



WaMH in PC

Wales Mental Health in Primary Care Information Sheet 17

A Briefing Note for GPs and Primary Care Practitioners Alcohol Use Disorder

Aims of this information sheet

- To examine how big a problem alcohol plays in a community's health
- To outline the harm caused by alcohol use
- To explore the presentation of problematic drinking
- To define levels of problematic alcohol use
- To outline the vital role a GP can play at all stages of presentation
- To outline the role played by specialist services
- To highlight the risk of Alcohol Use Disorder in doctors and signpost to appropriate services

Alcohol related harm

- Alcohol is the third biggest contributing factor to morbidity and mortality in the developed world, causing around 1000 deaths per year in Wales.
- Problem drinking costs Wales around £1 billion per year and the UK around £21 billion per year (BMA News, 2012).
- In 2010/11 there were over 1 million reported incidences of alcohol-related violent crime in England and Wales.
- Alcohol misuse is rising in the UK, with a corresponding drop in age of presentation of alcohol related liver disease.
- Alcohol plays a significant role in domestic violence, being involved in 62% of cases in the UK, with 48% of perpetrators being alcohol dependent (Gilchrist, 2003).
- 82% of 16-30-year-olds in the UK reported drinking alcohol before sexual activity. This increases vulnerability to unintended pregnancy, STIs and sexual assault (Alcohol and Sex: a cocktail for poor sexual health, Alcohol and Sexual Health Working Party, 2011).
- Alcohol is the biggest preventable cause of birth defects, with FASD (Foetal Alcohol Spectrum Disorder) affecting around 1% of live births in Europe (Autti-Ramo, 2002).

Levels of alcohol use in the UK

Despite its catastrophic effect on the lives of many, alcohol use has been embedded in our culture since primitive society, with evidence of its use as far back as 6000BC.

It is weaved into every aspect of our day to day lives, being glamorized by the media and the sports industry, available around the clock at affordable prices. So how much are we actually drinking? And is this OK?

- 69% of men and 55% of women drink alcohol at least once per week.
- 37% of men and 29% of women exceed the RDA (hazardous drinking).
- 3.6% of adults in the UK are dependent on alcohol (1.1 million people) (ONS/NHS England 2011) - of which only around 6% receive treatment (NICE CG115).

In Wales specifically, the report 'A profile of alcohol and health in Wales' (2009) suggests:

- Around 1,000 deaths per year in Wales are attributable to alcohol.
- The average annual number of alcohol-related hospital admissions in Wales is around 8,400 for males and 4,500 for females (1.5% of all admissions).
- Of the 40 countries surveyed, Wales had the highest % of 13 year olds having been drunk more than twice (27% of boys; 26% of girls).

What role can GPs play?

On average, a third of adult patients will be drinking in a way that puts their health at risk.

Screening for Alcohol Use Disorder

AUDIT is a 10 question screening tool for Alcohol Use, developed by the World Health Organisation (WHO).

The first 3 questions can exclude patients who have no evidence of problematic alcohol use (AUDIT C).

To fill in the screen, some basic understanding of alcohol units is required. This can be aided by access to a unit calculator, which is widely available, or a knowledge of how to calculate alcoholic units.

% Vol x Volume consumed in litres = units

e.g. Whisky 40% vol x 1 litre = 40 x 1 = 40 units

Lager 5% vol x 500 ml = 5 x 0.5 = 2.5 units

Any member of the primary healthcare team (who has had training in how to complete it) can administer the AUDIT screen.

PLEASE NOTE: The AUDIT screen can be accessed on many GP computer systems.

Interpretation of AUDIT score

Score <8 Simple health advice.

Score 8-15 Defined as 'Hazardous Drinking'. Brief advice is recommended.

Score 16-19 defined as 'Harmful Drinking'. Consider extended brief advice, or referral/signposting to local alcohol services.

Score >20 Increased risk of dependent drinking. Consider completing an SADQ (to assess for signs of dependence) and offer referral to local alcohol service.

More information and resources are available at:

- www.patient.co.uk/doctor/alcohol-use-disorders-identification-test-audit
- www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice

Identification of at risk groups

The list below is a suggestion of some common primary care presentations which should trigger a thought to ask about alcohol use. It is by no means exhaustive.

- **Physical health problems:**

Hypertension; obesity; GORD; diabetes; peripheral neuropathy; mouth cancers; falls; trauma.

- **Mental health problems:**

Anxiety; depression; insomnia; confusional states; memory problems; suicide attempts; other addictive processes.

- **Social problems:**

Domestic abuse; divorce; bereavement; homelessness; offending.

- **Investigation abnormalities:**

Raised GGT; abnormal LFT; raised MCV; low platelets; raised lipids.

Harmful drinking and mild dependence

The goal will usually be a reduction in alcohol use, and mainstay of intervention is psychological therapy, with the addition of pharmacological support such as Acamprosate or Naltrexone (NICE CG115).

This group of clients may also benefit from newer licensed agents such as Nalmefene.

Moderate and severe dependence:

The brain, if exposed on a regular basis to significant concentrations of alcohol, will undergo changes in receptor activity in order to function more efficiently in the presence of alcohol. These changes result in the brain overcompensating when alcohol is removed abruptly, resulting in a physical withdrawal syndrome developing.

