

# **ALCOHOL RELATED DISORDERS**

# 1. Introduction

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## 1.1 Definition of Harmful Alcohol Consumption

Alcohol consumption damaging to the psychological, physical or social well being of the individual.

## 1.2 Key Features of Alcohol Dependence

- Increased tolerance – larger doses are required.
- Withdrawal symptoms.
- Cravings.
- Obtaining the next drink becomes the most important part of a person's life.
- The pattern of consumption (timing, place and substance) becomes rigid.

Alcohol can cause dependence because drinking feels rewarding, whilst withdrawal feels distressing. In time, tolerance develops, so a greater quantity of alcohol is needed to obtain the same effect. Together, these factors encourage the development of dependence. (The DSM-IV and ICD-10 criteria for alcohol related illness are reproduced in **Appendix A.**)

## 1.3 Quantifying Alcohol Intake

The recommended safe limits of weekly alcohol intake are **21 units for men** and **14 units for women**, with at least 2 drink free days. (Endorsed by the Health Education Council and the Royal Colleges of Physicians, Psychiatrists and General Practitioners). Health is seriously at risk when weekly alcohol intake reaches **35 units for men** and **21 units for women**.<sup>1</sup>

A unit of alcohol (10ml) is approximately equivalent to: a small glass of wine, a pub single measure of spirits or half a pint of ordinary strength beer.

- A standard bottle of spirits contains 32 units.
- A standard bottle of wine contains 8 units.
- A standard can of lager contains 1.5 units.
- A bottle of alco-pop contains 1.5 units.
- **Each can of extra-strong lager or cider contains 4 units.**

These figures are only for guidance: alcohol is often sold in non-standard strengths and volumes.

## 2. Epidemiology

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- Globally, 140 million people are dependent on alcohol.<sup>2</sup>
- In the UK, the lifetime risk of alcohol dependence is about 1 in 4 for men and 1 in 22 for women.<sup>1</sup>
- 1 in 25 adults are dependent on alcohol. The male to female ratio is 2:1, but the rates in females and adolescents are increasing. Alcohol dependence peaks in the 20 – 30 age range, and the incidence is lowest in the over 45's.<sup>3,4</sup>

### The Population Prevalence of Harmful Drinking in the UK<sup>1</sup>

Alcohol Over Safe Limits	Male	Female
Without Complications	13%	7%
With Problems	7%	2%
With Dependence	5%	2%

- In the UK, the prevalence of alcoholic cirrhosis is 9 per 100,000.<sup>5</sup>
- In Britain, the total cost of alcohol misuse was £3 billion in 2000.<sup>6</sup>
- The cost of alcohol misuse to the NHS was £200 million in 2000.<sup>3</sup>
- 15% of UK acute hospital admissions were due to alcohol misuse in 2000.<sup>3</sup>
- About 25% of patients in general hospital wards drink excessively.<sup>1</sup>
- Alcohol related sickness absence in the UK cost £1,401 million in 1999.<sup>7</sup>
- Alcohol related unemployment in the UK cost £323 million in 1999.<sup>7</sup>

### 3. Aetiology

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The aetiology of alcohol abuse is often multifactorial, and may be influenced by a person's physical, psychological, genetic and social characteristics.

Some of the most important factors include:

- Alcohol is easily available and relatively inexpensive.
- Heavy drinking is widely seen as acceptable in our society. (Peer pressure.)
- Twin and adoption studies show that genetic and environmental factors each contribute to the development of alcohol dependence. It is 4 times more common where there is a family history.<sup>1,8</sup>
- Some occupations carry a high risk of alcohol abuse. Barmen, publicans and caterers are at highest risk, while members of the armed forces, journalists, commercial travellers, airline pilots and doctors are at above average risk.
- Self-medication for chronic pain or mental illness. Many mental health problems are associated with high levels of alcohol abuse:<sup>9</sup>

Mental Health Problem	Prevalence of Alcohol Abuse
Generalised Anxiety Disorder	51.6%
Antisocial Personality Disorder	46.9%
Drug Abuse	38%
Affective Disorders	33.7%
Phobias	33.7%
Panic Disorder	10%
Schizophrenia	7.7%

