

# Chapter 9. Specific populations



## 9. Specific populations

**This chapter provides an overview of management of alcohol problems in adolescents and young people, pregnant and breastfeeding women, Aboriginal and Torres Strait Islander Australians as well as people from other cultures, older people and cognitively impaired patients.**

### Adolescents and young people

The media continues to reflect society's considerable concern, both in Australia and overseas, about youth alcohol consumption, especially 'binge' drinking. The young adult age group in Australia is most at risk of drinking at levels associated with long-term harm.

The adolescent years are a period for experimentation and socialisation with peers, and often include engaging in high-risk substance abuse behaviours. Experimentation is much more common than progression to long-term regular use. Binge drinking and deliberate drinking to become intoxicated is common.

The 2002 national survey on the use of alcohol by Australian secondary school students (White & Hayman 2004) found that experience with alcohol was high. Alcohol consumption became more common as age increased:

- by age 14, around 90 per cent of students had tried alcohol
- by age 17, around 70 per cent of students had consumed alcohol in the month before the survey
- the proportion of students drinking in the week before the survey increased with age, from 19 per cent of 12-year-olds to 50 per cent of 17-year-olds (White & Hayman 2004).

Rates of drinking above the NHMRC 2001 guideline levels among 14- to 19-year-olds were similar to the rates for the general population – about 9 per cent for alcohol-related disease risk (long-term harm) and 39 per cent for accident and injury risk (short-term harm). People aged 20 to 29 showed the riskiest drinking profile. About 60 per cent of this group drank above the guideline levels for accidents and injuries and about 16 per cent drank above the guideline levels for alcohol-related diseases (AIHW 2008).

Children and young people under 18 years of age are at greater risk of harm from drinking than adults, due to:

- a lower alcohol tolerance than adults
- their propensity for risky behaviour
- the high risks of alcohol-related injury in this age group
- the likely effects of alcohol on developing brains.

Neurodevelopment, especially in regions linked to regulation of behaviour and emotion, is not complete until well into adulthood. Regular, heavy alcohol or other drug use frequently inhibits adolescent development, especially impairing cognitive maturation and reducing educational achievement.

Polydrug use is common among young people in addition to alcohol. Around 16 per cent of 14 to 19 year olds smoke cigarettes. Uptake of cannabis use usually peaks around the age of 16 to 17 years. Around 25 per cent of 14 to 19 year olds and 54 per cent of 20 to 29 year olds report using cannabis in their lifetime. Weekly use occurs in 20 per cent of 14 to 29 year olds and daily use in 10 to 15 per cent.

Excessive alcohol use in adolescence is also associated with a wide range of other co-existing problems, including:

- difficulty with relationships (especially with parents)
- homelessness
- poor school performance
- low employment prospects.

Early alcohol use also increases the likelihood of alcohol abuse and alcohol dependence continuing into adulthood; the risk highest appears associated with heavy alcohol consumption before 16 years. Early intervention with adolescents at risk of alcohol problems is therefore very important. The NHMRC (2009) recommends that children and young people under the age of 18 not drink alcohol at all (see Guideline 3 in Chapter 2).

Recommendation	Strength of recommendation	Level of evidence
9.1 NHMRC guidelines recommend that not drinking alcohol is the safest option for children and young people under 18 years of age.	D	IV

## Screening, assessment and engagement

### Assessing substance use

Problem drinking in young people is variably defined and may refer to quantity of alcohol consumed, frequency of drinking and/or to adverse outcomes attributable to drinking. Adolescent alcohol problems commonly constitute recurrent binge drinking, and related short-term adverse consequences, including trauma, assault and memory loss. Adverse outcomes related to alcohol consumption in young people are highly correlated to males and to conduct disorder.

DSM-IV criteria for alcohol use disorders have limitations when used with adolescents. This is because some of the criteria, such as withdrawal, repeated efforts to cut down, and alcohol-related medical problems, generally emerge only after several years of heavy drinking and have a low prevalence in adolescents. Other DSM-IV criteria for alcohol disorders have different implications in adolescents when compared to adults. For example, while tolerance is often considered to have high specificity in alcohol dependent adults, it has low specificity in adolescents. Further, some young people satisfy a clinically present rating for at least one DSM-IV alcohol disorder symptom but not within the period specified by the DSM-IV.

Polydrug use is very common among adolescent problem drinkers, therefore screening and intervention for tobacco and other drug use should occur routinely. Use of validated screening instruments for multiple drugs (for example, ASSIST) can be incorporated into screening approaches (see Chapter 10 and Appendix 1).

If the young person presents intoxicated at the time of the consultation, a risk assessment is usually needed. Where risk is assessed as low, it is usually appropriate to reschedule the appointment. Where risk is assessed as high, more detailed assessment (for example, for acute suicidal intention, psychosis) is needed.

**Bio-psychosocial assessment**

A broad medical and psychosocial history, rather than a substance use history, is needed to work effectively with young people. Screening for mental health problems is also important because most mental disorders begin during adolescence and young adulthood, and conditions, such as depression, suicidal ideation, anxiety, history of sexual abuse and antisocial behaviour, are common in young people with alcohol problems.

A psychosocial history includes information about the social, cultural, educational and vocational background of the adolescent. A range of tools, such as HEADSS (see box), provides a framework for gathering psychosocial history from adolescents.

<b>THE HEADSS ASSESSMENT</b>
The HEADSS mnemonic forms the basis for an assessment that provides a 'psychosocial biopsy', an opportunity to develop rapport, assess risk and provide a guide to any necessary interventions.
<p><b>H – Home environment</b></p> <p>Where do you live? Who lives with you? How does each member get along? Who could you go to if you needed help with a problem? Parent(s) jobs? Recent moves? Wanted to run away? Are there new people at home?</p>
<p><b>E – Education/employment</b></p> <p>What do you like/not like about school/work? What can you do well/what areas would you like to improve on? How do you get along with teachers/other students? How are your grades; any suspensions? Changes? Many young people experience bullying at school – have you ever had to put up with this?</p>
<p><b>E – Eating/exercise</b></p> <p>Do you have meals with your family? Who cooks at home? Are you worried about your weight? Do you think you are too thin or too fat? Sometimes when people are stressed they can over eat/under eat. Have you ever experienced either of these? In general, what is your diet like? In screening more specifically for eating disorders, you may ask about body image, the use of laxatives, diuretics, vomiting or excessive exercise and rigid dietary restrictions to control weight.</p>
<p><b>A – Activities and peer relationships</b></p> <p>With peers? (What do you do for fun? Where? When?) With family? Sports - regular exercise? Hobbies? Tell me about the parties you go to. Do you belong to any clubs? How much TV would you watch a night? Favourite music? Any trouble? Crimes? Arrests?</p>
<p><b>D – Drugs/cigarettes/alcohol</b></p> <p>Many people at your age are starting to experiment with cigarettes/alcohol. Have any of your friends tried these or maybe other drugs like marijuana, snorting or injecting drugs, etc? How about you, have you tried any? What effects have you found? Do you have any regrets? How much are you taking, how often and has frequency increased recently?</p>

