The treatment of alcohol abuse requires:

- routine screening of all individuals with behavioral, medical and social problems;
- comprehensive assessment of patients suspected of alcohol abuse;
- medical management of intoxication and withdrawal;
- development of an individualized treatment plan which acknowledges the chronicity of alcohol abuse; and
- ongoing care, making use of the full spectrum of community support.

ASSessment

The initial assessment must include a detailed history of the patient’s alcohol abuse, including amounts, frequency of use, and consequences of use including effects on cognitive, psychological, behavioral and physiologic functioning. A medical history must be obtained and a screening physical examination performed. Any previous treatment should be reviewed with emphasis on what appeared to help and what resulted in relapse. The patient’s support system should be documented including family, social and vocational supports, with specific reference to deterioration due to alcohol abuse. Routine screening of blood or breath for alcohol and medical testing for resultant conditions (e.g.: hepatitis, cardiomyopathy, peripheral neuropathy or dementia) should be performed.

Initial Management

The initial treatment of alcohol abuse is directed towards medical stabilization and engaging the patient in the process of recovery. Management of acute intoxication can usually be done in a calm, quiet, supportive environment using the support of friends or relatives. Individuals who are highly agitated or at risk for severe withdrawal (i.e. blood alcohol level > .200 or a previous history of severe withdrawal) will require referral for emergency care.

The management of withdrawal requires ongoing monitoring of the signs and symptoms of withdrawal. The most common method uses the CIWA (clinical institute withdrawal assessment) scale to rate the severity of withdrawal. A CIWA score <10 represents mild withdrawal, 10-20 moderate, 20-30 severe and >30 suggests a very high risk for delirium tremens. If a patient is experiencing moderate or severe withdrawal symptoms he/she should be treated with a cross-reacting sedative, typically chlor diazepoxide (Librium®) or diazepam (Valium®) if the patient can’t. The most important factor is mediating the patient early in the course of withdrawal. Once a patient goes into DTs, there may be little to be done other than supportive care while the condition progresses through its normal 3-day course.

FORMULATION AND IMPLEMENTATION OF A TREATMENT PLAN

Once the acute phase of alcohol withdrawal is resolved and the patient is cognitively clear, an individualized treatment plan should be implemented. The fundamental goal of treatment is to reduce the frequency and severity of alcohol abuse through a program of complete abstinence. The treatment plan must also address remediing the consequences of alcohol abuse, including physical, psychological, family, social and vocational dysfunction.

Successful treatment of alcohol abuse requires the development of a therapeutic alliance. The patient must be able to trust that the therapist and the program will be available during the process of recovery. Intensive therapy (i.e., inpatient rehabilitation) cannot compensate for the lack of a therapeutic alliance. In their most recent practice guideline, the APA indicates that research evidence supports the use of cognitive behavioral therapies (CBT), motivational enhancement therapy (MET), behavioral therapies, 12-step facilitation (TSF), interpersonal therapy (IPT), self help manuals, brief interventions, case management, group therapy and family therapy in the treatment of alcohol dependence. There remains, however, considerable debate as to the most appropriate treatment setting for early recovery. Many treatment providers advocate for residential treatment. However, there is little evidence that residential treatment results in outcomes superior to treatment in an intensive outpatient treatment (IOP) for the majority of patients. Therefore, residential care should be restricted to individuals who have failed at outpatient treatment, including both IOP and partial hospitalization programs. The support of family/friends and self help groups should be sufficient to maintain individuals exhibiting minimal commitment to abstinence and high degrees of craving between outpatient visits. Refer to CSAT publication, Intensive Outpatient Treatment for Alcohol and Other Drug Abuse for the particulars of an IOP.

The treatment of individuals with no social support, no vocational skills, and who live in an environment conducive to relapse is particularly problematic. The therapist’s goal is to protect the patient while the individual works through early recovery. Referral for long-term halfway house treatment for these patients is...
preferable to short-term residential care since little can be expected to change in
the patient's home environment while he is in short-term treatment.

Since alcohol abuse is a chronic, relapsing condition, all patients should receive
continuing support. For many this will involve transition to self-help groups and
other community support. However, others will need to build new support
systems to supplant the time and effort previously expended on substance
abuse. For many patients this involves increasing the significance of religion or
spirituality in their lives.

COMORBID MENTAL ILLNESS

Whether primary or secondary, a diagnosable mental illness in addition to
alcohol abuse results in a poorer prognosis and requires more complicated
treatment. Dual diagnosed patients fall into two broad categories: those with
serious and persistent mental illness, usually a psychotic disorder, and those
with less severe illnesses such as anxiety or depression.

Patients with serious mental illness should be case managed by individuals with
specialized skills in the dually diagnosed patient. Treatment is geared toward
controlling the psychosis with medications (frequently requiring depot
antipsychotics to increase compliance) while simultaneously providing:

- continuing monitoring of alcohol abuse,
- early intervention in the event of relapse, and
- ongoing support in an environment that tolerates individuals with
- serious mental illness.

Alcohol abusing patients who suffer from anxiety and depression represent a
unique therapeutic challenge. Since anxiety and depression are a consequence
of alcohol, the therapist must decide how long to wait in the process of recovery
before recommending pharmacological intervention for these conditions. When
recommending medications, the therapist must consider the possible harmful
consequences to the patient who abuses prescription drugs or mixes the
medications with other drugs of abuse. In the absence of clear guidelines,
psychoactive medications should only be prescribed if:

- the patient is significantly incapacitated by the symptoms or the
  symptoms clearly predate the onset of substance abuse,
- the prescriber is highly knowledgeable about the signs and
  symptoms of alcohol abuse,
- the prescriber carefully monitors the individual in conjunction with the
  alcohol counselor, and
- the prescriber limits the amount of medications prescribed at any
given time.

INTENT

This practice guideline is not intended to be construed or to serve as a standard
of medical care. Standards of medical care are determined on the basis of all
clinical data available for an individual case and are subject to change as
scientific knowledge and technology advance and patterns evolve. These
parameters of practice should be considered guidelines only. Adherence to
them will not ensure a successful outcome in every case, nor should they be
construed as including all proper methods of care or excluding other acceptable
methods of care aimed at the same results. The practitioner, in light of the
clinical data presented by the patient and the diagnostic and treatment options
available, must make the ultimate judgment regarding a particular clinical
procedure or treatment plan.

REFERENCES

These guidelines were adapted from the American Psychiatric Association's
practice guidelines [American Psychiatric Association: Practice Guidelines for
the Treatment of Patients With Substance Use Disorders: Alcohol, Cocaine,
Opioids. Am J Psychiatry 1995; November suppl] and [Practice
Guidelines for the Treatment of Patients with Substance Abuse Disorders. Am J
Psychiatry 2006; 163:8 (suppl) and subsequently modified by consensus among
a stratified sample of MHNet providers and clients. The reader is referred to the
original articles for detailed references (481) as well as the work group that
prepared the APA guidelines.

Detoxification protocols can be found in: Substance Abuse and Mental Health
Services Administration: Treatment Improvement Protocol Series # 19,
"Detoxification from Alcohol and Other Drugs," U.S. Department of Health and
Human Services, Rockwall II, 5600 Fishers Lane, Rockville, MD 20857.

Particulars of IOP programs can be found in: Center for Substance Abuse
Treatment: Treatment Improvement Protocol Series # 8, "Intensive Outpatient
Treatment of Alcohol and Other Drug Abuse," U.S. Department of Health and
Human Services, Rockwall II, 5600 Fishers Lane, Rockville, MD 20857.