preventing relapse** | | | | |
| 37 | Change Grow Live | Clear medication pathways for relapse prevention | Existing NICE guidance provides recommendations relating to acamprosate, naltrexone, and disulfiram with non-specific guidelines relating to treatment duration or how soon following successful withdrawal they should be started, resulting in treatment variation. | NICE CG115 [Overview | Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence | Guidance | NICE](https://www.nice.org.uk/guidance/cg115) |
| 38 | SCM1 | Access to medications to manage cravings from alcohol | To ensure patients are able to be access relevant medications via GPs, Drug and alcohol teams and hospitals | Nalmefene  <https://www.ukat.co.uk/detox/medication/nalmefene/>  <https://www.sciencedirect.com/topics/neuroscience/nalmefene>  Acamprosate  <https://www.alcoholrehabguide.org/treatment/acamprosate/>  <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3277871/>  Naltrexone  <https://www.alcoholrehabguide.org/treatment/naltrexone/>  <https://www.tandfonline.com/doi/abs/10.1300/J069v19n03_05>  <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1360-0443.2012.04054.x>  Baclofen  <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5248409/>  <https://www.frontiersin.org/articles/10.3389/fpsyt.2018.00708/full>  Disulfiram  <https://americanaddictioncenters.org/addiction-medications/disulfiram>  https://www.medicinenet.com/how\_alcohol\_affects\_your\_body/article.htm |
| 39 | SCM7 | Review of quality statement 12 | The evidence –base for relapse prevention medications was found to be a key priority for inclusion. However, these medications continue to be underutilised and recent data supports a decline in prescription items issued. There is considerable under use in these medications within NHS hospitals, which does not reflect the identified need. ACTs act as specialist services –reviewing the QS to include the possible commencement of acamprosate during MAW might help promote an increased treatment offer among those seen in hospital by ACT. Supporting increased engagement and treatment outcomes. I refer this suggestion to medical colleagues involved in the panel – the NICE 115 review did include a study where acamprosate was commenced during MAW and there is some evidence that acamprosate during withdrawal may improve sleep – clinical practice does reflect this among some services. **It would be useful to consider an updated review of the literature to support any change.** | The number and cost of drugs prescribed for the treatment of alcohol dependence and the rate of prescription items per 100,000 population by Clinical Commissioning Group <https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2021/data-tables>  NICE CG115 – Full Guideline Section 7.4 page 364  Lingford-Hughes, A., et al (2012) BAP updated guidelines: evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity. Journal of Psychopharmacology DOI: 10.1177/0269881112444324 |
| **Principles of care: Coordination of care** | | | | |
| 40 | ADFAM on behalf of Alcohol and Families Alliance (AFA) | Mental health support should be readily available as people go through life stage changes | Changes in life stages, such as retirement, parenthood, children leaving home or changing jobs can be a major trigger of alcohol-related harm and conflict amongst family members and within relationships. More awareness of this and relevant mental health support to support these life changes may help people that are using alcohol as a coping mechanism. | This was a key finding in a research report soon to be published by the Alcohol and Families Alliance looking at the impact of drinking on intimate partner relationships |
| 41 | Change Grow Live | Identification of and support for people with co-existing mental health needs and alcohol misuse. | National Statistics for England show 64% of people starting treatment for alcohol in 2020-21 reported a mental health need. Therefore, there may be a high proportion of people presenting to healthcare professionals with mental health needs who experience problems with alcohol use.  A recent Alcohol Healthcare Needs Assessment (HCNA) for the North East and North Cumbria ICS identified a gap in the data set and coding for mental health which does not have alcohol as a mandatory field, therefore currently it is difficult to capture need for this cohort. People who would benefit from referral into alcohol treatment services may be missed.  In 2017, PHE identified that people with alcohol/drug misuse and co-occurring mental health conditions (including those which had previously been outside of the scope of national guidance) are often unable to access the care they need. | National statistics for England ([Adult substance misuse treatment statistics 2020 to 2021: report - GOV.UK (www.gov.uk)](https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report))  NICE NG58 [Overview | Coexisting severe mental illness and substance misuse: community health and social care services | Guidance | NICE](https://www.nice.org.uk/guidance/ng58) & CG120 [Overview | Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings | Guidance | NICE](https://www.nice.org.uk/guidance/cg120) provide guidance relating to co-existing severe mental illness and substance misuse, and [Better care for people with co-occurring mental health, and alcohol and drug use conditions (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf) encompasses the breadth of mental health conditions and alcohol/drug use. |
