

Harmful drinking and alcohol dependence:

advice from recent NICE guidelines

INTRODUCTION

Harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol. Alcohol dependence is characterised by craving, tolerance, a preoccupation with alcohol, and continued drinking in spite of harmful consequences. In England over 24% of the population consumes alcohol in a way that is potentially or actually harmful to their health or wellbeing and alcohol dependence affects 4% of people aged between 16 and 65 years. The National Institute of Health and Clinical Excellence has produced guidance on alcohol use disorders covering, diagnosis, assessment, and management of harmful drinking and alcohol dependence,¹ and the diagnosis and management of alcohol-related physical complications² It is consistent with the Department of Health's report *Models of Care for Alcohol Misusers*.³ This set out four tiers of intervention; primary health care is a suitable setting for Tier one (identification of hazardous, harmful, and dependent drinkers; information on sensible drinking; simple brief interventions to reduce alcohol-related harm; and referral of those with alcohol dependence or harm for more intensive interventions) and Tier two (provision of open access facilities and outreach that provide: alcohol-specific advice, information, and support; extended brief interventions to help alcohol misusers reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems).

Both clinical guidelines are directed primarily to secondary care medical services and to specialist alcohol services, but there are areas of interest for primary care practitioners. The guidance is clear that all assessment and interventions, including prescribing, should only be carried out by professionals competent to do so.

GUIDANCE

A number of principles are important in the

delivery of care to people who misuse alcohol, including the importance of developing a trusting relationship, the need to be non-judgemental, and to be aware that people may minimise the problem because of the stigma attached to alcohol misuse. Families or carers may need assessment of their own needs. Recommendations are included to offer self-help with written material to families and carers, as well as information about support groups. Family meetings are recommended for families and carers who have not or are unlikely to benefit from support groups and have significant problems. If the patient has children or is in regular contact with children the impact of the parent's drinking on the child and the parent-child relationship needs to be considered.

Assessment

Four levels of assessment are described. Level one is case identification/diagnosis; level two is withdrawal assessment; level three is triage assessment; and level four is comprehensive assessment. The assessment of risk should be part of any assessment. This includes risk to self (including unplanned withdrawal, suicidality, and neglect) and risk to others. The extent of any associated health and social problems and the need for assisted alcohol withdrawal should also be part of assessment.

1. Case identification

The objective of case identification is to identify people who need an intervention for harmful drinking or alcohol dependence, and to identify those who may need referral for comprehensive assessment as they have not responded to brief interventions the in past, need assisted alcohol withdrawal, or show signs of clinically significant alcohol-related impairment. Case identification should consider:

- establishing the probable presence of an alcohol-use disorder;

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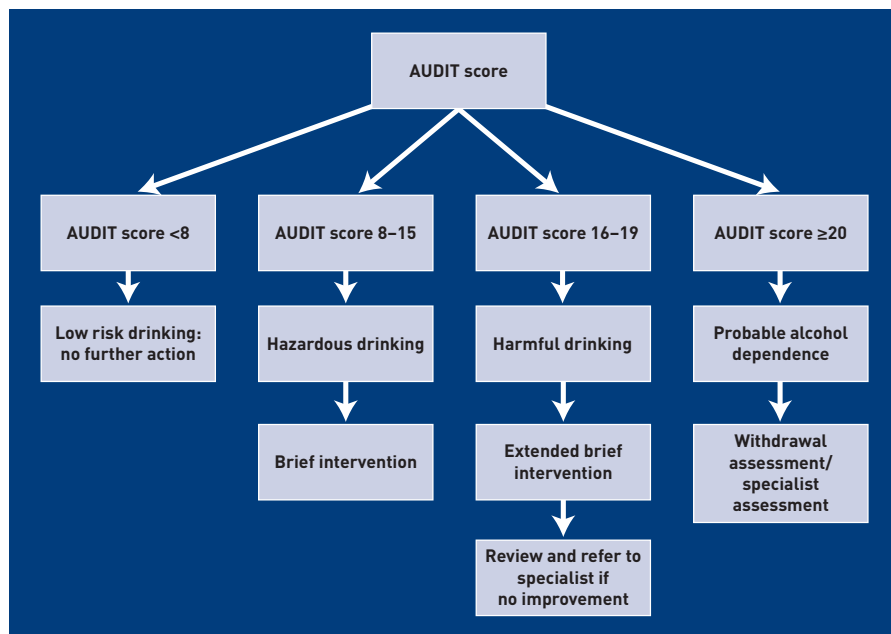


Figure 1. Case identification for adults — adapted from NICE CG115.

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- the level of alcohol consumption (as units of alcohol per day or per week);
- distinguish harmful drinking from alcohol dependence;
- establishing the presence of risks (for example, self-harm, harm to others, medical/mental health emergencies, and safeguarding children);
- establishing the capacity to consent to treatment or onward referral;
- experience and outcome of previous intervention(s);
- establishing the willingness to engage in further assessment and/or treatment;
- establishing the presence of possible co-existing common problems features (for example, additional substance misuse, medical, mental health, and social problems); and
- determining the urgency of referral and/or an assessment for alcohol withdrawal.

The guideline recommends the use of formal assessment tools and the Alcohol Use Disorders Identification Test (AUDIT) tool is recommended for case identification. The tool has 10 items across three domains: alcohol consumption, alcohol dependence, and alcohol-related problems. Using a cut off of >8, AUDIT has high sensitivity and specificity to identify alcohol-dependent patients in UK primary care. The AUDIT score indicates likelihood of need for assisted withdrawal from alcohol and ongoing pathway through services (Figure 1). The tool is freely available on the internet and is easily scored.

