NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Alcohol Dependence and Harmful Use GDG - Meeting 1
Thursday 26 March 2009, 10.30 – 16.00
4th Floor Standon House, 21 Mansell Street, London E1 8AA

Present:	Claire Turner (CT)	Trevor McCarthy (TM)	Julia Sinclair (JS)
Colin Drummond (CD)	Rob Saunders (RS)	Edward Day (ED)	Brendan Georgeson (BG)
Steve Pilling (SP)	Alejandra Perez (AP)	Jan Fry (JF)	Esther Flanagan (EF)
Linda Harris (LH)	Suffiya Omarjee (SO)	John Dervan (JD)	Victoria Thomas (VT)
Pamela Roberts (PR)	Sarah Stockton (SS)	Tom Phillips (TP)	
Stephenie Noble (SN)	Alex Copello (AC)	Adrian Brown (AB)	

Agenda item	Discussions and conclusions	Actions	Who
Introductions and apologies	The chair (CD) welcomed everyone and each person introduced themselves. Apologies were received from Anne-Lingford Hughes, Eilish Gilvarry, Jayne Gosnall & Marsha Morgan.		
Declaration of interests (DOI)	The Chair asked all GDG members to declare any new relevant conflicts of interest. CD, SP, PR, SN, CT, RS, AP, SO, SS, AC, TM, ED, JF, JD, TP, AB, JS, BG, EF, & VT all declared that they knew of no new personal specific, personal non-specific, non-personal specific or non-personal non-specific interest in the development of this guideline other than those already reported in the conflict of interest forms already submitted. • LH declared a non-personal pecuniary interest: Educational Grant from Schering Plough. • JS declared a non-personal pecuniary interest: Research project funded by MRC piloting Assertive Community Treatment. • ED declared a personal non-pecuniary interest: principal investigator on two grants in the substance misuse field (ACTAS study and COMBAT studies).		
Developing NICE	Presentation from CT Discussion:		

guidelines	• Legal issues- NICE guidance is not mandatory. • Media issues- If approached by media during development, send any issues straight to the communications lead at NICE Sarita Tamber (020 7045 2172). The recommendations and GDG discussions are confidential.		
The NCCMH	Presentation from SP Discussion: • The scope has been signed off and is not open to change. • It is important to identify cost-effectiveness issues early on in the process of guideline development.		
The Scope	Presentation from CD Discussion: • Pregnant women important population, however a separate NICE guideline is addressing this and for consistency with other alcohol guidelines it would not be appropriate here. • JD raised issue of considering complimentary treatments. We are not covering all complimentary treatments, but if we do find appropriate research evidence on specific approaches then we will consider them. What we recommend will always depend on the clinical and cost-effectiveness of other interventions. • Key issue- referral/transfer between levels of care. • Discussed ways in which we can achieve integrated guidance- joint members, steering groups and a joint glossary of terms.		
Service users/carers	Presentation from VT		
Clinical Questions	AP presented draft clinical questions Discussion: • Once we finalise the clinical questions we can put the papers into categories, then start evaluation/critical appraisal. • TP raised issue that term 'detoxification' gives impression of isolated treatment, though detox is part of the withdrawal and wider treatment process. SP- at present we have only done broad high order searches, the evidence has not been categorised into detox and withdrawal. Conclusion: in future we will be aware of not looking at detox as end of treatment or an isolated treatment. • Order of clinical questions is no reflection of importance. **Clinical Question 1- Assessment** • Amended to read: 'What are the most effective assessment tools for alcohol dependence & harmful alcohol use to make decisions about the most effective treatment may be?' 'What are the most effective ways of monitoring progress in alcohol dependence & harmful alcohol use?' • We are looking at populations classified by ICD-10: 1) Alcohol Dependence, 2) Harmful		

	Alcohol Use. • The Public Health group are screening such populations, but we are addressing further post-diagnosis issues of severity/co-morbidity for referral. • In order for a useful joint guidance with other groups- need to get terminology right and consistent. • Outcomes- need to consider primary outcomes as well as the impact of what happens during treatment. Main outcome comparable across studies is alcohol consumption. Can be defined using Standard measures = number of days drinking and amount of alcohol consumed per day. May look at days of abstinence over 90 days, abstinence to time of first drink, or relapse. • Abstinence shouldn't be only outcome measure, e.g moderate drinking could be an alternative. **Clinical Question 2- Planned detox** • Must consider the setting of the assisted withdrawal, e.g. inpatient units, residential rehab, community based programmes (including home treatment), and shared care options in PC. There is a substantial variation in community supervision- this needs to be considered. • Prison settings- limited treatment options, less monitoring and different assessment methods. May have to make distinct recommendations for this setting. • Detox methods- we are not looking at the impact of drug dose- covered by Clinical management group. • JD- mentioned many people do not need medication for alcohol withdrawal, so need to provide advice/support in other ways (may come under psych section). • Should include something on the preparation/engagement before detox. • An initial assessment could help predict which person would be better in treatment (setting and type). However, RCTs cannot always randomise properly due to risk. Moreover, levels of alcohol consumption do not always reflect the individual outcome of withdrawal. **Clinical Question 3- Pharmacological Interventions** • Considering range of comparators: placebo, standard care, other drugs, psych interventions and combinations. • Post detox and maintenance can fall as subcategories under psych/pharm interventions. • Can make recommendations on non-licensed drugs if strong evidence, but some are not worth considering. • Harm is important in both pharm/psych interventions. **Clinical Question 4- Psychological Interventions**		

	• Optimal treatment for certain subgroups, stepped versus matched care comparisons. • Paper in BJP which gives a good stepped-care framework for common mental health problems. • Suggestion of collapsing Q8 &Q10 into Q4- psych interventions? • Therapist factors come under delivery systems. There is evidence to show strong impact of quality of therapist on treatment outcome- needs to be considered. **Clinical Question 9- Neuropsychiatric complications** • NCC-CC looking at thiamine for the prevention of Wernickes, so we should get rid ofremove prevention from our question. • Diagnostic spectrum: cognitive impairment without physical damage and cognitive impairment with significant brain damage. Need to consider relevant care pathways after assessment and identification of such groups. **Clinical Question 11- Patient Experience** • SP- Need to consider outcomes e.g. Quality of life, how experience guides choice. • We will include a chapter which focuses on evidence of patient experience, and can use accounts from 'healthcare online' and analyse qualitatively. • Need to integrate the individual needs of families/carers. • Terminology- GDG will need decide on best terminology, e.g service user, patient, resident, person with X, carer, family/friends.	**Get paper**	RS/AP
Intervention definitions	• Function of these terms is to 1) classify papers into groups, 2) help in the write-up of the guideline, 3) get a common set of terms with other groups. • Need to distinguish between 1.1.1 and 1.1.2- DH effectiveness review has done this, so could look at their distinction.	**GDG send feedback on interventions to EF within 2 weeks.**	
Health Economics	Presentation from SO. Discussion: • NICE produce cost impact analysis and commissioning briefs.		
Topic Groups	• Topic groups will review evidence and draft recommendations then present to GDG. The topic group leads will write the introductions to the chapters. Depending on amount of literature, there should be between 3-4 additional meetings (can be done via teleconference). • Initial groups: 1. Assessment/case ID 2. psychological interventions 3. pharmacological interventions 4. inpatient/residential settings 5. children/adolescents 6. (At a later stage)- care pathways	**Send EF topic group preference**	