<p><b>S – Sexuality</b></p> <p>Some people are getting involved in sexual relationships. Have you had a sexual experience with a guy or a girl, or both?</p> <p>Degree and types of sexual experience? Number of partners?</p> <p>Masturbation/contraception? Knowledge about STDs</p> <p>Has anyone ever touched you in a way that's made you feel uncomfortable or forced you into a sexual relationship? (History of sexual or physical abuse?)</p> <p>How do you feel about relationships in general/about your own sexuality?</p>
<p><b>S – Suicide/depression/mood screen</b></p> <p>How do you feel about yourself at the moment on a scale of 1 to 10?</p> <p>What sort of things do you do if you are feeling sad/angry/hurt?</p> <p>Is there anyone you can talk to? Do you feel this way often?</p> <p>Some people who feel really down often feel like hurting themselves or even killing themselves. Have you ever felt this way?</p> <p>Have you ever tried to hurt yourself or take your own life? What have you tried?</p> <p>What prevented you from doing so? Do you feel the same way now? Have you a plan, etc.?</p>
<p><b>S – Safety</b></p> <p>Sun protection, immunisation, carrying weapons; for example, have you ever needed to carry a weapon to protect yourself?</p> <p>Have you ever driven a car or driven with someone who was 'over the limit' or high on anything?</p>
<p><b>S – Spirituality</b></p> <p>Beliefs, religion, music, what helps them relax, etc. What are you best at?</p> <p>Do you believe in another higher power? Does your family have any religious beliefs? Do you agree with them?</p>
<p>Source: Adapted from Goldenring, J &amp; Cohen, E 1988, 'Getting into adolescent heads', <i>Contemporary Paediatrics</i>, vol. 5, pp. 75–90.</p>

The differences between adult and adolescent problem drinkers have important implications for treatment. Apart from shorter drinking histories, adolescents engage in more polydrug use than adults. Also specific to adolescence are the rapid social and physical changes they experience, the range of co-existing life problems such as poor performance at school, difficult parental relationships, low employment prospects and accommodation difficulties, including homelessness.

A familial history of heavy alcohol and drug use also affects adolescents. Social and environmental factors, such as being exposed to a family culture that accepts heavy drinking, may contribute to development of dependence in the children of heavy drinkers. Genetic factors play a very important role in the complex interaction between an individual and his or her response to alcohol, including how alcohol is metabolised, its propensity to cause liver damage, and an individual's susceptibility to developing alcohol dependence. See also Chapter 3 for more information about assessment methods and instruments.

Recommendation	Strength of recommendation	Level of evidence
9.2 Screening and brief intervention for tobacco, alcohol and other drug use should occur routinely. Binge drinking and polydrug use are common among adolescent problem drinkers.	D	IV
9.3 A broad medical and psychosocial history is needed to work effectively with young people.	S	–

## Treatment

Engaging adolescents in treatment is a critical issue. The principles are similar to treatment of other chronic disorders in young people.

Just as with adults, working effectively with young people experiencing difficulties with alcohol requires establishment of good rapport. Barriers to effective consultation with adolescents have been extensively described in the past two decades and can be classified into four broad categories: availability, accessibility, acceptability and equity of health services. Concerns about confidentiality have been identified as a particularly significant barrier to young people seeking professional assistance. A non-judgemental approach is needed that encourages the young person to be honest about reporting ongoing difficulties with alcohol.

Young people are influenced by the 'here and now' rather than any future benefits of changing current drinking patterns; young people are more interested in achieving the goals of adolescence than in focusing on improving their health. Given this, treatment goals need to be framed as 'relevant' to young people. Approaches should include examining how alcohol affects their appearance; their reputation among their peers; their ability to socialise; their ability to achieve in recreational, sporting, educational and employment arenas; and their finances.

The clinician needs to conduct these discussions at a level that is developmentally and cognitively appropriate to the age of the young person. Working with the young person to develop concrete short-term (weeks to months) goals is recommended. Encouraging the young person to participate in negotiation of treatment plans facilitates engagement in treatment and empowers change.

**Families** are an important part of the treatment of young people with alcohol problems. Where young people are still closely engaged with family it is important to gauge the parental perspective. However, this should not be at the expense of seeing the young person alone for most of the consultation.

In some cases, the young person may have become disengaged from the family as a result of heavy drinking and other drug use. Families are an integral part of the adolescent's world and it is therefore important to try to help the young person rebuild the connection. Depending on the circumstance this may be through mediation by the health professional, or more formally, with family counsellors.

Where adolescents are not engaging well with alcohol or drug services, use of specific outreach and proactive services that cater appropriately for their developmental stage, and incorporate consideration of their cultural background, lifestyle and, in many cases, their family, will be needed.

Recommendation	Strength of recommendation	Level of evidence
9.4 Engagement and therapeutic relationships require an understanding of adolescent development and a cognitively and developmentally appropriate approach.	S	–

## Treatment approaches

Management of substance use disorders in adolescents requires a multi-pronged approach that takes into account the adolescent's stage of development and includes behavioural strategies, intervention for mental health and wellbeing and in some cases medication.

**Early intervention** for alcohol problems in young people is important. Alcohol and other substance use interferes with normal adolescent brain development, and neurodevelopment, especially in regions linked to regulation of behaviour and emotion, is not complete until early adulthood. Once young people have developed an alcohol use disorder, abstinence appears an unlikely outcome of treatment.

**Brief interventions** suit some adolescent drinkers who are in early stages of their drinking 'career', and can be a critical part of reducing the risk of ongoing alcohol and other drug problems. However, many young people will do better by forming ongoing relationships with counsellors or health care professionals. They need to be encouraged to return when they want or need to.

**More intensive treatment interventions**, such as motivational interviewing, cognitive behavioural therapies and family therapies in general, have been shown to be of benefit, especially in conferring improved knowledge about alcohol-related harms and at least a short-term reduction in alcohol and other drug use. Few differences in outcome have been found when comparing treatment settings and types of adolescents, although as with adult services, longer treatment retention is associated with better outcomes. Studies of longer-term outcomes from inpatient and outpatient treatment settings are less readily available.

Certain pre-treatment factors predict outcomes. A poorer prognosis is associated with more severe alcohol problems at the outset and with other drug use problems. Poor psychosocial functioning pre-treatment and lack of longer-term engagement in health services are also associated with negative outcomes. Abstinent peers in a young person's social network, on the other hand, increase the odds of remaining abstinent four-fold.

The evidence base for pharmacotherapy (naltrexone, acamprosate and disulfiram) for alcohol use disorders in young people remains limited, as few controlled trials have been conducted.

Recommendation	Strength of recommendation	Level of evidence
9.5 Brief interventions may suit some young people drinking excessively and/or experiencing alcohol-related harms.	A	Ia
9.6 Motivational interviewing, cognitive behavioural and family therapies have been shown to be of benefit in reducing alcohol and other drug use and related harms.	A	Ia
9.7 Limited evidence exists on the role of pharmacotherapies in reducing alcohol use in adolescents.	B	II

### Addressing comorbidity

While controversy about which comes first (temporal primacy) exists, the comorbidity of mental health disorders and alcohol problems is very strong. Treatment of young people with alcohol problems must, therefore, include screening for a history of sexual abuse and screening and management of common mental health disorders especially depression, suicidal ideation, anxiety, and antisocial behaviour. Reduced substance use has been noted when comorbid mental conditions are appropriately treated.

Adolescent drinkers may experience a range of psychosocial crises. In these cases, outreach and crisis interventions that cater appropriately for their developmental stage and incorporate consideration of their cultural background, lifestyle and in many cases their family, should be engaged.

Recommendation	Strength of recommendation	Level of evidence
9.8 Adolescent drinkers may experience a range of psychosocial crises. In these cases, outreach and crisis interventions should be engaged.	D	IV
9.9 Mental health disorders, including depression, suicidal ideation, anxiety, sexual abuse and antisocial behaviour, are common in young people with alcohol and other drug problems, and should be addressed in the treatment plan.	D	IV

## Pregnant and breastfeeding women

Limitations in the available evidence make it impossible to set a 'safe' or 'no-risk' drinking level for women to avoid harm to their unborn children or during breastfeeding. A conservative, public health approach is therefore needed when recommending that not drinking alcohol is the safest option for pregnant women, those who may soon become pregnant and those who are breastfeeding.

### NHMRC guidelines and advice about pregnancy and breastfeeding

Based on available evidence, the NHMRC (2009) provides guidance and advice on alcohol use during pregnancy and breastfeeding (see Guideline 4 in Chapter 2).