2. Withdrawal assessment

The assessment of the need for a medically managed withdrawal also uses the AUDIT score. A person who drinks more than 15 units of alcohol a day or scores ≥ 20 on AUDIT should be considered for an assisted withdrawal. Inpatient and residential assisted withdrawal should be considered if one or more of the following criteria are met:

- daily intake over 30 units of alcohol;
- have a score of more than 30 on the Severity of Alcohol Dependence Questionnaire (SADQ);
- have a history of epilepsy or experience of withdrawal-related seizures or delirium tremens during previous assisted withdrawal programmes;
- need concurrent withdrawal from alcohol and benzodiazepines; and
- regularly drink between 15 and 20 units of alcohol per day and have:
 - significant psychiatric or physical comorbidities (for example, chronic severe depression, psychosis, malnutrition, congestive cardiac failure, unstable angina, chronic liver disease); or
 - a significant learning disability or cognitive impairment.

People who are alcohol dependent should be advised not to suddenly reduce intake of alcohol to avoid withdrawal and referred to local alcohol support services.

Community-based assisted withdrawal is appropriate for people with mild to moderate dependence. Programmes should consist of a drug regimen and psychosocial support including motivational interviewing. An average of two to four meetings between staff and the patient per week in the first week is suggested. Fixed dose regimens are recommended for community-based withdrawal programmes and symptom-triggered regimes reserved for an inpatient setting where appropriate monitoring is available. A fixed dose regimen involves starting treatment with a standard dose, not defined by the level of alcohol withdrawal and reducing the dose to zero over 7–10 days according to a standard protocol. The preferred medication for assisted withdrawal is a benzodiazepine (chlordiazepoxide or diazepam). Clomethiazole should not be used for assisted withdrawal in the community because of the risk of overdose and misuse. The initial dose of medication should be titrated to the severity of alcohol dependence and/or regular daily level of alcohol consumption. The guidance

Table 1. Alcohol withdrawal symptoms and their timelines

Timeline from last drink	Alcohol withdrawal symptoms
Onset: 6–8 hours	Generalised hyperactivity, tremor, sweating, nausea, retching,
Peak: 10–30 hours	mood fluctuation, tachycardia, increased respirations,
Subsides: 40–50 hours	hypertension, and mild pyrexia
Onset: 0–48 hours	Withdrawal seizures
Onset: 12 hours	Auditory and visual hallucinations may develop that are
Duration: 5–6 days	characteristically frightening
Onset: 48–72 hours	Delirium tremens: coarse tremor, agitation, fever, tachycardia,
	profound confusion, delusions, and hallucinations

recommends installment dispensing, with no more than 2 days' medication supplied at any time. In a community-based assisted withdrawal programme, monitoring the patient every other day during assisted withdrawal and having a family member or carer oversee the administration of medication is recommended. The guideline is accompanied by a sample chlordiazepoxide dosing regime.

Patients can present in acute unplanned withdrawal. Admission to hospital is recommended for those with alcohol withdrawal seizures or delirium tremens, for those at high risk (for example, those who have a history of alcohol withdrawal seizures or delirium tremens), and for certain vulnerable people (for example, those who are frail, have cognitive impairment, multiple comorbidities, or lack social support). Admission is also recommended for people under 16 years in acute alcohol withdrawal. The guideline includes a helpful table of possible alcohol withdrawal symptoms and their timelines (Table 1).

Triage assessment and comprehensive assessment people are part of assessment by specialist alcohol services. Comprehensive assessment should be considered for all who score more than 15 on AUDIT.

General principles for all interventions

Everyone who misuses alcohol should be offered interventions to promote abstinence or moderate drinking as appropriate and prevent relapse. A motivational intervention should be carried out as part of the initial assessment. The intervention should contain the key elements of motivational interviewing including: helping people to recognise problems or potential problems related to their drinking, helping to resolve ambivalence, and encourage positive change and belief in the ability to change, adopting a persuasive and supportive rather than an argumentative and confrontational position. All people seeking help for alcohol misuse should be given information on the value and availability of community support

networks and self-help groups (for example, Alcoholics Anonymous or SMART Recovery) and supported to engage with such groups.

Interventions: maintenance of abstinence

For harmful drinkers and people with mild alcohol dependence, a psychological intervention focused specifically on alcohol-related cognitions, behaviour problems, and social networks is recommended. Acamprosate or oral naltrexone can be added for people who have not responded to psychological interventions alone, or who have specifically requested a pharmacological intervention.

For people with moderate and severe alcohol dependence acamprosate or oral naltrexone can be added following successful withdrawal. Disulfiram may be used when acamprosate and oral naltrexone are not suitable, or disulfiram is preferred and the patient understands the relative risks of taking the drug. The guideline provides details about the necessary evaluation required before prescribing these drugs and the monitoring required.

Comorbid conditions and complications of alcohol misuse

Comorbid mental health disorders commonly include depression, anxiety disorders, and drug misuse. Physical comorbidities are common, including gastrointestinal disorders (in particular liver disease) and neurological and cardiovascular disease. In some people these comorbidities may remit on stopping or reducing alcohol consumption, but many experience long-term consequences of alcohol misuse. For people with comorbid depression or anxiety disorders, the alcohol misuse should be treated first. Depression or anxiety persisting after several weeks' abstinence should be assessed and treated. People with significant comorbid mental health disorder, and those at high risk of suicide, should be referred to a psychiatrist to make sure that effective assessment, treatment, and risk-management plans are in place.

Thiamine should be given to people at high risk of developing, or with suspected, Wernicke's encephalopathy. Doses should be toward the upper end of the *British National Formulary* range. Oral thiamine should be given to harmful or dependent drinkers who are malnourished or at risk of malnourishment, have decompensated liver disease, are in acute withdrawal, or before and during a planned medically-assisted alcohol withdrawal.

Provenance

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