Complete Summary

GUIDELINE TITLE

The management of harmful drinking and alcohol dependence in primary care. A national clinical guideline.

BIBLIOGRAPHIC SOURCE(S)

Scottish Intercollegiate Guidelines Network (SIGN). The management of harmful drinking and alcohol dependence in primary care. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2003 Sep. 39 p. (SIGN publication; no. 74). [158 references]

GUIDELINE STATUS

This is the current release of the guideline.

Any amendments to the guideline in the interim period will be noted on Scottish Intercollegiate Guidelines Network (SIGN) Web site.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- May 2, 2007, Antidepressant drugs: Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Harmful drinking and alcohol dependence

GUIDELINE CATEGORY

Counseling
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Emergency Medicine
Family Practice
Internal Medicine
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Pharmacists
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

To provide evidence-based recommendations for the management of patients with harmful drinking and alcohol dependence

TARGET POPULATION

Patients with alcohol dependence, hazardous or harmful drinking seen in primary care (general practice and community nursing) and among those attending, but not admitted from, Accident & Emergency (A&E) Departments

The guideline does not address some specific situations:

- patients already in specialist care
- patients admitted to general or psychiatric hospitals
- driving

- drinking related to vocational or professional issues (e.g., for van drivers, surgeons, or teachers with alcohol problems)
- adolescents with an alcohol problem
- child safety
- the management of alcohol-related organ damage
- treatment of carers and family members of patients with an alcohol problem.

INTERVENTIONS AND PRACTICES CONSIDERED

Evaluation

1. Clinical history and patient self-assessment
2. Screening tests:
    - AUDIT (Alcohol Use Disorders Identification Test)
    - CAGE (Attempts to **C**ut back on drinking, being **A**nnoyed at criticisms about drinking, feeling **G**uilty about drinking, and using alcohol as an **E**ye-opener)
    - FAST (Fast Alcohol Screening Test)
    - PAT (Paddington Alcohol Test)
    - TWEAK (**T**olerance to the effects of alcohol, **W**orry about drinking, **E**ye-opener, **A**mnesia, felt the need to **K** cut down on your drinking)
    - T-ACE (**T**olerance, **A**nnoyed by someone criticizing your drinking, felt the need to **C**ut down, **E**ye-opener)
3. Biological markers including mean red blood cell volume (MCV), serum gamma glutamyl transferase (GGT), and carbohydrate deficient transferring (CDT)
4. Blood alcohol count (BAC)

Management

1. Brief interventions in the primary care, accident & emergency, and antenatal setting
2. Motivational interviewing
3. Detoxification in the primary care setting and the inpatient setting
4. Pharmacological detoxification including benzodiazepines (diazepam, chlordiazepoxide), clomethiazole, antiepileptic drugs, antipsychotic drugs, and vitamin supplements
5. Hospital admission for delirium tremens
6. Referral and follow-up
7. Psychosocial interventions (e.g., Alcoholic Anonymous)
8. Acamprosate or disulfiram for prevention of relapse
9. Selective serotonin reuptake inhibitor (SSRI) for patients with anxiety or depression

MAJOR OUTCOMES CONSIDERED

- Presence of comorbid physical and/or psychiatric illness
- Total alcohol consumption
- Episodes of binge drinking
- Length of time of sobriety/reduced alcohol consumption following intervention
- Number and severity of relapses

- Morbidity and mortality associated with harmful drinking and alcohol dependence

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

A systematic review of the literature was carried out using an explicit search strategy devised by a Scottish Intercollegiate Guidelines Network (SIGN) Information Officer. Databases searched include Medline, Embase, Healthstar, Cinahl, PsychINFO, Alcohol and Alcoholism, and the Cochrane Library. The year range covered was 1995 to 2001. Internet searches were carried out on various Web sites including the New Zealand Guidelines Programme, the UK Health Technology Assessment programme, the National Institute on Alcohol Abuse and Alcoholism Alcohol (NIAAA) and Alcohol Problems Science Database (ETOH), and the US National Guidelines Clearinghouse. The Medline version of the main search strategies can be found on the SIGN Web site in the section covering supplementary guideline material. The main searches were supplemented by material identified by individual members of the development group. All selected papers were evaluated by two members of the group using standard SIGN methodological checklists before conclusions were considered as evidence.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1++: High quality meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs with a very low risk of bias

1+: Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias

1-: Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias

2++: High quality systematic reviews of case control or cohort studies

High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+: Well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2-: Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3: Nonanalytic studies (e.g. case reports, case series)

4: Expert opinion

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The Scottish Intercollegiate Guidelines Network (SIGN) carries out comprehensive systematic reviews of the literature using customized search strategies applied to a number of electronic databases and the Internet. This is often an iterative process whereby the guideline development group will carry out a search for existing guidelines and systematic reviews in the first instance and, after the results of this search have been evaluated, the questions driving the search may be redefined and focused before proceeding to identify lower levels of evidence.

