Topics:
- Prevention
- Why bother with alcohol problems?
- Presentations of alcohol problems
- Management of alcohol problems
- Summary

Management of Alcohol Problems

NSW Rural Doctors Network
Coffs Harbour, 24-25 February 2007
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Prevention:
- ‘What works’ is clear
- Effective alcohol taxation
- Regulated outlet controls
  - Number
  - Conditions
- Harm reduction
- Prevention difficult because of immense power of alcohol beverage industry
- Role of medical profession

Why bother?
- Alcohol major contributor mortality, morbidity
- > 25% all drug related deaths, each 20 years expected life lost
- Huge social cost, violence
- Cost to economy $ 7 billion/year > cost illicit drugs
- Prevention, treatment are effective
- Like other medical conditions: aetiology, relapsing/remitting, response Rx, compliance

Presentations:
- Some decide to seek help
- Some forced to seek help
- Some detected at-risk through careful routine care other conditions
- Some found to have alcohol-related conditions

Management:
- Assessment
  - Drinking history
  - Health, social, financial, legal, other problems
  - Alcohol dependence
  - Patient’s drinking goals
  - Motivational interviewing
- Interventions
  - Controlled drinking
  - Abstinence
Controlled drinking:
- ‘Reduce, maintain drinking to a safer range’
- Better if younger (< 40), only mild-moderate alcohol dependence
- Nor for older, severely dependent
- Negotiate, record drinking ‘contract’
  - # drinks/day?
  - # days/week, which days?
  - Which beverage?
  - Any conditions?
  - Starting, finishing dates?

Controlled drinking strategies:
- Daily drinking diary
  - Document behaviour = change behaviour
  - Identify triggers (e.g. people, venues, emotions)
  - Identify strategies avoid, manage triggers
- Sip, don’t gulp a drink
- Put the drink down between sips
- Identify other means of achieving perceived benefits from alcohol

Controlled drinking strategies: 2
- Plan each drinking session
  - Starting, finishing times
  - Start, finish each drink
- Start new activities, interests
- Discussing new drinking with others
- Regular, frequent follow up
- ADIS 1 800 422 599
- DASAS 1 800 023 687

Abstinence:
- Is detoxification needed?
  - In-patient?
  - Out-patient?
  - 10-20 mg diazepam, 1-2 hours, loading dose
  - End point = ‘comfort’
- Managing ‘not drinking’
  - Drinks at home?
  - Approach outlets?
- Alcoholics Anonymous
  - Self-help, readily available, free, no appointments, no records
  - Not evaluated, black/white, spiritual

Abstinence: 2
- SMART Recovery
  - Self-help, less readily available, free, no appointments, no records
  - Not evaluated, shades of grey, non-spiritual, based CBT approaches, professional leaders
- Pharmacotherapy
  - Greatly under utilised
  - Expanding
  - 6-12 months
- Regular, frequent follow up
- Role assertive follow up?
- ADIS 1 800 422 599

Acamprosate (Campral):
- Interferes NMDA
- On PBS (part of programme)
- Doubles chance abstinence 12 months
- Abundant evaluation
- Well tolerated
- 6 tablets/day
Naltrexone (ReVia):
- Blocks gratification endogenous opioids
- On PBS (part of programme)
- Doubles chance abstinence 12 months
- Abundant evaluation
- Well tolerated
- Blocks opioid analgesia
- 1 tablet/day

Disulfiram (Antabuse):
- Old drug, early evaluation unfavourable
- Inhibits acetaldehyde dehydrogenase, build up acetaldehyde
- Alcohol + disulfiram very unpleasant
- Supervised disulfiram very effective
- Supervision: spouse, police, probation, parole, employer
- Not on PBS, but not expensive
- Avoid in elderly, infirm

Summary:
1. Level alcohol problems community reflects power industry vs. others
2. Effective prevention known, only partly implemented
3. Most patients needing intervention missed
4. Build in routine recording drinking history
5. Always offer help, sometimes rejected

Summary: 2
5. Controlled drinking younger, mild-moderate dependence
6. Abstinence older, severe dependence
7. Encourage self help
8. Encourage pharmaceuticals
9. Regular, frequent follow up
10. Role assertive follow up?