### 4. Consequences of Excess Alcohol Consumption

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Excess alcohol consumption has toxic effects on every organ system. As well as these specific conditions, alcohol-dependent patients often have nutritional deficiencies, multiple physical illnesses and social problems, which predispose them to further diseases such as pneumonia and tuberculosis. Physiological factors render women more susceptible to the effects of alcohol than men. This puts them at risk of the complications of alcohol at lower levels of intake.<sup>8</sup>

**80% of patients referred for treatment of alcohol abuse have physical complications.<sup>10</sup>**

#### 4.1 Acute Neurological Syndromes

Acute intoxication with alcohol is associated with symptoms of neurological impairment that escalate from euphoria and incoordination to confusion, nystagmus, ataxia, stupor and coma. When alcohol dependence is established, withdrawal symptoms are one of the cardinal features. These are most common in the first 24 – 48 hours of abstinence, although they can occur up to 10 days later. Typical features of withdrawal include tremor, nausea and sweating, with seizures and hallucinations in severe cases. Delirium tremens (the DTs) is the most serious manifestation of alcohol withdrawal, with a mortality of about 5%. The syndrome occurs in 5% of all patients admitted to hospital with physical complications of alcoholism. The patient becomes disorientated and experiences hallucinations, fear, paranoid delusions, extreme tremor and agitation. The symptoms typically resolve after several days.

#### 4.2 Neurological Syndromes due to Nutritional Deficiency

##### 4.2.1 Wernicke - Korsakoff Syndromes

The Wernicke - Korsakoff Syndromes are caused by thiamine deficiency, and may persist even after abstinence from alcohol and vitamin replacement. Wernicke's Disease comprises ophthalmoplegia, ataxia and a chronic confusional state, however, this triad of signs are not present in all cases and treatment should be initiated if any signs are present. Korsakoff syndrome describes dense antegrade and retrograde amnesia with confabulation.

##### 4.2.2 Peripheral Neuropathy

Alcohol is the commonest cause of peripheral neuropathy after diabetes. Peripheral neuropathy occurs in 10% of dependent drinkers, and affects motor and sensory nerves, especially in the lower limbs. The condition is symmetrical. Symptoms and signs include a burning sensation in the feet, a patchy loss of pain sensation, and absent ankle jerks. There may also be distal weakness and wasting of the muscles.

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### **4.3 Miscellaneous Neurological Conditions**

Excess alcohol may cause myopathy, which is associated with muscle pain and proximal muscle wasting. Alcohol's direct toxic effect on neurones can result in cortical atrophy, which may become evident through failure of memory, deterioration of personality and loss of intellectual ability. Alcohol can cause amnesic episodes, which are often described as "blackouts." Head injury and sub-dural haematoma are significantly more common amongst heavy drinkers. Fetal alcohol syndrome is a cluster of developmental abnormalities present in children born to alcohol dependent mothers.<sup>8</sup>

### **4.4 Gastrointestinal Conditions**

Alcohol is absorbed from the stomach and small intestine, and the rate of absorption is most rapid on an empty stomach.

Alcohol is predominantly eliminated (75%) by the liver at the rate of about 1 unit per hour.<sup>11</sup> The metabolism of alcohol is accelerated in heavy drinkers (tolerance), however, the onset of liver failure reverses this process, and the rate of metabolism then falls to less than normal.

The structure and function of the liver remains normal in 50% of patients dependent on alcohol. The first stage of liver damage is alcoholic fatty liver, which is an acute but reversible event. Continued drinking may lead to alcoholic hepatitis, which causes jaundice, fever and vomiting, and 80% of hepatitis cases eventually develop into cirrhosis of the liver. Alcoholic cirrhosis is irreversible fibrotic scarring of the liver and is associated with a 5-year survival of 48% if drinking continues, and 77% if it stops.<sup>12</sup>

Peptic ulcers, gastritis, pancreatitis, oesophageal varices and carcinoma of the oropharynx and oesophagus are all more common amongst patients dependent on alcohol.

