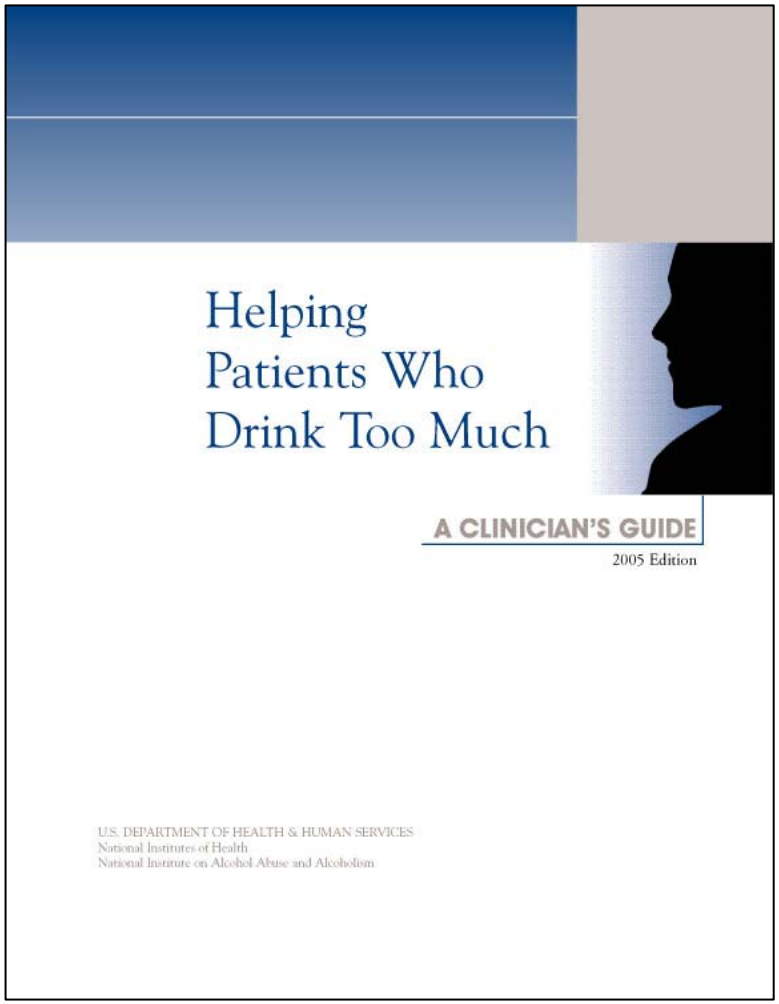
Using NIAAA's *Clinician's Guide*

A note to Instructors:
This slideshow is intended to be used as a companion to the full text version of the NIAAA *Clinician's Guide*. For best results, distribute copies of the *Guide* for student use during the presentation.



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Introduction

The Guide was written for primary care and mental health clinicians. It is produced by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), a component of the National Institutes of Health, with guidance from physicians, nurses, advanced practice nurses, physician assistants, and clinical researchers.

Introduction (cont'd)
How Much is "Too Much"?

Drinking becomes too much when it…

*Causes or elevates the risk for alcohol-related problems, or

* Complicates the management of other health problems

There are increased risks for alcohol-related problems for…

* Men who drink 5 or more standard drinks in a day (or 15 or more per week) and

* Women who drink 4 or more standard drinks in a day (or 8 or more per week)

Introduction (cont'd)

How Much Is "Too Much"?

However, individual responses to alcohol vary –

Drinking at lower levels may be problematic depending on many factors; for example…

* Patient's age
* Co-existing conditions
* Medication use

Note: The U.S. Surgeon General urges abstinence from drinking for women who are or may become pregnant.

Why Screen for Heavy Drinking?

At-risk drinking and alcohol problems are common

*About 3 in 10 adults drink at levels that elevate health risks.

*Among heavy drinkers, 1 in 4 has alcohol abuse or dependence.

*All heavy drinkers have a greater risk of hypertension, gastrointestinal bleeding, sleep disorders, major depression, hemorrhagic stroke, cirrhosis of the liver, and several cancers.

Heavy drinking often goes undetected

* Patients with alcohol dependence receive recommended care only about 10 percent of the time.

You are in a prime position to make a difference

* Brief interventions can promote significant, lasting reductions in drinking levels in at-risk drinkers who are not alcohol dependent.

Before You Begin…

The *Clinician's Guide* provides two screening methods—decide which you prefer:

Option 1. A Clinical Interview–a single question about heavy drinking days*

Option 2. The AUDIT–a written self-report instrument; takes about 5 minutes to complete

** The single question can be used at any time or in conjunction with the AUDIT.*

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
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	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: *This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect standard drink sizes in the United States, the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at* ***www.who.org****.*

The AUDIT is found on page 11…

PACIENTE: Debido a que el uso del alcohol puede afectar su salud e interferir con ciertos medicamentos y tratamientos, es importante que le hagamos algunas preguntas sobre su uso del alcohol. Sus respuestas serán confidenciales, así que sea honesto por favor.

Marque una X en el cuadro que mejor describa su respuesta a cada pregunta.

Preguntas	0	1	2	3	4	
1. ¿Con qué frecuencia consume alguna bebida alcohólica?	Nunca	Una o menos veces al mes	De 2 a 4 veces al mes	De 2 a 3 más veces a la semana	4 o más veces a la semana	
2. ¿Cuantas consumiciones de bebidas alcohólicas suele realizar en un día de consumo normal?	1 o 2	3 o 4	5 o 6	De 7 a 9	10 o más	
3. ¿Con qué frecuencia toma 5 o más bebidas alcohólicas en un solo día?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
4. ¿Con qué frecuencia en el curso del último año ha sido incapaz de parar de beber una vez había empezado?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
5. ¿Con qué frecuencia en el curso del último año no pudo hacer lo que se esperaba de usted porque había bebido?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
6. ¿Con qué frecuencia en el curso del último año ha necesitado beber en ayunas para recuperarse después de haber bebido mucho el día anterior?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
7. ¿Con qué frecuencia en el curso del último año ha tenido remor-dimientos o sentimientos de culpa después de haber bebido?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
8. ¿Con qué frecuencia en el curso del último año no ha podido recordar lo que sucedió la noche anterior porque había estado bebiendo?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
9. ¿Usted o alguna otra persona ha resultado herido porque usted había bebido?	No		Sí, pero no en el curso del último año		Sí, el último año	
10. ¿Algún familiar, amigo, médico o profesional sanitario ha mostrado preocupación por un consumo de bebidas alcohólicas o le ha sugerido que deje de beber?	No		Sí, pero no en el curso del último año		Sí, el último año	
					Total	

Note: *This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization and the Generalitat Valenciana Conselleria De Benestar Social. To reflect standard drink sizes in the United States, the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at* ***www.who.org****.*

…and a Spanish translation is found on page 12.

Before You Begin…

Think about clinical indications for screening.
Key opportunities include…

* As part of **routine examination**
* Before **prescribing medication**
* In the **emergency department**

* In patients who are…

  * **Pregnant** or trying to conceive
  * **Likely to drink heavily** (e.g. smokers, adolescents, young adults)
  * Having **health problems that might be alcohol induced**
  * Experiencing chronic **illness not responding to treatment**

