

## 2

## Alcohol

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## OVERVIEW

As well as harming family and community, alcohol can harm almost every system in the drinker's body. Many mental health problems can also be caused or made worse by drinking.

When someone is hooked on alcohol ('alcohol dependence' or alcoholism) they usually need a lot of support to get on top of it. They often need help with withdrawal and most need help to stay 'dry'. A range of approaches is available including counselling, mutual support groups, rehab and medicines. You can help clients choose which ones suit them best, and they can make use of several different approaches.

This chapter looks at the nature and causes of alcohol problems, how to recognise alcohol problems and give help earlier, and the range of approaches to help someone with alcohol dependence.

### History of drinking in Aboriginal and Torres Strait Islander communities

- Traditionally Aboriginal people in some regions made mild alcoholic drinks by fermenting plant products (e.g. sap from 'cider gum' in Tasmania, or crushed pandanus nuts in Borroloola).
- Aboriginal people learned about stronger forms of alcohol and new ways of drinking from outsiders.
- Makassan fishermen (from Indonesia) sailed to northern Australia every year in December, from 1720 or earlier up to around 1907. These fisherman brought strong alcoholic spirits with them, called *arrack*. This drink was introduced to Aboriginal people along a large area of the Northern Territory coastline, and perhaps the Kimberley coast.
- While in Australia, the Makassans would drink until they were drunk. But when they returned home each April, Aboriginal people were alcohol-free again.
- The English and Irish who came with the First Fleet brought rum and brandy. They also often drank until they were drunk.
- Aboriginal people watched the colonists and tried out their drinking styles. Aboriginal people were also encouraged to get drunk and even fight to amuse the audience – some acted drunk when they were not, for fun.

- The authorities issued licences to control the number of hotels, and passed laws to stop the supply of alcohol to Aboriginal people, but these policies were not successful. Aboriginal people experienced many problems in the 1800s because of alcohol.
- Banning the drinking of alcohol by Aboriginal people (and later Torres Strait and Pacific Islanders) started in the 1830s to protect them from being exploited. It was also to 'protect' colonists from drunken Aboriginal people. It was impossible to stop 'sly grogging' though and Aboriginal people then drank in secret, often in the open air. Because they were banned from hotels, Aboriginal people could not access beer, so they drank spirits or port. They were kept out of mainstream social drinking. Aboriginal people often drank quickly so as not to get caught.
- Laws banning Aboriginal people from drinking alcohol were lifted by different states and territories, between 1957 and 1972. There was no planning or training for Aboriginal people to help manage these new drinking rights.
- Since then, communities and governments have (separately or together) tried different ways to reduce the health and social troubles caused by alcohol.

### **How common are drinking or drinking problems?**

Aboriginal Australians are less likely to drink alcohol in any one year than other Australians. We do not have good information on drinking patterns, but we know that many Aboriginal drinkers drink on one day a week rather than every day. In one city-based survey, two out of every five Aboriginal men and one out of every five women drank at least 13 drinks whenever they consumed alcohol.

## WHAT HAPPENS IN INTOXICATION?

In small amounts, alcohol makes people feel more relaxed and often slightly 'high'. In larger amounts alcohol affects coordination, decision-making and problem solving skills. So people may have accidents and falls, or get into fights. People may say or do things they regret and act on the spur of the moment (i.e. they are more impulsive or have less inhibitions). In severe intoxication, alcohol can slow down or stop breathing, and cause death (alcohol poisoning).

### What happens inside your body when you drink?

There are many types of alcohol, but all contain the active ingredient of ethanol (ethyl alcohol).

Ethanol mixes easily in water, and so travels easily through the body. When a person drinks, it passes from the mouth to the stomach, and then on to the small intestine. From the moment alcohol touches the inside of the mouth a small amount enters the bloodstream (is absorbed). Some more is absorbed from the stomach. However, most is absorbed in the small intestine.

When people eat food their stomach empties into the small intestine more slowly, and this slows down how alcohol is absorbed in the body. So it is good for people to eat while drinking. On the other hand, smoking tobacco or mixing a soft drink with alcohol speeds up the stomach's emptying, so alcohol is absorbed more quickly and the person feels more intoxicated.

Once alcohol is in the bloodstream, it moves around the body and into the brain very quickly.

Women have less water in their bodies because they are smaller and have less muscle. So women generally get a higher blood alcohol level after the same amount of alcohol.

Only a small percentage of alcohol leaves the body through sweat, urine or breath.

Most of the alcohol that enters the bloodstream is broken down into smaller parts (molecules) in the liver. But the liver can only break down alcohol at the same steady rate – about one standard drink per hour. If a person drinks more than one small drink each hour the alcohol can remain in the body, or start to build up. So they stay intoxicated.

### **What is happening inside the brain when a person gets drunk?**

Alcohol turns down activity in the brain, so it is called a 'depressant'.

When a person has just had a little to drink, many people become more confident and talkative, and may do the first thing that comes into their mind (they have less inhibitions). This is because alcohol damps down the parts of the brain that help us stay calm and that control our behaviour.

One way alcohol turns down the brain's activity is by boosting the effect of a brain chemical called GABA (gamma amino butyric acid). GABA's main job is to make the brain slow down. So, because of this effect, small amounts of alcohol are relaxing, but large amounts cause people to lose their balance, see double and not remember things (see *Alcohol and the brain*, p. 200). If people drink far too much on one occasion their breathing may slow down and stop.

Alcohol also works on various feel good chemicals in the 'reward centre' of the brain; this includes the same receptors that heroin works on (opiate receptors), as well as serotonin and dopamine.

## WHEN IS DRINKING A PROBLEM?

There are different ways of drinking too much:

- *Risky drinking*: some people may not have had any problems but the way they drink may mean they have a greater chance of injury or long-term harms to their body.
- *Harmful drinking (or alcohol abuse)*: alcohol has already caused harms to the drinker or those around them. Harms can be to the body, mind, family or community. But the person drinks by choice, not because they are hooked on alcohol.
- *Dependence on alcohol (alcoholism)*: this is the most severe type of alcohol problem. The drinker usually has lost some control over drinking.

## How much alcohol is too much?

The more a person drinks the greater their risk of running into problems. For example, drinking:

- More than two 'standard' drinks most days means more chance of long-term health problems such as diabetes, cancer or high blood pressure.
- More than four standard drinks on any occasion increases the chance of injury.

A 'standard drink' is a small drink; for example:

- A glass (285ml) of full strength beer, which is less than one can
- A small glass (100ml) of wine
- A standard nip (30ml) of spirits.

In pregnancy: alcohol can harm unborn babies (see FASD, p. 364 and p. 206), so women who are pregnant are best to drink nothing at all. Also, younger woman who might become pregnant should avoid alcohol.

Young people: the younger a person starts drinking the more likely they are to run into problems from alcohol in later life. So it is best for young people (less than 18) to stay away from alcohol altogether. If they drink they should have as little as possible.

## HARMS FROM DRINKING

Drinking can cause harms to family and community, to mental health and to nearly every part of the body. For example, harms may be to:

- Family and community: drinkers may lose their jobs, marriages or families because of alcohol. Family violence may happen when people drink too much in one sitting, not just when they are hooked on alcohol (dependent).
- Physical health: people with alcohol problems may come to the GP or clinic with injuries or various health problems from alcohol. Health professionals may not always realise that alcohol is the cause.
- Mental health: alcohol tends to make any mental health problem worse; and regular use can cause disorders like depression or anxiety.

