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Alcohol-use disorders

NICE CG115; 2011

This guideline covers the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and in young people aged 10 to 17 years.

Children and young people – see full guideline.

Identification and assessment – see full guideline.

- NHS staff caring for people who potentially misuse alcohol should be competent in identifying harmful drinking and alcohol dependence and be able to assess the need for an intervention, or if not, to refer appropriately.
- Use formal assessment tools such as AUDIT.

Assessment tools

AUDIT	Alcohol Use Disorders Identification Test
SADQ	Severity of Alcohol Dependence Questionnaire
LDQ	Leeds Dependence Questionnaire
CIWA-Ar	Clinical Institute Withdrawal Assessment of Alcohol Scale, revised

Assessment in specialist alcohol services

- Conduct a brief triage assessment in all adults – see full guideline.
- Agree the treatment goal with the service user - abstinence is the appropriate goal for most people.
- Consider a comprehensive assessment for adults scoring more than 15 on AUDIT – see full guideline.

Interventions for alcohol misuse

- All interventions should be:
  - delivered by well-trained and competent staff,
  - the subject of routine outcome monitoring.
- Pharmacological interventions should be administered by specialist staff.
- For all people seeking help for alcohol misuse:
  - give information on community support networks and self-help groups e.g. Alcoholics Anonymous www.alcoholics-anonymous.org.uk, or SMART recovery www.smartrecovery.org
  - encourage people to go to meetings and arrange support so that they can attend.

Interventions for harmful drinking and mild alcohol dependence

First-line – psychological intervention (see full guideline) e.g. cognitive behavioural therapy (CBT), behavioural therapies, social network and environment-based therapies, or behavioural couples therapy.

If no response or service user requests drug treatment:

Second-line – acamprosate or naltrexone* **AND** a psychological intervention.

* Unlicensed indication. Obtain and document informed consent.

Assisted alcohol withdrawal for moderate to severe alcohol dependence

See algorithm in full guideline

- Consider an assisted withdrawal programme if a person drinks >15 units alcohol per day and/or scores ≥20 on AUDIT.

∞Drug regimens for assisted alcohol withdrawal

First-line – benzodiazepine e.g. chlordiazepoxide** or diazepam** **AND** psychosocial support.

Community-based assisted withdrawal

- Use fixed-dose drug regimens; start treatment with a standard dose then reduce dose to zero over 7 to 10 days according to a standard protocol.
- Initial dose should be based on severity of alcohol dependence and/or regular daily level of alcohol consumption.
- Prescribe for instalment dispensing; no more than 2 days' medication to be supplied at any time.
- A family member/carer should preferably oversee the administration of medication.
- Monitor the service user every other day.
- Adjust the dose if severe withdrawal symptoms or over-sedation occur.

Inpatient/residential assisted withdrawal

- Use a fixed-dose **OR** a symptom-triggered regimen.
- A symptom-triggered approach involves tailoring the drug regimen according to the severity of withdrawal symptoms.
- All staff should be competent in monitoring symptoms effectively.

Co-existing benzodiazepine and alcohol dependence

- Increase the dose of benzodiazepine used for withdrawal.
- Calculate initial daily dose based on requirement for alcohol withdrawal plus equivalent regularly used daily dose of benzodiazepine.
- Manage with one benzodiazepine (chordiazepoxide or diazepam) **NOT** multiple benzodiazepines.
- Community-based withdrawal should last longer than 3 weeks and be tailored to the person's symptoms and discomfort.
- Inpatient regimens should last for 2 to 3 weeks or longer depending on the severity of benzodiazepine dependence.

** See Summary of Product Characteristics for full prescribing information.

For unplanned acute alcohol withdrawal and complications including delirium tremens and withdrawal-related seizures: see NICE CG100; Alcohol-use disorders: physical complications.

∞ No drug recommended in this guideline is licensed for use in children/young people under the age of 18 years.

