

Alcohol-use disorders: diagnosis and management

Quality standard

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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 and QS156.

Introduction and overview

This quality standard covers the care of children (aged 10–15 years), young people (aged 16–17 years) and adults (aged 18 years and over) drinking in a harmful way and those with alcohol dependence in all NHS-funded settings. It also includes opportunistic screening and brief interventions for hazardous and harmful drinkers. The quality standard addresses the prevention and management of Wernicke's encephalopathy but does not cover the separate management of other physical and mental health disorders associated with alcohol use.

Introduction

Alcohol dependence and harmful alcohol use are associated with increased risk of physical and mental health comorbidities including gastrointestinal disorders (in particular liver disease), neurological and cardiovascular disease, depression and anxiety disorders and ultimately, premature death. It is estimated that 24% of people aged between 16 and 65 in England consume alcohol in a way that is potentially or actually harmful to their health or well-being. Depending on the diagnostic criteria used, alcohol dependence affects between 3% and 6% of people. Brief interventions can be effective in reducing drinking in hazardous and harmful drinkers, but people with alcohol dependence and some harmful drinkers will require more specialist alcohol services. Alcohol misuse is also an increasing problem in children and young people, with over 24,000 treated in the NHS for alcohol-related problems in 2008 and 2009. Current practice across the country is varied and access to a range of specialist alcohol services varies as a consequence. This quality standard describes markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for harmful drinkers and people with alcohol dependence.

Alcohol dependence and harmful alcohol use are associated with increased risk of physical and mental health comorbidities including gastrointestinal disorders (in particular liver disease), neurological and cardiovascular disease, depression and anxiety disorders and, ultimately, premature death.

This quality standard describes markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for harmful drinkers and people with alcohol dependence in the following ways:

- Preventing people from dying prematurely.
- Enhancing quality of life for people with long-term conditions.
- Ensuring that people have a positive experience of care.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

The [2011/12 Adult Social Care Outcome Framework](http://www.gov.uk) is available from www.gov.uk.

It is also expected that this quality standard will contribute to reducing alcohol-related hospital admissions and readmissions to hospital.

Overview

This quality standard refers to harmful drinking and alcohol dependence collectively as 'alcohol misuse'. Where a statement refers exclusively to harmful drinking, alcohol dependence or hazardous drinking, this is explicitly stated. Definitions of these terms can be found in [Developmental sources](#). The term 'alcohol misuse' is a working definition taken from [NICE clinical guideline 115](#) and is not used as a diagnostic term or to imply intentionality.

The quality standard for alcohol dependence and harmful alcohol use requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole care pathway. An integrated, multidisciplinary approach to provision of services is fundamental to the delivery of high-quality care to people who misuse alcohol. A specialist alcohol service is one in which the primary role is the assessment and management of alcohol misuse, including both psychological and physical effects. Some specialist addiction services will have this role for both drug and alcohol misuse.

NICE quality standards are for use by the NHS in England and do not have formal status in the social care sector. However, the NHS will not be able to provide a comprehensive service for all without working with social care communities. In this quality standard, care has been taken to make sure that any quality statements that refer to the social care sector are relevant and evidence-based. Social care commissioners and providers may therefore wish to use them, both to improve the quality of their services and support their colleagues in the NHS.

Subject to legislation currently before Parliament, NICE will be given a brief to produce quality standards for social care. These standards will link with corresponding topics published for the NHS. They will be developed in full consultation with the social care sector and will be presented and disseminated in ways that meet the needs of the social care community. As we develop this library of social care standards, we will review and adapt any published NICE quality standards for the NHS that make reference to social care.

List of statements

Statement 1. Health and social care staff receive alcohol awareness training that promotes respectful, non-judgmental care of people who misuse alcohol.

Statement 2. Health and social care staff opportunistically carry out screening and brief interventions for hazardous and harmful drinking as an integral part of practice.

Statement 3. People who may benefit from specialist assessment or treatment for alcohol misuse are offered referral to specialist alcohol services and are able to access specialist alcohol treatment.

Statement 4. People accessing specialist alcohol services receive assessments and interventions delivered by appropriately trained and competent specialist staff.

Statement 5. Adults accessing specialist alcohol services for alcohol misuse receive a comprehensive assessment that includes the use of validated measures.

Statement 6. Children and young people accessing specialist services for alcohol use receive a comprehensive assessment that includes the use of validated measures.

Statement 7. Families and carers of people who misuse alcohol have their own needs identified, including those associated with risk of harm, and are offered information and support.

Statement 8. People needing medically assisted alcohol withdrawal are offered treatment within the setting most appropriate to their age, the severity of alcohol dependence, their social support and the presence of any physical or psychiatric comorbidities.

Statement 9. People needing medically assisted alcohol withdrawal receive medication using drug regimens appropriate to the setting in which the withdrawal is managed in accordance with NICE guidance.

Statement 10. People with suspected, or at high risk of developing, Wernicke's encephalopathy are offered thiamine in accordance with NICE guidance.

Statement 11. Adults who misuse alcohol are offered evidence-based psychological interventions, and those with alcohol dependence that is moderate or severe can in addition access relapse prevention medication in accordance with NICE guidance.

Statement 12. Children and young people accessing specialist services for alcohol use are offered individual cognitive behavioural therapy, or if they have significant comorbidities or limited social support, a multicomponent programme of care including family or systems therapy.

Statement 13. People receiving specialist treatment for alcohol misuse have regular treatment outcome reviews, which are used to plan subsequent care.

In addition, quality standards that should also be considered when commissioning and providing a high-quality alcohol service are listed in related NICE quality standards.

Quality statement 1: Awareness training for health and social care staff

Quality statement

Health and social care staff receive alcohol awareness training that promotes respectful, non-judgmental care of people who misuse alcohol.

Quality measure

Structure:

a) Evidence of local arrangements to ensure that alcohol awareness training that promotes respectful, non-judgmental care is delivered to all health and social care staff who potentially work with patients or service users who misuse alcohol.

b) Evidence of local arrangements to ensure that local patient and service user feedback, in the form of surveys and complaints, is collected, analysed and acted upon within all health and social care settings.

Process: Proportion of health and social care staff potentially working with patients or service users who misuse alcohol, who have successfully completed alcohol awareness training that promotes respectful, non-judgmental care of people who misuse alcohol.

Numerator – the number of people in the denominator completing alcohol awareness training that promotes respectful, non-judgmental care of people who misuse alcohol.

Denominator – the number of health and social care staff potentially working with patients or service users who misuse alcohol.

What the quality statement means for each audience

Service providers ensure they deliver alcohol awareness training that promotes respectful, non-judgmental care, to all staff potentially working with patients or service users who misuse alcohol, and collect and act upon patient and service user feedback, in the form of surveys and complaints.

Health and social care professionals potentially working with patients or service users who misuse alcohol complete alcohol awareness training that promotes respectful, non-judgmental care of

people who misuse alcohol, embed this training into their routine practice, and use local patient and service user feedback policies and surveys.

Commissioners ensure they commission services that provide alcohol awareness training that promotes respectful, non-judgmental care, for all staff potentially working with patients or service users who misuse alcohol, and which collect and act upon patient and service user feedback, in the form of surveys and complaints.

People who misuse alcohol are cared for by health and social care staff who have received training in alcohol awareness that includes respectful and non-judgmental care, and have the opportunity to feedback their experience of staff attitudes using a survey or complaints procedure.

Source guidance

[NICE clinical guideline 115](#) recommendations 1.1.1.1, 1.1.1.2 and 1.2.1.2 (key priority for implementation) and [NICE public health guidance 24](#) recommendation 5.

Data source

Structure: a) and b) Local data collection.

Process: Local data collection.

Definitions

For the purposes of this statement, health and social care staff are defined as any worker potentially having contact with people who misuse alcohol in any health or social care setting, including those working in criminal justice, prison, community or voluntary sector settings.

There should be a stepped approach to alcohol awareness training provision, depending on staff roles and the nature of contact with people who misuse alcohol. As a minimum, all workers who potentially have contact with people who misuse alcohol should complete basic training that promotes a respectful and non-judgmental attitude to people who misuse alcohol and which takes into account the stigma and discrimination often associated with alcohol misuse.

[NICE public health guidance 24](#) recommends that health and social care professionals providing care for people at risk of hazardous and harmful drinking in NHS-commissioned services should

receive training in providing alcohol screening and structured brief advice and if there is local demand, should also be trained to deliver extended brief interventions.

Staff training should also cover provision of information to people misusing alcohol, appropriate to the worker's role.

Equality and diversity considerations

NICE clinical guideline 115 reports of stigma in healthcare settings towards people who misuse alcohol in general. In addition, women can be more likely to experience stigma in relation to their drinking than men and people from minority ethnic groups might find it more difficult to openly discuss their emotional problems due to cultural factors, such as cultural honour and respect. People who are homeless can be particularly vulnerable to discrimination. This quality statement advances equality by ensuring equitable staff conduct towards all patients, service users and clients, including those who (potentially) misuse alcohol.

