NHS
National Institute for Health and Clinical Excellence

Quick reference guide

Issue date: February 2011

Alcohol-use disorders

Diagnosis, assessment and management of harmful drinking and alcohol dependence

NICE clinical guideline 115
Developed by the National Collaborating Centre for Mental Health

About this booklet

This is a quick reference guide that summarises the recommendations NICE has made to the NHS in 'Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence' (NICE clinical guideline 115).

Who should read this booklet?

This quick reference guide is for GPs; social workers; staff in specialist alcohol services (including NHS and those funded by the NHS), acute hospitals and accident and emergency departments; staff in prison health services; and other staff who care for people who misuse alcohol.

Who wrote the guideline?

The guideline was developed by the National Collaborating Centre for Mental Health, which is based at the Royal College of Psychiatrists and the British Psychological Society. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), people who misuse alcohol and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

For more information on how NICE clinical guidelines are developed, go to **www.nice.org.uk**

Where can I get more information about the guideline?

The NICE website has the recommendations in full, reviews of the evidence they are based on, a summary of the guideline for service users and carers, and tools to support implementation (see back cover for more details).

National Institute for Health and Clinical Excellence
MidCity Place
71 High Holborn
London
WC1V 6NA

www.nice.org.uk

ISBN 978-1-84936-491-1

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance 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, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Contents

Introduction	4
Key to terms	4
Key priorities for implementation	5
Working with people who misuse alcohol	7
Identification and assessment	8
Interventions for alcohol misuse	12
Working with families and carers	23
Further information	24

This is one of three pieces of NICE guidance addressing alcohol-related problems and should be read along with:

- 'Alcohol-use disorders: preventing the development of hazardous and harmful drinking' NICE public health guidance 24 (2010). Available from **www.nice.org.uk/guidance/PH24**. Public health guidance on the price, advertising and availability of alcohol, how best to detect alcohol misuse in and outside primary care, and brief interventions to manage it in these settings.
- 'Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications' NICE clinical guideline 100 (2010). Available from **www.nice.org.uk/guidance/CG100**. A clinical guideline covering acute unplanned alcohol withdrawal including delirium tremens, alcohol-related liver damage, alcohol-related pancreatitis and management of Wernicke's encephalopathy.

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. Follow advice on seeking consent from the Department of Health or Welsh Assembly Government if needed. If the person 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' (available from **www.dh.gov.uk**).

Introduction

Harmful drinking and alcohol dependence cause many mental and physical health problems, and social problems. In England, 4% of people aged between 16 and 65 are dependent on alcohol (6% of men and 2% of women). More than 24% of the English population (33% of men and 16% of women) consume alcohol in a way that is potentially or actually harmful to their health or wellbeing. Alcohol misuse is also an increasing problem in children and young people. Current practice across the country is varied, which leads to variation in access to a range of assisted withdrawal and treatment services.

This guideline makes recommendations on the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and in young people aged 10–17 years.

At the time of publication, no drug recommended in this guideline has a UK marketing authorisation for use in children and young people under the age of 18. However, in 2000, the Royal College of Paediatrics and Child Health issued a policy statement on the use of unlicensed medicines, or the use of licensed medicines for unlicensed applications, in children and young people. This states that such use is necessary in paediatric practice and that doctors are legally allowed to prescribe unlicensed medicines where there are no suitable alternatives and where the use is justified by a responsible body of professional opinion.

Key to terms

Alcohol dependence: characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences.

Alcohol misuse: used in this guideline to refer to harmful drinking and alcohol dependence.

Mild alcohol dependence: a score of 15 or less on the Severity of Alcohol Dependence Questionnaire (SADQ).

Moderate alcohol dependence: a score of 15–30 on the SADQ.

Severe alcohol dependence: a score of 31 or more on the SADQ.

Harmful drinking: a pattern of alcohol consumption causing health problems directly related to alcohol (including psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis).

Hazardous drinking: a pattern of alcohol consumption that increases someone's risk of harm. This is covered in NICE public health guidance 24.