Once papers have been selected as potential sources of evidence, the methodology used in each study is assessed to ensure its validity. SIGN has developed checklists to aid guideline developers to critically evaluate the methodology of different types of study design. The result of this assessment will affect the level of evidence allocated to the paper, which in turn will influence the grade of recommendation it supports.

Additional details can be found in the companion document titled "An Introduction to the SIGN Methodology for the Development of Evidence-based Clinical Guidelines" (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50]). Available from the SIGN Web site.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The process for synthesizing the evidence base to form graded guideline recommendations is illustrated in the companion document titled "An Introduction to the SIGN Methodology for the Development of Evidence-based Clinical

Guidelines." (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50], available from the SIGN Web site.

Evidence tables should be compiled, summarizing all the validated studies identified from the systematic literature review relating to each key question. These evidence tables form an important part of the guideline development record and ensure that the basis of the guideline development group's recommendations is transparent.

In order to address how the guideline developer was able to arrive at their recommendations given the evidence they had to base them on, SIGN has introduced the concept of considered judgement.

Under the heading of considered judgement, guideline development groups are expected to summarise their view of the total body of evidence covered by each evidence table. This summary view is expected to cover the following aspects:

- Quantity, quality, and consistency of evidence
- Generalisability of study findings
- Applicability to the target population of the guideline
- Clinical impact (i.e., the extent of the impact on the target patient population, and the resources need to treat them.)

Guideline development groups are provided with a pro forma in which to record the main points from their considered judgement. Once they have considered these issues, the group is asked to summarise their view of the evidence and assign a level of evidence to it, before going on to derive a graded recommendation.

The assignment of a level of evidence should involve all those on a particular guideline development group or subgroup involved with reviewing the evidence in relation to each specific question. The allocation of the associated grade of recommendation should involve participation of all members of the guideline development group. Where the guideline development group is unable to agree on a unanimous recommendation, the difference of opinion should be formally recorded and the reason for dissent noted.

The recommendation grading system is intended to place greater weight on the quality of the evidence supporting each recommendation, and to emphasise that the body of evidence should be considered as a whole, and not rely on a single study to support each recommendation. It is also intended to allow more weight to be given to recommendations supported by good quality observational studies where randomised controlled trials (RCTs) are not available for practical or ethical reasons. Through the considered judgement process guideline developers are also able to downgrade a recommendation where they think the evidence is not generalisable, not directly applicable to the target population, or for other reasons is perceived as being weaker than a simple evaluation of the methodology would suggest.

On occasion, there is an important practical point that the guideline developer may wish to emphasise but for which there is not, nor is their likely to be, any research evidence. This will typically be where some aspect of treatment is

regarded as such sound clinical practice that nobody is likely to question it. These are marked in the guideline as "good practice points." It must be emphasized that these are not an alternative to evidence-based recommendations, and should only be used where there is no alternative means of highlighting the issue.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

A: At least one meta-analysis, systematic review of randomized controlled trials (RCTs), or RCT rated as 1++ and directly applicable to the target population; *or*

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B: A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; *or*

Extrapolated evidence from studies rated as 1++ or 1+

C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; *or*

Extrapolated evidence from studies rated as 2++

D: Evidence level 3 or 4; *or*

Extrapolated evidence from studies rated as 2+

COST ANALYSIS

Cost Effectiveness of Disulfiram and Acamprosate

The health technology assessment by the National Health Service (NHS) Quality Improvement Scotland included meta-analyses of the efficacy and cost effectiveness of medications for relapse prevention and found evidence of efficacy for disulfiram (supervised) and acamprosate. This was also the conclusion of a health technology assessment by the Swedish Council on Technology Assessment in Health Care and a literature review for the Aberdeen Health Economics Research Unit

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A national open meeting is the main consultative phase of Scottish Intercollegiate Guidelines Network (SIGN) guideline development, at which the guideline development group presents its draft recommendations for the first time. The national open meeting for this guideline was held on 29 April 2002 and was attended by around 150 representatives of all the key specialties relevant to the guideline. The draft guideline was also available on the SIGN Web site for a limited period at this stage to allow those unable to attend the meeting to contribute to the development of the guideline.

