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In this issue

Editorial 1

Online therapy for
problem drinking 1

Are doctors complacent
about alcohol? 3

NEW ADDRESS

The MCA has moved. Our new address is now 5 St Andrews Place, Regent's Park, London NW1 4LB. Telephone, fax and email remain the same as before

This bulletin will be published quarterly. Items for publication to be forwarded to the Editor.

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Hangovers and the twelve days of Christmas

The festive season of Christmas and Hogmanay is the time of year when alcohol consumption in UK is at its peak. Retailers have special deals suggesting that every little helps. Publicity campaigns primarily concentrate on urging people not to drink and drive: nothing wrong with that in principle except that the message needs to be hammered home on virtually a daily basis. It is also good to report that some constabularies are breathalysing drivers when necessary on their way to work thereby emphasising the possible intoxication of drivers during the morning rush hour following a night on the town.

It is around this time of year that the MCA office receives many media calls requesting information about the latest hangover cure: our response concentrates on avoidance, drink less alcohol, alternate with non-alcoholic drinks, prevent dehydration etc. Some of the media assume that hangovers are de rigeur at this time of year. Perhaps they should be more concerned with the rising number of young people requiring resuscitation in hospitals.

Brief interventions continue to be an effective method of education and treatment. The article by Postel, de Jong and de Jong describes the value of such



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interventions via email whereby a degree of anonymity can be sustained.

A further audit of taking alcohol histories by doctors from three acute trusts in Scotland is a timely reminder of the importance of an accurate history in most circumstances. It is surely a matter of routine that needs to be constantly emphasised.

Dr GE Ratcliffe, Editor

Online therapy for problem drinking

MG Postel MSc, TACTUS, Addiction Treatment Institute; CAJ de Jong MD PhD, Nijmegen Institute for Scientist Practitioners in Addiction and HA de Jong MD, TACTUS Addiction Treatment Institute

Alcoholism often goes undiagnosed and most problem drinkers will never seek treatment.¹ The online treatment programme www.alcoholdebaas.nl offers a solution for people who do not normally seek help from conventional treatment programmes. From a

prevention point of view this is extremely valuable. The Netherlands has 1.1 million problem drinkers. Experience has shown that only 3% of them seek help in conventional treatment facilities. Furthermore, people often only seek help at a late stage, usually after 10 years or

more of alcohol abuse or dependence. During that period their addictive behaviour has damaged their health, work, finances and/or relationships. Treatment starting at a later stage is not always successful, so it is important to provide timely help to prevent personal suffering and to reduce the costs to society. The internet, with widespread access and increasing usage, offers an opportunity to administer

continued overleaf

easy accessible interventions for problem drinkers.

The online treatment programme at alcoholdebaas.nl has been developed by TACTUS (a Dutch addiction treatment institute) as an extension of its existing services, and is accessible nationwide. People with a drinking problem receive personal help from experienced professional counsellors over the internet while remaining completely anonymous. The e-therapy programme is a structured treatment programme consisting of two phases in which client and therapist communicate asynchronously, via the

internet only. Both are in separate or remote locations and the interaction occurs with a delay between the responses. The aim of the e-therapy program is to motivate the client to change their drinking habits with the ultimate goal of reducing and stopping alcohol intake. The programme uses psycho-education, cognitive restructuring, self-control techniques and exposure techniques. The method underlying the programme is based on principles from the cognitive behaviour therapy and the bio-psychosocial model. This method has been used for years in conventional

addiction treatment. The structure of the programme fits with Prochaska and DiClemente's Stages of Change Model.² Each participant has individual contact with the same counsellor. Once or twice a week, usually for three months, the client and the counsellor exchange messages and assignments via a client file on the website which is accessible only to the two of them. The participants gradually build up files of their own which keep a record of their progress.

Phase 1 of the programme consists of four assignments focusing on the analysis of the participants drinking habits, rather than on behavioural change. Personal advice concerning further treatment is given at the end. The participant can then choose to continue therapy or not. Continuation is not allowed if there is a serious medical risk or acute danger in which case patients are referred to the regular treatment facilities. Phase 2 consists of five assignments. The client sets a goal to quit or reduce drinking, and in four steps learns to reach this goal. Clients can use the supportive forum for anonymously exchanging messages and sharing experiences with other participants and non-participants.

This new treatment method was launched on 21 March 2005. The scientific evaluation is done by the Nijmegen Institute for Scientist-Practitioners in Addiction. The first results are remarkable.³ Most of the people registering for online treatment are problem drinkers who until now were hard to reach – women, the well educated and people with jobs. The number of women and working people registering to our online therapy is twice as high compared with our conventional face-to-face treatment programme. Of those registering for conventional treatment, 15% have had university education, whereas 52% of alcoholdebaas.nl participants have had university-level or equivalent education.