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 (see page 8), 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, SADQ or Leeds Dependence Questionnaire [LDQ])
    - alcohol-related problems (using, for example, 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, they are living alone or have very little contact with family or friends) **or**
  - complex physical or psychiatric comorbidities **or**
  - not responded to initial community-based interventions (see page 12).
- 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 and for all interventions should:
  - receive regular supervision from individuals competent in both the intervention and supervision

continued

[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.

Key priorities for implementation *continued*

- 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 (see page 15) 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[2] in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol misuse (see page 13).

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
  - 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.

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 depression or anxiety continues after 3 to 4 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[3].

---

[2] At the time of publication (February 2011), oral naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

[3] See 'Depression in adults' NICE clinical guideline 90 (2009), available from **www.nice.org.uk/guidance/CG90** and 'Anxiety', NICE clinical guideline 113 (2011), available from **www.nice.org.uk/guidance/CG113**

Working with people who misuse alcohol

- Build a trusting relationship and work in a supportive, empathic and non-judgmental manner.
- Take into account that stigma and discrimination are often associated with alcohol misuse and that those presenting to services may minimise their alcohol problem.
- Hold discussions in settings in which confidentiality, privacy and dignity are respected.
- Provide information appropriate to the person's level of understanding about the nature and treatment of alcohol misuse to support choice from a range of evidence-based treatments.
- Make sure that comprehensive written information is available in an appropriate language or in an accessible format.
- Avoid clinical language without explanation.
- Provide independent interpreters if needed.

Identification and assessment

General principles

- 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 assess need.

- Staff responsible for assessing and managing assisted alcohol withdrawal should be competent in diagnosing and assessing alcohol dependence and withdrawal symptoms.
- Make sure all assessments include risk assessment (including risk to self and to others). This should inform the care plan.

Assessment tools

- Use formal assessment tools to assess the nature and severity of alcohol misuse, including the:
  - AUDIT for identification and as a routine outcome measure
  - SADQ or LDQ for severity of dependence
  - Clinical Institute Withdrawal Assessment of Alcohol Scale, revised (CIWA-Ar) for severity of withdrawal
  - APQ for the nature and extent of the problems arising from alcohol misuse.
- When assessing the severity of alcohol dependence and determining the need for assisted withdrawal, adjust the criteria for women, older people, children and young people, and people with established liver disease who may have problems with the metabolism of alcohol.

Initial assessments

- When conducting an initial assessment, as well as assessing alcohol misuse, the severity of dependence and risk, consider the:
  - extent of any associated health and social problems
  - need for assisted alcohol withdrawal.
- Carry out a motivational intervention as part of the initial assessment. Use 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
  - being persuasive and supportive rather than argumentative and confrontational.

Assessment and referral of children and young people aged 10–17 years

- If alcohol misuse is identified as a potential problem, with potential physical, psychological, educational, or social consequences, assess:
  - the duration and severity of the alcohol misuse (the standard adult threshold on the AUDIT for referral and intervention should be lower for young people aged 10–16)
  - any associated health and social problems
  - the potential need for assisted withdrawal.
- Refer all children and young people aged 10–15 years to a specialist child and adolescent mental health service (CAMHS) for a comprehensive assessment of their needs (see page 11), if their alcohol misuse is associated with physical, psychological, educational and social problems and/or comorbid drug misuse.
- When considering referral to CAMHS for young people aged 16–17 who misuse alcohol, use the same referral criteria as for adults (see 'Assessment in specialist alcohol services' below).

Assessment in specialist alcohol services

Brief triage assessment – all adults

- Conduct a brief triage assessment to assess:
  - the pattern and severity of the alcohol misuse (using AUDIT) and severity of dependence (using SADQ)
  - the need for urgent treatment including assisted withdrawal
  - any associated risks to self or others
  - comorbidities or other factors that may need further specialist assessment or intervention.
- Agree the initial treatment plan, taking into account the service user's preferences and outcomes of any previous treatment.