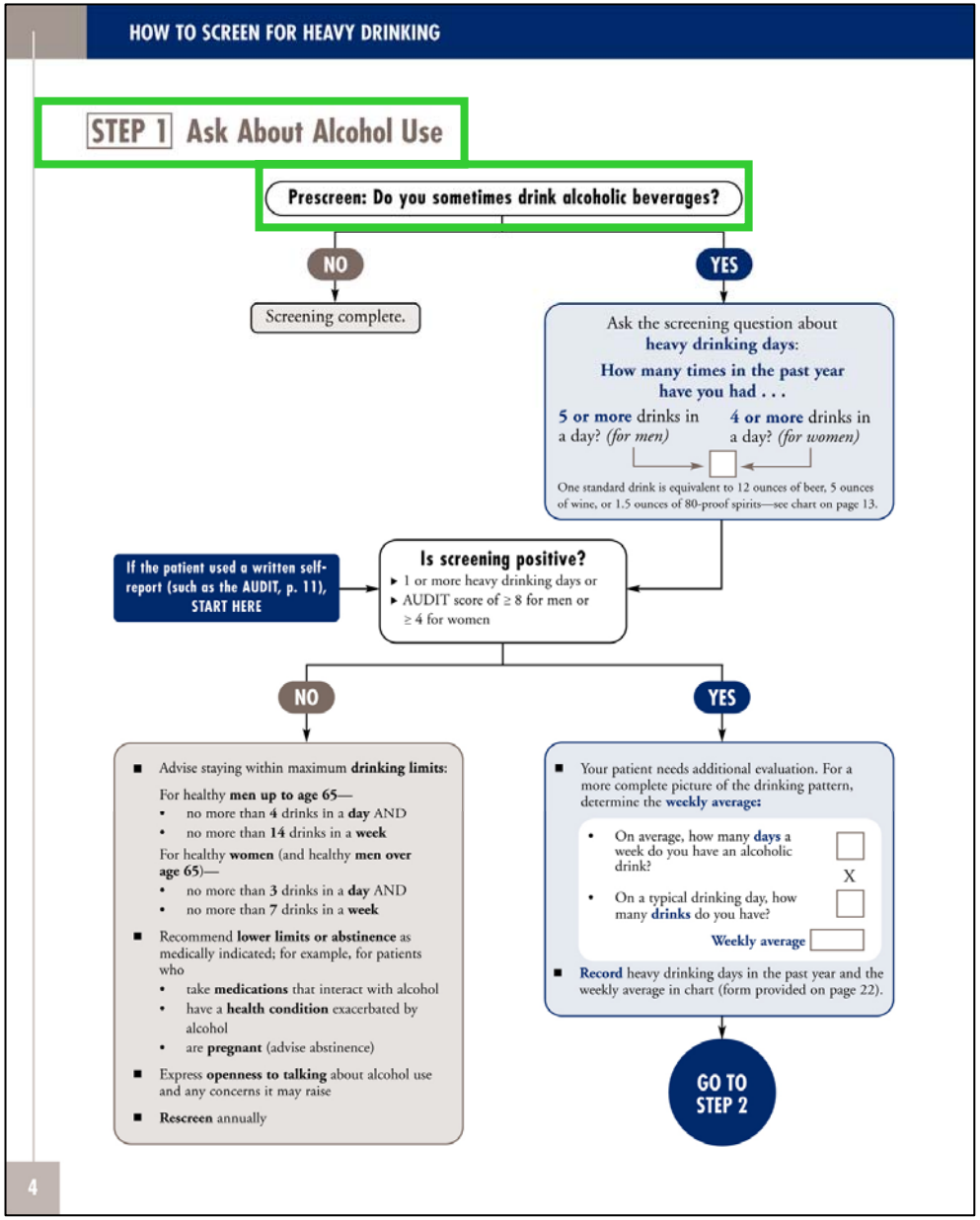
Before You Begin…

Set up your practice to simplify the process

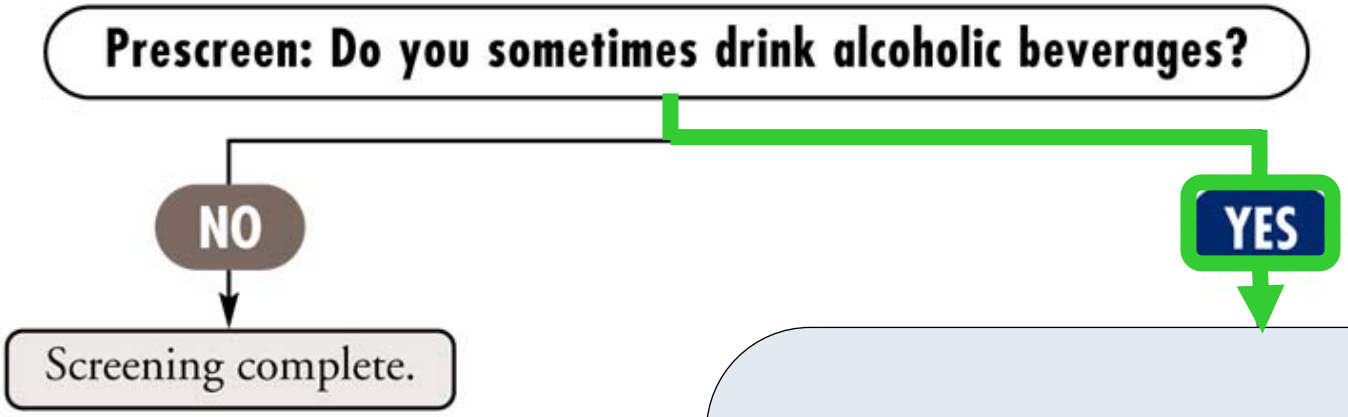
* Decide who will conduct the screening or administer the AUDIT.
* Use preformatted progress notes (pages 22–23).
* Use computer reminders.
* Keep copies of the Pocket Guide and referral information.
* Monitor your performance.

STEP 1: Ask About Alcohol Use

Prescreen: Do you sometimes drink alcoholic beverages?



For patients who drink, ask the Screening Question:



How many times in the past year have you had….

5 or more drinks in a day? (*men*)

4 or more drinks in a day? (*women*)

Tip: It may be useful to show patients the **Standard Drinks** chart on page 13.

What Is a Standard Drink?

Any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons).

12 oz. of beer or cooler	**8-9 oz. of malt liquor** 8.5 oz. shown in a 12-oz. glass that, if full, would hold about 1.5 standard drinks of malt liquor	**5 oz. of table wine**	**3-4 oz. of fortified wine** (such as sherry or port) 3.5 oz. shown	**2-3 oz. of cordial, liqueur, or aperitif** 2.5 oz. shown	**1.5 oz. of brandy** (a single jigger)	**1.5 oz. of spirits** (a single jigger of 80-proof gin, vodka, whiskey, etc.) Shown straight and in a highball glass with ice to show level before adding mixer*
						
12 oz.	**8.5 oz.**	**5 oz.**	**3.5 oz.**	**2.5 oz.**	**1.5 oz.**	**1.5 oz.**

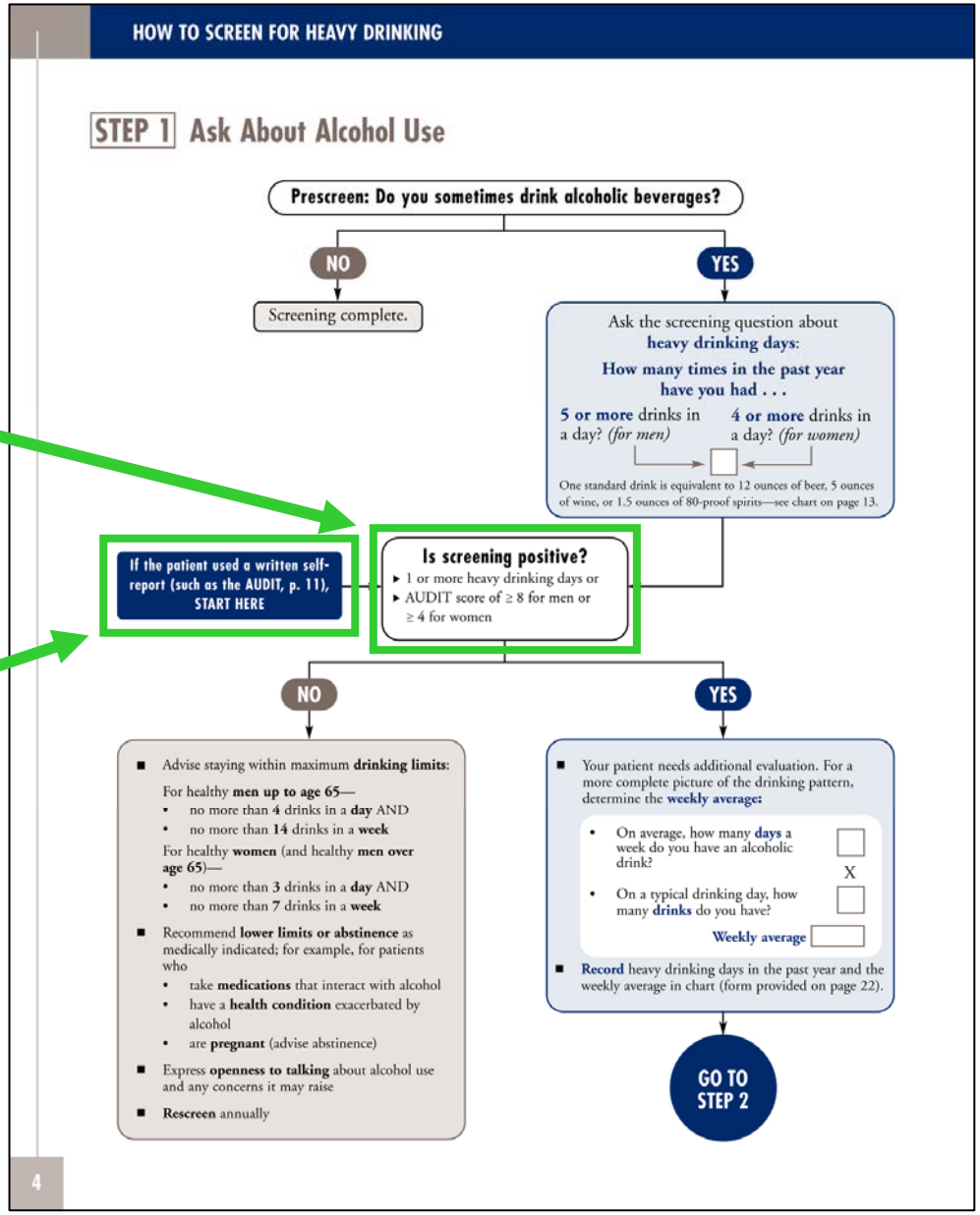
STEP 1 (continued):

Is the Screening Positive?

* 1 or more heavy drinking days, or

For patients given the AUDIT, start here: Positive Screening =

* AUDIT score of
  ≥ 8 for men
  ≥ 4 for women



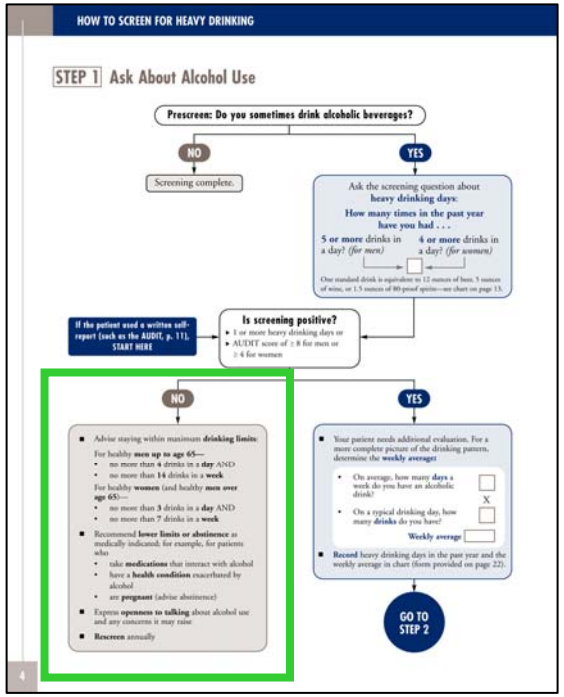
STEP 1: Is the Screening Positive?

If NO, then…

* Advise staying within maximum **drinking limits:**

For healthy **men up to age 65—**
* no more than **4** drinks in a **day** AND
* no more than **14** drinks in a **week**

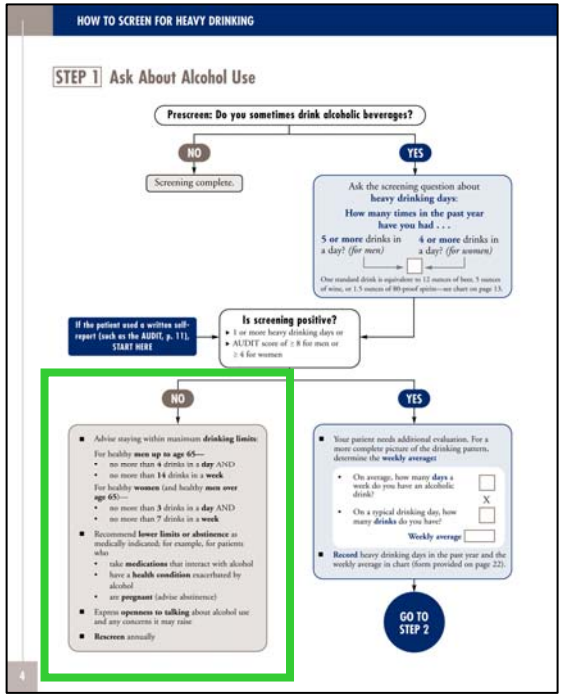
For healthy **women** (and healthy **men over age 65)—**
* no more than **3** drinks in a **day** AND
* no more than **7** drinks in a **week**



STEP 1: Is the Screening Positive?

