Quality in Practice Committee

ICGP

Helping Patients with Alcohol Problems – A Guide for Primary Care Staff

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The guide does not however override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of individual patients in consultation with the patient and/or guardian or carer.

Guidelines are not policy documents. Feedback from local faculty and individual members on ease of implementation of these guidelines is welcomed.

KEY TO EVIDENCE STATEMENTS AND GRADES OF RECOMMENDATIONS

Scottish Intercollegiate Guidelines Network 2003, Homepage of Scottish Intercollegiate Guidelines Network, [Online]. Available: *http://www.sign.ac.uk/pdf/sign74.pdf*

LEVELS OF EVIDENCE

1++ High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias

1+ Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1- Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++ High quality systematic reviews of case control or cohort or studies

High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+ Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2- Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3 Non-analytic studies, e.g. case reports, case series

4 Expert opinion

GRADES OF RECOMMENDATIONS

A At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 1++ or 1+

C A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 2++

D Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2+

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Introduction

This guide is written for primary care health professionals and staff. Alcohol is responsible for a wide range of health and social harms in society and places a significant burden on the resources of the State in dealing with the consequences of its use and misuse[1].

Ireland is ranked seventh highest for alcohol consumption in the EU[2]. With approximately 4 in 5 Irish adults reporting their consumption of the substance, alcohol use is suggested to be embedded within the cultural fabric of the nation, receiving a level of accommodation extended to no other drug[3,4]. On average, Irish adults binge drink more than adults in any other European country with 44% of those who drink stating that they binge drink on a regular basis[5].

Primary care has the responsibility to identify and intervene with patients whose drinking is hazardous and harmful to their health[6] (Grade D). Yet, only a small percentage of patients with alcohol problems are actually screened and treated in primary care as there is a reluctance to get involved in this area[7] (Grade D). This has been due to many factors including lack of training, poor outcome expectations and lack of support. These guidelines attempt to redress some of these difficulties.

It is not a "one size fits all" approach but that of trying to tailor the best fit to the patient. Many approaches are implementable in, and appropriate to the primary care setting[8].

In a Cochrane Review, Kaner *et al.* (2007) concluded that brief intervention in primary care settings consistently led to reductions in alcohol consumption[9].

In a meta-analysis review of 22 studies, Vasilaki *et al.* (2006) concluded that motivational interviewing is an effective intervention in relation to reducing alcohol consumption. Its value was particularly noticeable among young, heavy or low dependent drinkers, and among those who voluntarily seek help for alcohol problems[10].

If you are not already doing so, you are encouraged to incorporate alcohol screening and intervention into your practice. You are in a prime position to make a difference[11] (Grade D).

Why screen for alcohol problems?

It is now recognized that the traditional focus on heavy drinking needs to be broadened to include the large group of drinkers whose problems are less severe.[1]

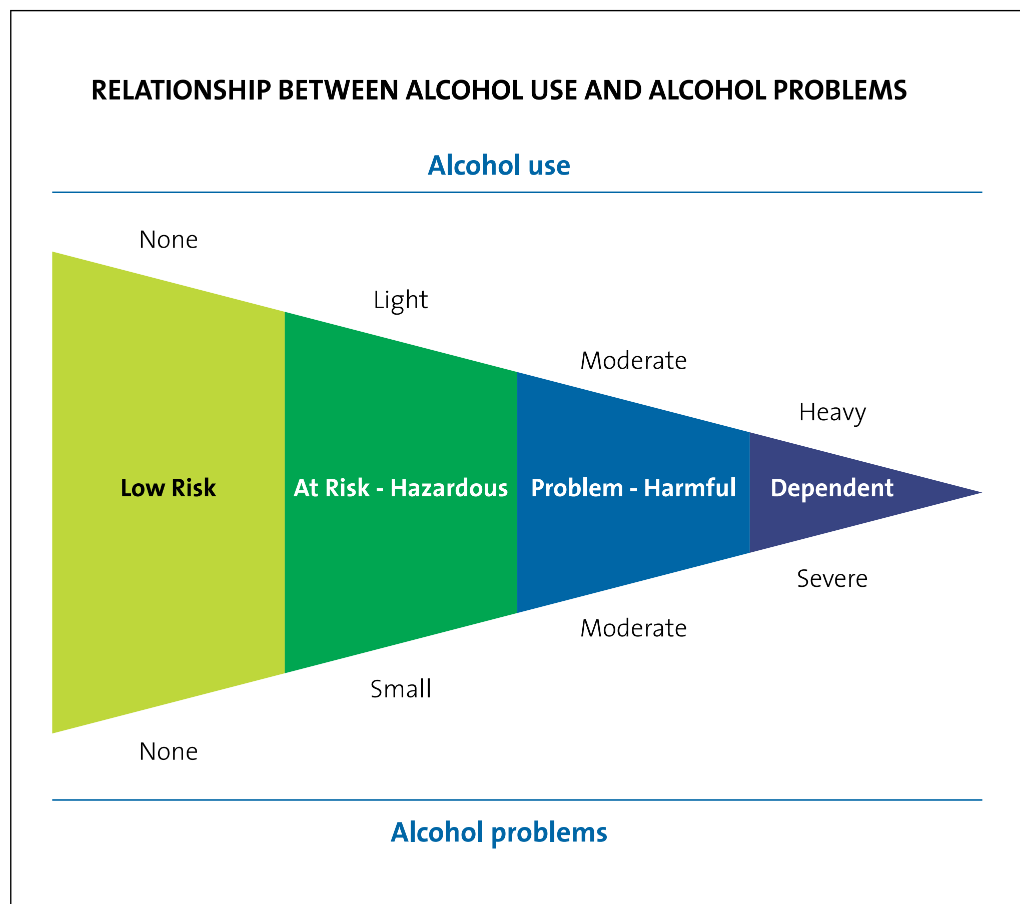
- Alcohol problems are very common in Ireland. All heavy drinkers have increased health risks[12] (Grade D).