Harms can be:

- Short-term: from even one occasion of drinking, or
- Long-term: from regular and ongoing drinking. These long-term effects on the body are most often seen after years of drinking.

### Short-term harms from drinking

Even a single occasion of drinking can cause short-term harms like:

- Injuries
- Violence
- Suicide
- Relationships problems (that can go on long after the drinking stops)
- Drownings
- Burns
- Having sex that was not planned or protected (leading to unwanted pregnancies, infections, and relationship and cultural problems)
- Money problems (including gambling)
- Alcohol poisoning (loss of consciousness and risk of death).

**Alcohol's effect on behaviour and the body depends on**

- How much alcohol the person drinks
- How long a person has been drinking that day and how quickly: six drinks over one hour will make a person more intoxicated than six drinks over 12 hours. But, even having six drinks spread over every day can still cause long-term harms to the body.
- Other drugs used: some drugs increase the effect of alcohol and can cause overdose (e.g. benzos, heroin, and painkillers containing codeine or morphine).
- How many months or years the person has been drinking: regular drinkers find they need more alcohol to feel its effects. These 'tolerant' drinkers may not appear drunk, but are more likely to get long-term harms from alcohol such as diabetes, or brain damage.
- Physical health: alcohol can make other major health problems worse (e.g. liver disease, heart disease, high blood pressure or diabetes). Their diet also makes a difference, as alcohol can cause the body to be short of vital vitamins (especially thiamine – vitamin B1).
- Mental health: when drunk, alcohol makes any feelings stronger (e.g. makes a person feel even more sad, or more angry). When used regularly, alcohol can also cause anxiety and depression. This is a trap, as drinking may make a person feel better, but all the while it is quietly making things worse.
- A person's body make-up (biological reasons): women generally feel the effects more than men from the same amount of alcohol. Also, some families have a greater chance of alcohol problems than others. This is partly because of the genes we inherit, and partly because of what each person is exposed to in life (e.g. traumas, or lots of drinkers around them). People sometimes say that Aboriginal people's bodies handle alcohol differently from non-Aboriginal people, but there is no evidence for that.

## Long-term harms from drinking

Alcohol can cause long-term harms in nearly every system of the body:

<b>System</b>	<b>Problem</b>
<i>Mental health</i>	<ul style="list-style-type: none"> <li>• Sleep problems</li> <li>• Anxiety</li> <li>• Depression</li> <li>• Makes any existing mental health problem worse</li> </ul>
<i>Brain and nerves</i>	<ul style="list-style-type: none"> <li>• Alcohol withdrawal</li> <li>• Confusion and/or staggering: Wernicke's Syndrome – a brain disease from not having enough thiamine (vitamin B1)</li> <li>• Loss of memory: from mild to very severe (e.g. in Korsakoff's Syndrome)</li> <li>• Dementia</li> <li>• Numbness/tingling from damage to nerves in arms and legs (peripheral neuropathy)</li> </ul>
<i>Stomach, gut, pancreas</i>	<ul style="list-style-type: none"> <li>• Heartburn (gastro-oesophageal reflux)</li> <li>• Nausea, pain from inflamed lining of the stomach (gastritis)</li> <li>• Pain from pancreatitis: irritated pancreas from heavy drinking. The pancreas is a small organ that helps with digestion and controls the release of hormones such as insulin. The pain can be sudden and severe then settle (acute) or it can stay around for a long time (chronic).</li> </ul>
<i>Liver</i>	<ul style="list-style-type: none"> <li>• Fatty liver – where the liver is enlarged</li> <li>• Alcoholic hepatitis: inflamed liver from heavy drinking – may have some pain, and liver may feel larger than normal and tender; may have yellow 'whites' of the eyes ('jaundice') and yellow skin (in clients with lighter skin; see Jaundice, p. 202)</li> <li>• Cirrhosis: scarred liver from long-term drinking (see Cirrhotic liver, p. 202). Scar tissue starts to block the normal blood flow through the liver. This can lead to bulging blood vessels in the oesophagus or fluid in the belly (ascites) and legs (oedema). If bulging blood vessels (varices) in the oesophagus burst, then the person can vomit very large amounts of blood quickly.</li> </ul>

<b>System</b>	<b>Problem</b>
<i>Bones</i>	<ul style="list-style-type: none"> <li>• Bones become less dense (less solid) and break easily (osteoporosis). They also heal more slowly after breaks.</li> </ul>
<i>Blood</i>	<ul style="list-style-type: none"> <li>• Tiredness or shortness of breath from effects on red blood cells ('anaemia')</li> <li>• Bleeding or bruising: alcohol or liver damage can make it harder for blood to clot properly.</li> </ul>
<i>Heart</i>	<ul style="list-style-type: none"> <li>• High blood pressure</li> <li>• Abnormal heart rhythm (fast and irregular)</li> <li>• Weak heart muscle (cardiomyopathy)</li> </ul>
<i>Lungs</i>	<ul style="list-style-type: none"> <li>• Increased chance of developing severe chest infections, including pneumonia and tuberculosis</li> </ul>
<i>Kidney</i>	<ul style="list-style-type: none"> <li>• Alcohol can hurt weak kidneys in two ways: by causing high blood pressure, or by making people 'wee' (pass urine) more and get dehydrated (loss of fluid) mainly in hot climates.</li> <li>• If someone has kidney failure, they cannot clear away all the fluid from alcohol and it can build up.</li> </ul>
<i>Body chemistry [metabolism]</i>	<ul style="list-style-type: none"> <li>• Vitamin deficiency (especially thiamine), e.g. causing confusion (Wernicke's Syndrome)</li> <li>• Shortages of other important vitamins or of healthy food, causing sickness</li> <li>• Very overweight (obese)</li> <li>• More likely to develop diabetes; more problems getting diabetes under control (high or low sugars)</li> <li>• Natural salts out of balance (e.g. low magnesium causes seizures; low sodium can cause confusion or severe illness)</li> </ul>
<i>Joints</i>	<ul style="list-style-type: none"> <li>• Gout: joint pain due to build-up of crystals in the joint tissues</li> </ul>
<i>Hormones and sexual function</i>	<ul style="list-style-type: none"> <li>• Sexual problems: impotence from low levels of male hormone (testosterone)</li> <li>• Breast enlargement in men ('man boobs'): from changes in the balance of female and male hormones because of liver problems.</li> </ul>

### **Why does alcohol cause long-term harms to the body?**

If a person regularly drinks too much (e.g. above recommended limits), they can develop long-term harms to many parts of their body. One reason for this is because alcohol is broken down in the body, by steps. Along the way, alcohol is changed into various other chemicals. One of these chemicals (acetaldehyde) is very harmful to the body. It causes cancers and causes damage known as 'oxidative stress'. In the brain, damage is made worse by a shortage of thiamine (Vitamin B).

### **How to recognise alcohol dependence**

If a person drinks at a risky level regularly over months or years they may become dependent on alcohol. Sometimes it is very obvious when someone is dependent on alcohol; they may be drinking very large amounts, and their life or health may be falling apart because of their drinking. Or the person may have very clear alcohol withdrawals when they stop. But other times the picture is not as clear. The person may drink a lot, but you are not clear whether this is by choice or whether they are losing control over their drinking. They may not drink every day and there may not be any withdrawal symptoms when they stop. For people like this, you need to ask specific questions to check for the presence of dependence (Assessing dependence, see p. 78).