Treatment goals

- Agree the goal of treatment with the service user at the initial assessment:
  - Abstinence is the appropriate goal for most people with alcohol dependence, and people who misuse alcohol and have significant psychiatric or physical comorbidity.
  - If a service user prefers a goal of moderation but there are considerable risks, advise strongly that abstinence is most appropriate but do not refuse treatment if they do not agree to abstinence.
  - For harmful drinking and mild dependence without significant comorbidities, if there is adequate social support, consider moderate drinking unless the person prefers abstinence or there are other reasons for advising abstinence.
  - If a person has severe alcohol dependence, or misuses alcohol and has a significant psychiatric or physical comorbidity, but is unwilling to consider a goal of abstinence or engage in structured treatment, consider harm reduction. However, ultimately the service user should be encouraged to aim for a goal of abstinence.
- When developing treatment goals, consider that some people who misuse alcohol may be required to abstain from alcohol as part of a court order or sentence.

Children and young people aged 10–17 years who misuse alcohol

- The goal of treatment should usually be abstinence in the first instance.

Comprehensive assessment for adults

- Consider a comprehensive assessment structured as a clinical interview for adults scoring more than 15 on the AUDIT. This should assess multiple areas of need and use relevant and validated clinical tools (see page 8). It should cover the following:
  - alcohol use, including consumption (historical and recent patterns of drinking, and if possible, additional information, for example, from a family member or carer), dependence (using, for example, SADQ or LDQ) and alcohol-related problems (using, for example, APQ)
  - other drug misuse, including over-the-counter medication
  - physical health problems
  - psychological and social problems
  - cognitive function (for example, MMSE)
  - readiness and belief in ability to change.

- Assess comorbid mental health problems as part of any comprehensive assessment, and throughout care for the alcohol misuse. Use this to inform the care plan (see section on comorbid conditions on page 22).
- If comorbid mental health problems do not significantly improve after abstinence from alcohol (typically after 3–4 weeks), consider providing or referring for specific treatment (see the relevant NICE guideline).
- Consider brief measures of cognitive functioning (for example, MMSE) to help with treatment planning. Formal measures of cognitive functioning should usually only be performed if impairment persists after a period of abstinence or a significant reduction in alcohol intake.
- Consider measuring breath alcohol as part of the management of assisted withdrawal. However, breath alcohol should not usually be measured for routine assessment and monitoring in alcohol treatment programmes.
- Consider blood tests to help identify physical health needs, but do not use them routinely for identifying and diagnosing alcohol use disorders.

Comprehensive assessment for children and young people aged 10–17 years

- Assess multiple areas of need, with a clinical interview using a validated clinical tool (such as the Adolescent Diagnostic Interview [ADI] or the Teen Addiction Severity Index [T-ASI]).
  Support the assessment with additional information from a parent or carer if possible.
  Cover the following:
  - consumption, dependence features and patterns of drinking
  - comorbid substance misuse (consumption and dependence features) and associated problems
  - mental and physical health problems
  - peer relationships and social and family functioning
  - developmental and cognitive needs, and educational attainment and attendance
  - history of abuse and trauma
  - risk to self and others
  - readiness to change and belief in the ability to change
  - obtaining consent to treatment
  - formulation of a care plan and risk management plan.

Interventions for alcohol misuse

General principles

- All interventions for people who misuse alcohol should be:
  - delivered by appropriately trained and competent staff
  - the subject of routine outcome monitoring. This should be used to inform decisions about continuing psychological and pharmacological treatments.
- Pharmacological interventions should be administered by specialist and competent staff[4].

- 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 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.
- For all people who misuse alcohol, offer interventions to promote abstinence or moderate drinking as appropriate (see 'Treatment goals' on page 9) and prevent relapse, in community-based settings.

- 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 having little contact with family or friends) **or**
  - complex physical or psychiatric comorbidities **or**
  - not responded to initial community-based interventions.

- 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.
- For people with alcohol dependence who are homeless, consider offering residential rehabilitation for a maximum of 3 months. Help the service user find stable accommodation before discharge.
- Consider stopping the treatment and review the care plan if there are signs of deterioration or no indications of improvement.

[4] 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.

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 responsible for the overall coordination of care.
- Case management should include:
  - a comprehensive assessment of needs
  - developing an individualised care plan with the service user and relevant others
  - coordinating the care plan to deliver a seamless multiagency and integrated care pathway and maximisation of engagement, including using motivational interviewing
  - monitoring the impact of interventions and revising the care plan when necessary.