#### Pregnancy

The evidence from systematic reviews of the literature and prospective cohort studies suggests that exposing the foetus to alcohol may result in adverse effects, ranging from mild to severe and affecting child's cognitive, behavioural and physical development. In addition, alcohol exposure is a strong predictor of premature or preterm birth, and low birth weight for gestational age.

The NHMRC (2009) gives the following advice about alcohol consumption during pregnancy:

- Not drinking alcohol is the safest option.
- The risk of harm to the foetus is highest when there is high, frequent maternal alcohol intake.
- The risk of harm to the foetus is likely to be low if a woman has consumed only small amounts of alcohol before she knew she was pregnant or during pregnancy.
- The level of risk to the individual foetus is influenced by maternal and foetal characteristics and is hard to predict.

However, women who have consumed alcohol during pregnancy can be reassured that the risk to their unborn child is likely to be low if they consumed alcohol at low risk levels (that is, less than seven standard drinks over a week and no more than two standard drinks on any one day). Women who drink alcohol sparingly (less than one standard drink per drinking day without intoxication) may be reassured that there is no consistent evidence this is harmful to their unborn child. Women who remain concerned should seek specialist medical advice.

Recommendation	Strength of recommendation	Level of evidence
9.10 Women who are or may become pregnant should be advised of new NHMRC guidelines that recommend abstinence. Clinicians who provide advice to pregnant women should familiarise themselves with the risk analysis described in those guidelines. Women who drink alcohol sparingly (less than one standard drink per drinking day without intoxication) may be reassured that there is no consistent evidence this is harmful.	S	–

### Breastfeeding

Existing evidence suggests that consumption of two standard drinks or more per day may adversely affect lactation, infant behaviour (for example, feeding, sleep–arousal cycle), and psychomotor development of the breastfed baby. However, the lack of high quality research makes it difficult to give definitive advice on safe levels.

The NHMRC (2009) gives the following advice about breastfeeding mothers consuming alcohol:

- Not drinking alcohol is the safest option.
- Women should avoid drinking alcohol in the first month after delivery until breastfeeding is well established.
- After that:
  - alcohol intake should be limited to no more than two standard drinks a day
  - women should avoid drinking immediately before breastfeeding
  - women who wish to drink alcohol should consider expressing milk in advance.

If a woman wishes to drink, it is recommended that she breastfeeds before drinking. Otherwise, wait until blood alcohol returns to zero (one hour per standard drink consumed) before resuming breastfeeding. It is not necessary to express or discard milk before this time.

The risk of accidental injury and/or harm to mother and infant if the mother is intoxicated while breastfeeding is high. For example she may fall, trip or become drowsy and accidentally drop or smother her baby. A breastfeeding mother needs to be advised to have a 'safety plan' for when she does drink alcohol that includes not sleeping in the same bed and/or having another trusted partner, family member, or friend who has not been drinking care for the baby (including when it sleeps) until she is sober and able to manage safely herself.

Recommendation	Strength of recommendation	Level of evidence
9.11 Breastfeeding women should be advised of current NHMRC guidelines that recommend abstinence from drinking. If a woman wishes to drink, it is recommended that she breastfeeds before drinking. Otherwise, wait until the blood alcohol returns to zero (one hour per standard drink consumed) before resuming breastfeeding. It is not necessary to express or discard milk before this time.	S	–

### Screening and brief interventions

In pregnant women, quantity–frequency estimation is recommended to detect any consumption of alcohol (see Chapter 3).

The T-ACE and TWEAK screening tests were designed for use with pregnant women and are adequately sensitive for detecting high-risk levels of consumption; in this the T-ACE performs better than TWEAK. T-ACE and TWEAK questionnaires may be used in this

population to detect consumption at levels likely to place the foetus at significant risk of alcohol-related harm (see Chapter 3 and Appendix 1). Neither instrument is designed to detect unproblematic low-level use of alcohol.

Brief interventions (see also Chapter 4) are effective in reducing drinking in pregnancy by non-alcohol dependent women and should be provided to all pregnant women and those contemplating pregnancy.

Partner participation significantly increases the effectiveness of brief interventions.

It has been demonstrated that brief interventions in this population result in:

- increased rates of abstinence before conception and during pregnancy
- significant reduction of both daily and binge drinking
- reduced foetal mortality rate
- higher birth weight and birth length in the newborn.

Recommendation	Strength of recommendation	Level of evidence
9.12 Brief interventions are recommended for use during pregnancy, including the partner where relevant. Follow-up evaluation of response to the intervention is important.	B	II

### **Impact of alcohol consumption on mother during pregnancy**

It is recognised that drinking alcohol during pregnancy can pose serious risks not only to the developing baby but also to the mother. It is important, therefore, for women in their childbearing years to be well educated about the toxicity of alcohol to themselves.

It is essential that women who have consumed or continue to drink alcohol during their pregnancy, at whatever level, see this as a health concern for themselves, as well as their foetus, but are not made to feel guilty. They need to feel supported in receiving the best obstetric and social care possible, and practical assistance in giving up or more safely managing their drinking.

Serious medical complications that a pregnant woman who drinks may experience include:

- miscarriage
- stillbirth
- premature birth
- injuries due to intoxication
- alcohol withdrawal during pregnancy, labour or post delivery
- excessive vomiting
- dehydration
- poor nutrition
- hypertension
- hypoglycaemia
- gestational diabetes
- reduced immune system function.

## Alcohol intoxication during pregnancy

Alcohol intoxication is a serious risk to a pregnant woman as well as to her foetus.

A pregnant woman with acute alcohol intoxication is at immediate risk of overdose, vomiting and choking, injury, miscarriage or premature labour. The progress of her pregnancy and her wellbeing therefore needs to be assessed immediately, preferably by an experienced midwife in consultation with the medical/obstetric team. She must be closely observed and nursed in a safe environment.

If possible undertake an initial assessment of the foetus by listening to its heartbeat.

If available undertake a cardiotocograph for electronic foetal monitoring, and follow up with an ultrasound if appropriate. Hospital admission is recommended for close monitoring, possible medical intervention, and a safe environment to prevent accidental injury.

Arrange for further assessment and follow-up throughout her pregnancy for problems with alcohol, general health and nutrition, psychological wellbeing, mental health problems, and social issues such as domestic violence.

Recommendation	Strength of recommendation	Level of evidence
9.13 If a woman presents intoxicated during pregnancy, hospital admission is recommended to assess foetal safety, maternal safety, and for comprehensive assessment and care planning.	D	IV

## Alcohol withdrawal during pregnancy

A pregnant woman at risk of withdrawal is typically drinking six standard drinks or more on most days. Physiological tolerance/dependence has occurred and she almost certainly meets the criteria for alcohol dependence syndrome (addiction).

If a woman is drinking at these levels and she significantly reduces or stops drinking she may undergo acute alcohol withdrawal. This can occur anytime during her pregnancy as well as during labour and after delivery.

As her blood alcohol concentration drops, onset of withdrawal can occur from 6 to 12 hours after her last drink. Alcohol withdrawal can be life threatening.

If the woman has been drinking heavily shortly before delivery or has undergone withdrawal during labour or delivery, the newborn is at risk of acute alcohol withdrawal. Onset of withdrawal for the newborn may begin 24 to 48 hours after delivery, depending on the time of the mother's last drink.

### Caring for a pregnant woman in acute withdrawal

A pregnant woman at risk of alcohol withdrawal needs to be hospitalised, at any stage of gestation, as alcohol withdrawal alone is potentially fatal, and there are additional risks to her health and that of her foetus at this time. Ideally her antenatal care plan will mean that her baby will be delivered in a hospital where both she and baby can receive specialised midwifery and medical care, as well as longer-term health and social support.

