

# Chapter 3. Screening, assessment and treatment planning



## 3. Screening, assessment and treatment planning

**This chapter provides clinical guidance about the role, and implementation of screening methods for people with potentially excessive alcohol consumption, clinical guidance about the comprehensive clinical assessment of problem drinkers, and an overview of treatment planning. It also alerts medical professionals to commonly encountered clinical problems.**

### Screening

Screening aims to identify people with risky or harmful patterns of alcohol use and initiate appropriate interventions. Screening facilitates identification of problem drinkers who may require comprehensive clinical assessment and targeting of brief, time-limited interventions aimed at reducing consumption for those with risky drinking patterns. Screening methods have been evaluated in a wide range of settings.

#### Where to screen

Screening should be conducted in settings where the prevalence of risky drinkers is likely to be highest and where detection will have the greatest salience for both the health care worker and the drinker. The settings appropriate for screening are:

- general practice and relevant specialist settings
- hospital settings, including emergency, mental health and general wards
- welfare and general counselling services
- the workplace.

The order of these settings reflects their probable effect; medical settings are most likely to show a high rate of identification.

#### General practice and relevant specialist settings

In routine general practice, without specific screening techniques, up to 70 per cent of risky and/or high risk drinkers are not detected. Australian evidence shows that screening and early intervention in primary care settings is cost-effective. Detection and brief intervention activities should be encouraged in general and relevant specialist medical practices. Because of their role in primary health care and their high rate of contact with the general public, general practitioners are ideally placed to detect and offer patients help with drug and alcohol problems.

Examples of initiatives to encourage screening in general practice settings include the Smoking, Nutrition, Alcohol and Physical Activity (SNAP) framework for general practitioners (University of New South Wales) and the Drink-Less package (University of Sydney).

Screening and brief interventions (see Chapter 4) are feasible in specialist settings where prevalence of alcohol use is high, such as drug and alcohol treatment services and sexual health services.

### **Hospital settings, including emergency, mental health and general wards**

Alcohol use disorders are typically detected in only 25 per cent of hospitalised patients who have alcohol problems. All general hospitals should have routine screening procedures in place for excessive alcohol consumption among inpatients and outpatients, and procedures for appropriate interventions. As well, all hospitals should have in place routine procedures for facilitating follow-up in the community following discharge. The major benefits of such procedures may lie in earlier recognition, prevention and treatment of alcohol withdrawal and alcohol-related medical toxicity.

Screening procedures should be followed by appropriate hospital-based interventions and referral into the community, as necessary. Patients may be receptive to interventions addressing alcohol use following hospital presentation.

Hospital-based interventions may include:

- brief interventions delivered by general hospital medical, nursing and allied health professionals
- management of withdrawal, intoxication, and other alcohol-related medical morbidity.

Referral should include a letter to the referring general practitioner and other referral services, providing feedback about the level of risky consumption and advising the need for ongoing monitoring and further intervention.

Strategies to increase the detection rate in the hospital setting include:

- undergraduate and postgraduate multidisciplinary training
- system redesign incorporating systematic electronic recording of alcohol consumption data, or equivalent paper-based information systems
- specialist drug and alcohol consultation liaison services within all hospitals.

### **Welfare and general counselling services**

Screening in welfare and counselling services offers the opportunity for problem identification and referral for intervention. It is likely in a significant proportion of cases that excessive alcohol intake has contributed to the presenting problem (relationship, financial, parenting, mental health, employment, violence, housing).

A structure needs to be developed in welfare and counselling settings where such screening would occur routinely. However, there are significant barriers and few incentives to implement screening activities in these settings.

### **The workplace**

Evidence of high rates of problem drinking in some workplace settings suggests it is a suitable venue for detection of risky drinking and intervention. Such screening and intervention has the potential to increase the health and safety of workers, and limit hazards and accidents in the workplace.

Detection of unsafe alcohol consumption should form part of any routine health evaluation in the workplace. Workplace occupational health and safety procedures should identify appropriate strategies and referral options for those workers identified as having alcohol-related problems. Young male drinkers, who are less likely to attend primary care settings,

may be screened in the workplace. Alcohol may also be detected through occupational breath test screening; in which case, the individual should be offered referral for assessment by a clinician with expertise in diagnosis and management of alcohol use disorders. Those with alcohol use disorders should be offered treatment, as described in these guidelines.

| Recommendation  | Strength of recommendation | Level of evidence |
|---|----------------------------|-------------------|
| 3.1 Screening for risk levels of alcohol consumption and appropriate intervention systems should be widely implemented in general practice and emergency departments. | A                          | Ia                |
| 3.2 Screening for risk levels of alcohol consumption and appropriate intervention systems should be widely implemented in hospitals.                                  | D                          | IV                |
| 3.3 Screening for risk levels of alcohol consumption and appropriate intervention systems should be widely implemented in community health and welfare settings.      | D                          | IV                |
| 3.4 Screening for risk levels of alcohol consumption and appropriate intervention systems should be widely implemented in high-risk workplaces.                       | D                          | IV                |

### How to screen

The methods for detecting risky drinkers include:

- asking the person about their alcohol consumption (quantity–frequency estimates)
- using screening questionnaires
- physically examining the person for intoxication or signs of harmful use of alcohol
- observing the biological markers of excessive alcohol consumption.

Evaluation of all methods suffers from the absence of a 'gold standard' against which they can be tested. The approaches used to detect people with risky drinking patterns vary considerably across settings. In some settings routine screening of all patients is recommended, in others this may not be feasible. Under such circumstances, it is important to identify alcohol use disorders where they are relevant to the presenting problem.

### Asking the person about their alcohol consumption (quantity–frequency estimates)

A quantitative alcohol history can be a reliable method of detecting risky patterns of alcohol consumption. Such a history comprises:

- the daily average consumption (grams per day or standard drinks per day) of alcohol
- the number of drinking days per week (or month).

Where use exceeds that recommended in the NHMRC guidelines, a more detailed assessment is indicated to exclude harmful use and/or dependence.

For socially stigmatised behaviours, the health professional's interviewing style is important, and includes:

- taking a non-judgmental approach, normalising alcohol use (for example, asking about a range of lifestyle factors including nutrition, tobacco use, caffeine intake, alcohol use)

- taking a 'top down' approach (for example, suggesting a level of drinking that is higher than expected so the patient is more likely to feel comfortable admitting the real level of drinking by bringing the estimation down to the correct level).

It is important to carefully interpret language. For example, if a patient says he has had 'a drink', this might mean one standard drink or a night of heavy drinking. Quantitative measures should replace non-specific terms, such as a 'social drink'.

| Recommendation  | Strength of recommendation | Level of evidence |
|---|----------------------------|-------------------|
| 3.5 Quantity–frequency estimates is the recommended way to detect levels of consumption in excess of the NHMRC 2009 guidelines in the general population. | D                          | IV                |

### Using screening questionnaires

One established method for detecting people with risky drinking habits is that of using a standard questionnaire. Many questionnaires have been designed to screen for alcohol dependence, but only a few have been devised specifically to detect risky drinkers who may be non-dependent. A comprehensive list of the available instruments for research use has been published (see Review of the Evidence).

Although none have been evaluated in relation to the current NHMRC guidelines, the recommended instruments are the Alcohol Use Disorders Identification Test (AUDIT) or related versions, such as AUDIT-C and AUDIT-3, for general populations, and the T-ACE or TWEAK for pregnant women.

### Alcohol Use Disorders Identification Test

The World Health Organization developed the AUDIT questionnaire, which is designed to detect people with risky alcohol consumption (see Appendix 1). AUDIT consists of ten questions that represent the three major conceptual domains of intake (Questions 1 to 3), dependence (Questions 4 to 6) and problems (Questions 7 to 10). It effectively distinguishes between risky and non-risky drinkers, identifies dependent drinkers, and has cross-cultural validity. It is short (10 items), may be self-administered, and is suitable for primary health care settings.