Interventions for harmful drinking and 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 (see table on page 14).

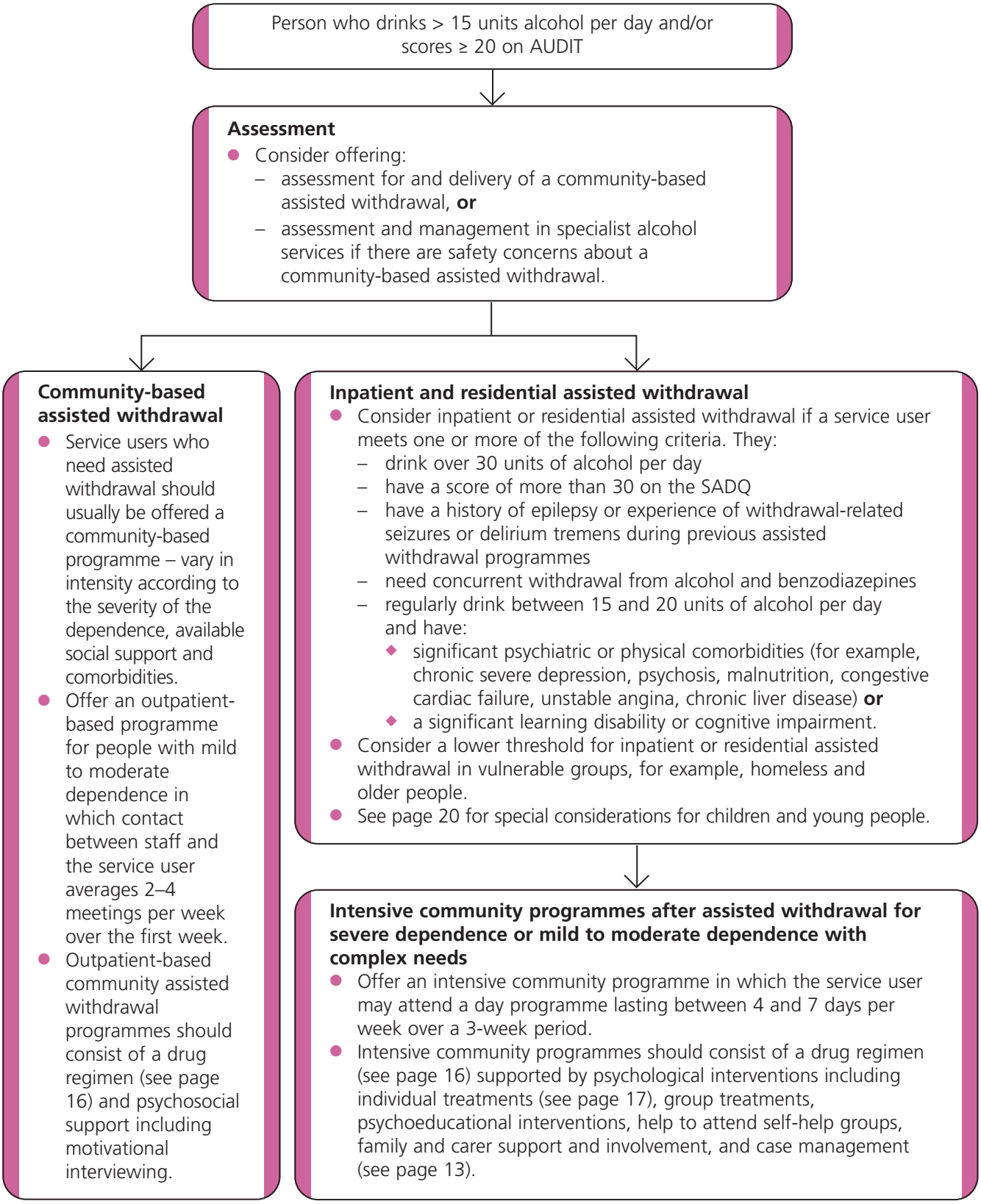
- Offer behavioural couples therapy to service users who have a regular partner who is willing to participate in treatment.
- If service users have not responded to psychological interventions alone, or specifically request a pharmacological intervention, consider offering acamprosate[5] or oral naltrexone[6] in combination with an individual psychological intervention (such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) or behavioural couples therapy. (See page 18 for pharmacological interventions and page 14 for psychological interventions.)

