NICE National Institute for Health and Care Excellence

NICE quality standard

# Alcohol-use disorders: diagnosis and management

Quality standard
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www.nice.org.uk/guidance/qs11

# Contents

This standard is based on CG100, CG115 and PH24.

This standard should be read in conjunction with QS83, QS96, QS15, QS14, QS23, QS38, QS88, QS93, QS102, QS100, QS99, QS95, QS9, QS115, QS116, QS152, QS156, QS188 and QS189.

# Quality statements

Statement 1Adults who are being asked about their alcohol use have a validated alcohol questionnaire completed to identify any need for a brief intervention or referral to specialist alcohol services. **[new 2023]**

Statement 2Adults seeking help for an alcohol-use disorder are given information on, and support to access, community support networks and self-help groups. **[new 2023]**

Statement 3Adults accessing specialist alcohol services have a brief triage assessment that includes any treatment needs and associated risks. **[new 2023]**

Statement 4Adults in acute alcohol withdrawal in hospital are assessed and monitored following locally specified protocols. **[new 2023]**

Statement 5Adults with moderate or severe alcohol dependence are offered psychological and, if appropriate, pharmacological interventions to prevent relapse following a successful unplanned withdrawal in hospital. **[2011, updated 2023]**

In 2023, this quality standard was updated, and statements prioritised in 2011 were updated (2011, updated 2023) or replaced (new 2023). For more information, see update information.

The previous version of the quality standard for alcohol-use disorders is available as a pdf.

# Quality statement 1: Use of validated alcohol questionnaires

## Quality statement

Adults who are being asked about their alcohol use have a validated alcohol questionnaire completed to identify any need for a brief intervention or referral to specialist alcohol services. **[new 2023]**

## Rationale

Using an appropriate validated alcohol questionnaire when asking adults about their alcohol use will identify if they should receive a suitable brief intervention (structured brief advice or extended brief intervention) or referral to specialist alcohol services, according to their needs and their identified level of risk.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Adults who are asked about their alcohol use who have a validated alcohol questionnaire completed.

Numerator – the number in the denominator who have a validated alcohol questionnaire completed.

Denominator – adults who are asked about their alcohol use.

**Data source:** Data can be collected from information recorded locally by health and social care practitioners and provider organisations, for example from patient and service user

records including new patient registrations, hospital admissions and records from other services such as criminal justice services. Records should use existing coding to identify if the person was asked about their alcohol use and if a validated alcohol questionnaire was completed.

### Outcome

a) Rates of brief intervention for alcohol use in adults asked about their alcohol use.

**Data source:** Data can be collected from information recorded locally by health and social care professionals and provider organisations, for example from patient and service user records.

b) Rates of referral to specialist alcohol services in adults asked about their alcohol use.

**Data source:** The Office for Health Improvement and Disparities annual substance misuse statistics reports for adults include data on the number of adults referred to and starting substance misuse treatment for alcohol only.

## What the quality statement means for different audiences

**Service providers** (such as primary care services, secondary care services, social care services, criminal justice services, and community and voluntary services) ensure that systems are in place for the use of validated alcohol questionnaires when asking adults about their alcohol use. They ensure that staff are trained to use validated alcohol questionnaires used within the service. They ensure that there are a range of questionnaires available that are appropriate to the setting, including abbreviated versions for when time is limited.

**Health and social care practitioners** (such as doctors, nurses, social workers, staff working in the criminal justice system, and community and voluntary sector workers) use a validated alcohol questionnaire, appropriate to the setting, when asking adults about their alcohol use. They use the questionnaire to decide if the person is at risk of harm and if a brief intervention (and if so, what kind) or referral to specialist alcohol services is needed. They explain the score from the validated alcohol questionnaire and what it means to the person.

**Commissioners** ensure that they commission services in which validated alcohol questionnaires are used when asking adults about their alcohol use to make decisions about offering brief interventions or referral to specialist alcohol services.

**Adults who are being asked about their alcohol use** complete an appropriate validated questionnaire about their alcohol use. This may be completed by a member of staff, or by themselves if they are able. It is used to check if they are at risk because of their alcohol use and decide if they need any advice and support, or a referral, according to their needs. The score from the completed questionnaire and what it means should be explained by a member of staff.