If NO, then…

* Recommend **lower limits or abstinence** as medically indicated for patients who-
  * take **medications** that interact with alcohol
  * have a **health condition** exacerbated by alcohol
  * are **pregnant** (advise abstinence)
* Express **openness to talking** about alcohol use and any concerns it may raise
* **Rescreen** annually



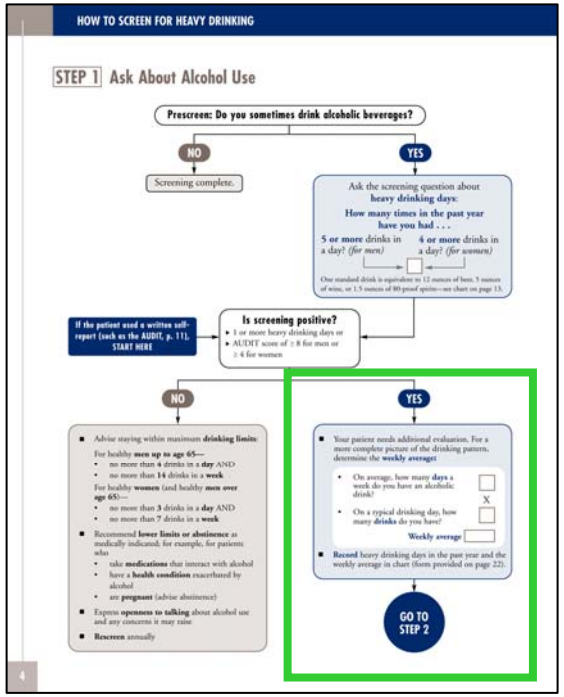
STEP 1: Is the Screening Positive?

If YES, then…

* Your patient needs additional evaluation. For a more complete picture of the drinking pattern, determine the **weekly average**:

- On average, how many **days** a week do you have an alcoholic drink? ☐ X
- On a typical drinking day, how many **drinks** do you have? ☐

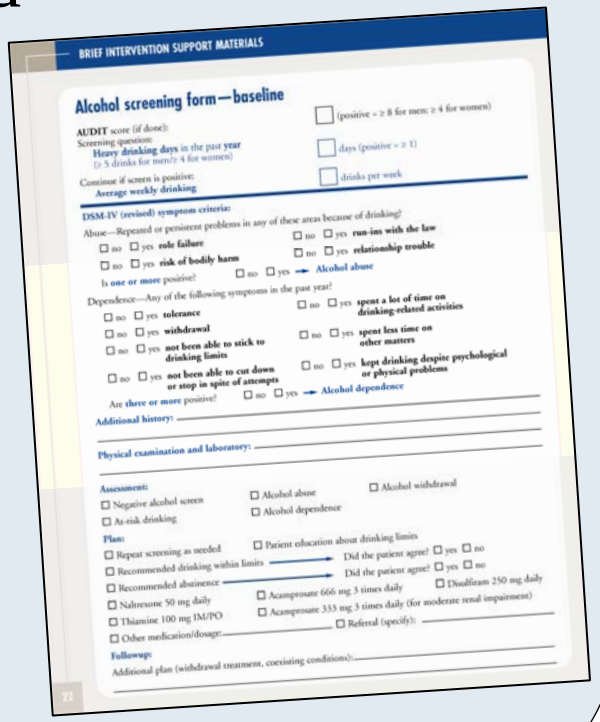
Weekly average ☐



STEP 1: Is the Screening Positive?

If YES, then…

* **Record** heavy drinking days in the past year and the weekly average in the chart (see the form provided in the appendix on **page 22**).



BRIEF INTERVENTION SUPPORT MATERIALS

Alcohol screening form—baseline

AUDIT score (if done): ☐ (positive = ≥ 8 for men; ≥ 4 for women)

Screening question:
Heavy drinking days in the past **year** (≥ 5 drinks for men/≥ 4 for women) ☐ days (positive = ≥ 1)

Continue if screen is positive:
Average weekly drinking ☐ drinks per week

DSM-IV (revised) symptom criteria:

Abuse—Repeated or persistent problems in any of these areas because of drinking?

☐ no ☐ yes **role failure**
☐ no ☐ yes **risk of bodily harm**
☐ no ☐ yes **run-ins with the law**
☐ no ☐ yes **relationship trouble**

Is **one or more** positive? ☐ no ☐ yes → **Alcohol abuse**

Dependence—Any of the following symptoms in the past year?

☐ no ☐ yes **tolerance**
☐ no ☐ yes **withdrawal**
☐ no ☐ yes **not been able to stick to drinking limits**
☐ no ☐ yes **not been able to cut down or stop in spite of attempts**
☐ no ☐ yes **spent a lot of time on drinking-related activities**
☐ no ☐ yes **spent less time on other matters**
☐ no ☐ yes **kept drinking despite psychological or physical problems**

Are **three or more** positive? ☐ no ☐ yes → **Alcohol dependence**

Additional history:

Physical examination and laboratory:

Assessment:
☐ Negative alcohol screen
☐ At-risk drinking
☐ Alcohol abuse
☐ Alcohol dependence
☐ Alcohol withdrawal

Plan:
☐ Repeat screening as needed
☐ Recommended drinking within limits → Did the patient agree? ☐ yes ☐ no
☐ Recommended abstinence → Did the patient agree? ☐ yes ☐ no
☐ Patient education about drinking limits
☐ Naltrexone 50 mg daily
☐ Thiamine 100 mg IM/PO
☐ Acamprosate 666 mg 3 times daily
☐ Acamprosate 333 mg 3 times daily (for moderate renal impairment)
☐ Disulfiram 250 mg daily
☐ Other medication/dosage:
☐ Referral (specify):

Followup:
Additional plan (withdrawal treatment, coexisting conditions):

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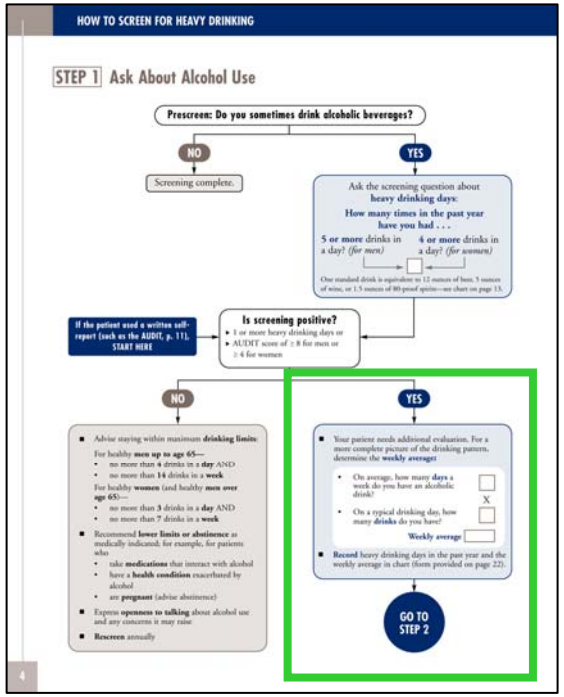

HOW TO SCREEN FOR HEAVY DRINKING

STEP 1 Ask About Alcohol Use

Prescreen: Do you sometimes drink alcoholic beverages?

NO → Screening complete.

YES → Ask the screening question about **heavy drinking days**:
How many times in the past year have you had . . .
5 or more drinks in a day? *(for men)* / **4 or more** drinks in a day? *(for women)*

One standard drink is equivalent to 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits—see chart on page 13.

If the patient used a written self-report (such as the AUDIT, p. 11), START HERE

Is screening positive?
- 1 or more heavy drinking days or
- AUDIT score of ≥ 8 for men or ≥ 4 for women

NO:
- Advise staying within maximum **drinking limits**:
  For healthy **men up to age 65**—
  - no more than **4** drinks in a **day** AND
  - no more than **14** drinks in a **week**
  For healthy **women** (and healthy **men over age 65**)—
  - no more than **3** drinks in a **day** AND
  - no more than **7** drinks in a **week**
- Recommend **lower limits or abstinence** as medically indicated; for example, for patients who
  - take **medications** that interact with alcohol
  - have a **health condition** exacerbated by alcohol
  - are **pregnant** (advise abstinence)
- Express **openness to talking** about alcohol use and any concerns it may raise
- **Rescreen** annually

YES:
- Your patient needs additional evaluation. For a more complete picture of the drinking pattern, determine the **weekly average**:
  - On average, how many **days** a week do you have an alcoholic drink? ☐
  - On a typical drinking day, how many **drinks** do you have? X
  - **Weekly average** ☐
- **Record** heavy drinking days in the past year and the weekly average in chart (form provided on page 22).

GO TO STEP 2

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GO TO STEP 2

STEP 2:
Assess for Alcohol Use Disorders (AUDs)

Determine if there is—

* a **maladaptive pattern of alcohol use**
* causing **clinically significant impairment** or **distress**

STEP 2 Assess for Alcohol Use Disorders

Next, determine whether there is a *maladaptive pattern of alcohol use*, causing *clinically significant impairment* or *distress*. It is important to assess the severity and extent of all alcohol-related symptoms to inform your decisions about management. See pages 14 and 15 for sample phrasing of the questions, which are adapted from the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, revised (DSM-IV, revised).*

Determine whether, in the past 12 months, your patient's drinking has **repeatedly** caused or contributed to

- ☐ **role failure** (interference with home, work, or school obligations)
- ☐ **risk** of bodily harm (drinking and driving, operating machinery, swimming)
- ☐ **run-ins** with the law (arrests or other legal problems)
- ☐ **relationship** trouble (family or friends)

If yes to **one or more** → your patient has **alcohol abuse**.

In either case, proceed to assess for dependence symptoms.