AUDIT has demonstrated validity among a wide range of patient populations, including primary care adolescents, drug-dependent patients, cross-cultural groups, drink–drivers, emergency ward patients, and psychiatric patients. AUDIT performs as well as the Michigan Alcoholism Screening Test (MAST) and the CAGE for identifying dependent drinking, and has higher sensitivity and specificity for harmful drinking.

A shortened version of AUDIT – AUDIT-C – consists of only alcohol consumption Questions 1 to 3 (Table 3.1). It has been used successfully with male Veterans' Affairs patients to screen for heavy drinking and in primary care setting for identifying alcohol misuse. Score of 5 or more indicates further assessment is required.

Table 3.1: AUDIT-C

| 1. How often do you have a drink containing alcohol?                                      |                   |                   |                  |                        |
|---|-------------------|-------------------|------------------|------------------------|
| Never   | Monthly or less   | 2–4 times a month | 2–3 times a week | 4 or more times a week |
| (0)   | (1)               | (2)               | (3)              | (4)                    |
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking? |                   |                   |                  |                        |
| 1 or 2  | 3 or 4            | 5 or 6            | 7 to 9           | 10 or more             |
| (0)   | (1)               | (2)               | (3)              | (4)                    |
| 3. How often do you have six or more drinks on one occasion?                              |                   |                   |                  |                        |
| Never   | Less than monthly | Monthly           | Weekly           | Daily or almost daily  |
| (0)   | (1)               | (2)               | (3)              | (4)                    |

The third question of the AUDIT taken alone (AUDIT-3) has been shown to have almost as good sensitivity and specificity as the longer forms.

### MAST and CAGE questionnaire

Instruments such as the MAST and the CAGE questionnaires (see Appendix 1) were devised for their ability to distinguish chronic alcohol dependent people from non-alcohol dependent people. While their performance is good, in that 95 per cent or more of chronic alcohol dependent people are detected, they are much less effective in detecting people with less severe drinking problems. Because of this limitation they are not advocated for screening in primary care settings.

### Other questionnaires

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is a useful screening questionnaire, recommended by the World Health Organization, which includes alcohol with other substances (see Chapter 10 and Appendix 1).

A number of other screening instruments have been developed to overcome the limitations of existing inventories. These are most useful for research rather than clinical settings and are not considered further in these guidelines.

| Recommendation   | Strength of recommendation | Level of evidence |
|--|----------------------------|-------------------|
| 3.6 AUDIT is the most sensitive of the currently available screening tools and is recommended for use in the general population. | A                          | I                 |

### Screening for alcohol use in pregnant women

Evolving Australian and international guidelines recommend minimal to no alcohol during pregnancy. The NHMRC advises that it is safest to consume no alcohol during pregnancy (NHMRC 2009). The low levels of consumption highlighted as a concern in recent guidelines cannot be identified using current questionnaires. A clinical history to estimate the quantity and frequency of alcohol use is the preferred method.

In light of the potential for adverse effects on the foetus, screening for alcohol use should be included in the usual antenatal history. All pregnant women should be asked about their level of alcohol consumption.

### TWEAK and T-ACE questionnaires

Two screening instruments – TWEAK and T-ACE – have been developed for use with pregnant women. Both identify levels of drinking associated with a significant risk of foetal alcohol-related harms and, until new tools are developed to better reflect the NHMRC 2009 guidelines, can be recommended for use in this population.

TWEAK is a modified five-item version of MAST (see Appendix 1) and has five items; a score of two or more suggests the patient is drinking at risky levels. Further assessment should be recommended.

T-ACE consists of three CAGE questions and a tolerance question (see Appendix 1). It is quick and easy to administer; a score of two or more indicates the patient may be drinking at risky levels, and should be further investigated.

Both T-ACE and TWEAK are more specific and sensitive than either MAST or CAGE in identifying risky drinking levels.

All pregnant women should be made aware of the current recommendations relating to alcohol use during pregnancy. If alcohol use continues, a full assessment of alcohol intake and any adverse effects should be undertaken and appropriate referrals should be made. It is appropriate to reassure pregnant women drinking minimal amounts of alcohol (for example, 1–2 standard drinks per week without escalation to higher amounts) that there remains no evidence this is harmful.

The ASSIST questionnaire that screens for alcohol and other substances can also be used in this population (see Chapter 10 and Appendix 1).

See Chapter 9 for more information.

| Recommendation  | Strength of recommendation | Level of evidence |
|---|----------------------------|-------------------|
| 3.7 In pregnant women, quantity–frequency estimation is recommended to detect any consumption of alcohol. 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. | D                          | IV                |

### Physical examination for intoxication or signs of harmful use of alcohol

Clinical presentations related to alcohol use cover a diverse spectrum, varying across health and welfare settings: a characteristic is multiplicity of problems across these domains. Common examples of potentially alcohol-related presentations include:

- mental health problems, such as depression, anxiety, suicidal ideation, insomnia
- social problems, including work, financial, marital and relationship, domestic violence
- medical conditions, such as trauma, liver disease and seizures.

Common physical indicators of excessive alcohol use include hypertension, dilated facial capillaries, bloodshot eyes, hand or tongue tremor, gastrointestinal disorders (duodenal ulcers, pancreatitis, liver cirrhosis), cognitive deficits, a pattern of accidents, signs of alcohol intoxication. These clinical features are not conclusive, however, and their absence does not rule out the existence of risky alcohol consumption.

Patients presenting with such problems should be screened for alcohol use, and if appropriate, proceed to a more comprehensive assessment. General practitioners and other health and welfare workers encountering these presentations should have screening systems in place.

## Biological markers of excessive alcohol consumption

Biological markers of excessive alcohol use include direct measures of alcohol (for example, alcohol in breath or blood) and a range of indirect indices such as liver enzymes activity, the levels of carbohydrate-deficient transferrin, characteristics of blood erythrocytes (for example, mean corpuscular volume) and others.

### Measures of alcohol levels

Measures of alcohol concentration (in breath and blood) are important when screening for alcohol use in occupational and other settings. They are useful indicators in emergency departments and in outpatient clinics to confirm recent alcohol use and to assess suspected intoxication. Alcohol breath tests are less invasive and are widely used in roadside testing. The correlation between breath alcohol levels and intoxication may be affected by a range of factors and may require careful clinical interpretation.

| Recommendation   | Strength of recommendation | Level of evidence |
|--|----------------------------|-------------------|
| 3.8 Direct measures of alcohol in breath and/or blood can be useful markers of recent use and in the assessment of intoxication. | D                          | II                |

### Indirect markers

A number of indirect biological markers are used to detect alcohol consumption, namely:

- liver function tests
  - alanine aminotransferase (ALT)
  - aspartate aminotransferase (AST)
  - serum gamma-glutamyltransferase (GGT)
- carbohydrate-deficient transferrin (CDT)
- high-density lipoprotein cholesterol (HDL)
- mean corpuscular volume (MCV)
- uric acid.

Serum GGT, a liver enzyme, is the most useful of the currently available tests but has only moderate sensitivity and specificity. It is elevated in 30 per cent of patients with alcohol dependence in primary care and, depending on the clinical circumstances, 50 to 100 per cent of hospitalised patients with alcohol dependence. However, it is less likely to be raised in women and young people.

Elevated GGT levels are not specific for alcohol use where certain conditions exist. These conditions include:

- obesity (now the most common cause for elevated GGT levels in some populations)
- obstructive liver disease
- medications that induce hepatic cytochromes (such as anticonvulsants).

The carbohydrate-deficient transferrin test is not reimbursed by Medicare and is rarely used outside forensic settings. It has similar sensitivity to GGT but has a higher specificity.

Other biological markers (including acetaldehyde-protein adducts, fatty acid ethyl esters) are under investigation but are not yet available for routine clinical use. The other available laboratory tests are less sensitive: for example, an elevated mean corpuscular volume is found in only 5 to 20 per cent of alcoholic patients. The value of these tests in detecting non-alcohol dependent people with risky alcohol consumption is correspondingly lower.

