Alcohol Use and Dependence

See also Alcohol Withdrawal

Disclaimer

Contents

Background

About alcohol intervention

- *Harmful alcohol use contributes to many health conditions, mainly acute problems (e.g. accident or injury), and chronic conditions (e.g. hypertension, stroke, liver disease, brain damage, Wernicke-Korsakoff syndrome and cancer).*
- *Evidence shows that a simple assessment of a patient's alcohol use, followed by a brief discussion of the benefits of reducing their alcohol intake has a beneficial effect on patient alcohol intake.*[1]

Assessment

Practice Point

Reassess motivation

Re-assess motivation to change at each consultation.

1. If patient is intoxicated, ensure their immediate safety and arrange follow-up for assessment when not intoxicated.
2. Perform a quick alcohol screen opportunistically using ***simple questions.***

Simple questions

- *Have you ever felt you needed to reduce your drinking?*
- *Have people annoyed you by criticizing your drinking?*
- *Have you ever felt guilty about drinking?*

3. Screen using the ***AUDIT C questionnaire*** if time permits (printable, consider uploading to patient profile).
    - If the AUDIT C score is ≥ 5, it is recommended to continue with the ***AUDIT questionnaire*** to determine the degree of harm.

AUDIT questionnaire

AUDIT is the gold standard for identification of alcohol problems with 96% validity, detecting alcohol problems at their lowest level. It takes no more than 5 minutes and is normally followed by a 10 minute intervention.

- *Online version to AUDIT questionnaire*
- *Hardcopy PDF version of AUDIT questionnaire*

- If the AUDIT questionnaire is not used, make a quick assessment of weekly alcohol intake by standard drinks equivalent.
- Record the patient's score and set a reminder to re-screen annually or at each health check.

4. Routinely screen for use of other drugs:
    - A helpful question may be: "Do you regularly use other substances such as illicit drugs or medicines not as prescribed?"
    - If more detailed assessment is required, consider using the eASSIST-lite questionnaire.

5. Assess the patient's ***readiness to change*** their behaviour.

Stages of change

- *Precontemplation (not ready)*
- *Contemplation (getting ready)*
- *Preparation (ready)*
- *Action*
- *Maintenance (sustained change)*
- *Relapse (learning)*

6. Perform a physical examination, looking for evidence of anaemia, chronic liver disease, malnutrition, nerve damage, alcohol-related brain damage, and other alcohol-associated signs of illness.

7. Consider FBE and LFTs to investigate signs of alcoholic hepatitis and anaemia. If low platelet count, consider further assessment to exclude cirrhosis as it may be an early indicator.

8. Consider the risks of family violence and the needs of any ***dependent children*** of the patient.

Dependent children

- *Children of parents with mental illness and addiction are a vulnerable group. See factsheet.*
- *Follow mandatory assessment and reporting process for child abuse and neglect*

Management

1. If significantly medically compromised, call **000** for ambulance and transfer to the nearest the Emergency Department for immediate assessment.
2. Manage according to risk and note that these categories are a continuum, meaning patients can move between definitions:

Low risk (infrequent, low volume drinker or AUDIT score < 8)

1. *Provide* **general advice** *on alcohol consumption, as indicated.*

General advice

- *One standard drink contains 10 g of pure alcohol, but volumes can vary based on a standard drinks equivalent.*
- *Drinking ≤ 2 standard drinks on any day reduces lifetime risk of harm from alcohol-related disease or injury.*
- *Drinking ≤ 4 standard drinks on a single occasion reduces the risk of alcohol-related injury arising from the occasion.*
- *For young people aged 15 to 17 years, the safest option is to delay the initiation of drinking for as long as possible.*

- *For women who are pregnant or breastfeeding, not drinking is the safest option.*

Moderate risk or problem drinking (occasions of harmful drinking but not dependent or AUDIT score 8 to 19)

1. *Manage based on* **stage of change** *and use motivational interviewing techniques.*

   Stage of change

   - ***Precontemplation*** *(patient not considering change) – Provide information to prompt contemplation e.g., educate about use and asking* **questions.**

     Helpful questions about risky drinking
     - *"This questionnaire indicates that your level of drinking is putting you at risk. I am concerned about how this is impacting on your health."*
     - *"Do you have any concerns about this information?"*
     - *"Would you like to change the way you drink?"*
     - *"Have you tried to make changes previously?"*
     - *If patient is reluctant to engage:*
       - *"Are other people concerned about your drinking?"*
       - *"Has your drinking ever impacted on your employment or relationships?"*
       - *"Do you ever find it hard to stop drinking once you have started?"*