The mother needs close observation and careful monitoring, generally using a withdrawal scale (see Chapter 5) and supportive nursing and medical care to reduce risk of complications for her and baby. NSW Health and SA Health recently published Australian management guidelines for this setting (NSW Health & SA Health 2006).

Guidelines for treating a pregnant patient at risk of withdrawal include:

- If she starts withdrawing, she needs immediate specialist medical and nursing care in a well-equipped hospital.
- She needs to be closely observed and monitored for any progression of signs and symptoms, and medically treated to prevent and manage any complications to her and the foetus.
- She will need medical and nursing care for at least 5 days after the onset of withdrawal and, depending on any other factors or co-existing medical conditions, perhaps longer.
- It is important to inform the receiving clinical team about her drinking history, the time of her last drink, her blood alcohol concentration when examined, vital signs and CIWA-Ar scores (see Chapter 5 and Appendix 3).

It is particularly important to report any history of alcohol withdrawal complications such as seizures or hallucinations, or delirium tremens, and risk of thiamine deficiency leading to Wernicke's encephalopathy.

Urgent consideration should be given to starting nutritional assessment and management. Parenteral **thiamine** supplementation should be commenced before administration of any glucose (see Chapter 5). **Folate** supplementation should be given (also parenterally, if doubts about likely absorption of oral tablets), given that alcohol misuse is associated with folate deficiency, which is a well-documented factor in neural tube defects. Other vitamin deficiencies should be considered as well as overall protein and calorie status. These deficiencies typically respond well to availability of a balanced diet in hospital once withdrawal has resolved, but may necessitate a longer hospital admission.

Once she has recovered from acute withdrawal and is willing, she should undergo a full drinking history and comprehensive assessment, including assessment of her family and any other children in the home. A comprehensive care plan should be developed.

The specialist medical and nursing team need to ensure the woman's general practitioner, obstetrician and/or midwife are notified immediately, and offer them clear guidelines on her assessment, stabilisation, medical, nursing and psychological management and support needs.

Recommendation	Strength of recommendation	Level of evidence
9.14 Alcohol withdrawal during pregnancy should be managed in a general hospital, ideally in a high-risk maternity unit in consultation with a specialist drugs-in-pregnancy team. Diazepam may be given as needed to control withdrawal. Nutritional intervention should be initiated, including parenteral thiamine, folate replacement and assessment for other supplementation in hospital.	S	–

### Health care service policies and protocols for managing pregnant women affected by alcohol or other drugs

A pregnant woman affected by alcohol (or other drugs) who presents to a clinic or emergency service in crisis may be experiencing:

- intoxication or acute withdrawal
- thiamine deficiency
- serious mental health problems
- acute illness, overdose or injury
- homelessness, unsafe housing, violence.

Each healthcare service needs to have clear policies and clinical protocols to assess and respond to such situations so pregnant women can be humanely and effectively cared for immediately as well as in the longer-term. Having clear policies and protocols will help to support duty of care and good practice in this regard.

Key questions to ask concerning the pregnant woman in withdrawal are:

- How far away is she from the nearest hospital?
- What is her general health status?
- What stage of gestation is she?
- Is she at serious risk from physical or mental illness, injury, poor nutrition, dehydration, infection, violence?
- Is she at risk of premature labour?
- Does she have dependent children or family members who rely on her (for example, is she a sole parent or carer of others)?
- Does she need temporary childcare while she is ill?

If your service cannot assess and care for her safely she should be transferred immediately to a major medical centre with the capacity to care for her and her foetus. She is likely to need a trusted female relative or friend to accompany her and/or her partner if she wishes.

She will need close follow-up and support after discharge. She may be willing to undertake specialist treatment for her drinking as well as antenatal care and is likely to need practical assistance to take up her referral.

Recommendation	Strength of recommendation	Level of evidence
9.15 Women who present during pregnancy with serious alcohol (and/or other drug) problems should be admitted to an appropriate hospital unit for stabilisation, comprehensive assessment and care planning.	S	–
9.16 Assertive follow-up is recommended for antenatal care, substance misuse treatment, and welfare support and child protection.	S	–

## Treatment of alcohol dependence during pregnancy and breastfeeding

Pregnant women and mothers who have developed or are at increased risk of alcohol dependence and related problems (such as physical, mental health and social problems) need professional advice, social support and specialist intervention for their alcohol dependence. Timely intervention is important both for their longer-term wellbeing, as well as for reducing more immediate risks of harmful alcohol effects during pregnancy and breastfeeding.

No sufficiently rigorous studies have been conducted with alcohol dependent women undergoing alcohol treatment during pregnancy to establish any evidence for particular interventions being effective.

Psychosocial treatment options should be offered (see Chapter 6), as use of pharmacotherapies for alcohol dependence cannot be recommended at this stage. Use of naltrexone, acamprosate or disulfiram during pregnancy or breastfeeding is not supported by sufficient safety data.

Recommendation	Strength of recommendation	Level of evidence
9.17 Pharmacotherapy to maintain abstinence from alcohol cannot be recommended during pregnancy due to insufficient safety data.	S	–

### Health effects of alcohol on the foetus

The foetus may have significant short-term and longer lasting health problems if the mother has been drinking during pregnancy.

The harmful effects of drinking alcohol during pregnancy on the foetus seem to depend on how much alcohol the mother consumes at any time during her pregnancy. These problems range from mild to very serious. The extent of alcohol-related harm may not become evident until the child is older and behavioural and learning problems become evident.

### Foetal alcohol spectrum disorders

Four known disorders (known as Foetal Alcohol Spectrum Disorders) are associated with foetal exposure to alcohol; they range from mild to severe.

The three less severe, but often more difficult to diagnose, disorders are:

- foetal alcohol effects
- foetal alcohol-related birth disorders
- alcohol-related neuro-developmental disorder.

The fourth disorder, foetal alcohol syndrome, is the most serious of these alcohol-related disorders. Babies born with foetal alcohol syndrome have particular abnormal physical features as well as any of a range of serious health and developmental problems, including:

- significant learning difficulties
- intellectual disability
- poor eye sight and hearing
- poor coordination and motor skills
- defects of the face and bones
- heart, liver and kidney defects
- slow physical growth after birth.

No blood or laboratory tests are currently available to help diagnose foetal alcohol spectrum disorders. Diagnosis therefore relies on a specialist's assessment of the child's growth and development, any characteristic facial features and physical disorders, central nervous system dysfunction (including intellectual ability), combined with confirmation that the mother did actually drink alcohol during her pregnancy.

Recommendation	Strength of recommendation	Level of evidence
9.18 Assertive antenatal care, including monitoring of foetal growth and health, is recommended.	S	–

### Neonatal withdrawal

Neonatal withdrawal occurs because the flow of alcohol from the mother's bloodstream through the placenta stops suddenly after delivery.

When there is concern that a pregnant woman may be alcohol dependent or a regular excessive drinker, it is important to closely monitor the newborn for onset of alcohol withdrawal. Signs and symptoms of alcohol withdrawal in a newborn baby include:

- tremor
- irritability
- seizures
- bloated abdomen
- vomiting.

Emergency medical treatment and/or evacuation of the newborn will be needed immediately if there are signs or symptoms of alcohol withdrawal and they are not in a well-equipped hospital.

A specialist service should be consulted and arrangements made for assessment and diagnosis of foetal alcohol syndrome if such expertise is unavailable locally. It is also necessary to sensitively prepare the mother, father and family for the need for future support and assessment of any of the less recognisable foetal alcohol spectrum disorders. The details of this assessment lie outside the scope of these guidelines.