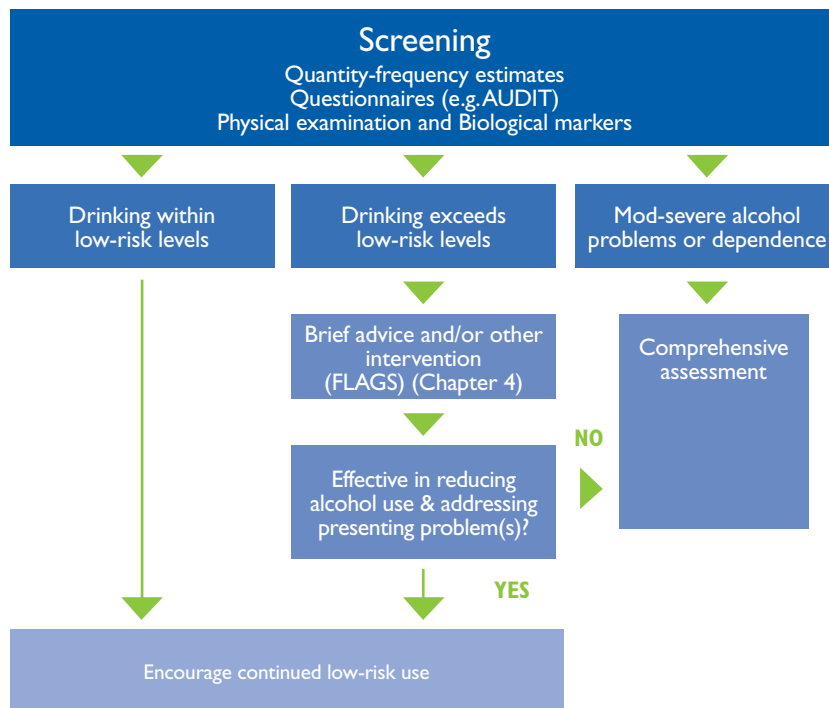
Combinations of tests have low specificity and cannot be used without further clinical evaluation.

Because of the greater sensitivity and specificity of questionnaire approaches (such as AUDIT) these are preferred to biological markers. Biological markers should only be used as an adjunct to other screening measures.

| Recommendation  | Strength of recommendation | Level of evidence |
|---|----------------------------|-------------------|
| 3.9 Indirect biological markers (liver function tests or carbohydrate-deficient transferrin) should only be used as an adjunct to other screening measures as they have lower sensitivity and specificity in detecting at-risk people than structured questionnaire approaches (such as AUDIT). | A                          | 1a                |

Patients drinking above low-risk levels (see NHMRC recommendations) should be offered a brief intervention. Those experiencing moderate to severe alcohol related problems, including dependence, require more comprehensive assessment and intensive treatment approaches (Figure 3.1)

Figure 3.1: Screening



## Comprehensive clinical assessment

It is important to conduct a clinical assessment before developing a comprehensive treatment plan for those drinkers who have:

- not responded to advice to reduce their consumption of alcohol
- severe alcohol-related problems
- asked for or need help to deal with their drinking.

Assessment should include diagnostic interviews, physical examination, investigation of clinical and biological markers, and gathering of collateral information about the patient. Assessment intensity and detail varies across settings; the amount of assessment relates to the level of specialisation in alcohol problems. The areas for assessment include:

- motivation to change
- alcohol consumption pattern and severity of dependence
- alcohol-related harms (such as physical and psychological health problems, relationship problems, occupational problems and legal problems)
- family factors
- cognitive functioning.

The need for comprehensive assessment must be balanced with the desire to engage and retain the patient in treatment. If the patient perceives that little or no progress is being made in the first sessions, their motivation to stay in treatment may wane. The assessment might be spread over several sessions, allowing some time in each session for setting preliminary treatment goals and working toward those goals. As more in-depth assessment occurs, these treatment goals and strategies may need adjustment. Assessment continues throughout treatment as the patient's progress is measured against the treatment goals.

From the first contact with the patient it is important to instil a sense of hope and a belief that change is possible. This is especially important in patients who have repeatedly tried to alter their drinking habits and failed. Self-efficacy (that is, the patient's belief that there is something they can do about their problem) is an important factor in treatment success. Self-efficacy may, in turn, be influenced by the therapeutic relationship (see Chapter 6).

### Purpose of assessment

Assessment has three important functions, namely:

- **To help the patient and clinician identify shared treatment goals and develop a treatment plan.**

Different patients will need different approaches, as problem drinkers do not have a homogeneous group of problems. Any underlying or accompanying problems should be identified and addressed, even if the causal relationship is unclear. The treatment plan should be based on the most effective intervention for the patient, not just on the kind of treatment typically provided by the agency. The patient should be informed about the range of options for intervention available locally and assisted to make a reasoned decision as to which intervention is most suited to his or her needs (see 'Treatment planning' below).

- **To engage the patient in the treatment.**

This is an opportunity for the clinician and patient to develop rapport. If the clinician shows the patient empathy and courtesy and provides a sense of hope and optimism,

the patient is less likely to take a defensive stance in the interview, and resist change. Feedback from the clinician can encourage the patient to appraise their situation from a new perspective. Assessment can be defined as the beginning of therapy; it often reveals, for the first time, the full extent of the drinking-related problems to both patient and clinician.

- **To motivate the patient to change drinking patterns and related behaviour.**

The patient's perception of a gap between their goals and their present state may improve motivation for change. It is important to highlight the patient's perception of the opportunity for change; this requires the clinician to have a positive and realistic approach and a sympathetic understanding of the implications of change for the drinker and their family.

| Recommendation   | Strength of recommendation | Level of evidence |
|--|----------------------------|-------------------|
| 3.10 Assessment should include patient interview, structured questionnaires, physical examination, clinical investigations and collateral history. The length of the assessment should be balanced against the need to keep the patient in treatment and address immediate concerns. | D                          | IV                |

## Diagnostic interviews

The initial assessment should ideally take the form of an open-ended, semi-structured interview where the patient and the clinician compile a narrative history, using appropriate questionnaires if desired (see Table 3.2). This has the advantage of clinician involvement that is personal and responsive to the drinker, rather than mechanical and impersonal. Yet, it should maintain a purposeful structure so as to avoid a vague, directionless discussion of the drinker's history or rumination on a few aspects. Standardised questionnaires are not often used at this stage, but in selected cases a number of validated instruments may prove useful.

**Table 3.2: Matters to be covered in a comprehensive assessment**

|   |   |
|---|---|
| <b>Presentation</b>   | <ul style="list-style-type: none"> <li>• Presenting problems</li> <li>• Role of drinking/drug use in presenting problems</li> <li>• Motivation for presentation</li> <li>• Other concerns</li> </ul>  |
| <b>Alcohol and other drug use</b>                             | <ul style="list-style-type: none"> <li>• Quantity, frequency, pattern of drinking and other drug use (tobacco, illicit drugs, pharmaceutical drugs, injecting drug use)</li> <li>• Last use of alcohol and other drugs (time and amount)</li> <li>• Duration of drug and alcohol problems</li> <li>• Features of abuse or dependence. If dependent, assess likely withdrawal severity and previous withdrawal complications (seizures, delirium, hallucinations).</li> </ul>  |
| <b>Medical and psychiatric comorbidity</b>                    | <ul style="list-style-type: none"> <li>• Physical health problems (including liver, gastro-intestinal, trauma, cardiovascular, neurological, cognitive, endocrine)</li> <li>• Mental health problems (depression, anxiety, psychosis, suicide risk)</li> </ul>  |
| <b>Social circumstances</b>                                   | <ul style="list-style-type: none"> <li>• Social functioning (including relationship, employment, financial, housing, legal)</li> </ul>  |
| <b>Examination (by suitably trained health professionals)</b> | <ul style="list-style-type: none"> <li>• Physical examination (general examination, signs of intoxication or withdrawal, nutritional assessment, neurological function, gastrointestinal, cardiovascular)</li> <li>• Mental state examination (signs of intoxication or withdrawal, cognitive function, mood, motivation and insight)</li> </ul>  |
| <b>Motivation and treatment goals</b>                         | <ul style="list-style-type: none"> <li>• Goals of treatment (abstinence versus reduced drinking, other health concerns)</li> <li>• Involvement of other health and/or welfare professionals</li> <li>• Clinical risks and risk management plan (harm to self/others, serious physical or mental illness, driving, child protection, domestic violence, occupational concerns)</li> <li>• Treatment plan (need for brief interventions, controlled drinking strategies, detoxification, relapse prevention strategies, management of comorbidities)</li> </ul> |

Note: Comprehensive assessment may require more than one consultation, and involve gathering of additional information from clinical investigations and collateral history.