### **4.5 Cardiovascular Conditions**

Alcohol related folate deficiency is an important cause of macrocytic anaemia. Cardiac function may be impaired by alcohol related cardiomyopathy and arrhythmias such as atrial fibrillation. At the population level, the incidence of ischaemic heart disease, hypertension and stroke is increased by alcohol excess.

### **4.6 Rheumatological Conditions**

Gout is commonly associated with alcohol excess. Unfortunately, the NSAID used to treat the symptoms of gout can further worsen the gastrointestinal complications of alcohol excess.

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### **4.7 Psychological Conditions<sup>13</sup>**

#### **4.7.1 Depression**

40% of alcohol abusers presenting for treatment have depression.<sup>14</sup> Alcohol has a direct depressant effect on the brain. Alcohol dependency can lead to social problems including unemployment, divorce and debt, and depression may follow. In turn, depression may lead to deliberate self-harm. About half of all men who take overdoses are dependent on alcohol.<sup>13</sup>

#### **4.7.2 Anxiety**

Alcohol is often used to self-medicate symptoms of stress and anxiety. The initial relief that is achieved is a powerful spur to develop alcohol dependence. Anxiety symptoms increase during the withdrawal from alcohol, so a vicious circle of increasing consumption can develop.

#### **4.7.3 Psychosis**

Alcoholic hallucinosis is a rare condition, separate from the acute effects of withdrawal. Auditory hallucinations occur in a setting of clear consciousness. These often take the form of a derogatory conversation about the patient. The phenomenon occurs when alcohol intake ceases or is reduced after a period of heavy drinking, and it usually lasts for a few days.

### **4.8 Social Complications of Excess Alcohol Consumption**

Marital problems may occur because the alcohol abuser is late coming home, is abusive or violent when drunk, becomes indebted or unemployed. Work problems may occur if the alcohol abuser has a poor attendance record and performs poorly. Legal problems may develop when an alcohol abuser encounters the police because of “drink driving” or violence. 50% of those sleeping rough are alcohol dependent.<sup>3</sup>

# 5. Screening and Diagnosis

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Screening for alcohol abuse is necessary, as many heavy drinkers do not seek help because they do not admit their drinking is harmful. GPs are aware of less than 20% of the alcohol related problems amongst their patients.<sup>10</sup> A high index of suspicion is required, especially in patients or claimants with medical or psychiatric conditions often associated with alcohol. Suspicion of alcohol dependency should also be increased in those who have had two or more drink-driving offences.<sup>15</sup>

## 5.1 CAGE Questionnaire

Many screening questionnaires have been developed to identify patients who may be at risk from their pattern of alcohol consumption. One of the simplest and best known is the four-item CAGE questionnaire where each of the letters CAGE is a letter from a key word. Two or more positive replies suggest that the patient has a drink problem. In general medical settings, CAGE has a high sensitivity (85%) and specificity (89%).<sup>1</sup>

- Have you ever felt you ought to **C**ut down on your drinking?
- Have people **A**nnoyed you by criticising your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye opener)?

## 5.2 Clinical Assessment of Alcohol Use

There is reluctance on the part of some people to talk about their alcohol problem and so a sensitive, non-confrontational and non-judgemental approach is needed.

### 5.2.1 Typical Drinking Day

A detailed picture of a typical day gives a good indication of how alcohol affects the claimant's life.

### 5.2.2 Alcohol history

- a) Typical alcohol consumption (units) in a week.
- b) Are there withdrawal symptoms?
  - Anxiety.
  - Tremor.
  - Night sweats or morning nausea.
  - Convulsions.
  - Delirium tremens.

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- c) Are there other features of dependence?
  - Tolerance.
  - Compulsion to drink, and drink-seeking behaviour.
  - Rapid reinstatement of heavy drinking after abstinence.
- d) Are there alcohol related problems?
  - Physical, e.g. gastritis, hepatitis, cirrhosis, pancreatitis, neuropathy, and accidental injuries.
  - Psychological, e.g. anxiety, depression, delusions, hallucinations, and paranoid ideation.
  - Social, e.g. marital, accommodation, occupational, legal or financial.
- e) Are other drugs being used?
- f) Previous treatment history: medication, GP or specialist alcohol treatment service.