   - ***Contemplation*** *(patient ambivalent about change) – Increase awareness and benefits.*
   - ***Preparation*** *(patient has decided to change) – Offer treatment options, reduction plan e.g., clarify patient goals, help lower barriers, encourage announcement of plan to change to family and friends.*
   - ***Action*** *(patient tries new behaviours) – Help execute the plan e.g., provide resources, identify supports, acknowledge difficulties, and arrange follow-up visit.*
   - ***Maintenance*** *(patient establishes behaviours on a long-term basis) – Provide practical strategies for coping and maintain supportive contact, review long-term goals.*
   - ***Relapse*** *(patient stops maintaining their alcohol goal) – Discuss as a learning opportunity, commend patient for honesty and address coping strategies.*

2. *If the patient does not want to engage, reassess at future contact.*

3. *Offer to refer all patients for management, counselling, and support to either of:*
   - *Low risk alcohol and drug treatment assessment*
   - *Moderate to high risk alcohol and drug treatment assessment.*

High risk or dependent drinking (daily, high volume drinker with withdrawal potential or AUDIT score ≥ 20)

This patient is at risk of alcohol withdrawal.

1. *Manage based on* **stage of change** *and use motivational interviewing techniques.*

Stage of change

- ***Precontemplation*** *(patient not considering change) – Provide information to prompt contemplation e.g., educate about use and asking leading questions.*
- ***Contemplation*** *(patient ambivalent about change) – Increase awareness and benefits.*
- ***Preparation*** *(patient has decided to change) – Discuss withdrawal management and relapse medication.*
- ***Action*** *(patient tries new behaviours):*
    - *Help execute the plan e.g., provide resources, identify supports, acknowledge difficulties, and arrange follow-up visit.*
    - *Consider shared care with a pharmacy for weekly pick-up of relapse medication and motivation.*
- ***Maintenance*** *(patient establishes behaviours on a long-term basis):*
    - *Provide practical strategies for coping and maintain supportive contact, review long-term goals.*
    - *Consider risks post withdrawal process. Increased support required to ensure maintenance.*
- ***Relapse*** *(patient stops maintaining their alcohol goal) – Discuss as a learning opportunity, commend patient for honesty and address coping strategies.*

2. *Discuss* **withdrawal process and treatment options** *with patient.*

Withdrawal process and treatment options

- *Acute withdrawal symptoms usually resolve within 5 to 7 days. Subacute withdrawal symptoms can persist for months, e.g. cravings, insomnia.*
- *Discuss risks associated with using other drugs during withdrawal.*
- *Treatment involves withdrawal management and continuing care to support relapse prevention.*
- *Treatment requirements and options:*

	Ambulatory	***Inpatient***
Expected withdrawal symptom severity	• *Mild or moderate*	• *Major*

Treatment	• *Daily review for at least a week:*
	  • *general practitioner on days 1 and 3*
	  • *detoxification nurse on all other days*
	• *Pharmacological treatment*
		• *Hospital admission (≤ 7 days)*
		• *Pharmacological treatment*
		• *Option to transition into residential rehabilitation programs*

Factors to consider	• *No complicating medical, psychological, or psychiatric factors.*	• *Complicating medical (including pregnancy and seizures), psychological or psychiatric factors*
	• *Supportive home environment*	• *Limited or no support*

	• *No other significant substance use*	• *May have significant use of other drugs*
Continuing care	• *Counselling* • *Pharmacotherapy* • *Home or community-based rehabilitation*	• *Counselling* • *Pharmacotherapy* • *Residential rehabilitation*

3 Consider most suitable ***environment for detoxification.***

Environment for detoxification

- *Environment needs to be comfortable and quiet with minimal external stimuli and dim lighting.*
- *Where there are minimal risks and support or supervision is available, home detoxification may be suitable.*
- *Inpatient detoxification should be considered:*
  - *if there are medical comorbidities or possible complications.*
  - *if the home environment is unsafe or there is no support available.*
  - *during pregnancy. Contact ReGen on* ***(03) 9497-1122*** *to consider admission.*
  - *where there is regular or heavy use of other drugs, e.g. benzodiazepines.*
  - *if there are expected or past severe withdrawal symptoms, e.g. alcohol withdrawal seizures.*

4. Give all patients ***thiamine*** to prevent Wernicke's encephalopathy.

Thiamine[2]

Always give thiamine before administering glucose to prevent precipitation of Wernicke's encephalopathy.