A complete assessment should evolve over two or more sessions as an ongoing part of the treatment. It should not be viewed as something that must be completed at the first visit and not revisited. Specific areas that need assessment include:

- level and history of alcohol consumption
- motivation
- dependence and alcohol-related harms
- physical wellbeing
- psychological and psychiatric disorders
- cognitive functioning.

While each area needs to be covered to ensure a comprehensive assessment, not every patient will need to be assessed extensively on each. In some cases, such a detailed assessment is unnecessary, as the status of the patient will be obvious. In other cases the information provided will allow the clinician to carry out a careful assessment of the important aspects.

The structure of clinical assessments differs between medical, psychological, nursing and other health professionals for a range of reasons and may need to be adapted to suit the environment in which it is being conducted. Structured diagnostic interviews are available but, due to their length, are not recommended for clinical practice; their use is limited to research and perhaps forensic settings (see also Review of the Evidence).

### **Assessing level and history of alcohol consumption**

The assessment should gather information about the patient's drinking history, including how the drinking pattern evolved, fluctuated and/or progressed over time. A quantitative alcohol history should be recorded in every case. This comprises:

- the daily average consumption (grams per day or standard drinks per day) of alcohol
- the number of drinking days per week (or month).

A number of studies have shown that in general, reproducible and relatively accurate information can be obtained from a well-taken alcohol history. Nonetheless, it is difficult to do with some patients. Based on cumulative population self-reporting, overall alcohol use is under-reported, but interviewing style can influence the accuracy of self-reporting.

Adopt a non-judgmental tone in asking about alcohol use. Generally, assume the patient does drink alcohol as a normal part of their lifestyle. It is useful for the clinician to use the 'top-down approach', suggesting a level of drinking that is higher than expected so the patient is more likely to be comfortable admitting the real level of drinking by bringing the estimation down to the correct level.

Language should be carefully interpreted; thus, the phrase 'a drink after work' may mean any number of drinks per drinking day, and any frequency of drinking from once a fortnight to every day. The community shows little recognition of a standard drink. This should be clarified in every case using an appropriate visual aid such as that shown in Appendix 9.

The assessment should include the patient's reconstruction of a typical drinking day and week, from the time of waking through all the day's activities. For example, the clinician might ask at what time the first drink is taken, where and with whom. The time spent drinking or the money spent on alcohol can be compared with the patient's estimate of the amount of alcohol consumed to test the accuracy of that estimation. Consumption can be linked to particular events, behaviours and times. An assessment of a typical day also gives information about the antecedents and consequences of drinking. This information can be incorporated into advice about relapse prevention. The clinician needs to distinguish between daily drinking and binge drinking where the weekly or monthly consumption is concentrated over several days and the patient is abstinent or drinks lightly at other times. The use of drink diaries or calendars may help clarify the patterns.

Several structured methods are available to perform this assessment, although they are not routinely used in clinical practice (for example, the quantity–frequency index and the retrospective diary are both reliable ways of identifying high risk levels and patterns of consumption. The 'timeline follow-back' method helps to obtain an accurate, retrospective account of alcohol consumption over a particular period, typically 3 months. These are time consuming but useful approaches to gaining detailed clinical information.

Other drug use, including smoking, use of sedative medications and illicit drugs, should also be assessed.

| Recommendation  | Strength of recommendation | Level of evidence |
|---|----------------------------|-------------------|
| 3.11 A quantitative alcohol history should be recorded. | A                          | I                 |

### Assessing motivation

Motivation to change is an important predictor of treatment outcome, so it is important to assess the drinker's level of motivation. Treatment planning should take motivational state into account so as to maintain and enhance motivation to control excessive drinking. For example, if there is a low level of motivation to change, motivational intervention may be helpful and intensive intervention is likely to be unhelpful (see Chapter 6 'Motivational interviewing').

#### Direct questioning

Perhaps the simplest way to assess a drinker's readiness to change is through direct questioning during the assessment interview. Questions should be asked with curiosity and a willingness to explore the patient's answers, not in a judgmental, confronting or adversarial way. This should be done after risky alcohol consumption has been discussed, and the patient has received feedback on their level of drinking. Some questions that might prove useful are:

- 'How interested are you in changing your drinking now?'
- 'Do you feel that you ought to stop drinking', or 'Do you want to stop drinking now?'
- 'What would you be prepared to do to solve this drinking problem?'
- 'How confident are you that you can achieve this?'

The patient may be encouraged to explore the various treatment options from the perspective of motivation to participate. Alternatively, the patient may simply be asked: 'How do you feel about your drinking at the moment?' Responses may vary from:

- Pre-contemplative responses such as, 'I'm happy with my drinking', 'I enjoy drinking', 'I'm not interested in stopping drinking'.
- Contemplative responses such as, 'I'm thinking about stopping', 'I'm not sure if I'm ready at the moment', 'I'm interested in weighing up stopping'.
- Action-oriented responses such as, 'I want to stop now', 'I may need some help', or 'The disadvantages of drinking outweigh the benefits for me'.

Several questionnaires have been validated to assess the drinker's readiness to change; they are the University of Rhode Island Change Assessment (URICA) scale, the Readiness to Change Questionnaire (RTCQ) and the 32-item Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). These are generally reserved for research use.

It would be counterproductive to over-emphasise the assessment of motivation, as the expressed level of motivation does not predict outcome in every case. The stages of change model – also known as the trans-theoretical model – is widely quoted but may oversimplify the concept of motivation. The stages of motivation are not mutually exclusive and may fluctuate quickly. There is little evidence of sequential movement through discrete stages. Many patients express highly selective motivation; that is, they may want to stop drinking, but not see a clinician.

Finally, ambivalence is a key characteristic of the risky drinking population, characterised by simultaneously being motivated in apparently opposing directions. For example, a patient may say that he still enjoys drinking but acknowledges he has been advised to abstain. Hence, it is not surprising that there is evidence that greater expressed readiness to change is not always predictive of reduced alcohol consumption.

| Recommendation   | Strength of recommendation | Level of evidence |
|--|----------------------------|-------------------|
| 3.12 Motivation to change should be assessed through direct questioning, although expressed motivation has only a moderate impact on treatment outcome | B                          | II                |

### Assessing dependence and alcohol-related harms

When assessing the patient's dependence on alcohol and the related harms he may be consequently suffering, clinicians should examine:

- the severity of dependence
- the consequences of drinking
- previous experiences of abstinence and treatment.

#### Severity of dependence

The measurement of the degree to which a drinker is dependent upon alcohol allows the clinician to plan treatment goals and interventions. The severity of dependence provides an indication of the risk of withdrawal and might also provide some initial indication of how intense the treatment program needs to be. For example, a person who is more alcohol dependent may be less able to achieve controlled drinking.

Table 3.3 shows the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, (DSM-IV-R) and the International Classification of Diseases (ICD-10) criteria for alcohol dependence and abuse syndromes (see also Appendix 2).