- It often goes undetected[12] (Grade D).
- It makes sense! – Numbers needed to treat; eight patients need to be advised for one patient to benefit[6] (Grade A).

Brief interventions in primary care and other interventions help patients to change their risk category[12] (Grade A).

What is an alcohol problem?

Traditionally alcohol problems were equated with alcohol dependence. In fact there are a range of alcohol problems - "low risk", "hazardous", "harmful" and "dependent".



Patients can move from low risk to hazardous and harmful drinking or vice versa at any stage of their lives.[13] (Grade B)

Definitions

Hazardous	A level of consumption or pattern of drinking that is likely to result in harm should present drinking habits persist. This includes any drinking by pregnant women, children under 16 years of age and people who are ill or receiving treatment or who perform activities that are not advised when drinking[6] (Grade B).
Harmful	A pattern of drinking that causes damage to health, either physical or mental[6] (Grade B).
	Heavy Episodic Drinking: Sometimes called binge drinking and particularly damaging to health. Regular consumption (at least once per week) of six or more standard drinks[6] (Grade B). In Irish culture binge drinking often refers to regularly 'drinking to get drunk'.
Dependence	A cluster of psychological, behavioural and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that once had greater value[6] (Grade B).
Standard drink	In Ireland a standard drink is equivalent to 10grams of alcohol

Irish Guidelines for Low risk Drinking[14]

HEALTH SERVICE EXECUTIVE (2009) A STANDARD DRINK IN IRELAND: WHAT STRENGTH?

	STD DRINK PER WEEK	GRAMS OF PURE ALCOHOL
Men	17	168
Women	11	112

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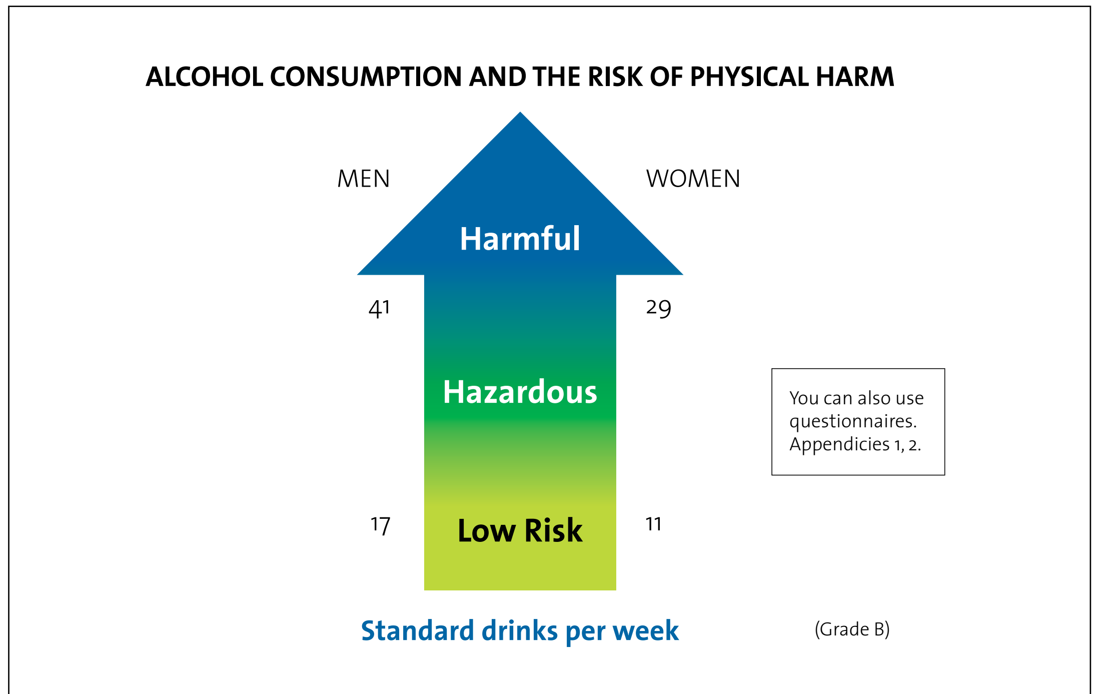
How can I help patients to find their risk category?

