Correspondence

Addressing alcohol addiction: lessons from a hospital based audit

Sir,

Alcohol addiction, a chronic relapsing disorder, is a fast growing public health problem in India. The production, availability, consumption and drinking patterns of alcohol have all undergone phenomenal changes in India and have been influenced by the combined effects of globalization, market forces, changing government policies, media promotion and also changing values of Indian society¹. Moreover, a large proportion of current alcohol users have hazardous or probably dependent patterns of alcohol use^{2,3}. At the same time, evidence from research suggests that some sections of the population such as younger onset drinkers, those with high family history of alcoholism, impulsivity, hyperactivity, *etc.* are more vulnerable to develop addiction¹.

In contrast to the need, the resources available to tackle this are abysmally inadequate. Most of the government funded treatment centres are defunct and the rates of help-seeking in these centres are the lowest in States with the highest prevalence of alcohol use^{4,5}. This situation exists despite encouraging results from literature that support better outcomes with pharmacotherapy and continued care coupled with brief counselling⁶⁻⁸. In this background, we conducted this retrospective chart review to understand the follow up pattern of patients with alcohol addiction attending a tertiary care neuropsychiatry hospital in Bangalore, South India.

The study was conducted at NIMHANS (National Institute of Mental Health and Neurosciences), Bangalore, after formal clearance from the institutional ethics committee. NIMHANS is a state run, public funded tertiary care neuropsychiatry hospital. On an average, 120 new patients seek help for emotional/ psychiatric problems every day throughout the year. At the first visit, a brief evaluation is done by a general duty medical officer and the case is referred to the psychiatrist following which appropriate treatment is initiated. On an average around 10 to 15 patients are evaluated in detail per day at the outpatient clinic. Once evaluated, patients are advised to come for follow up regularly *i.e.* at least once in two months irrespective of patient's condition (six visits in a year). This is essential in view of the relapsing and recurring nature of alcohol dependence. Further details of methodology have been described elsewhere⁹.

For this study, cross-sectional data of one year (2005) were collected. Patients who were evaluated in detail a year back and details were documented in the record, formed part of the study. Statistical analysis was done using SPSS 13 for Windows v. 13.0, USA.

As per (International Classification of Mental & Behavioural Disorders) ICD 10¹⁰, 17 per cent (N=464) of the total patients (N=2735) seen in detail in one year fulfilled criteria for alcohol dependence. A majority of patients (97%) were Hindus (419, 90.3%), males (45.3, 97.6%) and married (337, 72.6%). Mean age at the time of seeking treatment was 38.1 SD 9.91 years. Approximately 90 per cent of the patients consulted directly for alcohol addiction and were accompanied by family members. On an average, a person took twelve years (12.4 ± 7.8) between the possible development of dependence and consultation. A history of withdrawal seizure was present among 46 (10%) patients. Family history of alcohol use disorder *i.e.* likely dependence was present in 215 (46%) cases. The co-morbidities were 13 (6%) for affective and 6 (3%) for psychotic disorders. Diazepam (177, 38.1%) was the commonest agent used for management of withdrawal symptoms followed by lorazepam (98, 21.1%). About half (251, 54%) of the patients received long term medications for relapse prevention.

During the one year follow up period, 50 per cent patients did not come for follow up where as 30.6 per cent came for at least one follow up. Patients who came for two and three follow ups were 14 and 5.4 per cent respectively (Table). There was no information about the patients who had not come for treatment. Also it was observed that those who had a minimum of three follow ups were doing significantly better (P<0.001) (abstinent or reduced drinking) than those who had never reported for follow up. Around 60 per cent of the patients who visited at least once in year had either remained abstinent or had reduced drinking.