| 42 | Dementia UK | Inclusion of alcohol-related dementia in the quality standard | Emerging evidence for alcohol related dementia to be viewed as a separate diagnostic category (discrete from Wernicke’s Encephalopathy)  People living with alcohol related dementia often find it hard to access appropriate services, sometimes being denied access to traditional memory services because they are drinking, but not meeting the criteria for addiction services due to symptoms of dementia. | <https://www.cambridge.org/core/services/aop-cambridge-core/content/view/781C9017D415494F2F76B590B612F228/S0007125017000149a.pdf/div-class-title-addressing-alcohol-related-dementia-should-involve-better-detection-not-watchful-waiting-div.pdf>  <https://www.emerald.com/insight/content/doi/10.1108/DAT-12-2012-0011/full/html> |
| 43 | SCM3 | Improve services for individuals with alcohol use disorders and mental health problems | There is a considerable overlap between alcohol misuse and mental ill health yet individuals with both conditions can struggle to get integrated care. Mental health services may refuse to see them because of concerns that alcohol will interfere with the treatments on offer (both medication and psychosocial interventions) and addiction services may feel that the mental health problem interferes with their ability to engage the individual in addictions therapy. | Pathways need to be in place for the joint working of individuals with co-occurring alcohol dependence and mental health issues between mental health and addiction services. The concept of ‘no wrong door’ should be adopted so that a timely intervention can be put in place at the point where the individual presents with motivation. (Links to NICE QS188). |
| 44 | SCM3 | Improve service provision for individuals with neurodiversity | Individuals with neurodiverse conditions such as autism and ADHD can struggle to engage with alcohol treatment services. Both the environment and the way in which interventions are delivered can fail to take account of the reasonable adjustments needed.  The relationship between neurodiversity and alcohol dependence is complex with some studies suggesting reduced co-occurrence rates whereas others suggest higher rates. It has been suggested that, although AUDs are less likely in autistic individuals than in the general population, if it is present, it is likely to present as more severe. The presence of ADHD as well as autism possibly makes AUD more likely.  Ressel M, Thompson B, Poulin MH, Normand CL, Fisher MH, Couture G, Iarocci G. Systematic review of risk and protective factors associated with substance use and abuse in individuals with autism spectrum disorders. Autism. 2020 May;24(4):899-918. doi: 10.1177/1362361320910963. PMID: 32429819.  Yule AM, DiSalvo M, Biederman J, Wilens TE, Dallenbach NT, Taubin D, Joshi G. Decreased risk for substance use disorders in individuals with high-functioning autism spectrum disorder. Eur Child Adolesc Psychiatry. 2021 Aug 7:10.1007/s00787-021-01852-0. doi: 10.1007/s00787-021-01852-0. Epub ahead of print. PMID: 34363537; PMCID: PMC8936975. | Staff in all services to be trained in basic awareness of how to adapt processes for individuals with neurodiverse conditions.  Services to be designed appropriately to meet the needs of neurodiverse individuals.  *Bath University; Ambassadors for Autism Info:*[*www.tinyurl.com/AforAInfo*](http://www.tinyurl.com/AforAInfo) |
| 45 | SCM4 | People with alcohol use disorders need to have a care coordinator who ensures they receive the support and treatment they require and a case manager who ensures the engagement of the person and services | Alcohol use disorders may mean chaotic lifestyle, increasing the risk of slipping between the structures of conventional medical care. Care needs to be coordinated to ensure it is tailored to the individual. Support is needed 24/7 as crisis often occur outside ‘office’ hours. People do not fit into boxes and requiring support that reflects their circumstances (sometimes extending help beyond defined number of weeks) | CG 100 (2017) – 1.3.2 coordination of care and case management  QS 11 - statement 13 |
| 46 | SCM4 | Comorbid depression and anxiety disorders need to be monitored and treated during and after alcohol misuse treatment | Depression is often a symptom of alcohol use disorder or may be a separate mental health disorder. Therefore, if it does not improve following treatment for alcohol use disorders then follow up treatment and support for the depression or anxiety is essential | CG115 – Key priorities for interventions (for conditions comorbid with alcohol misuse)  CG 100 (2017) – 1.2.2.7 and 1.2.2.8 in assessment |
