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The management of harmful drinking and alcohol dependence in primary care

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KEY TO EVIDENCE STATEMENTS AND GRADES OF RECOMMENDATIONS

LEVELS OF EVIDENCE

1^{++}	High quality meta-analyses, systematic reviews of randomised 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	Non-analytic studies, e.g. case reports, case series
4	Expert opinion

GRADES OF RECOMMENDATION

Note: 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 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^{+}

GOOD PRACTICE POINTS

O	Recommended best practice based on the clinical experience of the guideline development group

1 Introduction

1.1 THE NEED FOR A GUIDELINE

Harmful drinking and alcohol dependence are common conditions which contribute considerably to morbidity, mortality and burden to the NHS, as well as causing social harm:

- in the Scottish population, at any one time 250,000 people report symptoms of mild alcohol dependence, and 16,000 report moderate to severe symptoms[1]
- deaths attributed to alcohol misuse more than doubled between 1990 and 1999 and they continue to rise[2]
- alcohol dependent patients consult their general practitioners (GPs) about twice as frequently as other patients in a practice[3,4]
- alcohol dependence and alcohol related diagnoses have been rising among patients discharged from Scottish general hospitals[2]
- Accident and Emergency (A&E) attendance surveys conducted in Glasgow[5] and Edinburgh[6,7] have noted a high burden to the A&E service of problems related to serious alcohol misuse
- there is widespread variation in practice, interest, knowledge and experience in dealing with alcohol dependence amongst healthcare professionals in primary care.[8]

1.2 DEFINITIONS

1.2.1 UNIT OF ALCOHOL

One "unit" in the UK usually means a beverage containing 8 g of ethanol, eg a half pint of 3.5% beer or lager, or one 25 ml pub measure of spirits. A small (125 ml) glass of average strength (12%) wine contains 1.5 units *(see Annex 7 for a list of the alcohol content of a range of beverages)*.

1.2.2 HAZARDOUS DRINKING

The term hazardous drinking is widely used. It is synonymous with "at-risk drinking" and can be defined as the regular consumption of:

- over 40 g of pure ethanol (5 units) per day for men
- over 24 g of pure ethanol (3 units) per day for women.

These figures derive from population studies showing the relationship of self reported levels of drinking to risk of harm. It is arbitrary which point on the risk curve is deemed to merit a warning.[9-13] Other authorities have quoted weekly recommended upper limits for alcohol consumption of 21 units per week for men and 14 units per week for women.[14]

Consuming over 40 g/day alcohol on average doubles a man's risk for liver disease, raised blood pressure, some cancers (for which smoking is a confounding factor) and violent death (because some people who have this average alcohol consumption drink heavily on some days). For women, over 24 g/day average alcohol consumption increases their risk for developing liver disease and breast cancer.[9-12] These studies used self reported consumption figures.

The term hazardous drinking is also used loosely to cover those who have experienced minimal as opposed to serious harm.

1.2.3 HARMFUL DRINKING

Harmful drinking is defined in the International Classification of Diseases (ICD-10) as a pattern of drinking that causes damage to physical (eg to the liver) or mental health (eg episodes of depression secondary to heavy consumption of alcohol).[15] The diagnosis requires that actual damage should have been caused to the mental or physical health of the user.

1.2.4 ALCOHOL DEPENDENCE

Alcohol dependence is defined as a cluster of physiological, behavioural, and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that previously had greater value.[15] A central characteristic is the desire (often strong, sometimes perceived as overpowering) to drink alcohol. Return to drinking after a period of abstinence is often associated with rapid reappearance of the features of the syndrome (priming).

A definitive diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous year:

- a strong desire or sense of compulsion to take alcohol
- difficulty in controlling drinking in terms of its onset, termination or level of use
- a physiological withdrawal state when drinking has ceased or been reduced (eg tremor, sweating, rapid heart rate, anxiety, insomnia, or less commonly seizures, disorientation or hallucinations) or drinking to relieve or avoid withdrawal symptoms
- evidence of tolerance, such that increased doses of alcohol are required in order to achieve effects originally produced by lower doses (clear examples of this are found in drinkers who may take daily doses sufficient to incapacitate or kill non-tolerant users)
- progressive neglect of alternative pleasures or interests because of drinking and increased amount of time necessary to obtain or take alcohol or to recover from its effects (salience of drinking)
- persisting with alcohol use despite awareness of overtly harmful consequences, such as harm to the liver, depressive mood states consequent to periods of heavy drinking, or alcohol related impairment of cognitive functioning.

1.3 POPULATION COVERED BY THE GUIDELINE

This guideline pertains to patients with alcohol dependence, hazardous or harmful drinking, in primary care (general practice and community nursing) and among those attending, but not admitted from, 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 eg 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.

A health technology assessment has been performed by NHS Quality Improvement Scotland on the prevention of relapse in alcohol dependence in specialist settings, which complements this guideline *(see Annex 8)*.

1.4 STATEMENT OF INTENT

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.

1.5 REVIEW AND UPDATING

This guideline was issued in 2003 and will be considered for review as new evidence becomes available.

2 Detection and assessment

2.1 CLINICAL HISTORY

There is evidence from clinical and epidemiological studies of a relationship between heavy drinking and certain clinical presentations (injuries, physical and psychiatric illnesses, frequent sickness absence) and social problems (*see Annex 2*). There are some signs at physical examination recognised by experts as linked to heavy drinking, such as injuries (including in the elderly), tremor of the hands and tongue, and excessive capillarisation of the facial skin and conjunctivae.[16,17] The exact association between these signs and actual heavy drinking has not been thoroughly investigated. 4

Research suggests that most people are not offended by being asked about their alcohol consumption and will give a reliable account if there is no sanction anticipated.[18,19]

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.**

2.1.1 THE ACCURACY OF SELF ASSESSMENT

Although evidence is not consistent, patients in research projects tend to report consumption that correlates with blood tests and is fairly close to that reported by their family.[20] It is not known if this is true for UK primary care consultations, where the GP may be perceived by the patient as having several roles, and where fears of employment, legal or insurance consequences affect what patients disclose to the GP. 2^{+}

Severely dependent drinkers may not want to admit a pattern of drinking, which they prefer to continue, or feel they cannot alter. Shame or guilt may lead some drinkers to minimise their reported consumption.[21]

O While most patients are factual about their drinking, the primary care team should recognise that some will under-report their consumption at times.

2.2 SCREENING FOR ALCOHOL DEPENDENCE AND THOSE AT RISK

There is a large volume of good quality evidence indicating that appropriate screening helps the detection and treatment of alcohol problems *(see Annex 2 for a list of alerts)*. This evidence has consistently shown that screening using the Alcohol Use Disorders Identification Test (AUDIT) is effective within primary care, A&E, pre- and antenatal settings. The AUDIT is more sensitive in the detection of hazardous drinking than 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; positive answers to two or more ⇒ probable alcohol dependence), unless CAGE is supplemented with questions on maximum daily and total weekly consumption (CAGE plus two).[22-33] 1^{++} 2^{++} 2^{+}

The scoring procedure for AUDIT can be difficult to memorise, and the questionnaire itself can take five minutes to complete. Abbreviated versions of AUDIT are preferred by many primary care workers, and accuracy is only slightly diminished. These include the Fast Alcohol Screening Test (FAST; *see Annex 3*), which is a thirty second version of the AUDIT and the Paddington Alcohol Test (PAT; *see Annex 4*).[22,31] TWEAK and T-ACE are abbreviated screening tools found to be particularly appropriate for A&E and obstetric settings.[25,26]

B **Abbreviated forms of AUDIT** *(eg FAST)***, or CAGE plus two consumption questions, should be used in primary care when alcohol is a possible contributory factor.**

C **In A&E, FAST or PAT should be used for people with an alcohol related injury.**

B **TWEAK and T-ACE** *(or shortened versions of AUDIT)* **should be used in antenatal and preconception consultations.**

When a patient registers with a GP, a medical history is taken which includes questions on alcohol consumption.[34] A screening questionnaire at this point is a useful tool for identifying hazardous drinking.

O When new patients register with a GP they should be asked about weekly and maximum daily alcohol consumption, or an appropriate screening tool should be used.

The screening and brief interventions algorithm shown in Box 1 in section 3.1 is based on the UK Alcohol Forum guidelines for the management of alcohol problems in primary care and general psychiatry[35] and is a useful tool to aid decision making.

2.3 BIOLOGICAL MARKERS OF ALCOHOL PROBLEMS

2.3.1 MARKERS OF ALCOHOL PROBLEMS

Elevations in mean red blood cell volume (MCV), serum gamma glutamyl transferase (GGT) and carbohydrate deficient transferrin (CDT) are markers of heavy drinking in preceding weeks. The difficulty in assessing their accuracy as diagnostic tests has been that self reported consumption is used as the "gold standard" but sometimes a biological marker may be more accurate than a self report.[36-38]

False positive results occur with GGT and MCV due to other causes of elevation. False positive MCV can occur as a result of vitamin B12 deficiency, folic acid deficiency, thyroid disease or chronic liver disease. False positives with GGT are due to other causes of liver disease or enzyme induction including some drugs. CDT is normal in mild to moderate liver disease. It may be raised in severe liver disease, but otherwise gives few false positives. If elevated due to alcohol, it remains elevated for several weeks after consumption has reduced. It will not detect a recent relapse. CDT may be a more accurate marker of very recent (past two weeks') drinking than GGT.[39,40] 2^+

As CDT measurement is not available within Scotland, it is recommended only when there is clinical difficulty in interpreting a normal or an abnormal GGT or other liver test result. King's College Hospital, London accept serum samples by post for CDT assay.

