

Summary of recommendations

Screening

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
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
3.6 AUDIT is the most sensitive of the currently available screening tools and is recommended for use in the general population.	A	I
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
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
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	Ia

Comprehensive assessment

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
3.11 A quantitative alcohol history should be recorded.	A	I
3.12 Motivation to change should be assessed through direct questioning, although expressed motivation has only a moderate impact on treatment outcome.	B	II
3.13 Assessment of the patient's alcohol-related problems, diagnosis and severity of dependence should be recorded.	S	–
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	–

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 stage examination. Referral for further specialist assessment may be needed if significant mental problems are suspected.	S	–
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	–
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	–
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	–
3.20 In the event of suspected or continuing concerns over safety of the patient or others, specialist consultation is advised.	S	–

Assessment

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
3.22 Patients should be involved in goal setting and treatment planning.	A	I
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	–
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	–

Brief interventions

Recommendation	Strength of recommendation	Level of evidence
4.1 Brief interventions are effective in reducing alcohol use in people with risky pattern of alcohol use and in non-dependent drinkers experiencing alcohol-related harms and should be routinely offered to these populations.	A	1a
4.2 Brief interventions are not recommended for people with more severe alcohol-related problems or alcohol dependence.	A	1b
4.3 Brief interventions may consist of the five components of the FLAGS acronym: feedback, listening, advice, goals, and strategies (or equivalent).	A	1a

Recommendation	Strength of recommendation	Level of evidence
4.4 Brief advice may be sufficient for those drinking above NHMRC recommendations but not experiencing harm.	S	–
4.5 Brief interventions should be implemented in general practice and other primary care settings.	A	Ia
4.6 Brief interventions should be implemented in emergency departments and trauma centres.	A	Ia
4.7 Brief interventions should be implemented in general hospital settings.	D	IV
4.8 Brief interventions in community health and welfare settings may be used, but should not be a sole intervention strategy.	D	IV
4.9 Brief interventions in high-risk workplaces may be used, but should not be a sole intervention strategy.	D	IV

Alcohol withdrawal: patient assessment and treatment planning

Recommendation	Strength of recommendation	Level of evidence
5.1 The risk of severe alcohol withdrawal should be assessed based on current drinking patterns, past withdrawal experience, concomitant substance use, and concomitant medical or psychiatric conditions.	B	II
5.2 Successful completion of alcohol withdrawal does not prevent recurrent alcohol consumption and additional interventions are needed to achieve long-term reduction in alcohol consumption.	A	Ia
5.3 Realistic goals of clinicians, patients and their carers for withdrawal services include: interrupting a pattern of heavy and regular alcohol use, alleviating withdrawal symptoms, preventing severe withdrawal complications, facilitating links to ongoing treatment for alcohol dependence, providing help with any other problems (such as accommodation, employment services).	D	IV
5.4 Ambulatory withdrawal is appropriate for those with mild to moderate predicted withdrawal severity, a safe 'home' environment and social supports, no history of severe withdrawal complications, and no severe concomitant medical, psychiatric or other substance use disorders.	D	IV
5.5 Community residential withdrawal is appropriate for those with predicted moderate to severe withdrawal, a history of severe withdrawal complications, withdrawing from multiple substances, no safe environment or social supports, repeated failed ambulatory withdrawal attempts, and with no severe medical or psychiatric comorbidity.	D	IV
5.6 Inpatient hospital treatment is appropriate for those with severe withdrawal complications (such as delirium or seizures of unknown cause), and/or severe medical or psychiatric comorbidity.	S	–
5.7 Hospital addiction medicine consultation liaison services should be accessible in hospitals to aid assessment, management and discharge planning.	S	–