The guideline was also reviewed in draft form by a panel of independent expert referees, who were asked to comment primarily on the comprehensiveness and accuracy of interpretation of the evidence base supporting the recommendations in the guideline.

As a final quality control check, the guideline is reviewed by an Editorial Group comprising the relevant specialty representatives on SIGN Council to ensure that the specialist reviewers´ comments have been addressed adequately and that any risk of bias in the guideline development process as a whole has been minimised.

Each member of the guideline development group then approved the final guideline for publication.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from the Scottish Intercollegiate Guidelines Network (SIGN) and National Guideline Clearinghouse (NGC): In addition to these evidence-based recommendations, the guideline development group also identifies points of best clinical practice in the original guideline document.

The strength of recommendation grading (A-D) and level of evidence (1++, 1+, 1-, 2++, 2+, 2-, 3, 4) are defined at the end of the "Major Recommendations" field.

Detection and Assessment

Clinical History

D - Primary care workers should be alerted by certain presentations and physical signs to the possibility that alcohol is a contributing factor and should ask about alcohol consumption.

Screening

B - Abbreviated forms of Alcohol Use Disorders Identification Test (AUDIT) *(e.g., Fast Alcohol Screening Test (FAST))*, or Attempts to **C**ut back on drinking, being **A**nnoyed at criticisms about drinking, feeling **G**uilty about drinking, and using alcohol as an **E**ye-opener (CAGE) plus two consumption questions, should be used in primary care when alcohol is a possible contributory factor.

C - In Accident & Emergency (A&E), FAST or Paddington Alcohol Test (PAT) should be used for people with an alcohol related injury.

B – **T**olerance to the effects of alcohol, **W**orry about drinking, **E**ye-opener, **A**mnesia, felt the need to **K** cut down on your drinking (TWEAK) and **T**olerance, **A**nnoyed by someone criticizing your drinking, felt the need to **C**ut down, **E**ye-opener (T-ACE) (or shortened versions of AUDIT) should be used in antenatal and preconception consultations.

Biological Markers

B - Biological tests are useful when there is reason to believe that self reporting may be inaccurate.

Brief Interventions

A – General Practitioners (GPs) and other primary care health professionals should opportunistically identify hazardous and harmful drinkers and deliver a brief (10 minute) intervention.

A - The intervention should, whenever possible, relate to the patient´s presenting problem and should help the patient weigh up any benefits as perceived by the patient, versus the disadvantages of the current drinking pattern.

D - Training for general practitioners, practice nurses, community nurses, and health visitors in the identification of hazardous drinkers and delivery of a brief intervention should be available.

B - Routine antenatal care provides a useful opportunity to deliver a brief intervention for reducing alcohol consumption.

B - Motivational interviewing techniques should be considered when delivering brief interventions for harmful drinking in primary care.

Detoxification

D - When medication to manage withdrawal is not needed, patients should be informed that at the start of detoxification they may feel nervous or anxious for several days, with difficulty in going to sleep for several nights.

A - Benzodiazepines should be used in primary care to manage withdrawal symptoms in alcohol detoxification, but for a maximum period of seven days.

D - For patients managed in the community, chlordiazepoxide is the preferred benzodiazepine.

D - Clomethiazole should not be used in alcohol detoxification in primary care.

C - Provided attention is paid to any acute or chronic physical illness, elderly patients should be managed the same way as younger patients.

B - Antiepileptic medication should not be used as the sole medication for alcohol detoxification in primary care.

B - Antipsychotic drugs should not be used as first line treatment for alcohol detoxification.

D - Patients with any sign of Wernicke-Korsakov syndrome should receive Pabrinex in a setting with adequate resuscitation facilities. The treatment should be according to British National Formulary (BNF) recommendations and should continue over several days, ideally in an inpatient setting.

D - Local protocols for admitting patients with delirium tremens should be in place.

Referral and Follow Up

A - Access to relapse prevention treatments of established efficacy should be facilitated for alcohol dependent patients.