Determine whether, in the past 12 months, your patient has

- ☐ **shown tolerance** (needed to drink a lot more to get the same effect)
- ☐ **shown signs of withdrawal** (tremors, sweating, nausea, or insomnia when trying to quit or cut down)
- ☐ **not been able to stick to drinking limits** (repeatedly gone over them)
- ☐ **not been able to cut down or stop** (repeated failed attempts)
- ☐ **spent a lot of time drinking** (or anticipating or recovering from drinking)
- ☐ **spent less time on other matters** (activities that had been important or pleasurable)
- ☐ **kept drinking despite problems** (recurrent physical or psychological problems)

If yes to **three or more** → your patient has **alcohol dependence**.

Does the patient meet the criteria for abuse or dependence?

NO → Your patient is still at risk for developing alcohol-related problems → GO TO STEPS 3 & 4 for AT-RISK DRINKING, page 6

YES → Your patient has an alcohol use disorder → GO TO STEPS 3 & 4 for ALCOHOL USE DISORDERS, page 7

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STEP 2:
Assess for Alcohol Use Disorders (AUDs)

It is important to assess the severity and extent of all alcohol-related symptoms to inform your decisions about management.

This can be done through questions adapted from the *DSM-IV, revised*.

STEP 2 Assess for Alcohol Use Disorders

Next, determine whether there is a *maladaptive pattern of alcohol use*, causing *clinically significant impairment* or *distress*. It is important to assess the severity and extent of all alcohol-related symptoms to inform your decisions about management. See pages 14 and 15 for sample phrasing of the questions, which are adapted from the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, revised (DSM-IV, revised)*.

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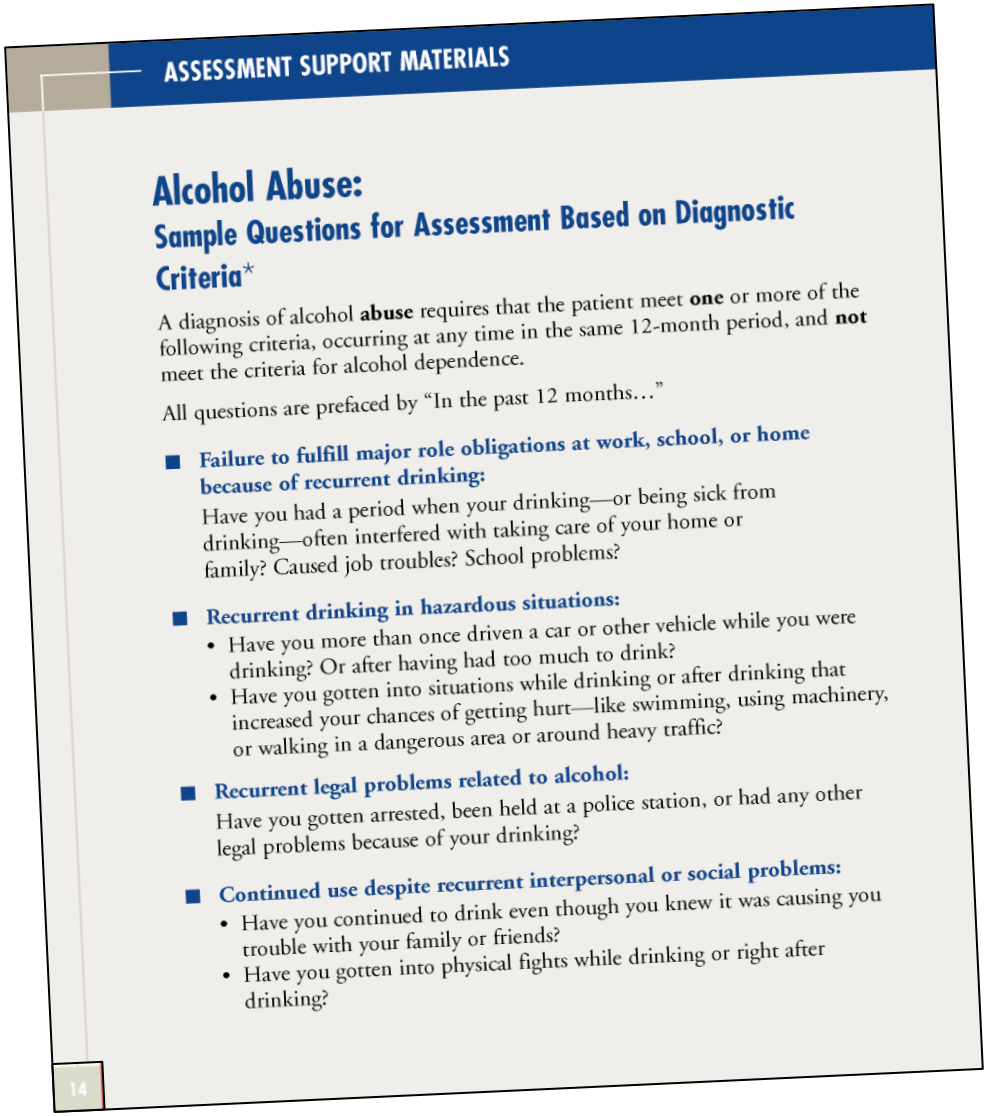
STEP 2:
Assess for Alcohol Use Disorders (AUDs)

For sample phrasing of the questions to ask, see pages 14–15 in the appendix.



ASSESSMENT SUPPORT MATERIALS

Alcohol Abuse:
Sample Questions for Assessment Based on Diagnostic Criteria*

A diagnosis of alcohol **abuse** requires that the patient meet **one** or more of the following criteria, occurring at any time in the same 12-month period, and **not** meet the criteria for alcohol dependence.

All questions are prefaced by "In the past 12 months…"

- **Failure to fulfill major role obligations at work, school, or home because of recurrent drinking:**
  Have you had a period when your drinking—or being sick from drinking—often interfered with taking care of your home or family? Caused job troubles? School problems?
- **Recurrent drinking in hazardous situations:**
  - Have you more than once driven a car or other vehicle while you were drinking? Or after having had too much to drink?
  - Have you gotten into situations while drinking or after drinking that increased your chances of getting hurt—like swimming, using machinery, or walking in a dangerous area or around heavy traffic?
- **Recurrent legal problems related to alcohol:**
  Have you gotten arrested, been held at a police station, or had any other legal problems because of your drinking?
- **Continued use despite recurrent interpersonal or social problems:**
  - Have you continued to drink even though you knew it was causing you trouble with your family or friends?
  - Have you gotten into physical fights while drinking or right after drinking?

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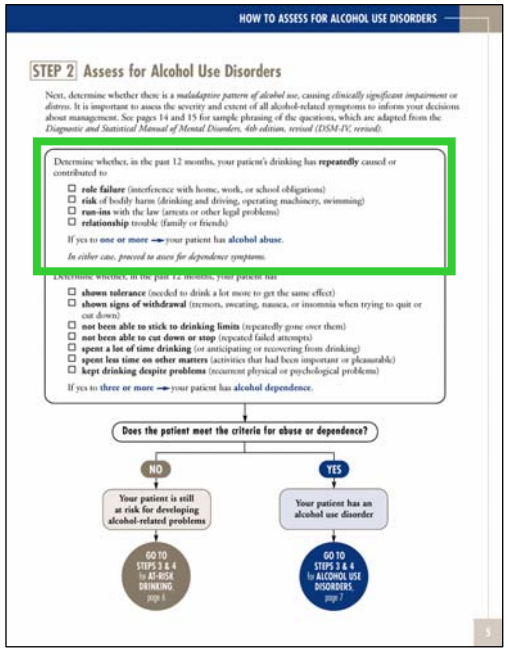
HOW TO ASSESS FOR ALCOHOL USE DISORDERS

STEP 2 Assess for Alcohol Use Disorders

Next, determine whether there is a *maladaptive pattern of alcohol use, causing clinically significant impairment or distress*. It is important to assess the severity and extent of all alcohol-related symptoms to inform your decisions about management. See pages 14 and 15 for sample phrasing of the questions, which are adapted from the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, revised (DSM-IV, revised)*.

Determine whether, in the past 12 months, your patient's drinking has **repeatedly** caused or contributed to

- ☐ **role failure** (interference with home, work, or school obligations)
- ☐ **risk** of bodily harm (drinking and driving, operating machinery, swimming)
- ☐ **run-ins** with the law (arrests or other legal problems)
- ☐ **relationship** trouble (family or friends)

If yes to **one or more** → your patient has **alcohol abuse**.

In either case, proceed to assess for dependence symptoms.

Determine whether, in the past 12 months, your patient has

- ☐ **shown tolerance** (needed to drink a lot more to get the same effect)
- ☐ **shown signs of withdrawal** (tremors, sweating, nausea, or insomnia when trying to quit or cut down)
- ☐ **not been able to stick to drinking limits** (repeatedly gone over them)
- ☐ **not been able to cut down or stop** (repeated failed attempts)
- ☐ **spent a lot of time drinking** (or anticipating or recovering from drinking)
- ☐ **spent less time on other matters** (activities that had been important or pleasurable)
- ☐ **kept drinking despite problems** (recurrent physical or psychological problems)

If yes to **three or more** → your patient has **alcohol dependence**.

Does the patient meet the criteria for abuse or dependence?

NO → Your patient is still at risk for developing alcohol-related problems → GO TO STEPS 3 & 4 for AT-RISK DRINKING page 6

YES → Your patient has an alcohol use disorder → GO TO STEPS 3 & 4 for ALCOHOL USE DISORDERS page 7

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STEP 2: Assess for AUDs:

Determine whether, in the past 12 months, your patient's drinking has <u>repeatedly</u> caused or contributed to…

- ✓ **Role failure**
- ✓ **Risk of bodily harm**
- ✓ **Run-ins with the law**
- ✓ **Relationship trouble**

Yes to <u>one</u> <u>or</u> <u>more</u> in past year: ➡ **Alcohol abuse**

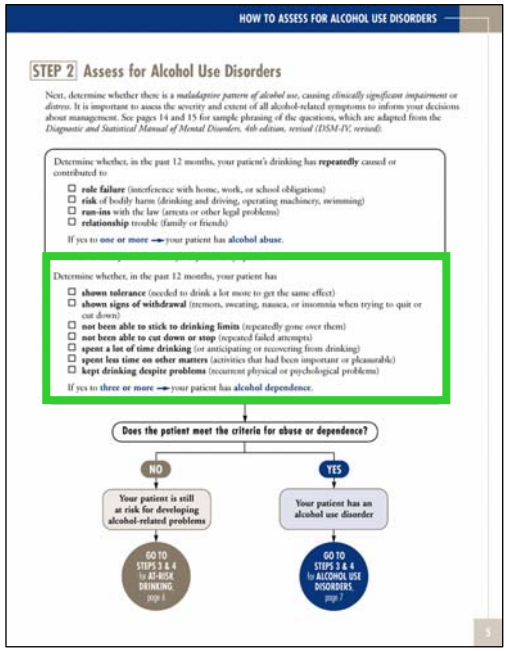
In <u>either</u> <u>case</u>, proceed to assess for dependence symptoms.