[5] Note that the evidence for acamprosate in the treatment of harmful drinkers and people who are mildly alcohol dependent is less robust than that for naltrexone. At the time of publication (February 2011), acamprosate did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.
[6] At the time of publication (February 2011), oral naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

Delivering psychological and psychosocial interventions

Intervention	Focus	Length and frequency
Cognitive behavioural therapies	Alcohol-related problems	Usually one 60-minute session per week for 12 weeks
Behavioural therapies	Alcohol-related problems	Usually one 60-minute session per week for 12 weeks
Social network and environment-based therapies	Alcohol-related problems	Usually eight 50-minute sessions over 12 weeks
Behavioural couples therapy	Alcohol-related problems and their impact on relationships. Aim: abstinence, or a level of drinking predetermined and agreed by the therapist and the service user to be reasonable and safe.	Usually one 60-minute session per week for 12 weeks

Assisted alcohol withdrawal



Drug regimens for assisted withdrawal

- Staff responsible for managing assisted alcohol withdrawal should be competent in using drug regimens appropriate to the setting.
- Prescribe and administer medication for assisted withdrawal within a standard clinical protocol.
- Use a benzodiazepine (chlordiazepoxide or diazepam) as the preferred medication.
- Consider using a formal measure of withdrawal symptoms such as the CIWA-Ar, particularly for people who are more severely alcohol dependent or those having a symptom-triggered regimen[7].
- Be aware that benzodiazepine doses may need to be reduced for children and young people[8], older people, and people with liver impairment.
- If benzodiazepines are used for people with liver impairment, consider one needing limited liver metabolism (for example, lorazepam), start with a reduced dose and monitor liver function carefully. Avoid using benzodiazepines for people with severe liver impairment.

Assisted withdrawal in the community

- Use fixed-dose medication regimens[9].
- Monitor the service user every other day.
- A family member or carer should preferably oversee the administration of medication.
- Adjust the dose if severe withdrawal symptoms or over-sedation occur.
- Avoid giving people large quantities of medication to take home to prevent overdose or diversion. Prescribe for installment dispensing, with no more than 2 days' medication supplied at any time.
- Do not offer clomethiazole because of the risk of overdose and misuse.

Assisted withdrawal in inpatient or residential settings

- Fixed-dose or symptom-triggered medication regimens can be used.
- If a symptom-triggered regimen is used, all staff should be competent in monitoring symptoms effectively and the unit should have sufficient resources to allow them to do so frequently and safely.

Using fixed-dose regimens

- Titrate the initial dose to the severity of alcohol dependence and/or regular daily level of alcohol consumption.
- In severe alcohol dependence higher doses will be required to adequately control withdrawal and should be prescribed according to the summary of product characteristics (SPC). Make sure there is adequate supervision if high doses are administered.
- Gradually reduce the dose of the benzodiazepine over 7–10 days to avoid alcohol withdrawal recurring.

---

[7] A symptom-triggered approach involves tailoring the drug regimen according to the severity of withdrawal and any complications. The service user is monitored on a regular basis and pharmacotherapy only continues as long as there are withdrawal symptoms.

[8] At the time of publication (February 2011), benzodiazepines did not have UK marketing authorisation for use in children and young people under 18. Informed consent should be obtained and documented.

[9] A fixed-dose 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.

Co-existing benzodiazepine and alcohol dependence

- Increase the dose of benzodiazepine used for withdrawal.
- Calculate the initial daily dose based on the requirements for alcohol withdrawal plus the equivalent regularly used daily dose of benzodiazepine[10].
- This is best managed with one benzodiazepine (chlordiazepoxide or diazepam) rather than multiple benzodiazepines.
- Inpatient regimens should last for 2–3 weeks or longer, depending on the severity of co-existing benzodiazepine dependence.
- Withdrawal managed in the community and/or in people with a high level of benzodiazepine dependence should last for longer than 3 weeks, and be tailored to the person's symptoms and discomfort.