Quality statement 2: Opportunistic screening and brief interventions

Quality statement

Health and social care staff opportunistically carry out screening and brief interventions for hazardous and harmful drinking as an integral part of practice.

Quality measure

Structure:

- a) Evidence of local arrangements to ensure that healthcare staff opportunistically carry out screening and brief interventions for hazardous and harmful drinking on a routine basis.
- b) Evidence of local arrangements to ensure that social care staff opportunistically carry out screening with people who may be at an increased risk of harm from alcohol and people who have alcohol-related problems, and deliver brief interventions for hazardous and harmful drinking.
- c) Evidence of local arrangements within the commissioning framework to ensure that brief interventions are reviewed to ensure effective practice.

Process:

- a) Proportion of people aged 16 years and over in the locally defined target population who receive alcohol screening.

Numerator – the number of people in the denominator receiving alcohol screening.

Denominator – the number of people aged 16 years and over in the locally defined target population for alcohol screening.

- b) Proportion of people aged 18 and older identified as hazardous or harmful drinkers who receive structured brief advice.

Numerator – the number of people in the denominator receiving structured brief advice.

Denominator – the number of people aged 18 and older identified as hazardous or harmful drinkers.

c) Proportion of people aged 16 or 17 identified as hazardous or harmful drinkers and people aged 18 and older not responding to structured brief advice for hazardous or harmful drinking, who receive an extended brief intervention.

Numerator – the number of people in the denominator receiving an extended brief intervention.

Denominator – the number of people aged 16 or 17 identified as hazardous or harmful drinkers and people aged 18 and older not responding to structured brief advice for hazardous or harmful drinking.

Outcome: Decrease in the quantity and frequency of alcohol consumption in the locally defined target population.

What the quality statement means for each audience

Service providers ensure that healthcare staff opportunistically carry out alcohol screening and brief interventions for hazardous and harmful drinking on a routine basis, and that social care staff opportunistically carry out alcohol screening with people who may be at an increased risk of harm from alcohol and deliver brief interventions for hazardous and harmful drinking.

Healthcare professionals ensure they opportunistically carry out screening and brief interventions for hazardous and harmful drinking as an integral part of practice and on a routine basis.

Social care professionals ensure they opportunistically carry out screening for people who may be at an increased risk of harm from alcohol and deliver brief interventions for hazardous and harmful drinking.

Commissioners ensure they commission services that opportunistically carry out screening and brief interventions for hazardous and harmful drinking as an integral part of practice, and develop commissioning frameworks that review this practice to ensure effectiveness.

People aged 16 and over are asked questions about their drinking during contact with health and social care professionals, and may be offered some brief advice about what this means or a longer session to help reduce their drinking.

Source guidance

[NICE public health guidance 24](#) recommendations 5, 7 and 9.

Data source

Structure: a), b) and c) Local data collection.

Process:

a) GP practices delivering the current [Directed Enhanced Service \(DES\)](#) specification for the Alcohol-related risk reduction scheme, England are required to send to commissioners an audit of:

- Number of newly-registered patients aged 16 and over within the financial year who have had the shortened standard test (FAST or AUDIT-C – both abbreviated versions of the alcohol use disorders identification test [AUDIT]).
- Number of newly-registered patients aged 16 and over who have screened positive using a short test during the financial year, who then undergo a fuller assessment using a validated tool (for example, AUDIT) to determine increasing risk, higher risk, or probable alcohol dependence.

The current [National patient survey of PCTs](#) collects the following data:

- Whether people have been asked by someone at their GP practice/health centre in the last 12 months about how much alcohol they drink.

And data on respondents' discussions with their GP, someone else at the surgery, another doctor or any other medical professional is available from the [Omnibus ONS drinking survey](#).

Contained within [NICE public health guidance 24: audit support](#) criteria 1, 4a, 4b and 5.

b) The DES requires participating GP practices to audit the number of newly-registered patients who have been identified as drinking at increasing risk or higher risk levels who have during that period received a brief intervention to help them reduce their alcohol-related risk. Contained within [NICE public health guidance 24: audit support](#) criterion 6.

c) Local data collection. Contained within [NICE public health guidance 24: audit support](#) criteria 3 and 8.

Outcome: Data on prevalence of alcohol misuse in adults is available by region from the [NHS Adult Psychiatric Morbidity Survey in England](#).

Definitions

The following definitions are adapted from [NICE public health guidance 24](#).

'Screening' involves identifying people who are not seeking treatment for alcohol problems but who may have an alcohol-use disorder. Practitioners may use any contact with clients to carry out this type of screening. The term is not used here to refer to national screening programmes such as those recommended by the UK National Screening Committee (UK NSC). Screening should be carried out with a validated alcohol questionnaire (such as the AUDIT).

'Brief intervention' comprises either a short session of structured brief advice or a longer, more motivationally-based session (that is, an extended brief intervention). Both aim to help someone reduce their alcohol consumption (sometimes even to abstain) and can be carried out by non-alcohol specialists.

Screening and extended brief interventions are recommended in people aged 16 or 17 years. Screening and structured brief advice are recommended as the first step in people aged 18 years and older. For those who do not respond to structured brief advice, an extended brief intervention is recommended.

For the purposes of this statement, health and social care staff are defined as any professional working in any health or social care setting, including those working in criminal justice, prison, community or voluntary sector settings who regularly come into contact with people at risk of harm from the amount of alcohol they drink.

NHS professionals should consider discussing alcohol consumption during new patient registrations at a GP practice, when screening for other conditions, and when managing chronic disease or carrying out a medicine review. Discussions should also take place when promoting sexual health, when seeing someone for an antenatal appointment and when treating minor injuries.

Social care professionals should focus on people who may be at an increased risk of harm and people who have alcohol-related problems. People who may be at an increased risk of harm from alcohol include those:

- at risk of self-harm
- involved in crime or other antisocial behaviour

- who have been assaulted
- at risk of domestic abuse
- whose children are involved with child safeguarding agencies
- with drug problems.

Figure 5 in the [full version of clinical guideline 115](#) provides a care pathway for case identification and possible diagnosis for adults, including criteria for brief interventions, extended brief interventions, and specialist referral.

Equality and diversity considerations

Lower screening thresholds may be needed when assessing older and younger people. In addition, by recommending that those aged 16 and 17 receive extended brief interventions (rather than structured brief advice) it may reduce the number of opportunities to receive an intervention, as extended brief interventions may be less readily available. Lower screening thresholds should also be considered for women and some black and minority ethnic groups too.

Discussions broaching the subject of alcohol and screening should be sensitive to people's culture and faith, and tailored to their needs. Discussions with young people should be sensitive to the person's age, their ability to understand what is involved and their emotional maturity. Relevant specialists should be consulted when it is not appropriate to use an English language-based screening questionnaire, for example when dealing with people whose first language is not English or who have a learning disability.

Quality statement 3: Referral to specialist alcohol services

Quality statement

People who may benefit from specialist assessment or treatment for alcohol misuse are offered referral to specialist alcohol services and are able to access specialist alcohol treatment.

Quality measure

Structure:

- a) Evidence of local arrangements to ensure effective identification of people who may benefit from specialist assessment or treatment for alcohol misuse.
- b) Evidence of the use of a local referral pathway in accordance with [NICE public health guidance 24](#) and [NICE clinical guideline 115](#) to ensure that people who may benefit from specialist assessment or treatment for alcohol misuse are offered referral to specialist alcohol services.
- c) Evidence of a local needs assessment highlighting gaps in and barriers to accessing specialist alcohol treatment as well as prevalence of alcohol misuse. Estimated burden of alcohol misuse and uptake of specialist treatment should be broken down by key equality groups such as women, people from minority ethnic groups, people who are homeless and people in different age groups.
- d) Evidence of audit of waiting times in specialist alcohol services from initial referral to assessment, assessment to treatment start, and total waiting time from referral to starting treatment.

Process: Proportion of people meeting NICE guidance criteria for referral to specialist alcohol services who are referred to specialist alcohol services.

Numerator – the number of people in the denominator referred to specialist alcohol services.

Denominator – the number of people meeting NICE guidance criteria for referral to specialist alcohol services.

Outcome:

a) Proportion of people in the local population estimated to be dependent on alcohol who access specialist alcohol services.

Numerator – the number of people in the denominator accessing specialist alcohol services.

Denominator – the number of people in the local population estimated to be dependent on alcohol.

NICE public health guidance 24 recommends that commissioners should ensure at least one in seven dependent drinkers can get treatment locally.

b) Decrease in the quantity and frequency of alcohol consumption in people who misuse alcohol.

What the quality statement means for each audience

Service providers ensure that access pathways are implemented for referring to specialist alcohol services and that appropriate arrangements are in place for self-referral for people who may benefit from specialist assessment or treatment for alcohol misuse.

Health and social care professionals ensure they are aware of local access pathways and offer referral to specialist alcohol services to people who may benefit from specialist assessment or treatment for alcohol misuse.

Commissioners ensure they commission services that implement effective access pathways to specialist alcohol services and commission specialist alcohol services with capacity for at least one in seven of the estimated dependent drinking population to access treatment.