STEP 2: Assess for AUDs

Determine whether, in the past 12 months, your patient has

- ✓ **Shown tolerance**
- ✓ **Shown signs of withdrawal**
- * **Not been able to stick to drinking limits**
- ✓ **Not been able to cut down or stop** (repeated failed attempts
- ✓ **Spent a lot of time drinking** (or anticipating/recovering from drinking)
- * **Spent less time on other matters** (activities that had been important)
- * **Kept drinking despite problems**

Yes to 3 or more in past year: → **Alcohol dependence**


HOW TO ASSESS FOR ALCOHOL USE DISORDERS

STEP 2 Assess for Alcohol Use Disorders

Next, determine whether there is a *maladaptive pattern of alcohol use, causing clinically significant impairment or distress*. It is important to assess the severity and extent of all alcohol-related symptoms to inform your decisions about management. See pages 14 and 15 for sample phrasing of the questions, which are adapted from the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, revised (DSM-IV, revised)*.

Determine whether, in the past 12 months, your patient's drinking has **repeatedly** caused or contributed to

- ☐ **role failure** (interference with home, work, or school obligations)
- ☐ **risk** of bodily harm (drinking and driving, operating machinery, swimming)
- ☐ **run-ins** with the law (arrests or other legal problems)
- ☐ **relationship** trouble (family or friends)

If yes to **one or more** → your patient has **alcohol abuse**.

Determine whether, in the past 12 months, your patient has

- ☐ **shown tolerance** (needed to drink a lot more to get the same effect)
- ☐ **shown signs of withdrawal** (tremors, sweating, nausea, or insomnia when trying to quit or cut down)
- ☐ **not been able to stick to drinking limits** (repeatedly gone over them)
- ☐ **not been able to cut down or stop** (repeated failed attempts)
- ☐ **spent a lot of time drinking** (or anticipating or recovering from drinking)
- ☐ **spent less time on other matters** (activities that had been important or pleasurable)
- ☐ **kept drinking despite problems** (recurrent physical or psychological problems)

If yes to **three or more** → your patient has **alcohol dependence**.

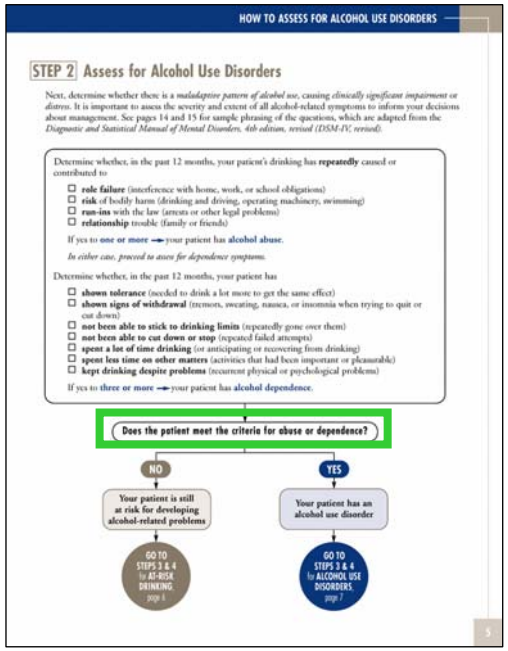
Does the patient meet the criteria for abuse or dependence?

NO → Your patient is still at risk for developing alcohol-related problems → GO TO STEPS 3 & 4 for AT-RISK DRINKING page 6

YES → Your patient has an alcohol use disorder → GO TO STEPS 3 & 4 for ALCOHOL USE DISORDERS page 7

STEP 2: Assess for AUDs

Does the patient meet the criteria for abuse or dependence?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STEP 2 Assess for Alcohol Use Disorders

Next, determine whether there is a *maladaptive pattern of alcohol use, causing clinically significant impairment* or *distress*. It is important to assess the severity and extent of all alcohol-related symptoms to inform your decisions about management. See pages 14 and 15 for sample phrasing of the questions, which are adapted from the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, revised (DSM-IV, revised)*.

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- ☐ **risk** of bodily harm (drinking and driving, operating machinery, swimming)
- ☐ **run-ins** with the law (arrests or other legal problems)
- ☐ **relationship** trouble (family or friends)

If yes to **one or more** → your patient has **alcohol abuse**.

In either case, proceed to assess for dependence symptoms.

Determine whether, in the past 12 months, your patient has

- ☐ **shown tolerance** (needed to drink a lot more to get the same effect)
- ☐ **shown signs of withdrawal** (tremors, sweating, nausea, or insomnia when trying to quit or cut down)
- ☐ **not been able to stick to drinking limits** (repeatedly gone over them)
- ☐ **not been able to cut down or stop** (repeated failed attempts)
- ☐ **spent a lot of time drinking** (or anticipating or recovering from drinking)
- ☐ **spent less time on other matters** (activities that had been important or pleasurable)
- ☐ **kept drinking despite problems** (recurrent physical or psychological problems)

If yes to **three or more** → your patient has **alcohol dependence**.

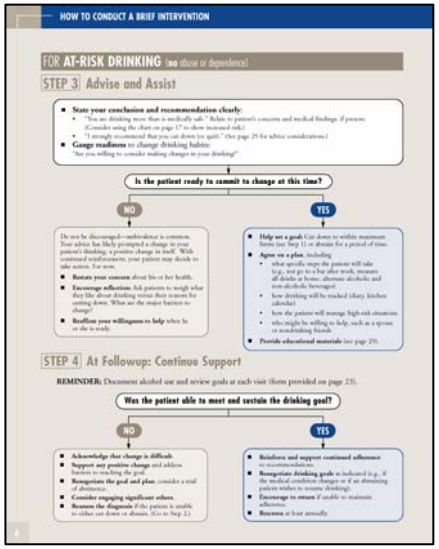
Does the patient meet the criteria for abuse or dependence?

NO → Your patient is still at risk for developing alcohol-related problems → GO TO STEPS 3 & 4 for AT-RISK DRINKING page 6

YES → Your patient has an alcohol use disorder → GO TO STEPS 3 & 4 for ALCOHOL USE DISORDERS page 7

If *NO:* patient is still at risk. Go to Steps 3 & 4 for *At-Risk Drinking* (Page 6)

If *YES:* Go to Steps 3 & 4 for *Alcohol Use Disorders* (Page 7)


HOW TO CONDUCT A BRIEF INTERVENTION

FOR AT-RISK DRINKING (no abuse or dependence)

STEP 3 Advise and Assist

- **State your conclusion and recommendation clearly:**
  - "You are drinking more than is medically safe." Relate to patient's concerns and medical findings, if present. (Consider using the chart on page 17 to show increased risk.)
  - "I strongly recommend that you cut down (or quit)." (See page 25 for advice considerations.)
- **Gauge readiness** to change drinking habits: "Are you willing to consider making changes in your drinking?"

Is the patient ready to commit to change at this time?

NO → Do not be discouraged—ambivalence is common. Your advice has likely prompted a change in your patient's thinking, a positive change in itself. With continued reinforcement, your patient may decide to take action. For now,
- **Restate your concern** about his or her health.
- **Encourage reflection:** Ask patients to weigh what they like about drinking versus their reasons for cutting down. What are the major barriers to change?
- **Reaffirm your willingness to help** when he or she is ready.

YES →
- **Help set a goal:** Cut down to within maximum limits (see Step 1) or abstain for a period of time.
- **Agree on a plan**, including
  - what specific steps the patient will take (e.g., not go to a bar after work, measure all drinks at home, alternate alcoholic and non-alcoholic beverages)
  - how drinking will be tracked (diary, kitchen calendar)
  - how the patient will manage high-risk situations
  - who might be willing to help, such as a spouse or nondrinking friends
- **Provide educational materials** (see page 29).

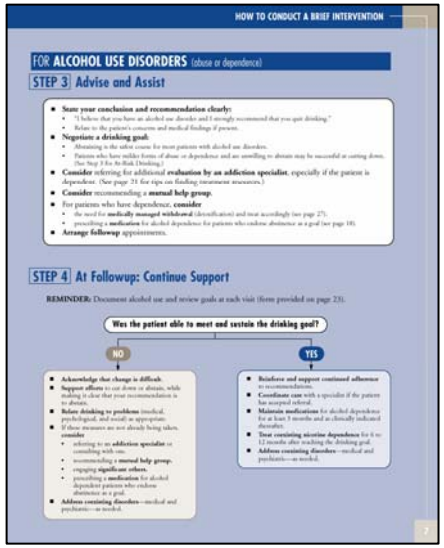
STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (form provided on page 23).

Was the patient able to meet and sustain the drinking goal?

NO →
- **Acknowledge that change is difficult.**
- **Support any positive change** and address barriers to reaching the goal.
- **Renegotiate the goal and plan:** consider a trial of abstinence.
- **Consider engaging significant others.**
- **Reassess the diagnosis** if the patient is unable to either cut down or abstain. (Go to Step 2.)

YES →
- **Reinforce and support continued adherence** to recommendations.
- **Renegotiate drinking goals** as indicated (e.g., if the medical condition changes or if an abstaining patient wishes to resume drinking).
- **Encourage to remain** if unable to maintain adherence.
- **Reassess** at least annually.


HOW TO CONDUCT A BRIEF INTERVENTION

FOR ALCOHOL USE DISORDERS (abuse or dependence)

STEP 3 Advise and Assist

- **State your conclusion and recommendation clearly:**
  - "I believe that you have an alcohol use disorder and I strongly recommend that you quit drinking."
  - Relate to the patient's concerns and medical findings if present.
- **Negotiate a drinking goal:**
  - Abstaining is the safest course for most patients with alcohol use disorders.
  - Patients who have milder forms of abuse or dependence and are unwilling to abstain may be successful at cutting down. (See Step 3 For At-Risk Drinking.)
- **Consider** referring for additional **evaluation by an addiction specialist**, especially if the patient is dependent. (See page 21 for tips on finding treatment resources.)
- **Consider** recommending a **mutual help group.**
- For patients who have dependence, **consider**
  - the need for **medically managed withdrawal** (detoxification) and treat accordingly (see page 27);
  - prescribing a **medication** for alcohol dependence for patients who endorse abstinence as a goal (see page 18).
- **Arrange followup** appointments.