Biological tests are of less value than self reports for screening with the intention of intervention. They have their greatest role where patients have a reason for minimising (or, less commonly, exaggerating) their consumption, and in monitoring patients' progress in reducing their drinking.

Even though these tests have limited sensitivity and specificity, if elevated in a given patient, they may help motivate a patient to reduce drinking and they are then useful in monitoring change in consumption.

2.3.2 BLOOD ALCOHOL CONCENTRATION

Blood alcohol concentration (BAC), normally measured by reference to breath alcohol, can contribute to screening[41] and is valuable for monitoring patients during detoxification in the community, as well as following progress thereafter. Breathalysers permit estimates to be made of very recent alcohol consumption and are often used by specialist nurses in the community. A breathalyser is a useful item of equipment in a Health Centre and in A&E. 2^+

Saliva alcohol tests also give a reliable estimate of BAC.[42,43]

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

O Biological tests are useful to motivate patients to review their drinking and to consider change.

O Biological tests should be used to monitor patients' progress in reducing their drinking.

O A&E departments and health workers regularly dealing with alcohol problems in the community should have access to a breathalyser.

2.4 PRESENTATION IN CRISIS

Patients presenting in crisis may place the primary care team in difficult situations. There is no evidence on how best to approach these encounters. This section discusses some possible common sense solutions.

2.4.1 PATIENT IN CRISIS

Suicidal threats or demands for immediate but undefined "help" require assessment, preferably within the surgery or by the out-of-hours service. Listening to the patient's concerns may help to alleviate the pressure on the healthcare professional to take additional action. Immediate admission is rarely indicated or possible but, if suicidal ideation persists it may be needed, in which case referral to psychiatric services is appropriate.

2.4.2 DRUNK PATIENTS ON THE TELEPHONE, OR IN PERSON, EXPRESSING THREATS

Physically threatening behaviour should be dealt with by calling the police.[44] Drunk patients should be listened to politely and with courtesy, as showing frustration may inflame the situation. The patient may respond to being listened to politely and may be gently encouraged to go home. Drunk patients on the telephone can be disruptive to surgery function and also out-of-hours services as they may block the line. Having given due consideration and advice on who to contact when the patient is sober, it may be appropriate to terminate the call. At times, it may be quicker to see these patients.

2.4.3 DOMESTIC ABUSE

The domestic violence/abuse liaison officers at police stations provide advice to victims of domestic abuse and can put them in touch with support systems, whether or not they wish to prosecute their partner. Sometimes the police arrest and charge the aggressor, even if the victim will not give evidence. The victim may need to be removed to a place of safety such as a refuge.

2.4.4 ORGANIC BRAIN DAMAGE

Community management of patients with organic brain damage can be difficult. They often do not attend appointments. The community nursing team may be able to offer advice and support to the patient. A community care assessment by the social work department may be needed. If drinking continues to be problematic, sometimes patients will agree to an arrangement with their family or their social worker such that, at any one time, they only have access to small amounts of their money.

3 Brief interventions for hazardous and harmful drinking

Within the literature, the terms "brief" and "minimal" interventions cover a range from one five minute interaction to several 45 minute sessions. The major positive studies discussed in this section typically consist of one interaction lasting between five and 20 minutes, sometimes with one brief follow up contact.

The acronym FRAMES[45] captures the essence of the interventions commonly tested under the terms "brief intervention" and "motivational interviewing":

- **F**eedback: about personal risk or impairment
- **R**esponsibility: emphasis on personal responsibility for change
- **A**dvice: to cut down or abstain if indicated because of severe dependence or harm
- **M**enu: of alternative options for changing drinking pattern and, jointly with the patient, setting a target; intermediate goals of reduction can be a start
- **E**mpathic interviewing: listening reflectively without cajoling or confronting; exploring with patients the reasons for change as they see their situation
- **S**elf efficacy: an interviewing style which enhances peoples' belief in their ability to change.

This guideline uses "brief intervention" throughout to cover short duration interventions which use the FRAMES style. The efficacy studies on brief interventions quoted have almost always excluded alcohol dependent patients because they were deemed inappropriate for this intervention.

3.1 BRIEF INTERVENTIONS IN GENERAL PRACTICE

There is consistent evidence from a large number of studies that brief intervention in primary care can reduce total alcohol consumption and episodes of binge drinking in hazardous drinkers, for periods lasting up to a year. There is limited evidence that this effect may be sustained for longer periods. All groups under study reduced alcohol consumption, but those with brief interventions did so to a greater extent than those in control groups. Very brief interventions (5-10 minutes) may have a similar effect to extended interventions (20-45 minutes or several visits), although the evidence is not consistent.[46-57] 1++ 1+

Studies have varied in whether the intervention is given on the day of detection or later, without revealing a preferred timing. Some successful studies have used a booster contact (a follow up intervention at a later date).[58,59]

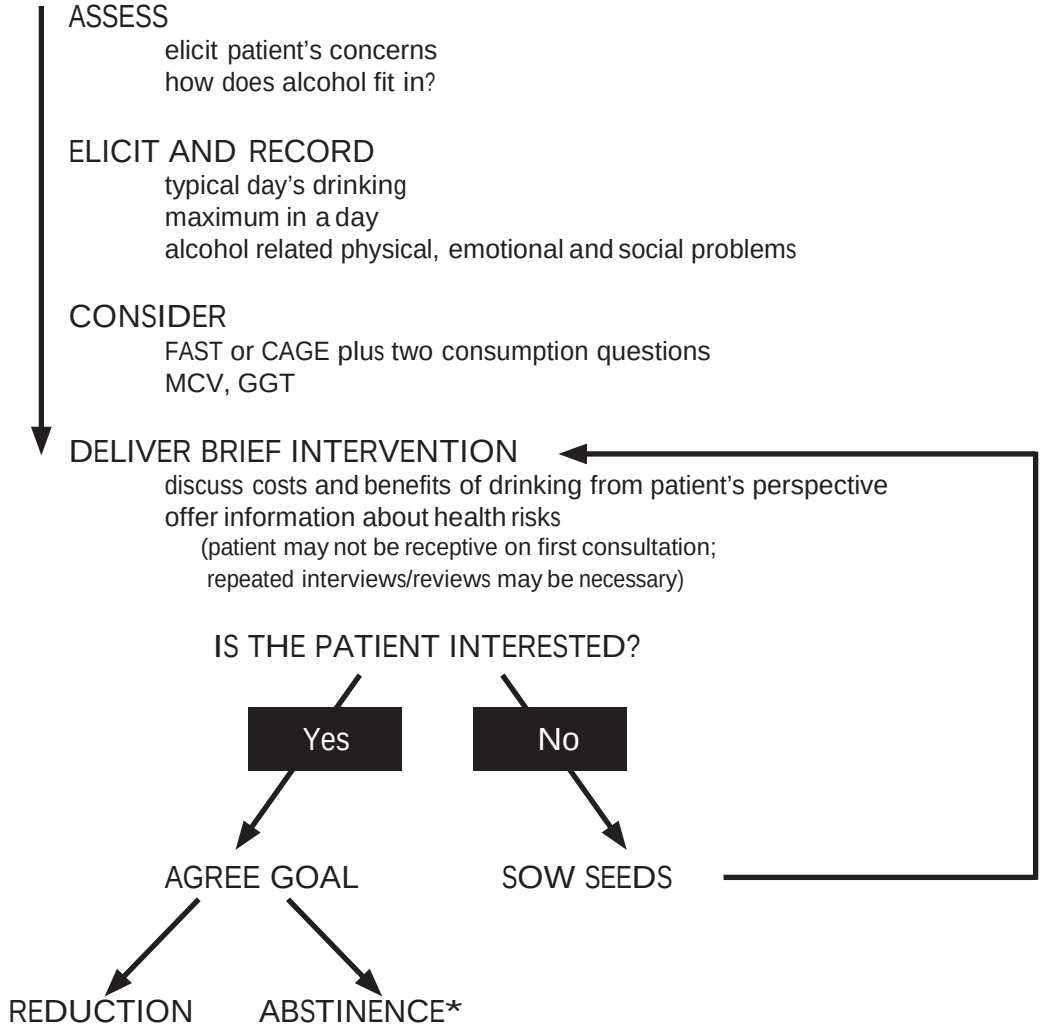
There is some evidence that the use of written media such as booklets or leaflets enhances the efficacy of brief interventions.[60]

The optimum type of intervention is still to be defined. Sometimes "advice" is given, while at other times the style of interaction epitomised in "motivational interviewing" has been used. Additionally, the comparative value of opportunistic intervention, versus intervention after population screening is not clear.

Data on follow up beyond one year are very limited.[61] One study found that the effect had disappeared at 10 years.[62] Another found a continuing small effect at four years.[63] A 10-16 year follow up of a sample recruited in a screening project found that intervening had reduced mortality, but the original intervention comprised sessions repeated regularly over up to two years – much more than a brief intervention.[64] 1+ 3 4

The evidence does not support the use of brief interventions for more severely affected patients seeking treatment.[57] A brief intervention is effective at the point when the hazardous or harmful drinker is newly identified (ie an opportunistic encounter).[54] This may be during attendance for a related or even unrelated illness or injury, at health screening for employment or insurance purposes, or at the time of registering with the practice *(see Box 7)*.