Recommendation	Strength of recommendation	Level of evidence
9.19 Management of infants with neonatal alcohol withdrawal should be undertaken in consultation with a specialist unit.	S	–
9.20 Infants born to women who have consumed alcohol regularly during pregnancy should be carefully assessed for foetal alcohol spectrum disorders by a paediatrician aware of the maternal history, with further management directed by the appropriate experts.	S	–

## Providing support to mothers and babies and education to the men in their lives

### Supporting pregnant women, mothers and babies

To increase the likelihood of healthy outcomes for mother and baby, women need to trust their healthcare providers and feel they receive good advice and support. Clinicians can earn this trust by being available, approachable, non-judgmental and willing to care for and support their pregnant and breastfeeding patients even if they choose to drink.

### Educating fathers and other men

It is important that fathers and other men be educated about the risks associated with women drinking during pregnancy and how they can support their female partner, and any other female family members, during pregnancy and breastfeeding. In particular, fathers, brothers and uncles can best support women who are pregnant or breastfeeding by not drinking near them, or by refraining from drinking.

Fathers, brothers, uncles and other male family members have a role to play in keeping mothers and babies safe by their also choosing not to drink or, if drinking, consuming alcohol at low-risk levels. If male partners or others do drink alcohol, they need to make sure they are not intoxicated or otherwise place the pregnant woman at risk.

Recommendation	Strength of recommendation	Level of evidence
9.21 Assessment of the family unit is an essential aspect of managing substance use in women. Intervention should be directed to the whole family unit to reduce consumption of alcohol.	S	–

### Cultural considerations

Beliefs about pregnancy and childbirth among women from diverse cultural backgrounds can differ between women and their healthcare providers. For example, an Indigenous woman might believe that her pregnancy is connected to her traditional Dreaming and not linked to her sexual activity. Her belief may mean that any discussions about her pregnancy and drinking alcohol may be difficult. Your health message to her about the risks of drinking, pregnancy and breastfeeding could take into account her belief that pregnancy may happen at any time, and then generalise the message of safety and risk of alcohol to 'any woman who is pregnant or breastfeeding' rather than focus directly on her (see also 'Indigenous Australians and people from other cultures' below).

For some women who hold particular cultural beliefs about pregnancy, it may be useful to help them consider not drinking any alcohol at all or only drink at very low-risk levels throughout their childbearing years.

Differing cultural beliefs may at least partially explain why some women do not present for antenatal care until late in their pregnancy. Another factor may be that they have limited access to acceptable and 'culturally safe' services.

Recommendation	Strength of recommendation	Level of evidence
9.22 Indigenous women should be offered referral to culturally appropriate clinical services.	D	IV

### Alcohol and mental health problems

Pregnancy and new motherhood can be less than positive experiences for some women. Women are particularly vulnerable if they have serious mental health problems, such as depression, post-natal depression, posttraumatic stress disorder, other anxiety disorder or a psychotic illness, and for many, co-existing alcohol dependence (comorbidity/dual diagnosis). This is especially concerning for women who have:

- experienced sexual abuse or other trauma in their life
- limited access to emotional and practical support; for example, no or minimal extended family nearby, single parenthood, or relationship problems
- family separations
- significant grief and loss
- labour and delivery complications
- problems with their baby's health.

Like any pregnant or new mother, it is important that her aspirations, life skills and particular needs are acknowledged, along with her fears and challenges about her pregnancy and parenting. Her health carers and other service providers need to build a strong therapeutic relationship with her, and ensure they have collaborative relationships between themselves that can ensure her needs are well understood and responded to holistically, so she can be helped to manage her 'actual life' challenges at this time.

It is important to explore issues of guilt about the effect of substance use on the infant, and to educate each woman about the likely outcomes in her case.

Linking women with health services and birthing programs early in their pregnancy, or as soon as possible, is crucial to providing them with the mental health and alcohol comorbidity expertise and any culturally appropriate support they need.

A father may also experience depression or anxiety, or other mental health problems, and may feel isolated from his partner and her baby. Acknowledging that parenting and a change in family relationships can be stressful for fathers and mothers can be the first step in treating their mental health, and comorbidity problems, and achieve recovery. Linking mothers and fathers with appropriate services and local support groups, and/or being available for counselling or an informal chat, are therefore very important elements that can help them throughout pregnancy and parenthood.

Recommendation	Strength of recommendation	Level of evidence
9.23 Comprehensive mental health assessment is an essential component of an integrated care plan for pregnant women with alcohol problems.	S	–

## Indigenous Australians and people from other cultures

This section provides guidance on managing alcohol problems among Indigenous Australians. Detailed guidelines are available in the *Alcohol Treatment Guidelines for Indigenous Australians* (Australian Government Department of Health and Ageing 2007). This section also briefly addresses approaches to patients from diverse cultural backgrounds.

Most evidence in this section is based on consultations with community, patients, clinicians, experts in the field, case studies and a few service evaluations.

### Specificity of the Indigenous population

Indigenous Australians suffer a greater burden of ill health than the rest of the population. According to the Australian Bureau of Statistics and the Australian Institute of Health, the burden of disease suffered by Indigenous Australians is estimated to be 2.5 times greater than the burden of disease in the total Australian population (AIHW & ABS 2008). Indigenous Australians have lower life expectancy and lower levels of access to health services than the general population. They have higher rates of chronic and preventable illnesses, poorer self-reported health and are more likely than non-Indigenous people to be hospitalised for most diseases and conditions. Indigenous Australians are more likely to report high or very high levels of psychological distress than non-Indigenous people.

Many Indigenous people and communities are at increased risk of alcohol problems because they are marginalised, disempowered and at a social disadvantage. Unemployment, overcrowded and/or inadequate housing as well as recurrent experience of grief, trauma and loss further contribute to risk. Separation from families, sometimes with subsequent childhood physical and/or sexual abuse, is an additional major risk factor. These factors also predispose Indigenous people to poor mental and physical health, and comorbidity is common. It is important to provide quality treatment of alcohol problems which is mindful of the comorbidities and the personal and broader community situation.

Limited data exist on the patterns of drinking among Indigenous Australians. It appears that Indigenous people are less likely to be current drinkers than their non-Indigenous

counterparts, but those who do drink are significantly more likely to drink at levels that place them at risk of harm. No data on the prevalence of alcohol dependence exist.

Indigenous people may face considerable barriers to accessing mainstream services for help, resulting in late presentation, namely:

- services are typically designed for and by the majority culture and may therefore seem unapproachable and inappropriate
- shame and/or fear of a judgemental response
- unawareness of the range of services available, such as early intervention, outpatient detoxification and relapse prevention medications.

Given the late presentation of alcohol problems, active detection is important. Mainstream services need to work with Indigenous communities and agencies to improve the accessibility and appropriateness of their services. Employment of Indigenous staff (and provision of appropriate support, training and career development opportunities for them) can improve service accessibility and appropriateness.

Recommendation	Strength of recommendation	Level of evidence
9.23a Given late presentation of alcohol problems, active detection is recommended.	D	IV

### **Current treatment approaches and treatment accessibility**

Minimal formal study has been done of the effectiveness of treatment approaches to alcohol problems when applied among Indigenous populations. As well as facing barriers to accessing mainstream services it also seems likely that Indigenous people are often not receiving access to the full range of treatment services. In particular the availability of early intervention, pharmacotherapies to reduce relapse, and quality aftercare seems to be limited or variable.

In surveys of drug and alcohol treatment service patients and of community members, many Indigenous respondents report their desire for Indigenous staff members to be part of their treatment team, in order to improve communication, understanding and trust. However, some Indigenous Australians have also reported changing their drinking habits as a result of feedback from respected non-Indigenous health professionals.

Consultation suggests the need for an increase in Indigenous-specific treatment services as well as the need for increased cultural sensitivity of mainstream services. Wherever possible, Indigenous patients should be offered access to an Indigenous staff member in mainstream health care services to more readily identify and address Indigenous spiritual and cultural needs. Some patients prefer their management to be coordinated through the local Aboriginal controlled Substance Misuse and Health Service or to attend an Indigenous-specific rehabilitation service. Some Indigenous patients do, however, prefer the relative anonymity of mainstream services, particularly for treatment of stigmatised disorders. Thus, the patient's right to choose between Indigenous and mainstream health services should be respected.

