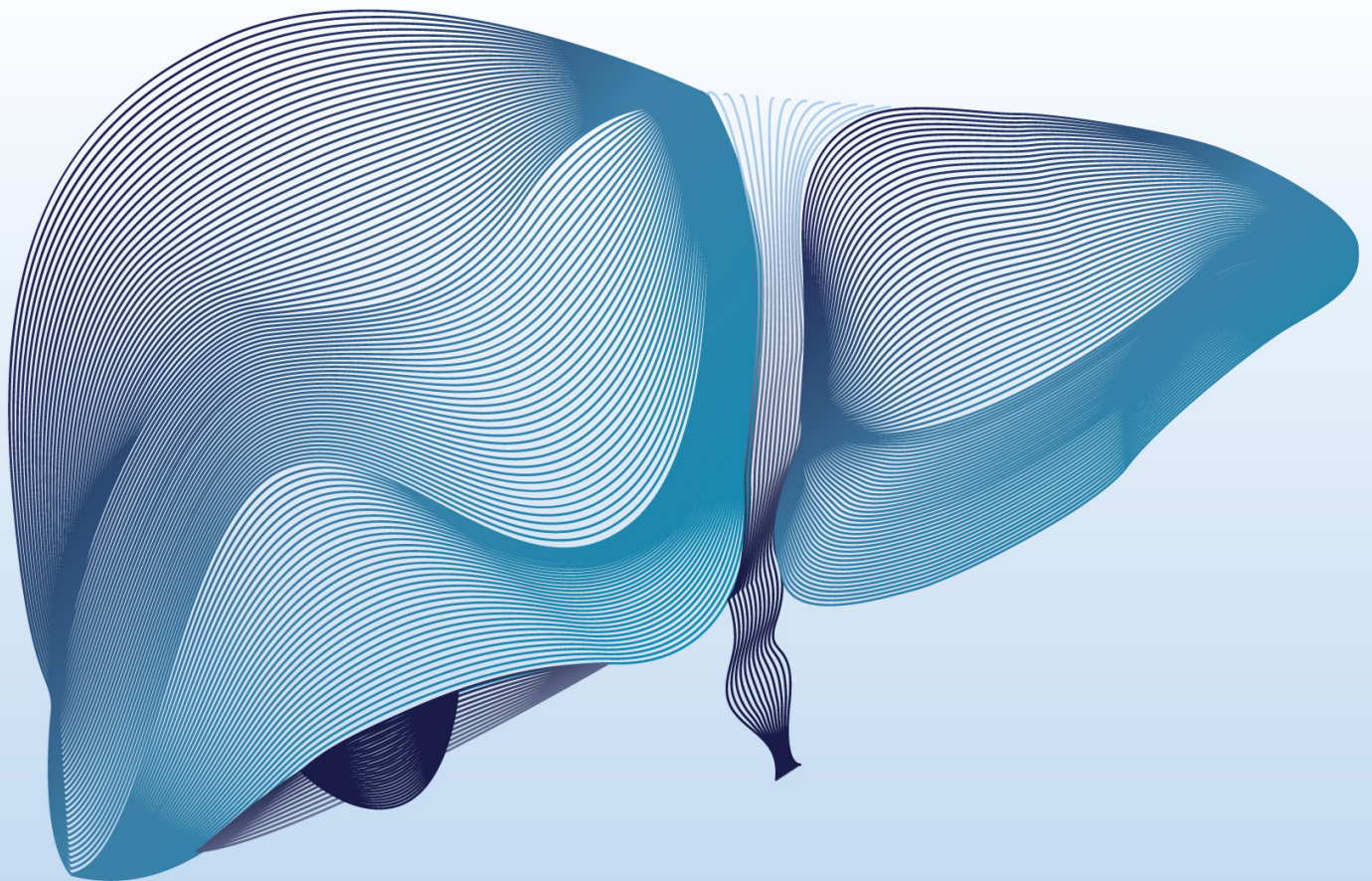


GENERAL PRACTITIONER

Alcohol use disorder in Australian general practice:

first-line management and when to assess the liver

2026



Alcohol use disorder in Australian general practice: first-line management and when to assess the liver

Alcohol use disorder (AUD) is common, treatable and often under-recognised in Australian general practice. Alcohol is an important cause of liver disease, but its harm extends well beyond the liver to include injury, mental illness, cardiovascular disease, neurological complications and cancer (as a class 1 carcinogen). This resource focuses on what GPs can do in practice, which is to:

- identify risky drinking early;
- assess withdrawal risk and immediate safety;
- provide brief interventions and evidence-based treatment; and
- assess the liver when clinically indicated.