People who may benefit from specialist assessment or treatment for alcohol misuse are offered referral to specialist alcohol services and are able to access specialist alcohol treatment.

Source guidance

NICE clinical guideline 115 recommendations 1.2.1.2 and 1.3.4.1 (key priorities for implementation) and NICE public health guidance 24 recommendations 5, 8, 9, 11 and 12.

Data source

Structure:

a), b), c) Local data collection.

d) Local data collection. The [National Alcohol Treatment Monitoring System \(NATMS\)](#) collects data on people presenting for structured treatment in specialist alcohol services; 'date referred to modality', 'date of first appointment offered for modality' and 'triage date' are collected. 'Modality start date' records when the person actually starts a treatment modality.

Process: GP practices delivering the [Directed Enhanced Service \(DES\)](#) specification for the Alcohol-related risk reduction scheme, England are required to send to commissioners an audit of:

- Number of newly registered patients scoring 20 or more on the full ten-question alcohol-use disorders identification test (AUDIT) questionnaire who have been referred for specialist advice for dependent drinking during that period.

The [National Alcohol Treatment Monitoring System \(NATMS\)](#) collects data on referral routes into specialist alcohol services for people who present for structured specialist treatment, that is, those who complete a structured treatment assessment.

Outcome:

a) Data on prevalence of alcohol misuse in adults is available from the [NHS Adult Psychiatric Morbidity Survey in England](#). The [NATMS](#) collects data on people receiving structured alcohol treatment, but does not differentiate between harmful drinkers and people with alcohol dependence.

b) Local data collection. Data on prevalence of alcohol misuse in adults is available by region from the [NHS Adult Psychiatric Morbidity Survey in England](#).

Definitions

See quality statement 2 on opportunistic screening and brief interventions for a definition of brief interventions.

[NICE public health guidance 24](#) recommends that referral for specialist treatment is considered for people aged 16 years and older if they:

- show signs of moderate or severe alcohol dependence or

- fail to benefit from structured brief advice and an extended brief intervention and desire to receive further help for an alcohol problem **or**
- show signs of severe alcohol-related impairment or related comorbid condition (for example, liver disease or alcohol-related mental health problems).

Referral for young people aged 16 or 17 years must be to services that deal with young people.

[NICE clinical guideline 115](#) recommends that people should be referred to specialist services for assessment of need where staff making the referral are not competent themselves to identify harmful drinking or alcohol dependence. It also recommends that service users who typically drink over 15 units of alcohol per day and/or who score 20 or more on the AUDIT should be considered for assessment and management in specialist alcohol services if there are safety concerns about a community-based assisted withdrawal.

Figure 5 in the [full version of clinical guideline 115](#) provides a care pathway for case identification and possible diagnosis for adults, including referral to specialist assessment.

Access to specialist alcohol services for those who might benefit from specialist treatment requires a responsive treatment system. A responsive treatment system is a pathway that ensures appropriate case identification and subsequent referral to specialist services, which respond appropriately to referrals and provide ease of access to treatment. Treatment access should include appropriate arrangements for self-referral.

People who are likely to benefit from specialist alcohol treatment who accept a referral to specialist alcohol services should expect the service to make contact with them as soon as possible. During any period of waiting, the service user remains under the care of the referrer (for example, their GP), who should continue monitoring and address any urgent needs as appropriate.

Equality and diversity considerations

This statement promotes equality by ensuring that all people who may benefit from specialist alcohol services are offered a referral and can access specialist alcohol services for assessment and treatment.

Currently, some equality groups may be under-referred, such as older adults (due to a lack of clinical suspicion or misdiagnosis) and young adults presenting at emergency departments or in primary care.

Homeless people can have difficulty accessing appointment-only services, women can regard services less suited to their needs in terms of children and childcare, and people from minority ethnic groups may find a lack of ethno-cultural peers and staff a barrier to treatment access. There is a risk that people who are housebound (which may include a large number of older people) currently wait longer to access specialist treatment.

Outreach and assertive engagement techniques should be considered with some of these groups who may otherwise find it difficult to engage in treatment.

Quality statement 4: Trained and competent specialist staff

Quality statement

People accessing specialist alcohol services receive assessments and interventions delivered by appropriately trained and competent specialist staff.

Quality measure

Structure:

- a) Evidence of local implementation of current [guidance](#) from the Royal College of Psychiatrists and Royal College of General Practitioners on training and competence for doctors working in substance misuse.
- b) Evidence of local arrangements to ensure that all staff carrying out initial assessments in specialist alcohol services are trained in the key elements of motivational interviewing.
- c) Evidence of local arrangements to ensure that care coordination with other agencies (for example, housing, employment and social care) is delivered by appropriately trained and competent staff working in specialist alcohol services.
- d) Evidence of local arrangements to ensure the use of competence frameworks developed from relevant treatment manuals that guide the structure and duration of psychological interventions for people who misuse alcohol.
- e) Evidence of local arrangements to ensure that staff responsible for assessing and managing assisted alcohol withdrawal are trained and competent in the diagnosis and assessment of alcohol dependence and withdrawal symptoms, and the use of drug regimens appropriate to the setting in which the withdrawal is managed.
- f) Evidence of local arrangements to ensure that staff working in specialist alcohol services receive appropriate monitoring and supervision.

Process: Proportion of staff carrying out assessments or delivering interventions in specialist alcohol services who are [Drugs and Alcohol National Occupational Standards \(DANOS\)](#) compliant.

Numerator – the number of people in the denominator who are [DANOS](#) compliant.

Denominator – the number of staff carrying out assessments or delivering interventions in specialist alcohol services.

Outcome: Decrease in the quantity and frequency of alcohol consumption in people who misuse alcohol.

What the quality statement means for each audience

Service providers ensure that specialist staff carrying out assessments or delivering interventions for alcohol misuse are appropriately trained and competent in accordance with current national guidance.

Health and social care professionals carrying out assessments or delivering interventions for alcohol misuse as part of specialist alcohol treatment ensure they are aware of current national guidance, participate in appropriate training, and engage in evaluation and supervision of their practice.

Commissioners ensure they commission specialist alcohol services with an adequate specialist workforce in accordance with current national guidance and where staff training and competence are monitored and maintained.

People accessing specialist alcohol services are assessed by and receive treatment from appropriately trained and competent specialist staff.

Source guidance

NICE clinical guideline 115 recommendations 1.2.1.6, 1.3.1.1, 1.3.1.5 (key priority for implementation) and 1.3.2.1.

Data source

Structure: a) to f) Local data collection.

Process: Local data collection.

Outcome: Local data collection. Data on the prevalence of alcohol misuse in adults is available by region from the NHS Adult Psychiatric Morbidity Survey in England.

Definitions

At the time of publication (June 2011), current national guidance on a specialist workforce includes:

- [NICE clinical guideline 115](#)
- [Royal College of Psychiatrists and Royal College of GPs: Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers guidance](#)
- Drug and Alcohol National Occupational Standards ([DANOS](#)).

[DANOS](#) should be considered a minimum requirement for practitioners in specialist alcohol services. In addition, relevant specialists will be required for some assessments and interventions, such as mental health assessments and delivery of cognitive behavioural therapy.

The level and type of training or specialism required will vary across different stages of the treatment system. Exact workforce composition and planning should be determined locally in accordance with local need. Provision for ongoing monitoring and evaluation of practice competence, for example, by using video and audio tapes and external audit and scrutiny, should be assured.

Quality statement 5: Assessment in specialist alcohol services – adults

Quality statement

Adults accessing specialist alcohol services for alcohol misuse receive a comprehensive assessment that includes the use of validated measures.

Quality measure

Structure:

- a) Evidence of local arrangements to ensure that adults accessing specialist alcohol services for alcohol misuse receive a comprehensive assessment that includes the use of validated measures.
- b) Evidence of local arrangements to ensure the use of a standardised comprehensive assessment form for adults accessing specialist alcohol services.
- c) Evidence of regular local audit of case files for adults in specialist alcohol services to ensure adherence to all assessment domains.
- d) Evidence of local arrangements in specialist alcohol services for effective coordination with other agencies relevant to adult service users.

Process:

- a) Proportion of adults accessing specialist alcohol services for alcohol misuse who receive a comprehensive assessment.

Numerator – the number of people in the denominator receiving a comprehensive assessment.

Denominator – the number of adults accessing specialist alcohol services for alcohol misuse.

- b) Proportion of adults accessing specialist alcohol services for alcohol misuse who are assessed using appropriate and validated measures for each applicable assessment domain.

Numerator – the number of people in the denominator assessed using appropriate and validated measures for each applicable assessment domain.

Denominator – the number of adults accessing specialist alcohol services for alcohol misuse.

What the quality statement means for each audience

Service providers ensure they implement validated measures for assessing adults accessing specialist alcohol services for alcohol misuse, and provide a standardised assessment form to ensure that all components of a comprehensive assessment are completed for every person.

Health and social care professionals ensure they complete all components of a comprehensive assessment including the use of validated measures, for adults accessing specialist alcohol services for alcohol misuse.

Commissioners ensure they commission specialist alcohol services that use validated measures for assessing adults accessing specialist treatment for alcohol misuse, and ensure that all components of a comprehensive assessment are completed for every person.

