Interventions for harmful drinking and alcohol dependence

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/alcohol-use-disorders
NICE Pathway last updated: 30 November 2018

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.

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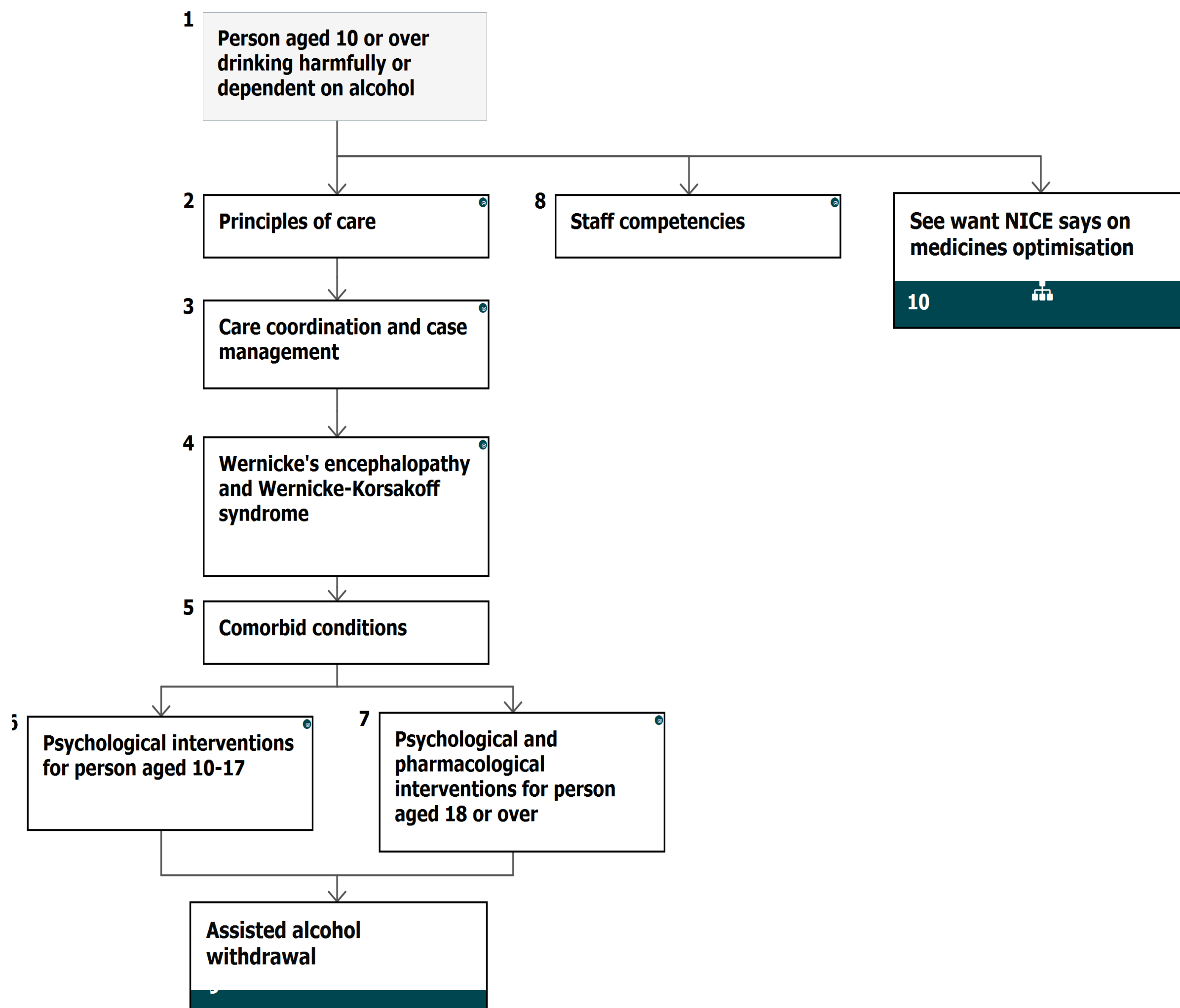

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1 Person aged 10 or over drinking harmfully or dependent on alcohol

No additional information

2 Principles of care

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

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

For all people who misuse alcohol, offer interventions to promote abstinence or moderate drinking as appropriate and prevent relapse, in community-based settings.