- For managing unplanned acute alcohol withdrawal, and complications including delirium tremens and withdrawal-related seizures, refer to 'Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications' (NICE clinical guideline 100).

Interventions for moderate and severe alcohol dependence after successful withdrawal

- Consider offering acamprosate or oral naltrexone[11] in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol misuse (see page 18).

- Consider offering acamprosate or oral naltrexone[11] in combination with behavioural couples therapy to service users who have a regular partner who is willing to participate in treatment (see page 14).
- Consider offering disulfiram[12] in combination with a psychological intervention to service users who:
  - want to achieve abstinence but for whom acamprosate and oral naltrexone are not suitable, **or**
  - prefer disulfiram and understand the relative risks of taking the drug (see page 19).
- Before starting treatment with acamprosate, oral naltrexone[11] or disulfiram, conduct a comprehensive medical assessment (baseline urea and electrolytes and liver function tests including gamma glutamyl transpeptidase [GGT]). In particular, consider any contraindications or cautions (see the SPC) and discuss with the service user.

[10] At the time of publication (February 2011), benzodiazepines did not have UK marketing authorisation for this indication, or for use in children and young people under 18. Informed consent should be obtained and documented. This should be done in line with normal standards of care for patients who may lack capacity (see **www.publicguardian.gov.uk** or **www.wales.nhs.uk/consent**) or in line with normal standards in emergency care.
[11] At the time of publication (February 2011), oral naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.
[12] All prescribers should consult the SPC for a full description of the contraindications and the special considerations of the use of disulfiram.

Drug treatments

Drug	Start treatment	Dosage	Usual duration of treatment	Supervision	Important information
Acamprosate	As soon as possible after assisted withdrawal.	Usually 1998 mg (666 mg three times a day) unless the service user weighs less than 60 kg, and then a maximum of 1332 mg per day.	Up to 6 months, or longer for those benefiting from the drug who want to continue with it[13].	At least monthly, for 6 months, and at reduced but regular intervals if continued after this. Do not use blood tests routinely, but consider them to monitor for recovery of liver function and as a motivational aid for service users to show improvement.	Stop treatment if drinking persists 4–6 weeks after starting the drug.
Oral naltrexone[14]	After assisted withdrawal.	Initially 25 mg per day, aiming for a maintenance dosage of 50 mg per day[14].	Up to 6 months, or longer for those benefiting from the drug who want to continue with it.	At least monthly, for 6 months, and at reduced but regular intervals if continued after this. Do not use blood tests routinely, but consider them for older people, for people with obesity, for monitoring recovery of liver function and as a motivational aid for service users to show improvement.	Draw the service user's attention to the information card that is issued with oral naltrexone about its impact on opioid-based analgesics. Stop treatment if drinking persists 4–6 weeks after starting the drug. If the service user feels unwell advise them to stop the oral naltrexone immediately.

[13] At the time of publication (February 2011), acamprosate did not have UK marketing authorisation for use longer than 12 months. Informed consent should be obtained and documented.
[14] At the time of publication (February 2011), oral naltrexone did not have UK marketing authorisation for this indication or at this dosage. Informed consent should be obtained and documented.

continued

Drug treatments *continued*

Drug	Start treatment	Dosage	Supervision	Important information
Disulfiram	At least 24 hours after the last alcoholic drink consumed.	Usually 200 mg per day. For people who continue to drink, if 200 mg taken regularly for at least 1 week does not cause a sufficiently unpleasant reaction to deter drinking, consider increasing the dosage in consultation with the person.	At least every 2 weeks for the first 2 months, then monthly for the following 4 months. Service users should be medically monitored at least every 6 months after the initial 6 months of treatment and monitoring.	Before starting treatment with disulfiram, test liver function, urea and electrolytes to assess for liver or renal impairment. Check the SPC for warnings and contraindications in pregnancy and in the following conditions: a history of severe mental illness, stroke, heart disease or hypertension. If possible, a family member or carer, who is properly informed about the use of disulfiram, should oversee administration of the drug. Warn service users taking disulfiram, and their families or carers, about: • the interaction between disulfiram and alcohol (which may also be found in food, perfume, aerosol sprays and so on), the symptoms of which may include flushing, nausea, palpitations and, more seriously, arrhythmias, hypotension, and collapse • the rapid and unpredictable onset of the rare complication of hepatotoxicity; advise service users that if they feel unwell or develop a fever or jaundice that they should stop taking disulfiram and seek urgent medical attention.