Adults accessing specialist alcohol services for alcohol misuse receive a full assessment of the different areas in which they might need help.

Source guidance

NICE clinical guideline 115 recommendations 1.2.1.4, 1.2.1.5, 1.2.2.5, 1.2.2.6 (key priority for implementation), 1.2.2.7 and 1.3.2.3.

Data source

Structure: a), b), c) and d) Local data collection.

Process:

a) The National Alcohol Treatment Monitoring System (NATMS) collects data on people presenting for structured treatment in specialist alcohol services; 'triage date' is collected, which is the date that triage/initial assessment took place (this is not necessarily a comprehensive assessment). It also collects data at the start of treatment for the numbers of drinking days in the last 28 days (self-report) and typical numbers of units consumed in an average drinking day. Full assessment requirements contained within NICE clinical guideline 115: audit support criteria 2 and 3.

b) Local data collection. Contained within NICE clinical guideline 115: audit support criterion 1.

Definitions

NICE clinical guideline 115 recommends the following validated assessment tools to assess the nature and severity of alcohol misuse:

- Alcohol Use Disorders Identification Test (AUDIT) for identification and as a routine (drinking) outcome measure
- Severity of Alcohol Dependence Questionnaire (SADQ) or Leeds Dependence Questionnaire (LDQ) for severity of dependence
- Alcohol Problems Questionnaire (APQ) for the nature and extent of the problems arising from alcohol misuse.

The Clinical Institute Withdrawal Assessment of Alcohol Scale, revised (CIWA-Ar) may be used to assess the severity of alcohol withdrawal.

NICE clinical guideline 115 recommends considering a comprehensive assessment for all adults referred to specialist services who score more than 15 on the AUDIT. A comprehensive assessment should assess multiple areas of need, be structured in a clinical interview, use relevant and validated clinical tools, and cover the following areas:

- alcohol use, including:
 - consumption: historical and recent patterns of drinking (using, for example, a retrospective drinking diary), and if possible, additional information (for example, from a family member or carer)
 - dependence (using, for example, SADQ or LDQ)
 - alcohol-related problems (using, for example, APQ)
- other drug misuse, including over-the-counter medication
- physical health problems
- psychological and social problems (including housing)
- cognitive function (using, for example, the Mini-Mental State Examination [MMSE])
- readiness and belief in ability to change.

Comorbid mental health problems should also be assessed as part of any comprehensive assessment, because many comorbid problems (though not all) will improve with treatment for alcohol misuse.

Any initial assessment, which may take place as a triage or as part of the comprehensive assessment, should also assess:

- the pattern and severity of alcohol misuse (using AUDIT) and severity of dependence (using SADQ)
- the need for urgent treatment including assisted withdrawal
- any associated risk to self or risk to others
- the presence of any comorbidities or other factors that may need further specialist assessment or intervention.

Equality and diversity considerations

When assessing the severity of alcohol dependence and determining the need for assisted withdrawal, the criteria should be adjusted for women, older people and younger people.

All assessments should be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People who need a comprehensive assessment should have access to an interpreter or advocate if needed.

Quality statement 6: Assessment in specialist services – children and young people

Quality statement

Children and young people accessing specialist services for alcohol use receive a comprehensive assessment that includes the use of validated measures.

Quality measure

Structure:

- a) Evidence of local arrangements to ensure that children and young people accessing specialist services for alcohol use receive a comprehensive assessment that includes the use of validated measures.
- b) Evidence of local arrangements to ensure the use of a standardised comprehensive assessment form in specialist services accessed by children and young people for alcohol use.
- c) Evidence of regular local audit of case files for children and young people in specialist services accessed by children and young people for alcohol use, to ensure adherence to all assessment domains.
- d) Evidence of local arrangements in specialist services for effective coordination with other relevant agencies for children and young people at risk of harm from alcohol use.

Process:

- a) Proportion of children and young people accessing specialist services for alcohol misuse who receive a comprehensive assessment.

Numerator – the number of people in the denominator receiving a comprehensive assessment.

Denominator – the number of children and young people accessing specialist services for alcohol use.

- b) Proportion of children and young people accessing specialist services for alcohol use who are assessed using appropriate and validated measures for each applicable assessment domain.

Numerator – the number of people in the denominator assessed using appropriate and validated measures for each applicable assessment domain.

Denominator – the number of children and young people accessing specialist services for alcohol use.

What the quality statement means for each audience

Service providers ensure they implement validated measures for assessing children and young people who access specialist services for alcohol use and ensure that all components of a comprehensive assessment are completed for every person.

Health and social care professionals ensure they carry out a comprehensive assessment of multiple areas of need using a validated measure such as the Adolescent Diagnostic Interview (ADI) or the Teen Addiction Severity Index (T-ASI) for children and young people accessing specialist services for alcohol use.

Commissioners ensure they commission specialist services for children and young people at risk of harm from alcohol use that use validated measures for assessment and ensure that all components of a comprehensive assessment are completed for every person.

Children and young people attending specialist services for alcohol problems receive a full assessment of different areas in which they may need help.

Source guidance

[NICE clinical guideline 115](#) recommendations 1.3.7.1, 1.3.7.2, 1.3.7.3 and 1.3.7.4 and [NICE public health guidance 24](#) recommendation 6.

Data sources

Structure: a), b), c) and d) Local data collection.

Process: Local data collection. The [National Drug Treatment Monitoring System \(NDTMS\)](#) collects data on young people (lower age limit 9 years old) presenting to specialist young people's drug and alcohol services; 'triage date' is collected, which is the date that triage/initial assessment took place (this is not necessarily a comprehensive assessment). Also collects data at treatment start on the numbers of drinking days in the last 28 days (self-report) and typical numbers of numbers of units

consumed in an average drinking day. Contained within [NICE clinical guideline 115: audit support criterion 15](#).

Definitions

[NICE clinical guideline 115](#) recommends that a comprehensive assessment for children and young people (supported if possible by additional information from a parent or carer) should assess multiple areas of need, be structured around a clinical interview using a validated clinical tool (such as the ADI or T-ASI), and cover the following areas:

- consumption, dependence features and patterns of drinking
- comorbid substance misuse (consumption and dependence features) and associated problems
- mental and physical health problems
- peer relationships and social and family functioning
- developmental and cognitive needs, and educational attainment and attendance
- history of abuse and trauma
- risk to self and others
- readiness to change and belief in the ability to change
- obtaining consent to treatment
- developing a care plan and risk management plan.

[NICE clinical guideline 115](#) recommends that comprehensive assessments for children and young people are carried out in child and adolescent mental health services (CAMHS). [NICE public health guidance 24](#) recommends that, for children aged 10–15 years, if there is a reason to believe that there is a significant risk of alcohol-related harm, referral to either CAMHS, social care or to young people's alcohol services for treatment, should be considered.

Any initial assessment of children and young people where alcohol misuse is identified as a potential problem, which may or may not form part of the comprehensive assessment, should assess:

- the duration and severity of the alcohol misuse (the standard adult threshold on the AUDIT for referral and intervention should be lowered for young people aged 10–16 years because of the more harmful effects of a given level of alcohol consumption in this population)
- any associated health and social problems
- the potential need for assisted withdrawal.

NICE public health guidance 24 recommends that, for children aged 10–15 years, a detailed history of their alcohol use (for example, using the Common Assessment Framework as a guide) should be obtained. Background factors such as family problems and instances of child abuse or under-achievement at school should also be included.

Equality and diversity considerations

All assessments should be age-appropriate and accessible to children and young people with additional needs such as physical, sensory or learning disabilities, and to children and young people who do not speak or read English. Children and young people needing a comprehensive assessment should have access to an interpreter or advocate if needed.

This statement applies to people aged 10–17 years only, which is appropriate given the different needs of children and young people compared to adults who misuse alcohol.

Quality statement 7: Families and carers

Quality statement

Families and carers of people who misuse alcohol have their own needs identified, including those associated with risk of harm, and are offered information and support.

Quality measure

Structure:

- a) Evidence of local arrangements to ensure that local services use promotional materials to encourage families and carers of people who misuse alcohol to access information and support.
- b) Evidence of local arrangements to ensure that families and carers of people who misuse alcohol are offered written and verbal information on alcohol misuse and its management, including how families and carers can support the person who misuses alcohol.
- c) Evidence of local arrangements to ensure those at risk of harm, including alcohol-related domestic violence, are offered information, advice and referral to other services where appropriate.
- d) Evidence of local arrangements to ensure that services are compliant with current national guidance on safeguarding children.
- e) Evidence of local arrangements to ensure that carers' assessments are offered to eligible carers of people who misuse alcohol.
- f) Evidence of local arrangements to ensure provision of guided self-help for families and carers of people who misuse alcohol, including facilitating contact with support groups.
- g) Evidence of local arrangements to ensure provision of family meetings for families and carers with significant problems, typically consisting of at least five weekly sessions providing information, identifying sources of stress and exploring coping behaviours.

Process:

a) Proportion of identified family members and carers (if not family) of people who misuse alcohol who receive appropriate written and verbal information.