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

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.

Quality standards

The following quality statements are relevant to this part of the interactive flowchart.

Alcohol-use disorders: diagnosis and management quality standard

4. Trained and competent specialist staff

13. Outcomes monitoring

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3 Care coordination and case management

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.

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.

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.

Quality standards

The following quality statements are relevant to this part of the interactive flowchart.

Alcohol-use disorders: diagnosis and management quality standard

4. Trained and competent specialist staff

5. Assessment in specialist alcohol services – adults

13. Outcomes monitoring

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4 Wernicke's encephalopathy and Wernicke-Korsakoff syndrome

Offer thiamine to prevent and manage Wernicke's encephalopathy

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 below.

Offer prophylactic oral thiamine to harmful or dependent drinkers:

- if they are malnourished or at risk of malnourishment **or**
- if they have decompensated liver disease **or**
- if they are in acute withdrawal **or**
- before and during a planned medically assisted alcohol withdrawal.

Offer prophylactic parenteral thiamine followed by oral thiamine to harmful or dependent drinkers:

- if they are malnourished or at risk of malnourishment **or**
- if they have decompensated liver disease

and in addition

- they attend an emergency department **or**
- are admitted to hospital with an acute illness or injury.

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.

Offer long-term placement to people with Wernicke-Korsakoff syndrome

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

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

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

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Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Alcohol-use disorders: diagnosis and management quality standard

10. Wernicke's encephalopathy

5 Comorbid conditions

Depression or anxiety disorders

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

See what NICE says on depression and generalised anxiety disorder.

Mental health disorders

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. (See also what NICE says on suicide prevention.)

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.

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Nicotine dependence

For comorbid alcohol and nicotine dependence, encourage service users to stop smoking. See what NICE says on smoking and drug misuse management in over 16s.

6 Psychological interventions for person aged 10– 17

For children and young people who misuse alcohol offer:

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

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

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

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

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

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

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

- engaging and motivating the family in treatment (enhancing perception that change is

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

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

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

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Alcohol-use disorders: diagnosis and management quality standard

12. Specialist interventions for children and young people

7 Psychological and pharmacological interventions for person aged 18 or over

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.

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

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

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

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

Behavioural couples therapy should be focused on alcohol-related problems and their impact on

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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.

Nalmefene

The following recommendation is from NICE technology appraisal on nalmefene for reducing alcohol consumption in people with alcohol dependence.

Nalmefene is recommended within its marketing authorisation, as an option for reducing alcohol consumption, for people with alcohol dependence:

- who have a high drinking risk level (defined as alcohol consumption of more than 60 g per day for men and more than 40 g per day for women, according to the World Health Organization's drinking risk levels) without physical withdrawal symptoms, **and**
- who do not require immediate detoxification.

The marketing authorisation states that nalmefene should:

- only be prescribed in conjunction with continuous psychosocial support focused on treatment adherence and reducing alcohol consumption, **and**
- be initiated only in patients who continue to have a high drinking risk level 2 weeks after initial assessment.

NICE has written information for the public on nalmefene.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Alcohol-use disorders: diagnosis and management quality standard

11. Psychological interventions and relapse prevention medication for adults

8 Staff competencies

All interventions for people who misuse alcohol should be delivered by appropriately trained and competent staff. Pharmacological interventions should be administered by specialist and competent staff[1]. Psychological interventions should be based on a relevant evidence-based treatment manual, which should guide the structure and duration of the intervention. Staff should consider using competence frameworks developed from the relevant treatment manuals

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and for all interventions should:

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

Quality standards

The following quality statements are relevant to this part of the interactive flowchart.

Alcohol-use disorders: diagnosis and management quality standard

4. Trained and competent specialist staff

11. Psychological interventions and relapse prevention medication for adults

13. Outcomes monitoring

9 Assisted alcohol withdrawal

See Alcohol-use disorders / Assisted alcohol withdrawal

10 See want NICE says on medicines optimisation

See Medicines optimisation

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

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ADI

adolescent diagnostic interview

Alcohol dependence

A cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use. Someone who is alcohol-dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations. For further information please refer to: 'Diagnostic and statistical manual of mental disorders' (DSM-IV) (American Psychiatric Association 2000) and 'International statistical classification of diseases and related health problems – 10th revision' (ICD-10) (World Health Organization 2007).