### **How to recognise alcohol withdrawal**

Some (but not all) dependent drinkers feel tense or uncomfortable when they stop drinking and have poor sleep. Others also experience 'the shakes', sweating, vomiting and diarrhoea. Severe withdrawal can be a life threatening sickness, and the person may be confused, paranoid, and see things that are not there. Alcohol withdrawal and how to manage it are described in more detail on p. 86.

### **How common is alcohol dependence and withdrawal?**

Around one in 20 people in Australia (4%) are dependent on alcohol, and may be at risk of alcohol withdrawal. Some Aboriginal Australians do not have daily access to alcohol (e.g. because they run out of money or live in a 'dry community'), and these individuals may get less severe withdrawals or no withdrawals when they stop.

## SCREENING FOR ALCOHOL PROBLEMS

It is often easy to detect a severe drinking problem, but milder problems can be missed. It is important to ask every person coming to a health service (and to settings like corrections) about their alcohol use so that they can be given a chance to think and talk about their drinking. Then help can be offered, where needed.

You can quickly screen for a drinking problem by asking 2–3 simple questions as part of an adult health check:

- How often do you drink?
- How many drinks do you have on a day when you are drinking?
- And (if it is not already clear): How often do you have six or more drinks on one day?

You can change how you ask these questions to suit your own setting and style. For example, instead of the third question (above), some people ask: “What about pay day or funerals?” This is to get a feel for the drinking on possible heavy days.

### Tools to help you screen for an alcohol problem

There are tools available to help you quickly check for an alcohol problem. These are used as part of a routine health check. If there is any hint of an alcohol problem, you then assess the drinking more fully to work out how severe it is.

- *AUDIT-C*: three simple questions on how much and how often people drink (see *AUDIT-C*, p. 426).
- *AUDIT*: 10 questions that ask about alcohol use, symptoms of dependence and related harms (developed by the World Health Organization; see *AUDIT*, p. 424).
- *IRIS (Indigenous Risk Impact Screen)*: a brief questionnaire that asks about alcohol, drug and mental health problems; developed by and for Indigenous Australians (see *IRIS*, p. 427).

The aim of these screening questions is to pick up a problem that you might not know about or that the client may not be aware of.

## HOW TO ASSESS A CLIENT WHO DRINKS ALCOHOL

If a client comes to you for help with drinking, or you suspect they have a problem with alcohol, you need to assess their drinking carefully. How you do this will depend on your setting.

Often it works best to start with just hearing the client's story. After getting a feel for what is going on and what are your client's main concerns, you can find out about specific points. Try to avoid writing at first, so the client can see that you are really listening.

### Taking a drinking history in a remote setting

If you are not from the local culture, seek advice from a local health worker on the best way to take an alcohol history. In more traditional areas, it may be best to avoid direct questions at first. A 'yarning' approach may work better. Instead of questions you can sometimes suggest two alternative scenarios: "Some people get the shakes when they stop drinking; some people are fine. What is it like for you when you stop?"

### Drinking history

An important step is to find out about the client's pattern of drinking. You can ask:

- How much do you drink?
  - How big is the glass? Drinks poured at home are usually bigger than 'standard' drinks.
  - If the client cannot give you the number of glasses, ask: "How many people were sharing the cask?" Or, for people who drink alone: "How long does it take you to go through a case of beer?"
  - Some people might tell you the amount that the group drinks, not what they drink themselves. Try to find out how many people usually share the cask of wine, and roughly how much your client drinks.
  - Ask what type of alcohol the client drinks. If they tell you (for example) about beer, also ask about wine and spirits.
  - Sometimes you can make the client more comfortable to admit to heavy drinking if you suggest a high amount, e.g. "How many cases do you get through in a day?"

- How often do you drink (and how)?
  - Do you drink with friends or family? For daily drinkers, ask: “What time of the day do you start drinking?”, “Do you drink with food?”, “Do you have any days off, when you are not drinking?”
- About withdrawal:
  - Ask: “What happens if you stop drinking? Do you become unwell or uncomfortable; do you feel uptight (anxious), get the shakes (tremor), or have problems with your sleep?”
  - If the person has not stopped drinking, ask: “What are you like in the morning, before your first drink?” Or are they drinking to avoid getting withdrawals? (see Assessment of withdrawal, p. 86).
- About dependence on alcohol
  - You need to find out if the person is dependent on alcohol because, for dependent drinkers, stopping drinking is usually the only option that will work. Knowing this will also help you work out how much support the client might need.

### **How to assess if your client is dependent on alcohol**

If a person gets alcohol withdrawal, then it is clear that they are physically dependent. But some dependent drinkers do not get withdrawal. You can find out if a drinker is psychologically dependent by checking if they have three or more of the following features:

- *A strong desire to drink (craving) or has to drink (compulsion)*: ask, “If there is no alcohol around, do you think about it a lot? How much do you miss it?”, “Do you feel you drink because you want to, or because you need to?”
- *It is hard to control drinking*: ask, “Have you tried to cut down or stop?” Their answer will show if they found they could not. You can also ask: “How easy would it be to stop?” and “Do you find you drink more than you plan to?”
- *The person needs more alcohol just to feel its effects (tolerance)*: are they drinking a large amount and can still walk and talk normally? Or you can ask: “How much do you need to drink to get the effect you are after? Did you always need that much?”
- *Withdrawal (see above)*.
- *Alcohol becomes ‘number one’*: is the person still able to do other activities they used to do (e.g. work, sport, music, spending time with family and friends)? Or are they doing these less because of drinking, or have they stopped doing them altogether? You can ask the client to describe their typical day and see if most of their time is spent drinking.
- *Keeps drinking in the face of clear harms*.

Try to get an overview of the person's lifetime drinking history. You can ask:

- What age did you start?
- Roughly, how much of your life have you been drinking, and how much have you been 'dry'?
- What are the major harms that drinking has caused (e.g. to physical or mental health, family and community)?

### **Consider local culture and views on causes of sickness**

In some communities, traditional beliefs may lead people to think that alcohol-related sickness and death (even alcohol-related road accidents) are not caused by drinking but happen because of sorcery and black magic.

Past treatment or approaches to stopping:

- In the past, have you managed to stop drinking? If so, what worked to achieve this; what did not work?

How ready is your client to change right now?

- If the client is not yet ready to change, you may be able to get them thinking about change (see Stages of change, p. 199 and p. 423; Brief intervention, p. 82).

### **Other drug use**

Ask the client about their other drug use, including benzos (see Benzos, p. 173).

### **Alcohol and other sedative drug use**

If a person is withdrawing from benzos and alcohol at the same time, withdrawal can be more severe. Also, being intoxicated from benzos or heroin at the same time as drinking can increase the chance of overdose (see Alcohol overdose, p. 103).

### **General health and other issues**

Are there major issues going on right now that will affect the client's drinking, or that the drinking will affect (e.g. physical or mental health, family, community, cultural or legal issues)?