Right from the start, the number of registrations has exceeded expectations. The counselling team has been expanded from three to fourteen during the first year, but still there are more people wanting to join. The programme has attracted much media attention again increasing

Interview with an alcoholdebaas.nl participant

(From *De Stentor*, a regional newspaper)

Femy (55), a well-educated woman working in communications, has had a drinking problem since she was 20. Every time a problem came into her life she started drinking.

This spring [2006], her relationship came to an end after 25 years. 'I felt like I'd lost everything and started to drink a lot, at least a bottle of wine and a few beers every day. I hated the fact that I'd lost control over myself, and my health was also suffering.'

“I fooled myself into thinking I was only a social drinker, but in fact I was trying to avoid dealing with my problems.”

Femy never talked to her general practitioner about her flight into alcohol. 'I always told myself that it wasn't such a problem, that I could handle it myself.' In March [2006] she read about the alcoholdebaas.nl website in one of the national papers. She signed up and was able to start counselling right away. She finished the programme in six weeks. 'It's still hard, almost every day, but now I don't touch a drop, which was the goal I'd set myself.'

As far as Femy was concerned, the anonymous e-mail contact wasn't necessary. 'The most important thing was that the treatment was individual and that I could do my homework in my own time.' Femy and the counsellor who was assigned to her were in e-mail contact twice a week. 'He listened closely to what I had to say, and picked out the relevant items. Sometimes he came back to certain things. It was very well organised.' There was no attempt to delve into her psyche or her past. 'I was given practical tips that really suited my own situation.' Femy received homework assignments, including keeping a daily log of how much she drank and analysing the points at which she started drinking. There were some real eye-openers. 'I discovered patterns I hadn't been aware of. What exactly were my reasons for wanting to drink, and what did I expect drinking to do for me? That gave me some clues about how to deal with things differently, and to find solutions other than drinking.'

Staying off alcohol is a matter of self-control. One of the techniques Femy has learned is to stop and think whenever she feels like a drink. 'And then I think of reasons why alcohol really doesn't help. Feeling like a drink doesn't mean I really have to drink. You can make the feeling go away, or channel it in another direction.'

demand for the service – sometimes as many as one hundred people try to join in a single day. We regularly have to put a temporary hold on website intakes. With enough counsellors, it seems likely that thousands of clients a year can be helped by the treatment programme.

The first patients that have finished treatment considerably reduced their alcohol consumption. Their alcohol-related health problems, such as depression, fatigue, sweating and heart palpitations, were significantly reduced. Their incentive to take and maintain control of their alcohol intake greatly increased, and they rated the online programme as very highly satisfactory. The one-on-one online contact with the same counsellor was seen as pleasant, safe

Further information

An English version of www.alcoholdebaas.nl, to be called www.takecontrolof alcohol.org, is now being produced.

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and personal. They also felt that the method gave them insight into their drinking problems and was an effective way of dealing with them. The scientific results will be published at the end of 2006.

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Are doctors complacent about alcohol?

Knowledge of alcohol, alcohol-related problems and their management in medical staff at three acute hospitals in Lanarkshire, Scotland

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Nationally the impact of alcohol consumption is being increasingly felt, whether this impact is noted on our streets on a weekend night, in our hospital wards or in the NHS and social services budgets. The annual healthcare cost of managing alcohol misuse in Scotland is estimated at £95.6 million, with indirect costs estimated at £404.5 million per year. Alcohol misuse places a heavy burden on Scottish society, greater than stroke, depression and diabetes mellitus.¹ Within the NHS, stigma towards those with alcohol-related problems has led to deficiencies in services, claiming that, 'they are not our problem'. The Scottish Executive in its Plan for Action on Alcohol Problems set out aims to address service attitudes towards those with alcohol problems.²

This article reports a survey of knowledge of alcohol, alcohol-related problems and their management in physicians, surgeons and psychiatrists

across all grades at Lanarkshire's three acute hospital sites. Data were obtained from 110 staff, approximately divided in thirds between physicians, surgeons and psychiatrists, and in half between senior house officers (SHOs) and senior grades. Alcohol-related problems are a major cause for admission at Lanarkshire's acute hospital sites, and a frequent cause of comorbidity among inpatients.

