NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Alcohol Dependence and Harmful Use GDG - Meeting 2
Monday 27 April 2009, 10.30 – 16.00
6th Floor Standon House, 21 Mansell Street, London E1 8AA

Present:

GDG members:
Colin Drummond (CD)
Pamela Roberts (PR)
Stephenie Noble (SN)
Julia Sinclair (JS)
Brendan Georgeson (BG)
Eilish Gilvarry (EG)
Alex Copello (AC)
Trevor McCarthy (TM)
Edward Day (ED)
Jan Fry (JF)
John Dervan (JD)
Tom Phillips (TP)
Jayne Gosnall (JG)
Marsha Morgan (MM)
Anne Lingford-Hughes (ALH)

NCCMH:
Steve Pilling (SP)
Alejandra Perez (AP)
Suffiya Omarjee (SO)
Sarah Stockton (SS)
Esther Flanagan (EF)

NICE:
Claire Turner (CT)
Dylan Jones (DJ)

Agenda item	Discussions and conclusions	Actions	Who
Introductions and apologies	The chair (CD) welcomed everyone and each person introduced themselves. Apologies were received from Adrian Brown and Linda Harris.		
Declaration of interests (DOI)	The Chair asked all GDG members to declare any new relevant conflicts of interest. CD, PR, SN, JS, BG, EG, AC, TM, ED, JF, JD, TP, JG, MM, ALH, SP, AP, SO, SS, EF, CT & DJ 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. TP declared a personal non-pecuniary interest: PI on two projects, as stated in application for post. Both explore screening and brief interventions. SIPS trial and AESOPS. SIPS trial DH funded and AESOPS trial HTA funded. (April 2009)		
Business matters	The GDG went through the minutes from the last GDG, which were agreed to be an accurate account of the meeting.		
Service	JS raised the need to decide on terminology for 'service users and carers'. This will be covered		

user/carer concerns	when considering the clinical question on patient experience.		
Revisiting clinical questions	**Clinical Question 1: Assessment** • Public Health group is looking at effectiveness of audit and screening, but not specifically at diagnosis (nor Chronic Conditions group), so we need to include both diagnostic tools and assessment measures. • Added clinical and physical assessment to 1.3. • Monitoring should occur both during and after treatment. Primary outcomes will include consumption behaviour (quantity and frequency), though secondary outcomes are important, such as QOL, social functioning, co-morbidity, bio/psych factors. • Cognitive functioning: depending on the seriousness of the cognitive impairment, may need either an in depth assessment or a routinely administered assessment. This will vary with setting and treatment stage. **Clinical Question 2 : Assisted withdrawal** • Use term 'assisted withdrawal' rather than 'planned detoxification'. Use of 'medically assisted withdrawal' used to encourage nurses to be part of process, but could be left out? • Chronic Conditions group have examined how to deliver assisted withdrawal, whereas we will focus on *who* it is appropriate for and the *setting* in which it is delivered (e.g. cost-effectiveness differences between residential and inpatient). This is important as techniques of assisted withdrawal differ between settings. • Need to be aware of differences of non-UK literature in terms of threshold for assisted withdrawal. **Clinical Question 3: Pharmacology** • Clarified that maintenance refers to 'maintenance of abstinence '. Prevention of relapse can fall under attenuation of drinking. • Clarified that y= another treatment, waiting list or placebo. • Discussed off-license drugs: need to be cautious about recommending these in terms of safety; however some are well-known for efficacy and safety from RCT evidence (could come from abroad and be used for treating other problems). • Need to get hold of unpublished trials. **Clinical Question 4: Psychological/psychosocial** • Psychological and psychosocial interventions will be looked at separately. • Need to be careful with differences in foreign literature in terms of case management	Set up meeting with NCC-CC to clarify this distinction. Write to MHRA after first TG meeting	EF AP/ EF

	versus standard care. • The delivery systems could possibly be moved into Q8- Service Delivery Teams. Group vs Individual was added to section 4.1. • Important to have a separate question addressing the needs of carers (4.2). **Clinical Question 5- Combination Intervention** • Amended to read 'treatment x and y, compared to z'. • This question could be a subheading under the pharmacology section. **Clinical Question 9- Neuropsychiatric Complications** • Still uncertain as to what the NCC-CC have covered in terms of the management of Wernicke-Korsakoff. Particularly important if they haven't examined care pathways and long-term cost of care. **Remaining Clinical Questions**: Revisit at future GDGs/TGs.		
Health Economic plan	SO presented the HE plan. The following issues were raised: • Based on the clinical data, the topic group on assessment and identification will help refine what is needed for the HE analysis. • Again, we need to clarify what the NCC-CC is covering on assisted withdrawal before prioritising this analysis as high. • Best option would be to combine all effective drugs and psych interventions into one model, however this is difficult due to the differences in data, e.g. drug vs placebo, and intervention vs TAU. Therefore, SO proposed developing two models. • Can potentially feed our data into Markov model developed by Christine Godfrey- e.g. if we can obtain original data on severity from residential vs community settings. • Topic group leads and others who are interested should attend the HE workshop at NICE.	SO contact economist at NCC-CC Send GDG upcoming dates and available places for this.	SO EF
Outcomes	• AP asked the GDG what inclusion criteria should be set in terms of: Quality, relevant population and relevant outcome measures. • Diagnostic criteria: Most studies will use diagnostic criteria, though some (especially older trials) will not have, but will refer to the population as 'those with chronic alcoholism' for example. Need to be careful about excluding older trials because of this. • TP raised the issue of diagnosis of under 18's. Most child/adolescents would fall under harmful rather than dependant. May have to include 'alcohol use disorder' for this group. Also need to ensure the study's primary outcome is related to alcohol, rather than a secondary outcome.. • Child topic group can start to think of the inclusion criteria for adolescents and check for	EG raise key issues for development at next GDG This will need to be added to the clinical questions.	EG

	overlap with the PH group. • ALH raised issue of co-morbid depression and prescription of anti-depressants. • The issue of overlap/division between drug treatments for withdrawal compared to maintenance was discussed, though these tend to become blurred. MM pointed out that the time delay between withdrawal and maintenance treatment can impact on the efficacy of different drugs. • Discussed the possibility of controlled drinking when entering treatment or even as a goal outcome. Should mention in the guidance for whom controlled drinking may be beneficial for. • CD: most likely outcomes are 1) quantity (# drinks per drinking day) and 2) frequency (# of alcohol free days). These outcomes will be helpful for the HE models, as they are driven by dichotomous rather than continuous data. May have more of a problem differentiating between short- and long-term trials.		
Methods	AP presented on systematic reviewing and meta-analysis.	Send GDG presentation slides	EF
Topic Groups	• First three reviews will be pharmacological interventions, psychological/social interventions and assessment. At the next GDG, should be able to present something on pharma- so the TG will need to meet before that.	Email GDG assigned topic groups Set up meetings for pharma and assessment groups before next GDG MM email pharma meta-analysis to AP	EF MM
Any other business	• Still need to consider the definitions of interventions- this could be done within the Psychology topic group then taken back to the GDG.		