### **Seek extra information from family or others**

Some drinkers report their drinking as less than what it really is. The most common reason for this is shame, though other people may be worried about getting into trouble with the law or with child protection agencies. Also, some people with alcohol problems can have memory problems or can be too drunk to remember what they drank. It can be useful to get extra information from family and friends, but only if your client says that this is okay. Talking to family members is also important because often the client's drinking impacts on them, and they may need your support. Family may also be able to support the drinker to make a change.

### **Your observations**

What you notice tells you some more about your client's drinking. Is your client:

- Intoxicated (slurred speech, unsteady, smells of alcohol)?
- In withdrawals (restless, tremor, sweaty palm of hands)?
- Showing signs of liver damage (yellow 'whites' of the eyes, swollen legs or belly, many bruises)?
- Staggering even while sober (this damage to the part of the brain that controls balance; or could mean there is Wernicke's Syndrome)?
- Confused or seeing things that are not there?
- Does what the client says match how they look? For example, if they say they are ready to change, do they appear convinced of this, or are they still not sure?

If you are trained to do a physical examination, is:

- The liver enlarged?
- Blood pressure, pulse or temperature raised (as in withdrawal)?

## Summing up after your assessment

After assessing a client you should be able to sum up:

- Whether their drinking is:
  - At a level that could give them problems in the future (risky or hazardous drinking)
  - Is already causing significant harms (harmful drinking), or
  - Is dependent, and, if so, will they need help with managing withdrawal
- What sorts of help they have tried in the past
- What are their other key health issues (physical and mental)
- What are the other key family, community or cultural issues that are relevant to their drinking.

## Getting a person thinking about their drinking (brief intervention)

Sometimes a person may not realise that their drinking is putting them at risk of future problems. Or they may already be having difficulties in their life, or be causing problems to others, but they have not linked these in their mind to their drinking. Other people may know they are drinking too much, but are not yet ready for change. When health clinics, hospitals or other settings ask everyone about alcohol use, this can allow a drinking problem to be picked up earlier, and the drinker can have a chance to step back and think about change. Even a brief conversation with a person can be a chance to get them thinking. This short conversation on alcohol is often known as ‘brief intervention’.

## Picking up an alcohol problem when someone is there for something else

When a client has come to a health clinic for some other reason (e.g. for a chest infection) or is in a setting like corrections or probation, it is a chance to find out about their drinking. For example, services can include three quick screening questions on alcohol in the adult health check or they can use another short screening tool (see Screening, p. 76). Every client is asked these questions, so no one has to feel they are being shamed or singled out. If an alcohol problem seems likely, you can then ask a few more questions to see if the client is dependent on alcohol and to work out if they have already started to think about changing their drinking (see Assessment, p. 78).

## Getting your client thinking about their drinking

Whether this is the first time your client has tried to change their drinking, or if they have tried many times before, a short conversation can help get them thinking about their drinking. It may help get them more ready for change.

Some points to remember:

- It is your client's right to choose if they drink. Your job is not to tell the client what to do, but to use every chance to get them thinking about their drinking. If you give them a plan to stop drinking, it is your plan. If they come up with a plan to stop drinking, then it is their plan, and is much more likely to work. You can also help the client make sure that their plan for change is achievable.
- Alcohol does not just harm the client. Remember that the client's drinking is like a stone being thrown into a pond. The ripples can go out and affect their family, their friends and the whole community.
- Try to step in your client's shoes. Work out what matters to them, and what factors might make them want to change their drinking. If family, community, land and culture are important to them, then try to help the client think about how drinking affects these.

**The steps of brief intervention can be summarised by the word 'FLAGS'****F***Feedback*

Listening to the client's story, and reflecting back with them, on what harms alcohol or drug use might be causing.

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**L***Listen*

What stage of change are they at?

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**A***Advise/assist*

Share information that you have which might help your client make a decision about their substance use.

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**G***Goals*

What goals is your client prepared to accept? Cutting down? Stopping? Having someone care for the kids when they're using?

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**S***Strategy*

Help your client identify steps or strategies to reach this goal. Is further support or treatment needed?

*Feedback*

- Feed back to the client parts of the story that they tell you ('reflective listening'). This can help them step back and understand their drinking better. It can make a clearer link in their mind between their drinking and the problems it is causing them, their family and community. For example: "You mentioned that it bothers you that your kids are scared when you've been drinking?"
- Try to give this feedback in a gentle way, like you are 'standing in their shoes' (i.e. with empathy). For example, you might say: "That was a tough time for you, those problems with the cops, last time you were drinking". Feedback should never be judgemental.
- Feedback can be a good way of starting a conversation about drinking. For example: "You know that screening test you filled in on drinking? Can I tell you about your results?"
- Feedback on raised blood tests for the liver can also help start this conversation (see Blood and other tests to assess drinking, p. 430).
- Help the client weigh up the good and not-so-good things about drinking (see Motivational interviewing, p. 24).

*Listening*

Showing that you are listening to the client is important. You should be able to pick up how ready they are to change. The Stages of Change picture can help you (or your client) think through where they are at in terms of changing their drinking (see Stages of change, p. 199 and p. 423).

If someone is happy with their drinking, then your conversation might help them get them to the point of thinking about change. However, if they are just thinking about change, you might be able to support them get to the point of taking action. Any progress is good.

*Advise/assist*

Sometimes the client may not realise that a particular problem is linked to alcohol. For example, they might have sleep problems and feel stressed every morning. You may be able to share with them what you know. For example, that sleep problems and anxiety in people can often start to get better a few weeks after stopping drinking. Try to be familiar with health problems that can be linked to alcohol, or get a resource to explain these (see Alcohol and the body, p. 201; Short-term harms, p. 71; Long-term harms, p. 73).

Sharing what you know about how much simpler life can be when alcohol is under control can be powerful.

If the person is drinking just a little over the recommended limits, but not experiencing any harms, they may be interested to see a chart of the health guidelines about drinking levels. This can show them how to reduce their chance of developing health problems like diabetes or cancers.

Sometimes, culturally, you may have the right to tell a client what to do. Or sometimes as a health professional you will have the authority to recommend a change. But most often your role is to help the person reach a decision themselves. Always respect the client's right to choose if they drink.

### *Goals*

What goals is your client prepared to accept? Do they want to stop drinking, cut down, or reduce the harms of drinking? Or are they not ready to make any change yet?

### *Strategies*

If your client is ready to make a change in their drinking, help them think through how they will reach their goals. Thinking about some practical strategies can make change more likely.

#### **Tips for drinkers who would like to cut down**

- Avoid friends when they are drinking or limit the time spent with them
- If being asked to drink, have an excuse ready: e.g. "I'm getting fit" or "My doctor has told me to cut back" or "It makes my sugars go out of whack"
- Drink only with food
- Have water when thirsty and between drinks
- Choose low alcohol beer
- Switch to a smaller size glass.

There are a number of visual aids available to help you give brief intervention. You can choose what best meets your needs or create your own resource (see Further reading, p. 104).

People who are dependent on alcohol usually find it impossible to cut down. For them, stopping is usually the only option. The following sections deal with strategies to help a dependent drinker stop drinking and stay dry.

## HOW TO HELP PEOPLE WHO WANT TO STOP DRINKING: OVERVIEW

People with more severe problems may need a lot of help and support, including treatment of withdrawal and approaches to help them stay dry.