| 47 | SCM5 | Co morbid mental health and physical health.  This may mirror the systems approach taken to All staff | The “dual diagnosis “ and challenges that people who are dependant on alcohol or face to accessing mental health services face.  Chronic and poor physical health as a cause of death. Can the approach of community and hospital systems be such as to engage better the needs of the person unwell due to their alcohol use?  Being excluded , consciously or by challenges that cant be met by the person using alcohol ( eg alcohol withdrawals whilst awaiting emergency treatment ) has a damming consequence.  Are we able to drive up standards in engagement of this group of people wby our general physical and mental health services…either through the Workforce quality standards or pathways and interventions that are expected to be delivered across specialities/departments.  Of note the past QS specifically picked out WKS – which is a valid and I suspect underdiagnosed and managed issue. I was not sure if being that detailed is helpful with a smaller no. of QS and wanted to raise the general physical and mental health co morbidities. Will await the committee discussion on this. |  |
| 48 | SCM5 | Workforce ( not just the workforce who work within the “Drug and Alcohol” sector – be they employed by NHS / Third sector /Private providers ) but those who work within General community and hospital services.  To have an understanding of their OWN alcohol use and beliefs and how this impacts on their general approach; screening and/or interventions they deliver. This is to be tied together with a non judgemental/empathetic approach addressing the fear and stigma that can often present in people who use alcohol.  A Culturally competent workforce will also be curious to understand their communities population of patients beliefs and approach re alcohol.  Both areas above can be achieved by a learning and development package ( training ) together with ( clinical ) practice supervision to be able to reflect and develop practice.  Using a competency framework that includes the standards referred to within the NICE guidance and the last QS( including Motivational interviewing approach ).  I think there was a valuable focus on the previous QS on workforce which could be amalgamated into one QS which highlights the systems approach to all. | Screening and Identification building onto the therapeutic alliance and intervention delivery- are reliant ( excluding any digital tech interventions which have AI component ) on the General Workforce to be ready and willing to screen and engage. So environments such as general memory clinics ; midwife appointments ; Emergency department presentations ; Social care appointments etc.  Ideally creating a “ no Wrong door “ / “ make every contact count “..approach when people interact with any health and social care staff – ie ensuring training and education to all , around alcohol effects and stepped up degrees of screening/intervention depending on roles.  I would add recognising that the legal status of Alcohol and the personal use of alcohol by health and social care staff does influence their engagement in screening and interventions and to ensure that this is addressed in training and reflective practice.  Alcohol use can present in a variety of ways and can also exacerbate a variety of mental and physical health conditions. Ensuring that this is identified in areas/interactions that are outside the Drug and Alcohol service is important. |  |
| **Principles of care: Information and advice** | | | | |
| 49 | Alcoholics Anonymous | 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. | Disseminating awareness of the evidence-base for the efficacy and reduced healthcare costs of peer-led Alcoholics Anonymous (AA) and professionally-delivered treatments that facilitate AA involvement (Twelve-Step Facilitation (TSF) interventions) in people with Alcohol Use Disorders will facilitate the engagement of people with Alcohol Use Disorders and referrals to AA from healthcare professionals and other agencies. | 1. The key study is the Cochrane Database of Systematic Reviews  www.cochranelibrary.com  Kelly JF, Humphreys K, Ferri M.  Alcoholics Anonymous and other 12-step programs for alcohol use disorder.  Cochrane Database of Systematic Reviews 2020, Issue 3. Art. No.: CD012880.  DOI: 10.1002/14651858.CD012880.pub2.  **Objectives**  To evaluate whether peer-led Alcoholics Anonymous (AA) and professionally-delivered treatments that facilitate AA involvement (Twelve-Step Facilitation (TSF) interventions) achieve important outcomes, specifically: abstinence, reduced drinking intensity, reduced alcohol-related consequences,  alcohol addiction severity, and healthcare costs.  **Methods**  Participants were non-coerced adults with Alcohol Use Disorder (AUD). We included randomized controlled trials (RCTs), quasi-RCTs and non-randomized studies that compared AA or TSF (AA/TSF) with other interventions, such as motivational enhancement therapy (MET) or cognitive behavioral therapy (CBT), TSF treatment variants, or no treatment. We also included healthcare cost studies.  **Results**  We included 27 studies containing 10,565 participants (21 RCTs/quasi-RCTs, 5 non-randomized, and 1 purely economic study). AA/TSF was compared with psychological clinical interventions, such as MET and CBT, and other 12-step program variants.  **Results and Conclusions**  There is high quality evidence that manualized AA/TSF interventions are more effective than other established treatments, such as CBT, for increasing abstinence. Non-manualized AA/TSF may perform as well as these other established treatments. AA/TSF interventions, both manualized and non-manualized, may be at least as effective as other treatments for other alcohol-related outcomes. AA/TSF probably produces substantial healthcare cost savings among people with alcohol use disorder.  2. The distilled summary version of this Cochrane review is this paper.  Kelly JF, Abry A, Ferri M, Humphreys K.  Alcoholics Anonymous and 12-Step Facilitation Treatments for Alcohol Use Disorder: A Distillation of a 2020 Cochrane Review for Clinicians and Policy Makers  Alcohol and Alcoholism, 2020, 55(6) 641–651 doi: 10.1093/alcalc/agaa050  Data bases up till August 2019 were searched for randomized controlled and other studies in participants with alcohol use disorders that compared the efficacy and costs of treatment that facilitated use of AA versus treatment using other methods such as cognitive behavior therapy and motivational enhancement therapy. The search revealed 27 studies pertaining to 10,565 persons. Meta-analyses showed that AA and facilitating use of AA (‘TSF’) produced similar benefits to other treatments on all drinking-related outcomes except for continuous abstinence and remission, where AA/TSF was superior. Studies analyzing costing found that use of AA/TSF also tended to reduce healthcare costs. |
| 50 | Alcoholics Anonymous | 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. Evidence is from the AA Fellowship and trustees of the GB and Continental Europe. 2. There is a stigma associated with seeking help for alcohol misuse. 3. Access to AA is variable in different geographical areas. 4. Online AA meetings have facilitated access to AA for many groups of people, especially older members, parents with young children and members who live in rural and remote areas. All these groups may find it difficult to attend face-to-face meetings for a variety of reasons. 5. Historically, healthcare professionals have been reluctant to refer people to AA, often since they believe that AA requires a belief in God. | **NICE CG115 Information for patients**  1. CG115 Evidence has many trials involving AA, as well as patient testimonies as to the support and efficacy of AA.  2. There is a commonly held view that AA is a religious organisation and that many people including professionals may be put off by the use of the 'God' word in AA literature and discourse. This is belied by findings from the most recent survey of AA members (the 2020 AA Membership Survey), which found that when respondents (n = 1694) were asked about the foundations of their views on spirituality and their notion of a higher power (or God), 65% reported that these were based on a secular foundation, compared with 35% who reported that their views of the above had an overtly religious basis.  <https://www.alcoholics-anonymous.org.uk/Members/2020-Survey> |
| 51 | SCM2 | 1.3.6 Interventions for moderate and severe alcohol dependence after successful withdrawal | I feel as though this area needs looking at closely. There is a lot of information about certain types of intervention without any key mention of peer led lived experience approach and on-going support rather than fixed interventions. An incredible opportunity exists to capitalise on a successful withdrawal and that chance is often missed/leads to re-admission due to gaps that exist in the current guidance/system (i.e. referral to existing statutory providers can often take many weeks and is fixed at certain intervals rather than immediate/on-going. Heavier focus on the community element as well as guidance on how health professionals can achieve these outcomes. | Personal lived experience.  -Personal experience of working with/for a community based alcohol/peer based recovery group (carers, parents, patients, etc).  -Dame Carol Black report on drugs (of which alcohol is a drug): [Review of drugs part two: prevention, treatment, and recovery - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery)  - BMJ Article on Patient Led Research: [P025 OSHI (open source healing initiative): an example of patient-led innovation in liver services | Gut (bmj.com)](https://gut.bmj.com/content/70/Suppl_3/A22.2) |