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Alcohol-use disorders

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Interventions AFTER successful withdrawal for moderate/severe alcohol dependence

Drug∞	Start treatment	Dose	Duration	Supervision	Counselling
First-line with a psychological intervention					
Acamprosate[a]	As soon as possible after assisted withdrawal.	≥ 60kg 1998mg daily (2 tablets three times a day). < 60kg 1332mg daily (4 tablets daily in divided doses).	Up to 6 months or longer if beneficial and person wants to continue use.[b]	At least monthly for 6 months then less often but at regular intervals if continued use.	♦ Stop treatment if drinking persists 4 to 6 weeks after starting the drug. ♦ Any opiate drug must be stopped 7 to 10 days before starting naltrexone.
Naltrexone[c]	After assisted withdrawal (see counselling).	Starting dose: 25mg daily. Maintenance dose: 50mg daily.[c]			
Second- line with a psychological intervention					
Disulfiram[a]	Do not start until at least 24 hours after the last alcoholic drink consumed.	Maintenance dose: 200mg daily.[a] If this dose (taken regularly for at least one week) does not deter drinking consider increasing the dose in consultation with the person.		At least every 2 weeks for the first 2 months, then monthly for the next 4 months.	♦ If possible, a family member/carer should oversee administration of drug. ♦ Advise service-user about: ➢ symptoms of flushing, nausea, and palpitations if taken with alcohol (also in food, perfume, sprays) and also arrhythmias, hypotension and collapse, ➢ hepatotoxicity (rare) – seek urgent medical attention if unwell or fever or jaundice occurs.

a see Summary of Product Characteristics for full prescribing information.
b acamprosate is not licensed for use longer than 12 months. Obtain and document informed consent.
c unlicensed use. Obtain and document informed consent.

Interventions for comorbid conditions

- For people with depression or anxiety disorders, treat the alcohol misuse first.
- If depression or anxiety continues after 3 to 4 weeks of abstinence, assess and consider referral and treatment. See relevant guidance:
  - NICE CG113; Anxiety.
  - NICE CG90; Depression in adults.
- For people with a significant comorbid mental health disorder, and those at high risk of suicide – refer to a psychiatrist.
- For alcohol misuse with opioid, stimulant, cannabis or benzodiazepine misuse – actively treat both conditions.
- Encourage people with nicotine dependence to stop smoking. See:
  - NICE PH1: Brief interventions and referral for smoking cessation in primary care and other settings.

Wernicke-Korsakoff syndrome

- See: NICE CG100: Alcohol-use disorders: physical complications.

Also see related NICE guidance:
NICE PH24; Alcohol-use disorders: preventing the development of hazardous and harmful drinking.

Monitoring

Acamprosate, naltrexone

- **Do NOT** use blood tests routinely but consider:
  - for older people,
  - for people who are obese,
  - to monitor recovery of liver function,
  - as a motivational aid.

Prescribing

Acamprosate, naltrexone or disulfiram

- Before prescribing conduct a comprehensive medical assessment including baseline urea, electrolytes and liver function tests.
- Consider any contraindications or cautions and discuss with the service user.
- The evidence for acamprosate in the treatment of harmful drinkers and mild alcohol dependence is less robust than that for naltrexone.

Disulfiram

- Contraindicated in people with a history of severe mental illness, stroke, heart disease or hypertension.
- Avoid in pregnancy – see SPC for details.
- Carry out a medical assessment at least every 6 months.

Benzodiazepines

- Doses may need to be reduced for children and young people∞, older people and in those with liver impairment.
- Avoid in severe liver impairment.
- In mild to moderate liver impairment consider using lorazepam*. Start at a low dose and monitor liver function carefully.

Do NOT :

- use gammahydroxybutyrate (GHB) for treating alcohol misuse,
- routinely use antidepressants for treating alcohol misuse alone,
- use clomethiazole for alcohol withdrawal,
- use benzodiazepines as ongoing treatment. Use for withdrawal only.

* Unlicensed indication. Obtain and document informed consent.

Care coordination and case management – see full guideline.

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