

Chapter 1. Introduction

Guidelines for the Treatment of Alcohol Problems

1. Introduction

These Guidelines for the Treatment of Alcohol Problems have evolved over the past 15 years. In 1993, the National Drug and Alcohol Research Centre published a monograph, 'An outline for the management of alcohol problems: Quality assurance in the treatment of drug dependence project' (Mattick & Jarvis 1993). The Australian Government commissioned the National Drug and Alcohol Research Centre to update this document and develop guidelines for treating alcohol problems, which were published in 2003 (Shand et al. 2003). The present document was commissioned to update the guidelines in light of recent evidence and to be integrated with the Australian Guidelines to Reduce Health Risks from Drinking Alcohol (NHMRC 2009).

Purpose of the guidelines

These guidelines provide up-to-date, evidence-based information to clinicians on the available treatments for people with alcohol problems. The guidelines are directed to the broad range of health care professionals who treat people with these problems, including primary care (general practitioners, nurses), specialist medical practitioners, psychologists and other counsellors, and other health professionals. As all forms of treatment will not be readily available or suitable for all populations or settings these guidelines may require interpretation and adaptation. Health service planners represent a significant audience for this document. These guidelines do not attempt to provide information about systems of treatment delivery, which is a policy decision that relates to the needs, resources and structure of health care within jurisdictions.

At the outset, the authors recognise that many people with alcohol problems change their behaviour without formal help or intervention. The way people identify a drinking problem, recognise their responsibility to change, and achieve the self-efficacy to do so, remains variable and incompletely understood. At best, professional treatment can only contribute to a person's self-awareness.

Structure of the guidelines

These guidelines are intended for interested clinicians and health service planners who want a comprehensive review of the treatment options for people with alcohol problems. This document is to be read in parallel with the updated Review of the Evidence, which provides more detail concerning the evidence base for the recommendations within these guidelines. A full list of references associated with recommendations is also provided in the Review of the Evidence.

A needs analysis was conducted with a range of health professionals (general practitioners, hospital-based workers, alcohol and drug workers and community counsellors) about the most appropriate content and format for guideline information to be used by clinicians.

These are described in a separate unpublished report (Cooney et al. 2008). Arising from this needs analysis the guidelines are also accompanied by:

- Quick Reference Guide for use at the point of care. These are designed to make key information more easily accessible to the busy health care worker. The Quick Reference Guide summarise information on assessment, brief interventions, withdrawal management, and post-withdrawal interventions (including psychosocial and pharmacotherapies) for dependent drinkers.
- Key resources for patients and carers, such as patient literature on alcohol withdrawal and post-withdrawal services, designed to reinforce clinical interventions.

These resources are available at <www.alcohol.gov.au> reflecting contemporary approaches by patients and health care professionals in accessing information.

Development of the guidelines

The guidelines were developed by:

- updating the review of the evidence for treatment of alcohol problems and published as a companion document (Proude et al. 2009)
- consulting with an expert panel
- seeking feedback from clinicians concerning the previous edition (reported separately).

In developing the guidelines, the authors relied on evidence from well-designed randomised controlled trials wherever possible. Where this evidence was not available, recommendations are based upon the best available research or clinical experience. Where appropriate, material from the 2003 edition and its accompanying literature review is included.

In almost all cases, the relevant evidence is cited in the revised Review of the Evidence and removed from the guidelines themselves. In turn, the Review of the Evidence has been structured to match the guidelines, so as to clarify the evidence that was considered for each recommendation (to the extent that this could be achieved).

Each chapter begins by briefly stating the aim of that chapter. The recommendations within each chapter identify key issues for clinical practice, and most have an identified supporting 'level of evidence' and 'strength of recommendation'; they are consolidated at the beginning of the guidelines. Consistent with contemporary approaches to guideline development (Shekelle et al. 1999), levels of evidence for causal relationships and observational relationships are presented as Levels I, II, III or IV and strength of recommendations are presented as A, B, C, D or S (Table I.1).

Recommendations aim to inform clinical decision-making. The strength of recommendation reflects the available evidence, and the clinical importance of the research. For example, it is possible to have methodologically sound (Category I) evidence about an area of practice that is of little clinical importance and therefore attracts a lower strength of recommendation. Alternatively, it is often necessary to extrapolate clinical recommendations from limited or low quality evidence, resulting in lower strength recommendations (B, C or D). Indeed in some circumstances, clinical recommendations are not based upon systematic evidence, but represent a consensus (practical or ethical) approach, indicated as S (standard of care).

