ABC of alcohol

Treatment for alcohol related problems

Bruce Ritson

When hazardous or harmful drinking is first identified in primary care or the hospital setting, patients should be offered brief intervention. This consists of 10 minutes of discussion and explanation, provision of a self-help booklet, and the offer of a further appointment in one or two weeks. Its cost effectiveness has been proved, although time may have to be set aside rather than trying to undertake intervention within normal practice. Training and employing a member of staff for the purpose is worth consideration.

Motivational interviewing

The value of motivational interviewing is proved. This essentially is an empathic, non-confrontational approach in which the doctor helps the patient identify his or her own reasons for change and strategies for achieving realistic goals. Essential components include sustaining commitment over time, involving the family when possible, acknowledging achievements, and dealing promptly with lapses. A patient's motivation to change his or her way of life fluctuates according to mood and circumstance, and patient and doctor can feel deflated by early setbacks.

The primary care team is ideally suited to provide long term support. Barriers to change need to be identified: some patients will have few barriers; others will have serious impediments that need to be dealt with.

Dependence and detoxification

Some patients will find it hard to cut down or stop drinking because they experience withdrawal symptoms. At first, these may not be recognised for what they are. Patients may describe feeling nervous without a drink or not being able to function effectively until the first drink of the day. Other features in patients who are physically dependent will provide supportive evidence. They vary in severity.

Mild symptoms can be dealt with by rest, relaxation, and reassurance. An explanation that withdrawal symptoms are evidence that the brain has adapted to living in an alcoholic environment and will take time to adjust to one that is alcohol free is helpful. Patients find it reassuring to know that symptoms, however unpleasant, will pass in a few days. This approach is often enough when patients are alcohol free at interview and report drinking <15 units a day in men and <10 units a day in women without recent withdrawal symptoms or recent drinking to relieve alcohol withdrawal.

When dependence is more advanced, the discomfort of withdrawal may necessitate medical detoxification. In most cases, this can be done at home, but patients whose symptoms are very severe and who have other prominent physical, psychological, and social factors, need referral for specialist treatment in hospital.

Drug treatment

Benzodiazepines are the drug of choice for managing withdrawal symptoms. Remember that they can induce temporary difficulties in cognition and recall. They are addictive if taken over time, and detoxification with benzodiazepines

This article is adapted from the 4th edition of the *ABC of Alcohol*, which will be available in February

Motivational interviewing

People believe what they hear themselves say

Empathic interviewing style

- Open ended questions
- Reflective listening
- Get on their "wavelength"

Feedback about risk

- Agree factual information about personal harm or impairment
- Balance sheet of pros and cons of changing/not changing

Roll with resistance

- Avoid confrontation
- Arguments about terms such as alcoholic are usually fruitless, particularly in the early stages

Support self efficacy

- Patient takes responsibility for achieving goals
- Choosing from menu of options
- Encourage belief that change is possible

Reinforce self motivating statements

- Recognition of harm caused
- Desire to change
- Feasibility of change

Alcohol withdrawal syndrome

Common features on stopping or reducing alcohol:

- Anxiety and agitation
- Tachycardia
- Sweating
- Tremor of extended hands, tongue, and eyelids
- Nausea and vomiting
- Insomnia
- Withdrawal fits
- Confusion
- Hallucinations

Factors indicating need for specialist or hospital referral

• Confusion • Hallucinations • Epilepsy or history of fits • Risk of suicide • Failed home detoxification • Poor nutrition	• Unsupportive home environment • Acute physical or psychiatric illness • Any symptoms of Wernicke's encephalopathy

should not be continued for more than seven days. It is sensible to start with a high daily dose, such as 120 mg chlordiazepoxide or 20 mg diazepam on the first day, and then reduce the dose. After the third day, the dose should have been reduced by at least 25%. Details of the drug regimen should be adjusted to the patient's condition.

Other support

Drug treatment is only one part of the treatment for withdrawal. Patients and families should receive a careful explanation and should be advised to stay off work, not drive, rest, and drink plenty of fluids (fruit juice rather than stimulants such as coffee). The need to abstain from all alcohol should be made clear. Ideally, a community nurse or general practitioner should visit daily to monitor progress, review drugs, assess mental state, and vital signs, and, if possible, breathalyse for alcohol. Withdrawal symptoms usually resolve in 4-6 days, after which time patients feel much better and optimistic about the future. They may believe they can now handle alcohol, but it needs to be made clear to patients and carers that on no account should drinking (however little) be resumed. The visiting health professional is well placed to establish a therapeutic alliance for the future and reinforce the need for continued abstinence.

Vitamins

No clear evidence shows that oral vitamins are needed for well nourished people with moderate alcohol dependence. In patients who are undernourished and have a history of frequent relapse and self neglect, however, 200-300 mg thiamine a day over three months or longer will help minimise the risk of damage to the brain and peripheral nervous system. Oral vitamins are absorbed poorly during the early stages of detoxification, so parenteral thiamine may be needed. If the patient is suspected to have or be developing Wernicke's encephalopathy, urgent treatment in hospital with parenteral thiamine is needed.