Numerator – the number of people in the denominator receiving appropriate written and verbal information.

Denominator – the number of identified family members and carers (if not family) of people who misuse alcohol.

b) Proportion of identified family members and carers (if not family) of people who misuse alcohol who receive guided self-help and information about support groups.

Numerator – the number of people in the denominator receiving guided self-help and information about support groups.

Denominator – the number of identified family members and carers (if not family) of people who misuse alcohol.

c) Proportion of family members and carers (if not family) of people who misuse alcohol not benefiting from guided self-help and/or support groups who attend a family meeting(s).

Numerator – the number of people in the denominator attending a family meeting(s).

Denominator – the number of family members and carers (if not family) of people who misuse alcohol not benefiting from guided self-help and/or support groups.

What the quality statement means for each audience

Service providers ensure they provide and promote a range of services to support families and carers of people who misuse alcohol, and implement guidance and procedures to safeguard those at risk of harm.

Health and social care professionals ensure they follow local policies for supporting families and carers of people who misuse alcohol including carrying out carers' assessments, identifying and safeguarding those at risk of harm, and promoting and delivering support groups and family meetings.

Commissioners ensure they commission services that provide and promote a range of services to support families and carers of people who misuse alcohol, and implement guidance to safeguard those at risk of harm.

Families and carers of people who misuse alcohol have the opportunity to discuss their own needs, and can access information and support.

Source guidance

NICE clinical guideline 115 recommendations 1.1.2.2, 1.1.2.3, 1.1.2.4 and 1.1.2.5.

Data source

Structure:

a), b) and c) Local data collection.

d) The National Alcohol Treatment Monitoring System (NATMS) collects data on the parental status of people receiving structured alcohol treatment as well as pregnancy and whether the person receiving specialist treatment lives with children.

e), f) and g) Local data collection.

Process: a), b) and c) Local data collection. See also data source for structure measure d).

Definitions

The definition of 'families' is broad and may include any relationship where regular care or contact occurs.

NICE clinical guideline 115 recommends that families and carers involved in supporting a person who misuses alcohol should have the opportunity to discuss concerns about the impact of alcohol misuse on themselves and other family members, and:

- receive written and verbal information on alcohol misuse and its management, including how families or carers can support the service user
- are offered a carer's assessment where necessary

- have the opportunity, along with the service user, to negotiate about their involvement in the service user's care and the sharing of information; the healthcare professional should make sure the service user's, family's and carer's right to confidentiality is respected
- are offered guided self-help, typically consisting of a single session, with the provision of written materials
- receive information about, and have contact facilitated with, support groups (such as self-help groups specifically focused on addressing the needs of families and carers).

If the families and carers of people who misuse alcohol have not benefited, or are not likely to benefit, from guided self-help and/or support groups and continue to have significant problems, consideration should be given to offering them individual family meetings that:

- provide information and education about alcohol misuse
- help to identify sources of stress related to alcohol misuse
- explore and promote effective coping behaviours
- usually consist of at least five weekly sessions.

All staff in contact with parents who misuse alcohol and who have care of or regular contact with their children, should take account of the impact of the parent's drinking on the parent-child relationship and the child's development, education, mental and physical health, own alcohol use, safety, and social network and be aware of and comply with the requirements of the [Children Act \(2004\)](#).

Equality and diversity considerations

Discussions with families and carers of people who misuse alcohol should be individualised and culturally sensitive.

Quality statement 8: Medically assisted alcohol withdrawal – setting

Quality statement

People needing medically assisted alcohol withdrawal are offered treatment within the setting most appropriate to their age, the severity of alcohol dependence, their social support and the presence of any physical or psychiatric comorbidities.

Quality measure

Structure:

- a) Evidence of local arrangements to ensure that people who need medically assisted alcohol withdrawal are offered treatment within the setting most appropriate to their age, the severity of alcohol dependence, their social support and the presence of any physical or psychiatric comorbidities.
- b) Evidence of local commissioning arrangements for provision of community-based medically assisted alcohol withdrawal in accordance with local need.
- c) Evidence of local commissioning arrangements for provision of residential and inpatient medically assisted alcohol withdrawal, including provision for children and young people, and people with highly complex needs such as those at high risk of severe alcohol withdrawal syndromes, and/or with severe physical or psychiatric comorbidity.
- d) Evidence of local arrangements to ensure that people in vulnerable groups who are in acute alcohol withdrawal are considered for admission to hospital for medically assisted withdrawal.

Process:

- a) Proportion of adults needing medically assisted alcohol withdrawal not requiring an inpatient or residential setting, who complete a successful community-based withdrawal.

Numerator – the number of people in the denominator completing a successful community-based medically assisted alcohol withdrawal.

Denominator – the number of adults needing medically assisted alcohol withdrawal not requiring an inpatient or residential setting.

b) Proportion of people needing medically assisted alcohol withdrawal meeting criteria for inpatient or residential care who complete a successful withdrawal in an inpatient or residential setting.

Numerator – the number of people in the denominator completing successful medically assisted alcohol withdrawal in an inpatient or residential setting.

Denominator – the number of people needing medically assisted alcohol withdrawal meeting criteria for inpatient or residential care.

c) Proportion of people in defined groups in acute alcohol withdrawal who are admitted to hospital for medically assisted withdrawal.

Numerator – the number of people in the denominator admitted to hospital for medically assisted withdrawal.

Denominator – the number of people in defined groups in acute alcohol withdrawal.

Outcome:

a) Proportion of people undergoing medically assisted alcohol withdrawal (planned or unplanned) who complete withdrawal successfully and without complications.

Numerator – the number of people in the denominator completing medically assisted withdrawal successfully and without complications.

Denominator – the number of people undergoing medically assisted alcohol withdrawal (planned or unplanned).

b) Decrease in quantity and frequency of alcohol consumption in people needing medically assisted alcohol withdrawal.

What the quality statement means for each audience

Service providers ensure that people needing medically assisted alcohol withdrawal are referred to and treated in the setting (community, residential or inpatient) most appropriate to their age, the severity of alcohol dependence, their social support and the presence of any physical or psychiatric comorbidities.

Healthcare professionals ensure they care for people needing medically assisted alcohol withdrawal in the setting (community, residential or inpatient) most appropriate to their age, the severity of alcohol dependence, their social support and the presence of any physical or psychiatric comorbidities.

Commissioners ensure they commission services with adequate residential, inpatient and community-based capacity to enable their local population needing medically assisted alcohol withdrawal to be treated within the setting most appropriate to their age, the severity of alcohol dependence, their social support and the presence of any physical or psychiatric comorbidities.

People needing medically assisted alcohol withdrawal are cared for in the place most appropriate to their needs, for example, this may be at home, in a clinic or in hospital.

Source guidance

NICE clinical guideline 115 recommendations 1.3.4.2, 1.3.4.5, 1.3.4.6 and 1.3.7.5.

NICE clinical guideline 100 recommendations 1.1.1.1 (key priority for implementation) 1.1.1.2 and 1.1.1.3.

Data source

Structure: a), b), c) and d) Local data collection.

Process:

a) Local data collection for denominator. The National Alcohol Treatment Monitoring System (NATMS) collects intervention type for people who present to specialist alcohol services and then start structured treatment. 'Alcohol – community prescribing interventions' is one of the interventions that can be recorded.

b) Local data collection for denominator. The NATMS collects data on the number of people receiving inpatient treatment for alcohol misuse (adults) and whether a person is in a substance misuse treatment specific residential placement (children and young people). The offer of inpatient or residential withdrawal (rather than programme completion) is contained within NICE clinical guideline 115: audit support criteria 5 and 16.

c) Local data collection. The [International statistical classification of diseases and related health problems \(ICD-10\)](#) code for alcohol withdrawal state with delirium is F10.4. Contained within [NICE clinical guideline 100: audit support criteria 1 and 2](#).

The [NHS Information Centre statistics on alcohol in England](#) reports on items prescribed for the treatment of alcohol dependence, including the setting in which they are prescribed.

Outcome: a) Local data collection. The [International statistical classification of diseases and related health problems \(ICD-10\)](#) code for alcohol withdrawal state with delirium is F10.4.

b) Local data collection. Data on prevalence of alcohol misuse in adults is available by region from the [NHS Adult Psychiatric Morbidity Survey in England](#).

Definitions

[NICE clinical guideline 115](#) recommends the following:

Service users who need assisted withdrawal should usually be offered a community-based programme, which should vary in intensity according to the severity of the dependence, available social support and the presence of comorbidities:

- For people with mild to moderate dependence, offer an outpatient-based assisted withdrawal programme in which contact between staff and the service user averages 2–4 meetings per week over the first week.
- For people with mild to moderate dependence and complex needs (for example, psychiatric comorbidity, poor social support or homelessness), or severe dependence, offer an intensive community programme following assisted withdrawal in which the service user may attend a day programme lasting between 4 and 7 days per week over a 3-week period.