The aim is to treat risky drinking and AUD directly and early, rather than waiting for abnormal liver test results, cirrhosis or other alcohol-related complications to appear.

No level of alcohol consumption is completely without risk. Australian National Health and Medical Research Council (NHMRC) guidance is that, to reduce risk, healthy adults should drink no more than 10 standard drinks per week and no more than four standard drinks on any one day. The less a person drinks, the lower their risk of harm. Although NHMRC recommendations are the same for men and women, evidence suggests that women may develop alcohol-related complications at lower levels of consumption than men.

Screening and diagnosis

Alcohol screening should be routine rather than reserved for patients with obvious liver disease or other end-organ complications (e.g. pancreatitis). It should be considered:

- during new patient assessments;
- in chronic disease reviews;
- in presentations for mental health problems, sleep disturbance, gastrointestinal symptoms, hypertension or recurrent injury;
- when patients have abnormal liver test results; and
- whenever alcohol may be contributing to symptoms or comorbidity.

Normalising the conversation increases the likelihood that patients will disclose their alcohol consumption.

The Alcohol Use Disorders Identification Test – Concise (AUDIT-C) is a practical first-step screening tool for use in primary care. It is brief, validated and easy to incorporate into routine consultations. A positive AUDIT-C result identifies risky drinking that warrants further assessment, but it does not establish a diagnosis of AUD. Higher scores should prompt review of the patient’s drinking pattern, loss of control, cravings, withdrawal symptoms, alcohol-related harms and readiness to change. The questions and interpretation of scores are shown in Table 1.

Table 1. Alcohol Use Disorders Identification Test – Concise (AUDIT-C)

Questions	Points				
	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2–4 times a month	2–3 times a week	4+ times a week
How many standard drinks containing alcohol do you have on a typical day?	1–2	3–4	5–6	7–9	10 or more
How often do you have six or more standard drinks on a single occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

* A score of ≥ 4 in men and ≥ 3 in women suggests risky drinking and warrants further assessment and brief intervention. Scores of ≥ 6 indicate a high probability of alcohol use disorder and should prompt a more comprehensive assessment.

Diagnosis of AUD remains clinical. In practice, it depends not only on how much a person drinks but on whether their alcohol use is becoming difficult to control and is affecting their health, relationships, work, mood, sleep, finances or safety.

A non-judgemental, matter-of-fact approach is essential. Framing questions about alcohol as a routine part of health care can reduce shame and defensiveness and improve engagement. Person-first language should be used, and terms such as “alcoholic” avoided.

Initial assessment: withdrawal risk and immediate safety

Once risky drinking or AUD is identified, the next step is to decide whether the patient can be managed safely in general practice or needs urgent specialist or hospital-based care. Key questions include:

- when the patient last drank alcohol;
- whether they drink daily or on waking;
- whether they have had previous withdrawal symptoms, seizures or delirium; and
- whether they have concurrent sedative use, major psychiatric illness, pregnancy, cognitive impairment, unstable medical comorbidity or poor social support.

Community-based withdrawal may be appropriate for patients with anticipated mild to moderate withdrawal, stable physical and mental health, reliable follow-up and a safe home environment. It is not appropriate for patients with prior severe withdrawal, withdrawal seizures or delirium, significant liver disease or decompensation, active suicidality or psychosis, polysubstance use, pregnancy, marked malnutrition or unsafe housing.

Assessment should also look for alcohol-related complications that require urgent escalation. These include:

- confusion;
- ataxia or ocular signs suggestive of Wernicke encephalopathy;
- jaundice;
- ascites;
- gastrointestinal bleeding;
- severe vomiting or inability to maintain oral intake;
- hallucinations;
- severe tremor;
- tachycardia;

- hypertension;
- fever; and
- other features of severe withdrawal.

