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

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National Collaborating Centre for Mental Health.
National Institute for Health and Clinical Excellence, 2011.

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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.

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

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

Interventions for harmful drinking and mild alcohol dependence

For harmful drinkers and people with mild alcohol dependence, offer a psychological intervention (such as cognitive-behavioural therapies, behavioural therapies or social

network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems and social networks.

Assessment for assisted alcohol withdrawal

For service users who typically drink over 15 units of alcohol per day and/or who score 20 or more on the AUDIT, consider offering:
- an assessment for and delivery of a community-based assisted withdrawal; or
- assessment and management in specialist alcohol services if there are safety concerns 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 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 are persuaded that this is how they should work in routine practice − a process reflected in the guideline's belief that "Psychological interventions should be based on a relevant evidence-based treatment manual, which should guide the structure and duration of the intervention". Yet it has recently become clear that for motivational interviewing, one of the most influential counselling styles in Britain, insisting that a manual guide the structure and duration of the intervention actually *reduces* its effectiveness (1 2 3).

Similarly, the report's stipulations about session numbers and durations of certain psychological therapies seem to reflect the fact that researchers have to package their interventions in order to standardise them, limit costs, and have a set end date from which the follow-up period can begin. Twelve weeks is the commonest compromise between a manageable research intervention and one which lasts long enough to possibly have the desired impacts. As a result, 12-week treatments have collected an evidence base around them, reflected in the report's recommendations for the main psychological therapies it advocates. Yet there is no reason to believe

that because 12 weeks is convenient for researchers, it is also the way patients should be treated. For example, a reanalysis of the US alcohol treatment trial Project MATCH showed that patients who did not return for a single therapy session did almost as well as those who went through all 12 sessions of the project's two most extensive therapies. Across the entire study, nearly all the improvement there was going to be in drinking had occurred by week one, before most of the treatment had been delivered.

Other issues

Among the important messages from the featured report not in the *Key implications* summarised above are that therapeutic staff should aim to build a trusting relationship with their clients and work in a supportive, empathic and non-judgmental manner, taking in to account that stigma and discrimination are often associated with drink problems and lead clients to understate these problems. Discussions should, the report says, take place in settings in which confidentiality, privacy and dignity are respected.

On one issue this NICE report seems clearly at variance with the relevant NHS Clinical Knowledge Summary provided on behalf of NICE by the Sowerby Centre for Health Informatics at Newcastle. Rather than a blanket recommendation that adults who typically drink over 15 units of alcohol a day should be considered for assisted withdrawal, this summary amends that guideline downwards for women to 10 units.

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.

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 Intercollegiate 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.

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