# Source guidance

Alcohol-use disorders: prevention. NICE guideline PH24 (2010), recommendations 7 and 9

# Definitions of terms used in this quality statement

## Brief intervention

This includes structured brief advice and extended brief interventions.

Structured brief advice comprises a 5-minute to 15-minute session of structured advice aimed at helping someone reduce their alcohol consumption or to stop drinking alcohol. It is offered immediately or by appointment as soon as possible. The advice should use a recognised, evidence-based resource based on FRAMES principles (feedback, responsibility, advice, menu, empathy and self-efficacy) and should cover:

- the potential harm caused by the person's level of drinking and reasons for changing their behaviour, including the health and wellbeing benefits
- the barriers to change
- practical strategies to help reduce alcohol consumption (to address the 'menu' component of FRAMES)
- identification of goals.

Extended brief intervention is for someone who is reluctant to accept a referral. It is aimed

at motivating them to reduce their alcohol consumption to low risk levels and reduce risk-taking behaviour as a result of drinking alcohol, or to consider stopping drinking alcohol. The intervention should explore with the person why they behave the way they do and identify positive reasons for making change, taking the form of 20 to 30 minutes of motivational interviewing or motivational enhancement therapy. [NICE's guideline on alcohol-use disorders: prevention, recommendations 9 to 12]

### Validated alcohol questionnaire

For example:

- Alcohol-use disorders identification test (AUDIT)**or**
- when time is limited, an abbreviated version such as:
  - AUDIT for consumption (AUDIT-C)
  - AUDIT for primary care (AUDIT-PC)
  - Single alcohol screening questionnaire (SASQ)
  - Fast alcohol screening test (FAST)
  - Paddington Alcohol Test (PAT).

Questionnaires used should be appropriate to the setting. For instance, in an emergency department FAST or PAT would be most appropriate. [Adapted from NICE's guideline on alcohol-use disorders: prevention, recommendation 9]

## Equality and diversity considerations

The presence of stigma in healthcare settings towards people with an alcohol-use disorder in general should be considered when asking about alcohol use, as well as the effect of cultural factors on openly discussing alcohol use for people from some faith groups.

People should be provided with a validated alcohol questionnaire that they can easily read, understand and complete themselves, or with support. The validated alcohol questionnaire should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter, or advocate in accordance with

NICE's guideline on advocacy services for adults with health and social care needs, if needed.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Professional judgement should be used as to whether to adjust thresholds for brief intervention and referral when screening due to factors that may make some people more vulnerable to alcohol than others, including:

- sex
- people who are, or are planning to become, pregnant
- younger people
- people aged 65 and over
- people from some minority ethnic family backgrounds that are less able to metabolise alcohol.

# Quality statement 2: Community support networks and self-help groups

## Quality statement

Adults seeking help for an alcohol-use disorder are given information on, and support to access, community support networks and self-help groups. **[new 2023]**

## Rationale

Community support networks and self-help groups can be of benefit to adults with an alcohol-use disorder and can provide support at any point in their care. The person may not be aware of community support networks and self-help groups that they can access locally or how they can help people with an alcohol-use disorder. They may need support to access and participate in these groups.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of adults seeking help for an alcohol-use disorder who are given information on, and support to access, community support networks and self-help groups.

Numerator – the number in the denominator who are given information on, and support to access, community support networks and self-help groups.

Denominator – the number of adults seeking help for an alcohol-use disorder.

**Data source:**No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by health and social care professionals

and provider organisations, for example from patient and service user records.

# What the quality statement means for different audiences

**Service providers** (such as primary care services, secondary care services, social care services, criminal justice services, community and voluntary services) ensure that systems are in place for staff to provide accurate and up-to-date information about community support networks and self-help groups for alcohol-use disorders and support for adults to access them. They make staff aware of local and national information sources where available.

**Health and social care practitioners** (such as doctors, nurses, social workers, staff working in the criminal justice system, and community and voluntary sector workers) provide information to adults seeking help for an alcohol-use disorder on the community support networks and self-help groups available and their value. They provide support to access them when needed and consider safeguarding needs where people may be vulnerable.

