

The health challenges behind alcohol

Key learning points:

- Alcohol is linked to many conditions seen in primary care and its contribution is frequently not recognised
- Very few patients who present in primary care are dependent upon alcohol and in need of a medically assisted detoxification
- Drinkers often have a series of physical, psychological and social problems and positive outcomes are related to them being treated in a positive and non-judgmental way

Alcohol is connected with a number of physical and psychological conditions witnessed in primary care. But asking a patient about their drinking is often seen as obtrusive and prying into personal life choices, whereas asking about smoking is now accepted. There is now a mounting body of international evidence¹ that if an individual is provided with information about their drinking they will make small changes that fit with their lifestyle.

Units and limits

The UK guidelines for sensible drinking have recently been revised² so that there are identical recommendations for men and women. These are to drink no more than 14 units of alcohol per week and to have two days alcohol free. To put this into context, this is the equivalent of seven pints of ordinary-strength beers or seven glasses of wine. Evidence suggests that individuals tend to interpret guidelines according to their own personal experience³ and that these limits can be seen as unrealistic. Thus it may be unhelpful to talk in terms of units and better to use the results of screening tools.

There is a belief that alcohol has cardioprotective effects. Evidence finds there is some benefit in women over 50, but the amount equates to less than a unit of alcohol daily. Above this, the risk of other health-related conditions such as hypertension or strokes is increased. And individuals tend to pour glasses of 2-3 units of alcohol. If a patient wishes to promote cardioprotective behaviour they are far better advised to make changes to their diet or take more exercise.

Hazardous and harmful drinking

Any person drinking above the sensible limits is running some risk of health-related harm over time and is defined as either a hazardous or harmful drinker. A hazardous drinker is 'someone drinking at a level where harm will result if the drinking persists', and a harmful drinker is 'someone who has already caused themselves physical or mental harm'.⁴

The cut-off for harmful drinking is more than 50 units of alcohol (male) or 35 (female) per week.⁴ In practice these people (also referred to as 'at-risk' drinkers) are more likely to present to primary care than a dependent drinker, who will be briefly discussed later. The best way of identifying hazardous or harmful drinkers is by using a screening tool such as the AUDIT.⁵ This has 10 questions and it is scored 0-40.

The same authors suggest that each patient should be screened for alcohol use annually. Alcohol is implicated in numerous health conditions and it would be good practice to administer the AUDIT if the patient has hypertension or signs of anxiety and depression, or complains of being in pain, or has experienced a recent fall or has a suspected stomach ulcer. The new guidelines have not recommended new AUDIT cut-off points and notwithstanding the fact that the sensible drinking limits for men and women are now identical, there is little

reason to change from the common recognised cut-off scores of 6 or less for women and 8 or less for men.

There is now good evidence that by using the principles of motivational interviewing⁶ most individuals will make changes that suit their lifestyles. Motivational interviewing uses non-judgmental techniques to recognise that most individuals are ambivalent about change and seeks to minimise resistance by allowing the patient to set their own goals. Specifically, it avoids the professional being seen as the expert, prescribing advice or telling a patient what is in their interests.

Babor et al⁵ suggest that if an individual has an AUDIT score of 8-15 they should be given 'simple advice' such as a leaflet. A patient with a score of 12 or above should also be provided with a brief intervention. Bein et al⁷ suggest this should be based on the principles of motivational interviewing, should last approximately 20 minutes and use the following principles:

- Feedback: feed back to the patient the results of the AUDIT, which indicates their drinking is at a level that risks damage to their health.
- Responsibility: emphasise that the patient is responsible for making the change.
- Advice: suggest that reduction in alcohol consumption would be beneficial.
- Menu: suggest a number of options for change. This is often included on the information leaflet.
- Empathy: adopt an empathetic approach.
- Self-efficacy: encourage the patient to be optimistic about their ability to make behavioural changes.

Babor et al also suggest brief counselling and continued monitoring if an individual has an AUDIT score of 16-19. It is likely that Babor considers these drinkers to belong to the 'harmful' category. However, in my experience these scores denote borderline dependent drinking.

Dependency

Alcohol dependency indicates a physical, psychological and social dependence on alcohol. Alcohol is one of the few drugs where a person becomes physically dependent on the substance because both the brain and the body adapt to many years of excessive alcohol consumption. Another term for this process is the development of tolerance.

Signs of physical alcohol dependence are symptoms such as sweats, shaking or general anxiety on stopping drinking as the blood alcohol level starts to drop. Often the individual will take a drink (or several) first thing on waking (which as the dependency increases could be any time of the day) in an attempt to increase or stabilise their blood alcohol level. This is called early morning drinking or topping up.