### Deciding on a plan to tackle alcohol

The information you put together from your assessment of the client's drinking will help you and your client come up with a safe and sensible plan for stopping drinking. For most clients there are two main elements to this plan:

- *How to manage withdrawal:* Try to work out whether your client will go through withdrawal. If withdrawal is expected you can help them choose the right place for it to be safely completed. Also, if a person knows that they can get help for their withdrawal symptoms, this can give them the confidence to stop drinking.
- *How to stay dry:* Stopping drinking is only the first step, and staying dry is usually the bigger challenge. Once the client's withdrawal is under control, they can be offered support to help stay dry, such as counselling, group support and/or medicines. Other clients may prefer or need to go to a rehab.

## ASSESSING AND PLANNING FOR ALCOHOL WITHDRAWAL

Alcohol withdrawal can vary from being very mild and hard to notice, through to being a severe life threatening illness. Withdrawal usually starts within a day of stopping drinking and lasts less than a week. It is important to be sure that the client is safe during withdrawal.

The most common symptoms of withdrawal are:

- Sleep problems (insomnia)
- Anxiety
- Tremor
- Sweating
- A strong desire to drink (craving).

The more severe the withdrawal, the longer it lasts:

- *Mild*: poor sleep for a few nights, a bit stressed by day, feels anxious or mildly restless. Typically lasts 1–3 days.
- *Moderate*: tremor, anxiety, sweating, diarrhoea and vomiting, fast heart rate, raised blood pressure and temperature. Finishes within a week.
- *Severe*: may include hallucinations and confusion, as well as the other features of withdrawal. This type of confusion is called 'delirium tremens' (DTs) and needs urgent medical treatment (see DTs, p. 96). People with DTs can die if not treated quickly. DTs can last up to 10 days.
- *Seizure (fit)*: a seizure can be life threatening; it may also be a warning sign of a more serious withdrawal that is still developing. It is most common on the first day after stopping drinking.

#### **How soon after drinking is withdrawal at its worst?**

- *Moderate withdrawal*: usually peaks at 48 hours and finishes within a week.
- *Severe withdrawal*: can continue to get worse for longer, peaking at day 4; it also lasts longer (up to 10 days).
- *Seizure*: if it occurs, is often in the first 24 hours after stopping drinking.

#### **Will your client experience a withdrawal?**

When a person plans to stop drinking it is important to try to work out if they will experience withdrawal, and how severe it will be. This helps you to discuss with the client the best place to stop drinking (e.g. at home, 'out bush' away from their community, or in a detox unit or hospital). It also helps you work out if the client needs a medical assessment before stopping drinking.

Find out about your client's past withdrawal experience:

- What happened when they have stopped or cut down before?
- Have they had withdrawal symptoms? If so, what? "Do you have sleep problems, or feel tense, or get the shakes?" Your client may not realise that these symptoms are part of withdrawal.
- If the client has never tried to stop drinking, ask what they feel like each morning before their first drink. "Do you feel tense or bad tempered? Do you get tremors (the shakes)?"
- Have they ever had severe withdrawal symptoms like seizures or DTs?

**Withdrawal is likely to be more severe in a person who:**

- Drinks more alcohol on a drinking day
- Drinks often
- Has been drinking for longer (e.g. more weeks or months) during this latest period of drinking
- Has been drinking for several years altogether
- Is dependent on alcohol (see Assessing dependence, p. 78)
- Has had significant withdrawals in the past.

**Severity of withdrawal varies from person to person**

- Not all drinkers who are hooked on alcohol (dependent) get physical withdrawal symptoms.
- Sometimes a person who has been drinking heavily for many years can stop without much withdrawal. This may be due to differences in a person's make-up (i.e. genetic factors).

**Where should withdrawal take place?**

You can help a client choose the best place to go through alcohol withdrawal. If there is any doubt on the best setting, talk with the client and an experienced doctor or specialist advisory service. In general if you are expecting a:

- *Mild withdrawal (e.g. sleep problems, anxiety only)*: many people can stop drinking at home (or 'out bush') without medical help.
- *Moderate withdrawal (e.g. tremor, sleep problems)*:
  - This can sometimes be managed at home with the help of a doctor. It is best if the drinker sees the doctor before stopping drinking.
  - Other clients need to go into a detox unit (or hospital) because their home environment is not suitable or because they have trouble stopping drinking, or for medical reasons.
  - Valium (diazepam) can be prescribed by the doctor and given during the withdrawal (for 1–7 days) to relieve symptoms and to prevent complications such as seizures or DTs.
- *Past seizure or severe withdrawal (e.g. seeing things that are not there, very unwell during past withdrawal)*: it is best if the client can go into a hospital or detox unit where they can be given diazepam and be monitored carefully.

Wherever the withdrawal is managed, clients will benefit from knowing they are in a safe environment, and from support and reassurance.

**Clients who may be suitable for home detox:**

- Have never had seizures or a severe withdrawal (for example, with hallucinations)
- Are relatively healthy (mentally and physically)
- Have support people around who do not drink. If others around them are drinking, it may be better for the client to go to a household with non-drinkers or to a dry community or other dry place to go through withdrawal.

**Getting remote clients to a safe spot**

If the client has had severe withdrawals in the past, and lives in a remote community with no medical help, it is better if they plan to go through withdrawal somewhere where medical help is available.

**Clients who are best going through withdrawal in a detox unit or hospital include those who:**

- Have had seizures or severe withdrawals in the past (including DTs). Their next withdrawal can be severe even if they have only restarted drinking a short time ago.
- Have another serious illness (e.g. pneumonia, unstable diabetes, kidney failure, epilepsy). These clients are more likely to get severe withdrawal symptoms and are better managed in a detox unit that can give diazepam or hospital.
- Have serious mental health problems (e.g. very depressed, suicidal or psychotic).
- May withdraw from another drug (benzo withdrawal is particularly risky when happening at the same time as alcohol withdrawal).

## WHAT YOU CAN DO TO HELP SOMEONE IN ALCOHOL WITHDRAWAL

The health worker has an important role in making sure the client is safe and in supporting the client and their family. For example:

In mild withdrawal (e.g. anxiety, sleep problems), if this is managed at home, then family members or other support people should be told:

- The person will need plenty of fluids, encouragement and reassurance
- What withdrawal symptoms to expect
- What to do if things go wrong. Call for medical or nursing help if:
  - Someone has a seizure: first lie them on their side in the coma position (see CPR guide, p. 436); call for an ambulance if available.
  - Withdrawal symptoms get worse.

If the client's withdrawal is moderate (e.g. tremor, anxiety):

- Support them to see a doctor who can arrange diazepam to help with withdrawals. For a home detox, diazepam is given to the client daily. Usually only a nurse, doctor or pharmacist can give it out.
- Monitor how the client is feeling during the withdrawal. An alcohol withdrawal scale is a good way of keeping track of the client's progress.
- If the withdrawal is not well controlled, arrange to transfer the client to a detox unit or from the detox unit or hospital.

If the client has a seizure or more severe withdrawal (including DTs, severe vomiting, agitation):

- Transfer them to a hospital (or if not available to a detox unit that can offer diazepam). In DTs, withdrawal symptoms need to be monitored every hour until they come under control.

### How to monitor alcohol withdrawal

It is important to monitor withdrawal carefully to check that it is staying under control and that treatment is right. For a home detox a daily check is usually enough. Sometimes the client is asked to come into the clinic daily (this is known as 'ambulatory detox'). If a trained nurse is available for home visits, they can check the client and they can also give them diazepam for that day if needed. In a detox unit or hospital, if a more severe withdrawal is expected, the client may be monitored every four hours or more often.