**Commissioners** ensure that they commission services in which accurate and up-to-date information about community support networks and self-help groups is provided to adults seeking help for an alcohol-use disorder, and support is provided to access them when needed.

**Adults seeking help for an alcohol-use disorder** are given information on local community support networks and self-help groups, and the benefits of attending these. They can also get help to access these networks and groups if needed.

# Source guidance

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence. NICE guideline CG115 (2011), recommendation 1.3.1.7

# Definitions of terms used in this quality statement

## Alcohol-use disorder

Alcohol-use disorders cover a range of conditions, including:

- hazardous drinking (a pattern of alcohol consumption that increases someone's risk of harm)
- harmful drinking (a pattern of alcohol consumption that is causing mental or physical damage)
- alcohol dependence (behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use)
- acute alcohol withdrawal (the physical and psychological symptoms that people can experience when they suddenly reduce the amount of alcohol they drink if they have previously been drinking excessively for prolonged periods of time).

[Adapted from NICE's guideline on alcohol-use disorders: prevention, glossary]

## Community support networks and self-help groups

Both commissioned and peer-led networks and groups, including Alcoholics Anonymous and SMART Recovery, that may have in-person or online meetings. [Adapted from NICE's guideline on alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence, recommendation 1.3.1.7]

# Equality and diversity considerations

The presence of stigma in healthcare settings towards people with an alcohol-use disorder in general should be considered when giving information and support, as well as the effect of cultural factors on openly discussing alcohol-use disorders for people from some faith groups.

Additional support, such as transport, help accessing information on meetings and access to technology, may be needed:

- for people due to their socio-economic status
- for people experiencing homelessness
- for people who are underserved for reasons such as living in an area where there are fewer community support networks and self-help groups.

People should be provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with health and social care services. Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter, or advocate in accordance with NICE's guideline on advocacy services for adults with health and social care needs, if needed.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

# Quality statement 3: Triage assessment in specialist alcohol services

## Quality statement

Adults accessing specialist alcohol services have a brief triage assessment that includes any treatment needs and associated risks. **[new 2023]**

## Rationale

A brief triage assessment carried out as soon as possible in specialist alcohol services, and ahead of any comprehensive assessment, allows care to start that is appropriate to the person's treatment needs. The assessment produces an agreed initial treatment plan, which may include emergency or acute interventions, such as referral to an emergency department for an acute medical problem, to a crisis team for a mental health emergency, or to support for social problems.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of referrals to specialist alcohol services where a brief triage assessment was carried out that included any treatment needs and associated risks.

Numerator – the number in the denominator where a brief triage assessment was carried out that included any treatment needs and associated risks.

Denominator – the number of referrals to specialist alcohol services.

**Data source:** Data can be collected from information recorded locally by health and social

care professionals and provider organisations, for example from patient and service user records.

### Outcome

a) Rates of adults accessing specialist alcohol services receiving a referral for treatment of assessed needs.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations, for example from patient and service user records.

b) Rates of successful completion of treatment in specialist alcohol services.

**Data source:** The Office for Health Improvement and Disparities annual substance misuse statistics reports for adults include data on the number of adults who successfully complete substance misuse treatment for alcohol only.

## What the quality statement means for different audiences

**Service providers** (specialist alcohol services) ensure that systems are in place for brief triage assessments to be carried out for adults accessing specialist alcohol services, and for an initial treatment plan to be produced that takes into account the person's preferences and outcomes of any previous treatment and is agreed with them. They ensure that systems are in place for care to be provided that is appropriate to the person's treatment needs.

**Health and social care practitioners** (such as doctors, nurses, specialist alcohol service staff and support workers) carry out a brief triage assessment with adults accessing specialist alcohol services. They agree an initial treatment plan that considers the person's preferences and outcomes of any previous treatment and facilitates any treatment that is appropriate to their assessed needs. This may include emergency or acute interventions such as referral to an emergency department for an acute medical problem, to a crisis team for a mental health emergency or to support for social problems.

**Commissioners** ensure that they commission services in which adults accessing specialist

alcohol services receive a brief triage assessment and have an initial treatment plan agreed. They ensure that services provide care that is appropriate to the person's assessed needs.