Typical presentation is of anxiety and craving for alcohol, progressing to tremor, sweating, headache, nausea and vomiting, and, if untreated, potentially developing into altered perceptions, hallucinations, acute confusional state, seizures and ultimately death in a small amount of cases.

The majority of dependent patients treat withdrawal early with consumption of alcohol, but unmediated withdrawal may result if the alcohol is unavailable, due to intercurrent illness, funding issues, incarceration or overly keen relatives.

Even if the GP may not be specialised in alcohol detoxification, there is a great deal that can be done in primary care to support this group of patients. The following is a good place to start:

1. **Take an accurate history and identify the problem.**
2. **Offer signposting / referral to local alcohol services.**
3. **Organise routine investigations** to include FBC, LFT, GGT, U and E and, if there is evidence of liver impairment, clotting studies.
4. **Prescribe Thiamine** at a dose of up to 100mg tds.
5. **Signpost to voluntary sector** support groups such as AA, but warn patients of dangers of abrupt cessation of alcohol.
6. **Screen for co-existing addictive process**, such as opioid painkiller dependence, or misuse of illicit drugs.
7. **Screen for underlying factors** that may have triggered alcohol use, such as social anxiety or mood disorder, and consider treating these with caution and careful monitoring.
8. **Review prescribed medications**, and prescribe with caution those which may interact adversely with alcohol, such as benzodiazepines, NSAIDs, anticoagulants.
9. Provide the patient with ongoing **non-judgmental support and motivation.**

What is brief advice?

Brief advice has been formalised to allow it to be acknowledged and taught. But it outlines to a large extent the bread and butter of what we as GPs do day in, day out, in our consultations. It is very likely that you are delivering brief advice on a daily basis, perhaps without labelling it formally as such.

The structure can be outlined using the 'FRAMES' acronym:

- **Feedback:** to the patient regards a clinical observation (test result, AUDIT score, symptom or clinical condition)
- **Responsibility:** The holy grail of healthcare- empowering the client to make choices regarding their outcome
- **Advice:** Pros and cons of behaviour change
- **Menu of options:** Choices for a patient to consider (reduction vs. abstinence, AA, local services, online resources, bibliotherapy etc.)
- **Empathy:** The key element of engagement in a therapeutic relationship.
- **Self efficacy:** Belief in the patient's ability to change their behaviour

Post detoxification support of relapse prevention

Once a patient has undergone a medically assisted detoxification, they will be encouraged to remain abstinent. This is more difficult than it may sound, and the majority of patients will relapse within the first year. There are many things that can be done to lessen the risk of relapse, and some of these are ideally delivered from primary care. All clients should be offered psycho social support (usually delivered through specialist services) and also signposting to the voluntary sector. There are several medications licensed for use in relapse prevention:

Acamprosate is designed to reduce cravings to drink. It is initiated at detox, and NICE recommend its use for the first year post detox, as long as abstinence is being maintained. It requires no specialist monitoring, although patients should be engaging in some form of psycho social intervention. It is not dangerous to consume alcohol, but if regular consumption is resumed prescribing should be reviewed and usually withdrawn.

Disulfiram disables aldehyde dehydrogenase, therefore blocking alcohol metabolism at the stage of the highly toxic aldehyde metabolite. It does nothing to reduce craving to drink, but can serve as a severe deterrent to alcohol consumption, as the effects of consuming alcohol while on this medication are unpleasant, and can be dangerous. It is recommended to be prescribed only by those with specialist knowledge of its use, however GPs can play a part by supporting the patient with the required 12 weekly LFT monitoring, and ensuring patients are not unwittingly exposed to alcohol in a clinical situation (alcowipes for example).

Naltrexone is now licensed for use in relapse prevention following alcohol detoxification. LFTs are required prior to starting treatment, and patients must be made aware that the medication, being an opioid blocker, will significantly interfere with any opioid based painkillers. It is contra indicated for this reason in opioid dependence, as it will precipitate withdrawal.

Alcohol Use Disorder in doctors

Many a doctor has identified a patient with alcohol problems as one who drinks more than them, but with increasing understanding of alcohol use in the profession, this may be an unwise benchmark. A report in 1998 by the BMA working group estimated that 'one in 15 doctors may be affected by a drug or alcohol problem at some point in their career'. The demographic of those most likely to be affected were male doctors in primary care, beyond the mid point of their career.

If this factsheet, or other information has raised concerns about your own health, don't panic! You are not alone and help is available. The good news is that research indicates that once given the right help, doctors have exceptionally positive outcomes - with over 80% doing well over a 5 year follow up period (Galanter 1990, Bohigan 1996). Here are some useful resources for doctors:

- **Have your own GP** - and learn to 'be a patient'
- **General Medical Council (GMC) website:** www.gmc-uk.org/concerns/doctors_health_concerns.asp
- **British Medical Association (BMA) website:** bma.org.uk/practical-support-at-work/doctors-well-being/websites-for-doctors-in-difficulty
- **British Doctors and Dentists Group (BDDG) website:** www.bddg.org
- **Health for Health Professionals Wales (HHP Wales):** www.hhpwales.co.uk or call 0800 058 2237. Health for Health Professionals Wales is a Welsh Government funded initiative which offers a **free, confidential helpline** to any doctor in Wales, access to 8 sessions of CBT and signposting to support resources.

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