| 52 | SCM2 | Lived Experience/Peer led interventions at earliest possible stage followed up by on-going support rather than fixed appointment. |  | Personal lived experience.  -Personal experience of working with/for a community based alcohol/peer based recovery group (carers, parents, patients, etc).  -Dame Carol Black report on drugs (of which alcohol is a drug): [Review of drugs part two: prevention, treatment, and recovery - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery) - BMJ Article on Patient Led Research: [P025 OSHI (open source healing initiative): an example of patient-led innovation in liver services | Gut (bmj.com)](https://gut.bmj.com/content/70/Suppl_3/A22.2) . |
| 53 | SCM2 | 1.1.1.4 For people who are [alcohol dependent](https://www.nice.org.uk/guidance/cg100/chapter/recommendations#alcohol-dependence) but not admitted to hospital, offer advice to avoid a sudden reduction in alcohol intake and information about how to contact local alcohol support services. Note that a sudden reduction in alcohol intake can result in severe withdrawal in dependent drinkers. **[2010]** | This is good, but how can we get it practiced more routinely in its application? Also; what advice is given; in my experience people are told don’t stop at any costs without first getting detox (which can seem impossible if not on deaths door) or seeing specialist statutory provider (very difficult to engage with/not immediately useful). I understand there are litigation risks of recommending a specific withdrawal regimen albeit pointing someone to a resource to make an informed decision about safe levels of withdrawal (i.e 5 to 10% reduction per day with the caveat of re-attending hospital if any sudden changes). Also; along with info to contact local support services, also include mutual aid, potentially have sign posting to a named individual independent of the hospital or an NHS volunteer that can sign post to the local community in the mean time to provide hope/direction to people who are often lost/at end of tether (hence presentation to hospital). | Personal lived experience.  -Personal experience of working with/for a community based alcohol/peer based recovery group (carers, parents, patients, etc).  --Dame Carol Black report on drugs (of which alcohol is a drug): [Review of drugs part two: prevention, treatment, and recovery - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery) -[How to safely detox from alcohol at home - With You (wearewithyou.org.uk)](https://www.wearewithyou.org.uk/help-and-advice/advice-you/how-safely-detox-alcohol-home/) |
| 54 | SCM5 | Provided at time of interview and will expand on as part of committee. Areas of focus  : Pooling of young people approaches including digital interface.  Co production /Working together with local community and those with lived experience to enhance the clinical engagement and relapse prevention.  Identifying Harm Reduction approaches- to ensure that this first form of engagement for people is a recognised end point to reduce harm whilst also being for some the first step towards abstinence. |  |  |
| 55 | SCM7 | NICE 115 guidance previous emphasised the need for patients and services users to be fully informed regarding their care – The current QS do not place emphasis, or empower the patient/service user | Over the last decade, the field have built on the NICE guidance and the development of recovery and importance of lived experience. A previous document Understand NICE guidance: Information for people who use NHS service (NICE, 2011) helped inform patients and service users. It is important to acknowledge patients beyond the current statement (QS13) to include:   * For people **accessing services** information on treatment choices, mutual aid, waiting times, and available interventions (including medications). * People **receiving treatment** should have clear negotiated and agreed goals related to their drinking (i.e. abstinence, gradual reduction) which are regularly reviewed by a named individual within the service who is appropriately trained. | Existing NICE guidance CG115 and associated document – NICE (2011) Understand NICE guidance: Information for people who use NHS service. |
| **Principles of care: Families and carers** | | | | |
| 56 | ADFAM on behalf of Alcohol and Families Alliance (AFA) | Training and support to professionals working in frontline services to recognise those struggling with a family member’s alcohol use | Workforce development of practitioners in drug and alcohol treatment, and other frontline services, is key in ensuring that families negatively impacted by alcohol are supported as well as possible.  Practitioners that are likely to come into contact with people affected by a family member’s drinking should have access to training and resources to help them identify and support families affected in this way, and equip practitioners with the relevant tools and knowledge to help families sensitively or to signpost onto specialist services. |  |