Consider inpatient or residential assisted withdrawal if a service user meets one or more of the following criteria. They:

- drink over 30 units of alcohol per day
- have a score of more than 30 on the SADQ
- have a history of epilepsy, or experience of withdrawal-related seizures or delirium tremens during previous assisted withdrawal programmes

- need concurrent withdrawal from alcohol and benzodiazepines
- regularly drink between 15 and 30 units of alcohol per day and have:
 - significant psychiatric or physical comorbidities (for example, chronic severe depression, psychosis, malnutrition, congestive cardiac failure, unstable angina, chronic liver disease) or
 - a significant learning disability or cognitive impairment.

Also consider a lower threshold for inpatient or residential assisted withdrawal in vulnerable groups, for example, homeless and older people.

Offer inpatient care to children and young people aged 10–17 years who need assisted withdrawal.

NICE clinical guideline 100 recommends that people in acute withdrawal with, or assessed to be at high risk of developing, alcohol withdrawal seizures or delirium tremens, should be offered admission to hospital for medically assisted alcohol withdrawal. A lower threshold for admission to hospital for medically assisted withdrawal should also be considered in certain vulnerable people, for example people who:

- are frail
- have cognitive impairment
- have multiple comorbidities
- lack social support
- have learning difficulties
- are 16 or 17 years.

Young people under 16 years who are in acute alcohol withdrawal should be offered admission to hospital for physical and psychosocial assessment, in addition to medically assisted alcohol withdrawal.

Equality and diversity considerations

A lower threshold for inpatient assisted withdrawal, whether planned or unplanned, should be considered for people who are homeless, older people and children and young people, to ensure their safety.

Quality statement 9: Medically assisted alcohol withdrawal – drug regimens

Quality statement

People needing medically assisted alcohol withdrawal receive medication using drug regimens appropriate to the setting in which the withdrawal is managed in accordance with NICE guidance.

Quality measure

Structure: Evidence of local arrangements to ensure that people undergoing medically assisted alcohol withdrawal are prescribed medication that is administered using drug regimens in accordance with [NICE clinical guideline 115](#) and [NICE clinical guideline 100](#).

Process:

a) Proportion of people undergoing planned medically assisted alcohol withdrawal who receive medication using drug regimens in accordance with [NICE clinical guideline 115](#).

Numerator – the number of people in the denominator receiving medication using drug regimens in accordance with [NICE clinical guideline 115](#).

Denominator – the number of people undergoing medically assisted alcohol withdrawal.

b) Proportion of people in acute (unplanned) alcohol withdrawal who receive medication using drug regimens in accordance with [NICE clinical guideline 100](#).

Numerator – the number of people in the denominator receiving medication using drug regimens in accordance with [NICE clinical guideline 100](#).

Denominator – the number of people in acute (unplanned) alcohol withdrawal.

Outcome: Proportion of people undergoing medically assisted alcohol withdrawal (planned or unplanned) who complete withdrawal successfully and without complications.

Numerator – the number of people in the denominator completing medically assisted withdrawal successfully and without complications.

Denominator – the number of people undergoing medically assisted alcohol withdrawal (planned or unplanned).

What the quality statement means for each audience

Service providers ensure that people undergoing planned medically assisted alcohol withdrawal are prescribed medication that is administered using drug regimens in accordance with [NICE clinical guideline 115](#) and people in acute (unplanned) withdrawal are prescribed medication that is administered using drug regimens in accordance with [NICE clinical guideline 100](#).

Healthcare professionals caring for people undergoing planned medically assisted alcohol withdrawal ensure they use drug regimens in accordance with [NICE clinical guideline 115](#) and, for people in acute (unplanned) withdrawal, use drug regimens in accordance with [NICE clinical guideline 100](#).

Commissioners ensure they commission services for planned medically assisted alcohol withdrawal that use drug regimens in accordance with [NICE clinical guideline 115](#) and for people in acute (unplanned) withdrawal, that use drug regimens in accordance with [NICE clinical guideline 100](#).

People undergoing medically assisted alcohol withdrawal are given medication in a manner (frequency and amount) determined by the place where withdrawal is carried out.

Source guidance

[NICE clinical guideline 115](#) section 1.3.5, recommendation 1.3.7.6 and [NICE clinical guideline 100](#) recommendations 1.1.3.1 and 1.1.3.4.

Data source

Structure: Local data collection.

Process:

a) Local data collection. Prescription of clomethiazole (which should not be offered for community-based withdrawal) is contained within [NICE clinical guideline 115: audit support criterion 7](#).

b) Local data collection. Contained within [NICE clinical guideline 100: audit support criteria 3 and 4](#).

The [NHS Information Centre statistics on alcohol in England](#) reports on items prescribed for the treatment of alcohol dependence, including the setting in which they are prescribed.

Outcome: Local data collection. The [International statistical classification of diseases and related health problems \(ICD-10\)](#) code for alcohol withdrawal state with delirium is F10.4.

Definitions

All prescribing for medically assisted alcohol withdrawal should be carried out in accordance with [NICE clinical guideline 115](#) section 1.3.5, recommendation 1.3.7.6 and [NICE clinical guideline 100](#) recommendations 1.1.3.1 and 1.1.3.4 on drug regimens for assisted withdrawal.

Prescribers should use each drug's summary of product characteristics (SPC) with regard to current licensed indications, contraindications and special considerations to inform their decision about a person they are prescribing for. If a drug is used at a dose or for an application that does not have UK marketing authorisation, informed consent should be obtained and documented.

Quality statement 10: Wernicke's encephalopathy

Quality statement

People with suspected, or at high risk of developing, Wernicke's encephalopathy are offered thiamine in accordance with NICE guidance.

Quality measure

Structure: Evidence of local arrangements to ensure that people with suspected, or at high risk of developing, Wernicke's encephalopathy are offered thiamine in accordance with [NICE clinical guideline 115](#) and [NICE clinical guideline 100](#).

Process:

a) Proportion of people misusing alcohol, meeting NICE guidance criteria for prophylactic oral thiamine, who receive oral thiamine.

Numerator – the number of people in the denominator receiving prophylactic oral thiamine.

Denominator – the number of people misusing alcohol, meeting NICE guidance criteria for prophylactic oral thiamine.

b) Proportion of people misusing alcohol, meeting NICE guidance criteria for parenteral thiamine followed by oral thiamine, who receive parenteral thiamine followed by oral thiamine.

Numerator – the number of people in the denominator receiving parenteral thiamine followed by oral thiamine.

Denominator – the number of people misusing alcohol, meeting NICE guidance criteria for parenteral thiamine followed by oral thiamine.

Outcome: Proportion of people misusing alcohol who have Wernicke's encephalopathy or Wernicke-Korsakoff syndrome.

Numerator – the number of people in the denominator with Wernicke's encephalopathy or Wernicke-Korsakoff syndrome.

Denominator – the number of people misusing alcohol.

What the quality statement means for each audience

Service providers ensure that systems are in place to provide thiamine in accordance with NICE guidance to people with suspected, or at high risk of developing, Wernicke's encephalopathy.

Healthcare professionals ensure they offer thiamine in accordance with NICE guidance to people with suspected, or at high risk of developing, Wernicke's encephalopathy.

Commissioners ensure they commission services that provide thiamine in accordance with NICE guidance for people with suspected, or at high risk of developing, Wernicke's encephalopathy.

People with suspected, or at high risk of developing, Wernicke's encephalopathy, which is a condition that affects the brain and nervous system, and is caused by a lack of thiamine (also called vitamin B1) in the body, are offered thiamine (either as tablets or as an injection followed by tablets, depending on the situation) to help prevent the condition developing or getting worse.

Source guidance

[NICE clinical guideline 115](#) recommendation 1.3.8.5 and [NICE clinical guideline 100](#) recommendations 1.2.1.1, 1.2.1.2, 1.2.1.3 and 1.2.1.4.

Data source

Structure: Local data collection.

Process:

a) Local data collection.

b) Local data collection. The [International statistical classification of diseases and related health problems \(ICD-10\)](#) code for Wernicke's encephalopathy is E51.2 and alcohol amnesic syndrome is F10.6.

Outcome: See process b) data source for information relevant to the numerator. Data on the prevalence of alcohol misuse in adults is available by region from the [NHS Adult Psychiatric Morbidity Survey in England](#).

Definitions

NICE clinical guideline 100 recommends that thiamine is offered to people at high risk of developing, or with suspected, Wernicke's encephalopathy. Thiamine should be given in doses toward the upper end of the 'British national formulary' (BNF) range.

Prophylactic oral thiamine should be offered to harmful or dependent drinkers:

- if they are malnourished or at risk of malnourishment or
- if they have decompensated liver disease or
- if they are in acute withdrawal or
- before and during a planned medically assisted alcohol withdrawal.

Parenteral thiamine followed by oral thiamine should be offered to people with suspected Wernicke's encephalopathy and harmful or dependent drinkers if they:

- are malnourished or at risk of malnourishment or
- have decompensated liver disease and in addition
 - attend an emergency department or
 - are admitted to hospital with an acute illness or injury.

In addition, NICE clinical guideline 115 recommends offering parenteral thiamine followed by oral thiamine to people entering planned assisted alcohol withdrawal in specialist inpatient alcohol services or prison settings who are malnourished, at risk of malnourishment or have decompensated liver disease.