### 5.3 Clinical Signs of Alcohol Excess and Liver Damage

- **There may be no symptoms or signs.**
- Alcohol excess is associated with diseases of every organ system, and the signs of any of them may be detected. Some of the commonest features are described below.
- Acute intoxication may be evident from slurred speech, impaired co-ordination or a labile or inappropriate manner.

#### 5.3.1 Appearance

- Stigmata of chronic alcohol abuse include unkempt appearance, the smell of alcohol on the breath, a plethoric face, bloodshot conjunctivae, acne rosacea, tremor, potbelly and Dupuytren's contracture.

#### 5.3.2 Gastrointestinal Disease

- In compensated liver disease: hepatomegaly or a small hard liver in cirrhosis, palmar erythema, gynaecomastia, clubbing, xanthelasmata and spider naevi.
- In portal hypertension: ascites, caput medusa, and splenomegaly.
- In decompensated liver disease: jaundice, pruritus, hepatic encephalopathy, leuconychia, oedema.
- There may be evidence of previous surgery for peptic ulceration or pancreatitis. Abdominal tenderness may indicate that these conditions are active.

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### 5.3.3 Cardiovascular Disease

- Cardiovascular examination may show evidence of bounding pulse, arrhythmia, hypertension, heart failure (associated with cardiomyopathy), or peripheral vascular disease.

### 5.3.4 Neurological Disease

- Peripheral neuropathy is a frequent complication of alcohol dependence, and may cause impaired sensation in a “glove and stocking” distribution with distal muscle weakness and wasting.
- Alcoholic myopathy may cause proximal muscle wasting or muscle tenderness.
- Wernicke’s disease and cerebellar atrophy may produce signs of incoordination and ophthalmoplegia.

### 5.3.5 The Mental State Examination

#### **Appearance and Behaviour**

A person who is appropriately dressed, clean, able to make good eye contact, and who behaves appropriately during the assessment is likely to be functioning relatively well. However, it is important to consider the history and variability of their condition, avoiding a potentially misleading “snapshot” assessment.

#### **Cognitive Function**

A person’s ability to conduct a conversation and provide information is a test of their concentration and memory. However, those with severe cognitive impairment may be able to mask their disability by confabulating. Sometimes this can be detected by noting inconsistencies between the claimant’s account and other sources of information.

#### **Mood**

Anxiety and depression are frequently associated with alcohol abuse. An anxious person may appear ill at ease, and they may be tearful, sweating or shaky. A person who is depressed may look sad, speak in a monotone, and have a flat affect and a downcast gaze. They may be tearful and preoccupied with guilt or hopelessness about the future. In people who abuse alcohol, the risk of suicide is relatively high. Risk factors for self-harm are described in the protocol about ***Depression***.

#### **Thoughts and Perceptions**

Alcohol abuse is associated with psychotic mental illness. Signs such as suspiciousness, pressure of speech, thought blocking, distractibility, or the experience of hallucinations would suggest psychosis.

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### Insight and Motivation

Does the person acknowledge that there is a problem, and are they realistic about the impact that it is having on their health and lifestyle? Are they motivated to control their drinking? These factors have a major impact on prognosis. A lack of insight and motivation strongly suggest a poor outlook.

## 5.4 Investigations

- Laboratory markers of alcohol excess may be normal, or may show raised MCV (Mean Corpuscular Volume), elevated  $\gamma$ -GT (Gamma Glutamyl Transpeptidase), raised transaminases (AST and ALT) or raised alkaline phosphatase. The MCV and  $\gamma$ -GT are sometimes used as markers for excess alcohol consumption, although there are a number of possible confounding factors which may make them unreliable on their own. In advanced disease, the liver's ability to metabolise and excrete is compromised, so there will be low albumin, raised INR, raised bilirubin, and low glucose and sodium.<sup>1,8,10-12</sup>
- Ultrasound scanning is useful for assessing the size and texture of the liver.
- Liver biopsy can help to identify the cause of liver disease.