The east end of Glasgow, where this survey was conducted, has one of the highest levels of alcohol consumption in Scotland. A survey of 100 consecutive admissions for alcohol abuse in 1990 showed that two-thirds of the population had a family history of alcohol abuse. Over three-quarters showed self-neglect and half showed signs of peripheral neuropathy. There was a history of delirium tremens in over half, and approximately a third had a history of seizures.³ An analysis of admissions to general medicine in Glasgow and Edinburgh acute hospital sites showed that alcohol-related conditions accounted for half of gastroenterology admissions, and a large proportion of inpatients in

cardiology and respiratory medicine had alcohol problems. Patients admitted due to alcohol have longer lengths of stay and experienced higher morbidity and mortality.⁴

The consequences of heavy alcohol consumption and mismanaged withdrawal can be long lasting and are prevalent. Alcohol-related brain damage (ARBD) accounts for 10% of all dementias and 12.5% of the dementias under 65 years old; recent prevalence figures suggest 7 per 10,000 in Argyll and Clyde. Presently 75% of the ARBD population are men, however increasing numbers of women now present, and the age of presentation is lowering reflecting changes in drinking habits in Scotland over recent decades. This is also reflected in new long-stay mental hospital patients in Scotland, of which 9% have a diagnosis of ARBD. Of old long-stay patients 5% are related to ARBD.⁵

A questionnaire was sent to all 200 doctors across the Lanarkshire acute hospital sites (Monklands, Wishaw and Hairmyres General Hospitals), involving all grades from SHO to consultant level. The questionnaires were sent to psychiatry, medicine and its subspecialties and surgery including obstetrics and gynaecology, and orthopaedics. These specialties were chosen as they are likely to treat patients who may develop alcohol-related comorbidity. →

Using a 13-item self-constructed questionnaire, information such as awareness of safe levels of alcohol consumption, frequency of alcohol history taking and the level of awareness of local policy for managing alcohol withdrawal and Wernicke's encephalopathy was obtained. The majority of questions tested knowledge of alcohol-related issues and their management. Some questions also assessed awareness of local services for alcohol. Three questions, using a modified Likert-type scale, allowed assessment of behaviour by asking about frequency of alcohol history taking, use of the CAGE questionnaire and quantification of alcohol consumption. The questionnaire was sent once, completed anonymously and returned using an addressed envelope. Data were obtained from 110 staff, of whom 39% were physicians, 30% were surgeons and 31% were psychiatrists. Senior house officers made up 52% of the staff and 48% were senior grades (staff grades, specialist registrars and consultants). A 55% response rate was obtained.

There were some large deficits in knowledge and behaviour. Doctors were confident about their diagnoses of alcohol withdrawal and Wernicke's encephalopathy, and distinguishing between the two. This may represent over-confidence as the two diagnoses may be difficult to distinguish. A limitation of this survey is that it relies on self-reported behaviour and knowledge. Reported knowledge may not reflect actual knowledge, likewise with behaviour. A recommendation is to audit medical notes to objectively assess this knowledge and behaviour.

In terms of specialty, surgeons seemed to have the least knowledge of alcohol. Psychiatry scored the highest in terms of knowledge, use of CAGE questionnaire and awareness of the standardised chlordiazepoxide reduction regime. There seemed little difference between specialties about awareness of local trust policy. Grade of doctor demonstrated that the tendency to complete an alcohol history reduced with seniority. With regards to acute complications senior colleagues felt more confident about recognising the acute syndromes than SHOs possibly as a result of greater experience.

It is important to always perform an alcohol history in specialties that are likely to encounter patients with alcohol problems. There is some evidence to show improving medical education about alcohol improves the quality of history taken.⁶ A good way to screen for such patients is to use the CAGE questionnaire and quantify the units of alcohol consumed. There is some debate as to the CAGE questionnaire's usefulness, but it does prompt the clinician to ask questions regarding harmful use. Scottish Intercollegiate Guidelines Network guidelines recommend the CAGE questionnaire be supplemented by questions about maximum daily and total weekly consumption.⁷

An alcohol history is an integral part of any admission assessment to determine the possible contribution to the presenting symptoms and the risk of withdrawal and Wernicke's encephalopathy. The lack of such knowledge and behaviour confirms results from other similar surveys. It can be hypothesised that a proportion

of potentially treatable patients are being missed which can only further strain hospital and community resources. Doctors have an integral role to not only treat alcohol patients but also to educate them. We must see ourselves as a fundamental part of the system to decrease the ever-heavy burden of alcohol upon our society.

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The Medical Council on Alcohol is a small national charity committed to improving the medical understanding of alcohol-related problems

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