**Adults referred to specialist alcohol services** have a short assessment of their needs when they first attend the service. This includes assessing their risk of harm related to their alcohol use and checking for any other health and social problems. They may then be treated or assessed in more detail if needed. They agree an initial treatment plan that considers their views and the results of any treatment they have had before.

# Source guidance

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence. NICE guideline CG115 (2011), recommendation 1.2.2.5

# Definitions of terms used in this quality statement

## Brief triage assessment

An assessment carried out when adults first access a specialist alcohol service that assesses:

- the pattern and severity of the alcohol misuse (using the alcohol-use disorders test [AUDIT]) and severity of dependence (using the severity of alcohol dependence questionnaire [SADQ])
- any treatment needs, including:
  - urgent need for assisted withdrawal
  - the presence of any comorbidities or other factors that may need further specialist assessment or intervention (for example, additional substance misuse, medical health needs such as alcohol-related liver disease, mental health needs and social problems)
- any associated risks to the person or others (for example, self-harm, harm to others, physical or mental health emergencies, and safeguarding children).

An initial treatment plan is developed with the person, based on this assessment, considering their preferences and the outcomes of any previous treatment. [NICE's guideline on alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence, recommendation 1.2.2.5 and full guideline section 5.25.1, and expert opinion]

# Equality and diversity considerations

The presence of stigma in healthcare settings towards people with an alcohol-use disorder in general should be considered when conducting brief triage assessments, as well as the effect of cultural factors on openly discussing alcohol-use disorders for people from some faith groups.

Some adults accessing specialist alcohol services, such as those who may lack capacity, those with a learning disability and those experiencing homelessness may benefit from the involvement of an advocate when having their needs assessed and agreeing an initial treatment plan (see NICE's guideline on advocacy services for adults with health and social care needs).

# Quality statement 4: Acute alcohol withdrawal

## Quality statement

Adults in acute alcohol withdrawal in hospital are assessed and monitored following locally specified protocols. **[new 2023]**

## Rationale

Adults in acute alcohol withdrawal in hospital may need care from 1 or more services and further assessment to determine what care is needed. Locally specified protocols will provide guidance for next steps, treatment, and the appropriate setting for care. They also need ongoing monitoring to ensure that their treatment is meeting their needs. This will help ensure that they receive appropriate treatment and do not develop critical care needs and complications such as alcohol withdrawal seizures, Wernicke's encephalopathy, or delirium tremens.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Structure

Evidence of local processes and written protocols for the assessment and monitoring of adults in acute alcohol withdrawal in hospital.

**Data source:** Data can be collected from information recorded locally by health and social care professionals and provider organisations, for example from care pathways.

## Process

a) Proportion of adults in acute alcohol withdrawal in hospital assessed following locally specified protocols.

Numerator – the number in the denominator who are assessed following locally specified protocols.

Denominator – the number of adults in acute alcohol withdrawal in hospital.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by health and social care professionals and provider organisations, for example from patient and service user records.

b) Proportion of adults in acute alcohol withdrawal in hospital monitored following locally specified protocols.

Numerator – the number in the denominator who are monitored following locally specified protocols.

Denominator – the number of adults in acute alcohol withdrawal in hospital.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by health and social care professionals and provider organisations, for example from patient and service user records.

## Outcome

Rates of completed withdrawal from alcohol in hospital.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by health and social care professionals and provider organisations, for example from patient and service user records.

# What the quality statement means for different audiences

**Service providers** (secondary care services) ensure that systems are in place for adults in hospital in acute alcohol withdrawal to be assessed and monitored following local protocols by healthcare professionals skilled in assessing and monitoring withdrawal symptoms and signs.

**Healthcare professionals** (such as doctors and nurses) assess and monitor adults in hospital who are in acute alcohol withdrawal following local protocols.

**Commissioners** ensure that they commission services that have local protocols for assessment and monitoring of adults in acute alcohol withdrawal in hospital.

**Adults in hospital who are in acute alcohol withdrawal** have their needs assessed and their condition monitored by skilled healthcare professionals, who follow local processes to ensure the treatment they receive is right for them.