**Table 3.3: How dependent on alcohol is your patient?**

| Features common to both sets of criteria | ICD-10  | DSM-IV-R  |
|--|---|---|
| <b>Impaired control</b>                  | Subjective awareness of an impaired capacity to control drinking  | Drinking larger amounts or longer period than intended  |
| <b>Craving/compulsion</b>                | Awareness of a strong desire or sense of compulsion to drink craving  | Persistent desire or unsuccessful attempts to cut down  |
| <b>Drinking 'taking over' life</b>       | Preoccupation with drinking to the neglect of other responsibilities or interests                             | Much time spent seeking alcohol, drinking, or getting over alcohol's effects<br>Important social or work activities reduced or given up |
| <b>Tolerance</b>                         | Tolerance – increased amounts of alcohol are required in order to achieve the desired effects                 | Increased drinking to achieve the same effect   |
| <b>Withdrawals or withdrawal relief</b>  | Withdrawal symptoms on cessation or reduction of alcohol intake; or using alcohol to relieve or prevent these | Withdrawal signs or symptoms, or drinking to relieve or prevent these   |
| <b>Persistent use despite harm</b>       | Persistence of alcohol use despite clear evidence of overtly harmful consequences                             | Use despite physical or psychological consequences  |

Notes: Dependence is indicated if three or more criteria are met. ICD-10 – International Classification of Diseases; DSM-IV-R – *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision.

Source: Reproduced by permission of Oxford University Press, Table 4.4 (p. 78) from chapter 'Alcohol' in Latt, N, Conigrave, K, Marshall, J, Saunders, J & Nutt, D (eds) 2009, *Addiction Medicine*, Oxford University Press.

Explore the patient's experiences of dependence, tolerance and withdrawal by asking the patient to describe the last two or three occasions on which they reached intoxication and the last two or three occasions when they did not become intoxicated. (Assessment of withdrawal is discussed in Chapter 5).

Three of the several questionnaires that measure alcohol dependence are included in Appendix 1, as are the shortened version of the Severity of Alcohol Dependence Questionnaire (SADQ-C), the Short Alcohol Dependence Data (SADD) questionnaire, the Severity of Dependence Scale (SDS) and the Alcohol Dependence Scale (ADS) (see also Review of the Evidence). These questionnaires can either serve as a checklist to help organise the clinician's questions or the patient can complete them during assessment.

### **Consequences of drinking**

The clinician should assess the range of problems the patient has encountered as a result of their drinking. In addition to physical and mental health, the patient's drinking may have led to family problems, detrimentally affected work performance, social relations or financial stability (Table 3.3). Alcohol-related offences such as drink-driving are also relevant. A specific crisis in one of these areas may have been the impetus for seeking help, and this should be explored.

Discussion of the 'less good things' about drinking can enhance the patient's readiness for change (see Chapter 6). Alcohol harms are usually assessed using unstructured clinical interviewing. The Alcohol Problems Questionnaire (APQ) is a reliable instrument that covers eight domains – friends, money, police, physical, affective, marital, children and work.

| Recommendation  | Strength of recommendation | Level of evidence |
|---|----------------------------|-------------------|
| 3.13 Assessment of the patient's alcohol-related problems, diagnosis and severity of dependence should be recorded. | S                          | –                 |

### **Previous experiences of abstinence and treatment**

It is important to characterise previous periods of abstinence or reduced alcohol use, whether they were voluntary or imposed, whether they were self-initiated or the result of treatment, whether the patient felt better as a consequence, and how those periods ended.

In parallel, it is important to understand previous treatment exposure as it helps plan future treatment, both in terms of what worked and what did not, as well as to clarify the patient's experiences and tolerances.

### **Assessing physical wellbeing**

According to the professional background and skills of the health professional, all patients' physical health should be assessed, including:

- medical history
- current physical symptoms
- use of medication
- current features of withdrawal or intoxication
- previous or current health problems related to drinking.

If any active medical issues are evident, it is appropriate to encourage the patient to see their general or other medical practitioner.

If no significant symptoms are evident, but alcohol history places the patient at risk of medical illness, medical referral for physical examination and blood tests should also be recommended. Medical practitioners should conduct a thorough medical assessment, including history, examination and clinical investigations. Physical examination should at least assess signs of intoxication or withdrawal, signs of liver disease, vital signs (temperature, blood pressure, pulse) and screen for organic brain damage.

The value of telling the patient the results of their medical examination and any clinical investigations cannot be over-emphasised. Discussion about the implications of abnormal liver function tests has been shown to reduce subsequent alcohol consumption. The advantages of feedback are less clear when medical tests show normal results. However, the assessment should allow patients to accurately consider the degree of their alcohol-related problems and normal medical results should not detract from this endeavour. Normal results can be examined within the context of a clinical interaction and is further discussed in Chapter 6.

| Recommendation   | Strength of recommendation | Level of evidence |
|--|----------------------------|-------------------|
| 3.14 Assessment for alcohol-related physical health problems should be routinely conducted. A medical practitioner should assess patients at risk of physical health problems. | S                          | –                 |

### Assessing psychological and psychiatric disorders

Psychological problems and psychiatric comorbidity – most commonly depression and anxiety – are more prevalent among alcohol-dependent people than the general population. It is essential to discover if psychiatric comorbidity and/or psychological problems are present in alcohol-dependent patients. Such problems can include:

- anxiety, depression, post traumatic stress disorder, psychosis
- suicidal ideations and past history of suicide attempts
- childhood issues, including sexual and physical abuse.

The presence of psychological problems requires mental-state examination by suitably trained clinicians and clinical assessment of mental symptoms. A targeted risk assessment of the possibility of harm to self and/or others, including children, should be performed. It is important that all clinicians in this area develop basic mental health skills and links with other relevant services to help manage these disorders.

Patients need to be reassessed at regular intervals, for example after 3 or 4 weeks of treatment to reduce alcohol consumption, and a final psychiatric diagnosis will be delayed until this time. It is likely that many mental symptoms are reactions to the chaos and disarray in the patient's life that are associated with the drinking problem, or to the neurological effects of alcohol. Some of these symptoms resolve, without formal therapy, when the drinking ceases or decreases. The drinking problem may also be causing the anxiety, rather than the reverse, but serious anxiety disorders may be present and may precipitate relapse.

A high percentage of alcohol-dependent women in treatment have had some experience of physical and/or sexual abuse. Questions about sexual abuse should be framed in a non-threatening way so the patient can choose whether to discuss the issue. Women with a history of child sexual abuse who are pressured to discuss the issue with non-specialist counsellors may endure negative treatment outcomes. Based on these trends, and drawing on clinical expertise, it has been argued that if child sexual abuse is an issue, the patient should be offered referral for specialist intervention. Many patients will not wish to pursue the issue.

Although caution should be exercised in addressing child sexual abuse, clinicians need to discuss it without seeming tentative or fearful. In some jurisdictions, training in dealing with child sexual abuse is now available for alcohol and drug counsellors. A number of jurisdictions have established services for treating victims of child sexual abuse but resources are limited.

A variety of scales are used in clinical and research settings for assessing mental health conditions (see Table 3.4). They are variously used according to clinician preference, treatment setting and patient population. For example, the Kessler 10 Symptom Scale is reasonably widely used in the public sector. In general, these instruments have not been validated in alcohol-dependent populations.

