The National Institute for Clinical Excellence (NICE) Guidelines for Treatment of Alcohol Use Disorder

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NICE: Background

- NICE set up in 1999 to reduce variation in availability and quality of NHS treatments.
- Does this by:
  - Evidence based guidance for health care workers.
  - Quality standards for those providing and commissioning health care services
  - Provides information for practitioners
- Clinical guidelines provide advice on individual patient management:
  - Systematically – developed statements to assist professional decisions.
AUD Guidelines: Background

- Developed by panel of experts, lay members, service users and guideline experts
- Based upon best-available research
- Attempts to evaluate the research to translate it into recommendations
- Where evidence is lacking, develop consensus statements and recommendations.
Translation into Clinical Practice

- Guidelines only released in 2011.
- Thus no research on whether it has been adopted.
- Only one study examining NICE compliance, regarding alcohol screening, suggesting practice is in line with guidelines.
Intervention Principles

- Assessment: Motivational Interview
  - Help people recognise their problems
  - Help resolve ambivalence, encourage positive change
  - Takes a persuasive and not a confrontational position.
- Offer community based intervention if MI is not successful.
- If homeless, residential setting for 3 months
- All staff should be appropriately trained, supervised and monitored.
- All clinical outcomes should be measured.
- All subjects should be encouraged to self-help groups and community support.
Abstinence versus Harm Reduction

- For patients with alcohol dependence: abstinence is preferred outcome
- For those with alcohol dependence who don’t want to abstain, harm reduction is appropriate goal, with advice about preference of abstinence.
- For mild dependence/harmful drinking, harm reduction can be an appropriate goal, if that is what the patient wants.
- Abstinence can also be the target in this population.
Interventions after Withdrawal: Pharmacotherapy

- Consider oral naltrexone or acamprosate in combination with individual psychological therapy
- Or combined with couples therapy.
- Consider disulfiram as alternative, if patient prefers.
- Conduct baseline medical assessment inc liver function tests.
- If using acamprosate:
  - 6 weeks only if keeps drinking.
- If using naltrexone:
  - 6 weeks only if keeps drinking.
Acamprosate

- Based upon analysis of 19 published clinical trials
- Evidence considered strong
- Usual dose 666mg x3/day for up to 6 months or longer if patient is benefitting
- Routine blood tests not required but may help monitor liver function recovery
- Little evidence of benefit for harmful / mild dependence
Oral naltrexone

- Based upon 27 published clinical trials.
- Recommended for relapse prevention in moderate to severe dependence, with psychological intervention.
- Begin prescribing at 25mg/day and aim for 50mg/day.
- Prescribe for up to 6 months or longer if benefitting.
- Routine blood tests not required but consider these for older/obese patients - may help monitor liver function recovery.
- Also recommended at 50mg/day dose for less severe / non-dependence.
- Injectable naltrexone: Evidence is limited and inconclusive, not recommended in routine clinical practice.
Combination naltrexone/acamprosate

- Based upon 4 published clinical trials
- Evidence considered moderate
- Some evidence for the combination of naltrexone and acamprosate together in some outcome variables only
- For higher dependency alcoholics only
Disulfiram

- Evidence was considered moderate, not high.
- Prescribed at dose of 200mg per day, can be increased
- Thorough medical assessment
- Patient should be under supervision for 6 months
- Family member or carer should help administration
- Full warning regarding:
  - Interaction with alcohol
  - Rare onset of hepatotoxicity
Anti-depressants

- Little to no effect on depression symptoms for those who are non-abstinent
- Effect on alcohol use limited: abstinence not sustained
- Severe depression improved by antidepressants, but alcohol-focussed treatment still needed.
- Little evidence that one antidepressant is better than another
Interventions after Withdrawal: Psychotherapy

- Strongest evidence for behavioural couples therapy

- Advantage over treatment as usual, active controls and other active interventions

- Recommended as an effective stand-alone intervention for harmful / mild dependence where a partner is willing to engage

- 1x60min session per week for 12 weeks
Recommended therapies

- Limited but strong evidence of superiority over treatment as usual / controls for
  - Individual CBT and behavioural therapy (1 x 60min session per week for 12 weeks)
  - Social network / environment-based therapy (8 x 50min sessions over 12 weeks)
Other therapies

- No evidence of superiority over other interventions / treatment as usual / control for...
  - Twelve step facilitation
  - Motivational techniques

- BUT
  - These techniques are useful as a component of psychosocial interventions
  - Community support (e.g. AA) is a key element of care coordination
Other therapies

- Inconclusive evidence for...
  - Contingency management
- Limited, low-quality evidence for...
  - Counselling
  - Short-term psychodynamic therapy
  - Multi-modal treatment
  - Self-help-based treatment
  - Psychoeducational interventions
  - Mindfulness meditation
Dual diagnosis

- Co-morbid Depression / anxiety
- Antidepressants have not been shown to reduce alcohol misuse alone
- Limited use of benzodiazepines may be continued to manage anxiety
- Anxiety symptoms may persist 6-8 weeks into abstinence

Recommendation:
- Address alcohol misuse first,
- Assess for ongoing mood symptoms 3-4 weeks into abstinence
- Treat symptoms if they have not abated
Alcohol and depression

- Some evidence that sertraline and naltrexone is better than either alone
- Mixed evidence regarding CBT
- Outcomes improve when one week's abstinence is allowed before diagnosis
- Treat alcohol misuse first, assess for depressive symptoms after 3-4 weeks, and then treat.
Société Française d’Alcoologie (1999)

- Highlighted the need for diversified and coherent organisation
  - Access, competency in personnel, increased manpower, social support, outpatient clinics, evaluation of provisions for care
  - Recommend regrouping of services into specialised alcohol networks.

- General guidelines
  - Patient should be informed of possibilities of follow-up and care
  - Need to facilitate setting up a network of supports and interventions in line with the patient's wishes
  - Need to use validated tools to set up social support
  - Need to monitor efficacy and tolerance of medications, and keep abreast of new therapies
Société Française d’Alcoologie (1999)

- Psychosocial interventions
  - Like NICE, strongest recommendations for CBT and couples therapy
  - Highlighted value of family therapies and mutual aid groups
- Pharmacological intervention
  - Disulfiram – call for further research at the time, potential for harm
  - Cautioned use of benzodiazepines – limit their use during detox, no evidence for effectiveness in reducing drinking
  - No comment at the time on acamprosate or naltrexone
NICE guidelines revisions

- A formal review of the need to update a guideline is usually undertaken by NICE 3 years after its publication.
- At this time it may be updated partially or in its entirety, or no update may be deemed necessary.
- New evidence may be incorporated before the 3-year point where there is a concern about patient safety or significant alteration in practice.
Advantages of NICE Guidelines

- Clear and precise
- Based upon clinical evidence, thorough and exhaustive
- Only use expert recommendation if evidence lacking
- Used in addition to other NICE guidelines in psychiatry and general medicine.
- Published in English, widely accessible, makes the guidelines more easily translatable to other countries.
- Updated regularly.