# 6. Treatment of Alcoholic Dependence

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The long-term goals of treatment for patients who drink to excess include abstinence or reduction in use, relapse prevention, and rehabilitation. Treatment can be successful. Approximately 70% of all patients achieve a reduction in the number of days of drinking and improved health status within 6 months. Patients typically report drinking heavily on 75% of the days during a 3-month period before treatment. After treatment, patients are often abstinent on 70%-90% of days, and they engage in heavy drinking on only 5%-10% of days. However, the majority of patients have at least one relapse during the first year following treatment.<sup>4,16,17</sup>

## 6.1 Advice and Information

“Brief Interventions” are appropriate for general medical settings and have been shown to achieve a 20% reduction in alcohol consumption among problem drinkers.<sup>10</sup> They are described in **Appendix B**.

## 6.2 Detoxification

Withdrawal or “de-tox” from alcohol can often be achieved at home or on an outpatient basis under daily supervision.<sup>18</sup> Relief from the symptoms of withdrawal can be achieved by tapering doses of benzodiazepines over about a week. Diazepam is now replacing chlordiazepoxide as the preferred drug.

For the most severe or intractable cases, and those without social support, admission to an alcohol treatment unit may be more appropriate.

Patients with delirium tremens require emergency treatment in hospital.

Adequate nutrition and vitamin B<sub>1</sub> (thiamine) supplements are necessary to replace inadequate stores and prevent the serious consequences of alcohol related nutritional deficiency.

## 6.3 Alcoholic Liver Disease

It is necessary to stop drinking alcohol to prevent further liver damage.

Liver transplantation is occasionally appropriate and possible.

## 6.4 Controlled Drinking

Where abstinence is not feasible, controlled drinking may be an appropriate goal. This can be achieved by setting a limit on drinking, and facilitated by tactics such as choosing low alcohol drinks and drinking only at certain times of the day.

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### 6.5 Maintaining Abstinence

Abstinence is especially desirable in established dependence, alcohol related physical disease and failed controlled drinking.<sup>10</sup>

Disulfiram (Antabuse) may be used to help to prevent drinking. The combination of alcohol and Antabuse causes a potentially dangerous reaction of nausea, vomiting, breathlessness, headache, flushing, and tachycardia. Fear of this reaction can achieve 60% abstinence at 1 year, but the treatment relies on the motivation of the patient to take the tablet each day.<sup>10,19</sup>

Acamprosate (Campral) acts to reduce the craving for alcohol, and in combination with counselling, may be helpful in maintaining abstinence. It should be initiated as soon as possible after abstinence is achieved, and continued if the patient relapses.<sup>19,20</sup>

Naltrexone is an opioid antagonist that was originally developed to aid abstinence from opiate drugs, but has been shown to be effective in the treatment of alcohol abuse. (Animal studies suggest that the reinforcing effects of the first drink are mediated by opioid receptors.)<sup>4,20,21</sup>

Preliminary research suggests that SSRI antidepressants may help to control problem drinking in patients without depression.<sup>4,20</sup>

### 6.6 Psychological Support and Rehabilitation

The facilities for alcohol treatment vary across the country, and may be provided by a range of organisations in the community or on a residential basis. Typically, a patient might present to their GP who would refer them to the local Community Alcohol Team (CAT) for home or inpatient detoxification and rehabilitation.<sup>22</sup>

Cognitive therapy and behavioural therapy have been shown to be effective treatments for patients dependent on alcohol. Many treatment centres rely on a variety of techniques to help individual patients to control or abstain from their drinking. Examples include education about alcohol, group meetings, individual psychotherapy, social skills and assertiveness training, analysis of the triggers for drinking and planning to avoid relapses, and a system of goals and rewards.<sup>4,10</sup> Therapeutic interventions of this type can achieve reductions of alcohol intake of at least 50% in about half of the patients, and maintain them for years.<sup>17,16</sup>

### 6.7 Alcoholics Anonymous

Alcoholics Anonymous is a spiritual, but non-religious organisation that advocates a strict abstinence policy, provides a social structure to replace drinking, and provides support from former alcoholics. *"AA is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking."*