# Source guidance

Alcohol-use disorders: diagnosis and management of physical complications. NICE guideline CG100 (2010), recommendation 1.1.2.2

# Definitions of terms used in this quality statement

## Acute alcohol withdrawal

The physical and psychological symptoms that people can experience when they suddenly reduce the amount of alcohol they drink if they have previously been drinking excessively for prolonged periods of time. [NICE's guideline on alcohol-use disorders: diagnosis and management of physical complications, terms used in this guideline]

## Locally specified protocols

In the context of this quality statement, this refers to evidence-based protocols for assessment, as soon as possible after presentation of alcohol dependence, and

monitoring of people in hospital with acute alcohol withdrawal. Assessment and monitoring should be carried out by skilled health and social care practitioners to support treatment and care for acute alcohol withdrawal, based on the person's needs. Such treatment and care may include:

- offering pharmacotherapy to treat symptoms of acute alcohol withdrawal
- a symptom-triggered regimen for drug treatment
- advice from an experienced healthcare professional for people with decompensated liver disease
- offering information on how to contact local alcohol support services
- offering prophylactic oral thiamine.

Assessment should be made using clinical judgement and possibly a tool that gives a validated score such as the Clinical Institute Withdrawal Assessment – Alcohol, revised [CIWA–Ar] scale.

Protocols are agreed and implemented in local health and social care systems, and should specify what assessment and monitoring should include, who should conduct it, and any tools that may be used. [NICE's guideline on alcohol-use disorders: diagnosis and management of physical complications, recommendations 1.1.2.2, 1.1.2.3, 1.1.3.1 to 1.1.3.4, 1.2.1.2, and expert opinion]

# Equality and diversity considerations

The presence of stigma in healthcare settings towards people with an alcohol-use disorder in general should be considered when conducting assessment and monitoring, as well as the effect of cultural factors on openly discussing alcohol-use disorders for people from some faith groups.

Some people in acute alcohol withdrawal, such as those who may lack capacity, those with learning disabilities and those experiencing homelessness may benefit from the involvement of an advocate when having their needs assessed (see NICE's guideline on advocacy services for adults with health and social care needs).

# Quality statement 5: Interventions to prevent relapse after unplanned withdrawal from alcohol in hospital

## Quality statement

Adults with moderate or severe alcohol dependence are offered psychological and, if appropriate, pharmacological interventions to prevent relapse following a successful unplanned withdrawal in hospital. **[2011, updated 2023]**

## Rationale

After a successful unplanned withdrawal from alcohol while in hospital, adults with moderate or severe alcohol dependence can benefit from a range of psychological and pharmacological interventions to help prevent relapse. Decisions about which interventions to use are made with the person, according to their needs and preferences and in line with their care plan.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

It is not the intention that services should achieve a score of 100% for process measure b, because not everyone will need a pharmacological intervention.

### Process

a) Proportion of adults with moderate or severe alcohol dependence offered psychological interventions to prevent relapse following a successful unplanned withdrawal in hospital.

Numerator – the number in the denominator who are offered psychological interventions to

prevent relapse.

Denominator – the number of adults with moderate or severe alcohol dependence who have had a successful unplanned withdrawal in hospital.

**Data source:** Data can be collected from information recorded locally by health and social care professionals and provider organisations, for example from patient and service user records. The Office for Health Improvement and Disparities annual substance misuse statistics reports for adults have data on adults accessing services for alcohol treatment only who receive a psychosocial intervention.

b) Proportion of adults with moderate or severe alcohol dependence offered pharmacological interventions to prevent relapse following a successful unplanned withdrawal in hospital.

Numerator – the number in the denominator who are offered pharmacological interventions to prevent relapse.

Denominator – the number of adults with moderate or severe alcohol dependence who have had a successful unplanned withdrawal in hospital.

**Data source:** Data can be collected from information recorded locally by health and social care professionals and provider organisations, for example from patient and service user records. The NHS Digital statistics on alcohol include data on prescription items for the treatment of alcohol dependence, prescribed in primary care and dispensed in the community, including acamprosate and disulfiram.