Table 3.4: Mental health assessment scales

| Instrument  | Description  |
|---|--|
| <b>Beck Depression Inventory (BDI)</b>                            | Measures depression and its symptoms   |
| <b>Beck Hopelessness Scale</b>                                    | Measures hopelessness and negative views about the future, and is an indicator of suicide attempts.  |
| <b>Depression, Anxiety and Stress Scale (DASS) *</b>              | Measures symptoms of depression, anxiety and stress. Australian population data have been published.   |
| <b>General Health Questionnaire (GHQ) *</b>                       | Designed as a screening instrument to identify likely non-psychotic psychiatric cases in general health settings.  |
| <b>Kessler-10 Symptom Scale *</b>                                 | A scale of psychological distress, suitable for use as an outcome measure in people with anxiety and depressive disorders. It has become the standard scale for use by Australian general practitioners and mental health workers. |
| <b>Modified PTSD Symptom Scale *</b>                              | A brief (17-item) measure of post-traumatic stress disorder symptoms.  |
| <b>Short Form 12 (SF-12) *</b>                                    | Assesses possible limitations in both physical and mental health, with age and gender matched population norms.  |
| <b>Social Anxiety Interaction Scale and Social Phobia Scale *</b> | Useful for assessing social phobia.  |
| <b>Spielberger State Trait Anxiety Scale</b>                      | Measures current anxiety (state anxiety) and a more enduring personality characteristic (trait anxiety).   |

Note: \* all in the public domain, the others need to be purchased.

| Recommendation  | Strength of recommendation | Level of evidence |
|---|----------------------------|-------------------|
| 3.15 Assessment for mental health problems, such as anxiety, depressive symptoms and suicidal risk, should be routine, including mental state examination. Referral for further specialist assessment may be needed if significant mental problems are suspected. | S                          | –                 |

### Assessing cognitive functioning

Health professionals must be aware of the possibility of alcohol-related brain damage and be watchful for signs of it in the clinical interview. Since there is a high prevalence of cognitive dysfunction among people with alcohol problems (see Review of the Evidence), drug and alcohol workers should screen for deficits in cognitive function (see Chapter 8).

Wernicke–Korsakoff's syndrome is one of the forms of alcohol-related cognitive deficit, and has high prevalence in alcohol dependent people. It is a potentially fatal neurological disorder caused by thiamine (Vitamin B1) deficiency (see Chapter 5).

Other medical causes of cognitive impairment include:

- cerebrovascular disease
- dementia
- Alzheimer's disease
- chronic subdural haematoma
- cerebral neoplasm
- syphilis
- HIV/AIDS.

If cognitive impairment is suspected, an appropriate medical practitioner should assess the patient. In most cases, if abstinence is achieved, cognitive function improves considerably over the subsequent 2 to 4 weeks. Formal cognitive assessment should therefore be deferred until the patient has achieved 6 weeks of abstinence.

### Screening instruments for cognitive impairment

The most widely used screening approach in clinical practice is a clinical assessment for orientation, short- and long-term memory as part of the mental state examination.

The mini-mental state examination can be used for a quick screening for cognitive dysfunction. However, it should be used with caution. The use of age- and education-specific cut-off scores may improve sensitivity without affecting specificity. The test may have limited sensitivity to subtle deficits.

The Clock Drawing Test (see Appendix 1) is another widely used screening test for cognitive dysfunction that can be recommended but to achieve optimal performance, caution needs to be applied to ensure testing is not conducted while the patient is intoxicated or undergoing detoxification, or while affected by benzodiazepines or other sedatives. As well, the clinician must be aware of other factors, such as concomitant anxiety or depression, when interpreting tests of cognitive dysfunction.

| Recommendation   | Strength of recommendation | Level of evidence |
|--|----------------------------|-------------------|
| 3.16 Screening for cognitive dysfunction should be conducted if the clinician suspects the patient has cognitive impairment. Referral to a clinical psychologist or neuropsychologist for further testing may be appropriate. The need for formal cognitive assessment is generally deferred until the patient has achieved several weeks of abstinence. | S                          | —                 |

### Gathering collateral information

Many patients may be reluctant to acknowledge their excessive alcohol use and its consequences because of the stigma attached to such behaviour. Collateral interviews can, therefore, play a central role where the patient does not self-report their problem with alcohol. Collateral information is particularly needed where a discrepancy appears likely; for example, a patient may say he has reduced his drinking but his liver tests remain elevated. The patient's spouse or other close family members are often aware of drinking and may be more aware of alcohol-related problems than the patient. Work colleagues may provide evidence of impairment or intoxication while on duty. Reports from other clinicians or hospital records may also be revealing.

Significant barriers limit access to collateral reports. Privacy legislation limits the distribution of personal information without consent. It may also be unethical to pursue such enquiries without patient consent. Even if legally, ethically and clinically appropriate, the patient may object to such enquiries. In such cases, the therapeutic relationship may be disrupted. Finally, it is time-consuming and at times costly to pursue these enquiries.

Many people freely acknowledge their use of alcohol and its consequences; in which case, there may be little to be gained from interviewing others. Indeed, unnecessary collateral interviews in this setting can undermine an evolving therapeutic relationship.

| Recommendation   | Strength of recommendation | Level of evidence |
|--|----------------------------|-------------------|
| 3.17 Collateral reports should be incorporated in the assessment where inconsistencies appear likely, with the patient's permission where possible, and subject to legal and ethical boundaries. | S                          | –                 |

### Family factors

Patients should be encouraged to explore relevant family issues during assessment. Such issues may include relationships with their spouse or partner, their parents, their children, and other significant people in their lives, and attributions about the effects of the patient's drinking.

Domestic violence and sexual abuse, either as perpetrator or victim, are common and serious problems associated with alcohol and other substance use. Because of the sensitivity of these issues, it may not be appropriate to raise them in the first contact session unless the clinician believes there may be a current safety risk. It is important to determine whether the patient wishes to discuss these issues. Specialist assessment and intervention is typically needed.

Enquire into the family's role in convincing the patient to seek help. A patient who is self-referred may be responding to family pressure and this is important information when assessing the patient's motivations and ambivalence. When it is possible the clinician should interview the spouse and/or family members. The interview should provide family members with the opportunity to discuss:

- Their observations about the drinker's behaviour.
- The problems they have had in coping with the drinking behaviour. The clinician will need to evaluate the levels of distress within the family, feelings of isolation and confusion, specific crises preceding help seeking, and who feels responsible for solving the family problems.
- Expectations family members have about treatment. If the spouse or partner is going to be involved in the alcohol treatment, the clinician needs to assess whether the couple has adequate communication to enable mutual problem solving (see Chapter 6).
- What happens before and after drinking episodes, so particular dynamics relevant to the drinking can be identified. If the spouse's role in therapy is aimed at selectively reinforcing certain behaviours in their partner, the clinician should be sure that does not threaten the spouse's wellbeing by reinforcing the notion that she or he is responsible for the partner's drinking.

The family interview is an opportunity for family members to ask questions and to voice their concerns. It is also a good time to help the family put the drinking problem into perspective. For instance, family members should be advised that achieving abstinence or moderation does not necessarily resolve family problems, and that their personal health and wellbeing does not necessarily depend upon resolution of the drinker's problem. The attitude of the clinician should permit the partner to help him or her self rather than feeling obligated to help the drinker.

While this kind of complex information is best obtained by clinical interview, the Alcohol Problems Questionnaire has a subscale assessing family problems and one assessing marital/relationship problems (see Appendix 1).

### Child protection

Clinicians should determine if the patient cares for any children under the age of 16. A child or young person can be at risk of harm because:

- their basic physical or psychological needs are not being met, or are at risk of not being met
- the parents or caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive necessary medical care
- they have been, or are at risk of being physically or sexually abused or ill-treated
- they are living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm, and/or
- a parent or caregiver has behaved in such a way towards the child or young person that the child or young person has suffered, or is at risk of suffering serious psychological harm.