Monitoring alcohol withdrawal severity

Recommendation	Strength of recommendation	Level of evidence
5.8 Patients withdrawing from alcohol should be regularly monitored for physical signs, severity of alcohol withdrawal and general progress during withdrawal.	S	–
5.9 Alcohol withdrawal scales (CIWA-Ar, AVS) can be used to assess withdrawal severity, to guide treatment (such as symptom-triggered medication regimens) and to aid objective communication between clinicians; but should not be used as diagnostic tools.	A	Ia
5.10 Alcohol withdrawal scales should not be used to guide treatment in patients concurrently withdrawing from other substances, or with significant medical or psychiatric comorbidity. Health professionals should consult a specialist drug and alcohol clinician about monitoring and management needs.	B	Ib
5.11 Scores on alcohol withdrawal scales are not always reproducible and should be checked before using them to make management decisions.	S	–

Supportive care in treatment of alcohol withdrawal

Recommendation	Strength of recommendation	Level of evidence
5.12 Patients (and carers) should be provided with information about the likely nature and course of alcohol withdrawal, and strategies to cope with common symptoms and cravings.	C	III
5.13 Treatment environment should be quiet, non-stimulating, and non-threatening, and where alcohol and other drugs are not available.	S	–
5.14 Supportive counselling should be provided to maintain motivation, provide strategies for coping with symptoms, and reduce high-risk situations.	D	III
5.15 Clinicians should ensure oral rehydration is adequate. Intravenous fluids may be necessary in severe dehydration and/or in those not tolerating oral fluids.	S	–

Prophylaxis of Wernicke's encephalopathy

Recommendation	Strength of recommendation	Level of evidence
5.16 Thiamine should be provided to all patients undergoing alcohol withdrawal to prevent Wernicke's encephalopathy.	D	IV
5.17 Thiamine should be given before any carbohydrate load (such as intravenous glucose) as carbohydrates can cause rapid use or depletion of thiamine and precipitate Wernicke's encephalopathy.	D	III
5.18 Healthy patients with good dietary intake should be administered oral thiamine 300 mg per day for 3 to 5 days, and maintained on 100 mg oral thiamine for a further 4 to 9 days (total of 1 to 2 weeks of thiamine).	D	IV
5.19 Chronic drinkers with poor dietary intake and general poor nutritional state should be administered parenteral (intramuscularly or intravenously) thiamine doses of 300 mg per day for 3 to 5 days, with subsequent oral thiamine doses of 300 mg per day for several weeks. The intramuscular route should not be used for patients with coagulopathy.	D	Ib

Recommendation	Strength of recommendation	Level of evidence
5.20 Thiamine supplementation should be continued indefinitely in an alcohol-dependent patient who continues to drink alcohol.	S	–
5.21 Sedatives (such as benzodiazepines) should not be continued beyond the first week of withdrawal. Behavioural approaches to management of anxiety and sleep problems should be encouraged.	D	IV
5.22 Clinicians should facilitate links to post-withdrawal treatment services during withdrawal treatment.	D	III

Using benzodiazepines to treat alcohol withdrawal

Recommendation	Strength of recommendation	Level of evidence
5.23 Benzodiazepines are the recommended medication in managing alcohol withdrawal. In Australia, diazepam is recommended as 'gold standard' and as first-line treatment because of its rapid onset of action, long half-life and evidence for effectiveness.	A	Ia
5.24 Shorter acting benzodiazepines (lorazepam, oxazepam, midazolam) may be indicated where the clinician is concerned about accumulation and over sedation from diazepam, such as in the elderly, severe liver disease, recent head injury, respiratory failure, in obese patients, or where the diagnosis is unclear.	D	III
5.25 Benzodiazepines should not be continued beyond the first week for managing alcohol withdrawal due to the risk of rebound phenomenon and dependence.	D	III
5.26 Diazepam should be administered in a symptom-triggered regimen in residential withdrawal settings for people with no concomitant medical, psychiatric or substance use disorders.	B	Ia
5.27 Diazepam should be administered in a loading regimen (20 mg 2 hourly until 60 to 80 mg or light sedation) in patients with a history of severe withdrawal complications (seizures, delirium); in patients presenting in severe alcohol withdrawal and/or with severe withdrawal complications (for example, delirium, hallucinations, following withdrawal seizure).	B	Ib
5.28 Diazepam should be administered in a fixed dose regimen in ambulatory settings, or for those with concomitant medical, psychiatric or substance use disorders.	C	Ib