### 7. Prognosis

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- Globally, alcohol is responsible for 1.5% of all deaths.<sup>23</sup>
- 1 in 4 deaths in men aged 15 - 29 in Europe are attributable to alcohol.<sup>2</sup>
- Alcohol causes about 33,000 deaths per annum in England and Wales.<sup>10</sup>
- In alcohol dependency, the lifetime risk of suicide is 7%.<sup>24</sup>
- Alcohol is a factor in 80% of suicides.<sup>10</sup>
- Alcohol is a factor in 20 - 30% of all accidents,<sup>25</sup> and about 50% of road accident fatalities.<sup>1</sup>
- Workers who misuse alcohol are 2 - 3 times more likely to be involved in an accident.<sup>3</sup>

Alcohol dependence is often characterised by periods of remission and relapse, but a third of patients manage to recover without professional intervention.<sup>4,10,26</sup> Alcohol abuse is associated with social deprivation. A 1997 census of patients seeking treatment for alcohol dependency showed that 36% were receiving sickness benefits, 31% were unemployed, and 18% were either homeless or in temporary accommodation.<sup>27</sup>

**A good prognosis is associated with a healthy premorbid personality, insight into the dependency, motivation to change lifestyle, and effective family and social support.**

# 8. Main Disabling Effects

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Alcohol excess is a chronic and variable condition with possible consequences affecting the physical, mental and social functioning of the sufferer. Both the full range of problems and their variability must be assessed to arrive at a true picture of a claimant's disability.

## 8.1 Assessing the Claimant

**Claimants with alcohol related disability must always have their mental state assessed.**

The assessment should be made using all the information available. This includes information from the claimant's file, informal observations, medical history, alcohol history, typical day, and examination. When it is available, information from family or carers accompanying the claimant may also be valuable. A focused physical examination should assess any areas of physical disability reported, or which become apparent during the interview.

If a claimant is in a state of intoxication, then consideration should be given to aborting the examination, as it will be impossible to complete a full assessment. It may, however, still be possible to provide the Decision Maker with a useful report containing advice on their disability and functional impairment.

Intoxication may increase the risk of aggressive or violent behaviour, and this must be borne in mind. See the CME module "**Dealing with Potentially Violent Situations**," for detailed advice.

If severe alcohol abuse or the complications of alcohol abuse are unexpectedly discovered, then you should seek the claimant's informed consent to notify their GP, and follow the **Unexpected Findings** procedure.

To take account of the variability of alcohol dependence, remission and relapse, it is important to ask about the claimant's condition over time. Considering events in the last 2 years will give a representative impression.

There is a wide range of severity amongst claimants with alcohol related disability:

### 8.1.1 Mild Alcohol Related Disability

Claimants who drink to excess and are suffering some of the milder acute consequences such as gastritis or problems in their home life are likely to have little or no restriction in their Activities of Daily Living. They should be able to live independently and continue with their usual interests and hobbies. **NB:** Amnesic "blackouts" that may be associated with heavy drinking are not a form of epileptic fit.

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### **8.1.2 Moderate Alcohol Related Disability**

Claimants who have been drinking heavily for several years and have developed dependence or chronic consequences such as peripheral neuropathy or epileptic fits are likely to have significant difficulties with their Activities of Daily Living. Their disabilities may be physical, mental or a combination of both.

These claimants are likely to have attempted detoxification and abstinence with the support of their GP or the local alcohol services. They may have had hospital referrals for investigation of alcohol related physical or mental illness, or been admitted for emergencies such as fits, delirium tremens, pancreatitis or haematemesis. They may be unkempt, and may have early features of cognitive impairment. They are likely to have a history of alcohol related social problems such as marital break-up or loss of their home.

### **8.1.3 Severe Alcohol Related Disability**

Claimants who have been drinking heavily for many years are likely to eventually develop severe, chronic and life threatening complications such as cirrhosis, cardiomyopathy and cognitive impairment. This group will have very poor general health and social function.

## **8.2 Informal Observation**

The claimant's appearance will give clues about their general state of health and nutrition. Is the claimant unkempt? Do they smell of alcohol? Are they jaundiced? Observe their gait and balance for signs of neuropathy and ataxia.

## **8.3 Physical Assessment**

When a claimant has a history of frank or suspected alcohol abuse, it is important to consider the full range of conditions to which they may be susceptible. In particular, their nutritional status, and the possible presence of gastrointestinal, cardiovascular, and neurological complications should be considered.