In many jurisdictions it is mandatory for police, teachers, health workers and other people who work with children to notify relevant authorities if they believe a child is being abused or neglected. Clinicians should act according to jurisdictional guidelines if they are concerned about a child's welfare.

| Recommendation   | Strength of recommendation | Level of evidence |
|--|----------------------------|-------------------|
| 3.18 The social support for the patient should be assessed and this information should be incorporated into the management plan.   | S                          | –                 |
| 3.19 Clinicians should determine if the patient cares for any children under the age of 16, and act according to jurisdictional guidelines if there are any concerns about child welfare | S                          | –                 |

### Assessing risk

Full risk assessment involves assessment of a number of aspects of safety of the patient or others, including suicide risk, violence risk, physical safety (for example, self-care, risk of accidental injury), child care, driving and workplace safety. Detailed considerations of full risk assessment are beyond the scope of these guidelines. In many cases, intervention to help the patient abstain from alcohol will substantially reduce many risks. However, where concern about safety of the patient or others remains, specialist consultation should be advised.

| Recommendation  | Strength of recommendation | Level of evidence |
|---|----------------------------|-------------------|
| 3.20 In the event of suspected or continuing concerns over safety of the patient or others, specialist consultation is advised. | S                          | –                 |

### Treatment planning

When developing a treatment care plan it is important to identify suitable interventions, set goals, and plan long-term follow-up aftercare to prevent relapse.

## Identifying suitable interventions and developing treatment care plans

Treatment is only one factor in promoting change in individuals but it can help patients change by teaching them to act and think differently about drinking. Sometimes the act of seeking help from a health professional can be an important first step for people to start changing their drinking patterns.

The cumulative evidence from large-scale treatment trials, such as Project MATCH (Project MATCH Research Group 1993) and the United Kingdom Alcohol Treatment Trial (UKATT Research Team 2005) suggests that:

- there is a range of effective interventions and treatment approaches for alcohol disorders
- no single intervention is effective for all people with alcohol problems
- there may be treatments that reduce the likelihood of finding large differential effects between empirically supported interventions.

These treatments provide a framework for clinical responses to people with alcohol-related problems.

### Assessment and feedback

A comprehensive assessment is fundamental in treatment planning (see 'Comprehensive clinical assessment' above).

Sharing assessment information with patients in plain, non-judgemental language should be standard practice in a collaborative and motivationally-oriented approach to treatment, and can increase the patient's motivation to change as well as his understanding of and engagement in the treatment.

| Recommendation   | Strength of recommendation | Level of evidence |
|--|----------------------------|-------------------|
| 3.21 Assessment should lead to a clear, mutually acceptable comprehensive treatment plan that structures specific interventions to meet the patient's needs. | D                          | IV                |

### Engaging the patient in treatment

Patient engagement may be viewed in terms of intensity and duration of treatment participation. High levels of engagement are predictive of positive treatment outcomes but are contingent upon patient, clinician and clinic characteristics, namely:

- **Patient characteristics** include pre-treatment motivation, severity of disorder, previous treatment experiences, strength of therapeutic relationship, and perception of helpfulness of the treatment services.
- **Clinician characteristics** include degree of empathy, therapeutic relationship, adequate time and interest, and counselling skills. Basic counselling 'micro skills' including warmth and optimism, and strong interpersonal skills are associated with better retention in treatment and indirectly with better treatment outcomes.
- **Clinic characteristics** include removal of practical access barriers such as transportation, fees, hours, physical surroundings, and perceptions about other patients of the service.

Treatment adherence and completion are prominent issues in alcohol and other drug treatment and the factors that improve it are not yet well understood. A focus in early interactions with patients should be on maximising engagement with the professional and the service and fostering a sense of collaboration. Central to provision of any intervention is a strong bond and therapeutic alliance between patient and clinician.

In addition to identifying clinical disorders and effective interventions, negotiation of treatment goals requires clarification of the patient's insight, values and expectation. Evidence shows that providing the patient with a choice of treatment options improves treatment retention.

### **Goal setting: abstinence, moderation and reduced drinking**

Identifying and agreeing upon treatment goals regarding alcohol consumption is an important step for many patients.

Patients with no or low levels of dependence who are not experiencing significant or irreversible alcohol-related harms may be able to achieve a goal of moderation. Consumption within NHMRC guidelines can be recommended, as it is associated with less than 1 per cent risk of serious alcohol-related harms.

The most realistic drinking goal for patients with severe alcohol dependence and/or those presenting with associated problems (such as organ damage, cognitive impairment and co-existing mental health problems) is likely to be abstinence. For many such patients, achieving abstinence will be accompanied by the risk of alcohol withdrawal syndrome. If this is the case, it should be managed before longer-term abstinence or reduced drinking can be achieved (see Chapter 5).

In clinical practice, patients often present with firm ideas about their drinking goal. They may wish to drink at levels that can continue to cause harm, or may not be realistically sustained. Several options can be considered when a patient's expressed preference for moderation is at odds with clinician advice. When serious consequences from continued alcohol use are highly likely, options include:

- declining assistance and explaining that it would be unethical for you to support such a goal; this approach is unlikely to engage or retain the patient in treatment
- accepting the goal provisionally and for a stipulated period
- negotiating a period of abstinence (for example, 1 to 3 months) to allow the patient to get through withdrawal (if relevant), provide some recovery from the effects of alcohol, and provide time to acquire new skills, such as controlled drinking strategies
- agreeing to gradually reduce drinking to achieve abstinence, setting realistic, intermediate goals and monitoring the number of drinks consumed daily
- negotiating a period of trial moderation, include daily drink monitoring and controlled drinking strategies (coping skills training).

Ongoing review and monitoring of drinking against identified goals is central to successful intervention. If the goals are too difficult to achieve, abstinence may seem a more reasonable goal; this should be clearly identified and agreed upon with the patient from the outset. Some interventions require protracted but important negotiations for goal setting. For strategies to manage patients who continue to drink at harmful levels, see Chapter 11.

| Recommendation   | Strength of recommendation | Level of evidence |
|--|----------------------------|-------------------|
| 3.22 Patients should be involved in goal setting and treatment planning. | A                          | I                 |

### Development of treatment care plan

Information the clinician obtains at patient assessment is used to develop a case formulation that entails a shared understanding of alcohol and other drug problems, co-existing health and social problems and other concerns, and to formulate hypotheses about their development, maintenance and inter-relationships. The case formulation, which continues to be refined as more is learned about the patient, is used to guide treatment planning.

The choice of interventions for addressing alcohol use disorders will depend on a number of factors, including the patient's presenting problems, pattern of alcohol and other drug use, medical and psychiatric comorbidity, motivation and treatment preferences, and social circumstances, as well as available resources.

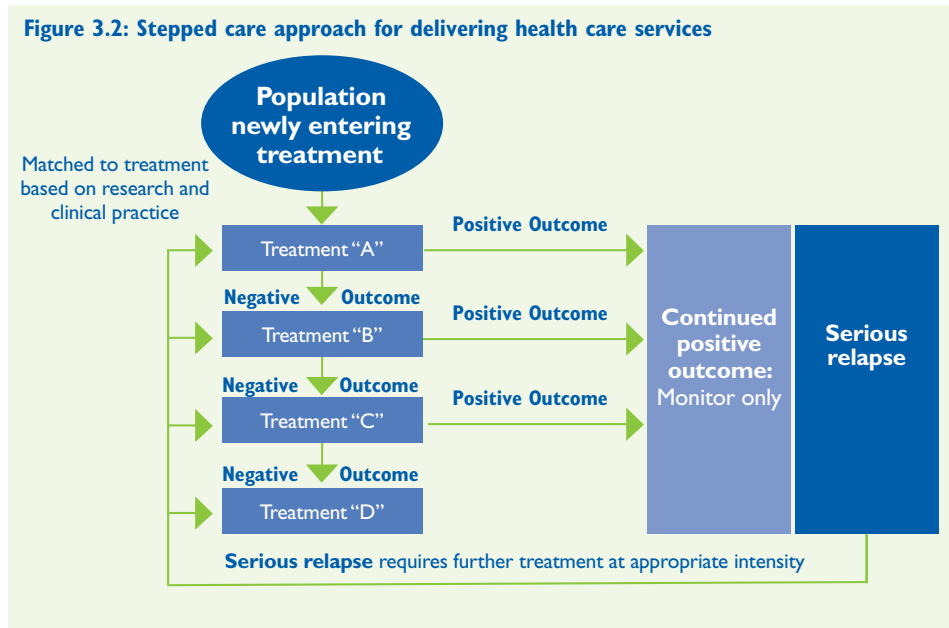
Any treatment plan must address the patient's presenting problem. Often the presenting problem is alcohol-related (for example, liver disease, depression, domestic violence) so it will be necessary to also address the patient's alcohol use in order to effect comprehensive longer-term change. However, the sequence of interventions is often determined by immediate needs (for example, hospitalisation for hepatic failure or suicide attempt, emergency shelter to avoid further violence).