Alternative and symptomatic medications in treatment of alcohol withdrawal

Recommendation	Strength of recommendation	Level of evidence
5.29 Carbamazepine is safe and effective as an alternative to benzodiazepines, although it is not effective in preventing further seizures in the same withdrawal episode.	A	Ia
5.30 Phenytoin and valproate are not effective in preventing alcohol withdrawal seizures and are not recommended.	A	Ia
5.31 Newer anticonvulsant agents (such as gabapentin) are not recommended at this stage due to limited clinical evidence.	D	IV
5.32 There is no benefit in adding anticonvulsants to benzodiazepines to manage alcohol withdrawal.	A	Ia

Recommendation	Strength of recommendation	Level of evidence
5.33 Anticonvulsant medications should be continued in patients who take them regularly (such as for epilepsy not related to withdrawal).	S	–
5.34 Antipsychotic medications should only be used as an adjunct to adequate benzodiazepine therapy for hallucinations or agitated delirium. They should not be used as stand-alone medication for withdrawal.	A	Ia
5.35 Anti-hypertensive agents (beta-blockers) should be used for managing extreme hypertension that has not responded to adequate doses of diazepam for alcohol withdrawal.	D	IV
5.36 A range of symptomatic medications may be used for addressing specific symptoms (such as paracetamol for headache, anti-emetics, anti-diarrhoeal agents).	D	IV
5.37 Electrolyte replacement may be a necessary adjunctive treatment for patients with electrolyte abnormalities (such as hypomagnesaemia, hypokalaemia). Hyponatraemia should not be aggressively corrected due to the risk of central pontine myelinolysis.	S	–
5.38 Chlormethiazole, barbiturates, alcohol, beta-blockers, clonidine and gamma-hydroxybutyric acid (GHB) are not recommended in the routine management of alcohol withdrawal.	A	Ia

Managing alcohol withdrawal seizures

Recommendation	Strength of recommendation	Level of evidence
5.39 Alcohol withdrawal seizure should only be assumed if the clinical presentation is typical of an alcohol withdrawal seizure, no other causes of seizure are suspected, and the patient has a history of previous alcohol withdrawal seizures. All other cases need full investigation.	B	II
5.40 Heavy drinkers with a seizure of unknown cause should be admitted to hospital and monitored for at least 24 hours. Investigations include biochemical tests and MR neuro-imaging, and possibly EEG.	C	III
5.41 Loading with benzodiazepines (diazepam, lorazepam) and close monitoring for at least 24 hours is recommended after an alcohol withdrawal seizure.	A	Ia
5.42 Anticonvulsants are not effective in preventing further seizures in the same withdrawal episode.	A	Ia
5.43 Long-term anticonvulsant treatment is not recommended to prevent further alcohol withdrawal seizures.	D	IV

Managing alcohol withdrawal delirium

Recommendation	Strength of recommendation	Level of evidence
5.44 Alcohol withdrawal delirium requires hospitalisation, medical assessment, and close monitoring.	A	I
5.45 The patient should be managed in a quiet environment with minimal sensory stimulation.	C	III
5.46 Dehydration and electrolyte imbalance should be corrected.	S	–
5.47 Benzodiazepines should be used to achieve light sedation. Oral diazepam or lorazepam loading until desired effect is the treatment of choice. Intravenous diazepam or midazolam is appropriate if rapid sedation is needed.	A	Ia

Recommendation	Strength of recommendation	Level of evidence
5.48 Antipsychotic medications should be used to control agitation of alcohol withdrawal as an adjunct to (not instead of) adequate benzodiazepine doses.	A	Ia