Indigenous Australians should have access to the full range of evidence-based treatment services, even while specific evidence is gathered on what approaches may be appropriate to their needs. Mainstream treatment services can strive to improve their accessibility and cultural appropriateness by employing Indigenous staff and collaborating with Aboriginal controlled Substance Misuse and Health Services.

Recommendation	Strength of recommendation	Level of evidence
9.24 Indigenous Australians, like all other Australians should have access to the full range of treatment services, including early intervention and where appropriate, relapse prevention medications.	D	IV
9.25 Indigenous Australians should be offered access to trained Indigenous health care workers and services where possible.	D	IV
9.26 Non-Indigenous clinicians should work in partnership with Indigenous health professionals and/or agencies to improve treatment access and appropriateness for communities.	D	IV

### Brief intervention

Everyone who attends a health service should be periodically screened for their level of drinking, and offered opportunistic brief intervention if appropriate.

The principles of brief intervention as developed in the mainstream population (see Chapter 4) are likely to apply in Indigenous settings, if appropriately delivered, including:

- using non-judgemental style
- giving feedback on evidence of harm or risk associated with drinking and keeping in mind what is likely to be relevant to that individual
- listening to the patient's response (for example, what past attempts they may have made to change their drinking; how ready they are to consider change)
- providing specific advice about safe use of alcohol
- respecting the goals the patient is prepared to accept and helping them identify practical strategies for changing their drinking habits.

Strategies to change the consumption patterns of a dependent drinker are likely to include referral to a specialist service or clinician.

### Assessing an Indigenous patient

Indigenous communities around Australia differ widely. Clinicians must avoid making assumptions, but be mindful that the patient's life-view and mode of communication may be very different from their own. Respect and a willingness to learn is a key ingredient to good communication with Indigenous people. It is important to consider the patient in the context of both family and community.

Involvement of an Indigenous health professional in assessment and treatment is likely to improve communication and hence quality of the information imparted and likelihood of engagement with treatment. Some Indigenous people consider a series of direct questions impolite and intrusive. A clinician is likely to achieve better engagement and more accurate history by taking time to introduce him or herself in an unhurried way and letting the patient tell their story; any apparent gaps in the history can be elicited with questions later if necessary.

In some remote Indigenous communities it is a sign of respect to pause and consider a question before responding. Clinicians may need to refrain from jumping in with a clarifying question. Lack of eye contact by people in more traditional Indigenous communities can easily be misinterpreted as evasiveness.

Language, including use of English words, differs across communities. It is often challenging to quantify alcohol consumption because numbering systems differ, and people in Indigenous communities usually share alcohol. Finding out how many people share the supply (for example, a case of beer) may help and frequency of drinking (for example, only on payday, or daily) will help determine the risk of withdrawal. Past withdrawal symptoms, such as 'grog shakes', are also important in predicting severity of withdrawal.

One brief screening instrument, the Indigenous Risk Impact Screen (IRIS; see Appendix 1), has been specifically validated in an Australian Indigenous setting, and screens jointly for alcohol problems, other drug problems and mental health disorders.

Australia's Indigenous population suffers a high prevalence of poor health. Medical conditions contributing to the ill health Indigenous people experience include:

- circulatory system diseases (including heart disease)
- diabetes
- respiratory diseases
- musculoskeletal conditions
- rheumatic fever and rheumatic heart disease
- kidney disease
- eye and ear problems.

As well, Indigenous adults are twice as likely to report high or very high levels of psychological distress as non-Indigenous adults.

Careful assessment of physical and psychiatric complications and comorbidities is essential.

Recommendation	Strength of recommendation	Level of evidence
9.27 A respectful, holistic and integrated approach to assessment and management is necessary, considering the patient in the context of both the family and the community.	D	IV
9.28 Indigenous cultures and customs vary. Use of language and approach to communication should be appropriate for both the individual and the community.	D	IV
9.29 Given the high prevalence of physical and mental comorbidities in the Indigenous population, clinicians should consider the possibility of physical and/or mental comorbidity in all presentations.	A	I

## Managing alcohol withdrawal

The setting for elective withdrawal management should be carefully considered, based on knowledge of past withdrawal severity, frequency and amount of consumption, and of comorbidities and social setting. Any medical condition (such as diabetes or heart disease) can make withdrawal more serious, and general hospital admission may be needed for some patients (see Chapter 5).

## Preventing relapse

Presentation for treatment is often late, when dependence is at an advanced stage. Residential rehabilitation may help break the cycle of drinking, particularly in the dependent drinker who has had recurrent relapses or who lives with other heavy drinkers.

If alcohol dependence is treated early in its course, the person may be able to be treated as an outpatient with psychotherapy and relapse prevention medications (see Chapters 6 and 7).

No evidence suggests that Indigenous Australians should have a biologically different response to pharmacological treatments compared to the general population. Indigenous people with alcohol dependence, as all other Australians, should be offered access to pharmacotherapies to reduce relapse in alcohol dependence, if there are no contraindications. The role of medication and of non-pharmacological treatment options should be carefully explained, where possible with the involvement of an Indigenous health professional.

Some patients may prefer the convenience of once-per-day dosing of naltrexone above three-times-daily acamprosate. Disulfiram is often contraindicated in the Indigenous population due to concurrent health problems incompatible with the significant side effects of this medication.

Quality aftercare is needed, including skilled counselling and support. It is important to take a holistic and integrated approach to management, which considers not only the alcohol use disorder, but also physical and psychiatric comorbidities, housing and financial needs, and family and community context.

## Reducing harm

Both at an individual and a community level, harm reduction measures should be considered where a drinker is unable or unwilling to stop drinking. Such measures should include administration of thiamine for those who continue to drink and consideration of child protection, domestic violence and road safety needs.

## Preventing and reducing alcohol problems for Indigenous communities

Clinical efforts need to combine with advocacy to successfully deploy measures to address underlying social risk factors for alcohol problems, and to support and empower communities in their efforts to reduce drinking and improve wellbeing. Communities and governments need to work together to implement a full range of evidence-based measures to reduce alcohol problems including, where appropriate, controlling supply.

Communities and individuals need culturally appropriate education on how to detect alcohol problems earlier, and on the risks of drinking above recommended limits. Education should specifically include information about the risks of alcohol-related harm to the pregnant mother, the foetus and the breastfed infant. Partnership between mainstream services and Indigenous health professionals, services and communities increases the chance of achieving reduction in alcohol problems both at the individual and at the community level.

Recommendation	Strength of recommendation	Level of evidence
9.30 The ongoing impact of colonisation should be considered and efforts to provide a range of treatment options for alcohol problems to Indigenous population should be combined with wider community measures addressing both alcohol misuse-related problems and underlying social determinants of alcohol misuse.	D	IV

## Dealing with patients from diverse cultural backgrounds

People from some ethnic groups will consider certain issues personal, sensitive or irrelevant and as a result may feel offended if you try to discuss those issues directly.

You should ask the patient if they would like a family member or friend to be present when you are assessing or interviewing them. For example, a chaperone may be needed for physical examinations.

Clinicians must be sensitive to the patient's possible embarrassment or reluctance to discuss certain issues; some topics may not usually be discussed. It would also be useful to have an understanding about culturally-specific taboos or beliefs about the reason for, or perception of, the illness, including its course and treatment.

Family is very important in many cultures; the patient may wish to seek family opinion before making a decision about treatment. It is advisable to welcome and encourage family involvement in managing the problem as it may maximise compliance to treatment and support for the patient. Always check to make sure the patient correctly understands what you have said. Be aware that certain physical actions (such as pointing at someone) are offensive in some cultures.