Oral thiamine should be given to all patients undergoing withdrawal. In-hospital parenteral thiamine should be given when malnutrition or Wernicke encephalopathy is suspected.

Once the patient’s immediate safety has been assessed, the consultation can move to treatment planning. This should include the patient’s goals, readiness to change, likely need for withdrawal support and whether management can begin in primary care or should be shared with addiction, mental health or hepatology services.

Managing alcohol withdrawal in general practice

For selected patients who are suitable for community-based management, alcohol withdrawal can often be managed safely in general practice with close follow-up, clear instructions and a low threshold for escalation. Symptoms usually begin within 24 hours of the last drink and typically peak over the first 24–72 hours. They commonly include tremor, sweating, anxiety, nausea, insomnia, tachycardia and agitation.

Benzodiazepines remain first-line treatment for alcohol withdrawal. Diazepam is often used in community settings because of its long half-life, but oxazepam is preferred when there is significant liver dysfunction or concern about prolonged sedation. Prescribing should be cautious, with staged supply and daily or early review where possible. Patients should be advised not to drive, not to combine benzodiazepines with alcohol or other sedatives, and to seek urgent review if symptoms worsen rather than settle. An example withdrawal schedule is shown in Table 2.

Table 2. Example of community-based alcohol withdrawal schedule

Days since last alcohol-containing drink	Suggested diazepam dose*
1–2	5–10 mg three to four times daily
3–4	5–10 mg two to three times daily
5	5–10 mg daily at night

* Oxazepam 7.5–15 mg should be substituted for diazepam if there is significant liver dysfunction or concern about prolonged sedation.

Thiamine 300 mg daily should be prescribed to all patients undergoing withdrawal. Supportive care is also important, including attention to hydration, nutrition, sleep and practical supports at home. Involving a family member or support person can improve safety and adherence.

Escalation to hospital-based care is required if severe tremor, marked autonomic instability, hallucinations, seizures, confusion, ataxia, ocular signs, jaundice, ascites, gastrointestinal bleeding or inability to maintain oral intake develops. Once withdrawal has settled, management should shift to relapse prevention, including psychosocial support, follow-up and consideration of pharmacotherapy for AUD.

Brief intervention

A brief intervention can make a meaningful difference, particularly for patients with risky drinking or mild AUD. In general practice, this intervention should be practical, non-judgemental and linked to the patient's own health priorities rather than framed as a moral issue. Patients are often more receptive to advice when alcohol is discussed in the context of sleep, mood, blood pressure, weight, liver health, relationships, work or recurrent injury. The aim is to help the patient recognise their risk, consider change and leave the consultation with a clear next step.

A useful brief intervention includes clear feedback about risk, exploration of goals and simple negotiated advice. This may involve discussing current drinking in relation to NHMRC guidance, identifying triggers for heavier drinking and agreeing on a realistic goal, such as reducing intake, avoiding binges or working towards abstinence. Practical strategies may include having alcohol-free days, not keeping alcohol at home, planning for high-risk situations, involving a support person or replacing drinking with other routines.

For patients with moderate to severe AUD, a brief intervention alone is usually insufficient. These patients require a more structured treatment plan, including regular follow-up, psychosocial support and consideration of relapse-prevention pharmacotherapy. General practice remains an appropriate place to start this process. A patient does not need to be ready for complete abstinence before treatment begins. Some patients will aim for abstinence, whereas others may initially aim to reduce harm or regain control. Shared decision-making is important, and treatment goals can evolve over time.

Follow-up should be planned early and framed as part of routine care. Early review allows the GP to reassess alcohol intake, withdrawal symptoms, mood, sleep, medication tolerance and any emerging complications. Relapse or return to alcohol use should be approached as a clinical issue, not a failure.