As a rough guide, the following consumption arrow chart can be used to assess risk. This can be copied and discussed with patients.



[Developed for ICGP Project by Anderson, R., based on chart used in 'Medical Students Handbook – Alcohol and Health' by Morgan, M. and Ritson, B. London: Medical Council on Alcohol (2003) and based on figures from Steering Group Report on National Substance Misuse Strategy 2012 Dept of Health Dublin]

Standard drink		*(all approximate)*
	1 pint of beer	= 2 standard drinks
	1 can lager	= 2 standard drinks
	1 can strong lager	= 3 standard drinks
	1 measure of spirits	= 1 standard drink
	1 glass of sherry	= 1 standard drink
	1 small glass of wine	= 1 standard drink (100mls)
	1 bottle of wine	= 7-9 standard drinks (depending on %)

Patients are often unaware of risk limits therefore primary care staff have an important role in giving accurate information on limits in general, as well as specific limits such as: age, gender, life events and biological factors. What constitutes low risk for one patient may be hazardous for another so clinical judgement is always important. The use of the ICGP/HSE Standard Measure Glass issued in 2014 may be helpful in this regard. More information on the Standard Measure Glass is available from: *www.icgp.ie/drinksguide*

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Decisions to be made prior to screening for alcohol problems

Who should do the screening?

Screening of risk should be part of any assessment and staff should be competent to identify alcohol misuse. This assessment should also identify the need for appropriate intervention whether by Primary Care team members or specialist service. The screening can be conducted by:

- GP only
- Practice Nurse only
- GP and Practice Nurse
- Questionnaire distributed by Receptionist – scores discussed with patients by Doctor/Practice Nurse (If receptionist involved it is essential to have signs up in the surgery)

How long should screening take?

An issue frequently raised is the length of time this consultation could take and how to allocate this time in a busy general practice. According to the WHO guidelines on brief intervention in hazardous alcohol drinking screening should only take two to four minutes with less than one minute taken to score the test[15,16].

Which screening tool(s) should you use?

Full A.U.D.I.T. is probably best (Appendix 1) but AUDIT 'C' (Appendix 2) is recommended for initial screening[6,16] (Grade B). The CAGE[17] (Grade B) questionnaire (Appendix 2) can be used in addition, usually only when dependence is suspected.

Who will you screen?

- All new patients
- Patients attending for occupational health issues
- Patients attending for women's/men's health screening
- Random screening and/or Opportunistic screening of all patients
- Target Patients (based on symptoms, clinical suspicion, information from family members) (see Appendix 6).

How you will record the data?

Alcohol consumption and pattern of drinking should be recorded. The results of the questionnaire(s) should be noted and dated. If possible information given by family members regarding the patient's drinking should be included in the notes. Patients should always give permission for screening if such screening is random.

Screening – the Double AA Approach* (Grade D)

*[*Anderson, R. developed this specific concept for Irish College of General Practitioners Project: "Helping Patients with Alcohol Problems" (2000 – 2007), based on other brief interventions]*

Step 1 - ASK

- Ask patients about their alcohol consumption. Ask about amounts, frequency and patterns. Use 'A.U.D.I.T. C'. Inform patient of results. Encourage those who are 'low risk' to stay in that category. Remember some patients will be 'no risk' as they do not drink at all. Some will have stopped drinking due to problems in the past. If positive result from A.U.D.I.T. C (i.e. 4 or more for adult women, 5 or more for adult men) then move to step two.

Step 2 – ASSESS

- Level of risk (hazardous, harmful or dependent), by using results of full A.U.D.I.T., consumption arrow chart and clinical observations/examination/ biological tests. You can use CAGE in addition if dependence is suspected.