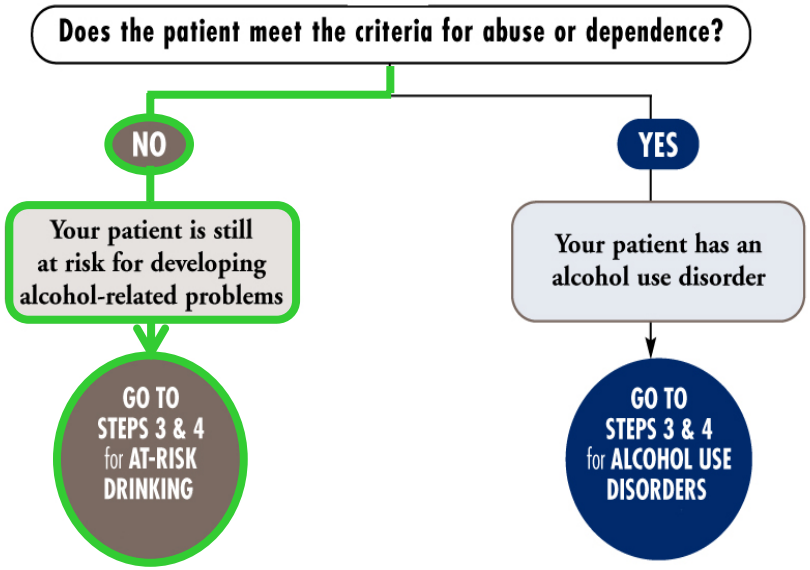
STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (form provided on page 23).

Was the patient able to meet and sustain the drinking goal?

NO →
- **Acknowledge that change is difficult.**
- **Support efforts** to cut down or abstain, while making it clear that your recommendation is to abstain.
- **Relate drinking to problems** (medical, psychological, and social) as appropriate.
- If these measures are not already being taken, **consider**
  - referring to an **addiction specialist** or consulting with one.
  - recommending a **mutual help group.**
  - engaging **significant others.**
  - prescribing a **medication** for alcohol dependent patients who endorse abstinence as a goal.
- **Address coexisting disorders**—medical and psychiatric—as needed.

YES →
- **Reinforce and support continued adherence** to recommendations.
- **Coordinate care** with a specialist if the patient has accepted referral.
- **Maintain medications** for alcohol dependence for at least 3 months and as clinically indicated thereafter.
- **Treat coexisting nicotine dependence** for 6 to 12 months after reaching the drinking goal.
- **Address coexisting disorders**—medical and psychiatric—as needed.



Page 6

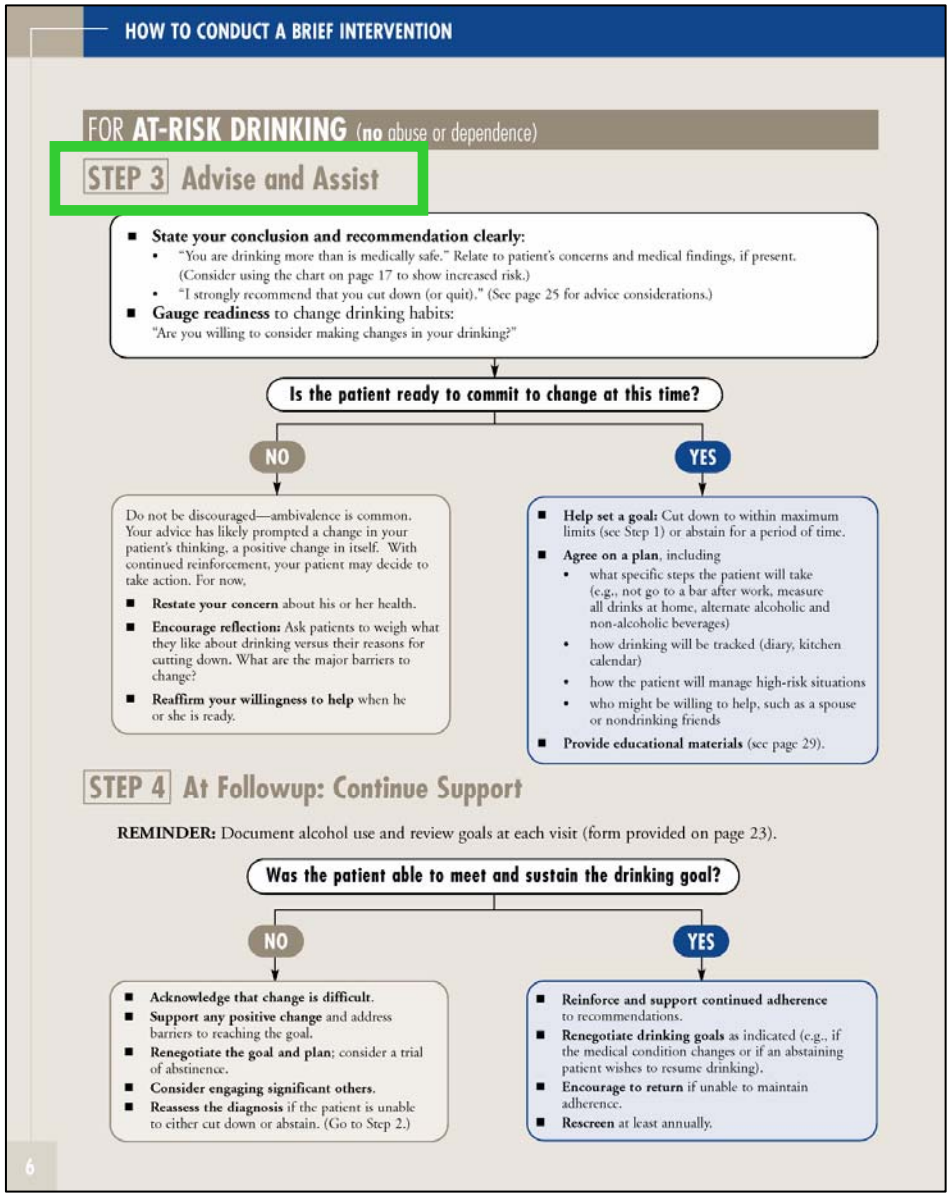
First Example--

For a Patient with

At-Risk Drinking

(no abuse or dependence)

STEP 3: Advise and Assist



HOW TO CONDUCT A BRIEF INTERVENTION

FOR **AT-RISK DRINKING** (**no** abuse or dependence)

STEP 3 Advise and Assist

- **State your conclusion and recommendation clearly:**
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  - "I strongly recommend that you cut down (or quit)." (See page 25 for advice considerations.)
- **Gauge readiness** to change drinking habits:
  "Are you willing to consider making changes in your drinking?"

Is the patient ready to commit to change at this time?

NO

Do not be discouraged—ambivalence is common. Your advice has likely prompted a change in your patient's thinking, a positive change in itself. With continued reinforcement, your patient may decide to take action. For now,

- **Restate your concern** about his or her health.
- **Encourage reflection:** Ask patients to weigh what they like about drinking versus their reasons for cutting down. What are the major barriers to change?
- **Reaffirm your willingness to help** when he or she is ready.

YES

- **Help set a goal:** Cut down to within maximum limits (see Step 1) or abstain for a period of time.
- **Agree on a plan**, including
  - what specific steps the patient will take (e.g., not go to a bar after work, measure all drinks at home, alternate alcoholic and non-alcoholic beverages)
  - how drinking will be tracked (diary, kitchen calendar)
  - how the patient will manage high-risk situations
  - who might be willing to help, such as a spouse or nondrinking friends
- **Provide educational materials** (see page 29).

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (form provided on page 23).

Was the patient able to meet and sustain the drinking goal?

NO

- **Acknowledge that change is difficult.**
- **Support any positive change** and address barriers to reaching the goal.
- **Renegotiate the goal and plan;** consider a trial of abstinence.
- **Consider engaging significant others.**
- **Reassess the diagnosis** if the patient is unable to either cut down or abstain. (Go to Step 2.)

YES

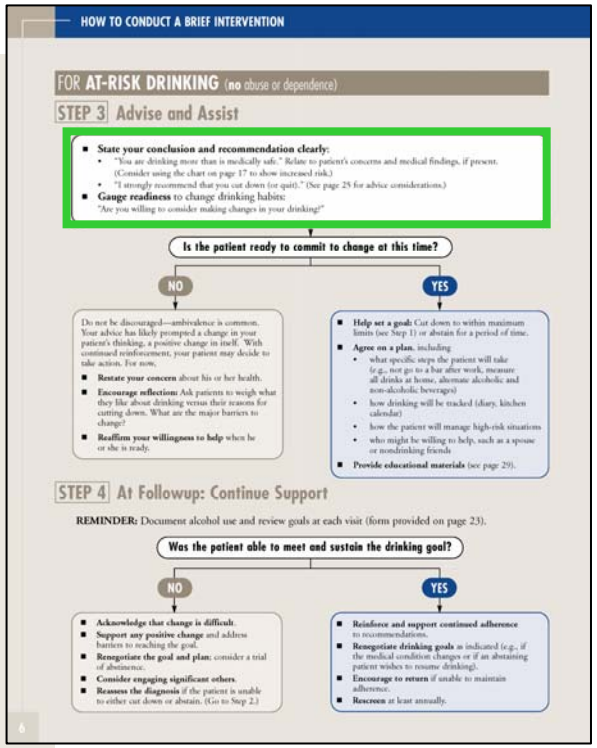
- **Reinforce and support continued adherence** to recommendations.
- **Renegotiate drinking goals** as indicated (e.g., if the medical condition changes or if an abstaining patient wishes to resume drinking).
- **Encourage to return** if unable to maintain adherence.
- **Rescreen** at least annually.

