NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Alcohol Dependence and Harmful Use GDG - Meeting 4
Tuesday 27 July 2009, 10.30 – 16.00
6th Floor Standon House, 21 Mansell Street, London E1 8AA

Present:

GDG:
Colin Drummond (CD)
Stephenie Noble (SN)
Anne lingford-Hughes (ALH)
Alex Copello (AC)
Trevor McCarthy (TM)
Edward Day (ED)
John Dervan (JD)
Tom Phillips (TP)
Brendan Georgeson (BG)
Eilish Gilvarry (EG)
Adrian Brown (AB)
Marsha Morgan (MM)

NCCMH:
Steve Pilling (SP)
Alejandra Perez (AP)
Suffiya Omarjee (SO)
Esther Flanagan (EF)
Rob Saunders (RS)
Clare Taylor (CT)

Specialist advisor:
John Lewis (JL)

Agenda item	Discussions and conclusions	Actions	Who
Introductions and apologies	CD welcomed the GDG to its 4th meeting, and introduced a specialist advisor to the GDG Dr John Lewis, who is a paediatrician. Apologies were received from Pamela Roberts, Julia Sinclair, Jan Fry, Jayne Gosnall and Linda Harris.		
Declaration of interests (DOI)	The Chair asked all GDG members to declare any new relevant conflicts of interest. CD, SN, ALH, BG, EG, AC, TM, ED, JD, TP, AB, MM, SP, AP, SO, EF, RS & CT 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. AB declared a personal pecuniary interest- Received payment for attending focus groups of professionals and acting as 'expert' on site at conference presentation (Archimedes Pharma- educational material for Wernike-Korsakoff and Pabrinex). ALH declared a non-personal pecuniary interest NIHR grant to study pharmacology in alcohol detoxification.		
Matters arising	• CD raised the issue of maintaining confidentiality if approached by the press. • The issue of terminology for 'service users and carers' was re-raised. CD suggested the term 'alcohol misuser' could be suitable, as long as defined at the outset. This incorporates dependence and harmful use as defined by ICD-10. Alcohol abuse and alcohol use disorder could be seen pejorative.	• Bring suggestion to steering group meeting on 31st July.	CD/EF

	• The title of the 'clinical management' guideline will be misleading for those searching for information. Suggest something similar to 'physical management of alcohol use disorders in acute medical care'. • The final GDG date has been proposed for 27th July 2010.	• Bring suggestion to steering group meeting on 31st July.	CD/ EF
Service user and carer concerns	Clare Taylor, editor of the NCCMH, took the GDG through the structure of the Experience of Care chapter. • We will need to collect testimonies from service users and carers (and possibly staff), so if the GDG have any contacts or know of any useful resources, please let CT or EF know. CD also suggested autobiographies. • AC mentioned a qualitative (UKAT) trial on the experience of treatment. CD and MM also mentioned related qualitative evidence. • Should also consider perspectives of children of parents with alcohol problems. Could examine more modern mediums to gain these perspectives, e.g. online blogs?	• Send paper to CT or EF • GDG to recommend any other marker papers	AC GDG
Finalising outcomes	The group briefly revisited the primary outcomes for the guideline: • These include- drinking days, drinks per drinking day and time to relapse. Death is an unlikely outcome with relatively short follow-up periods. The group discussed the difference between relapse and abstinence, e.g. how many drinks would define a 'relapse' rather than a 'lapse'. Project MATCH defines this based on what is clinically meaningful (harm). • Outcomes will be examined on a timescale, such at 3, 6, 12 and 18 months depending on data available. TM also noted that intention of the study is important, e.g. is the goal abstinence or controlled drinking?		
Pharmacological evidence	AP and RS presented data on topiramate, acamprosate and naltrexone. • Issues of sponsorship/financial interest of those involved in pharmacological trials were discussed. This is widespread and the same could be said for psychological interventions. Just need to be aware of this, which is also why we try to gain unpublished data. <u>Topiramate:</u> • Discussed the use of looking at both SMDs and WMDs, as well as accounting for random effects in heterogenous samples. • Baseline measures of consumption were quite low (10 and 11 units per day). This led to discussion of how a unit is classified differently across countries, e.g. US, UK, Australia and Canada- these will need to be converted to UK units. • Need to consider the outcomes from the OCD-S carefully. • ALH noted that we need to be cautious in making recommendations about topiramate, as there are only two trials and the side-effect profile is uncertain. If lack of evidence could be better to say nothing and leave it at the discretion of the specialist. <u>Acamprosate</u>: • The GDG looked through numerous forest plots. Overall there seemed to be a consistent but small effect favouring treatment over placebo. • Though important to look at the subgroup analyses, the GDG decided it would be better to combine the data to examine more inclusive effects first. <u>Naltrexone</u>:	• Contact authors for this info (pending)	AP/AL H

	• Less consistent effects, often with no significant differences between treatment and placebo. Again we need to combine the data for more robust results and re-examine at the next GDG.	• Arrange pharm topic group in September	EF
Finalising the economic plan	• NICE asked whether we could produce an integrated eco model with the PH group if looking at screening tools. However, they have assessed sensitivity/specificity of numerous tools in primary care, whereas we will look at severity and diagnosis in secondary settings. Cost-effectiveness will depend on factors such as the number of tools used, resource/training and setting. • The GDG discussed how to analyse settings in relation to AAW. Physicians group have recommended symptom triggered based on clinical- and cost-effectiveness. This would not be appropriate in some settings, e.g. CJS. SP mentioned that prison should not be a comparator, due to lack of treatment choice. • Also issues of defining settings, for example differences between residential rehab and inpatient, or community care which could range from just GP prescriptions to home visits. • Unlikely any studies will have setting as primary outcome, so may have to resort to consensus where cost-effectiveness is clear. • We will need to consider the long-term management of neuropsychiatric problems, such as Wernicke-Korsakoff, but there will probably be no RCTs on the way in which this population is managed. Need to examine cognitive assessment (also refer to dementia guideline?).		
Update on pharma topic group	ALH updated the GDG on the progress of the pharmacology topic group. • ALH suggested we could revisit anti-convulsant clomethiazole for AAW (considered by physicians group) for psychiatric settings. Our remit is to focus on relapse prevention- so maybe we could comment on the physician's guideline during consultation on this issue instead.		
Update on Psychology topic group	AC updated the GDG on the progress of the psychology topic group. • The TG have finalised the definitions of psychological interventions. • Mesa grande review was compared with our searches in terms of the number of papers picked up for different interventions. Many of the studies compare treatments to other treatments rather than a control. Also, within therapies, e.g CBT, there are many differences in delivery which need to be looked at. • EG raised issue of lack of evidence on young people.		
Update on assessment/ID	TP updated the GDG on the progress of the assessment/ID topic group. • Papers are being collected now- next the quality of literature needs to be assessed. Then papers will be clustered to determine efficacy of tools, e.g. biomarkers, clinical interviews. • In terms of analysis, depending on volume of trials, we could do a meta-analysis using sensitivity/specificity data (roc curves).		