Alcohol Interventions: NICE guidelines and beyond

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What this presentation covers

• Background
• Scope
• Methodology
• What is new?
• Implications for practice
• Implementation
• International collaboration
UK Health Performance
Murray et al., 2013, Lancet
% change DALYs 1990-2010

- All causes
- Neoplasm
- Liver cancer
- Oral cancer
- Alcoholic liver disease
- Pancreatitis
- Alcohol use disorders

% change
Background

- Current practice and service provision across the country is varied and often poorly coordinated
- Lack of guidance on best practice
- Negative attitudes, lack of training and competence
- Only 6% per year of adults who are alcohol dependent receive treatment per annum (range 1%-8% across regions) compared to ~50% in class A drug misuse
- Low identification in primary care (1 in 60 harmful; 1 in 20 dependent drinkers) and mental health care
- Comorbid mental and physical disorders are common
NICE Guidance 2010-11

• Alcohol use disorders
  – Preventing harmful drinking (PH24)
  – Diagnosis and clinical management of alcohol related physical complications (CG100)
  – Diagnosis, assessment and management of harmful drinking and alcohol dependence (CG115)

• Related guidance
  – Psychiatric comorbidity (CG)
  – Complex pregnancies (CG)
Preventing harmful drinking (PH24)

• All NHS professionals and non-NHS
• Routine alcohol screening
  – Universal
  – Targeted “if not feasible”
• Validated screening tool (AUDIT, FAST etc)
• Don’t use biological markers
• Structured brief advice- all hazardous/harmful
• Extended brief- non-responders
• Referral of moderate/severe alcohol dependence/non-responders to brief interventions
Clinical management CG100

• Unplanned withdrawal:
  – Admit high risk, vulnerable and under 16s
  – Symptom triggered regime more cost effective
  – Benzodiazepine or carbamazepine
  – CIWA monitoring

• Wernicke’s encephalopathy
  – Oral thiamine for most
  – Parenteral for malnourished, liver disease and in AED or admitted for acute illness or injury
ALCOHOL USE DISORDERS

THE NICE GUIDELINE ON DIAGNOSIS, ASSESSMENT, AND MANAGEMENT OF HARMFUL DRINKING AND ALCOHOL DEPENDENCE

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH
Scope

◆ Diagnosis, assessment and management of harmful drinking and alcohol dependence in young people and adults
◆ NHS funded services; full pathway
◆ Does not cover:
  • children younger than 10 years
  • pregnant women
  • severe comorbidity
  • Mutual aid organisations
◆ Overlap with other NICE guidelines!
  • Prevention (PH24)
  • Physical complications (CG100)
Definitions

• (Hazardous drinking – consumption of alcohol likely to cause harm)

• Harmful drinking – consumption already causing mental or physical health problems

• Alcohol dependence – ICD10 definition
  – Mild dependence = Severity of Alcohol Dependence Questionnaire (SADQ) score 15 or less
  – Moderate dependence = SADQ score of 15–30
  – Severe dependence = SADQ score of 31 or more.
Methodology

• Most comprehensive systematic review of the evidence base on alcohol treatment to date
• Core expert group supported by technical group
• Stricter inclusion/exclusion criteria for studies
• Meta-analyses based on new classification of studies
• Implications for different settings considered
• Consideration of different levels of severity/complexity
• Organisation and delivery of care
• Sequencing and combination of interventions
• Integrated care pathways
Systematic reviews

- Organisation of care – 4
- Rehabilitation – 5
- Psychological interventions – 12
- Pharmacological interventions – 13
- Economic studies – 4
- Total number of SR – 38
What we are saying that is “new”

– Importance of identification and assessment in both specialist and non-specialist settings including use of validated assessment tools
– Different treatment needed for different severity/complexity
– Importance of care coordination/case management, motivational interviewing, referral to mutual aid
– Need for combination treatments organised in a care pathway
– Wider indications for inpatient assisted withdrawal and structured day programmes
– Limited indications for residential rehabilitation
– Greater emphasis on individual needs
Screen (FAST, SASQ, AUDIT-C) indicates possible alcohol use disorder

Administer: AUDIT

- **AUDIT < 8**
  - Hazardous drinking
  - Brief intervention

- **AUDIT 8–15**
  - Harmful drinking
  - Extended brief intervention(s)
  - Review of progress
  - Referral to specialist assessment where no improve maintained
  - Consider Tier 2 interventions

- **AUDIT 16–19**
  - Probable alcohol dependence
  - Referral to specialist assessment

