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BMHP6029 – Psychological classification and provisions 1

BMHP6029-Psychopathological Classifications and Provisions

Component 2: Written Assignment(Report)

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Introduction

Alcohol Use Disorder (AUD) is one of the most important issues of national health in the United Kingdom and abroad. It is coded in the International Classification of Diseases, Eleventh Revision (ICD-11) in Chapter 6: Mental, Behavioral or Neurodevelopmental Disorders, in the block "Disorders due to Substance Use or Addictive Behaviors" (World Health Organization, 2022). The magnitude of the issue is shocking: 8,274 alcohol-related deaths in England were reported by the Office of Health Improvement and Disparities . OHID) in (2023), the highest number in history, the increase compared to 2022 is 4.6, and the increase compared to 2019 is 42.2. OHID, (2025). In England alone, alcohol-specific hospital admissions occurred in 2023-2024 at 339,916 . OHID, (2025). This report discusses the classification and diagnosis of AUD in the framework of ICD-11 critically, assesses conventional treatment and rehabilitation strategies, discusses the modern discussion.

Classification and Diagnosis

ICD-11 AUD is included in the parent block "Disorders due to Substance Use or Addictive Behaviors' (BlockL1-6C4), with alcohol-specific disorders coded 6C40. ICD-11 that was implemented on 1 January of 2022 has brought significant revisions compared to its

predecessor ICD-10, which was published in 1992 .Matone et al., (2022). according to the new classification system, what previously represented combined diagnoses are now disaggregated into separate categories: harmful pattern of alcohol use (6C40.0), alcohol dependence (6C40.1), alcohol intoxication (6C40.2), alcohol withdrawal (6C40.3), and alcohol-induced disorders with specific coding requirements (WHO, 2022).

One of the main linguistic characteristics of ICD-11 is that it consciously refers to disorder instead of disease or illness. It is an international agreement to use a clinically neutral, non-stigmatizing language . Saunders, (2017). In 2024, the Clinical Descriptions and Diagnostic Requirements (CDDR) were published to provide an extensive guideline to clinicians (Saunders et al., 2024).

The UK generally has a structured approach to clinical assessment such as the Alcohol Use Disorders Identification Test (AUDIT) and the Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) during diagnostic processes (NICE, 2011). ICD-11 has severity qualifiers, mild, moderate, and severe, and this is a major improvement on ICD-10 with its binary distinction between harmful use and dependence and more clinically meaningful categorization (Matone et al., 2022). New codes of harmful episodes of use are also introduced by the new system, which allow tracing and intervening with a person at a more initial stage, before complete dependence has been formed. Saunders et al., (2024).

Treatment and Rehabilitation

The most common ways of treatment of AUD in the UK are informed by the guidelines of NICE Clinical Guideline CG115 (NICE, 2011) and the more recent draft UK Clinical Guidelines in Alcohol Treatment published by OHID (2023).

The acute treatment is still based on pharmacological management especially in the management of alcohol withdrawal. The initial drug in medically supervised detoxification is benzodiazepines, which is usually chlordiazepoxide, to mitigate chances of withdrawal seizures and delirium tremens (NICE, 2011). Acamprosate and naltrexone are the main pharmacological agents recommended by NICE in the prevention of relapse after detoxification, and disulfiram is used in certain situations under strict conditions.

One of the best-evidenced psychological interventions in AUD is Cognitive Behavioral Therapy (CBT), which has shown a small but long-lasting effect size in randomized controlled trials and aids patients to spot and change maladaptive thoughts and behavioral patterns related to alcohol consumption. McHugh et al., (2010). Working in a person-centered, directive manner that promotes intrinsic motivation. OHID, (2023). Also with good evidence is social network and relationship-based interventions such as Behavioral Couples Therapy (BCT) which reduces alcohol use and enhances relationship outcomes (NICE, 2011).

The CDDR references in ICD-11 define rehabilitation as not only covering abstinence-oriented objectives but recovery-oriented outcomes that cover social reintegration, employment, housing, and wellbeing (WHO, 2022). In practice the UK rehabilitation services incorporate community based structured day programmers, residential rehabilitation, and mutual aid groups like the Alcoholics Anonymous and SMART Recovery. Nevertheless, the Committee of Public Accounts (2023) in Parliament found a lot of deficiency in the provision and stated that there are chronic underfunding, workforce shortages, and disjointed commissioning arrangements that restrict access to evidence-based treatment, especially that of people with socioeconomically deprived backgrounds.

One of the most outstanding shortcomings of the existing treatment methods is the high incidence of relapses, which is estimated to be 40-60 percent in the first year of treatment (Witkiewitz and Marlatt, 2004). This has led to renewed interest in digital interventions and blended care models, which can enhance access and flexibility, although the effectiveness of these approaches, specifically in AUD, is still developing OHID, (2023).