Box 1: Screening and brief interventions



Assisting goal of reduction	Assisting goal of abstinence
Elicit patient's concerns	Enlist support of family and friends
	Consider use of local alcohol services
Regular review to offer encouragement	Plan medically assisted withdrawal if indicated, at home or in hospital
	Recommend Alcoholics Anonymous, especially if other support for abstinence is lacking
Monitor (see or telephone patient; information from family/GGT)	Consider specific pharmacotherapy: acamprosate (reduces intensity of and response to cues and triggers to drinking) and/or disulfiram (deterrent)
	Initiate active intervention if other psychiatric problems (depression/anxiety) persist >2 weeks
Reassess with patient the costs and benefits of change	Monitor (see or telephone patient; information from family/GGT)

* Absolute indications for abstinence:
- alcohol related organ damage
- severe dependence (eg morning drinking to stop the shakes or previous failed attempts to control drinking)
- significant psychiatric disorders

Relative indications for abstinence:
- epilepsy
- social factors (eg legal, employment, family)

Based on the UK Alcohol Forum guidelines for the management of alcohol problems in primary care and general psychiatry.[35]

The effectiveness of brief interventions has been reported as number needed to treat (NNT) of 7-9. That is between seven and nine patients will need to be given a brief intervention in order to achieve a reduction of drinking to within non hazardous levels in one patient.[54,56,63] 1++ 1+

This compares favourably with treatment for other medical conditions (eg the use of statins to prevent cardiovascular mortality following myocardial infarction over trial duration, NNT≈30-90[65] or the use of antihypertensive therapy to prevent a cardiovascular event within five years, NNT≈40-125).[66]

In research studies of brief intervention, patients were recruited by screening all attenders at the practice, or all those on the practice list. Of attenders screened, less than 5% met criteria and entered the treatment arm.[54,58,67-70] Thus, at an NNT of eight, 1000 patients would need to be screened for around six patients to show clear benefit. For this reason, primary care professionals should rely on case detection based on clinical presentation, with judicious use of questionnaire tools where there is suspicion, rather than the screening of whole populations.

A

- **General Practitioners and other primary care health professionals should opportunistically identify hazardous and harmful drinkers and deliver a brief** *(70 minute)* **intervention.**
- **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.**

3.1.1 TRAINING

Training healthcare providers in the use of structured interventions enhances the efficacy of brief interventions.[71]

Training practice nurses at health centres in screening and delivering brief interventions has the potential for increasing the availability of these services, but more research is needed to verify this.[71]

There are well documented difficulties in disseminating research findings to primary care providers. Research on implementing screening and brief alcohol intervention showed personal meetings to effect most behaviour change in GPs, but ongoing telephone support to be the most cost effective measure.[72-74]

Training is required in order to deliver effective brief interventions.

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

3.2 BRIEF INTERVENTIONS IN THE ACCIDENT AND EMERGENCY SETTING

A few studies have been conducted of brief interventions to non-admitted A&E patients. One involved the use of a routine follow up letter to patients advising attendance at alcohol counselling services. The letter appeared to be useful in encouraging a significant minority of people to attend appropriate specialist services.[75] The use of follow up correspondence may be a low cost intervention which could produce positive results but more research is needed in this area. 1+

Another study delivered an onsite intervention to adolescents presenting with alcohol problems and showed a positive effect of a single intervention in this patient group.[76] This study has limitations in its design and only applies to a limited subset of A&E attenders. 1-

A third study compared standard care, motivational interviewing or motivational interviewing plus a booster session 7-10 days later.[59] This study recruited injured patients who screened positive for harmful or hazardous drinking. At one year follow up, the "motivational interviewing plus booster session" group reduced their alcohol related injuries by 30% more than those who received standard care. There was no difference between standard care and a motivational interview offered at the time without the booster session. The interventions were delivered by research staff trained in motivational interviewing. 1+

In A&E departments where brief interventions are offered by busy A&E staff, uptake of such interventions by patients may be very low.[77]

When conducted by specially trained and allocated staff offering and arranging follow up, brief intervention can be beneficial. There is insufficient evidence however, to recommend routine brief intervention alone in A&E.

O Patients who screen positive for harmful drinking or alcohol dependence in A&E should be encouraged to seek advice from their GP or given information on how to contact another relevant agency.

3.3 BRIEF INTERVENTIONS IN THE ANTENATAL SETTING

Advice from the Health Education Board for Scotland (now NHS Health Scotland) is that light, occasional drinking during pregnancy (one or two units once or twice a week) is not likely to do any harm.[78] Heavy drinking is associated with miscarriage, and sometimes with serious effects on the baby's development.[78] Some authorities recommend complete abstinence during pregnancy (the US National Institute on Alcohol Abuse and Alcoholism: http://www.niaaa.nih.gov/publications/brochure.htm).

Two studies have been identified which looked at brief interventions in the antenatal setting. One study, in women of childbearing age identified by screening as "at-risk drinkers", compared giving the patient a booklet without additional advice with two 15 minute physician consultations that incorporated a workbook, a drinking agreement and drink diary cards. Both groups reduced consumption with the physician intervention group reducing consumption to a greater extent. Differences overall were significant but the magnitude of difference between groups was small. Subjects who became pregnant however, showed the greatest reduction.[53] 1+

A study of women receiving antenatal care compared an "alcohol consumption assessment only" group with a brief intervention group. Both groups reduced their drinking during the rest of the pregnancy, but differences in reductions by group were not statistically significant. Those who received the brief intervention maintained higher rates of abstinence.[79]

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

3.4 EFFECTIVENESS OF MOTIVATIONAL INTERVIEWING

Motivational interviewing (a non-judgemental interviewing style which avoids confrontation, helps the individual weigh up the pros and cons of change, and enhances self efficacy) is a style which is helpful in brief interventions (*see Annex 5*).[80] A systematic review showed that motivational interviewing has a significant effect on reducing alcohol consumption in the primary care setting.[81] There is no evidence to support a confrontational style of interviewing. 1+

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

O Staff who deliver motivational interviewing should be appropriately trained.

4 Detoxification

4.1 INTRODUCTION

Detoxification refers to the planned withdrawal of alcohol. Alcohol withdrawal carries risks and requires careful clinical management.

The choice of timing for a preplanned detoxification is important, in relation to the patient's commitment and medium term plans. Detoxification should be seen as the first step towards achieving abstinence.

4.2 PRIMARY CARE DETOXIFICATION VERSUS INPATIENT DETOXIFICATION

A comparison between community and inpatient detoxification of alcohol dependent patients found no difference in the number of patients remaining sober six months later.[82] At least three out of four such patients can be detoxified successfully in the community.[82] 1++

No studies of outpatient detoxification using medication were identified where fits occurred but studies had, appropriately, excluded patients with a history of withdrawal seizures or with impending delirium.[83]

Home detoxification does not appear to have any clinical advantages but may offer cost savings.[82-85] There are too few reports to be able to show rare serious events and publication bias may contribute to the current favouring of home detoxification as the first line. 1++, 1+, 2-,3

There is evidence that many patients prefer home detoxification.[86] 2+

Community detoxification is an effective and safe treatment for patients with mild to moderate withdrawal symptoms. Personnel involved in detoxification may include GPs, community psychiatric nurses, primary care nurses and community pharmacists. There are resource implications, including the cost of a breathalyser.

- Where community detoxification is offered, it should be delivered using protocols specifying daily monitoring of breath alcohol level and withdrawal symptoms, and dosage adjustment.
- Every GP practice (and out-of-hours service) would benefit from access to a breathalyser for use in the acute situation and for follow up.
- Intoxicated patients presenting in GP practices, out-of-hours services and A&E, requesting detoxification should be advised to make a primary care appointment and be given written information about available community agencies.

See Annex 6 for advice to give to patients who undergo home detoxification.

4.2.1 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:[35]

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[87]
- 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.

4

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

4.3 PHARMACOLOGICAL DETOXIFICATION

4.3.1 WHEN IS MEDICATION FOR WITHDRAWAL INAPPROPRIATE?

Cessation of drinking is unlikely to be complicated in milder dependence.[35]

Medication may not be necessary if:

- the patient reports consumption is less than 15 units/day in men / 10 units/day in women and reports neither recent withdrawal symptoms nor recent drinking to prevent withdrawal symptoms
- the patient has no alcohol on breath test, and no withdrawal signs or symptoms.

4

Among periodic drinkers, whose last bout was less than one week long, medication is seldom necessary unless drinking was extremely heavy (over 20 units/day).[35] Patients need to be informed of the likely symptoms if medication for withdrawal is not given. Annex 7 may be used to assist in deciding whether medication for withdrawal and admission are necessary.

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.**

4.3.2 THE EFFICACY OF BENZODIAZEPINES IN DECREASING ALCOHOL WITHDRAWAL SYMPTOMS

A body of evidence, based on randomised controlled trials (RCTs), has shown that benzodiazepines are currently the best drug group for alcohol dependence detoxification. The studies are of variable quality, with some reporting on small numbers of patients. Although the evidence is mostly derived from inpatient studies, the conclusions are generalisable to primary care.[88-92]

1^{++}
1^{+}

Benzodiazepines can cause temporary cognitive slowing and may interfere with learning and planning.[93] This, and the need to avoid benzodiazepine dependence, are reasons for keeping the length of treatment to a maximum of seven days.