Table I.1: Categories of evidence and strength of recommendations

Categories of evidence for causal relationships and treatment	
Ia	Evidence from meta-analysis of randomised controlled trials
Ib	Evidence from at least one randomised controlled trial
IIa	Evidence from at least one controlled study without randomisation
IIb	Evidence from at least one other type of quasi-experimental study
III	Evidence from non-experimental descriptive studies, such as comparative studies, correlation studies and case-control studies
IV	Evidence from expert committee reports or opinions and/or clinical experience of respected authorities
Categories of evidence for observational relationships	
I	Evidence from large representative population samples
II	Evidence from small, well-designed, but not necessarily representative samples
III	Evidence from non-representative surveys, case reports
IV	Evidence from expert committee reports or opinions and/or clinical experience of respected authorities
Strength of recommendation	
A	Directly based on Category I evidence
B	Directly based on Category II evidence or extrapolated recommendation from Category I evidence
C	Directly based on Category III evidence or extrapolated recommendation from Category I or II evidence
D	Directly based on Category IV evidence or extrapolated recommendation from Category I, II or III evidence
S	Standard of care

Sources: Shekelle, PG, Woolf, SH, Eccles, M & Grimshaw, J 1999, 'Clinical guidelines: developing guidelines', *British Medical Journal*, vol. 318, no. 7183, pp. 593–96; Lingford-Hughes AR, Welch S, Nutt DJ 2004, 'Evidence-based guidelines for the pharmacological management of substance misuse, addiction and comorbidity: recommendations from the British Association for Psychopharmacology', *Journal of Psychopharmacology*, vol. 18, no. 3, pp. 293–335.

The 2003 edition of the guidelines used the NHMRC levels of evidence hierarchy (I to IV) to summarise research evidence (NHMRC 2000), and a three-tier system for strength of recommendation (strong, moderate, fair). However, it did not directly link the recommendations to the evidence levels.

The framework adopted for this edition more closely links evidence to clinical recommendations, allowing for greater emphasis to be placed upon consensus recommendations and standards of care that reflect good clinical practice and avoiding therapeutic nihilism where there is insufficient evidence available.

Although experimental research evidence is the most appropriate way to determine the relative efficacy of one treatment against another, the effects seen in research trials might be diluted when the interventions are applied in normal clinical settings. Most trials examine the effects of interventions under highly controlled and relatively ideal conditions. Loss of effect can result from factors associated with the realities of health care delivery, such as the training and experience of clinicians, the faithfulness with which the intervention is delivered, and the time and resources available to implement the intervention. These problems are present in all areas of health care, although they are likely to be more marked in non-pharmacological and non-proprietary methods of intervention.

Evidence-based health care

A range of treatment procedures supported by current research and specialist opinion is described so clinicians can select those approaches that match the setting and patient needs. Individual clinicians may use the guidelines to guide but not to limit treatment needed for their individual patients. It is no longer appropriate for clinicians in Australia to continue using treatment approaches of uncertain efficacy when there are procedures for which there is now reasonable evidence of effectiveness. It is the responsibility of individual clinicians, as well as the government systems which support treatment provision, to ensure the treatments

made available are those believed to be the most effective. Interventions not described in these guidelines were excluded because there was no research supporting their effectiveness (based on the Review of the Evidence), or they were deemed irrelevant because of undeveloped research, or they were not easily implemented.

Community and population approaches to alcohol problems

A key limitation of treatment for alcohol problems is that it addresses the drinking of only a proportion of the risky and problem drinkers in our society, and only once these problems have become manifest. A comprehensive public health approach to reducing the harms associated with alcohol consumption (including injuries, violence and public disorder) also includes community-level responses aimed at preventing excessive use of alcohol. Like clinical interventions, these interventions should be supported by evidence of feasibility, effectiveness and cost-effectiveness (Ministerial Council on Drug Strategy 2006; RACP & RANZCP 2005). Such interventions include:

- Decreasing affordability through increased pricing, to be achieved by volumetric taxation reform (RACP & RANZCP 2005).
- Reducing access to alcohol through restricting outlet density in communities, blocking access altogether in specific locations (as in some Aboriginal communities) or to certain age groups (Livingston et al. 2007; Hogan et al. 2006).
- Restricting alcohol advertising (for example, those targeting high-risk groups, such as young people).
- Running campaigns to promote public awareness of risky patterns of alcohol use (for example, NHMRC 2009); however, the effectiveness of this approach is unclear (Babor et al. 2005; Loxley et al. 2004).
- Increasing the personal or community consequences associated with excessive drinking; for example, drink-drive legislation and random breath testing with associated penalties, workplace programs that lead to sanctions for presentations under the influence of alcohol (Ritter & Cameron 2006).

A note on terminology

These guidelines do not use any specific terminology to define the levels of drinking in relation to the *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* (NHMRC 2009). Where necessary, we indicate that the levels are either within or in excess of the current guidelines. Alcohol consumption is described in terms of standard drinks (see Glossary). Specific diagnostic terms, definitions of alcohol-related harm and risk levels, and some traditional terms describing levels and patterns of drinking, are also included in the Glossary.

These guidelines use the term patient rather than client or consumer to refer to the person seeking treatment for a drinking problem. Some evidence shows that users of treatment services themselves prefer the term. The authors acknowledge that some health professionals prefer not to use the term.

Further, the authors avoid using the term alcoholic except as an adjective, such as alcoholic liver disease. In these guidelines the term 'problem drinker' is used to indicate a person with alcohol-related problems without specific diagnosis.