Assessing and managing Wernicke's encephalopathy

Recommendation	Strength of recommendation	Level of evidence
5.49 Clinicians should consider MR contrast neuro-imaging where the diagnosis of Wernicke's encephalopathy is not clinically established.	D	III
5.50 All patients exhibiting any features of Wernicke's encephalopathy should be treated as though Wernicke's encephalopathy is established.	D	III
5.51 All patients suspected of Wernicke's encephalopathy should be treated with high-dose parenteral thiamine (at least 500 mg daily) for at least 3 to 5 days. The intramuscular route should not be used for patients with coagulopathy. Subsequent oral thiamine doses of 300 mg per day for several weeks.	D	III
5.52 Patients suspected of Wernicke's encephalopathy should have hypomagnesaemia corrected in order for thiamine supplements to be effective.	D	III

Psychosocial interventions for alcohol-use disorders

Recommendation	Strength of recommendation	Level of evidence
6.1 A stepped care approach is recommended as a framework for selecting psychosocial interventions, incorporating assessment, monitoring, implementation of a treatment plan, regular review of progress, and increasing intervention intensity in the absence of a positive response to treatment.	D	IV
6.2 Motivational interviewing approaches can be used as a first-line or stand-alone treatment, or as an adjunct to other treatment modalities in addressing patient's ambivalence to change their drinking or other behaviours.	A	Ia
6.3 Behavioural self-management (controlled drinking program) can be recommended as a treatment strategy for people with no or low level dependence and for when patient and clinician agree that moderation is an appropriate goal.	A	Ib
6.4 Coping skills training is recommended for people who appear to lack the relevant skills to achieve and remain abstinent.	A	Ib
6.5 Cue exposure in conjunction with other psychosocial interventions can be an effective intervention for treating alcohol dependence.	A	Ib
6.6 Behavioural couples therapy, which focuses on drinking behaviour as the problem, can improve drinking outcomes following treatment and should be delivered by an appropriately trained clinician.	A	Ia
6.7 Psychosocial relapse prevention strategies are recommended for use with all moderately to severely alcohol-dependent patients.	A	Ib
6.8 Psychosocial relapse prevention strategies are best delivered as soon as acute withdrawal symptoms have subsided.	C	III
6.9 Residential rehabilitation programs can be effective for patients with moderate to severe dependence who need structured residential treatment settings.	D	IV

Pharmacotherapies for alcohol dependence

Recommendation	Strength of recommendation	Level of evidence
7.1 Pharmacotherapy should be considered for all alcohol-dependent patients, in association with psychosocial supports.	A	Ia
7.2 Naltrexone is recommended as relapse prevention for alcohol-dependent patients.	A	Ia
7.3 Naltrexone is not suitable for people who are opioid dependent or who have pain disorders needing opioid analgesia.	S	–
7.4 Naltrexone should be started as soon as possible after completion of withdrawal (usually 3 to 7 days after last drink).	A	Ib
7.5 Naltrexone is usually taken for at least 3 to 6 months.	D	IV
7.6 Acamprosate is recommended as relapse prevention for alcohol-dependent patients.	A	Ia
7.7 Acamprosate should be started as soon as possible after completion of withdrawal (usually 3 to 7 days after last drink).	A	Ib
7.8 Acamprosate is usually taken for at least 3 to 6 months.	D	IV
7.9 Disulfiram is recommended in closely supervised alcohol-dependent patients motivated for abstinence and with no contraindications.	A	Ia
7.10 Disulfiram is usually taken for at least 3 to 6 months.	D	IV
7.11 A range of medications appear promising agents in reducing alcohol relapse (such as topiramate, gabapentin, baclofen, aripiprazole); however, need further research and are not recommended as first-line options at this stage.	B	II
7.12 Benzodiazepines and antidepressants are not recommended as relapse prevention agents in alcohol dependence.	B	II
7.13 Medication compliance can be improved with use of adherence enhancing strategies.	B	Ia