- Do not use:
  - gammahydroxybutyrate (GHB) for treating alcohol misuse
  - antidepressants routinely for treating alcohol misuse alone
  - benzodiazepines as ongoing treatment for alcohol dependence. Use for withdrawal only (see page 16).

Special considerations for children and young people aged 10–17 years

Assisted withdrawal

- Offer inpatient care.
- Base assisted withdrawal on the recommendations for adults (see pages 16 and 17) and in NICE clinical guideline 100.
- Consult the SPC and adjust drug regimens to take account of age, height and body mass, and stage of development[15].

Promoting abstinence and preventing relapse

- Offer individual cognitive behavioural therapy for those with limited comorbidities and good social support.
- Offer multicomponent programmes (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy; see page 21) for those with significant comorbidities and/or limited social support.
- After carefully reviewing the risks and benefits, specialists may consider offering acamprosate[16] or oral naltrexone[17] in combination with cognitive behavioural therapy to people aged 16 and 17 years who have not engaged with or benefited from a multicomponent treatment programme.

[15] If a drug does not have UK marketing authorisation for use in children and young people under 18, informed consent should be obtained and documented.
[16] At the time of publication (February 2011), acamprosate did not have UK marketing authorisation for this indication, or for use in children and young people under 18. Informed consent should be obtained and documented.
[17] At the time of publication (February 2011), oral naltrexone did not have UK marketing authorisation for this indication or for use in children and young people under 18. Informed consent should be obtained and documented.

Delivering psychosocial interventions for children and young people

Intervention	Focus	Length and frequency
Multidimensional family therapy	Aim to improve: ● alcohol and drug misuse ● the child or young person's educational and social behaviour ● parental wellbeing and parenting skills ● relationships with the wider social system. There should be a strong emphasis on care coordination and, if necessary, crisis management. Individual interventions may also be provided for the child or young person and the parents.	Usually, 12–15 family-focused structured treatment sessions over 12 weeks
Brief strategic family therapy	● 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	Usually, fortnightly meetings over 3 months
Functional family therapy	Focus on improving interactions within the family, including: ● engaging and motivating the family in treatment ● 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).	Over 3 months by health or social care staff
Multisystemic therapy	● Focus specifically on problem-solving approaches with the family ● Use the resources of peer groups, schools and the wider community	Over 3–6 months by a dedicated member of staff with a low caseload (typically between three and six cases)

Interventions for comorbid conditions

- For treating comorbid mental health disorders, see the relevant NICE guideline (see back page).

- For people with comorbid depression or anxiety disorders, treat the alcohol misuse first.
- If depression or anxiety continues after 3 to 4 weeks of abstinence, assess the depression or anxiety and consider referral and treatment in line with the relevant NICE guideline[18].

- Refer people with a significant comorbid mental health disorder, and those at high risk of suicide, to a psychiatrist to make sure that there is effective assessment, treatment and a risk-management plan.
- For alcohol misuse comorbid with opioid misuse, actively treat both conditions taking into account the increased risk of mortality with taking alcohol and opioids together[19].
- For alcohol misuse comorbid with stimulant, cannabis[20], 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 a psychological intervention for comorbid mental health disorders.
- For comorbid alcohol and nicotine dependence, encourage service users to stop smoking and refer to 'Brief interventions and referral for smoking cessation in primary care and other settings' (NICE public health guidance 1).