**The absence of physical signs does not exclude significant alcohol related physical disease.**

## **8.4 Psychological Assessment**

Claimants with alcohol related disabilities are sometimes difficult to assess. It is especially important to attempt to develop a rapport in order to maximise the information that can be obtained at interview. A sensitive non-judgemental approach is more likely to elicit the necessary data about alcohol consumption.

The loss of friends, social isolation, the avoidance of people, poor interpersonal skills, negativism, poor self-care and a chaotic lifestyle are a cluster of features found in some claimants with alcohol related disability. These claimants function very poorly, and are highly disabled. Questions about social activities such as going to the pub or seeing their family may provide useful clues.

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### 8.5 Assessment of Alcohol Use

The most important discriminating factor in assessing the impact of alcohol excess on a claimant is to determine whether they are dependent on alcohol. (See *section 1.1.3.*)

Alcohol use should be assessed by taking a drinking history, including a typical drinking day. A standard typical day history and a mental state examination complete the assessment of the claimant's mental health functioning.

### 8.6 How to Assess Prognosis

#### 8.6.1 Physical Prognostic Factors

- The presence of any symptom or sign of alcohol related disease shows that the claimant's alcohol consumption is already at a harmful level.
- **The onset of chronic complications of alcohol predicts a poor prognosis.**

#### 8.6.2 Mental Prognostic Factors

- Does the claimant have another mental illness? The combined disabling effects of multiple illnesses are likely to be severe. The assessment should focus on the most significant condition.
- Is the claimant using other drugs, and are they dependent on them? This is a relatively common scenario in our work as disability analysts, and is likely to increase their level of disability. (See the protocol about **Substance Use Disorders.**)
- Does the claimant have insight into their condition? Insight into dependence is associated with a better prognosis.
- What is their motivation for change, taking account of their medical and behavioural history? Is the claimant attending a self-help group such as Alcoholics Anonymous? A motivated claimant has a better prognosis.
- What treatment have they received in the past, and is the claimant currently receiving treatment for their alcohol abuse? Rapidly returning to excess alcohol consumption after attempts at rehabilitation suggests a poor prognosis.
- Has the claimant been able to abstain from alcohol? Claimants with a history of long periods of successful abstinence have a better prognosis.

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### 8.6.3 Social Prognostic Factors

- Where is the claimant living? Do they have a home of their own, or are they living in a hostel, at home with their parents, or of no fixed abode? The lack of a safe home may indicate the claimant's life has disintegrated because of their dependence on alcohol.
- The claimant's employment history is often useful. Frequent job changes, or losing a job because of the effects of alcohol suggest a significant alcohol problem.
- Does the claimant have an effective social support network? If so, it improves their prognosis.

## 8.7 IB-PCA Considerations

The burden of multi-system dysfunction may progressively reduce exercise tolerance. In the IB-PCA, this is particularly likely to affect the activities 'Walking' and 'Climbing Stairs.' Evidence of this can be elicited by asking about the claimant's ability to manage shopping or travelling, for example.

Neurological complications may cause balance problems that could affect the activities 'Walking', 'Climbing Stairs', 'Standing' and 'Rising from a Chair.' Establishing whether the claimant can get in and out of the bath, manage the stairs, or use public transport will provide useful information.

Although the mental health assessment only includes one question specifically about alcohol, the range of functions covered by the remaining questions will successfully assess the functional abilities of claimants with alcohol related disabilities.

There are a number of situations where exemption from the IB-PCA should be considered:

- If marked physical or mental symptoms and signs relating to the abuse of alcohol are found, consider exemption under the category severe mental illness: "the presence of mental disease which severely and adversely affects a person's mood or behaviour and which severely restricts his social functioning or his awareness of his immediate environment."
- Claimants with evidence of severe chronic physical complications of alcohol abuse such as liver failure, portal hypertension, a history of bleeding oesophageal varices, recurrent pancreatitis, cardiomyopathy, and Wernicke – Korsakoff syndrome should be exempt from the assessment for two years or "in the longer term," depending on the prognosis of the conditions and the age of the claimant.
- Claimants undergoing residential detoxification and rehabilitation should be given exemption from the IB-PCA until the end of their treatment. A review after 6 - 12 months would usually be appropriate.

