Alcohol Interventions: NICE guidelines and beyond

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What this presentation covers

• Epidemiology
• Background
• Scope
• Methodology
• What is new?
• Implications for practice
• What’s next?
• Conclusions
Epidemiology

• 3rd leading cause of disability in Europe; 20,000 UK deaths
• 24% of adults hazardous/harmful drinkers; 4% alcohol dependence
• SIPS: 30% in PHC; 40% in ED; 65% in CJS; 50% in MH
• Consumption doubled in adolescents in past 10 yrs
• Alcohol related hospital admissions doubled in last 8 years
• Increasing prevalence of AD: 2000 1.1 M, 2008 1.6M
• UK societal cost £25 billions
• Alcohol dependence years of potential life lost: 25 years
UK Health Performance
Murray et al., 2013, Lancet
% change DALYs 1990-2010
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
Gap between need and access (PSUR) by region

- North East
- Yorks and Humber
- Eastern
- South East
- East Midlands
- West Midlands
- South West
- London
- North West
- ENGLAND
Review of the effectiveness of treatment for alcohol problems

Duncan Raistrick, Nick Heather and Christine Godfrey
Figure 1  A spectrum of responses to alcohol problems

Source: Rastrick et al. (2006),\(^1\) adapted from Institute of Medicine (1990).\(^2\)
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 (CG)

• 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
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
Management of harmful drinking and alcohol dependence

- Identification and assessment
- Care coordination
- Settings
- Assisted withdrawal
- Psychosocial interventions
- Pharmacological interventions
- Comorbidity
- Children and young people
Identification and assessment

- Competence
- Motivational interviewing
- Alcohol misuse, dependence, problems, risk, need for assisted withdrawal
- Formal assessment tools (AUDIT, SADQ, LDQ, APQ, CIWA, MMSE)
- Treatment goals
- Children and young people
Screen (FAST, SASQ, AUDIT-C) indicates possible alcohol use disorder

**Administer: AUDIT**

- **AUDIT < 8**
  - Harmful 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+**
  - Probable alcohol dependence
  - Tier 2 or 3 interventions/withdrawal assessment for acute inpatients settings and prisons
Interventions: delivery and setting

- 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
Assisted withdrawal

• Threshold for assessment: >20 AUDIT >15 units/day
• Community based withdrawal programme - most
• Inpatient assisted withdrawal
  – >30 SADQ, fits or DTs
  – OR 15-30 plus benzodiazepine, mental or physical comorbidity, learning disability, cognitive impairment
  – Lower threshold for homeless, older, younger, pregnancy, homeless
• Regimes
  – Community: fixed dose
  – Inpatient: fixed dose or symptom triggered
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)
Psychological therapies

- Need for greater training, competency, supervision
- Use of evidence based therapy manuals
- Motivational interventions as routine approach from point of first contact
- Some therapies have greater evidence of effectiveness: CBT, BT, SNT, BCT
- Should be time limited and provided against a background of care coordination/case management
- Delivery in structured day care for more severe/complex
- Limited indications for residential rehabilitation
Pharmacological therapies

- Naltrexone and acamprosate strongest evidence
- Better in dependent than harmful drinkers
- Disulfiram evidence base weaker, potential risks: therefore second line treatment
- Use with adjunctive psychosocial therapies and medical monitoring
- Duration 6-12 months
- Don’t use GHB, antidepressants, benzodiazepines
- Some other promising medications, but currently lack sufficient evidence to recommend
Association between baseline severity and effect size in naltrexone versus placebo trials (logRR)
What next?

- NICE Quality Standards in alcohol treatment, 2011
- NICE commissioning guidelines, 2011
- DH Payment by Results, 2011-2012
- New DH alcohol strategy, 2012
- NICE QOF and COF standards, 2013
- CG115 guideline revision, 2013
- RCPsych national detox audit, 2014
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 will require additional investment
• Impact will be crucially dependent on funding and commissioning (which is currently in transition), and uptake by practitioners
Find out more

• Visit [www.nice.org.uk/guidance/CG115](http://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