Alcohol withdrawal presentation	*Thiamine dose*
Non-nutritionally deficient alcohol dependent patient with no signs of Wernicke-Korsakoff syndrome	• *200 to 300 mg IM in divided doses daily for 3 days* • *100 mg orally or IM daily after day 5*
Alcohol dependent patient with risk factors for thiamine deficiency	• *300 mg IV or IM for 3 to 5 days* • *Then 300 mg orally daily*
Suspected Wernicke-Korsakoff syndrome	• *At least 500 mg (< 900 mg) daily IV or IM for 3 to 5 days or until symptoms subside* • *Then 300 mg orally daily*

Initial doses of thiamine should be given prior to carbohydrate load e.g. dextrose infusions.

5. If medication is required for withdrawal symptoms, generally give ***diazepam*** unless patient has signs of severe liver disease – for these patients, seek specialist advice as hospitalisation may be preferred.

Diazepam regimen for ambulatory alcohol withdrawal

- *Dosing regimen should be individualised and options include:*
  - *Symptom-triggered dosing*
  - *Fixed dose tapering schedule*
  - *Loading dose with or without ongoing fixed dose tapering or symptom- triggered dosing (inpatient)*
  - *Example of fixed dose tapering schedule*
    - *Day 1: 5 to 15 mg four times a day*
    - *Day 2: 5 to 10 mg four times a day*
    - *Day 3: 5 to 10 mg three times a day*
    - *Day 4: 10 mg twice a day*
    - *Day 5: 5 mg twice a day*
  - *Tapering doses may be required over the next 1 to 2 days*
  - *Do not continue beyond 1 week due to risk of patient developing dependence.*
- *Lower doses may be required for some patients e.g., elderly, frail.*
- *Patient should be seen daily by prescribing general practitioner or supporting drug and alcohol worker and provided with only 1 day's supply at a time.*
- *Script should be for quantities expected to be required by patient, not necessarily full PBS quantity.*
- *Contraindications:*
  - *respiratory failure*
  - *significant liver impairment*
  - *possible head injury*
  - *cerebrovascular injury*

Specialist consultation is essential for these patients.

6. Provide ***symptomatic treatment*** for headache, nausea, vomiting, or diarrhoea as needed.

Symptomatic treatment for alcohol withdrawal

Symptom	Medication	Dose
Nausea and vomiting	*Metoclopramide*	*10 mg every four to six hours, not exceeding 30 mg in 24 hours. Reduce dose rate to every eight hours as symptoms abate.*
	Prochlorperazine	*12.5 mg every four to six hours (oral or intramuscular). Reduce dose rate to every eight hours as symptoms abate.*
Diarrhoea	*Loperamide*	*4 mg as a first dose, then 2 mg after each loose stool, to a maximum of 16 mg per day.*
Headache	*Paracetamol*	*500 to 1000 mg every four to six hours, to a maximum of 4 g per day.*

7. Encourage appropriate fluid intake and monitor carefully for signs of dehydration.

8. Provide ***daily monitoring*** in general practice.

Daily monitoring

- *Patient progress – Have they ceased drinking?*
- *Compliance with medications*
- *Temperature, pulse rate, and blood pressure*
- *Level of hydration*
- *Mental state and suicide risk*

9. Discuss:
    - when the patient should make contact with the general practitioner or emergency services.
    - strategies for managing the withdrawal and prevention:
        - Relaxation and distraction techniques
        - Anxiety management
        - Sleep hygiene
        - Stress management
        - Healthy lifestyle choices e.g., nutrition, rest, exercise
10. Consider offering ***relapse prevention medications.***

Relapse prevention medications

- *Treatment duration for all relapse prevention medications is ≥ 6 months.*
- *Choice of drug needs to be individualised:*
    - *Naltrexone reduces rate of relapse and increases number of abstinence days. Well tolerated, once daily dosing. Blocks the effects of opioid analgesia.*
    - *Acamprosate will not interfere with pain relief but is hard to achieve compliance with, due to 3 times daily dosing.*
    - *Disulfiram (Antabuse) is no longer widely used due to lack of effects on cravings, difficulties with compliance and dangers associated with concomitant alcohol use.*
    - *Other agents such as baclofen, anticonvulsants, and ondansetron are showing promising evidence, but their use is off-label and specialist advice is suggested.*