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

4.3.3 LONGACTING VERSUS SHORTACTING BENZODIAZEPINES

There is insufficient consistent evidence to make a recommendation about the use of longacting versus shortacting benzodiazepines.[88,94-96] 1+ 2+, 4

4.3.4 MISUSE OF BENZODIAZEPINES

All benzodiazepines have a potential for misuse, but diazepam is the benzodiazepine most associated with misuse and alcohol related fatality.[97,98] If used in community detoxification, diazepam requires supervision to avoid misuse.[99] Chlordiazepoxide has a more gradual onset of its psychotropic effects and therefore may be less toxic in overdose. These factors probably contribute to chlordiazepoxide being less often misused and having less 'street' resale value. 3 4

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

4.3.5 THE ROLE OF CLOMETHIAZOLE IN PRIMARY CARE ALCOHOL DETOXIFICATION

Although clomethiazole (former name chlormethiazole) is an effective treatment for alcohol withdrawal, there are well documented fatal interactions with alcohol which render it unsafe to use without close supervision.[90,98,100-103] 1- 3 4

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

4.3.6 DO ELDERLY PEOPLE REQUIRE DIFFERENT PHARMACOLOGICAL MANAGEMENT?

Physical illness sometimes increases the risk of delirium in the elderly, but otherwise there is no difference between alcohol withdrawal symptoms in the elderly, or the amount of benzodiazepine required for detoxification, as compared to younger patients.[104,105] Nevertheless, the risk of accumulation of a drug in the elderly patient needs to be considered. 2+

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

4.3.7 ANTIEPILEPTIC MEDICATION

There is insufficient evidence to support the use of antiepileptic medication as the sole treatment for the management of alcohol withdrawal or in the prevention of alcohol withdrawal seizures.[106,107] 1+

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

People with a history of alcohol related seizures should be referred to specialist services for detoxification management.

4.3.8 ANTIPSYCHOTIC DRUGS

Antipsychotic drugs have been shown to prevent delirium but increase the incidence of seizures.[88] 1+

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

Delusions and hallucinations due to alcohol withdrawal, which would indicate the need for antipsychotic drugs, should be managed by specialist services.

4.3.9 SYMPTOM-TRIGGERED DOSING

Although there are studies of the efficacy of symptom-triggered dosing and/or loading dosing in inpatients, there is no evidence regarding the use of these methods in primary care.[92,108-110] Tapered fixed dose benzodiazepine regimen is likely to be as effective in primary care. 1+ 2+

Tapered fixed dose regimen of a benzodiazepine is recommended for primary care alcohol detoxification, with daily monitoring whenever possible.

4.4 THE ROLE OF VITAMIN SUPPLEMENTS IN DETOXIFICATION

There are very few high quality studies on which to base recommendations in this area. To do such studies now would be inappropriate.

4.4.1 TREATMENT OF ACUTE WERNICKE-KORSAKOV SYNDROME

Detoxification may precipitate Wernicke's encephalopathy *(see Box 2)*, which must be treated urgently with parenteral thiamine.[111] 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.[112] 4

Box 2: Pointers to diagnosis of Wernicke-Korsakov syndrome

Signs of possible Wernicke-Korsakov syndrome in a patient undergoing detoxification
- confusion - ataxia, especially truncal ataxia - ophthalmoplegia - nystagmus - memory disturbance - hypothermia and hypotension - coma

One RCT has examined the role of parenteral vitamin supplements in inpatient alcohol detoxification using memory function as the outcome.[113] This study was done in people who did not have Wernicke-Korsakov symptoms. 1+

Any patient who presents with unexplained neurological symptoms or signs during detoxification should be referred for specialist assessment.

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.**

4.4.2 TREATMENT OF THOSE AT RISK OF WERNICKE-KORSAKOV SYNDROME

There is no published evidence and conflicting expert opinion on the treatment of malnourished patients, and the specification and treatment of "at-risk" patients (those with diarrhoea, vomiting, physical illness, weight loss, poor diet), with the majority of experts recommending parenteral vitamin supplementation during detoxification.[111] 4

For the malnourished patient in the community, intramuscular Pabrinex given in the GP surgery, A&E department, outpatient clinic or day hospital is indicated if facilities for treating anaphylactic reactions are available, such as in any setting where routine immunisations take place.

Patients detoxifying in the community should be given intramuscular Pabrinex (one pair of ampoules daily for three days) if they present with features which put them at risk of Wernicke-Korsakov syndrome.

4.4.3 ORAL SUPPLEMENTATION

No studies were identified that have looked at oral thiamine and its benefit to memory in either the recovering alcoholic or those who continue to drink in general practice. Absorption is diminished when patients continue to drink and should be given in divided doses to maximise absorption. The BNF recommended dose for treatment of severe deficiency is 200-300 mg daily.[114]

Patients who have a chronic alcohol problem and whose diet may be deficient should be given oral thiamine indefinitely.

4.5 THE PREFERRED SETTING FOR TREATING DELIRIUM TREMENS

Delirium tremens is defined here as withdrawal symptoms complicated by disorientation, hallucinations or delusions. Autonomic overactivity is a potentially fatal aspect of this condition.

A Clinical Resource and Audit Group (now part of NHS Quality Improvement Scotland) good practice statement on delirium tremens recognises the serious medical aspects of this syndrome and recommends that local protocols for admitting patients with delirium tremens are used.[87]

4

Although the proportion of such patients seen by psychiatrists varies across Scotland, the majority of cases are treated by the acute medical service. This is because there is often a coexisting medical condition such as pancreatitis, pneumonia or other infection and there may be life threatening complications.

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

5 Referral and follow up

5.1 WHO TO REFER, AND TO WHOM

Specialist treatments for alcohol problems are effective. A health technology assessment from NHS Quality Improvement Scotland concluded that specialist services are effective for relapse prevention if offering behavioural self control training, motivational enhancement therapy, family therapy/community reinforcement approach and/or coping/communication skills training *(see Annex 8)*.[115] 1++

General Practitioners are able to manage more patients with alcohol related problems if they perceive that they are working in a supportive environment which includes access to help with difficult patients.[116] 4

Research aiming to predict which patients will do better with which type of specialist treatments has given few leads. The GP's decision where to refer a patient should be guided in large part by the patient's choice. Some predictors however, have emerged: patients who are angry at the initial assessment appear to do better, in the short term, if given motivational interviewing.[117,118] 1+
Patients with psychiatric disorders ('dual diagnosis') tend to do better if referred to specialist psychological or psychiatric services than to 12-step Alcoholics Anonymous (AA) groups.[119] 2++
Patients referred to specialist care, who live or work in environments where there is a lot of drinking and little support for abstinence, may do better in a service which offers consultations which emphasise the 12-step AA approach, rather than specialised psychological therapy.

One underpowered study found no advantage to specialist treatment over general practice management in the UK.[120] Two North American studies have shown that milder alcohol dependence can sometimes be successfully managed without specialist care.[121,122] However, brief primary care intervention has usually excluded alcohol dependent patients who should, in general, be referred for specialist care. 1-
1+

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

5.1.1 PATIENTS WITH ALCOHOL RELATED PHYSICAL DISORDER

American studies have shown that for patients with alcohol related physical disorders, integrated medical care and addiction treatment gives a better outcome than when the two services are separate.[122,123] If this is extrapolated to the NHS, it suggests that these are patients for whom particularly good links between the alcohol agency and medical care should be nurtured or where the treatment of the alcohol problem should be based as much as possible in primary care. 1+
4

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.**

5.1.2 STEPPED CARE

Stepped care[124] (in a tiered treatment service[2,125]) occurs when treatment is chosen where possible to match the patients' needs and wishes and cause least disruption to their family and their work. More intensive treatment is only required if the outcome is unsatisfactory. 4

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

5.2 WAITING TIME TO REFERRAL

Two case control studies and one cohort study found that increased waiting times made attendance at specialist clinics less likely.[126-128] None found a link between delay in referral or waiting time for assessment with ultimate outcome of treatment. 2+

5.3 MONITORING

Low intensity monitoring over the course of one to three years has been shown to reduce the severity of relapses.[129,130] This may be done by telephone or a brief appointment. In these studies, benefit may have been partly due to earlier rereferral to specialist services. 1+

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

5.4 EFFECTIVENESS OF LAY SERVICES

5.4.1 ALCOHOLICS ANONYMOUS

The health technology assessment from NHS Quality Improvement Scotland supports the appropriate use of AA.[115]

Alcoholics Anonymous believes that alcohol dependence is a chronic and progressive illness without cure, for which total abstinence is the only solution. Alcoholics Anonymous is widely available and entirely self-funding, but there is limited formal evidence of efficacy from randomised studies. It is a network of support including advice for individuals in crisis. Their members are willing to help primary care teams link patients with AA. 2+

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

5.4.2 OTHER LAY AND NON-STATUTORY SERVICES

Motivational interviewing and coping skills training for relapse prevention have been shown to be effective when delivered by psychologists.[131] Counselling by lay and non-statutory agencies is available in most of Scotland (eg by Councils on Alcohol) but has not been evaluated in controlled studies.[132] These agencies welcome referrals from NHS primary care. The evidence for efficacy of client-centred counselling for alcohol dependence is conflicting. Less defined counselling and education appear to be ineffective. Day care/drop-in centres are available in certain areas. 2+

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

5.5 EFFECTIVENESS OF MEDICATIONS TO PREVENT RELAPSE

The health technology assessment by 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.[115] This was also the conclusion of a health technology assessment by the Swedish Council on Technology Assessment in Health Care[106] and a literature review for the Aberdeen Health Economics Research Unit.[32]

Other meta-analyses support these findings[133,134] as does the joint guideline of the US Agency for Healthcare Research and Quality/American Society of Addiction Medicine (2002). Acamprosate is believed to act by modulating disturbance in the gamma-aminobutyric acid /glutamate system associated with alcohol dependence, reducing the risk of relapse during the postwithdrawal period. It is a safe drug with few unwanted side effects, and is not liable to misuse. Its value is in the first months after detoxification. Acamprosate is not effective in all patients so its efficacy should be assessed at regular appointments, and the drug withdrawn if there has not been a major reduction in drinking. Where it appears to be effective, good practice suggests prescribing for 6-12 months. The studies were conducted in specialist centres where psychosocial treatment was offered. It is an assumption that, as long as there is a system of monitoring compliance and efficacy, these data are applicable to primary care. 1++ 1+

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

Acamprosate will usually be initiated by a specialist service within a few days of successful detoxification. If a specialist service is not available, the GP should offer acamprosate, monitor its efficacy and provide links to local support organisations.