Alcohol treatment

a programme designed to reduce alcohol consumption or any related problems; it could involve a combination of counselling and medicinal solutions

Alcohol-related harm

Physical or mental harm caused either entirely or partly by alcohol. If it is entirely as a result of alcohol, it is known as 'alcohol-specific'. If it is only partly caused by alcohol it is described as 'alcohol-attributable'.

Alcohol-use disorders

Alcohol-use disorders cover a wide range of mental health problems as recognised within the international disease classification systems (ICD-10, DSM-IV). These include hazardous and harmful drinking and alcohol dependence.

CI

Confidence interval. There is always some uncertainty in research. This is because a small group of people is studied to predict the effects of an intervention on the wider population. The confidence interval is a way of expressing how certain we are about the findings from a study, using statistics. It gives a range of results that is likely to include the 'true' value for the population.

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The CI is usually stated as '95% CI', which means that the range of values has a 95 in a 100 chance of including the 'true' value. For example, a study may state that 'based on our sample findings, we are 95% certain that the 'true' population blood pressure is not higher than 150 and not lower than 110'. In such a case the 95% CI would be 110 to 150.

A wide confidence interval indicates a lack of certainty about the true effect of the test or treatment – often because a small group of patients has been studied. A narrow confidence interval indicates a more precise estimate (for example, if a large number of patients have been studied).

APQ

alcohol problems questionnaire

ASA

Advertising Standards Authority

AUDIT

AUDIT is an alcohol screening test designed to see if people are drinking harmful or hazardous amounts of alcohol. It can also be used to identify people who warrant further diagnostic tests for alcohol dependence.

OR

Odds ratio. Odds are a way to represent how likely it is that something will happen (the probability). An odds ratio compares the probability of something in one group with the probability of the same thing in another.

An odds ratio of 1 between two groups would show that the probability of the event (for example a person developing a disease, or an intervention working) is the same for both.

Sometimes probability can be compared across more than two groups – in this case, one of the groups is chosen as the 'reference category', and the odds ratio is calculated for each group compared with the reference category. For example, to compare the risk of dying from lung cancer for non-smokers, occasional smokers and regular smokers, non-smokers could be used as the reference category. Odds ratios would be worked out for occasional smokers compared with non-smokers and for regular smokers compared with non-smokers.

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BAC

blood alcohol concentration

Brief interventions

This can comprise either a short session of structured brief advice or a longer, more motivationally-based session (that is, an extended brief intervention). Both aim to help someone reduce their alcohol consumption (sometimes even to abstain) and can be carried out by non-alcohol specialists.

CIWA–Ar

The Clinical Institute Withdrawal Assessment – Alcohol, revised (CIWA–Ar) scale is a validated 10-item assessment tool that can be used to quantify the severity of the alcohol withdrawal syndrome, and to monitor and medicate patients throughout withdrawal.

RCT

Randomised controlled trial. A study in which a number of similar people are randomly assigned to two (or more) groups to test a specific drug or intervention. One group (the experimental group) receives the intervention being tested, the other (the comparison or control group) receives an alternative intervention, a dummy intervention (placebo) or no intervention at all. The groups are followed up to see how effective the experimental intervention was. Outcomes are measured at specific times and any difference in response between the groups is assessed statistically. This method is also used to reduce bias.

CAMHS

child and adolescent mental health service

DCSF

Department for Children, Schools and Families

Decompensated liver disease

liver disease complicated by jaundice, ascites, variceal bleeding or hepatic encephalopathy

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Diversion

when the drug is being taken by someone other than for whom it was prescribed

Extended brief intervention

This is motivationally-based and can take the form of motivational-enhancement therapy or motivational interviewing. The aim is to motivate people to change their behaviour by exploring with them why they behave the way they do and identifying positive reasons for making change.

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ES

Effect size. A measure that shows the magnitude of the outcome in one group compared with that in a control group.

For example, if the absolute risk reduction is shown to be 5% and it is the outcome of interest, the effect size is 5%.

The effect size is usually tested, using statistics, to find out how likely it is that the effect is a result of the treatment and has not just happened by chance (that is, to see if it is statistically significant).

