RCGP ACCREDITED

Ask About Alcohol

Module 3: Diagnosing and treating alcohol dependence

There is a spectrum of severity for alcohol dependence. It is not solely defined by the quantity of alcohol consumed or physical symptoms such as tolerance and withdrawal.[1]

Amongst the patients that you see every day there are likely to be some hidden alcohol dependent patients – most likely mild-moderately dependent drinkers. Many of these patients can be identified and treated in both primary and secondary care. Not all patients will require referral to specialist or secondary services.[2]

When to consider alcohol dependence

The following patients require further diagnostic evaluation for possible alcohol dependence.[3]

- Patients who fail to respond to brief advice or an extended intervention
- Patients who score 20 and above on full AUDIT

Diagnosing dependence using ICD-10

The WHO International Classification of Diseases defines a diagnosis of alcohol dependence as: when any three or more of the following criteria have been present simultaneously during the past year.[1]

Cognitive/Behavioural	Consequences	Physiological
1. A strong desire or compulsion to take alcohol	3. Neglect of alternative interests due to alcohol use	5. Tolerance
2. Difficulties in controlling the use of alcohol	4. Persisting with alcohol use despite evidence of harmful consequences	6. Withdrawal symptoms

Severity of dependence

NICE classifies alcohol dependence into three broad categories[4]:

mild dependence moderate dependence severe dependence

More than 80% of those in the UK with alcohol dependence are thought to be **mildly dependent**.[5]

SADQ

To understand more about a patient's severity of dependence on alcohol, it may be useful to use the Severity of Alcohol Dependence Questionnaire, which NICE recommends.[4]
The SADQ includes questions relating to the physical and psychological withdrawal symptoms, relief drinking and frequency of alcohol consumption which may be associated with alcohol dependence.

SADQ scores

15 or less: Mild dependence. In the majority of cases, these patients do not usually require assisted alcohol withdrawal and can therefore be managed in primary care.

16 to 30: Moderate dependence. These patients may need to be referred to specialist or secondary services for assisted alcohol withdrawal.

31 or more: Severe alcohol dependence. These patients should be urgently referred to specialist services.

Clinicians should use their clinical judgement to adjust the threshold for certain patients, such as women, older people and those with liver disease.[4]

Treatment goals
NICE discusses two treatment goals; abstinence or reduction of consumption to lower risk levels also known as moderate drinking.

Abstinence is recommended for most people who have **moderate to severe** alcohol dependence and **significant co-morbidities.**

Reduced drinking may be appropriate for patients with **mild alcohol dependence** and no **significant co-morbidities**.

Treating mildy dependent patients in Primary Care
Patients who have mild alcohol dependence, without significant co-morbid conditions, and who don't require a medically assisted withdrawal, do not usually need to be referred to specialist services. They can be effectively managed in primary care.

Setting appropriate treatment goals is key to the successful management of alcohol dependence.

Patients are more likely to remain engaged in treatment when they are given more than one treatment option as well as a degree of responsibility and control over treatment decisions.[6]
Many patients do not enter treatment for alcohol dependence, because they are not ready to stop drinking alcohol altogether.[7]

Supporting alcohol dependent patients is **much like the management of other chronic conditions in primary care**, for example overseeing smoking cessation and supporting other long-term conditions such as diabetes or obesity.
Psychosocial support is the backbone of an effective management strategy for alcohol dependence in primary care; using motivational interviewing techniques, applying the FRAMES principles (discussed in Module 2) and collaborating with your patient to achieve mutually agreed goals.[8]

NB: The RCGP have accredited video modules 1 to 3 as an educational resource.

www.alcoholreduction.co.uk/ask
A video series for primary care

Provided by Lundbeck Ltd
in association with the
Ask About Alcohol resource

Lundbeck

1. WHO. ICD-10, F10–F19 Mental and behavioural disorders due to psychoactive substance use
2. Babor T F et al. AUDIT: The Alcohol Use Disorders Identification Test. Guidelines for Use in Primary Care. Second Edition. World Health Organization (WHO) 2001
3. NICE Public Health Guideline 24
4. NICE clinical guideline 115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence February 2011
5. National Treatment Agency for Substance Misuse. Alcohol Treatment in England 2011-2012. January 2013
6. Ambrogne JA. Reduced-risk drinking as a treatment goal: what clinicians need to know. J Subst Abuse Treat 2002; 22 (1): 45–53
7. Aubin HJ, Daeppen JB. Emerging pharmacotherapies for alcohol dependence: a systematic review focusing on reduction in consumption. Drug Alcohol Depend. 2013; 133 (1): 15-29
8. Henry-Edwards S, et al. Brief intervention for substance use: a manual for use in primary care (draft 1.1). Geneva, WHO, 2003.