Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.
National Collaborating Centre for Mental Health.

This impressive assessment of what evaluation research means for alcohol dependence treatment in Britain is distinguished by reviews of the latest literature on the sub-topics it covers; in some cases these starkly reveal the inadequacies of the evidence base.

SUMMARY This summary is based on the quick reference guide associated with the guidance.

Noting that current practice across the country is varied, leading to variation in access to assisted withdrawal and treatment services, this guideline makes recommendations on the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and young people aged 10–17.

Person-centred care
Treatment and care should take into account people’s individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow people to reach informed decisions about their care. If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care. If caring for young people in transition between paediatric and adult services, refer to Transition: getting it right for young people.

Key priorities for implementation

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

Assessment in specialist alcohol services
Consider a comprehensive assessment for all adults referred to specialist services who score more than 15 on the Alcohol Use Disorders Identification Test (AUDIT). A comprehensive assessment should assess multiple areas of need, be structured in a clinical interview, use relevant and validated clinical tools, 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, the Severity of Alcohol Dependence Questionnaire (SADQ) or the Leeds Dependence Questionnaire (LDQ); alcohol-related problems, using, for example, the Alcohol Problems Questionnaire (APQ);
• other drug misuse, including over-the-counter medication;
• physical health problems;
• psychological and social problems;
• cognitive function, using, for example, the Mini-Mental State Examination (MMSE);
• readiness and belief in ability to change.

In the initial assessment 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. 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.

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

For people with severe alcohol dependence, or those who misuse alcohol and have significant psychiatric or physical comorbidity, but who are unwilling to consider a goal of abstinence or engage in structured treatment, consider a harm reduction programme of care. However, ultimately the service user should be encouraged to aim for a goal of abstinence.

General principles for all interventions
Consider offering interventions to promote abstinence and prevent relapse as part of an intensive structured community-based intervention for people with moderate and severe alcohol dependence who have:
• very limited social support, for example, living alone or with very little contact with family or friends; or
• complex physical or psychiatric comorbidities; or
• not responded to initial community-based interventions.

All interventions for people who misuse alcohol should be delivered by appropriately trained and competent staff. Psychological interventions should be administered by specialist and competent staff.
**Interventions for harmful drinking and mild alcohol dependence**

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

**Assessment for assisted alcohol withdrawal**

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

**Interventions for moderate and severe alcohol dependence**

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

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

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

**Interventions for conditions comorbid with alcohol misuse**

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

**2013 update**

An update on the evidence released in January 2013 which does not replace current guidance was also considered not to justify any changes to this guidance. Generally the new reviews and studies identified in the update were consistent with the research reviewed for the original document and with the original practice recommendations based on that research.

**FINDINGS COMMENTARY** This report offers a thoroughly researched, root and branch re-assessment of what evaluation research means for alcohol dependence treatment in the British context. It is distinguished by the many fresh searches for and reviews of the literature on the sub-topics it covers, including where appropriate meta-analytic syntheses of the findings in to single, easily understood metric. Thoughtful narrative reviews explain the contexts of the studies and an expert and experienced group sifted and adapted the findings to British caseloads, services and resources. Limits imposed on the report by the available research (below) detract from its ability to advance practice, but not from an impressive attempt to offer comprehensive, coherent, evidence-informed guidance based on the research to hand.

**Research lacking in some areas**

Despite the fresh searches, the main limitation faced by the report’s authors was that in some cases the evidence remained very thin, leaving the guidance largely devoid of an evidential basis for what are presumed to be crucial treatment strategies. Among these were using research-validated assessment tools as opposed to a more ad-hoc approach, whether it is important to offer a coherent, case managed programme or whether patients do as well using a ‘pick and mix’ or ‘take what’s available’ approach, and whether offering the least intensive intervention first (‘stepped care’) risks demoralising failure or is a cost- and trouble-saving strategy with no major downsides. In these situations, the expert group which drafted the guidance had to rely substantially on experience and common sense – in other words, continuation of the ‘way we do things now’ – rather than research-based advancements.

For example, in respect of the crucial case management function intended to knit together assessment, planning, coordination and monitoring of care and treatment, just three studies met the most stringent methodological criteria (randomised trials with a control group), were concerned with drinkers, and provided the required outcome data. Another important and common approach to care planning is to offer the least restrictive and least costly intervention first and move up the scale if that fails – so called ‘stepped care’ – yet the report found that “none of [the potentially relevant] studies delivered a form of stepped care that was fully consistent with the definition of a stepped care approach adopted for this guideline”. Assessment is clearly a critical stage, determining what services the client will be offered and at what intensity, yet at just six suitable studies, the evidence base for adults was too thin to permit use of the most appropriate statistical methods to judge what works best.

**Interpreting the research**

On other issues the expert group was vulnerable to seeing what researchers have chosen to study for research purposes as the way practitioners should do things. This happens because the researchers’ choices gather an evidence base around them which is not gathered by more rarely researched approaches such as routine medical management or the exercise of clinical judgement. Examples below.

In particular, researchers like to standardise the interventions they research so that they know what causes the impacts they observe, and so that other researchers can replicate or extend their findings. The key way this is done is to manualise the intervention and ensure that highly trained interventionists stick to the manual. Manualised interventions then gather an evidence base around them, and practitioners...
Alcohol dependence and harmful alcohol use quality standard

Concise statement of 13 practices which constitute high quality health care for problem drinkers and good practice in identifying and advising hazardous drinkers. The standards may be used to assess and reward providers and health service commissioning authorities.

Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults Guidance for commissioners on how to organise and procure alcohol treatment and brief intervention services in an area which implement related national clinical guidance and satisfy policy requirements.

For the nearest Scottish equivalent to the featured document see these guidelines developed for the Scottish Intercolligiate Guidelines Network.

Thanks for their comments on this entry in draft to Mary Longley and to Brian Kidd of Tayside Primary Care Trust. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Related guidance

Other related NICE guidance documents are listed below.

Alcohol-use disorders: preventing the development of hazardous and harmful drinking Prevention guidelines which prioritised population-wide changes like price rises and outlet restrictions which affect everyone, independent of the choices they make.

Alcohol use disorders: diagnosis and clinical management of alcohol-related physical complications Clinical guidelines on the medical care of people suffering acute alcohol withdrawal or alcohol-related lack of thiamine, liver disease, or inflammation of the pancreas.

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