- **AUDIT 20+**
  - Harmful drinking
  - Extended brief intervention(s)
  - Review of progress
  - Referral to specialist assessment
  - Tier 2 or 3 interventions/
  - withdrawal assessment for acute inpatients settings and prisons

Tier 2 or 3 interventions/
withdrawal assessment for acute inpatients settings and prisons
Delivery systems and settings

- Competence, manuals, supervision
- Care coordination
- Intensive case management – alcohol dependence
- Stepped care and Assertive Community Treatment
- Inpatient withdrawal management
- Structured intensive community programme
  - Moderate severe dependence, social support, complex needs
- Residential rehabilitation
  - Moderate severe dependence AND homeless
  - 3 months
AUDIT

AUDIT > 20
Consider need for alcohol withdrawal

AUDIT < 20

- Assess the presence of one or more of the following:
  - Dependence severity: SADQ/units per typical drinking day
  - Comorbid problems

Outcome of assessment

- SADQ < 15
  - Typical drinks per day < 15
  - Consider Tier 2 or 3 interventions:
    - Psychological and pharmacological interventions
    - Comprehensive assessment where comorbid features present

- SADQ 15–30
  - Typical drinks per day < 30 units
  - Absence of comorbid features
  - Outpatient (Tier 3 interventions):
    - Assisted alcohol withdrawal

- SADQ ≥ 30
  - Typical drinks per day ≥ 30 units
  - Comorbid features present
  - Inpatient (Tier 4 interventions):
    - Assisted alcohol withdrawal
Interventions

• Harmful/mild dependence
  – CBT, BT, Social Network therapy
  – BCT
  – Non-responders: offer acamprosate or naltrexone plus psychosocial

• Moderate/severe dependence
  – Assisted withdrawal followed by:
  – Intensive rehabilitation programme
    • Structured community programme
    • Residential rehabilitation: homeless
  – Acamprosate or naltrexone plus
  – CBT, BT, SNT, BCT
  – Disulfiram (second line, preference or not suitable for first line)
Association between baseline severity and effect size in naltrexone versus placebo trials (logRR)
POMH-UK Quality improvement programme

PRESCRIBING IN SUBSTANCE MISUSE: ALCOHOL DETOXIFICATION

Baseline audit
March 2014

Royal College of Psychiatrists
Prescribing Observatory for Mental Health
CLINICAL PRACTICE STANDARDS FOR AUDIT

1. The decision to undertake acute alcohol detoxification of an inpatient should be informed by:
   - A documented assessment of drinking history and current daily alcohol intake
   - A physical examination, carried out on admission

2. Blood tests relevant to the identification of alcohol-related physical health problems (e.g. liver function tests including GGT, albumin, full blood count, glucose and renal function tests) should be carried out during the admission

3. Pharmacotherapy to treat the symptoms of acute alcohol withdrawal should be limited to a benzodiazepine, carbamazepine or clomethiazole

4. Phenytoin should not be prescribed to prevent or treat alcohol withdrawal seizures

5. Thiamine should be prescribed parenterally for inpatients in acute alcohol withdrawal

Derived from NICE CG100, NICE CG115, and BAP evidence-based guidelines for the pharmacological management of substance abuse, 2012
METHOD

Participants
- 43 Mental Health Trusts participated 84%
- 174 clinical teams
- 1,197 adult patients
  - Modest sample size may reflect the difficulties in clinical coding of alcohol detoxification when not the primary reason for admission to a mental health unit

Audit data collected
- Demographic, diagnosis, type of service
- Documentation of alcohol misuse, physical and neurological assessments
- Medication prescribed to treat alcohol withdrawal, dosage and details of regimen
- Specialist advice sought during alcohol detoxification and for continuing management
AUDIT STANDARD 2 Blood tests relevant to the identification of alcohol-related physical health problems (e.g. liver function tests including GGT, albumin, full blood count, glucose and renal function tests) should be carried out during the admission.