Criteria for Alcohol Dependence Syndrome –ICD 10[18] (Grade B)

- **evidence of tolerance**
- **physiological withdrawal state when alcohol is reduced or ceased**
- **persisting with alcohol use despite clear evidence of harmful consequence**
- **preoccupation with alcohol use**
- **impaired capacity to control drinking behaviour**
- **a strong desire or compulsion to use alcohol**

Return to drinking after a period of abstinence is often associated with rapid reappearance of the features of the syndrome

- Mental state, with particular reference to depression and treat accordingly.
- Collateral history from a relative or friend if possible.
- Readiness to change, consider using 'Wheel of Change'[19] (Grade D) and 'Decision Balance'[20] (Grade D). (These are illustrated on the accompanying sheet for use in the consultation – See Appendix 9).

Step 3 – ASSIST

- Inform patients of results from assessment.
- Respond to the patient's presenting complaint.
- Give advice on alcohol interaction with any medication prescribed.
- Encourage patients to change, by using brief intervention[12] (Grade A) and motivational techniques[21] (Grade B), (Appendix 3), gentle persuasion, mutual respect, sincere concern and patience (see below).

- Inform patients of the advantages of cutting down or stopping, such as improved health, relationships and financial status.
- Explain result to patients and risk categories.
- Provide practical help:
  - If in hazardous category advise patients to
    - » set a date to cut down and look for support
    - » keep a weekly diary of consumption (see Apendix 9)
    - » water down alcohol and drink slowly
    - » drink water and/or soft drinks between alcoholic drinks
    - » put alcohol in least favoured hand at meals and have a glass of water in the favoured hand in order to consume less alcohol
    - » avoid solitary or secretive drinking
    - » never drink and drive
    - » keep active and develop interests
    - » continue to ask for help from family, friends, self-help groups and professionals (Grade D).
  - if in harmful/dependent category advise patients to
    - » discuss methods of stopping and how to stay stopped
    - » set a date to stop drinking and look for support
    - » drink water and/or soft drinks
    - » keep active and develop interests
    - » consider taking specific medication that reduces craving or is a deterrent, if appropriate
    - » attend specialist Counsellors and/or Psychiatrists as appropriate.
    - » attend support groups such as Alcoholics Anonymous and ANEW (for women only) if appropriate
    - » talk to someone in recovery, (you might ask another patient in recovery that you know and trust, to talk to the patient in confidence)
    - » undergo specialist detoxification, or arrange same, as appropriate
    - » take vitamins as necessary
    - » read recommended literature including leaflets
    - » continue to ask for help from family, friends, self-help groups and professionals (Grade D).

The specific health advantages from stopping and/or cutting down should be carefully discussed and explained.

Offer one of the patient information sheets (see Appendix 7).

Step 4 - ARRANGE

- arrange a follow up appointment for patients in hazardous, harmful and dependent categories and continue to be actively involved
- relapse should be addressed as a learning opportunity and the approach should be based on patience and long term goals
- arrange appropriate repeat prescriptions, tests and appointments if necessary
- consider arranging a consultation with family members to support

Formal assessment tools should be used to determine the nature and severity of the alcohol misuse to include a determination for assisted withdrawal, whether by Primary Care interventions or specialist services[22].

Conclusion

Given the significant public health consequences associated with heavy drinking and the benefits associated with its reduction, all health care professionals working in community health services must consider reduction of heavy drinking as a meaningful measure of treatment effectiveness.

Appendix 1: Full AUDIT questionnaire and scoring system

THE ALCOHOL USE DISORDERS IDENTIFICATION TEST: INTERVIEW VERSION

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year. Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer in the box at the right.

1. How often do you have a drink containing alcohol?

(0) Never
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How may drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

Skip to Question 9 & 10 if total score for Questions 2 & 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Scores in brackets on the left hand side, put in box on right and add up TOTAL

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Audit Scoring System

- Items 1–8 score 0, 1, 2, 3, 4 respectively
- Items 9 and 10 score 0, 2, 4 respectively
- Then carefully add up the total score

The scoring system for the Audit is generally interpreted as follows

Females with a score of **7–14** and males with a score of **8–14** are drinking too much or have previously had problems with drinking (e.g.) injury or binge drinking (check item 3) BUT are unlikely to be physically dependent on alcohol. They should be advised to cut down on drinking.

Females and males with a score of **15** or more have problems with drinking which is most likely harmful to their health and if they score **20** or more they may be dependent on alcohol[16] (Grade B). They should be advised to abstain from alcohol. Advice should be reinforced with leaflets and the patient should have a thorough physical examination including blood tests.