Pharmacotherapy for AUD in general practice

For patients with moderate to severe AUD, relapse-prevention pharmacotherapy should be considered early rather than being reserved for specialist settings. Medication works best when combined with psychosocial support and planned follow-up, but general practice is an appropriate place to start treatment once acute withdrawal has settled and the patient's goals are clear. In Australia, acamprosate and naltrexone are the main first-line options subsidised by the Pharmaceutical Benefits Scheme (PBS).

Acamprosate 666 mg three times daily, or 333 mg three times daily if body weight is under 50 kg, supports abstinence and is most suitable when the patient's goal is to stop drinking rather than simply reduce intake. It is usually started after withdrawal has resolved. Kidney function should be checked before prescribing, as acamprosate is contraindicated in patients with renal insufficiency.

Naltrexone 50 mg daily can reduce the risk of relapse to heavy drinking and support abstinence. It should not be used for patients who are taking opioids or likely to require opioid analgesia, and it is contraindicated in those with acute hepatitis or severe liver failure. Liver function should be reviewed before treatment. Naltrexone is usually started after acute withdrawal has settled.

Treatment is usually continued for 3–6 months, depending on response and patient goals.

Psychosocial treatment and supports

Psychosocial interventions are a core part of treatment for AUD, particularly for patients with moderate to severe disease. The choice of intervention should be guided by the patient's goals, readiness to change, coexisting mental health symptoms, cultural context and local service availability.

Table 3. Suggested thresholds for further liver assessment or referral

Test or symptom	Interpretation
FIB-4	
Online calculator: https://liver.org.au/health-professionals/fib-4-calculator/	
<1.3	Low risk
≥1.3	Secondary fibrosis assessment or referral pathway
In adults aged >65 years, some pathways use >2.0 as the threshold for secondary assessment	
Transient elastography (FibroScan)	
<8 kPa	Low risk
≥8 kPa	Intermediate–high risk; consider referral
ELF	
Local laboratory or pathway cut-off (9.8 often used in EASL-based pathways)	Advanced fibrosis
Ultrasound: nodular contour, splenomegaly, ascites or portal hypertension	Hepatology referral
Jaundice, ascites, gastrointestinal bleeding, hepatic encephalopathy or marked synthetic dysfunction	Urgent hospital assessment

EASL = European Association for the Study of the Liver; ELF = Enhanced Liver Fibrosis; FIB-4 = Fibrosis-4.

Cognitive behavioural therapy and related structured approaches have the strongest evidence base. In practice, psychosocial treatment may include:

- motivational interviewing;
- psychoeducation about cravings and relapse;
- identification of triggers;
- development of alternative routines;
- coping skills;
- emotion regulation; and
- relapse prevention planning.

Some patients will benefit from referral to a psychologist or other mental health clinician, including through Medicare-supported pathways where appropriate.

Comorbid mental health conditions, such as anxiety, depression, trauma and other substance use, should be assessed and addressed as part of the treatment plan. Linking patients with community alcohol and other drug services and culturally safe services may improve engagement and continuity of care. A mental health care plan should be considered for those wanting to privately access community psychologists.

Peer support can also be valuable. SMART Recovery and Alcoholics Anonymous groups are widely available and may complement formal treatment. Some patients will also benefit from online or telephone counselling, particularly where access to in-person services is limited. Youth-focused

services may be appropriate for younger people, and Aboriginal community-controlled health organisations can provide culturally safe care for First Nations people.

Family and social supports should be considered wherever appropriate. Involving a partner, family member or other trusted support person can strengthen treatment adherence and safety, while family support groups may help reduce distress and improve coping.

When to assess the liver

Initial liver assessment in general practice should include liver biochemistry, measurement of bilirubin, albumin and international normalised ratio (INR), and a full blood count, including platelets. Persistently abnormal liver test results should be investigated rather than attributed to alcohol alone. Significant fibrosis may be present despite only mildly abnormal results, or even when liver enzyme levels are normal. Thrombocytopenia, a raised bilirubin level, low albumin level or prolonged INR may suggest more advanced liver disease. Suggested thresholds for further assessment or referral are shown in Table 3.