| 57 | ADFAM on behalf of Alcohol and Families Alliance (AFA) | Greater outreach to ensure families affected by alcohol know where support is available and how they can access it | Family members affected by the alcohol use of a loved one often don’t self-refer to services, either because they are in crisis and/or they are focused on their loved one’s recovery. Their needs are often quite complex or hidden, so support needs to be offered proactively and highly effective identification and referral pathways need to be in place. | An overwhelming finding of a research study, soon to be published by the Alcohol and Families Alliance looking at the impact of drinking on intimate partner relationships, was that many people who are affected by their partner’s alcohol use often do not know that they themselves are in need of, or eligible for support in their own right. In situations where they do seek support, this is often when a point of crisis has been reached.  Support services need to ensure that their doors are open and they are actively reaching these people before a crisis develops. |
| 58 | Royal College of General Practitioners | Families and carers of people who misuse alcohol have their own needs identified, including those associated with risk of harm, and are offered information and support.  **(From 2011)** | We feel this is an important area to cover – and emphasis should be made on evaluation by services of how successful this support is and where it can be improved. |  |
| 59 | SCM4 | Families, carers and people important to the person who has an alcohol use disorder have their own needs identified and provided with information about how to support their person | People important to the person (might be family and carers but may be someone else) with the alcohol use disorder need to be supported themselves so they in turn can support the person. Being unsupported can lead to:  • increased stress for family and carers  lack of information about the persons condition and how to help them can lead to misunderstandings and inappropriate support from the family/carers etc | QS 11 – statement 7  CG100 (2017) – 1.1.2 working and supporting families and carers |
| **Additional areas: Awareness of Alcohol Use Disorders** | | | | |
| 60 | ADFAM on behalf of Alcohol and Families Alliance (AFA) | Improved public awareness on the impact alcohol has on families and relationships with others, and to challenge stigma. | Despite the prevalence of alcohol in society, alcohol dependence is heavily stigmatised. Stigma can play a damaging role in preventing those who have a drinking problem, and their families, from coming forward and asking for help.  There needs to be more awareness amongst the general public about the damage stigma does to people and their families impacted by alcohol dependence, and to help people to be more understanding and sympathetic in their language and approach. | Research from Adfam shows that stigma can be a powerful block to seeking support, and that some families effectively stigmatise themselves through feelings of guilt and low self-worth.  <https://adfam.org.uk/files/docs/adfam_challenging_stigma.pdf> |
| **Additional areas: Training and staff understanding** | | | | |
| 61 | SCM4 | All front-line health and social care staff receive alcohol awareness training and are competent in supporting people with alcohol use disorders in a respectful, non-judgmental way | The stigma attached to alcohol use disorders and the misinformation about how to treat and support people is such that people experience inappropriate or poor treatment | QS 11 - Statement 1 and 4  CG 15 – Key priorities for implementation (identification) and general principles  CG100 (2010) – recommendations assessment and monitoring 1.1.2.1  CG100 (2017) 1.1.1 in building a trusting relationship and 1.2.1.2 and 1.2.1.6 in identification and monitoring and 1.3.1.5 in interventions |
| 62 | SCM7 | Trained and competent specialist staff | Since the publication of NICE CG115 there have been considerable changes to the workforce interfacing with individuals in need of treatment and recovery. There has been a decline in the Consultant grade training, reductions in the number of role of nurses and psychologists. The vast majority of the workforce is characterised as ‘practitioners’. A number of competency documents have been published to help support the development of all these roles, which might need to be considered alongside the existing quality statement (#4).  Furthermore the role and safeguards for supporting peer-mentors and volunteers might need to be strengthened in this section. | Care Quality Commission (2018) Brief Guide: substance misuse services –workforce qualifications. Care Quality Commission.  Phillips, T., et al. Clinical Competencies for the Care of Hospitalized Patients with Alcohol Use Disorders, *Alcohol and Alcoholism*, Volume 55, Issue 4, July 2020, Pages 395–400, <https://doi.org/10.1093/alcalc/agaa024>  Public Health England and Royal College of Nursing (2017) The Role of Nurses in Alcohol and Drug Treatment Services. A resource for commissioners, providers and clinicians. Public Health England and Royal College of Nursing.  Royal College of Nursing (2015) Caring for people with liver disease: a competence framework for nursing. Revised edition. Royal College of Nursing. |