The study showed that a substantial number of consultations to psychiatric services were primarily for alcohol addiction (17%) which is comparable to that of psychotic disorders (21%) and anxiety disorders (14%)⁹. For the majority, this was the first contact at a health care setting for addressing alcohol use and there was a substantial delay in seeking help. Diazepam was the most commonly used drug for withdrawal management. The use of diazepam for alcohol withdrawal management is in line with the existing literature. Long acting drugs

Table. Profile of patients included in the present study	
Age at the time of presentation (yr)	38.1 ± 9.91
Age at onset of alcohol dependence (yr)	25.9 ± 6.96
Gender (%)	
Male Female	97 3
Monthly income (₹)	
<2000 >2000	70% 30%
Marital status (%)	
Married Single	72.3 27.7
Family history of alcohol dependence (%)	46
Long term medication to prevent relapse	Acamprosate (n=106; 44.3%) Disulfiram (n=68; 28.5%) Naltrexone (n=26; 10.2%) Ondansetron (n=24; 9.4%) Topiramate (n=19; 7.5%)
Follow up in one year (%) No follow up One follow up Two follow ups Three and more follow ups	50 (n=236) 30.6 (n=142) 14 (n=65) 5.4 (n=21)

like diazepam and chlordiazepoxide are preferred for smooth recovery from alcohol withdrawal¹¹. For long term relapse prevention, acamprosate, an anti-craving agent was the most commonly prescribed drug (44.3%) compared to disulfiram, an aversive agent (28.5%). This is in contrast to previous reports where disulfiram was the most commonly prescribed medication for alcohol dependence^{12,13}. This change might be a reflection of a better neurobiological understanding of alcohol addiction thereby increasing the use of newer anticraving drugs like acamprosate, naltrexone topiramate, etc^{14} .

One of the major findings of this study was that almost half of the patients did not return after the first contact with the hospital services. In normal circumstances, a patient is advised to visit for at least four to six times in a year. Studies done in India have reported variable follow up rates. Studies from a private hospital at Goa, reported retention rates close to 95 per cent after a year^{15,16}. The above study was primarily a pharmacological intervention study and patients were advised to come weekly for three months and thereafter fortnightly for the rest of the year along with a family member for counselling. The study population was highly educated, had higher income and a stable family member who could accompany them to the treatment network¹⁵⁻¹⁷. In contrast, the patients in our study were poor, often illiterate, and could not afford to come so frequently for hospital visit. Studies from a specialized addiction treatment centre reported that more than 50 per cent attrition occurred after three months of initial contact. The admitted patients reported to have better follow up rates compared to outpatient treatment¹⁸.

In view of the magnitude of the problem and its chronic nature, it is only expected that interventions for persons with significant and refractory dependence produce only a limited impact. Studies done in community based and hospital based settings have shown the effectiveness of continued care in predicting improved outcome in alcohol dependence⁶. In this context, the role of the primary care physician in early identification of alcohol abuse is very important. This will reduce the delay in seeking help and possibly prevent the development of addiction which is chronic and needs specialized care. It is during this window that primary health care physicians can effectively intervene. Thus, there is a need to train doctors to identify and manage alcohol use disorders. Guidelines have been developed for alcohol use disorders at primary, secondary and tertiary care levels¹⁹. At the same time, there is a need for an effective and coherent responses and policy shifts by the government to tackle this public health problem and limit the number of persons going on to develop dependence. Public measures like strictly reducing the age limit of alcohol intake, education about safe drinking, discouraging the initiation to drink particularly in individuals at high risk (*e.g.* family history of alcoholism), restriction of advertising and promotion of alcohol, timings of alcohol sale and location of outlets might help in the long run to prevent as well as minimize this problem¹.

Our retrospective study had limitations. Cases included were from all adult psychiatry units and not exclusively from the specialised addiction treatment services. It has not been possible to ascertain reasons for drop out, confirm compliance to medication, *etc.* all of which may have been possible in a prospective study. But it still provides an understanding of the burden from alcohol addiction, emphasises the need for early identification and intervention, and the need for training primary health care service providers to effectively assess and manage alcohol dependence in primary health care settings.

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