Consider referring the patient to a clinician who comes from a similar background or who speaks their language. It is often valuable to provide support or advice to the other clinician, and to ensure he or she knows how to access other health professionals (such as counsellors) appropriate to their own community.

## Older people

Older Australians (aged 65 years or more) represent approximately 13 per cent of the population but within the next 50 years they are expected to represent more than 25 per cent of the population (ABS 2007). Despite the proportional increase in the size of the older community, research on alcohol use among older Australians remains scarce, and data from older people are often aggregated in large-scale studies, making it difficult to accurately determine the prevalence of at-risk alcohol consumption across the older age group spectrum.

Based on the 2007 National Drug Strategy Household Survey (AIHW 2008) of Australians aged 60 years and older, it is estimated that:

- 15.6 per cent drank alcohol on a daily basis
- 34.6 per cent drank alcohol on a weekly basis
- 14.9 per cent of older men and 7.5 per cent of older women drank at levels that potentially put their health at risk in the short-term
- 7.4 per cent of men and 5.5 per cent of older women drank at levels that put them at risk of long-term harm.

In general, alcohol use and the prevalence of alcohol dependence usually decline with age, and are often associated with the onset of health problems. However, alcohol problems may endure throughout life and continue into older age, and in some people, alcohol use may increase later in life, typically following adverse life events such as loss of long-term partner or retirement from work. Such cases may present with challenging management problems.

## Benefits of light to moderate alcohol use in older adults

A number of studies suggest that light to moderate alcohol use (1 to 2 drinks per day) may convey some health benefits to older adults, including:

- reduced bone loss
- reduced risk of cardiovascular conditions, such as heart failure, stroke and atherosclerosis
- reduced risk of cognitive impairment and dementia.

## Health risks of alcohol use in older adults

Older people are potentially more vulnerable to the effects of alcohol, due to age-related physiological changes (including a higher blood alcohol concentration for a given dose due to a reduction in total body water and changes in hepatic metabolism), comorbid medical or psychiatric conditions, and interactions with medications, poor nutrition and social isolation.

Alcohol-related health risks in older people include:

- increased risk of falls
- cognitive function, and in particular memory, may be more vulnerable to the effects of alcohol in older drinkers and can impair driving ability
- increased prevalence of cancers, including breast cancer due to longer exposure to alcohol
- increased risk of suicide.

## Who to target for screening and brief interventions

Diagnosis of alcohol use disorders may be difficult, as alcohol use and related disorders may be mistaken for the effects of aging or other conditions prevalent in this age group. A high index of suspicion and thorough history taking can aid early detection and appropriate management. Therefore:

- Every person over the age of 60 should be screened for their concomitant alcohol and other drug use, with a particular focus on patients taking medications for other conditions.
- As older people are unlikely to present at traditional alcohol or other drug treatment settings, it is important that opportunistic screening in mainstream and gerontology settings occur. Screening is recommended in general practice settings, general hospital wards, emergency departments and community health and welfare settings.

Older people have typically been excluded from large-scale outcome studies, but there is some evidence that brief intervention in primary care settings can effectively reduce alcohol use in older people.

Recommendation	Strength of recommendation	Level of evidence
9.31 Older Australians should be screened for alcohol use and related harms (such as trauma, exacerbation illness, drug interactions, violence or physical neglect) across a range of health and welfare settings.	D	IV
9.32 Brief interventions should be employed for older people drinking at risky levels or experiencing alcohol-related harms (such as falls, driving impairment, drug interactions).	A	Ia

## Comprehensive assessment

Routine assessment for alcohol consumption among older people is recommended as older people tend not to discuss their drinking and health professionals can often mistake the effects of alcohol for a physical or mental health problem.

Clinicians should assess alcohol-related harms in this age group; these can include falls, exacerbation of medical conditions, drug interactions, violence and/or abuse. Comprehensive assessment should include physical, mental and cognitive capacity, nutrition, chronic pain, social conditions, overall general functioning, and a review of medications (see Chapter 3).

Medical practitioners should review older drinkers taking other medications, in particular those taking multiple medications or psychoactive medications (such as sedatives, anti-depressants), to assess any drug interactions (see Appendix 4).

The severity and management of concomitant physical and mental conditions should be reviewed several weeks to months after cessation of drinking and completion of withdrawal. Abstinence can be associated with marked improvements in other conditions (such as hypertension, cognitive function, mental state). Memory and executive skills appear to be resistant to recovery, or at least slower to recover with abstinence in the older dependent drinkers. Alternatively, alcohol use may have been masking underlying illness.

Recommendation	Strength of recommendation	Level of evidence
9.33 Concurrent physical or mental illness, medications, social conditions and functional limitations need to be considered when assessing older drinkers.	D	IV
9.34 Abstinence can be associated with marked physical, mental and cognitive improvements; alternatively, alcohol use may have been masking underlying illness. Consequently, the severity and management of concomitant physical and mental conditions should be reviewed several weeks to months after cessation of drinking.	D	IV

## Managing withdrawal in older dependent drinkers

Older dependent drinkers attempting alcohol withdrawal should be closely monitored, generally in a supervised withdrawal setting (detoxification unit or hospital).

- Poor diet and housing, physical inactivity, and concomitant illness may make older patients more vulnerable to complications, such as dehydration, nutritional deficiency (risk of Wernicke's encephalopathy), hypertension or infections, during withdrawal.
- Older patients should receive adequate thiamine, rehydration and nutritional support, and close monitoring of other conditions (such as blood pressure, blood glucose, mental state).
- Diazepam has the potential for over-sedation due to accumulation in older people (delayed hepatic clearance of long-acting active metabolites). Shorter acting benzodiazepines, such as oxazepam or lorazepam, should be considered as first-line medication for moderate to severe alcohol withdrawal (see Chapter 5). Doses should be titrated according to clinical effect.

Recommendation	Strength of recommendation	Level of evidence
9.35 Withdrawal management of older dependent drinkers requires close monitoring, nutritional supplements, careful use of sedative medication, and management of comorbid conditions.	S	–
9.36 Caution should be exercised when prescribing medications to older drinkers. Short-acting benzodiazepines (such as oxazepam, lorazepam) are preferred for alcohol withdrawal management over long-acting benzodiazepines (such as diazepam).	D	IV

### Treating dependence

Treatment is becoming increasingly important as the population ages; however, to date very few experimental studies of psychological or pharmacological treatment approaches have been conducted with the older age groups, especially those aged over 70 years. Most studies are longitudinal studies or retrospective analyses of data.

Recommendation	Strength of recommendation	Level of evidence
9.37 Psychological and pharmacological treatment approaches should be tailored to physical, cognitive and mental health of older patients.	D	IV

### Cognitively impaired patients

Impaired cognitive functioning is related to poorer treatment outcome, particularly for treatments that require acquisition of new skills.

### Screening, assessment and treatment planning

An assessment of cognitive functioning should be integral to any patient screening and results should be used to guide treatment planning. If significant impairment is suspected, a more thorough assessment by an appropriately qualified professional is indicated (see Chapter 3). In light of the myriad potential causes of cognitive impairment in alcohol dependent people, including frontal lobe dysfunction, such assessment should include diagnostic assessment. Issues relating to diagnosis and treatment of an acute confused state in alcohol dependent patients (Wernicke's encephalopathy, alcohol withdrawal delirium) are discussed in Chapter 5.

A formal cognitive assessment should be deferred until the patient has achieved several weeks of abstinence. Following full neuropsychological assessment, the clinician should discuss the results with the patient and provide summaries in an easily understood format.