Self-help programs

Recommendation	Strength of recommendation	Level of evidence
8.1 Long-term participation in Alcoholics Anonymous can be an effective strategy to maintain abstinence from alcohol for some patients.	B	II
8.2 Assertive referral practices to Alcoholics Anonymous increase participation and improve outcome.	A	I
8.3 SMART Recovery® may be an effective self-help alternative to Alcoholics Anonymous for reducing alcohol consumption.	D	IV
8.4 Self-help groups for families may provide support for those affected by people with alcohol dependence.	D	IV

Specific populations: Adolescents and young people

Recommendation	Strength of recommendation	Level of evidence
9.1 NHMRC guidelines recommend that not drinking alcohol is the safest option for children and young people under 18 years of age.	D	IV

Recommendation	Strength of recommendation	Level of evidence
9.2 Screening and brief intervention for tobacco, alcohol and other drug use should occur routinely. Binge drinking and polydrug use are common among adolescent problem drinkers.	D	IV
9.3 A broad medical and psychosocial history is needed to work effectively with young people.	S	–
9.4 Engagement and therapeutic relationships require an understanding of adolescent development and a cognitively and developmentally appropriate approach.	S	–
9.5 Brief interventions may suit some young people drinking excessively and/or experiencing alcohol-related harms.	A	Ia
9.6 Motivational interviewing, cognitive behavioural and family therapies have been shown to be of benefit in reducing alcohol and other drug use and related harms.	A	Ia
9.7 Limited evidence exists on the role of pharmacotherapies in reducing alcohol use in adolescents.	B	II
9.8 Adolescent drinkers may experience a range of psychosocial crises. In these cases, outreach and crisis interventions should be engaged.	D	IV
9.9 Mental health disorders, including depression, suicidal ideation, anxiety, sexual abuse and antisocial behaviour, are common in young people with alcohol and other drug problems, and should be addressed in the treatment plan.	D	IV

Specific populations: Pregnant and breastfeeding women

Recommendation	Strength of recommendation	Level of evidence
9.10 Women who are or may become pregnant should be advised of new NHMRC guidelines that recommend abstinence. Clinicians who provide advice to pregnant women should familiarise themselves with the risk analysis described in those guidelines. Women who drink alcohol sparingly (less than one standard drink per drinking day without intoxication) may be reassured that there is no consistent evidence this is harmful.	S	–
9.11 Breastfeeding women should be advised of current NHMRC guidelines that recommend abstinence from drinking. If a woman wishes to drink, it is recommended that she breastfeeds before drinking. Otherwise, wait until the blood alcohol returns to zero (one hour per standard drink consumed) before resuming breastfeeding. It is not necessary to express or discard milk before this time.	S	–
9.12 Brief interventions are recommended for use during pregnancy, including the partner where relevant. Follow-up evaluation of response to the intervention is important.	B	II
9.13 If a woman presents intoxicated during pregnancy, hospital admission is recommended to assess foetal safety, maternal safety, and for comprehensive assessment and care planning.	D	IV
9.14 Alcohol withdrawal during pregnancy should be managed in a general hospital, ideally in a high-risk maternity unit in consultation with a specialist drugs-in-pregnancy team. Diazepam may be given as needed to control withdrawal. Nutritional intervention should be initiated, including parenteral thiamine, folate replacement and assessment for other supplementation in hospital.	S	–

Recommendation	Strength of recommendation	Level of evidence
9.15 Women who present during pregnancy with serious alcohol (and/or other drug) problems should be admitted to an appropriate hospital unit for stabilisation, comprehensive assessment and care planning.	S	–
9.16 Assertive follow-up is recommended for antenatal care, substance misuse treatment, and welfare support and child protection.	S	–
9.17 Pharmacotherapy to maintain abstinence from alcohol cannot be recommended during pregnancy due to insufficient safety data.	S	–
9.18 Assertive antenatal care, including monitoring of foetal growth and health, is recommended.	S	–
9.19 Management of infants with neonatal alcohol withdrawal should be undertaken in consultation with a specialist unit.	S	–
9.20 Infants born to women who have consumed alcohol regularly during pregnancy should be carefully assessed for foetal alcohol spectrum disorders by a paediatrician aware of the maternal history, with further management directed by the appropriate experts.	S	–
9.21 Assessment of the family unit is an essential aspect of managing substance use in women. Intervention should be directed to the whole family unit to reduce consumption of alcohol.	S	–
9.22 Indigenous women should be offered referral to culturally appropriate clinical services.	D	IV
9.23 Comprehensive mental health assessment is an essential component of an integrated care plan for pregnant women with alcohol problems.	S	–