6

FOR **AT-RISK DRINKING** (**no** abuse or dependence)

STEP 3: Advise and Assist

*** State your conclusion and recommendations clearly**



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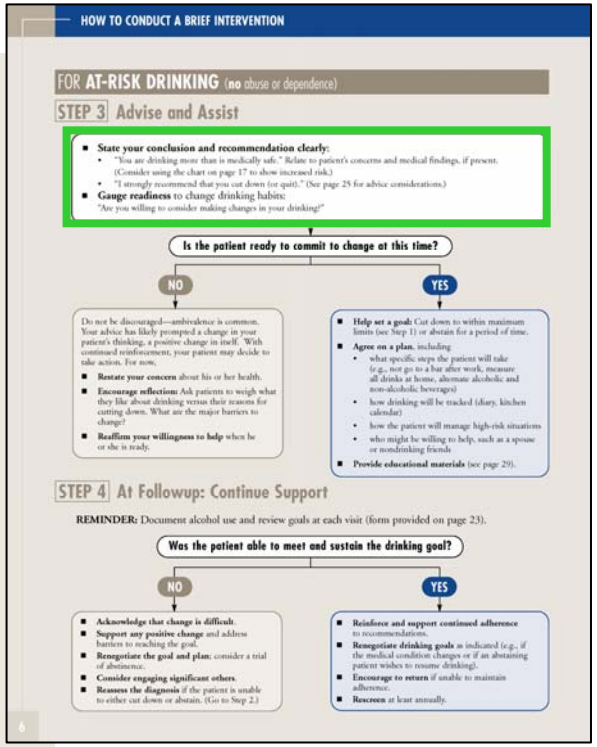
"You are drinking more than is medically safe."

image credit: Comstock

FOR **AT-RISK DRINKING** (**no** abuse or dependence)

STEP 3: Advise and Assist

*** State your conclusion and recommendations clearly**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"I strongly recommend that you cut down or quit."

image credit: Comstock

FOR **AT-RISK DRINKING** (**no** abuse or dependence)

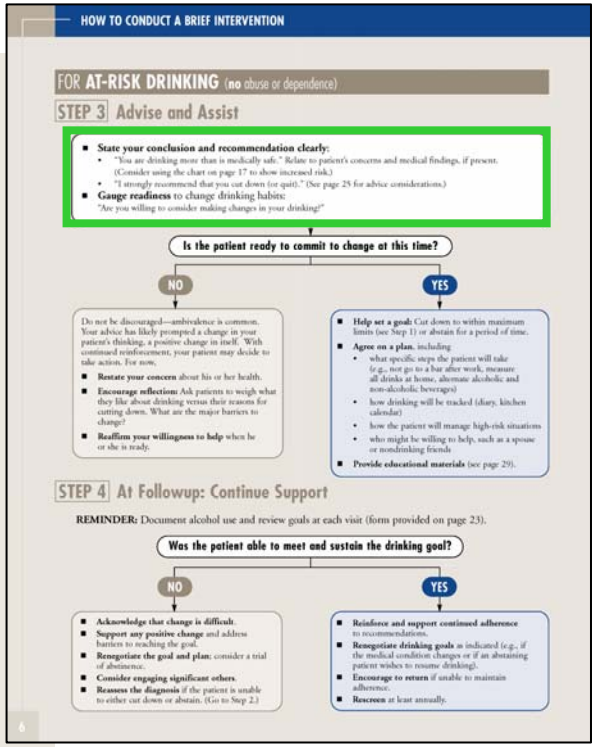
STEP 3: Advise and Assist

* **State your conclusion and recommendations clearly**

* **Gauge readiness to change**

image credit: Comstock

"Are you willing to consider making changes to your drinking?"



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6

FOR **AT-RISK DRINKING** (**no** abuse or dependence)

STEP 3: Advise and Assist

Is the patient ready to commit to change at this time?

↓

NO

↓

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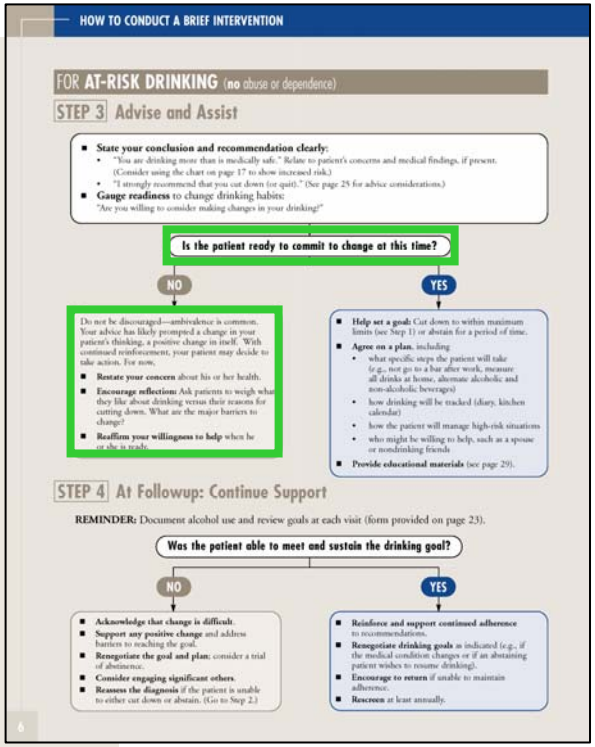

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6

FOR **AT-RISK DRINKING** (**no** abuse or dependence)

STEP 3: Advise and Assist

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↓

NO

↓

For now…

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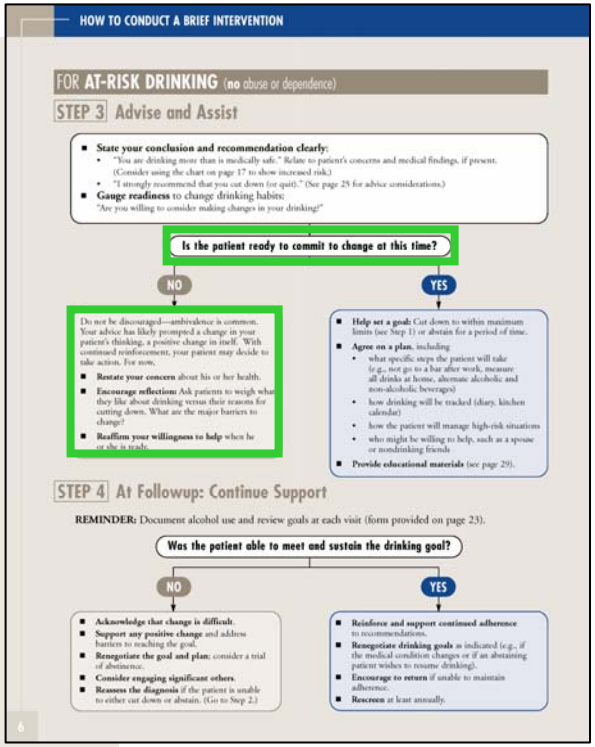
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FOR **AT-RISK DRINKING** (**no** abuse or dependence)

STEP 3: Advise and Assist

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↓

NO

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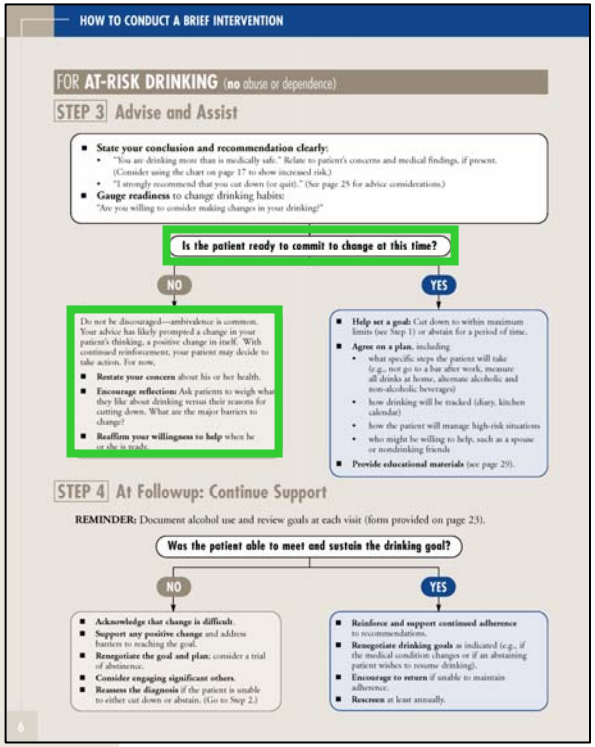
HOW TO CONDUCT A BRIEF INTERVENTION

FOR AT-RISK DRINKING (no abuse or dependence)

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Was the patient able to meet and sustain the drinking goal?

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6

FOR **AT-RISK DRINKING** (**no** abuse or dependence)