Other drugs are rarely necessary. Antacids will help relieve stomach pains. Anticonvulsants are of little value in preventing withdrawal fits, and the management of alcohol dependent people with established epilepsy is best supervised by a specialist clinic. Antidepressants are not indicated at this stage in treatment, and antipsychotics are needed rarely.

Preventing relapse

The drinker will need to devise strategies to cope with life without recourse to alcohol or with controlled drinking. Some people will find it relatively easy to change this habit; this is often most true of those who identified the problem early and have not developed severe physical, social, and psychological problems.

A drinking diary and a balance sheet of the good and bad consequences of continued drinking, which are often used in the initial assessment, are useful tools throughout follow up, and they can be used to set goals and monitor progress. Patients are encouraged to set their own goals and identify ways of dealing with triggers to relapse. If possible, involve the family in the plan and encourage persistence, even in the face of relapses. Sometimes major barriers to change that are not responding to motivational approaches will be obvious, and more specialist help will be required.

Many problem drinkers risk becoming dependent on benzodiazepines, which have been initiated over a series of failed detoxification episodes.

Detoxification regimen

Detoxification—daily check

- Tremor
- Pulse
- Temperature
- Blood pressure
- Level of consciousness
- Orientation
- Dehydration
- Evidence of continued drinking

Wernicke's encephalopathy

Signs may include:

- Confusion
- Ataxia, especially truncal ataxia
- Ophthalmoplegia
- Nystagmus
- Coma
- Hypotension
- Hypothermia
- Unexplained neurological signs during withdrawal

Requires urgent specialist assessment and treatment with parenteral thiamine—eg Pabrinex intramuscular

Triggers to relapse

Environment	<ul style="list-style-type: none"> • Availability • Pub atmosphere
Custom	<ul style="list-style-type: none"> • Always drink at certain times, occasions, and situations
Interpersonal	<ul style="list-style-type: none"> • Stress • Conflicts
Intrapsychic	<ul style="list-style-type: none"> • Expectations • Anxiety • Social phobias • Depression or elation (celebration)
Overconfidence	<ul style="list-style-type: none"> • Feeling good • "I have got over my drinking problem" • "I can take some alcohol again"

Pharmacotherapy

Disulfiram

Disulfiram is a well established drug that acts as a deterrent to drinking by blocking the metabolism of alcohol and thus flooding the body with the toxic substance acetaldehyde. This produces flushing, palpitations, nausea, faintness, and in some cases collapse. Very rarely the consequences are serious or even fatal.

Problems most often occur when high doses are taken. An initial dose of 200 mg a day, if tolerated, can be increased after a few days to 400 mg; eventually a supervised dose of 400 mg two or three times a week is usually enough. Disulfiram should not be given to patients with serious active liver disease or cardiovascular disorders, to pregnant women, or patients who are suicidal or cognitively impaired. The action should be explained carefully to patients and their families. Patients should carry explanatory leaflets and a card explaining the actions of the drug.

The efficacy of disulfiram has been shown only when its use is supervised—for instance, by relatives or by clinic, primary care, or occupational health staff. Disulfiram interferes with the metabolism of other drugs, most notably tricyclic antidepressants, monoamine oxidase inhibitors, heparin, and some anticonvulsants. Drowsiness is noted by some users. Hepatotoxicity is a recognised risk, and regular monitoring of liver function in the early months of treatment is advisable.

Acamprosate

Acamprosate has proved helpful as an adjunct to psychological therapies. It should be started as soon as abstinence is achieved and can be continued during a relapse. If the patient makes good progress, it can be continued for one year. The dose is 666 mg three times daily for patients aged 18–65 years who weigh 60 kg or more. Patients who weigh less than 60 kg should take 666 mg at breakfast, 333 mg at midday, and 333 mg at night. Side effects are rare and are mostly mild gastric upsets.

Naltrexone also improves outcome and reduces the severity of relapse, but it is not yet licensed for regular use in the United Kingdom.

Referral

Referral to another agency should be timed carefully. Referral should not be too early because the patient may feel rejected; neither should it be too late, when the patient and family have become despondent or further damage has occurred. At the time of referral, a further follow up appointment should be made to find out whether the patient attended and how they got on. The dropout rate at the point of referral is high.

For people with established alcohol dependency, Alcoholics Anonymous is a valuable resource. It is best to make a personal introduction if possible.

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Bruce Ritson is a former consultant psychiatrist, Royal Edinburgh Hospital, Edinburgh EH10 5HD (drbruceritson@zoom.co.uk).

The ABC of Alcohol is edited by Alex Paton, retired consultant physician, Oxfordshire (PatonAlex@aol.com) and Robin Touquet, consultant in accident and emergency medicine, St Mary's Hospital, London (R.Touquet@imperial.ac.uk).

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Drug treatments should always be accompanied by psychological support and therapy aimed at attaining a longer term change of lifestyle that is essentially drug free

St Martin, patron saint of alcoholics and alcoholism

Referral

- Make sure the patient knows why he or she is being referred and give a follow up appointment to review progress
- It is good practice to get to know the specialist resources available in your area as they vary considerably

Further reading

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