Medication	Mode of Action	Contraindications	Dosage	PBS availability
Naltrexone (Vivitrol, Revia)	*Blocks effects of endogenous opiates released during alcohol consumption, which reduces the pleasurable effect and possibly reduces alcohol cravings.*	*Current or recent use of opioid medication. Patients who suffer from depression should be monitored closely. Acute hepatitis or liver failure.*	*50 mg daily (one tablet).* *Can be started early in withdrawal.* *Consider starting with ½ tablet daily for 1 to 2 days to reduce side-effects.*	*Phone authority for alcohol dependence as part of a comprehensive treatment program with the goal of maintaining abstinence.*
Acamprosate (Campral)	*Reduces neuronal hyperexcitability*	*Pregnancy or*	*Initiate approximately*	*Streamlined authority for*

	characteristic of alcohol withdrawal. Not effective in the acute phase but reduces symptoms of protracted alcohol withdrawal e.g., anxiety, irritability, insomnia, craving.	*breastfeeding.* *Renally cleared. Do not use if serum creatinine is > 120 micromole/L.*	*1 week after cessation of drinking.* *Patients weighing ≥ 60 kg: 666 mg, three times per day.* *Patients weighing < 60 kg: 666 mg in the morning, 333 mg at midday, and 333 mg at night.*	*alcohol dependence as part of a comprehensive treatment program with the goal of maintaining abstinence*
Disulfiram (Antabuse)	*Interacts with alcohol causing unpleasant and sometimes dangerous effects.*	*Significant medical conditions.* *Concerns about compliance.*	*100 mg per day initially.* *Maximum of 300 mg per day.*	*Not PBS listed*
Baclofen	*Muscle relaxant. Showing promise in medium to long term relapse prevention.*	*Seek specialist advice.*	*Seek specialist advice.*	*Off-label, therefore not available on PBS.*

11. Offer to refer all patients for management, counselling, and support via moderate to high risk alcohol and drug treatment assessment.

12. If patient has co-morbid mental health condition and is opposed to seeing a drug and alcohol service, consider referral to adult psychological therapies.

13. Consider seeking advice:
    - If patient is pregnant, contact the Women's Alcohol and Drug Service
    - If requiring clinical advice regarding management of patients, phone Drug and Alcohol Clinical Advisory Service (DACAS) on 1800-812-804.
    - If patient is not ready for face-to-face advice or support, provide contact details for ***DirectLine.***

      DirectLine

      - *Provides (24 hours, 7 days a week) statewide referral and advice for patients, families, and health professionals.*
      - *Phone:* ***1800 888 236***
      - *DirectLine Website*

Referral

- If significantly medically compromised, call 000 for ambulance and transfer to the nearest the Emergency Department for immediate assessment.
- Offer to refer all patients for management, counselling, and support to either of:
  - Low risk alcohol and drug treatment assessment
  - Moderate to high risk alcohol and drug treatment assessment
- If patient has co-morbid mental health condition and is opposed to seeing a drug and alcohol service, consider referral to adult psychological therapies.

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Information

For health professionals

Education

ThinkGP – Active Learning Module and Allied Health Skills: Alcohol and Other Drugs and Sexual Health in Young People

Further information

- Australian Department of Health – Brief Intervention Using FLAGS Approach
- Australian Prescriber – Brief Interventions for Alcohol and Other Drug Use: Table 2 - The 5As Framework for Preventative Care
- Turning Point – Alcohol and Drug Withdrawal Guidelines

For patients

- Australian Department of Health – Reduce Your Risk: New National Guidelines for Alcohol Consumption
- Hello Sunday Morning
- ReachOut.com – Alcohol (for youth)

Sources

References

1. Pennay A, Lubman DI, Frei M. Alcohol: prevention, policy and primary care responses. Aust Fam Physician. 2014 Jun;43(6):356-61.
2. Manning V, Arunogiri S, Frei M, Ridley K, Mroz K, Campbell S, Lubman D. Alcohol and other Drug

Withdrawal: Practice Guidelines. 3rd ed. Richmond, Victoria: Turning Point Alcohol and Drug Centre; 2018.

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