Disulfiram's function is to deter the patient from resuming drinking. If taken regularly there is an unpleasant reaction when alcohol is consumed. It has unwanted effects in some patients, and carries special warnings. The health technology assessment by NHS Quality Improvement Scotland found some support for the use of supervised disulfiram and none for its non-supervised use.[115] If used, it should be offered for six months in the first instance, with regular review. Supervision is agreed by the patient to increase the likelihood that the medication is taken even at times of ambivalence. 2+

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.**

Disulfiram supervision may be undertaken by the spouse, healthcare or support worker, or the workplace representative if appropriate.

Naltrexone, although supported by the above reports, and used by specialists in Scotland, is not licensed in the UK for the treatment of alcohol dependence.

5.6 TREATING ALCOHOL DEPENDENCE AND ANXIETY OR DEPRESSION

In patients with an alcohol problem, there is good evidence that most anxiety and depression resolves with standard treatment for alcohol dependence.[133,135-138] 1+

For patients with panic disorder and social phobia, there is no consistent evidence of extra benefit of cognitive behavioural therapy beyond the simultaneous treatment for the alcohol problem.[139,140] 1+

In detoxified patients with definite depressive illness, antidepressants improve depressive symptoms and in some studies drinking outcomes.[133,135-138] The strongest effect is with fluoxetine, although this treatment seems to reduce the beneficial effect of cognitive behavioural therapy in the type of patients characterised by early onset and prominent social problems.[141] Therefore caution should be exercised in prescribing selective serotonin reuptake inhibitors (SSRIs) to patients characterised by early onset of alcohol problems and antisocial behaviour. 1+

There is insufficient evidence that antidepressants improve drinking outcomes in non-depressed patients.

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 an SSRI or referring for counselling or specialist psychological treatment along with the relapse prevention treatment.**

If severe anxiety symptoms persist for more than two weeks in abstinent patients, consideration should be given to using an SSRI, or referring for specialist psychological treatment along with the relapse prevention treatment.

5.7 TREATING ALCOHOL DEPENDENCE WHEN OTHER PSYCHIATRIC ILLNESS IS PRESENT

Patients with comorbid schizophrenia/schizoaffective disorder and substance misuse benefit from motivational interviewing, cognitive behavioural therapy and family interventions aimed at decreasing their dependence.[143-146] These patients are best treated by specialist services. | 1+ 2+ 4

Disulfiram may be used with caution in these patients bearing in mind drug interactions.[147] | 4

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 non-confrontational approaches.**

Patients with psychoses should be referred for psychiatric advice.

5.8 EFFECTIVENESS OF ALTERNATIVE THERAPIES

Information on outcomes following use of alternative therapies was found only for acupuncture and transcendental meditation. RCTs and systematic reviews have not demonstrated an effect for acupuncture in the treatment of alcohol dependence.[148-150] | 1+ 1- 4

A review of transcendental meditation[151] (plus the accompanying erratum[152]) reports that this may be useful as an adjunctive treatment for people with an alcohol or drug dependence. The studies included in this review were heterogeneous and patient selection criteria were not reported. | 4

There is insufficient evidence to make any recommendations about the use of acupuncture, transcendental meditation or other alternative therapies in treating patients with an alcohol problem.

6 Advising families

The drinker's family may seek advice on how they should intervene when the drinker is not motivated to change. "Detaching with love" (one of the principles by which Al-Anon members lessen the risk of harm to their own mental health resulting from living with a drinker), or simple confrontation, are less likely to get the drinker to change or seek help than using an approach based on community reinforcement and family training (CRAFT).[153,154] Although not tested in primary care, the method can be taught to non-specialists. 1+

CRAFT instructs the family or "committed significant other" to reinforce, by encouragement or other rewards, any changes or statements that the drinker makes towards stopping or reducing the drinking, and to do nothing to enable or reward drinking. The treating team lays down the groundwork for rapid availability of outpatient treatment for the drinker in the event that he or she opts to begin therapy. The family are prepared from the beginning to recognise and respond safely to any potential for domestic violence during the introduction of what may be a new way of reacting to the drinker and the drinking.

The family are helped to:

- understand the nature of alcohol dependence
- improve communication with the drinker
- selectively apply or withdraw reinforcement, to amplify non-drinking
- apply pressure without bickering or recrimination
- learn stress reduction and gain more reward in their own life
- use effective methods and optimal times for proposing treatment entry to the drinker, such as restricting key messages to moments of sobriety, and exploiting alcohol related crises
- support the drinker through treatment.

The following recommendation has been extrapolated from the above trials.

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.**

7 Information for discussion with patients and carers

The following points were drawn up by the guideline development group to reflect the issues likely to be of most concern to patients and carers. These points are provided for use by health professionals when discussing alcohol problems with patients and in guiding the production of locally produced patient information materials.

7.1 PATIENT FEARS AND PERCEPTIONS WHEN PRESENTING WITH AN ALCOHOL PROBLEM

Research carried out by System Three Social Research,[2] and the SIGN patient involvement project, commissioned by the Scottish Executive, has identified recurrent themes of concern to patients presenting with an alcohol problem.

There is a widespread acceptance that the GP is the most appropriate first point of contact once a patient has decided to seek help. However, there are considerable fears or reservations associated with seeking such help even where a good relationship exists with the GP. Such fears include:

- the normal shyness or hesitancy associated with a condition perceived to be "shameful"
- being labelled an "alcoholic"
- jeopardising one's work by admitting to having an alcohol problem
- being concerned that children may be taken into care
- not being treated seriously or being told to "pull yourself together".

Other general points to emerge from the SIGN research and the literature:

- continuity of personnel providing support is essential as establishing trust is very important
- speed of referral is also very important as, once the difficult decision to seek help has been made, it needs to be followed up quickly or this positive attitude may evaporate
- there are wide differences in understanding of the terms "alcohol misuse", "alcohol problems" and "alcoholic". A common usage is for alcohol misuse to mean "beginning to impinge on normal life" and alcoholism to mean the above plus "a need or compulsion to drink" *(see section 7 2 for medical definitions)*
- there is confusion regarding what constitutes the standard unit of alcohol
- patients may have heard of Alcoholics Anonymous but will rarely have any knowledge of its methods or operations
- there is widespread belief that there are substantial facilities for sufferers from drug abuse but very little for those with alcohol problems.

7.2 KEY MESSAGES FOR PATIENTS

Problems with alcohol are suffered by people in varying degrees, ranging from occasional excess consumption to an addiction or dependence, which may affect the person and their whole lifestyle. Patients often progress from mild misuse of alcohol to more extreme stages so it is important to try to address any problem at an early stage, seeking medical assistance where necessary.

7.2.1 EFFECTS ON THE PERSON

At a personal level alcohol misuse has many effects including:

- anxiety, which often leads to a compounding of the problem
- health problems caused by the alcohol consumption itself including liver and brain damage and other serious conditions such as epilepsy and heart disease
- consequential health problems caused by the effects of alcohol such as malnutrition, injuries and gaps in memory
- difficulties in sustaining employment.

7.2.2 EFFECTS ON THE FAMILY

Having a family member with an alcohol problem can seriously affect the family, where family members and friends can become anxious, depressed or alienated.

Financial problems caused by the purchase of alcohol, coupled with reduced earnings potential also impact on the family.

7.2.3 HELP AVAILABLE FROM THE PRIMARY CARE TEAM

The range of advice, treatment and referral available from the GP and the primary care team includes:

- initial discussion and support
- advice regarding non-hazardous drinking levels and ways to reduce drinking
- counselling and therapy for the individual
- counselling and therapy for the family
- treatment options including medication to relieve the physical effects of stopping drinking and to help to reduce the incidence of drinking in the longer term
- referral to a specialist nurse, often within the practice, for individual help
- referral to another agency for clinical care with information about treatment options available
- referral to a voluntary agency for lay counselling
- link with a mutual help association such as Alcoholics Anonymous
- longer term support and monitoring.

O It should be stressed to patients that stopping or cutting down their drinking can only result from their own decision to do so. Any treatment, from whatever source, can only be an aid to taking this decision and following it through.

7.3 ORGANISATIONS WHICH PROVIDE USEFUL INFORMATION

At-ANON
Mansfield Park, Unit 6, 22 Mansfield Street
Glasgow, G11 5QP
24h telephone service: 0141 339 8884
Website: www.al-anonuk.org.uk
Support for families and friends of alcoholics

Alcoholics Anonymous
National helpline: 0845 76 97 555
Website: www.alcoholics-anonymous.co.uk

Alcohol Concern
Waterbridge House. 32-36 Loman Street
London, SE1 0EE
Tel: 020 7922 8667 (Information Team)
Email: info@alcoholconcern.org.uk
Website: www.alcoholconcern.org.uk
Provides information on a wide range of alcohol related subjects. Alcohol Concern does not operate a helpline.

Alcohol Focus Scotland (formerly the Scottish Council on Alcohol)
2nd floor, 166 Buchanan Street
Glasgow, G1 2LW
Tel: 0141 572 6700, Fax: 0141 333 1606
Email: admin@sca-online.co.uk
Website: www.alcohol-focus-scotland.org.uk

Down Your Drink
Online program for reducing drinking
Website: www.downyourdrink.org.uk

National Alcohol Information Resource
Information and Statistics Division
Trinity Park House
Edinburgh, EH5 3SQ

NHS 24
Tel: 08454 24 24 24
Website: www.nhs24.com

NHS Health Scotland (formerly the Health Education Board for Scotland)
Woodburn House, Canaan Lane
Edinburgh, EH10 4SG
Tel: 0131 536 5500, Fax: 0131 536 5501
Website: www.hebs.org

8 Implementation, audit and further research

8.1 LOCAL IMPLEMENTATION

Implementation of national clinical guidelines is the responsibility of local NHS organisations 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.