Wernicke–Korsakoff syndrome

- Follow the recommendations in NICE clinical guideline 100 on thiamine for people at high risk of developing, or with suspected, Wernicke's encephalopathy.
- In addition, offer parenteral thiamine followed by oral thiamine to prevent Wernicke–Korsakoff syndrome in people who are entering planned assisted alcohol withdrawal in specialist inpatient alcohol services or prison settings and who are malnourished or at risk of malnourishment (for example, people who are homeless) or have decompensated liver disease.
- 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 service users should be supported to help maintain abstinence.

[18] 'Depression in adults' NICE clinical guideline 90 (2009), available from **www.nice.org.uk/guidance/CG90** and 'Anxiety', NICE clinical guideline 113 (2011), available from **www.nice.org.uk/guidance/CG113**
[19] See 'Drug misuse: opioid detoxification', NICE clinical guideline 52 (2007), available from **www.nice.org.uk/guidance/CG52** and 'Drug misuse: psychosocial interventions', NICE clinical guideline 51 (2007), available from **www.nice.org.uk/guidance/CG51**
[20] See 'Drug misuse: psychosocial interventions'. NICE clinical guideline 51 (2007), available from **www.nice.org.uk/guidance/CG51**

Working with families and carers

- Encourage families and carers to be involved in the treatment and care of people who misuse alcohol to help support and maintain positive change.
- Discuss concerns about the impact of alcohol misuse on themselves and other family members.
- Provide written and verbal information on alcohol misuse and its management, including how families or carers can support the service user.
- Negotiate with the service user and their family or carer about the family or carer's involvement in their care and the sharing of information. Respect the right to confidentiality of the service user and their family and carers.
- Offer a carer's assessment if necessary.
- When the needs of families and carers have been identified:
  - offer guided self-help, usually consisting of a single session, with written materials
  - provide information about, and facilitate contact with, support groups.
- If the families and carers of people who misuse alcohol do not benefit, or are not likely to benefit, from guided self-help or support groups and continue to have significant problems, consider offering individual family meetings. These should:
  - provide information and education about alcohol misuse
  - help to identify sources of stress related to alcohol misuse
  - explore and promote effective coping behaviours
  - usually consist of at least five weekly sessions.
- All staff in contact with parents who misuse alcohol and who have care of or regular contact with their children, should:
  - take account of the impact of the parent's drinking on the parent–child relationship and the child's development, education, mental and physical health, own alcohol use, safety and social network
  - be aware of and comply with the requirements of the Children Act (2004).

Further information

Ordering information

You can download the following documents from **www.nice.org.uk/guidance/CG115**

- The NICE guideline – all the recommendations.
- A quick reference guide (this document) – a summary of the recommendations for healthcare professionals.
- 'Understanding NICE guidance' – a summary for patients and carers.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

For printed copies of the quick reference guide or 'Understanding NICE guidance', phone NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote:

- N2440 (quick reference guide)
- N2441 ('Understanding NICE guidance').

Implementation tools

NICE has developed tools to help organisations implement this guidance (see **www.nice.org.uk/guidance/CG115**).

Related NICE guidance

For information about NICE guidance that has been issued or is in development, see **www.nice.org.uk**

- Anxiety. NICE clinical guideline 113 (2011).
- Pregnancy and complex social factors. NICE clinical guideline 110 (2010).
- Alcohol-use disorders: physical complications. NICE clinical guideline 100 (2010).
- Alcohol-use disorders: prevention. NICE public health guidance 24 (2010).
- Depression in adults. NICE clinical guideline 90 (2009).
- School-based interventions on alcohol. NICE public health guidance 7 (2007).
- Interventions to reduce substance misuse among vulnerable young people. NICE public health intervention guidance 4 (2007).
- Varenicline for smoking cessation. NICE technology appraisal guidance 123 (2007).
- Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007).
- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007).
- Brief interventions and referral for smoking cessation. NICE public health intervention guidance 1 (2006).

Updating the guideline

This guideline will be updated as needed, and information about the progress of any update will be available at **www.nice.org.uk/guidance/CG115**

National Institute for Health and Clinical Excellence
MidCity Place
71 High Holborn
London
WC1V 6NA

www.nice.org.uk

N2440 1P 8k Feb 11

ISBN 978-1-84936-491-1