Alcohol misuse

Alcohol misuse - F10 (Clinical term: Mental and behavioural disorders due to use of alcohol Eu10)

Presenting complaints

Patients may present with:

- depressed mood
- nervousness
- insomnia
- physical complications of alcohol use (eg ulcer, gastritis, liver disease, hypertension)
- accidents or injuries due to alcohol use
- poor memory or concentration
- evidence of self-neglect (eg poor hygiene)
- failed treatment for depression.

There may also be:

- legal and social problems due to alcohol use (eg marital problems, domestic violence, child abuse or neglect, missed work)
- signs of alcohol withdrawal (eg sweating, tremors, sickness, hallucinations [usually visual] seizures)

Patients may sometimes deny or be unaware of alcohol problems. Family members may request help before patient does (eg because patient is irritable at home or missing work). Problems may also be identified during routine health promotion screening.

Diagnostic features

Harmful alcohol use:

- heavy alcohol use (eg >28 units per week for men and >21 units per week for women)
- overuse of alcohol has caused physical harm (eg liver disease, gastrointestinal bleeding), psychological harm (eg depression or anxiety), or has led to harmful social consequences (eg loss of job or breakdown of a relationship).

Alcohol dependence is present when three of the following are present:

- a strong desire or compulsion to use alcohol
- difficulty controlling alcohol use
- withdrawal symptoms (eg anxiety, tremors, sweating) when drinking is ceased
- tolerance (eg drinks large amounts of alcohol without appearing intoxicated)
- continued alcohol use despite harmful consequences
- neglect of other activities due to alcohol.

Blood tests such as gamma-glutamyl transferase (GGT) and mean corpuscular volume (MCV) can help identify heavy drinkers. Administering the CAGE (see CAGE questionnaire) or AUDIT (see Audit questionnaire) questionnaire may also help diagnosis.

Differential diagnosis and co-existing conditions

Symptoms of anxiety or depression may occur with heavy alcohol use. Alcohol use can also mask other disorders, eg agoraphobia, social phobia and generalized anxiety. Assess and manage symptoms of depression or anxiety if symptoms continue after a period of abstinence. See Depression - F32# or Generalized anxiety - F41.1.

Drug misuse may also co-exist with this condition. Presentation of other psychiatric disorders should trigger inquiry about alcohol and drug misuse history.

Essential information for patient and family

- Alcohol dependence is an illness with serious consequences.
- Ceasing or reducing alcohol use will bring mental and physical benefits.
- Drinking during pregnancy may harm the baby.
- Goal-setting needs to be negotiated and matched to individual needs and assessment, as well as overall pattern of drinking and dependence.
- For most patients with alcohol dependence, physical complications of alcohol abuse or psychiatric disorder, abstinence from alcohol is the preferred goal (ref 15). Sometimes, abstinence is also necessary for social crises, to regain control over drinking or because of failed attempts at reducing drinking. Because abrupt abstinence can cause withdrawal symptoms, medical supervision is necessary
- In some cases of harmful alcohol use, controlled or reduced drinking is a reasonable goal, or a reasonable starting goal where the alcohol-dependent patient is unwilling or unable to quit.
- As in many chronic behavioural disorders, relapses are common. Controlling or ceasing drinking often requires several attempts. Outcome depends on the motivation and confidence of the patient.

References

15 Rosenberg H. Prediction of controlled drinking by alcoholics and problem drinkers. Psychol Bull 1993, 113: 129-139. (BII) This is a qualitative review of the literature. Successful achievement of controlled drinking is associated with less severe dependence and a belief that controlled drinking is possible.

General management and advice to patient and family

(ref 16, 17)

In assessing patients with alcohol or other type of addictive behaviour, the framework of cycles of change can be helpful in assessing the patient's readiness for change. A patient may be:

- precontemplative (ie not considering any change)
- contemplative (ie considering change or prepared to change behaviour), or
- in an action phase where they are actually in the process of change.

Of course, because of the relapsing nature of these disorders, patients might shift from an action phase, back to a precontemplative change and then move through the phases of change. Assessment can be a prompt for some to move into a contemplative or action phase.

For all patients:

- discuss costs and benefits of drinking from the patient's perspective
- feedback information about health risks, including the results of GGT and MCV
- emphasize personal responsibility for change
- give clear advice to change and discuss alternative strategies to alter drinking pattern
- assess and manage physical health problems and nutritional deficiencies (eg vitamin B)
- consider options for problem-solving or targeted counselling to deal with life problems related to alcohol use
- brief interventions in primary care settings are effective with hazardous drinking (ref 18).