The AUDIT score for assessing alcohol dependency is contentious. Babor suggests 20. In my experience this is very high and the cut-off point of 18 is suggested. If there are other serious physical or psychological co-morbidities, the cut-off may be as low as 14.

I recommend that if the AUDIT score is 14 or above that the Severity of Alcohol Dependence Questionnaire (SADQ)⁸ is also administered. This is a 20-item self-report questionnaire that measures the physical and affective symptoms of alcohol withdrawal, craving and relief drinking, typical daily alcohol consumption and reinstatement of symptoms after heavy drinking within the past six months. Each item can attain a score of 0, 1, 2 or 3; thus the maximum score is 60. Scores of 30 or more equate to a severe degree of dependency and should prompt a referral to specialist substance use services.

Presentation of dependency

It is important to note that alcohol dependency rarely presents itself in isolation. Individuals who are alcohol dependent often have accompanying physical and mental illness, most notably liver disease, stomach ulcers, anxiety and depression. Furthermore, they are already likely to be extensive users of health and social services, most notably accident and emergency. In consequence they are often seen as unpopular patients and there is a strong probability they have had a negative experience of treatment services.

People with mental illness are subject to stigma and this is particularly acute for those who are also dependent on drugs or alcohol.⁹ Thus it is important for the primary care nurse to deal with alcohol-dependent patients in a non-judgmental manner, and while brief intervention techniques are insufficient for this group, the principles of non-judgmental engagement techniques and leaving the ultimate decision with the patient are still appropriate – people will not change unless they want to. Some may want to stop drinking, others may wish to cut down and attempt ‘controlled drinking’, others may not want to change.

As a general rule, if an individual has an SADQ score of 30 or more, controlled drinking is unlikely to be a realistic goal. The safest way to help someone to stop drinking is a detoxification regime as the consequences of alcohol withdrawal are life threatening and can on rare occasions be fatal.

It is possible to detoxify a patient at home if there is someone who can supervise and some services can organise this as a drop-in facility.

Two large charities that can provide advice on safe detoxification and aftercare are Change Grow and Live (CGL)¹¹ and Turning Point.¹² The main national support service is Alcoholics Anonymous (AA),¹³ but this is abstinence based and has a quasi-religious philosophy that does not appeal to everyone.

Also, although there are women-only groups, it tends to be dominated by men.

I would advise you visit the local substance use services and ascertain what they can offer locally. A number will have close links with their GP practices and are often commissioned to deliver assisted detoxifications in conjunction with the GP (eg Haringey Alcohol Advisory Services).¹⁴

Typically, support groups are offered, which may promote controlled drinking or abstinence goals. Often their mission statements and commissioning contracts require them to respect diversity and they welcome patients who are women, from ethnic minority groups and have a history of mental illness – though the typical attender is still a white male.

Older people

Older people (65 and over) are now presenting a greater challenge to primary care. Drinking patterns have become more ingrained as a result of the real price of alcohol falling over a number of years and alcohol becoming more available. In consequence, people who are now 65 and over are drinking more than previous generations.

The Royal College of Psychiatrists¹⁶ points to a sub-group of older drinkers who have become ‘invisible addicts’, often in response to bereavement, retirement and greater isolation. To add to the health implications, one-third of all men and women aged 65 and over are prescribed four or more types of prescription drug daily,¹⁷ and might also be using over-the-counter medication (which most surveys do not consider). Painkillers are easy to purchase in this way and have adverse reactions when combined with alcohol.

Research has considered AUDIT cut-offs for elderly drinkers presenting to primary care and the cut-offs of 6 for males and 4 for females are recommended. If an older person presents with higher AUDIT scores the nurse should deliver a brief intervention using the principles previously described.⁷

Part of this intervention should include providing information about the consequences of

drinking while using prescription medication and over-the-counter medications, most notably painkillers. AUDIT could be done again each time an older person is prescribed an additional medication.

Opportunity for constructive engagement

Primary care professionals should see each contact with someone drinking at an at-risk or dependent level as an opportunity for constructive engagement. The principles should be:

- Provide information but do not prescribe treatment.
- Leave the options with the patient.
- Expect small changes, which should be praised and reinforced.

When dealing with the dependent drinker it is important to understand that drinking is likely to be one of a number of health and social problems and that this is a group that will frequently have negative experiences with health and social care services. Relapse is highly likely and sustained behaviour change is difficult. However, if the nurse can handle relapse constructively and engage the dependent patient, positive change can result.

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