8.2 KEY POINTS FOR AUDIT

- Are primary care workers opportunistically identifying people with an alcohol problem and delivering appropriate brief interventions?
- At new patient registration in general practice, what is the proportion of completed sections on alcohol consumption?
- Are staff delivering treatments such as motivational interviewing according to recognised methodology?
- Are there local protocols for alcohol withdrawal management in place and in use?
- Does the practice have access to a breathalyser?

A brief instrument which has been used in audit of outcomes is the Alcohol Related Problems Questionnaire.[155]

8.3 RECOMMENDATIONS FOR RESEARCH

Further high quality research in a representative population group is needed to:

- establish the effectiveness of routine brief intervention in the A&E setting
- compare outcomes for in/outpatient detoxification
- study the use of oral vitamin preparations in primary care, and whether subsequent Wernicke-Korsakov syndrome, neuropathy or cerebellar damage is delayed/prevented
- appraise alcohol policy initiatives in order to ascertain the cost effectiveness of such treatments, and of "brief interventions"
- simplify screening tools
- study the efficacy of alternative therapies in treating patients with an alcohol problem.

9 Development of the guideline

9.1 INTRODUCTION

SIGN is a collaborative network of clinicians, other healthcare professionals, and patient organisations, funded by NHS Quality Improvement Scotland. SIGN guidelines are developed by multidisciplinary groups of practising clinicians using a standard methodology based on a systematic review of the evidence. Further details about SIGN and the guideline development methodology are contained in "SIGN 50: A Guideline Developer's Handbook", available at **www.sign.ac.uk**

9.2 THE GUIDELINE DEVELOPMENT GROUP

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Dr Bahar Ashraf-Uzzaman	*General Practitioner, Airdrie, Lanarkshire*
Mr Ken Barrie	*Director, Centre for Alcohol and Drug Studies, University of Paisley*
Mr Richard Brooks	*Health Economist, Strathclyde University, Glasgow*
Mr Robert Burns	*Lay Representative*
Professor Peter Brunt	*Consultant Physician, Aberdeen Royal Infirmary*
Ms Francesca Chappell	*Information Officer, SIGN*
Dr Alan Clubb	*General Practitioner, Musselburgh*
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Dr Sandy Elder	*Consultant Occupational Physician, Lanarkshire*
Dr Ali El-Ghorr	*Programme Manager, SIGN*
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Sister Michelle amieson	*Senior Nurse, Accident and Emergency Department, Royal Infirmary of Edinburgh*
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Dr Claire McIntosh	*Specialist Registrar, Alcohol Problems Clinic, Royal Edinburgh Hospital*
Mr David Pattison	*Health Promotion Manager, Forth Valley NHS Board, Stirling*
Mr Walter Simpson	*Lay Representative*
Dr Richard Watson	*General Practitioner, Glasgow*

The membership of the guideline development group was confirmed following consultation with the member organisations of SIGN. Declarations of interests were made by all members of the guideline development group. Further details are available from the SIGN Executive. Guideline development and literature review expertise, support, and facilitation were provided by the SIGN Executive.

9.3 SYSTEMATIC LITERATURE REVIEW

The evidence base for this guideline was synthesised in accordance with SIGN methodology. A systematic review of the literature was carried out using an explicit search strategy devised by a SIGN Information Officer. Databases searched include Medline, Embase, Healthstar, Cinahl, PsychINFO, Alcohol and Alcoholism, and the Cochrane Library. The year range covered was 1995-2001. Internet searches were carried out on various websites including the New Zealand Guidelines Programme, the UK Health Technology Assessment programme, the NIAAA Alcohol 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 website, 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.

9.4 CONSULTATION AND PEER REVIEW

9.4.1 NATIONAL OPEN MEETING

A national open meeting is the main consultative phase of 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 website for a limited period at this stage to allow those unable to attend the meeting to contribute to the development of the guideline.

9.4.2 SPECIALIST REVIEW

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. SIGN is very grateful to all of these experts for their contribution to this guideline.

Dr Peter Anderson	*Public Health Consultant, Nijmegen, The Netherlands*
Dr Alan Begg	*General Practitioner, Montrose*
Mr Graham Bell	*Lay Representative*
Mr Colin Bennie	*Community Alcohol Services Manager, Bannockburn Hospital*
Reverend Professor Chris Cook	*Professor of the Psychiatry of Alcohol Misuse, University of Kent, Canterbury*
Mr Mike Craigie	*Lay Representative*
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Dr Kathy Long	*General Practitioner, Airdrie*
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Dr Grahame Mitchell	*General Practitioner, Aultbea*
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Dr Marsha Morgan	*Reader in Medicine and Honorary Consultant Physician, Royal Free and University College Medical School, London*
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Mrs Lorraine Park	*Senior Occupational Therapist, Sunnyside Royal Hospital, Montrose*
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Ms Penny Richardson	*Director, Edinburgh and Lothian Council on Alcohol*
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Dr Sheila Scott	*Director of Health Planning, Royal Alexandra Hospital, Paisley*
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Dr Robin Touquet	*Consultant in Accident and Emergency, St Mary s Hospital, London*
Ms Catherine Tully	*Pharmacist, Parkland Hospital, Glasgow*
Professor Hazel Watson	*Assistant Head of Department of Nursing, School of Nursing, Midwifery and Community Health, Glasgow Caledonian University*
Dr Barbara West	*General Practitioner, Glasgow*

9.4.3 SIGN EDITORIAL GROUP

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. The Editorial Group for this guideline was as follows:

Dr David Alexander	*Scottish General Practice Committee*
Dr Keith Brown	*Royal College of Psychiatrists*
Professor Gordon Lowe	*Chair of SIGN*
Dr Lesley Macdonald	*Faculty of Public Health Medicine*
Dr Safia Qureshi	*SIGN Programme Director*
Dr Sara Twaddle	*Director of SIGN*
Dr Bernice West	*National Nursing, Midwifery, Health Visiting Advisory Committee*

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

9.5 ACKNOWLEDGEMENTS

Dr Roch Cantwell	*Senior Lecturer in Psychiatry, Glasgow University*
Dr Brian Scott	*General Practitioner, Glasgow*
Ms oanne Topalian	*SIGN Programme Manager/Patient Project Manager*

Annex 1
Alcohol content of some beverages

Beverage type		Alcohol by volume (%)	Measure	Alcohol content (units)
Beers/lagers	Barbican	0.02	440ml	<0.01
	Kaliber	0.05	Pint	0.03
	Tennents LA	1.2	440ml	0.5
	Mild/light beers (various brands)	3.1	Pint	1.8
	Best bitter (various brands)	3.5	Pint	2.0
	Skol	3.6	Pint	2.0
	McEwans/Labatt	4.0	Pint	2.3
	Guinness draft stout	4.1	Pint	2.3
	Grolsch	5.0	440ml	2.2
	Premium beer/lager (various brands)	5.0	Pint	2.8
	Stella Artois	5.2	330ml	1.7
	Lowenbrau Pils	6.0	440ml	2.6
	Hofmeister Special	9.0	440ml	4.0
	Kestral Super	9.5	440ml	4.2
Ciders/Perries	Strongbow LA	0.9	330ml	0.3
	Woodpecker	3.5	Pint	2.0
	Strongbow	4.5	1000ml	4.5
	Old English	5.5	Pint	3.1
	Strongbow Super	8.0	Pint	4.5
	Diamond White	8.2	275ml	2.3
	Strong White Cider	8.4	1000ml	8.4
Spirit based drinks with mixers (alcopops)	Hooch	4.7	330ml	1.6
	WKD Original Vodka Blue or Iron Brew	5.5	330ml	1.8
	Smirnoff Ice	5.5	275ml	1.5
	Bacardi Breezer	5.4	275ml	1.5
	Metz Snapps (Black, Still or Original)	5.4	275ml	1.5
	Vodka Red Square (Barrs Irn Bru)	5.5	275ml	1.5
	Aftershock	40.0	700ml	28.0
Vodka Hooch	Lemon/Apple/Orange/Hoopers Hooch	4.7-5.1	330ml	1.6-1.7
Shooters (addition to main drink)	Jelly Pots	15.0	47ml	0.7
	Sidekick	20.0	30ml	0.6
	Aftershock	40.0	30ml	1.2
	Frostbite	50.0	30ml	1.5
	Absinthe	75.0	30ml	2.3
Wines	Various brands	9-14	750ml	6.8-10.5
A purchased glass of wine can vary from 125 to 250 ml and can contain 1.1-3.5 units per glass depending on % alcohol. A small (125ml) glass of average strength (12%) wine contains 1.5 units.				
Fortified Wines and similar	Cinzano bianco/Buckfast	14.7	750ml	11.0
	Croft Original Sherry	17.5	750ml	13.1
	Cockburn's Port	20.0	750ml	15.0
Spirits	Gordons Dry Gin/Smirnoff Vodka	37.5	700ml	26.3
	Bacardi White Rum	37.5	700ml	26.3
	Bells Whisky/Martell cognac brandy	40.0	700ml	28.0
	Captain Morgan's dark rum	40.0	700ml	28.0
A purchased measure of spirit is 25 or 35 ml. A 25ml measure of 40% spirit contains 1 unit of alcohol.				
Liqueurs	Bailey's Irish Cream	17.0	350ml	6.0
	Archers Peach Schnapps	23.0	700ml	16.0
	Apricot Brandy/Crème de Menthe/Malibu	24.0	700ml	16.8
	Pernod/Cointreau/Drambuie	40.0	700ml	28.0

Formula: the amount of alcohol (in units) = volume (in litres) x percentage alcohol

Note: there are 1,000 ml in 1 litre and 1 pint = 568 ml.
The information in this table has been adapted from three sources: the Medical Council on Alcoholism,[14] Alcohol Focus Scotland and the Portman Group.