B - When the patient has an alcohol related physical disorder, the alcohol treatment agency should have close links with the medical and primary care team.

D - The principles of stepped care should be followed for patients with alcohol problems and dependence.

B - Primary care teams should maintain contact over the long term with patients previously treated by specialist services for alcohol dependence.

C - Alcohol dependent patients should be encouraged to attend Alcoholics Anonymous.

D - If patients are referred to a lay service, agencies where lay counsellors use motivational interviewing and coping skills training should be utilised.

Medications to Prevent Relapse

B - Acamprosate is recommended in newly detoxified dependent patients as an adjunct to psychosocial interventions.

C - Supervised oral disulfiram may be used to prevent relapse but patients must be informed that this is a treatment requiring complete abstinence and be clear about the dangers of taking alcohol with it.

Alcohol Dependence and Psychiatric Illness

B - Patients with an alcohol problem and anxiety or depression should be treated for the alcohol problem first.

B - If depressive symptoms persist for more than two weeks following treatment for alcohol dependence, consideration should be given to using a selective serotonin reuptake inhibitor (SSRI) or referring for counseling or specialist psychological treatment along with the relapse prevention treatment.

D - If severe anxiety symptoms persist for more than two weeks in abstinent patients, consideration should be given to using a selective serotonin reuptake inhibitor (SSRI), or referring for specialist psychological treatment along with the relapse prevention treatment.

B - Patients with psychotic disorder and alcohol dependence should be encouraged to address their alcohol use and may benefit from motivational, cognitive behavioural, family, and nonconfrontational approaches.

Advising Families

C - The primary care team should help family members to use behavioural methods which will reinforce reduction of drinking and increase the likelihood that the drinker will seek help.

Definitions:

Grades of Recommendation

A: At least one meta-analysis, systematic review of randomized controlled trials (RCTs), or RCT rated as 1++ and directly applicable to the target population; *or*

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B: A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; *or*

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D: Evidence level 3 or 4; *or*

Extrapolated evidence from studies rated as 2+

Levels of Evidence

1++: High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias

1+: Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias

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3: Nonanalytic studies (e.g. case reports, case series)

4: Expert opinion

CLINICAL ALGORITHM(S)

Algorithms are provided in the original guideline document for "Screening and Brief Interventions" and "Assisting Withdrawal from Alcohol" (see Annex 7 in the original guideline document)

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Improved detection and treatment of alcohol problems within primary care settings
- Reduced total alcohol consumption and episodes of binge drinking
- Increased length of time of sobriety/reduced alcohol consumption
- Effective use of medication for alcohol dependence detoxification
- Decreased number of relapses
- Reduced depressive symptoms and anxiety in patients with comorbid psychiatric illness

POTENTIAL HARMS

Screening

- False positive results may occur with serum gamma glutamyl transferase (GGT) and mean red blood cell volume (MCV) due to other causes of elevation.

Medication

Benzodiazepines

- Benzodiazepines can cause temporary cognitive slowing and may interfere with learning and planning. This, and the need to avoid benzodiazepine dependence, are reasons for keeping the length of treatment to a maximum of seven days.
- All benzodiazepines have a potential for misuse, but diazepam is the benzodiazepine most associated with misuse and alcohol related fatality. If used in community detoxification, diazepam requires supervision to avoid misuse.
- The risk of accumulation of benzodiazepine in the elderly patient needs to be considered.

Pabrinex

- There is a very small risk of anaphylaxis with parenteral vitamin supplementation. This is less likely with the intramuscular route. There has been one case of anaphylaxis solely attributable to intramuscular Pabrinex since 1996.

Disulfiram

- Disulfiram has unwanted effects in some patients, and carries special warnings.

Fluoxetine

- Fluoxetine seems to reduce the beneficial effect of cognitive behavioural therapy in the type of patients characterised by early onset and prominent social problems. Therefore caution should be exercised in prescribing selective serotonin reuptake inhibitors (SSRIs) to patients characterised by early onset of alcohol problems and antisocial behaviour.

CONTRAINDICATIONS

CONTRAINDICATIONS

Situations Where Inpatient Detoxification Would be Advised

The following list is based on expert opinion and comprises validated and best practice contraindications to managing withdrawal at home.