These are the withdrawal signs that are usually monitored:

- Sweating
- Tremor
- Anxiety
- Agitation/restlessness
- Hallucinations – does the client appear to be seeing or hearing things that are not there?
- Temperature
- Orientation (e.g. does the person know what day it is and where they are?).

### **Using an alcohol withdrawal scale**

Alcohol withdrawal scales are useful to assess and monitor alcohol withdrawal (e.g. see AWS, p. 432). These can help monitor whether the client is getting better or worse. They can also help clinicians decide how much diazepam is needed.

Some tips for using a withdrawal scale:

- Score the signs of withdrawal that can be seen, from 0 (when not present at all) through to the top score, when there are severe signs.
- If the score is getting higher the withdrawal is probably getting worse and more diazepam and/or a review by a doctor is needed.
- Conditions like chest infections, anxiety or other mental disorders can also raise the score on a withdrawal scale. If someone has a problem like that, get a medical review:
  - Sometimes the doctor will tell you to take less notice of some items in the scale, e.g. if a person is always anxious even when sober for months, you may take less notice of the anxiety score. Or if they have a fever from a chest infection, you may ignore the temperature item.

## Use of diazepam in alcohol withdrawal

Diazepam (e.g. Valium) controls the symptoms of alcohol withdrawal and makes seizures and more severe withdrawal less likely. If it is given daily, with careful supervision, it can be life saving. If a person has a history of seizures or severe withdrawal it is important for them to see a doctor before stopping drinking if possible, or if not as early as possible. The doctor can then organise for diazepam to be given soon after the person stops drinking to prevent these problems. Seizures can occur on the first day after stopping drinking. Sometimes the seizure happens before there are other signs of withdrawal.

There are risks in using diazepam:

- Too much can make a person too sleepy or even become unconscious and stop them breathing.
- If a person keeps taking the diazepam for six weeks or more, they may become dependent on it.

Because of these risks, only certain health professionals (e.g. doctor, nurse or pharmacist) are allowed to give the client diazepam.



### Tips for using diazepam safely

- Careful supervision by a health professional and/or family member is needed.
- If the person is going through withdrawal at home, arrange for the diazepam to be given out daily (this also allows for daily monitoring of the withdrawal).
- The client needs to avoid driving and take care when crossing roads.
- Stop the diazepam if the person starts drinking again or if they seem sleepy.
- Take special care in clients with bad livers, who are older, or who have lung problems; a doctor will sometimes advise a shorter acting benzo (like Serepax, which is oxazepam) for these clients.
- Use diazepam no more than one week (except up to 10 days for DTs).

Diazepam can be prescribed for alcohol withdrawal in three ways:

- A fixed dose regime
- As needed, where the dose given varies according to the client's score on a withdrawal scale
- A loading regime (higher doses early on).

The doctor decides which regime will work best for the client and their setting.

*Fixed diazepam regimes*

Fixed regimes are often used during home detox (outpatient or ambulatory withdrawal). They are also sometimes used in detox units or hospitals.

- If a person has a history of withdrawal seizures but cannot be managed in hospital, this regime can help prevent seizures.
- A typical regime for mild to moderate withdrawal is shown below. Up to eight (5mg) tablets (i.e. 40mg in total) are given daily for the first two or three days. Then the dose is gradually cut down to nothing within a week.
- If a person is expected to have a milder withdrawal, lower doses may be enough.
- The regime can be adapted to fit how the withdrawal is going.

**Adjusting the diazepam regime to fit the client's needs**

- Extra diazepam may be prescribed to keep withdrawal symptoms under control (e.g. to keep the alcohol withdrawal scale score below the recommended cut off (e.g. below 4 for AWS, or below 10 for CIWA-AR).
- If the client needs more than 12 (5mg) tablets (i.e. 60mg in total) of diazepam in one day, then they may need to be moved to a detox unit that can provide diazepam or a hospital, as this means that they are having a severe withdrawal.
- If the person is sleepy during the day the diazepam dose may be too strong for them. They should talk to a doctor or nurse before taking any more.

*'As needed' diazepam regime*

This method is often used in hospital or detox units if it is not clear if the person will experience an alcohol withdrawal.

- The withdrawal scale is measured every four hours (or more often if a severe withdrawal is expected), and the amount of diazepam is adjusted to fit how severe the withdrawal symptoms are.

*Diazepam loading regime*

This 'upfront loading' regime is sometimes used in 'inpatient' (live in) detox units. Up to four (5mg) diazepam tablets are given every two hours, until the client is mildly sleepy, then less is given on later days. This regime is not used for home withdrawal, as the person will usually become sedated.

Further information on the different diazepam regimes to manage withdrawal can be found in the National Guidelines for Treatment of Alcohol problems (see Further reading, p. 104).

## Tips for managing withdrawal

- Monitor the withdrawal regularly.
- Diazepam (or other benzos) need to be used very carefully (see Diazepam tips, p. 92) and should be stopped within 7–10 days.
- Seek review by a doctor (or if not available, an experienced nurse) if the withdrawal does not behave as you expect:
  - If withdrawal is still not under control after 12 tablets (60mg) for a home withdrawal or 18 tablets (i.e. 80mg) of diazepam in a detox unit, the doctor can check if there is another health problem going on, or see if benzos are needed through a drip. A number of serious medical conditions can have symptoms that can look like withdrawal.
  - If the client becomes confused, it could be that they are getting the DTs and need more diazepam, or it could be they had too much diazepam. Also a number of serious medical conditions can cause confusion, including shortage of thiamine or low or high blood sugars.
- Make sure the person has plenty of fluids. People in withdrawal may get too dry (dehydrated) because of fever, sweating, vomiting or diarrhoea. They should drink more water than usual or if they are vomiting they may need intravenous fluids (through a 'drip' into the vein).
- Give thiamine to prevent brain damage from vitamin shortage.

### Other problems that can look like withdrawal

Sometimes it can be hard to know if what the client is going through is caused by withdrawal or by another health problem. Several health problems can give a raised score on a withdrawal scale; for example:

- A fever from any infection can make a person sweaty and their heart beat fast.
- If a person is anxious for any reason, they may have a tremor or be sweaty.
- A severe chest infection with shortness of breath can make a person anxious, make their heart beat faster and give them a raised temperature.
- A head injury or abnormal blood sugars in diabetes or vitamin B shortage can cause confusion.

If the person stopped drinking more than 10 days ago, then any sickness they are experiencing is *not* linked to alcohol withdrawal. There must be another reason for it.

If you think that something else could be going on, ask for a skilled doctor or nurse to assess the client as soon as possible. If there is no doctor or nurse available, get phone guidance from a specialist advisory service (see Specialist advice, p. 435).

## Thiamine (vitamin B1)

People who are dependent on alcohol may become short on essential vitamins and minerals because:

- They may not be eating properly.
- Their stomach lining may be irritated and swollen (inflamed) which makes it hard to absorb some of these nutrients.
- Alcohol can make it hard for the body to make use of thiamine (vitamin B1).

A shortage of thiamine is common in people with alcohol dependence. This can lead to a sickness called Wernicke's Syndrome, which can cause severe and permanent brain damage (see p. 97).