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Annex 2
Clinical presentations where the role of alcohol should be considered

Hazardous drinking and alcohol dependence present in many ways. The following presentations should alert clinicians to the possibility that alcohol may be involved:

Social

- marital disharmony and domestic violence
- neglect of children
- criminal behaviour such as driving offences, breach of the peace, shoplifting
- misuse of the emergency telephone services
- unsafe sex
- financial problems

Occupational

- repeated absenteeism, especially around weekends
- impaired work performance and accidents
- poor employment record

Psychiatric

- amnesia, memory disorders and dementia
- anxiety and panic disorders
- depressive illness
- morbid
- alcoholic hallucinosis
- treatment resistance in other psychiatric illnesses and as a factor in relapse
- repeated self harming

Physical

- multiple acute presentations to A&E with trauma and head injury
- dyspepsia, gastritis, haematemesis
- diarrhoea and malabsorption
- acute and chronic pancreatitis
- liver abnormalities from deranged liver function tests, through hepatitis, to fatty liver and cirrhosis
- cardiac arrhythmias
- hypertension and stroke
- cardiomyopathy
- peripheral neuropathy, cerebellar ataxia
- impotence and problems with libido
- withdrawal seizures and fits starting in middle age
- falls and collapses in the elderly
- blood dyscrasias such as low platelet count and white cell count (neutrophils)
- acne rosacea, discoid eczema, psoriasis, multiple bruising
- cancers of mouth, pharynx, larynx, oesophagus, breast and colon
- acute and chronic myopathies
- unexplained infertility
- gout

Annex 3

The Fast Alcohol Screening Test (FAST) for the detection of probable hazardous drinking[31]

For the following questions please circle the answer which best applies.

1 drink = 1 unit ½ pint of beer or 1 glass of wine or 1 single spirits

1. MEN: How often do you have EIGHT or more drinks on one occasion?
WOMEN: How often do you have SIX or more drinks on one occasion?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Only ask Questions 2, 3 & 4 if the response to Question 1 is "Less than monthly" or "Monthly"

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily

3. How often during the last year have you failed to do what was normally expected of you because of drink?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No	Yes, on occasion	Yes, on more than one one occasion

Scoring is quick and can be completed with just a glance at the pattern of responses as follows:[156]

Stage 1
The first stage only involves question 1.
If the response to question 1 is never then the patient is not misusing alcohol.
If the response to question 1 is Weekly/Daily or Almost Daily then the patient is a hazardous, harmful or dependent drinker. Over 50% of people will be classified using just this one question.
Only consider Questions 2, 3 & 4 if the response to Question 1 is Less than monthly or Monthly.

Stage 2
If the response to Question 1 is Less than monthly or Monthly then each of the four questions is scored 0 to 4. These are then added resulting in a total score between 0 and 16. The person is misusing alcohol if the total score for all four questions is 3 or more.

Score Questions 1, 2 & 3 as follows:	Score Question 4 as follows:
Never= 0 Less than monthly = 1 Monthly = 2 Weekly = 3 Daily or almost daily = 4	No = 0 Yes, on one occasion = 2 Yes, on more than one occasion = 4

In summary, score Questions 1, 2 & 3: 0,1,2,3,4. Score Question 4: 0,2,4
The minimum score is 0
The maximum score is 16
The score for hazardous drinking is 3 or more.

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Annex 4
The one minute Paddington Alcohol Test (PAT)[157]

Please complete for ALL A&E PATIENTS where there is any INDICATION OF ALCOHOL MISUSE: eg assault, head especially facial injury, fall, non-specific gastrointestinal problem, "unwell", fit, blackout, collapse, insomnia, sweating, hypo/hyperglycaemia, palpitations, chest pain, gout, rashes, depression, overdose; note **REPEAT** attendance (perhaps with unexplained symptoms) and **DELAYED** attendance 4 hours (perhaps intoxicated at the time of "incident").

Remember the elderly presenting with: falls, confusion, incontinence and self neglect.

1. Quite a number of people have times when they drink more than usual; what is the most you will drink in any one day?

N.B. Please note if home or pub measures. Units (1 unit 8 grams alcohol) relating to pub measures, are shown in brackets.

TYPE OF DRINK	**AMOUNT**	
Beer/Lager/Cider	Pints (2) or Cans (1.5)	___=Units/day
Strong Beer/Lager/Cider	Pints (5) or Cans (4)	
Wine	Glasses (1.5) or Bottles (9)	
Fortified Wine (Sherry, Martini)	Glasses (1) or Bottles (12)	
Spirits (Gin, Whisky, Vodka)	Singles (1) or Doubles (2) or Bottles (30)	

2. If this is more than 8 units/day for a man, or 6 units/day for a woman, does this happen:

Once a week or more?	YES: PAT +ve
or	
Between once a month and once a week?	YES: PAT +ve
or	
Neither (ie once a month or less)?	YES: PAT -ve (go to Question 3)

3. Do you feel your current attendance in A&E is related to alcohol?

YES: PAT +ve
NO: PAT -ve

ie PAT +ve if >8 units male or 6 units female more than once a month, and/or YES to Question 3.

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Annex 5
Important elements of motivational interviewing

Adapted from Miller and Rollnick, 2002.[158]

Portraying empathy

- use of open ended questions and avoiding premature closure
- respect for individual differences
- reflective listening so that patients sense you are trying to *"get on their wavelength"*
- expressing interest/concern
- acceptance that ambivalence is normal.

Developing discrepancy

- patients are helped to see the gap between the drinking and its consequences and their own goals/values - the gap between *"where I see myself, and where I want to be"*
- enhancing their awareness of consequences, perhaps adding feedback about medical symptoms and test results: *"How does this fit in " "Would you like the medical research information on this "*
- weighing up the pros and cons of change and of not changing
- progressing the interview so that patients present their own reasons for change.

Avoiding argument (*"rolling with resistance")*

- resistance, if it occurs (such as arguing, denial, interrupting, ignoring) is not dealt with head-on, but accepted as understandable, or sidestepped by shifting focus
- labelling, such as *"I think you have an alcohol problem"* is unnecessary, and can lead to counterproductive arguing.

Supporting self efficacy

- encouraging the belief that change is possible
- encouraging a collaborative approach (patients are the experts on how they think and feel, and can choose from a menu of possibilities)
- the patient is responsible for choosing and carrying out actions towards change.

Facilitating and reinforcing "self motivating statements"

- recognising that alcohol has caused adverse consequences
- expressing concern about effects of drinking
- expressing the intention to change
- being optimistic about change.

A tenet of motivational interviewing is *"People believe what they hear themselves say"*.

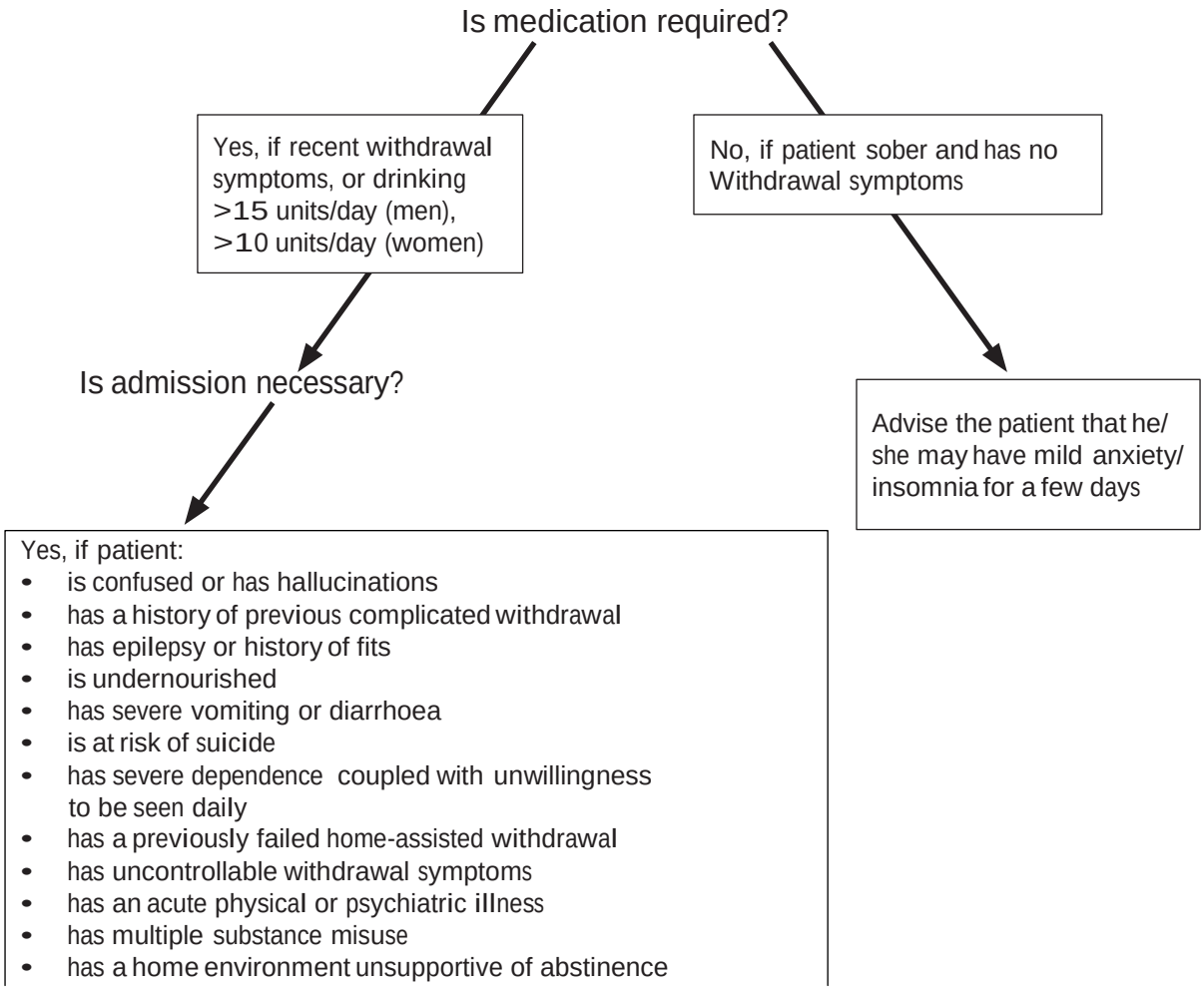
Annex 6
Advice to patients on withdrawing from alcohol at home