Notes

1. This questionnaire is not diagnostic and referral to specialists will be necessary in most cases of dependence. Clinical judgement taking other factors into account should always be used.
2. High scores on the first three items in the absence of elevated scores on the remaining items suggest Hazardous drinking.
3. Elevated scores on items 4 through 6 imply the presence or emergence of Alcohol Dependence. High scores on the remaining items suggest harmful drinking.
4. Ask about binge drinking.

Appendix 2:
AUDIT 'C' and CAGE questionnaire and scoring system

AUDIT 'C' Questionnaire[6, 16]

1. How often do you have a drink containing alcohol?

(0) Never
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week ☐

2. How may drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more ☐

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily ☐

Scores in brackets on the left hand side, put in box on right and add up
TOTAL: ☐

Recommendation: Ask these questions from memory and do a mental "tot".
Use full A.U.D.I.T. if score in AUDIT 'C' is:
> or = 5 for adult men
>or = 4 for adult women

and/or

Use consumption 'Arrow' Chart, and if concerned (i.e. above hazardous, harmful limit) do full A.U.D.I.T.

If dependence is suspected – consider using CAGE Questionnaire[17] (Grade B).

CAGE Questionnaire

The CAGE questionnaire is used to assess dependence and comprises four questions that can be incorporated into the consultation informally.

- Have you ever felt you should CUT down your drinking?
- Have people ANNOYED you by criticising your drinking?
- Have you ever felt bad or GUILTY about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (EYE- opener)?

Scoring: Alcohol dependence is probable if the patient gives 2 or more positive answers. It should be supplemented by two questions:-

- How many days per week do you drink?
- How many standard drinks do you have on a typical day?

Appendix 3: Brief Intervention including motivational interviewing

The method of choice for screening and intervention for alcohol problems[12] (Grade A).

Brief Interventions are as the name suggests a quick way for practitioners to help patients with alcohol problems. They are of proven efficacy and are most effective for patients in the hazardous range[23] (Grade A). There may be a time lag before patients respond.

The key components of brief interventions are:

Giving Feedback	Regarding alcohol risk category
Providing Information	On specific risks if the patient was to continue to drink at this level
Establishing a goal	To change drinking behaviour
Giving advice on limits	See Alcohol consumption arrow
Providing encouragement	Change is possible[6, 12] (Grade B).

Brief interventions appear to be equally effective for men and women and for young and old[12] (Grade A).

A motivational interviewing style is more likely to be successful[6, 12] (Grade B). This has been described as a directive, client centred style of counselling that helps patients to explore and resolve their ambivalence about changing behaviours. Primary care staff should use techniques that improve trust, build confidence and reduce resistance to change.

The focus should be on:

- increasing readiness to change (use wheel of change to assess – (see Apendix 9)
- understanding the patient's own view of things accurately
- avoiding argumentation and reducing resistance
- increasing self-efficacy
- increasing patients perceived discrepancy between their actual and ideal behaviour.

Appendix 4: Withdrawal advice

Medically supervised withdrawal from alcohol is usually only necessary for patients who are dependent on alcohol but heavy drinkers or patients who have a once off binge can also require detoxification.

Withdrawal from alcohol can be mild, moderate or severe. The amount the person has consumed and over what period of time mostly accounts for the classification but other factors are important too. These include the patients pre-existing medical and nutritional status, and the presence or absence of other medications and/or illicit drugs (Grade D).

The clinical features of withdrawal can range from mild tremulousness to severe anxiety attacks, pains and aches to cardiovascular problems, tingles, to neurological problems and impact on the autonomic nervous system. DT's (Delirium Tremens) occurs uncommonly, perhaps in less than 5% of cases (Grade D).

The main decision for the G.P. is whether the patient can be managed at home or in hospital. Most withdrawals can be managed at home under the supervision of the GP[12] (Grade A). The key aspect is the degree of support if home management is chosen. The patient should have someone to supervise home detoxification. A patient living on his/her own would not usually be a candidate for home detoxification unless someone can come in to stay/supervise.

Key points to consider

- Give information about the nature of withdrawal symptoms and what to expect
- Decide on the setting for detoxification from alcohol
- Involvement of a significant other to provide support
- Arrange for follow up
- Plan daily activities for the period following detox
- Check for co- morbidity.

Hospital detoxification is advised if the patient[12] (Grade D):

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

Medication

The general rule is to use as little medication as possible (Grade D). Benzodiazepines are currently the best drug group for alcohol dependence detoxification[12] (Grade A).They should be given in daily reducing doses and limited to a maximum of 7 days[12] (Grade A). For patients managed in the community, chlordiazepoxide is the preferred benzodiazepine[12] (Grade D). Provided attention is paid to any acute or chronic physical illness, elderly patients should be managed the same way as younger patients[12] (Grade D).