All people going through alcohol withdrawal should have extra thiamine to prevent this:

- Tablets may be enough if the client has been eating a healthy diet, and alcohol dependence is not severe. Give 100mg tablet, three times each day for the first five days.
- Injection into the muscle (intramuscular or IM) is safest if there is vomiting or stomach pain, if the person has not been eating well, or if alcohol dependence is severe.
- Injection into the vein (intravenously or IV) is needed if the client is confused, or if there is any other reason to suspect Wernicke's Syndrome.
- The client can continue thiamine tablets (1–3 times each day) for a few weeks.



### **Give thiamine as soon as possible for very heavy drinkers**

Try to give thiamine as soon as a heavy drinker comes into detox and before they have sugary drinks or sweet food. Giving sugary drinks or food (or glucose in a drip) first can trigger Wernicke's Syndrome and lead to permanent memory loss.

Always have some thiamine on hand. If you are caught out without thiamine, toast and vegemite is safer than sweet foods.

The one exception to this rule is when a person has diabetes. If their blood sugar might be low (e.g. they had their insulin or diabetes tablet, then missed a meal), they may need sugar urgently.

## Managing the complications of withdrawal

### *Delirium tremens (DTs)*

As described above, DTs are a severe form of alcohol withdrawal and a life threatening condition. The client needs to be urgently transferred to a high dependency unit (or 'intensive care unit') in hospital. In remote areas a medivac is usually needed.

The features of DTs usually include:

- Confusion
- Not knowing when or where you are (disorientation)
- Seeing, hearing or feeling things that are not there (hallucinations)
- Severe fear of things that are not real (paranoia).

These features occur along with the other symptoms and signs of withdrawal, such as sweating, diarrhoea, vomiting, rapid pulse and high blood pressure.



Medical treatment is needed urgently in DTs to avoid death from dehydration, heart attack, stroke or suicide. Without medical treatment, up to one in every six individuals with DTs may die. DTs can be prevented if withdrawal is treated well from the start.

### **There is a higher chance of severe withdrawal and DTs if your client:**

- Has more severe alcohol dependence and over a longer period of time
- Has had severe alcohol withdrawals in the past
- Has any recent onset (acute) and/or severe medical conditions
- Has had recent surgery (an operation)
- Is older.

The prompt treatment for DTs is needed, for example:

- Diazepam or related medicine (midazolam) is usually injected into the vein by a doctor or nurse. This is done carefully, in small doses at a time, to prevent breathing problems. Sometimes midazolam is given constantly and slowly through a 'drip'.
- An anti-psychotic drug may be given to help with hallucinations or agitation (e.g. olanzapine).
- The fluid balance is monitored (i.e. the amount of fluids taken in compared with the amount of urine) and the client usually needs a drip (intravenous fluids).
- Thiamine is given direct into the vein or through the drip.
- A calm environment helps to reduce anxiety and agitation.

### *Wernicke's Syndrome*

As explained earlier, Wernicke's is a serious brain sickness (encephalopathy) that is caused by a lack of thiamine in the body. Wernicke's can happen in alcohol withdrawal or while your client is still drinking. Without treatment Wernicke's can lead to coma and death or to permanent, severe memory loss.

Signs of Wernicke's can include:

- Staggering and being unbalanced when trying to walk (ataxia), even when sober
- 'Eye signs' – jerking, flickering movements of the eye (nystagmus) or paralysed eye muscles (i.e. not being able to move the eyes from side to side). The client may have double vision
- Confusion or short-term memory loss.

If you suspect Wernicke's, a thiamine injection (if possible into the vein) is given straight away and in high doses for at least three days. Urgent review by a doctor is needed.



If you do not have someone to give a thiamine injection to your client, give thiamine by mouth while you transfer the client urgently to a clinic or hospital.

If not treated, Wernicke's Encephalopathy can lead to life-long and profound memory loss. This is known as Korsakoff's Syndrome. Memories of the distant past (e.g. youth) are kept, but no new memories can be laid down. So the person cannot remember what happened five minutes earlier and will often make up the details they have forgotten ('confabulation').

Wernicke's Syndrome can be prevented by eating healthy food and taking thiamine tablets, or, in sick clients or dependent drinkers, by arranging a thiamine injection.



Your client or their family can get thiamine tablets at the chemist. No script is needed.

### **Preventing complications by early treatment of withdrawal**

- Help your client plan for stopping drinking and to talk to a doctor about withdrawal.
- If your client has a hospital admission coming up for a medical or surgical condition:
  - The doctors and nurses need to know that alcohol withdrawal may happen, so they can monitor the client and give early treatment for it.
  - Even better, if the client can stop drinking a month before planned surgery they may have less complications and quicker healing.

## **HELPING A PERSON STAY DRY**

Once the client has safely stopped drinking, and any withdrawal is over, they should be offered some form of support to help them stay dry. This can include counselling (psychosocial intervention), group support (which may include AA or SMART Recovery) and medicines. Other clients may prefer or need to go to a rehab. Often clients need more than one type of treatment at the same time to help them avoid relapse.

### **Case management and support**

The care and support you provide can be very important in helping your client stay dry. Clients also often need support with practical problems such as housing or training. Help with these issues can assist your client to stay dry (see Case management, p. 43).

## Counselling

Every client should be offered some form of psychosocial treatment such as motivational interviewing and cognitive behavioural therapy (CBT). Counselling can increase the chance of staying dry (see Counselling, p. 27).

## Medicines to help prevent relapse

Suggest to your client that they see their doctor for a medical check-up and to ask about medicines to help prevent relapse. These medicines should be considered for all clients with alcohol dependence. They can start once withdrawal is nearly over.

There are three medicines approved for the treatment of alcohol dependence: naltrexone (Revia), acamprosate (Campral) and disulfiram (Antabuse; see p. 99). The GP can help advise which medicine will be best for your client. For example:

- Revia makes it a bit easier for the client to stay dry. It does this by slightly reducing their strong desire (craving) for alcohol; also, if they slip up, the drinker get less 'high' from alcohol.
- Campral can help make the craving for alcohol less and can also help with the anxiety that some clients feel in the early months after coming off alcohol.
- Antabuse 'punishes' drinking because the client gets a severe reaction if they drink even a small amount of alcohol. Drinking alcohol while on Antabuse causes headache, heart pounding (palpitations) and vomiting. It works best for clients who have someone to watch them taking the medicine each day. It can only be used in clients who are relatively healthy. People with major health problems like diabetes, heart disease and kidney failure cannot usually take Antabuse.

Note: these medicines can be combined (e.g. one medicine to reduce craving, used together with Antabuse to 'scare' people off drinking). Clients should have a say in choosing the best medicine for them.

### Cost of relapse prevention medicines

Revia and Campral are subsidised by the PBS when part of a comprehensive treatment program (i.e. when the client has been offered counselling and measures such as AA, and when the GP monitors their progress). This means they are cheaper for clients or free under CTG (Close the Gap).

Antabuse is not currently subsidised by the PBS, which makes it more expensive (at least \$70 per month). But Antabuse can be very effective and some clients point out that it costs a lot less than drinking.