| **Additional areas: Clinical leadership** | | | | |
| 63 | SCM6 | Clinical leadership for management of alcohol-use disorders (esp. in acute hospital trusts) | In 2013, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) released their report “Measuring the Units: a review of patients who died from alcohol-related liver disease”, which provided new data about the impact of alcohol on health, along with some challenges for NHS provision. It highlighted alarming statistics, which included that patient care was rated as less than good for more than half of the patients, who died following admission with acute alcohol-related liver disease. The report also highlighted inadequate facilities, a lack of specialist expertise of those caring for patients with liver disease and a series of missed opportunities to intervene. This included deficiencies in primary and secondary care, where earlier diagnosis and intervention could have avoided the prevention to progressive liver disease.  NCEPOD made a series of recommendations, the overarching theme being that clinical leadership for those presenting with AUD was required to ensure strategic and operational systems were in place in each acute hospital trust, to improve the care of those with alcohol-related harm.  Specifically, NCEPOD in their report recommend each acute hospital should establish an alcohol care team, integrated across primary and secondary care. A clinical expert group convened by PHE reached the same conclusion (2014). Subsequently, there is national guidance (NHSE&I, 2019) that provides the best available evidence on how an alcohol care team should be configured.  Even if an acute hospital trust does not have an alcohol care team (or wish to establish one), they must still ensure appropriate clinical governance exists to improve the quality of care for AUD. | 1. NCEPOD, Measuring the Units, A review of patients who died with alcohol-related liver disease, 2013 2. Alcohol care in England’s hospitals. An opportunity not to be wasted. Public Health England (2014)   Alcohol Care Teams: Core Service Descriptor NHSE&I (2019) |
| **Identification: Liver disease** | | | | |
| 64 | SCM6 | Early identification of those with liver disease | People drinking alcohol at increasing risk should be screened for the presence of alcohol-related liver disease. This should be with a measure of liver fibrosis because normal liver blood tests do not exclude advanced fibrosis.  NICE recommend that those drinking more than 35 units per week (women) or 50 units per week (men) should be offered Transient Elastography (Fibroscan®) to diagnose fibrosis/cirrhosis. Those diagnosed with advanced fibrosis or cirrhosis should be referred to specialist liver services. | 1. Cirrhosis in over 16s: assessment and management, NICE NG 50, 2016 |
| 65 | SCM6 | Early specialist review and consideration of critical care | Decompensated cirrhosis is a medical emergency with a high mortality. Despite this, the NCEPOD report found that initial consultant input was sometimes insufficiently prompt, with initial management plans that were sometimes unclear and failed to recognised organ failure. A quarter of patients were never seen by a liver specialist.  NCEPOD recommended that all those admitted with decompensated ARLD cirrhosis should be seen by a specialist with experience in the management of patients with liver disease, ideally within 24 hours. To aid in the acute management of patients admitted with decompensated cirrhosis, particularly within this initial 24hours, a ‘care-bundle’ has been developed (BSG).  Patients with ARLD are susceptible to developing critical illness, which can often require escalation and admission to critical care, including high dependency or intensive care. NCEPOD found that there were missed opportunities for escalation of care in those that may have benefited. Escalation of care should be actively pursued for patients with ARLD, who deteriorate acutely and whose background functional status is good. | https://www.bsg.org.uk/clinical-resource/bsg-basl-decompensated-cirrhosis-care-bundle-first-24-hours/ |
| **General comments** | | | | |
| 66 | NHS England | Key area for quality improvement 2 | General comment | The new European Medicines Agency (EMA) guidance impacts on the prescribing of benzo diazepine and is currently with Medicines & Healthcare Products Regulatory Agency (MHRA), so would anticipate this would be part of their remit for feedback.  NICE is looking at how to link guidance rather than repeating it, so linking with the Fetal Alcohol Spectrum Disorder Guidance (FASD) guidance would be safest way to proceed. |
| 67 | Royal College of Paediatrics and Child Health | General | No Comments |  |
| 68 | SCM7 | NOTE: UK Alcohol Clinical Guideline being developed by OHID and due for consultation in autumn 2022: |  |  |