If there is no evidence of physical or psychological harm due to drinking and the patient is not dependent, a controlled drinking programme is a reasonable goal:

- negotiate a clear goal for decreased use (eg no more than two drinks per day, with two alcohol-free days per week).
- discuss strategies to avoid or cope with high-risk situations (eg social situations and stressful events)
- introduce self-monitoring procedures (eg a drinking diary) and safer drinking behaviour (eg time restrictions, drinking more slowly, interspersing with non-alcoholic drinks). (see How to cut down on your drinking)

For patients with physical or mental illness and/or dependency, or failed attempts at controlled drinking, an abstinence programme is indicated.

For patients willing to stop now:

- set a definite day to quit
- discuss symptoms and management of alcohol withdrawal
- discuss strategies to avoid or cope with high-risk situations (eg social situations and stressful events)
- make specific plans to avoid drinking (eg ways to face stressful events without alcohol, ways to respond to friends who still drink)
- help patients to identify family members or friends who will support ceasing alcohol use
- consider options for support after withdrawal.

For patients not willing to stop or reduce now, a harm-reduction programme is indicated:

- do not reject or blame
- clearly point out medical and social problems caused by alcohol
- consider thiamine preparations
- make a future appointment to re-assess health and alcohol use.

For patients who do not succeed, or who relapse:

- identify and give credit for any success
- discuss the situations that led to relapse
- return to earlier steps above

- avoid blame or criticism
- be aware of the patient's sense of failure or self-criticism and give support if needed.

Self-help organizations (see Resources for patients and families), voluntary and non-statutory agencies are often helpful for patients, families and other people involved (ref 19).

Doctors have a responsibility to inform patients that they are obligated to inform the DVLA if they have been given a diagnosis of alcohol misuse or dependency; licence restoration only after a period free from alcohol problems and satisfactory medical reports (ref.3). This advice should be documented in the medical records.

References

3 Driver and Vehicle Licensing Agency. At a Glance Guide to Medical Aspects of Fitness to Drive. URL http://www.dvla.gov.uk. Further information is available from The Senior Medical Adviser, DVLA, Driver Medical Unit, Longview Road, Morriston, Swansea SA99 ITU, Wales.

16 NHS Centre for Reviews and Dissemination. Brief interventions and alcohol use. Effect Health Care Bull 1993, 1: 1-12. (AI) Brief interventions, including assessing drinking and related problems, motivational feedback and advice, are effective. They are most successful for less severely affected patients.

17 Slattery J, Chick J, Cochrane M et al. Prevention of Relapse in Alcohol Dependence. Health Technology Assessment Report 3. Glasgow: Health Technology Board for Scotland, 2003. URL http://www.htbs.co.uk. (A1) This study looked at treatments for individuals with alcohol dependence. Psychological treatments are effective but brief psychological treatments have no effect. Acamprosate and naltrexone showed significant beneficial effects.

18 Miller WR, Wilbourne PL. Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders. Addiction 2002, 97(3): 265-277. (A1) Three hundred and sixty-one studies were analysed. There is strong evidence for the use of psychological treatments and the drugs acamprosate and naltrexone in treatment of alcohol use disorders.

19 McCrady B, Irvine S. Self-help groups. In: Hester R, Miller W (eds.) Handbook of Alcoholism Treatment Approaches: Effective Alternatives. 2nd edition. New York: Allyn and Bacon, 2003. (AIV) This chapter discusses the characteristics of patients who are good candidates for Alcoholics Anonymous (AA). Several studies show AA to be an important support in remaining alcohol-free to patients who are willing to attend.

Medication

(ref 17)

Detoxification:

- For patients with mild withdrawal symptoms, frequent monitoring, support, reassurance, adequate hydration and nutrition are sufficient treatment without medication (ref 20).
- Patients with a moderate withdrawal syndrome may require benzodiazepines and vitamins in addition. Most can be detoxified, with a good outcome, as outpatients or at

home (ref 21). Community detoxification should only be undertaken by practitioners with appropriate training and supervision.