Cognitive impairment can affect motivation, attention span, the capacity to critically evaluate situations and the ability to acquire new skills, but they can (indeed often do) improve after a period of abstinence from alcohol. Therefore, clinicians should take into account the possibility of improvement in cognitive functioning by allowing a sufficient period of abstinence from alcohol to elapse before finalising treatment planning. Establishing a routine may, however, mask cognitive impairment and if the routine is interrupted, the full extent of the deficits may again be evident.

Where severe cognitive impairment is present:

- treatment in an inpatient facility may be more effective than outpatient treatment
- treatment elements that require significant cognitive processing should not be employed as they are likely to be ineffective
- information presented to patients should be concrete and provided in more than one modality, that is, written and spoken
- patients should be given opportunities to practice behaviours taught, in various settings, with and without prompting.

Although clinicians have for some time recognised that many people who suffer from risky drinking and alcohol dependence also suffer from cognitive impairment, little evidence has been produced about which treatments are most effective. Nevertheless, level of cognitive functioning should be used to guide treatment planning. Even subtle cognitive deficits could affect treatment effectiveness in a number of ways.

People who suffer from alcohol abuse or dependence may have little insight into the nature and extent of their cognitive deficits. Due to concrete and rigid thought processes, patients with cognitive impairment may have difficulty processing all the relevant information about their problem and may be inflexible about changing their behaviour.

Clinicians must be aware, therefore, that this inflexibility results from an inability to understand the need to change, rather than denial of a problem and refusal to change behaviour. In these situations, particularly where cognitive deficits are temporary, clinicians should try different treatment approaches to engage the person in treatment (see below).

Recommendation	Strength of recommendation	Level of evidence
9.38 A brief assessment of cognitive functioning should be a routine part of assessment upon treatment entry.	S	–
9.39 More detailed diagnostic and functional assessment should be carried out where brief assessment suggests that a patient suffers from significant cognitive deficits.	S	–
9.40 The possibility of improvement in cognitive functioning should be taken into account by allowing a sufficient period of abstinence from alcohol to elapse before finalising treatment planning.	D	IV
9.41 Where cognitive impairment is confirmed, information presented to patients should be concrete and patients should be given opportunities to practice behaviours taught in treatment.	B	II

### Engaging the cognitively impaired patient in treatment

While many of the strategies discussed in this section apply to all patients, they may be particularly important for engaging patients who suffer cognitive deficits. The following strategies may increase the cognitively impaired patient's engagement in treatment:

- **Provide written information to the patient about treatment** – the patient may be more likely to enter treatment if they understand what treatment will involve, the process of treatment, and what they will be required to do.
- **Discuss different treatment options with simple explanations** – although patients suffering cognitive impairment should only be offered treatment interventions that do not require complex cognitive processing, the different options available to them

should be discussed. Where the clinician judges that the patient is capable of making a decision, the patient should be involved in deciding which treatment to participate in.

- **Establish a positive relationship with the patient by:**
  - keeping information simple and structured without being patronising
  - adopting an empathetic, non-judgemental, non-authoritarian approach
  - listening carefully to what the patient has to say
  - scheduling sufficient time for consultations
  - treating patients with respect
  - respecting confidentiality, except where there is a threat to life or in cases of abuse.
- **Maintain contact** with patients with cognitive deficits. To increase the likelihood that patients will attend appointments, clinicians should:
  - telephone before a consultation to remind the patient they have an appointment
  - schedule the appointment at the same time on the same day to decrease the likelihood of forgetting
  - telephone if an appointment has been forgotten and arrange an alternative time
  - arrange for referral to aftercare before completing treatment to ensure there is no gap in continuing care. It is often this gap that leads to relapse.

Cognitive deficits can also affect treatment by limiting the patient's ability to effectively express their thoughts and feelings and to understand communication from the clinician. The clinician should keep all communication as simple as possible, and repeat information several times.

The clinician should frequently check that the patient understands what he or she is saying, and that the clinician understands what the patient is saying.

Patients with memory problems should be encouraged to record their thoughts and questions in a diary and be directed to refer to their notes as a way to ensure the memory problem does not affect potential treatment outcomes.

Some evidence suggests that cognitive impairment is associated with an increased risk of relapse. To reduce the likelihood of relapse, cognitively impaired patients should participate in psychosocial relapse prevention (see Chapter 6) or be prescribed pharmacotherapy (see Chapter 7).

Recommendation	Strength of recommendation	Level of evidence
9.42 Clinicians should engage cognitively impaired patients in treatment by providing information about treatment, discussing different treatment options and maintaining contact with the patient.	S	—
9.43 Cognitively impaired patients should be taught relapse prevention strategies.	D	IV

## Managing a patient with alcohol-related cognitive impairment

Although evidence about the effect of cognitive deficits on treatment outcome is limited, available research indicates that cognitive impairment may adversely affect treatment outcome. Even less evidence shows which treatments are more or less effective. However, one viable explanation is that poor treatment outcome is caused by an inability of cognitively impaired patients to process the information imparted in therapy. Therefore, treatments that are simple, structured, and require less cognitive processing are thought to be more effective for patients with cognitive deficits.

- Screen for cognitive impairment as part of drug and alcohol assessment (see Chapter 3).
- If cognitive impairment is present, determine if it is acute (delirium) or chronic or acute on chronic (that is, acute exacerbation of a chronic condition).
- Use the mini-mental state examination if impairment is suspected, as well as bedside tests of frontal lobe dysfunction (such as the Clock Drawing Test; see Appendix 1).
- Where the patient appears to have an **acute** confused state:
  - Hospitalise where appropriate. Consider compulsory detention according to the Mental Health Act relevant to your state or territory, if behaviourally disordered and not accepting of voluntary treatment.
  - Consider Wernicke's encephalopathy. Treat urgently with parenteral thiamine (see Chapter 5).
  - Rule out and treat other causes of confusion, such as sepsis, dehydration, metabolic disturbances, subdural haematoma, post-ictal confusion, substance intoxication, ischaemia/infarction, hepatic encephalopathy. Carry out appropriate investigations: urinalysis, blood alcohol concentration, routine blood tests, x-rays, EEG, CT or MRI.
  - Orientate confused patient with familiar staff and relatives, use of calendars and clocks, bright lights at night.
  - Use benzodiazepines with or without antipsychotic medication for acute behavioural disturbance.
- Where cognitive impairment is **non-acute** or slow to resolve, consider the presence of alcohol-related frontal lobe impairment, alcoholic dementia, Korsakoff's syndrome:
  - Carry out more detailed bedside tests of cognitive function: mini-mental state examination plus bedside frontal lobe testing (such as the Clock Drawing Test, verbal fluency, alternating sequences, trailmaking, Luria's tests, abstraction).
  - If available, refer for neurocognitive assessment with clinical psychologist once the patient is abstinent for 6 weeks or more.
  - Investigate and treat other potential causes of pathology, such as Alzheimer's, dementia, neoplasm, ischaemia/infarction.
  - Rule out psychiatric comorbidity, which may present with cognitive changes, for example, major depressive disorder, severe anxiety, psychosis.
  - Conduct a risk assessment of the patient's safety to live independently in the community. Include social worker and occupational therapist in assessment.
  - Consider placement options. Meet with the family to discuss the patient's limitations and requirements for activities of daily living. Review supported accommodation options where appropriate.

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- Consider the need for guardianship if the patient is significantly impaired, unsafe to live independently but has little insight about requirements for care.
- Consider the need for involuntary treatment if the patient continues to drink and refuses to engage in appropriate treatment.
- Consider selected rehabilitation options if cognitive impairment is minimal and there is some capacity to learn new material and skill. Use strategies described above to engage patient in treatment and maintain contact.
- Where possible, focus on teaching appropriate behavioural management and relapse prevention in a repetitive, relatively concrete manner.
- Consider the possibility of improvement in cognitive function after a significant period of abstinence, and adjust treatment plan accordingly.