**Pros and cons of medicines used to prevent relapse**

	<i>Campral</i>	<i>Revia</i>	<i>Antabuse</i>
Once a day	✗	✓	✓
Reduces cravings	✓	✓	✗
Helps stop a slip-up becoming an all-out relapse	✗	✓	✓
Can help with anxiety/sleep problems	✓	✗	✗

**How alcohol relapse prevention medicines work**

- Campral (acamprosate): helps the brain adapt more quickly to not having alcohol there. It does this by helping set the brain's natural stimulation back towards normal. At a chemical level this is turning down the NMDA/glutamate system.
- Revia (naltrexone): stops some of the 'high' (euphoria) from drinking. It does this by blocking alcohol's effect on the opiate receptor. It also reduces craving.
- Antabuse (disulfiram): blocks the normal breakdown of alcohol. Because of this, there is a build-up of a very unpleasant chemical called acetaldehyde. It is acetaldehyde that gives a person a bad reaction to drinking.

**Mutual support groups**

Some clients find mutual help groups such as Alcoholics Anonymous (AA) or SMART Recovery helpful when trying to stay dry (see Mutual support groups, p. 54).

## Rehab

If a client has already either tried (or is not suited to) the approaches described above and continues to drink heavily, spending time at a residential rehabilitation (rehab) may be helpful. Rehabs offer intensive programs to clients, it gives them time to feel more stable, and helps to make them stronger (build resilience) to prevent relapse. Programs can last from weeks to months.

Many rehabs need clients to detox first (i.e. to finish their 5–7 day withdrawal, either at home or in a detox unit) before entering the rehab (see Resi rehab, p. 59). This can be a challenge if you cannot get the client straight from the detox to the rehab. Sometimes there is a gap of a week or more, when you might be left trying to support the client to stay dry.

## Coping with relapses in alcohol dependence

People who are trying to stop drinking because they are dependent often need a lot of support. In some cases, helping a drinker can be very rewarding and they can turn their life around. Other times it can be disappointing and frustrating, for the drinker and for everyone around them.

It is important for the worker, the family and the client to remember that the person may not stop drinking forever straight away. Some drinkers cycle through the different stages of change many times (see Stages of change p. 199 and p. 423). If this happens, the drinker will stay dry for a while, then will slip up, but then later may become dry again. Every time they are dry, their body is having a break, and their family and community is having a break from their drinking.

If a client relapses to drinking, the worker and family can encourage the client to start thinking about change again. They may do this, for example, by helping the drinker balance up the good and not-so-good parts of drinking. They can also remind the drinker about how good things were last time they were dry. Once the drinker has become dry again, they can look back and learn from their slip-up. Understanding why the drinker slipped up can help keep them safer in the future when they might be tempted to drink.

## Reducing harms to drinkers who cannot or will not stop

There will always be clients who will continue to drink – some because they cannot stop and some because they do not want to. Even if they continue drinking, you can still provide ongoing advice and support. Every time you meet with the client you can sensitively bring up the issues around the harms from their drinking, and the benefits of changing the way they drink.

Some tips you can offer clients to reduce the harms of alcohol use:

- Taking thiamine tablets may reduce the risk of developing memory loss but it cannot stop all the harm from alcohol to the brain (or other parts of the body).
- Leave the car keys at home if the client knows that they are going to drink heavily (see Alcohol, drugs and driving, p. 322). If you know your client is continuing to drive while drunk, discuss this with another senior clinician to help you decide whether you need to report their drink driving to the drivers' licensing authority.
- Consider the safety of any children in your client's care. They should organise care for their children if they are planning to drink. If the client is unable to arrange support and safety for the children and continues to drink, in a way that puts them at risk, discuss this with a senior clinician. You may need to notify the child protection authority (see Protecting and supporting families, p. 370).
- Living with a dependent drinker is not easy and families are often distressed. Family members may be able to get some extra help from Al Anon (a mutual support group for families of alcoholics) or from other family focused services such as Family Drug Support.

## Managing emergencies in drinkers

A number of situations can need urgent medical care. These include:

- Severe alcohol withdrawal, which can be life threatening
- Seizures: the client's first seizure, or seizures that go on for a long time, or keep happening often
- Confusion or unexplained sleepiness: if someone becomes confused (e.g. does not know who, when and where they are), they could either be entering DTs or have Wernicke's Syndrome, both of which need urgent medical treatment (see DTs, p. 96; Wernicke's, p. 97). The person can be given thiamine (by injection if possible) even while waiting for other treatment.

### *Managing alcohol poisoning (alcohol overdose)*

Because alcohol is a depressant, if a person drinks enough it can make them unconscious and can even stop their breathing. This is a particular risk for young people who are not yet tolerant to alcohol or for people who combine alcohol with other depressants like benzos or heroin. The person can die from alcohol poisoning alone, or from breathing in their vomit while unconscious ('drowning in their vomit' or 'aspiration').

For this reason it is very important:

- To put an unconscious person on their side, in the recovery position (see CPR guide, p. 436)
- For overdose, if breathing is very slow, get medical help quickly (e.g. calling 000 for an ambulance).
- If the person may have used opioids like heroin or strong painkillers, then the opioid antidote, Narcan (naloxone), can be life saving.

### **Alcohol use in pregnancy and FASD (Foetal Alcohol Spectrum Disorders)**

Alcohol is a poison in pregnancy (a 'teratogen') that may damage an unborn child (foetus). It particularly affects the brain. The more a woman drinks, the higher the chance of damage to the unborn child. The range of problems in the child caused by the mother's drinking during pregnancy is described by the term Foetal Alcohol Spectrum Disorders (FASD; see p. 364 and p. 206).

## COMMUNITY ACTION TO REDUCE THE HARMS FROM ALCOHOL

At a community level, if there are many drinking problems, people can work together to try to reduce alcohol-related harms. To do so, some communities might start with a community meeting to discuss possible solutions. Many work with the licensing commission in their state or territory to try to reduce the supply of alcohol (see p. 337). This can be done in cities as well as in regional and remote areas.

These measures often take time and effort. The alcohol and hotels industry will often oppose these changes strongly because they do not want to lose money. However, there are many examples where communities have succeeded. Bringing agencies and community members to work together is important, so that you can show the licensing commission that there is strong support in the community for action. Some communities are able to get help from a 'pro bono' lawyer if required (i.e. for free).

In addition to controlling the supply of alcohol, communities and households can look to create alcohol-free zones to ensure a safe space for the whole community. Some households have also got support from the housing department to make their house alcohol-free. This can help a person tell relatives that they cannot drink in the house.

## FURTHER READING

For a short overview of treatment of alcohol problems:

Haber P, Lintzeris N, Proude E & Lopatko O (2009). *Quick reference guide to the treatment of alcohol problems: Companion document to the guidelines for the treatment of alcohol problems*. Canberra: Prepared for the Australian Government Commonwealth Department of Health and Ageing. Available from: [www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/treat-quick](http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/treat-quick).

For the fuller version of how to treat alcohol problems:

Haber P, Lintzeris N, Proude E & Lopatko O (2009). *Guidelines for the treatment of alcohol problems*. Canberra: Prepared for the Australian Government Commonwealth Department of Health and Ageing. Available from: [www.nhmrc.gov.au/your-health/alcohol-guidelines](http://www.nhmrc.gov.au/your-health/alcohol-guidelines).

Find out about blood tests to assess drinkers on p. 430.

Go to the Indigenous HealthInfoNet website and type alcohol in the search box: [www.healthinfonet.ecu.edu.au](http://www.healthinfonet.ecu.edu.au).