*May not be clinically indicated in all patients*
INITIAL ASSESSMENT: DOCUMENTED ASSESSMENT OF SIGNS/SYMPTOMS OF WERNICKE’S ENCEPHALOPATHY

<table>
<thead>
<tr>
<th>Signs and symptoms assessed</th>
<th>1 documented assessment</th>
<th>2 documented assessments</th>
<th>3 documented assessments</th>
<th>0 documented assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation/confusion</td>
<td>✓</td>
<td>✓ ✓</td>
<td>✓ ✓</td>
<td>✓ ✓</td>
</tr>
<tr>
<td>Ataxia</td>
<td>✓</td>
<td>✓ ✓</td>
<td>✓ ✓</td>
<td>✓ ✓</td>
</tr>
<tr>
<td>Ophthalmoplegia and/or nystagmus</td>
<td>✓</td>
<td>✓ ✓</td>
<td>✓ ✓</td>
<td>✓ ✓</td>
</tr>
</tbody>
</table>

Total number of cases n (% of TNS)  
- Orientation/confusion: 128 (11%)  
- Ataxia: 12 (1%)  
- Ophthalmoplegia and/or nystagmus: 13 (1%)  
- Total: 295 (37%)  

The graph shows the proportion of patients with no signs/symptoms, some signs/symptoms, or all signs/symptoms assessed for each trust code.
Audit standard 5  Thiamine should be prescribed parenterally for inpatients in acute alcohol withdrawal

Derived from NICE CG 100, 1.2.1.3, NICE CG 115 1.3.8.5, NICE Quality Standard for Alcohol Dependence and Harmful Alcohol Use, QS 11 statement 10 and BAP evidence-based guidelines for the pharmacological management of substance abuse, 2012

<table>
<thead>
<tr>
<th>Prescription of thiamine</th>
<th>Admitted under non-specialist care N= 848 (71%)</th>
<th>Admitted under specialist care N=349 (29%)</th>
<th>Total sample N = 1,197</th>
<th>Daily intake of alcohol in units median, range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenteral</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IM, followed by oral</td>
<td>325 (38%)</td>
<td>223 (64%)</td>
<td>548 (46%)</td>
<td>28, 4-112</td>
</tr>
<tr>
<td>IM only</td>
<td>78 (9%)</td>
<td>7 (2%)</td>
<td>85 (7%)</td>
<td>28, 6-80</td>
</tr>
<tr>
<td>IV, followed by oral</td>
<td>10 (1%)</td>
<td>41 (12%)</td>
<td>51 (4%)</td>
<td>30, 7-70</td>
</tr>
<tr>
<td>IV only</td>
<td>4 (0%)</td>
<td>0 (0%)</td>
<td>4 (&lt;1%)</td>
<td>45, 8-82</td>
</tr>
<tr>
<td>Oral</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orally only</td>
<td>359 (42%)</td>
<td>64 (18%)</td>
<td>423 (35%)</td>
<td>28, 4-100</td>
</tr>
<tr>
<td>Not prescribed</td>
<td>72 (8%)</td>
<td>14 (4%)</td>
<td>86 (7%)</td>
<td>18, 1-60</td>
</tr>
</tbody>
</table>
DISCHARGE

Specialist continuing care

- Most commonly arranged for patients whose admission for detoxification had been planned
- Referral to specialist alcohol services for continuing management in only a half of cases with unplanned admissions

Relapse prevention medication

- At discharge, a quarter of the total sample was prescribed medication recommended by NICE for relapse prevention
- More likely to be prescribed under specialist care
Conclusions

- Most comprehensive systematic review of the alcohol treatment literature to date
- Significant changes needed in organisation and delivery of care
- Some recommendations will be easier to implement than others
- Significant training implications for whole NHS workforce
- Some recommendations require additional investment
- Impact will be crucially dependent on funding and commissioning (which has changed radically), and uptake by practitioners
- Do we need more collaboration on clinical guidelines across Europe?
A case for European collaboration on clinical guidelines

• Why?
• Many country specific guidelines published or in development
• All reviewing the same international evidence base
• Large costs and complex logistics
• Similarities and differences between treatment systems in Europe? AMPHORA
• Variations in resources and quality
Challenges in harmonization

• Costs and logistics
• Agreement on core findings and principles may be difficult to achieve
• Results may not be specific
• Legitimacy and relevance of guidance at country level
• Constantly evolving evidence base
• Language
• Other bodies: e.g. EMCDDA
What could be done?

• What EUFAS is already doing
  – Collaborative network of European addiction societies
  – Working group on clinical guidelines
  – 3 symposia (ESBRA, Albatros, ISAM)
  – Peer review of French guidelines
  – International committee membership

• What could we do?
  – Review of European guidelines → publication
  – Guideline task force
  – Translation
  – Guidelines on principles of developing guidelines
  – International peer review process
  – More?
Find out more

- Visit www.nice.org.uk/guidance/CG115 for:
  - the full guideline
  - the quick reference guide
  - ‘Understanding NICE guidance’
  - costing report and template
  - audit support
  - baseline assessment tool
  - sample chlordiazepoxide dosing regimen