- Patients at risk of a complicated withdrawal syndrome (eg with a history of fits or delirium tremens, very heavy use and high tolerance, significant polydrug use, benzodiazepine dependence, severe co-morbid medical or psychiatric disorder) who lack social support or are a significant suicide risk may require specialist input and likely inpatient detoxification, which should be carried out in liaison with specialist alcohol services.
- Chlordiazepoxide (Librium; 10 mg) is recommended. The initial dose should be titrated against withdrawal symptoms, within a range of 5–40 mg four times a day. (BNF section 4.10.) This requires close, skilled supervision.
- The following regimen is commonly used, although the dose level and length of treatment will depend on the severity of alcohol dependence and individual patient factors (eg weight, sex and liver function):

Days 1 and 2:	20–30 mg qds
Days 3 and 4	15 mg qds
Day 5:	10 mg qds
Day 6:	10 mg bd
Day 7:	10 mg nocte

- Naltrexone may decrease alcohol consumption in people with alcohol dependency but their compliance with treatment appears problematic (ref 22).
- Chlomethiazole is not recommended for outpatient detoxification under any circumstances (ref 23).
- Dispensing should be daily or involve the support of family members to prevent the risk of misuse or overdose. Confirm abstinence by checking the breath for alcohol, or using a saliva test or breathalyser for the first 3-5 days.
- Thiamine (150 mg per day in divided doses) should be given orally for 1 month (ref 24). As oral thiamine is poorly absorbed, transfer patient immediately to a general hospital or clinic with appropriate resuscitation facilities for parenteral supplementation if any one of the following is present: ataxia, confusion, memory disturbance, delirium tremens, hypothermia and hypotension, ophthalmoplegia or unconsciousness.
- Daily supervision is essential in the first few days, then advisable thereafter, to adjust dose of medication, assess whether the patient has returned to drinking, check for serious withdrawal symptoms and maintain support.

References

17 Slattery J, Chick J, Cochrane M et al. Prevention of Relapse in Alcohol Dependence. Health Technology Assessment Report 3. Glasgow: Health Technology Board for Scotland, 2003. URL http://www.htbs.co.uk. (A1) This study looked at treatments for individuals with alcohol dependence. Psychological treatments are effective but brief psychological treatments have no effect. Acamprosate and naltrexone showed significant beneficial effects.

20 American Psychiatric Association. Practice Guidelines: Substance Use Disorders, 1996. (BIV) Where patients have mild to moderate withdrawal symptoms, general support, reassurance and frequent monitoring is sufficient treatment for two thirds of them, without pharmacological treatment.

21 Collins MN, Burns T, Van den Berk PA, Tubman GF. A structured programme for out-patient alcohol detoxification. Br J Psychiatry 1990, 156: 871-874. (BIV)

22 Srisurapanont M, Jarusuraisin N. Opioid antagonists for alcohol dependence (Cochrane Review). In: The Cochrane Library, Issue 1, 2003. Oxford: Update Software. (B1) Nineteen studies were analysed. Naltrexone may decrease alcohol consumption in people with alcohol dependency but their compliance with treatment appears problematic. It should be given with psychological intervention.

23 Duncan D, Taylor D. Chlormethiazole or chlordiazepoxide in alcohol detoxification. Psychiatr Bull 1996, 20: 599-601. (AIV) This paper describes randomized controlled trials that show chlordiazepoxide and chlomethiazole to be of equal efficacy; however, chlordiazepoxide is a safer alternative (there is a risk of fatal respiratory depression with alcohol and chlomethiazole) and chlomethiazole is no longer recommended for outpatient use.

24 Cook CC, Hallwood PM, Thomson AD. B vitamin deficiency and neuropsychiatric syndromes in alcohol misuse. Alcohol Alcoholism 1998, 33(4): 317-336.

Supporting abstinence

- Anxiety and depression often co-occur with alcohol misuse. The patient may have been using alcohol to self-medicate. If symptoms of anxiety or depression increase or remain after a period of abstinence of >2-3 weeks, see Depression - F32# or Generalized anxiety - F41.1. Selective serotonin re-uptake inhibitor (SSRI) antidepressants are preferred to tricyclics because of the risk of tricyclic–alcohol interactions (fluoxetine, paroxetine and citalopram do not interact with alcohol). Other newer drugs such as venlafaxine and mirtazepine can also be considered (BNF section 4.3.3.) For anxiety, benzodiazepines should be avoided because of their high potential for abuse (ref 25) (BNF section 4.1.2.)
- Disulfiram (Anatabuse) produces an aversive reaction including flushing, headaches, palpitations and nausea if combined with alcohol. Extreme reactions can produce hypotension, cardiac arrythmias and collapse, resulting in several contraindications and limiting its use. It is more effective if supervised. (BNF section 4.10) (ref 26)
- Acamprosate may help to maintain abstinence from alcohol as an adjunct to psychosocial treatment in some cases.
- Naltrexone has a similar profile to Acamprosate, but is not currently licensed for this indication in the UK.

For information on brief interventions for people whose drinking behaviour puts them at risk of becoming dependent, see Alcohol Concern's Brief Intervention Guidelines (ref 27).