Equality and diversity considerations

This statement applies only to groups at high risk of developing Wernicke's encephalopathy. People with alcohol dependence who are homeless are likely to be included in this group.

Quality statement 11: Psychological interventions and relapse prevention medication for adults

Quality statement

Adults who misuse alcohol are offered evidence-based psychological interventions, and those with alcohol dependence that is moderate or severe can in addition access relapse prevention medication in accordance with NICE guidance.

Quality measure

Structure:

- a) Evidence of local arrangements to ensure that adults who misuse alcohol are offered evidence-based psychological interventions appropriate to their circumstances, in accordance with [NICE clinical guideline 115](#).
- b) Evidence of local formal evaluation of psychological interventions within the commissioning framework, including routine review and follow-up, to ensure adherence to evidence-based practice.
- c) Evidence of local arrangements to ensure that people with moderate or severe alcohol dependence are considered for relapse prevention medication after a successful medically assisted withdrawal.

Process:

- a) Proportion of adults accessing specialist services for alcohol misuse who receive evidence-based psychological interventions in accordance with [NICE clinical guideline 115](#).

Numerator – the number of adults in the denominator receiving evidence-based psychological interventions in accordance with [NICE clinical guideline 115](#).

Denominator – the number of adults accessing specialist services for alcohol misuse.

- b) Proportion of adults with moderate or severe alcohol dependence completing a successful medically assisted withdrawal who receive relapse prevention medication.

Numerator – the number of adults in the denominator receiving relapse prevention medication.

Denominator – the number of adults with moderate or severe alcohol dependence completing a successful medically assisted withdrawal.

Outcome:

- a) Decrease in the quantity and frequency of alcohol consumption in people who misuse alcohol.
- b) Reduction in the rates of relapse to heavy drinking.

What the quality statement means for each audience

Service providers ensure provision of evidence-based psychological interventions in accordance with [NICE clinical guideline 115](#), and ensure that relapse prevention medication is offered to those with moderate or severe alcohol dependence following a successful withdrawal.

Healthcare professionals use competence frameworks developed from relevant treatment manuals to ensure they offer and deliver evidence-based psychological interventions to adults misusing alcohol and consider relapse prevention medication for those with moderate or severe alcohol dependence following a successful withdrawal.

Commissioners ensure they commission services that provide evidence-based psychological interventions in accordance with [NICE clinical guideline 115](#), which are offered to adults accessing specialist treatment for alcohol misuse, and that relapse prevention medication is offered to those with moderate or severe alcohol dependence following a successful withdrawal.

Adults who misuse alcohol are offered psychological treatment, and those with moderate or severe alcohol dependence may also receive medication to help them stay alcohol-free following a successful withdrawal from alcohol.

Source guidance

[NICE clinical guideline 115](#) recommendations 1.3.1.5 (key priority for implementation), 1.3.3.1 (key priority for implementation) 1.3.3.2–1.3.3.7, 1.3.4.4, 1.3.6.1 (key priority for implementation), 1.3.6.2 and 1.3.6.3.

Data source

Structure: a), b) and c) Local data collection.

Process:

a) Local data collection. The [National Alcohol Treatment Monitoring System \(NATMS\)](#) collects data on intervention type for people in structured specialist treatment. 'Alcohol – structured psychosocial interventions' can be recorded although the details of the intervention cannot be specified. Contained within [NICE clinical guideline 115: audit support](#) criterion 4.

b) Local data collection. The [NHS Information Centre statistics on alcohol in England](#) reports on items prescribed for the treatment of alcohol dependence, including relapse prevention medication.

Outcome:

a) Local data collection. Data on the prevalence of alcohol misuse in adults is available by region from the [NHS Adult Psychiatric Morbidity Survey in England](#).

b) Local data collection of relapse rates. See also data source for process b).

Definitions

[NICE clinical guideline 115](#) defines moderate dependence as an SADQ score of between 15 and 30 and a need for assisted alcohol withdrawal, which can typically be managed in a community setting unless there are other risks. Severe alcohol dependence is defined as an SADQ score of more than 30 and a need for assisted alcohol withdrawal, typically in an inpatient or residential setting.

[NICE clinical guideline 115](#) recommends the following psychological interventions for harmful drinkers and people with alcohol dependence:

- behavioural couples therapy where people have a regular partner who is willing to participate in treatment
- cognitive behavioural therapies
- behavioural therapies

- social network and environment-based therapies.

Recommendations 1.3.3.4–1.3.3.7 provide guidance on the duration and frequency of these psychological interventions.

In addition, acamprosate or oral naltrexone in combination with a psychological intervention should be considered for people with moderate and severe alcohol dependence following successful withdrawal. Disulfiram may be considered if acamprosate and oral naltrexone are not suitable for clinical reasons or if it is the informed service user's choice.

Acamprosate and oral naltrexone may also be considered for harmful drinkers and people with mild alcohol dependence who have not responded to psychological interventions alone, or who have specifically requested a pharmacological intervention.

All prescribing should be carried out in accordance with [NICE clinical guideline 115](#). Prescribers should use each drug's summary of product characteristics (SPC) with regard to current licensed indications, contraindications and special considerations to inform their decision about a person they are prescribing for. If a drug is used at a dose or for an application that does not have UK marketing authorisation, informed consent should be obtained and documented.

Equality and diversity considerations

This statement promotes equality of access to evidence-based psychological interventions as well as relapse prevention medication for those most likely to benefit.

Quality statement 12: Specialist interventions for children and young people

Children and young people accessing specialist services for alcohol use are offered individual cognitive behavioural therapy, or if they have significant comorbidities or limited social support, a multicomponent programme of care including family or systems therapy.

Quality measure

Structure: Evidence of local provision in specialist services of individual cognitive behavioural therapy and multicomponent programmes of care tailored to children and young people accessing these services for alcohol use, which may include multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy.

Process:

a) Proportion of children and young people with limited comorbidities and good social support accessing specialist services for alcohol use who receive individual cognitive behavioural therapy.

Numerator – the number of people in the denominator receiving individual cognitive behavioural therapy.

Denominator – the number of children and young people with limited comorbidities and good social support accessing specialist services for alcohol use.

b) Proportion of children and young people with significant comorbidities and/or limited social support accessing specialist services for alcohol use who receive a multicomponent treatment programme of care including family or systems therapy.

Numerator – the number of people in the denominator receiving a multicomponent treatment programme of care including family or systems therapy.

Denominator – the number of children and young people with significant comorbidities or limited social support accessing specialist services for alcohol use.

Outcome: Decrease in quantity and frequency of alcohol consumption in children and young people with identified alcohol-related problems.

What the quality statement means for each audience

Service providers ensure that systems are in place to provide children and young people accessing specialist services for alcohol use with individual cognitive behavioural therapy or, for those with significant comorbidities or limited social support, multicomponent programmes of care including family or systems therapy.

Health and social care professionals ensure they support children and young people accessing specialist services for alcohol use to receive individual cognitive behavioural therapy or, for those with significant comorbidities or limited social support, a multicomponent programme of care including family or systems therapy.

Commissioners ensure they commission specialist services with provision specifically for children and young people at risk of harm from alcohol use, with adequate provision of individual cognitive behavioural therapy or, for those with significant comorbidities or limited social support, multicomponent programmes of care including family or systems therapy.

Children and young people receiving specialist support for alcohol use are offered a psychological treatment called cognitive behavioural therapy (or CBT for short) or, if they have other health or family problems, they are offered different types of help including psychological treatment that involves their family and other people in their life.

Source guidance

NICE clinical guideline 115 recommendations 1.3.7.8 (key priority for implementation), 1.3.7.10, 1.3.7.11, 1.3.7.12 and 1.3.7.13.

Data source

Structure: Local data collection.

Process: a) and b) Local data collection. The National Drug Treatment Monitoring System (NDTMS) collects data on intervention type for young people (lower age limit 9 years old) starting treatment in specialist young people's drug and alcohol services. There are a number of intervention types that can be recorded, including 'Psychosocial – cognitive behavioural therapy' and 'Psychosocial – family work', although the nature of these is not specified and they are not currently reported by primary substance (that is, alcohol or drugs).

Outcome: Local data collection. From 2011–12 the [NDTMS](#) will start to record the frequency of drinking days at treatment start and at treatment exit (for planned exits only) if alcohol is the young person's main 'drug' of choice. The NHS Information Centre conducts an annual survey [Smoking, drinking and drug use among young people in England](#).

Definitions

Multicomponent treatment programmes may include multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy. [NICE clinical guideline 115](#) makes recommendations about the content, structure and duration of these therapies in recommendations 1.3.7.10, 1.3.7.11, 1.3.7.12 and 1.3.7.13.

Equality and diversity considerations

This statement applies to people aged 10–17 years only, which is appropriate given the different needs of children and young people compared with adults who misuse alcohol. In general the range of specialist services for younger people is less comprehensive than for adults. This statement therefore promotes equality in providing interventions suited to the needs of children and young people.