### Outcome

Rates of relapse following unplanned withdrawal from alcohol dependence in hospital.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by health and social care professionals and provider organisations, for example from patient and service user records.

## What the quality statement means for different

# audiences

**Service providers** (such as primary care services, secondary care services, forensic mental health services, and community-based specialist alcohol services) ensure that systems are in place to provide psychological and, if appropriate, pharmacological interventions, aimed at preventing relapse, for adults with moderate or severe alcohol dependence who have completed an unplanned withdrawal from alcohol in hospital.

**Health and social care practitioners** (such as doctors, nurses and specialist alcohol service staff) offer psychological and, if appropriate, pharmacological interventions based on the needs and care plans of adults with moderate or severe alcohol dependence who have completed an unplanned withdrawal from alcohol in hospital. They offer psychological interventions as soon as appropriate after discharge and include pharmacological interventions in discharge plans. Where appropriate and with consent, they encourage families and carers to be involved in the treatment and care of the person receiving it.

**Commissioners** ensure that they commission services in which psychological and, if appropriate, pharmacological interventions aimed at preventing relapse are provided for adults with moderate or severe alcohol dependence that have completed an unplanned withdrawal from alcohol in hospital.

**Adults with moderate or severe alcohol dependence who have completed an unplanned withdrawal from alcohol in hospital** are given psychological therapy and sometimes medicines to help prevent them drinking again after they have stopped. They decide with their healthcare professional which treatments will work best for them and have these detailed in their care plan. When it is appropriate and they consent, their families and carers are encouraged to be involved in their treatment.

# Source guidance

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence. NICE guideline CG115 (2011), recommendations 1.3.1.2, 1.3.3.1 to 1.3.3.3, and 1.3.6.1 to 1.3.6.3

# Definitions of terms used in this quality statement

## Alcohol dependence

A cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use. Someone who is alcohol-dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations. [NICE's guideline on alcohol-use disorders: diagnosis and management of physical complications, terms used in this guideline]

## Psychological interventions

Therapies focused specifically on alcohol misuse and given after successful withdrawal, ideally within 2 weeks, for people with moderate or severe alcohol dependence including:

- cognitive behavioural therapies usually consisting of one 60-minute session per week for 12 weeks
- behavioural therapies usually consisting of one 60-minute session per week for 12 weeks
- behavioural couples therapy to service users who have a regular partner and whose partner is willing to participate in treatment usually consisting of one 60-minute session per week for 12 weeks
- social network and environment-based therapies usually consisting of eight 50-minute sessions over 12 weeks.

[NICE's guideline on alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence, recommendations 1.3.3.1, 1.3.3.2, 1.3.3.4 to 1.3.3.7, and 1.3.6.1 to 1.3.6.3]

## Pharmacological interventions

Medication prescribed after a successful withdrawal and included in discharge plans for people with moderate or severe alcohol dependence after a comprehensive medical assessment that considers any contraindications or cautions, and discussion with the person. Medicines may include:

- acamprosate
- oral naltrexone
- disulfiram.

[NICE's guideline on alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence, recommendations 1.3.6.1 to 1.3.6.4]

# Equality and diversity considerations

The presence of stigma in healthcare settings towards people with an alcohol-use disorder in general should be considered when offering interventions, as well as the effect of cultural factors on openly discussing alcohol-use disorders for people from some faith groups.

When offering interventions people should be provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with health and social care services. Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter, or advocate in accordance with NICE's guideline on advocacy services for adults with health and social care needs, if needed.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Additional support to access interventions, such as transport and access to technology, may be needed due to people's circumstances, such as people experiencing homelessness.

# Update information

**July 2023:** This quality standard was updated, and statements prioritised in 2011 were updated or replaced. The topic was identified for update following the annual review of quality standards. The review identified:

- changes in the priority areas for improvement
- changes in commissioning.

Statements are marked as:

- **[new 2023]** if the statement covers a new area for quality improvement
- **[2011, updated 2023]** if the statement covers an area for quality improvement included in the 2011 quality standard and has been updated.

The previous version of the quality standard for alcohol-use disorders is available as a pdf.

# About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the

quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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# Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

# Supporting organisation

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- PTSD UK