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- Claimants who are dependent on alcohol and have suffered a loss of personality and self-regard leading involuntarily to extreme poverty and neglect and an inability to function socially should be exempt from the IB-PCA. The period of exemption should range from 18 months in a younger person, to “in the longer term” for a claimant over 50 years old with a long history of alcohol dependence.
- Claimants, who are habitually intoxicated and would pose a threat to themselves or others in the workplace, should be exempt from the IB-PCA.
- Where a claimant has presented for examination in a state of intoxication there may be enough information from the case file and the observed appearance to consider exemption from the PCA.
- Claimants who have developed **severe** cognitive impairment, characterised by failure of memory, loss of intellectual ability and deterioration of personality should be exempt from the assessment “in the longer term.”
- In general, the review period of a claimant’s exemption will depend on their history. Claimants with very long histories of intractable alcoholism should be reviewed after no less than 18 months, but those with acute problems, or a history of long remissions should be reviewed after 6 months.

## Appendix A - Definitions of Dependency and Abuse

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### DSM-IV Dependence (3 items required)

1. **Tolerance**, as defined by either of the following:
    - a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
    - b) Markedly diminished effect with continued use of the same amount of the substance.
  2. **Withdrawal**, as manifested by either of the following:
    - a) The characteristic withdrawal syndrome for the substance.
    - b) The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
  3. The substance is often taken in larger amounts or over a longer period than was intended.
  4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
  5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recovering from its effects.
  6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
  7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption.)
- Specify with physiological dependence:  
Evidence of tolerance or withdrawal (i.e., either Item 1 or 2 is present.)
  - Specify without physiological dependence:  
No evidence of tolerance or withdrawal (i.e., neither Item 1 nor 2 is present.)

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### **DSM-IV Abuse (1 item required)**

1. Recurrent substance use resulting in inability to fulfil major role obligations at work, school, or home.
2. Recurrent substance-related legal problems.
3. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
4. Recurrent substance use in situations in which it is physically hazardous.

### **ICD-10 Dependence (3 items required)**

1. A strong desire or sense of compulsion to use a substance or substances.
2. Evidence of impaired capacity to control the use of a substance or substances. This may relate to difficulties in avoiding initial use, difficulties in terminating use, or problems about controlling levels of use.
3. A withdrawal state or use of the substance to relieve or avoid withdrawal symptoms, and subjective awareness of the effectiveness of such behaviour.
4. Evidence of tolerance to the effects of the substance.
5. Progressive neglect of alternative pleasures, behaviours, or interests in favour of substance use.
6. Persisting with substance use despite clear evidence of harmful consequences.

### **ICD-10 Harmful Use (1 item required)**

1. Clear evidence that the use of a substance or substances was responsible for causing actual psychological or physical harm to the user.

# Appendix B - Brief Intervention

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### Brief Intervention for Excess Alcohol Consumption

Studies have shown that a 5-minute advisory session can be effective in reducing hazardous alcohol consumption.<sup>1</sup> This is particularly likely to be effective if the patient is “ready to change.” Amongst excessive drinkers in hospital, 29% were found not to be ready for change, 26% were ready to change, and 45% were ambivalent.

1. Give firm advice to cut down.
2. Explain the harmful effects of alcoholism.  
e.g. Sexual problems, poor work performance, accidents, liver disease and financial problems.
3. Explain the beneficial effects of drinking less.  
e.g. Slimmer and fitter, better concentration, better relationships with families and friends.
4. Agree a realistic target to cut down drinking. Some patients prefer to abstain altogether.
5. Give advice about dealing with situations that could lead to relapse.  
e.g. If drinking mainly occurs in a social setting, it might be best to socialise away from the pub.  
e.g. If drinking is used to ease stress, what other activities could be used instead?  
e.g. In the pub: “don’t drink until the slowest drinker in the group has done so.”  
“Sip, don’t gulp.”
6. Ask the patient to keep a drinking diary.
7. Agree a review date.
8. Give the patient literature to supplement the advice and to inform them about sources of information and support such as Alcoholics Anonymous.

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