Before commencing, a comprehensive medical assessment should be conducted, (including base line blood tests if possible including FBC, U+E and LFTs). Particular care is needed for those with liver disease or impairment.

Oral fluids and Vitamin Supplementation

Oral fluids and vitamin supplements should be recommended as per clinical judgement (Grade D). Patients at risk of Wernicke-Korsakoff's syndrome should be given parenteral thiamine[6] (Grade D). There is a risk of anaphylaxis with parenteral vitamin supplementation so facilities for treating such reactions should be available[12] (Grade D). Ideally, such patients should be treated in an in-patient setting[12] (Grade D).

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Appendix 5: Biological markers and medications for alcohol dependence

Biological markers

Tests to determine mean red corpuscle volume (MCV) and gamma glutamyl transferase (GGT) and carbohydrate deficient transferring (CDT) can be useful as markers of heavy drinking in preceding weeks. Biological tests are of less value than self reports for screening with the intention of intervention. They have their greatest role where patients are minimising their drinking and in monitoring changes in consumption. They can be helpful in motivating patients to consider change[12] (Grade B).

Medications for alcohol dependence

Anti-craving medication for treatment of alcohol dependence

Acamprosate

When used in combination with counselling Acamprosate may be helpful in maintaining abstinence in alcohol-dependent patients. It is initiated as soon as possible after abstinence has been achieved and continued for 1 year. If the patient has a temporary relapse treatment should be maintained but stopped if the patient returns to regular or excessive drinking that persists 4–6 weeks after starting treatment. Acamprosate is not effective in all patients, so efficacy should be regularly assessed."[24] (Grade D)

Naltrexone

Naltrexone is an opioid-receptor antagonist, which can be used as an adjunct in the treatment of alcohol dependence after a successful withdrawal. Treatment should be initiated and continued under specialist supervision. Treatment should be reviewed monthly for the first six months. Treatment should be stopped if the patient returns to regular or excessive drinking that persists 4-6 weeks after starting treatment.[24]

Deterrent medication for treatment of alcohol dependence

Disulfiram

Supervised oral disulfiram may be used to prevent relapse but patients must be informed that this is a treatment requiring complete abstinence and be clear about the dangers of taking alcohol with it[12] (Grade C).

Disulfiram is indicated as an adjunct to the treatment of alcohol dependence (under specialist supervision). It is indicated when Acamprosate or Naltrexone are not suitable or when the patient expresses a preference for its use. Ingestion of

even a small amount of alcohol (including toiletries and mouthwashes) gives rise to extremely unpleasant reactions.

Symptoms can occur within 10 minutes of alcohol ingestion and include flushing of the face, throbbing headache, palpitation, tachycardia, nausea and vomiting. If exposed to larger doses of alcohol, arrhythmias, hypotension, and collapse may result. After stopping treatment alcohol should be avoided for at least one week. During treatment with disulfiram, patients should be monitored at least every 2 weeks for the first 2 months then each month for the following 4 months and at least every 6 months thereafter.[24] (Grade D)

Appendix 6: Clinical Presentations
(Where the role of alcohol should be considered)[12] *(Grade D)*

Social

- Marital Disharmony and domestic violence
- Neglect of children
- Criminal behaviour
- Unsafe sex
- Financial problems

Occupational

- Repeated absenteeism, especially patterned
- Impaired work performance and accidents
- Poor employment record

Psychiatric

- Amnesia, memory disorders and dementia
- Anxiety and panic disorders
- Depressive illness
- Treatment resistance and as a factor in relapse in other illnesses
- Repeated self-harming

Physical

- Multiple acute presentations to 'A&E' with trauma and head injury
- Dyspepsia, gastritis and haematemesis
- Diarrhoea and malabsorption
- Acute and chronic pancreatitis
- Liver abnormalities
- Cardiac arrhythmias
- Hypertension and stroke
- Cardiomyopathy
- Peripheral neuropathy, cerebellar ataxia
- Impotence and libido problems
- Withdrawal seizures
- Falls and collapses of older patients
- Blood dyscrasia
- Acne rosacea, discoid eczema, psoriasis, multiple bruising
- Cancers of the mouth, pharynx, larynx, oesophagus, breast and colon
- Acute and chronic myopathies
- Unexplained infertility
- Gout

WOULD YOU LIKE TO *CUT DOWN* ON YOUR DRINKING?

Why?

Your Doctor or Practice Nurse will have discussed the results of the questionnaire(s) with you and tried to assess your ability and 'readiness to change'. The results indicate that your drinking habits could be bad for your health.

How?