Specific populations: Indigenous Australians and people from other cultures

Recommendation	Strength of recommendation	Level of evidence
9.23a Given late presentation of alcohol problems, active detection is recommended.	D	IV
9.24 Indigenous Australians, like all other Australians should have access to the full range of treatment services, including early intervention and where appropriate, relapse prevention medications.	D	IV
9.25 Indigenous Australians should be offered access to trained Indigenous health care workers and services where possible.	D	IV
9.26 Non-Indigenous clinicians should work in partnership with Indigenous health professionals and/or agencies to improve treatment access and appropriateness for communities.	D	IV
9.27 A respectful, holistic and integrated approach to assessment and management is necessary, considering the patient in the context of both the family and the community.	D	IV
9.28 Indigenous cultures and customs vary. Use of language and approach to communication should be appropriate for both the individual and the community.	D	IV

Recommendation	Strength of recommendation	Level of evidence
9.29 Given the high prevalence of physical and mental comorbidities in the Indigenous population, clinicians should consider the possibility of physical and/or mental comorbidity in all presentations.	A	I
9.30 The ongoing impact of colonisation should be considered and efforts to provide a range of treatment options for alcohol problems to Indigenous population should be combined with wider community measures addressing both alcohol misuse-related problems and underlying social determinants of alcohol misuse.	D	IV

Specific populations: Older people

Recommendation	Strength of recommendation	Level of evidence
9.31 Older Australians should be screened for alcohol use and related harms (such as trauma, exacerbation illness, drug interactions, violence or physical neglect) across a range of health and welfare settings.	D	IV
9.32 Brief interventions should be employed for older people drinking at risky levels or experiencing alcohol-related harms (such as falls, driving impairment, drug interactions).	A	Ia
9.33 Concurrent physical or mental illness, medications, social conditions and functional limitations need to be considered when assessing older drinkers.	D	IV
9.34 Abstinence can be associated with marked physical, mental and cognitive improvements; alternatively, alcohol use may have been masking underlying illness. Consequently, the severity and management of concomitant physical and mental conditions should be reviewed several weeks to months after cessation of drinking.	D	IV
9.35 Withdrawal management of older dependent drinkers requires close monitoring, nutritional supplements, careful use of sedative medication, and management of comorbid conditions.	S	–
9.36 Caution should be exercised when prescribing medications to older drinkers. Short-acting benzodiazepines (such as oxazepam, lorazepam) are preferred for alcohol withdrawal management over long-acting benzodiazepines (such as diazepam).	D	IV
9.37 Psychological and pharmacological treatment approaches should be tailored to physical, cognitive and mental health of older patients.	D	IV

Specific populations: Cognitively impaired patients

Recommendation	Strength of recommendation	Level of evidence
9.38 A brief assessment of cognitive functioning should be a routine part of assessment upon treatment entry.	S	–
9.39 More detailed diagnostic and functional assessment should be carried out where brief assessment suggests that a patient suffers from significant cognitive deficits.	S	–

Recommendation	Strength of recommendation	Level of evidence
9.40 The possibility of improvement in cognitive functioning should be taken into account by allowing a sufficient period of abstinence from alcohol to elapse before finalising treatment planning.	D	IV
9.41 Where cognitive impairment is confirmed, information presented to patients should be concrete and patients should be given opportunities to practice behaviours taught in treatment.	B	II
9.42 Clinicians should engage cognitively impaired patients in treatment by providing information about treatment, discussing different treatment options and maintaining contact with the patient.	S	–
9.43 Cognitively impaired patients should be taught relapse prevention strategies.	D	IV