Quality statement 13: Outcomes monitoring

Quality statement

People receiving specialist treatment for alcohol misuse have regular treatment outcome reviews, which are used to plan subsequent care.

Quality measure

Structure:

- a) Evidence of local implementation of the Alcohol Use Disorders Test (AUDIT) and the Alcohol Problems Questionnaire (APQ) for outcome monitoring in specialist alcohol services.
- b) Evidence of local arrangements to ensure that interventions for people receiving specialist treatment for alcohol misuse are the subject of routine outcome monitoring.
- c) Evidence of regular local audit of case files in specialist alcohol services to ensure that people receiving treatment for alcohol misuse have an individualised care plan that is frequently reviewed and revised based on treatment outcomes.

Process: Proportion of people receiving specialist treatment for alcohol misuse who have a current individualised care plan.

Numerator – the number of people in the denominator with a current individualised care plan.

Denominator – the number of people receiving specialist treatment for alcohol misuse.

Outcome: Proportion of people accessing specialist alcohol services who achieve their treatment goals.

Numerator – the number of people in the denominator achieving their treatment goals.

Denominator – the number of people accessing specialist alcohol services.

What the quality statement means for each audience

Service providers ensure systems are in place for the regular review of treatment outcomes in people receiving specialist treatment for alcohol misuse, and for individualised care plans to be based on outcome reviews.

Health and social care professionals ensure they regularly review treatment outcomes in people receiving specialist treatment for alcohol misuse, and maintain care plans to be individualised and current based on outcome reviews.

Commissioners ensure they commission specialist alcohol services that review regularly treatment outcomes in people receiving specialist treatment for alcohol misuse, and maintain care plans to be individualised and current based on outcome reviews.

People receiving specialist treatment for alcohol misuse have their treatment reviewed regularly and have the opportunity to be involved in planning further care, based on these reviews.

Source guidance

NICE clinical guideline 115 recommendations 1.2.1.4, 1.3.1.5 (key priority for implementation), 1.3.1.6 and 1.3.2.3.

Data source

Structure: a), b) and c) Local data collection.

Process: Local data collection for the numerator. The National Alcohol Treatment Monitoring System (NATMS) collects data on the number of people receiving specialist alcohol treatment.

Outcome: Local data for detail on achievement of specific treatment goals. The NATMS collects data on the number of people receiving specialist alcohol treatment and discharge status.

Definitions

NICE clinical guideline 115 recommends that all interventions for people who misuse alcohol should be the subject of routine outcome monitoring and that this be used to inform decisions about continuation of both psychological and pharmacological treatments. If there are signs of

deterioration or no indications of improvement, consideration should be given to stopping the current treatment and the care plan reviewed.

The AUDIT tool may be used as a routine outcome measure for drinking-related outcomes and the APQ may be used for monitoring changes in alcohol-related problems.

Using the quality standard

It is important that the quality standard is considered alongside current policy and guidance documents listed in the [development sources](#) section.

Commissioning support and information for patients

NICE has produced a [support document](#) to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard. [Information for patients](#) using the quality standard is also available on the NICE website. A full [commissioning guide on services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults](#), that supports the local implementation of NICE guidance is also available.

It is also noted that service user preference and choice need to be taken into account, and practitioners should offer appropriate evidence-based interventions in their consultations with individuals. Reflecting this choice will be particularly important when measuring achievement against statements using the process measures. However, the quality standard uses the term 'receive' so as to facilitate measurability, audit and reporting.

Quality measures and national indicators

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of healthcare. They are not a new set of targets or mandatory indicators for performance management.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so aspirational achievement levels are likely to be 100% (or 0% if the quality statement states that something should not be done). However, it is recognised that this may not always be appropriate in practice taking account of patient safety, patient choice and clinical judgement and therefore desired levels of achievement should be defined locally.

We have indicated where national indicators currently exist and measure the quality statement. National indicators include those developed by the NHS Information Centre through their [Indicators for Quality Improvement Programme](#). For statements where national quality indicators do not exist, the quality measures should form the basis for audit criteria developed and used locally to improve the quality of healthcare.

For further information, including guidance on using quality measures, please see [What makes up a NICE quality standard](#).

Diversity, equality and language

During the development of this quality standard, equality issues were considered.

People with alcohol dependence, and harmful drinkers, should have the opportunity to make informed decisions about their care and treatment, in partnership with health and social care professionals. Good communication between staff and people who misuse alcohol is essential. Treatment and care, and the information people are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Harmful drinkers and people with alcohol dependence should have access to an interpreter or advocate if needed.

Development sources

Evidence sources

The documents below contain clinical guideline recommendations or other recommendations that were used by the TEG to develop the quality standard statements and measures.

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE clinical guideline 115 (2011; NHS Evidence accredited).

Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications. NICE clinical guideline 100 (2010; NHS Evidence accredited).

Alcohol-use disorders: preventing the development of hazardous and harmful drinking. NICE public health guidance 24 (2010; NHS Evidence accredited).

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

Department of Health (2011) Transparency in outcomes – a framework for quality in adult social care.

Department of Health (2010) The NHS Outcomes Framework 2011/12.

Department of Health (2009) Local routes: Guidance for developing alcohol treatment pathways.

National Audit Office (2008) Reducing alcohol harm: health services in England for alcohol misuse.

Department of Health (2007) Safe. Sensible. Social. The next steps in the National Alcohol Strategy.

Department of Health (2006) Signs for improvement – commissioning interventions to reduce alcohol-related harm.

Department of Health and National Treatment Agency for Substance Misuse (2006) Models of care for alcohol misusers (MoCAM).

National Treatment Agency for Substance Misuse (2006) [Review of the effectiveness of treatment for alcohol problems](#).

Department of Health (2005) [Alcohol needs assessment project \(ANARP\)](#).

Definitions and data sources

The definition of harmful alcohol use in this quality standard is that of the World Health Organisation (WHO) [The International statistical classification of diseases and related health problems \(ICD-10\)](#): "a pattern of psychoactive substance use that is causing damage to health. The damage may be physical (for example, hepatitis) or mental (for example, depressive episodes secondary to heavy alcohol intake). Harmful use commonly, but not invariably, has adverse social consequences; social consequences in themselves, however, are not sufficient to justify a diagnosis of harmful use".

In ICD-10 the 'dependence syndrome' is defined as: "a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state".

The term hazardous drinking indicates a pattern of alcohol consumption that increases someone's risk of harm. Some would limit this definition to the physical or mental health consequences (as in harmful use). Others would include the social consequences. The term is currently used by WHO to describe this pattern of alcohol consumption. It is not a diagnostic term.

References included in the definitions and data sources sections can be found below:

Care Quality Commission and Picker Institute (2008) [National survey of local health services](#).

[Children Act \(2004\)](#).

Department of Health (2010) [The Primary Medical Services \(Directed Enhanced Services\) \(England\) Directions 2010](#).

Department of Health (2009) [Signs for improvement – commissioning interventions to reduce alcohol-related harm](#).

National Treatment Agency for Substance Misuse. The National Drug Treatment Monitoring System (NDTMS) and the National Alcohol Treatment Monitoring System (NATMS).

NHS Information Centre (2011) Statistics on alcohol: England 2011.

NHS Information Centre (2010) Smoking, drinking and drug use among young people in England 2009.

NHS Information Centre (2009) Adult psychiatric morbidity in England, 2007: results of a household survey.

NICE (2011) Alcohol dependence and harmful alcohol use – audit support. NICE clinical guideline 115.

NICE (2010) Alcohol-use disorders: physical complications – audit support. NICE clinical guideline 100.

NICE (2010) Alcohol-use disorders: preventing harmful drinking – audit support. NICE public health guidance 24.

Office for National Statistics (2010) Drinking: adults' behaviour and knowledge in 2009 (Opinions Survey Report No. 42).

Royal College of Psychiatrists and Royal College of GPs (2005) Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers.

Skills for Health (2010) Drugs and Alcohol National Occupational Standards (DANOS).

World Health Organisation (2007) The International statistical classification of diseases and related health problems (ICD-10).

Related NICE quality standards

Patient experience in adult NHS services. NICE quality standard 15 (2012).

Service user experience in adult mental health. NICE quality standard 14 (2012).

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About this quality standard

NICE quality standards are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions. Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

The methods and processes for developing NICE quality standards are described in the [healthcare quality standards process guide](#).

This quality standard has been incorporated into the NICE [alcohol-use disorders pathway](#).

We have produced a [summary for patients and carers](#).

Changes after publication

April 2015: minor maintenance.

October 2014: change to the definitions section of statement 8 to reflect a post publication correction to recommendation 1.3.4.5 in the NICE guideline on [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#).

August 2013: minor maintenance.

July 2013: minor maintenance.

April 2013: minor maintenance.

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Supporting organisations

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.

- [Alcohol Concern](#)
- [British Psychological Society](#)
- [European Association for the Treatment of Addiction UK \(EATA\)](#)
- [Medical Council on Alcohol](#)
- [Royal College of Nursing](#)
- [Royal College of Physicians](#)
- [Royal Pharmaceutical Society](#)
- [Specialist Clinical Addiction Network](#)