1. If you have been chemically dependent on alcohol, stopping drinking causes you to get tense, edgy, perhaps shaky or sweaty, and unable to sleep. There can be vomiting or diarrhoea. This “rebound” of the nervous system can be severe. Medication controls the symptoms while the body adjusts to being without alcohol. This usually takes three to seven days from the time of your last alcoholic drink. If you don’t take medication, the symptoms would be worst in the first 48 hours, and then gradually disappear. This is why, if you do take medication, the dose starts high and then reduces. If you have been prescribed 10 mg tablets of chlordiazepoxide, use the table below to remind you when to take the right number of tablets.
2. **YOU HAVE AGREED NOT TO DRINK ALCOHOL.** You may get thirsty. Drink fruit juices and water but do not overdo it. You do not have to “flush” alcohol out of the body. More than three litres of fluid could be too much. Don’t drink more than three cups of coffee or five cups of tea. These contain caffeine which disturbs sleep and causes nervousness.
3. **AIM TO AVOID STRESS.** The important task is not to give in to the urge to take alcohol. Help yourself relax by going for a walk, listening to music, or taking a bath.
4. **SLEEP.** You may find that even with the capsules, or as they are reduced, your sleep is disturbed. You need not worry about this - lack of sleep does not seriously harm you, starting to drink again does. Your sleep pattern will return to normal in a month or so. It is better not to take sleeping pills so that your natural sleep rhythm returns. Try going to bed later. Take a bedtime snack or milky drink.
5. **The capsules may make you drowsy so you must not drive or operate machinery. If you get drowsy, miss out a dose.**
6. **MEALS.** Even when you are not hungry, try to eat small amounts regularly. Your appetite will return.

Number of chlordiazepoxide (10 mg) tablets to take and when to take them when withdrawing from alcohol as an outpatient

	First thing	12 noon	6 pm	Bedtime
Day 1	-	3	3	3
Day 2	2	2	2	3
Day 3	2	1	1	2
Day 4	1	1	-	2
Day 5	-	1	-	1

Annex 7
Assisting withdrawal from alcohol



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Annex 8

The NHS Quality Improvement Scotland recommendations on the prevention of relapse in alcohol dependence[115]

Psychosocial interventions

- Behavioural Self Control Training (BSCT), Motivational Enhancement Therapy (MET), Marital/ Family Therapy and Coping/Social Skills Training are clinically and cost effective psychosocial interventions and are recommended treatment options for the prevention of relapse in alcohol dependence.
- Brief Interventions are not recommended, as trials in alcohol dependent people have failed to show any benefit. However, this guideline recommends Brief Interventions for hazardous drinkers (a less severely affected group than those who are considered to be alcohol dependent).
- Other psychosocial interventions are not recommended as their clinical effectiveness is unproven.

Pharmacological interventions

- Acamprosate and supervised oral disulfiram are treatment options recommended as adjuncts to psychosocial interventions. Naltrexone does not have a Marketing Authorisation for the treatment of alcohol dependence in the UK and is not recommended for routine use in NHSScotland.

Delivery of services

- Alcohol services should aim to reduce the delay between detoxification and interventions for the prevention of relapse. This would be facilitated by joint working between specialist mental health services, primary care, social work addiction services and non-statutory agencies, as recommended by the Joint Futures Group.
- Acamprosate or supervised oral disulfiram should usually be initiated by a specialist service. The specialist service will ensure that the patient meets the criteria for suitability; ensure the assessment of the motivation and ability of the patient to use the medication correctly; monitor efficacy; and ensure that adjunctive psychosocial treatment is organised. Usage should be in accordance with the Summary of Product Characteristics and reviewed regularly during the first 12 weeks after initiation of treatment, at which stage transfer of prescribing to the general practitioner may be appropriate, even though specialist care may continue (shared care).
- Introduction to AA and non-statutory agencies such as local Councils on Alcohol (Alcohol Focus Scotland) should be part of the overall strategy of specialist NHS services for the prevention of relapse. As with other psychosocial treatments, attendance is most likely to be beneficial if it is an informed voluntary decision.
- People who are alcohol dependent should be informed about treatment choices. Their needs, preferences and social circumstances should be considered. As a result, the choice of interventions should be a shared decision between the health professional and the patient.
- NHS specialist services should contact people who drop out of treatment programmes and offer them another appointment.

Communication with patients

- Health professionals should provide patient information, including leaflets, which should be used to support discussion between health professionals and patients about the most appropriate treatment option.
- Written information about the range of available services should be readily accessible to people with alcohol problems, their families, carers and to health professionals, especially GPs. Alternative formats such as cartoons or audiovisual material should be used to support discussions with people who have low reading skills or poor concentration. Alcohol Action Teams could coordinate information requirements.
- A regularly updated comprehensive directory of alcohol services and accommodation should be developed for the benefit of NHSScotland staff, patients and their families, friends and carers.

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Abbreviations

AA	Alcoholics Anonymous
A&E	Accident and Emergency
AUDIT	Alcohol Use Disorders Identification Test
BAC	Blood alcohol concentration
BNF	British National Formulary
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
CDT	Carbohydrate deficient transferrin
CRAFT	Community reinforcement and family training
FAST	Fast Alcohol Screening Test
GGT	Serum gamma glutamyl transferase
GP	General practitioner
ICD-10	International Classification of Diseases version 10
MCV	Mean red blood cell volume
NNT	Number needed to treat **PAT**
	Paddington Alcohol Test
RCT	Randomised controlled trial
SIGN	Scottish Intercollegiate Guidelines Network
SSRI	Selective serotonin reuptake inhibitor
T-ACE	**T**olerance, **A**nnoyed by someone criticising your drinking, felt need to **C**ut down, **E**ye-opener
TWEAK	**T**olerance to effects of alcohol, **W**orry about drinking, **E**ye -opener, **A**mnesia, felt the need to **K** cut down your drinking
W-K	Wernicke-Korsakov

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THE MANAGEMENT OF HARMFUL DRINKING AND ALCOHOL DEPENDENCE IN PRIMARY CARE

DETECTION AND ASSESSMENT

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.**

B **Abbreviated forms of AUDIT[t]** *(eg FAST[t])*, **or CAGE[t] plus two consumption questions, should be used in primary care when alcohol is a possible contributory factor.**

C **In A&E, FAST[t] or PAT[t] should be used for people with an alcohol related injury.**

B **TWEAK[t] and T-ACE[t]** *(or shortened versions of AUDIT)* **should be used in antenatal and preconception consultations.**

BRIEF INTERVENTIONS

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

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

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

DETOXIFICATION

Pharmacological detoxification

Medication may not be necessary if:

- the patient reports consumption is less than 15 units/day in men or 10 units/day in women and reports neither recent withdrawal symptoms nor recent drinking to prevent withdrawal symptoms
- the patient has no alcohol on breath test, and no withdrawal signs or symptoms

DELIRIUM TREMENS

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

Hospital detoxification is advised if the patient:

- is confused or has hallucinations
- has a history of previous complicated withdrawal
- has epilepsy or a history of fits
- is undernourished
- has severe vomiting or diarrhoea
- is at risk of suicide
- has severe dependence and is unwilling 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.

Community detoxification

Community detoxification is an effective and safe treatment for patients with mild to moderate withdrawal symptoms

O Where community detoxification is offered, it should be delivered using protocols specifying daily monitoring of breath alcohol level and withdrawal symptoms, and dosage adjustment.

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.**

VITAMIN SUPPLEMENTS

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.**

O Patients detoxifying in the community should be given intramuscular Pabrinex (one pair of ampoules daily for three days) if they present with features which put them at risk of Wernicke-Korsakov syndrome.

O Patients who have a chronic alcohol problem and whose diet may be deficient should be given oral thiamine indefinitely.

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.**

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

LAY SERVICES

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.**

ALCOHOL DEPENDENCE AND PSYCHIATRIC ILLNESS

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

O Patients with psychoses should be referred for psychiatric advice.

PATIENTS AND 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.**

There is widespread acceptance that the GP is the most appropriate first point of contact once a patient has decided to seek help. However, there are considerable fears or reservations associated with seeking such help even where a good relationship exists with the GP.

Patients often progress from mild misuse of alcohol to more extreme stages so it is important to try to address any problem at an early stage, seeking medical assistance where necessary.

Having a family member with an alcohol problem can seriously affect a family, where family members and friends can become anxious, depressed or alienated. Financial problems caused by the purchase of alcohol, coupled with reduced earnings potential also impact on the family.

O t should be stressed to patients that stopping or cutting down their drinking can only result from their own decision to do so. Any treatment, from whatever source, can only be an aid to taking this decision and following it through.