References

25 Kranzler H, Burleson J, Del Boca F et al. Buspirone treatment of anxious alcoholics: a placebo-controlled trial. Arch Gen Psychiatry 1994, 51: 720-731. (BII)

26 Hughes JC, Cook CC. The efficacy of disulfiram: a review of outcome studies Addiction 1997, 92(4): 381-395. (C1) Thirty-eight studies were analysed. Support for the general use of oral disulfiram is equivocal, mostly leading to reduced quantity of alcohol consumed and a reduced number of drinking days.

27 Alcohol Concern. Brief Interventions Guidelines. London, 1997. Available from Alcohol Concern, Waterbridge House, 32-36 Loman Street, London SE1 OEE, UK. Tel: +44 20 7928 7377. URL http://www.alcoholconcern.org.uk.

Referral

Consider referral:

- to non-statutory Alcohol Advice and Counselling Agency, if available, and if no psychiatric illness is present
- to a specialist NHS alcohol service if the patient has alcohol dependence and requires an abstinence-based group programme or has an associated psychiatric disorder, or if there are no appropriately trained practitioners available in primary care
- for general or specialist hospital inpatient detoxification if the patient does not meet the criteria for community detoxification (see Medication)
- to targeted counselling, if available, to deal with the social consequences of drinking (eg relationship counselling)
- non-urgently to secondary mental health services if there is a severe mental illness (see relevant disorder), or if symptoms of mental illness persist after detoxification and abstinence.

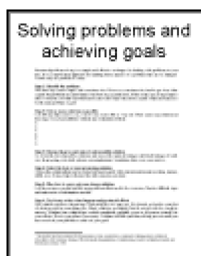
If available, specific, social skills training (ref 28) and community-based treatment packages (ref 29) both may be effective in reducing drinking.

References

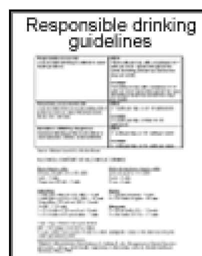
28 Holder H, Longabaugh R, Miller W, Rubonis A. The cost effectiveness of treatment for alcoholism: a first approximation. J Stud Alcohol 1991, 52: 517-540. (AI) Treatments aim to improve self-control and social skills - for example, relationship skills, assertiveness and drink refusal.

29 Hunt G, Axrin N. A community reinforcement approach to alcoholism. Behav Res Ther 1973, 11: 91-104. (AI) This approach uses behavioural principles and includes training in job finding, support in developing alcohol free social and recreational activities, and an alcohol-free social club.

Resources for patients and families


Solving problems and achieving goals

Solving problems and achieving goals


Responsible drinking guidelines

Responsible drinking guidelines

How to cut down your drinking

How to cut down on your drinking

Al-Anon Family Groups UK and Eire 020 7403 0888 (24-hour helpline)
Website: http://www.al-anonuk.org.uk
Understanding and support for families and friends of alcoholics whether still drinking or not.

Alcoholics Anonymous 0845 769 7555 (24-hour helpline)
Website: http://www.alcoholics-anonymous.org.uk
Helpline and support groups for men and women trying to achieve and maintain sobriety and help other alcoholics to get sober.

National Association for Children of Alcoholics 0117 924 8005
Email: help@nacoa.org.uk; Website: http://www.nacoa.org.uk

Drinkline National Alcohol Helpline 0800 917 8282 (11am–7pm, Monday–Friday)

Secular Organisations for Sobriety (SOS) 020 8698 9332/020 8291 5572 (helpline)
A non-religious self-help group.

Northern Ireland Community Addiction Service 02890 664 434

Alcohol Focus Scotland 0141 572 6700
Email:jacklaw@alcohol-focus-scotland.org.uk; website: http://www.alcohol-focus-scotland.org.uk
Formerly the Scottish Council on Alcohol, initiates and supports actions to promote a healthy approach to the use of alcohol.

Health Education Authority 020 7430 0850

Health Development Agency (HDA) 020 7430 0850
Recorded alcohol information is also available on freephone 0500 801802
Email: communications@hda-online.org.uk; website: http://www.hda-online.org.uk
Produces leaflets on sensible drinking.

Health Education Board for Scotland 0131 536 5500
Website: http://www.hebs.scot.nhs.uk
Provides leaflets to support brief interventions for people at risk of becoming dependent on alcohol.
Leaflets are available from the Royal College of Psychiatrists (http://www.rcpsych.ac.uk): Alcohol, Alcohol and Depression, Alcohol and Other Drug Misuse