Fixed-dose medication regimen

involves starting treatment with a standard dose, not defined by the level of alcohol withdrawal, and reducing the dose to zero over 7-10 days according to a standard protocol

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involve starting treatment with a standard dose, not defined by the level of alcohol withdrawal, and reducing the dose to zero over 7-10 days according to a standard protocol

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FRAMES

FRAMES is an acronym summarising the components of a brief intervention. Feedback (on the client's risk of having alcohol problems), responsibility (change is the client's responsibility), advice (provision of clear advice when requested), menu (what are the options for change?), empathy (an approach that is warm, reflective and understanding) and self-efficacy (optimism about the behaviour change).

GHB

gammahydroxybutyrate

i

NICE analysts have calculated this figure using data from the original study.

GGT

gamma glutamyl transferase

ICER

Incremental cost effectiveness ratio. A measure of the cost effectiveness of a treatment or health intervention. It estimates how much more the benefits of a certain treatment cost, compared with other treatments or health interventions.

GUM

genito-urinary medicine

NNT

Number needed to treat. The average number of people who need to receive an intervention to get a positive outcome. For example, if the NNT is four, then 4 people would have to receive the intervention to ensure one of them gets better. The closer the NNT is to one, the better the intervention. However, as with most data, caution is needed when considering whether results apply to populations beyond the sample described in the original study.

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GMC's

General Medical Council's

LDQ

Leeds dependence questionnaire

Looked-after children

The term 'looked after' has a specific legal meaning. It refers to children and young people who are provided with accommodation on a voluntary basis for more than 24 hours. This compares with the term 'in care' which refers to those who are compulsorily removed from home and placed in care under a court order.

MMSE

mini-mental state examination

PCTs

primary care trusts

PAT

Paddington alcohol test

QALY

Quality-adjusted life year. A measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One QALY is equal to 1 year of life in perfect health.

QALYS are calculated by estimating the years of life remaining for a person following a particular treatment or intervention and weighting each year with a quality of life score (on a zero to one scale). It is often measured in terms of the person's ability to perform the activities of daily life, freedom from pain and mental disturbance.

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Responsible authorities

Responsible authorities have to be notified of all licence variations and new applications and can make representations regarding them. The Licensing Act 2003 lists responsible authorities. They include the police, environmental health, child protection service, fire and rescue and trading standards.

SADQ

severity of alcohol dependence questionnaire

SD

Standard deviation. A measure used to summarise numerical data and describe how 'spread out' a set of measures (or 'values') are from the average. For example, the average height of a group of schoolchildren can be calculated using the total of all their heights added together and then divided by the number of schoolchildren in the group. Standard deviation measures the 'spread' of those heights. So, in the example it tells you whether all those in the group were about the same height or whether some were very tall and some were short.

Saturated

In relation to licensed premises, this describes a specific geographical area where there are already a lot of premises selling alcohol – and where the awarding of any new licences to sell alcohol may contribute to an increase in alcohol-related disorder.

Schools

For the purposes of this guidance, schools include: state-sector, special and independent primary and secondary schools; city technology colleges, academies and grammar schools; pupil referral units, secure training and local authority secure units; and further education colleges.

Screening

For the purposes of this guidance, screening involves identifying people who are not seeking treatment for alcohol problems but who may have an alcohol-use disorder. Practitioners may use any contact with clients to carry out this type of screening. The term is not used here to refer to national screening programmes such as those recommended by the UK National

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Screening Committee.

SSRIs

selective serotonin reuptake inhibitors

SPC

summary of product characteristics

Structured brief advice

a brief intervention that takes only a few minutes to deliver

T-ASI

teen addiction severity index

Treatment

a programme designed to reduce alcohol consumption or any related problems. It could involve a combination of counselling and medicinal solutions

Unit

In the UK, alcoholic drinks are measured in units. Each unit corresponds to approximately 8 g or 10 ml of ethanol. The same volume of similar types of alcohol (for example, 2 pints of lager) can comprise a different number of units depending on the drink's strength (that is, its percentage concentration of alcohol).

Sources

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (2011) NICE guideline CG115

Alcohol-use disorders: diagnosis and management of physical complications (2010, updated 2017) NICE guideline CG100

Nalmefene for reducing alcohol consumption in people with alcohol dependence (2014) NICE technology appraisal guidance 325

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Your responsibility

Guidelines

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to

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have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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