VITAMIN SUPPLEMENTS

D **Patients with any sign of Wernicke-Korsakov syndrome should receive Pabrinex in a setting with adequate resuscitation facilities. The treatment should be according to British National Formulary *(BNF)* recommendations and should continue over several days, ideally in an inpatient setting.**

☑ Patients detoxifying in the community should be given intramuscular Pabrinex (one pair of ampoules daily for three days) if they present with features which put them at risk of Wernicke-Korsakov syndrome.

☑ Patients who have a chronic alcohol problem and whose diet may be deficient should be given oral thiamine indefinitely.

DELIRIUM TREMENS

D **Local protocols for admitting patients with delirium tremens should be in place.**

REFERRAL AND FOLLOW UP

A **Access to relapse prevention treatments of established efficacy should be facilitated for alcohol dependent patients.**

B **When the patient has an alcohol related physical disorder, the alcohol treatment agency should have close links with the medical and primary care team.**

B **Primary care teams should maintain contact over the long term with patients previously treated by specialist services for alcohol dependence.**

LAY SERVICES

C **Alcohol dependent patients should be encouraged to attend Alcoholics Anonymous.**

D **If patients are referred to a lay service, agencies where lay counsellors use motivational interviewing and coping skills training should be utilised.**

ALCOHOL DEPENDENCE AND PSYCHIATRIC ILLNESS

B **Patients with an alcohol problem and anxiety or depression should be treated for the alcohol problem first.**

☑ Patients with psychoses should be referred for psychiatric advice.

ALTERNATIVE THERAPIES

There is insufficient evidence to make any recommendations about the use of acupuncture, transcendental meditation or other alternative therapies in treating patients with an alcohol problem.

PATIENTS AND FAMILIES

C **The primary care team should help family members to use behavioural methods which will reinforce reduction of drinking and increase the likelihood that the drinker will seek help.**

There is widespread acceptance that the GP is the most appropriate first point of contact once a patient has decided to seek help. However, there are considerable fears or reservations associated with seeking such help even where a good relationship exists with the GP.

Patients often progress from mild misuse of alcohol to more extreme stages so it is important to try to address any problem at an early stage, seeking medical assistance where necessary.

Having a family member with an alcohol problem can seriously affect a family, where family members and friends can become anxious, depressed or alienated. Financial problems caused by the purchase of alcohol, coupled with reduced earnings potential also impact on the family.

☑ It should be stressed to patients that stopping or cutting down their drinking can only result from their own decision to do so. Any treatment, from whatever source, can only be an aid to taking this decision and following it through.

USEFUL INFORMATION

Alcoholics Anonymous
National helpline: 0845 76 97 555
Website: www.alcoholics-anonymous.co.uk

AL-ANON
Mansfield Park, Unit 6
22 Mansfield Street
Glasgow, G11 5QP
24h telephone service: 0141 339 8884
Support for families and friends of alcoholics

Down Your Drink
Online program for reducing drinking
Website: www.downyourdrink.org.uk

Scottish Intercollegiate Guidelines Network

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Management of harmful drinking and alcohol dependence in primary care

Quick Reference Guide

September 2003

Management of harmful drinking and alcohol dependence in primary care

This Quick Reference Guide provides a summary of the main recommendations in the SIGN guideline on the Management of harmful drinking and alcohol dependence in primary care.

Harmful drinking and alcohol dependence are common conditions which contribute considerably to morbidity, mortality and burden to the NHS, as well as causing social harm.

This guideline contains recommendations for effective practice based on current evidence.

The recommendations are graded A B C D to indicate the strength of the supporting evidence.

Good practice points ☑ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: **www.sign.ac.uk**

DEFINITIONS

Unit of alcohol = a beverage containing 8 g of ethanol, eg a half pint of 3.5% beer or lager, or one 25 ml pub measure of spirits. A small (125ml) glass of average strength (12%) wine contains 1.5 units.

Hazardous drinking = the regular consumption of over 40 g of pure ethanol (5 units) per day for men or over 24 g of pure ethanol (3 units) per day for women.

Harmful drinking = a pattern of drinking that causes damage to physical (eg to the liver) or mental health (eg episodes of depression secondary to heavy consumption of alcohol).

Alcohol dependence = a cluster of physiological, behavioural, and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that previously had greater value. A central characteristic is the desire (often strong, sometimes perceived as overpowering) to drink alcohol.

DETECTION AND ASSESSMENT

D **Primary care workers should be alerted by certain presentations and physical signs, to the possibility that alcohol is a contributing factor and should ask about alcohol consumption.**

B **Abbreviated forms of AUDIT† *(eg FAST†)*, or CAGE† plus two consumption questions, should be used in primary care when alcohol is a possible contributory factor.**

C **In A&E, FAST† or PAT† should be used for people with an alcohol related injury.**

B **TWEAK† and T-ACE† *(or shortened versions of AUDIT)* should be used in antenatal and preconception consultations.**

BRIEF INTERVENTIONS

A **General Practitioners *(GPs)* and other primary care health professionals should opportunistically identify hazardous and harmful drinkers and deliver a brief *(10 minute)* intervention.**

B **Motivational interviewing techniques should be considered when delivering brief interventions for harmful drinking in primary care.**

☑ Staff who deliver motivational interviewing should be appropriately trained.

D **Training for GPs, practice nurses, community nurses and health visitors in the identification of hazardous drinkers and delivery of a brief intervention should be available.**

☑ Patients who screen positive for harmful drinking or alcohol dependence in A&E should be encouraged to seek advice from their GP or given information on how to contact another relevant agency.

† Details of these screening tests are available in the full guideline or from the SIGN website **www.sign.ac.uk**

DETOXIFICATION

Hospital detoxification is advised if the patient:

- is confused or has hallucinations
- has a history of previous complicated withdrawal
- has epilepsy or a history of fits
- is undernourished
- has severe vomiting or diarrhoea
- is at risk of suicide
- has severe dependence and is unwilling to be seen daily
- has a previously failed home-assisted withdrawal
- has uncontrollable withdrawal symptoms
- has an acute physical or psychiatric illness
- has multiple substance misuse
- has a home environment unsupportive of abstinence.

Community detoxification

Community detoxification is an effective and safe treatment for patients with mild to moderate withdrawal symptoms.

☑ Where community detoxification is offered, it should be delivered using protocols specifying daily monitoring of breath alcohol level and withdrawal symptoms, and dosage adjustment.

☑ Intoxicated patients presenting in GP practices, out-of-hours services and A&E, requesting detoxification should be advised to make a primary care appointment and be given written information about available community agencies.

Pharmacological detoxification

Medication may not be necessary if:

- the patient reports consumption is less than 15 units/day in men or 10 units/day in women and reports neither recent withdrawal symptoms nor recent drinking to prevent withdrawal symptoms
- the patient has no alcohol on breath test, and no withdrawal signs or symptoms.

D **When medication to manage withdrawal is not needed, patients should be informed that at the start of detoxification they may feel nervous or anxious for several days, with difficulty in going to sleep for several nights.**

A **Benzodiazepines should be used in primary care to manage withdrawal symptoms in alcohol detoxification, but for a maximum period of seven days.**

D **For patients managed in the community, chlordiazepoxide is the preferred benzodiazepine.**