Urgent hospital assessment is required for patients with jaundice, ascites, gastrointestinal bleeding, hepatic encephalopathy or marked synthetic dysfunction. New-onset jaundice with systemic unwellness in a person who is drinking heavily should also raise concern about severe alcohol-related hepatitis. The aim is not to make liver

disease the trigger for action but to identify patients in whom alcohol use has already translated into clinically important hepatic injury.

Useful resources

Further reading

Haber PS, Riordan BC, Winter DT, et al. New Australian guidelines for the treatment of alcohol problems: an overview of recommendations. *Med J Aust* 2021; 215 Suppl 7: S3-S32.

Palmer AJ, Connor JP, Clark PJ. Alcohol use disorder: an Australian perspective on screening, diagnosis, treatment and prevention. *Intern Med J.* 2026; 56 (4): 521-532.

Websites

- National Alcohol and Other Drug Hotline
<https://www.health.gov.au/contacts/national-alcohol-and-other-drug-hotline>
- Alcohol and Drug Counselling Online
<https://www.counsellingonline.org.au>
- Smart Recovery Australia
<https://au.meetings.smartrecovery.org/meetings/>
- Lives Lived Well (Queensland and northern NSW only)
<https://www.liveslivedwell.org.au>
- Alcoholics Anonymous Australia
<https://meetings.aa.org.au>
- Al-Anon Family Groups Australia
<https://al-anon.org.au>
- Alateen
<https://al-anon.org.au/alateen/>

Acknowledgements

This resource was written by the following health care professionals:

Prof Paul Clark, Gastroenterologist/Hepatologist, Director of the Alcohol and Drug Assessment Unit, Princess Alexandra Hospital, Mater Hospital, Brisbane, QLD, Australia
Prof Jason Connor, Director of the National Centre for Youth Substance Use Research, University of Queensland and Clinical Psychologist with the Alcohol and Drug Assessment Unit at Princess Alexandra Hospital, Brisbane, QLD, Australia
A/Prof Miriam Levy, Gastroenterologist/Hepatologist, Director of Hepatology Service, Gastroenterology and Liver Service, Liverpool Hospital, Liverpool, NSW Australia
Dr Andrew Palmer, Gastroenterologist, Princess Alexandra Hospital, Brisbane, QLD, Australia, University of Queensland, QLD, Australia

The resource was reviewed and edited by the GESA Liver Faculty that included the following health professionals:

Prof Jessica Howell (Chair, Liver Faculty), Gastroenterologist, St Vincent's Hospital, NHMRC Principal Research Fellow, Head Hepatitis B and Liver Cancer Program, Burnet Institute, Honorary Professorial Fellow, University of Melbourne, Adjunct Senior Research Fellow, Monash University, Melbourne, VIC Australia
Prof Neeraj Bhala, Head of Gastroenterology and Hepatology, University of Melbourne, Consultant Royal Melbourne Hospital, Melbourne, VIC Australia
A/Prof Purnima Bhat, Gastroenterologist, Senior Research Fellow, Australian National University, Canberra Hospital, Canberra, ACT Australia
A/Prof Asif Chinnaratha, Gastroenterologist/Hepatologist, Eastwood, SA Australia
Dr Madeleine Gill, Hepatology Fellow, Royal Prince Alfred Hospital, Sydney, NSW, Australia
Dr Enoka Gonsalkorala, Gastroenterologist/Hepatologist, Royal Brisbane and Women's Hospital, Brisbane, Qld Australia
Dr Katharine Irvine, Researcher at Mater Research Institute, University of Queensland, Brisbane, Qld Australia
Dr Ken Liu, Hepatologist, Royal Prince Alfred Hospital, Sydney, NSW, Australia
A/Prof Ammar Majeed, Gastroenterologist, Cabrini Hospital, Melbourne, VIC Australia
Dr Tim Mitchell, Gastroenterologist/Hepatologist, St John of God Midland Public and Private Hospitals, Midland, WA Australia
Prof James O'Beirne, Hepatologist Sunshine Coast University Hospital, Sunshine Coast, QLD Australia

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Level 3, 517 Flinders Lane Melbourne VIC 3000 | Phone: 1300 766 176 | E-mail: gesa@gesa.org.au | Website: <http://www.gesa.org.au>

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