Ongoing Discussions and New Problems.

4.1. Brain Disease Model of Addiction.

The conceptualization of AUD as a brain disease is one of the most disputed issues on the scope of addiction science. The addiction model of compulsive brain disease (cBDMA) in which AUD is perceived as a chronic and relapsing neurological disorder with disturbed brain circuits has been at the center of policy and treatment paradigms since the 1990s (Blithikioti et al., 2025). Advocates believe that the model decreases moral stigma and legitimizes clinical treatment (Leshner, 1997). But, an increasing literature of critical scholarship questions this framing. In article published in The Lancet Psychiatry, Blithikioti et al. (2025) believe that the cBDMA over-estimates the role of biological determinism and can paradoxically promote stigma and diminish self-efficacy in people with AUD. An experimental study based in the UK revealed that framing addiction as a compulsive brain disease was much more likely to lower the confidence of problematic drinkers to change behaviour than were choice-based framings (Morris et al., 2025).

4.2 Stigma and Language

Stigma has been identified as one of the biggest obstacles to treatment among the people with AUD in the UK. Morris and Schomerus (2023), who authored an article in Drug and Alcohol Review, define alcohol problems as one of the most stigmatized health conditions, which are perceived by people as blameworthy, dangerous and weak-minded. In their draft clinical guidelines, the UK government is explicit on stigma as a significant help-seeking barrier and urges practitioners to be compassionate and non-judgmental OHID, (2023).

4.3 The Neurodivergence and Differential Vulnerability.

Another area of AUD that is not fully explored is the connection between neurodivergent conditions and varying susceptibility to harmful alcohol consumption. According to Alcohol Change UK (2022), alcohol can be used by neurodivergent people (ADHD, autism spectrum disorder (ASD)) to cope with anxiety, sensory sensitivities, or social issues, and up to 43 percent of people with ADHD develop AUD in their lifetime. Researchers at King's College London conducted a systematic review in BJPsych Open that determined that alcohol consumption in ASD is characterized by a complex and interacting risk factor of biological, psychological, social, and environmental factors, and that current therapeutic methods are seldom tailored to autistic patients. Paleri et al., (2025).

4.4 Health Inequalities

AUD is disproportionately impacting deprived populations. According to OHID data, there is twice as much alcohol-specific mortality in the most deprived tenth of local authority areas as in the least deprived (OHID, 2025). In 2023, the North East of England had the highest alcohol-specific death rate of 25.7 per 100,000 compared to 11.5 of the East of England . OHID,

(2025). Such disparities are enhanced by differences in receiving treatment services, as community addiction services are often under-invested in the most needy areas (Parliament, 2023). Gender and age inequalities are also noted: women have alcohol-related cognitive damage after fewer years of harmful drinking compared to men . Davies et al., (2024).

Recommendations

To begin with, the ICD-11 diagnostic system needs to be accompanied by recommendations that prompt clinicians to diagnose neurodivergent disorders like ADHD and ASD as a part of a comprehensive AUD evaluation. Since co-occurrence is high, and neurodivergent people have unique care requirements, not doing that will lead to misdiagnosis and ineffective care. This is in line with the recommendation of the SABA-A partnership . Paleri et al., (2025).

Second, the UK government and NHS England need to invest heavily in alcohol treatment services especially high deprivation areas. According to the Committee of Public Accounts (2023), systemic underfunding was one of the key causes of poor outcomes. The implementation of Minimum Unit Pricing (MUP), which is already in use in Scotland and linked to a comparatively smaller number of deaths linked to alcohol than in England (Institute of Alcohol Studies, 2024), should be applied in England and Wales as a preventive measure.

Third, brain disease framing prevailing in contemporary UK public health messaging could be reevaluated through the prism of the emerging evidence that it might decrease self-efficacy and raise stigma .Blithikioti et al., 2025; Morris et al., (2025).

Fourth, the use of person-first, non-stigmatizing language should be integrated into clinical education, and obligatory supervision frameworks. This is in line with the OHID (2023) guidelines but needs to be systemic not just guidance.

Fifth, digital and blended care approaches need to be created and tested as a supplement to face-to-face care especially in populations experiencing barriers to access like rural populations, caregivers, or those unable to utilize traditional service systems.

Conclusion

Alcohol Use Disorder is a multidimensional and complex condition, the classification in ICD-11 being a major improvement over its predecessor in distinguishing the severity and clinical usefulness. Nevertheless, there are still considerable difficulties. There is an endemic lack of resources to provision of treatment in the UK, there is inequitable access, and the current discussions about the model of brain disease, the stigma, the language, and neurodivergence are not completely embedded in either classification or practice. The suggestions presented below are based on existing evidence, and are designed to bring about better outcomes in people with AUD throughout the severity spectrum, as well as help create a more equitable and effective public health response.

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