- Keep a diary of your daily and weekly consumption (Remember as a general rule, low risk drinking means less than 17 standard drinks per week for an adult male and 11 standard drinks for an adult female per week).
- Try to drink no more than 3 standard drinks per day for males and 2 standard drinks per day for females.
- Have at least 2 or 3 non drinking days.
- Avoid fast drinking and binge drinking. Sip your drinks and drink more slowly.
- Drink water and/or non alcoholic drinks between drinks.
- If you drink spirits dilute them with water and soft drinks.
- Avoid drinking in rounds.
- Set a date to change.
- Consider telling your close family and friends.
- Stick to your resolutions, set a limit that is realistic for you.
- Have an explanation ready for people who push you to drink, for example: 'Doctor's orders', or 'I want to cut down for a while', or 'I was drinking too much'.
- Treat yourself
- List the 'pros and cons'.

Some of the advantages:

- You will have more energy.
- You will sleep better.
- Food will taste better.
- You are more likely to develop leisure activities and get involved in exercising.
- You will have more disposable income.
- You will not put on as much weight.
- Your memory and intellect will be sharper.
- Your emotions will be more stable.
- Your health will improve.

A follow-up appointment can be made to help support you with this change.

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WOULD YOU LIKE TO *STOP* DRINKING?

Why?

Your Doctor or Practice Nurse will have discussed the results of the questionnaire(s) with you. The results have indicated that your drinking habits are not good for your health and there are signs of dependence. This will also seriously affect all other aspects of your life.

How?

Changing from heavy or harmful drinking to abstinence will not be easy and you need to carefully prepare and use all available supports.

- You may be referred to an Alcohol specialist for further help and assessment. This will involve talking about the 'pros and cons' of change and ways to succeed in your goals. Your family will also need to be involved in this process. This will be an opportunity to discuss other personal issues as well.
- Set a start date and tell your close family and friends.
- Think about joining a self-help group such as 'Alcoholics Anonymous' and/or 'Anew' (for females only). Work out and list the pros and cons of change yourself.
- Decide what times and places put you most at risk and take steps to develop alternative interests and leisure pursuits.
- Talk to someone who has gone through this process of change before.
- Ask your Doctor for more details and ask any questions that you need answers to. The Doctor may prescribe medication to help you withdraw from alcohol or to reduce craving or to act as a deterrent. Read literature on the subject. The practice can recommend suitable material.
- Reward yourself for success.

Some of the advantages:

- Your general health should improve; you will sleep better and have more energy.
- Your appetite and eating patterns should be better too.
- You will have more time for leisure activities and to get involved in exercise.
- You will have a more positive outlook on exercise and fitness.
- You are likely to have much better relationships with family and friends.
- Your memory and intellect will be sharper. You will develop better self-esteem and experience less guilt.
- You should be more reliable and your work performance and/or attendance is likely to improve.
- You are less likely to be depressed.

A follow-up appointment can be made to help support you with this change.

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Appendix 8: Further information (updated 2014)

Self-help

- A.A. (Hq) (for patients with alcohol dependence) *www.alcoholicsanonymous.ie* Unit 2, Block C, Santry Business Park, Swords Road, Dublin 9 (01) 8420700
- Al-Anon (for adult family members) *www.al-anon-ireland.org/* 5 Capel Street, Dublin 1 (01) 8732699
- Anew (for women) *www.ANEW.ie* Tel: 086 1024743
- Aware (for depression) *www.aware.ie* 72 Lower Leeson Street, D2 (01) 6617 211
- HSE infoline on 1850 241850
- HSE (2012) A Quick Question *http://www.drugsandalcohol.ie/18438/1/aquickquestion.pdf*

Other useful contacts:

Keep your own list of contacts here:

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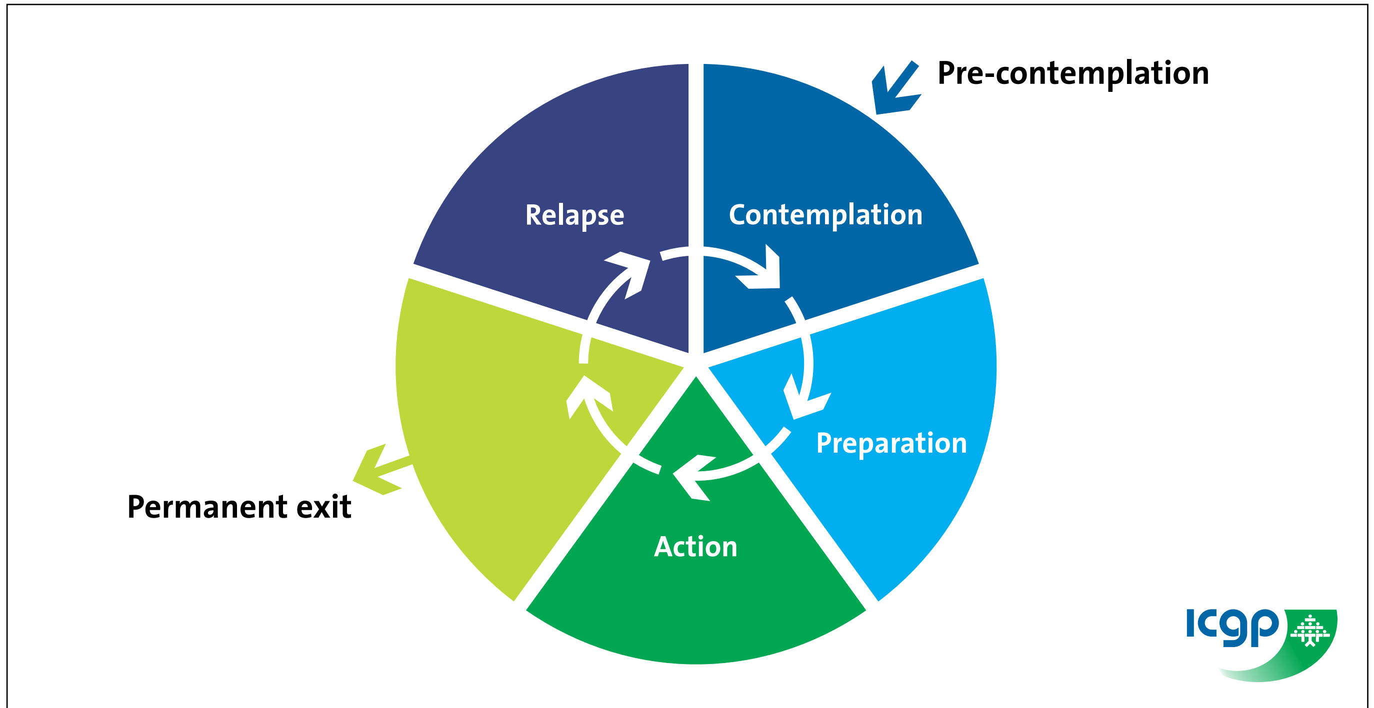
Wheel of Change[19] (Grade D)

Useful for assessing readiness to change



It can be beneficial to discuss this chart with patients, but explain in plain English!

Decision Balance Sheets[20] (Grade D)

Useful for assessing readiness to change

How important is it for you to stop/cut down your drinking?

0 1 2 3 4 5 6 7 8 9 10

(SCORE: ______________)

How confident are you that you can stop/cut down your drinking?

0 1 2 3 4 5 6 7 8 9 10

(SCORE: ______________)

Ask patients to rate themselves on a scale of 0–10 for importance of stopping/cutting down and confidence in stopping/cutting down. Depending on their score the next question might be: "What would it take for you to move to a better score?" for example from a 3 to a 4 for importance. The discussion itself can improve motivation.

Another useful tool to help patients to ascertain their own drinking patterns.

Ask patients to use a consumption diary to find out how much alcohol they actually consume each week in standard drinks. They should be encouraged, if they intend to cut down, to use a consumption diary every week. You will need to explain the concept of the standard drink.

Consumption Diary

DAY OF THE WEEK	NO.OF STANDARD DRINKS	DAY OF THE WEEK	NO.OF STANDARD DRINKS
Day 1 (e.g. Mon.)		Day 5	
Day 2		Day 6	
Day 3		Day 7	
Day 4		Total no. of standard drinks per week:	

Most patients underestimate the amount they drink without such a diary.

AUDIT 'C' Questionnaire[6, 16]

1. How often do you have a drink containing alcohol?

(0) Never
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

❑

2. How may drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

❑

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

❑

Scores in brackets on the left hand side, put in box on right and add up **TOTAL**: ❑

Recommendation: Ask these questions from memory and do a mental "tot".
Use full A.U.D.I.T. if score in AUDIT 'C' is:
> or = 5 for adult men
>or = 4 for adult women

and/or

Use consumption 'Arrow' Chart, and if concerned (i.e. above hazardous, harmful limit) do full A.U.D.I.T.

Useful Reading List

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Patient/Carer Self Help Books

Anderson, R. Living with a Problem Drinker. 2010

Marcantoio, S. An Introduction to Sensible Drinking 2011

Web Sites

http://www.hse.ie/eng/services/publications/topics/alcohol/

http://yourmentalhealth.ie/

http://ie.reachout.com/inform-yourself/alcohol-drugs-and-addiction/alcohol/

http://drinkhelp.ie/

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