Treatment options should be discussed with patients (and their families or carers, as relevant) to identify what is involved with each treatment approach and the likely outcomes (including potential adverse outcomes) and to give the patient an opportunity to ask questions or raise concerns.

As in any health care intervention, informed consent is essential.

A stepped care approach (see Figure 3.2), which serves as a guide to clinical decision-making and treatment planning, is proposed. Stepped care identifies that patients should first be offered the intervention most appropriate to their presentation; if that proves insufficient to achieve the patient's agreed treatment goals, the next level of intensity of treatment should be offered until the desired treatment goals are achieved. This approach requires continuous reassessment of the patient, their response to treatment and any changes in their presentation.

**Figure 3.2: Stepped care approach for delivering health care services**



Source: Sobell, MB & Sobell, LC 2000, 'Stepped care as a heuristic approach to the treatment of alcohol problems', *Journal of Consulting and Clinical Psychology*, vol. 68, no. 4, pp. 573–79.

People with chronic heavy alcohol use often have a range of medical, psychiatric, social and legal problems that are usually beyond the scope of a single service provider to address. It is crucial in such cases to develop a treatment plan that involves multiple services as well as a case manager to coordinate close communication between service providers and to ensure long-term follow-up. Complex cases may be best managed by comprehensive multi-skilled clinical services.

| Recommendation   | Strength of recommendation | Level of evidence |
|--|----------------------------|-------------------|
| 3.23 Treatment plans should be modified according to reassessment and response to interventions (stepped care approach).           | S                          | –                 |
| 3.24 Evidence-based treatment should be offered in a clinical setting with the appropriate resources based on the patient's needs. | S                          | –                 |

### Relapse prevention, aftercare and long-term follow-up

Relapse is a common problem in alcohol treatment; approximately 60 per cent of patients relapse to problematic drinking within the first month of treatment.

Specific situations or mood states are associated with relapse, including:

- negative emotional states (such as frustration, anxiety, depression or anger)
- interpersonal conflict (such as relationships with partner, work colleagues, friends)
- direct or indirect social pressure to drink.

Relapse prevention intervention is a set of strategies that aim to help the patient maintain treatment gains (see Chapter 6). Relapse prevention teaches patients cognitive and behavioural strategies that help prevent lapses becoming relapses. It addresses itself to maintenance of change and development of self-efficacy and coping skills.

Relapse prevention can be assisted through use of medication (including alcohol pharmacotherapies such as naltrexone, acamprosate, disulfiram) for reducing alcohol use or medication for addressing psychological problems, such as anxiety or depression.

Aftercare refers to the period immediately following intensive treatment (see Chapter 11). Aftercare acknowledges that severe alcohol problems are prone to reoccur and that to maintain change patients may need ongoing monitoring and assistance beyond the active phase of initial treatment. Aftercare is particularly suited to people with severe dependence whose likelihood of relapse is great. It consists of planned telephone or face-to-face contact following after treatment to discuss progress and any problems that may have arisen since the end of active treatment. Structured clinician-driven aftercare is more effective than unstructured patient-initiated aftercare.

Clinicians may use referral to self-help programs (such as Alcoholics Anonymous and SMART Recovery) as forms of continuing care but aftercare generally refers to contact with the treating clinician or service with the goal of maintaining treatment gains. Often primary care workers (such as general practitioners) can provide this function through ongoing follow-up of other health issues.

Given the nature of alcohol dependence, long-term follow-up is an important part of a comprehensive treatment plan.

| Recommendation  | Strength of recommendation | Level of evidence |
|---|----------------------------|-------------------|
| 3.25 Alcohol dependence is a chronic and relapsing disorder such that long-term care is generally appropriate through self-help programs, primary care or other interventions that are acceptable to the patient. | S                          | –                 |

**Figure 3.3: Assessment and treatment planning**

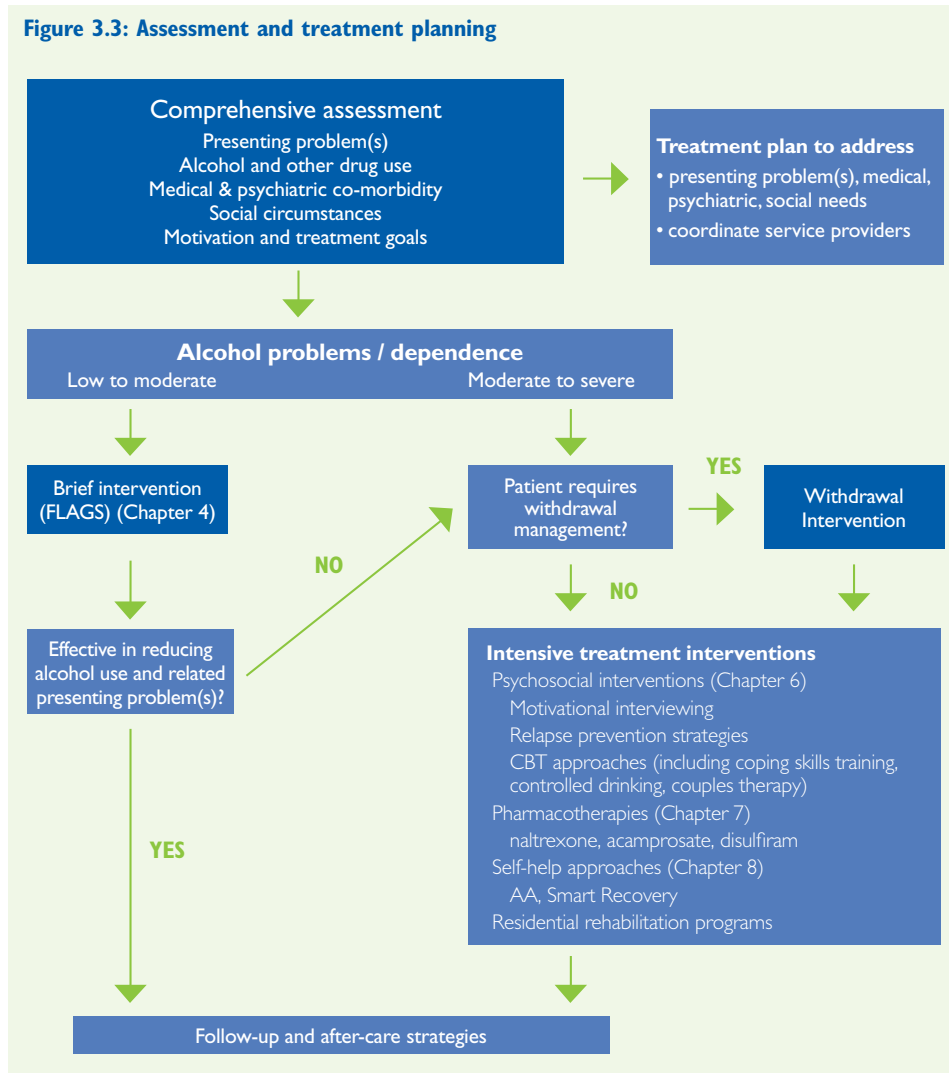


Figure 3.3 summarises the major points of comprehensive assessment and treatment planning for alcohol use disorders.