Managing patients with alcohol-related physical comorbidity

Recommendation	Strength of recommendation	Level of evidence
10.1 Comprehensive assessment is indicated for patients with physical comorbidity related to alcohol, as multiple pathology is the rule.	A	I
10.2 Abstinence is recommended for those with physical comorbidity related to alcohol unless mild and reversible pathology is present. In particular, pancreatitis may recur after a single drink.	D	IV
10.3 Comprehensive management requires a single practitioner with a broad range of clinical skills or close coordination between an appropriate team.	S	–

Managing co-occurring mental and alcohol-use disorders

Recommendation	Strength of recommendation	Level of evidence
10.4 Patients with comorbid disorders of alcohol use and persisting mental health comorbidity should be offered treatment for both disorders.	A	Ib
10.5 More intensive interventions are needed for comorbid patients, as this population tends to be more disabled and carries a worse prognosis than those with single pathology.	B	I
10.6 AUDIT is recommended for screening psychiatric populations.	A	Ib
10.7 Assessment for comorbid disorders should take place once the patient's withdrawal syndrome has diminished, since some anxiety and depressive symptoms may abate once alcohol consumption is reduced or ceased.	B	II
10.8 Comorbid mood and anxiety disorders that do not abate within 3 to 6 weeks after alcohol withdrawal is complete should be treated with integrated/concurrent cognitive behavioural therapy for the comorbid disorder.	B	II
10.9 Cognitive behavioural therapy, behaviour therapy, cognitive therapy, and interpersonal therapy should be considered for treatment of patients with comorbid mental and alcohol use disorders because of their demonstrated effectiveness in non-comorbid cases.	B	Ib
10.10 Integrating psychosocial treatment for mood disorders and psychoses with psychosocial treatment for alcohol-use disorder may be beneficial in treating patients with such comorbidity.	D	IV

Recommendation	Strength of recommendation	Level of evidence
10.11 Selective serotonin reuptake inhibitor antidepressants are not recommended as primary therapy to reduce alcohol consumption in patients with comorbid mood or anxiety disorders.	B	II
10.12 Benzodiazepines are not recommended for treatment of comorbid anxiety in patients with alcohol-use disorders due to high risk of dependence and a potential synergistic interaction with alcohol.	S	–

Managing polydrug use and dependence

Recommendation	Strength of recommendation	Level of evidence
10.13 All patients with alcohol-use disorders should be screened for other substance use using quantity–frequency estimates, or through structured screening instruments such as the ASSIST questionnaire.	D	IV
10.14 Polydrug dependence is typically associated with higher levels of physical, psychiatric and psychosocial comorbidity that should be addressed in comprehensive treatment plans.	D	IV
10.15 Use of other drugs can be affected by cessation or reduction in alcohol use, and treatment plans should address use of alcohol and other drugs together.	D	IV
10.16 Patients undergoing polydrug withdrawal need close monitoring, increased psychosocial care, and increased medication. Consider specialist advice.	D	IV
10.17 Fixed diazepam dosing regimens are preferred for managing alcohol withdrawal in the context of other drug withdrawal, with regular review of dosing regimens. Withdrawal scales (such as CIWA-Ar) need careful interpretation in patients withdrawing from multiple drugs, and should not be used to direct medication.	D	IV
10.18 Patients dependent on alcohol and benzodiazepines or opioids should be stabilised on substitution medications while undergoing alcohol withdrawal.	D	IV

Aftercare and long-term patient follow-up

Recommendation	Strength of recommendation	Level of evidence
11.1 Long-term follow-up of patients following an intensive treatment program is recommended as part of a comprehensive treatment plan, reflecting the chronic relapse possibility of alcohol dependence.	D	IV
11.2 A range of clinical strategies should be used to reduce alcohol-related harm in people who continue to drink heavily and resist treatment. These include attending to medical, psychiatric, social and medico-legal issues, maintaining social supports, and facilitating reduction in alcohol intake.	D	IV