Hospital detoxification is advised if the patient:

- is confused or has hallucinations
- has a history of previously complicated withdrawal
- has epilepsy or a history of fits
- is undernourished
- has severe vomiting or diarrhoea
- is at risk of suicide
- has severe dependence coupled with unwillingness to be seen daily
- has a previously failed home-assisted withdrawal
- has uncontrollable withdrawal symptoms
- has an acute physical or psychiatric illness
- has multiple substance misuse
- has a home environment unsupportive of abstinence

Note: If admission to hospital is unavailable or the patient refuses, specialist opinion should be sought to aid risk assessment.

QUALIFYING STATEMENTS

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This guideline is not intended to be construed or to serve as a standard of medical care. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor, following discussion of the options with the patient, in light of the diagnostic and treatment choices available. It is advised however, that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient´s case notes at the time the relevant decision is taken.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Implementation of national clinical guidelines is the responsibility of local National Health Service (NHS) organizations and is an essential part of clinical governance. It is acknowledged that not every guideline can be implemented immediately on publication, but mechanisms should be in place to ensure that the care provided is reviewed against the guideline recommendations and the reasons for any differences assessed and, where appropriate, addressed. These discussions should involve both clinical staff and management. Local arrangements may then be made to implement the national guideline in individual hospitals, units and practices, and to monitor compliance. This may be done by a variety of means including patient-specific reminders, continuing education and training, and clinical audit.

Key points for audit are identified in the original guideline document.

IMPLEMENTATION TOOLS

Clinical Algorithm
Patient Resources
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Scottish Intercollegiate Guidelines Network (SIGN). The management of harmful drinking and alcohol dependence in primary care. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2003 Sep. 39 p. (SIGN publication; no. 74). [158 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Sep

GUIDELINE DEVELOPER(S)

Scottish Intercollegiate Guidelines Network - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

Scottish Executive Health Department

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All members of the Scottish Intercollegiate Guidelines Network (SIGN) guideline development groups are required to complete a declaration of interests, both personal and non-personal. A personal interest involves payment to the individual concerned (e.g., consultancies or other fee-paid work commissioned by or shareholdings in the pharmaceutical industry); a non-personal interest involves payment which benefits any group, unit or department for which the individual is responsible (e.g., endowed fellowships or other pharmaceutical industry support). Details of the declarations of interest of any guideline development group member(s) are available from the Scottish Intercollegiate Guidelines Network executive.

GUIDELINE STATUS

This is the current release of the guideline.

Any amendments to the guideline in the interim period will be noted on Scottish Intercollegiate Guidelines Network (SIGN) Web site.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Scottish Intercollegiate Guidelines Network (SIGN) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Quick reference guide: The management of harmful drinking and alcohol dependence in primary care, Scottish Intercollegiate Guidelines Network, 2003. 1 p. Available in Portable Document Format (PDF) from the Scottish Intercollegiate Guidelines Network (SIGN) Web site.
- SIGN 50: A guideline developer´s handbook. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network. (SIGN publication; no. 50). Available from the SIGN Web site.
- Appraising the quality of clinical guidelines. The SIGN guide to the AGREE (Appraisal of Guidelines Research & Evaluation) guideline appraisal instrument. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network, 2001. Available from the SIGN Web site.
- Slattery J, Chick J, Cochrane M, Craig J, Godfrey C, Kohli H, Macpherson K, Parrott S, Quinn S, Single A, Tochel C, Watson H. Prevention of relapse in alcohol dependence. Health Technology Assessment Report 3. Glasgow (Scotland): Health Technology Board for Scotland; 2003. Available in Portable Document Format (PDF) from the Scottish Medicines Consortium.

PATIENT RESOURCES

The following are available:

- Understanding HTBS advice: prevention of relapse in alcohol dependence. Glasgow (Scotland): Health Technology Board for Scotland; 2002 Dec. Available in Portable Document Format (PDF) from the Scottish Medicines Consortium.
- Advice to patients on withdrawing from alcohol at home. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 1 p. Electronic copies: Available in Portable Document Format (PDF) from the SIGN Web site.

NGC STATUS

This NGC summary was completed by ECRI on May 3, 2004. The information was verified by the guideline developer on December 1, 2004. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This summary was updated by ECRI Institute on November 6, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs.

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Readers with questions regarding guideline content are directed to contact the guideline developer.

Date Modified: 9/22/2008


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