STEP 3: Advise and Assist

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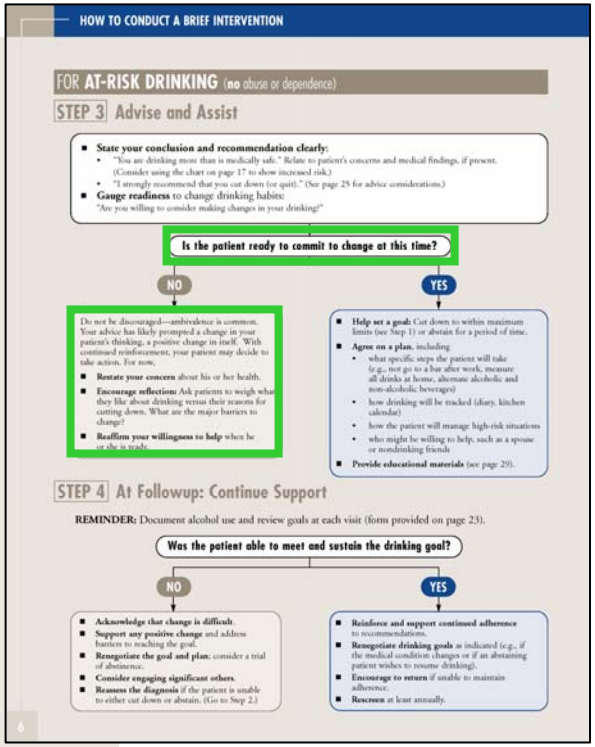
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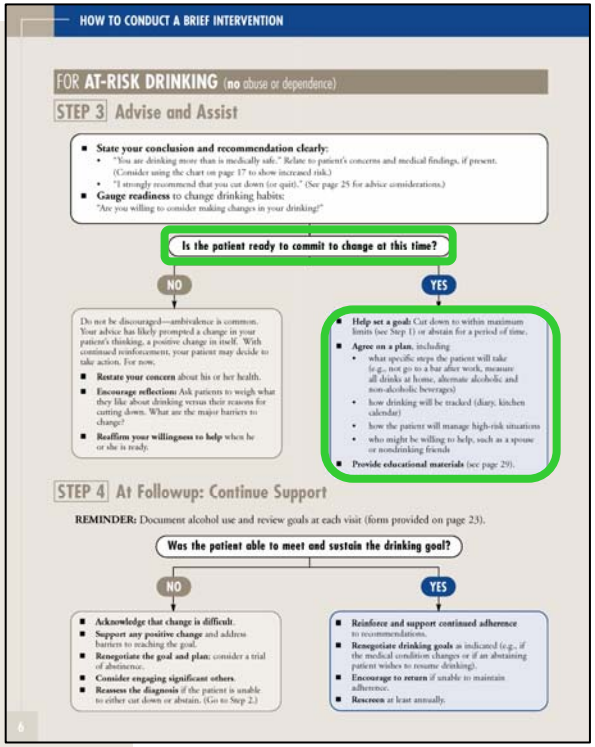
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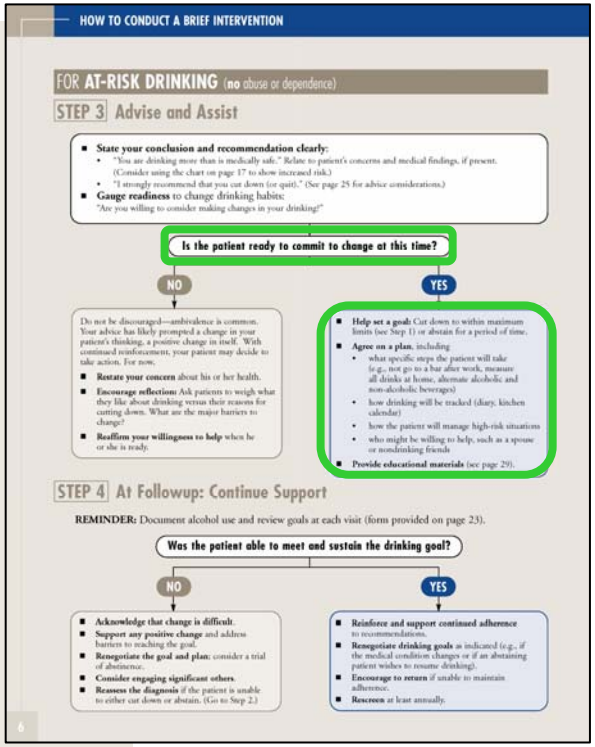
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FOR **AT-RISK DRINKING** (**no** abuse or dependence)

STEP 3: Advise and Assist

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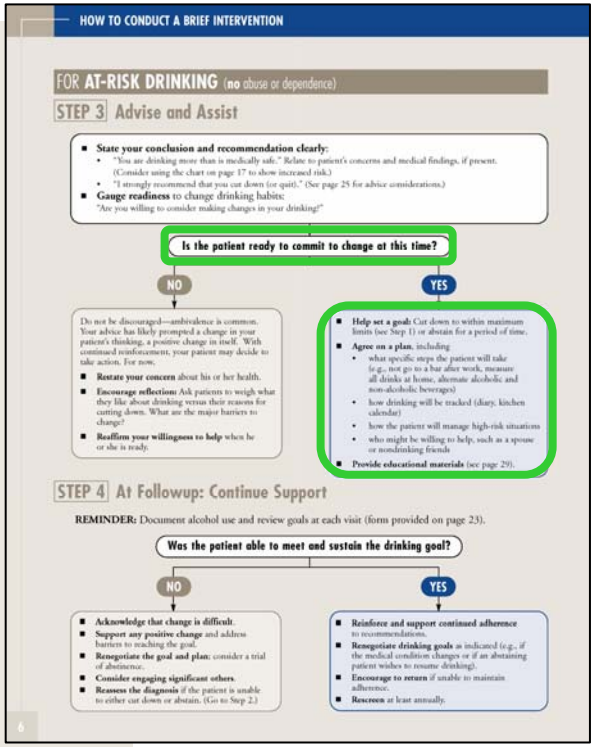
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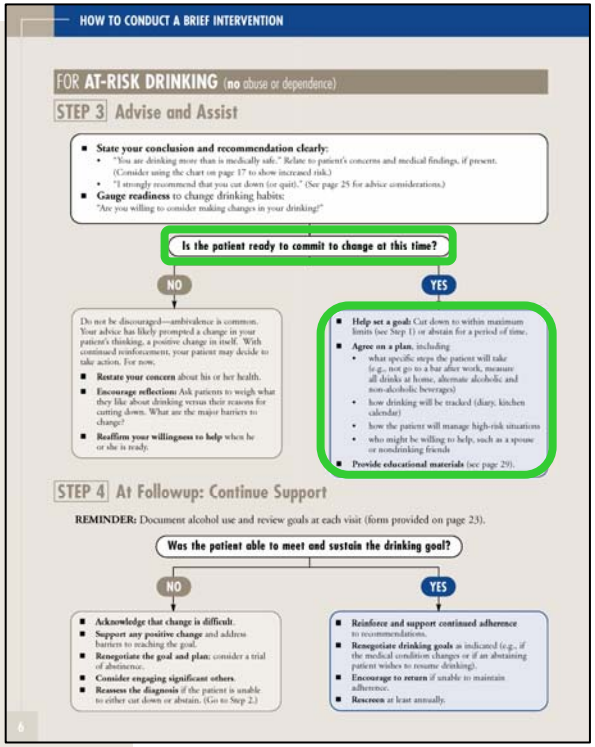
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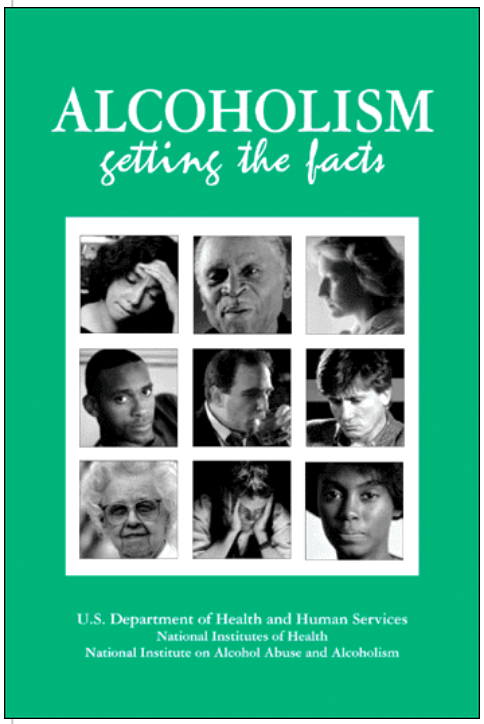
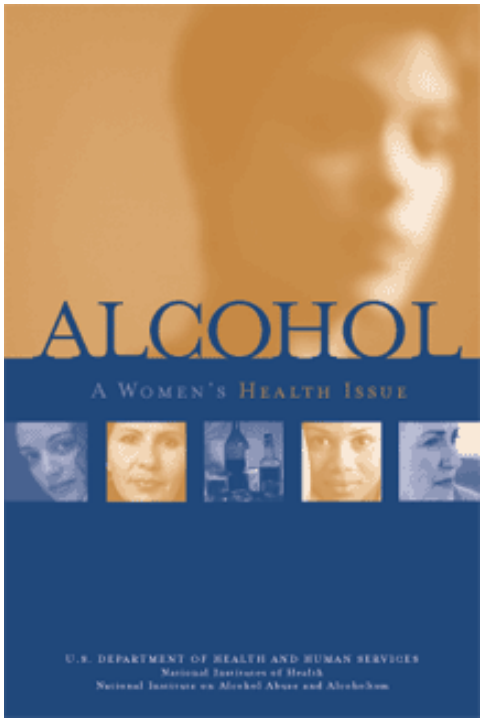
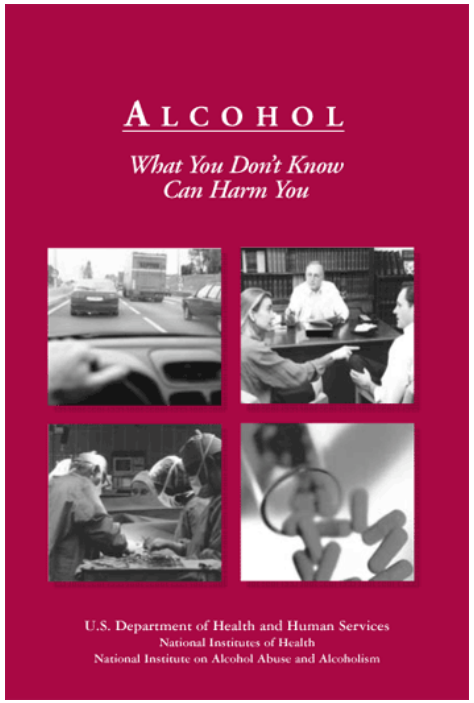
Examples of Free Patient Education Materials from NIAAA



Alcoholism: Getting the Facts



Alcohol: A Women's Health Issue



Alcohol: What You Don't Know Can Harm You

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STEP 4: At Followup: Continue Support

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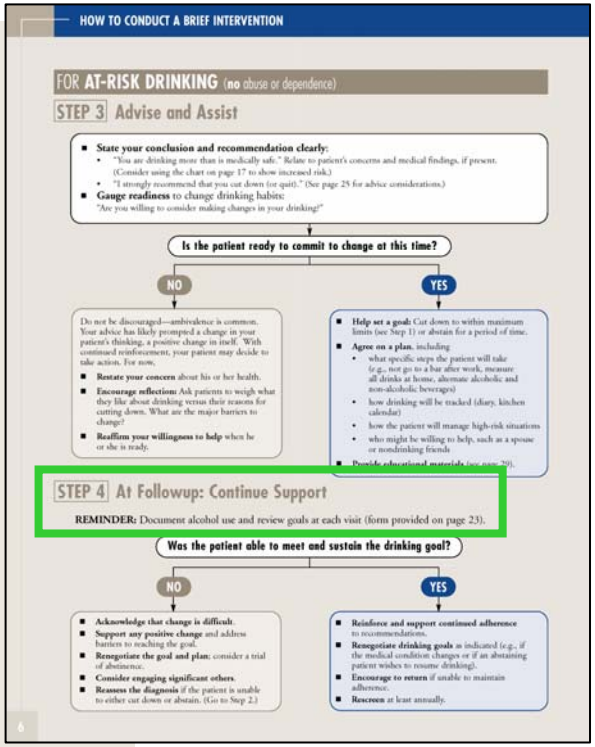
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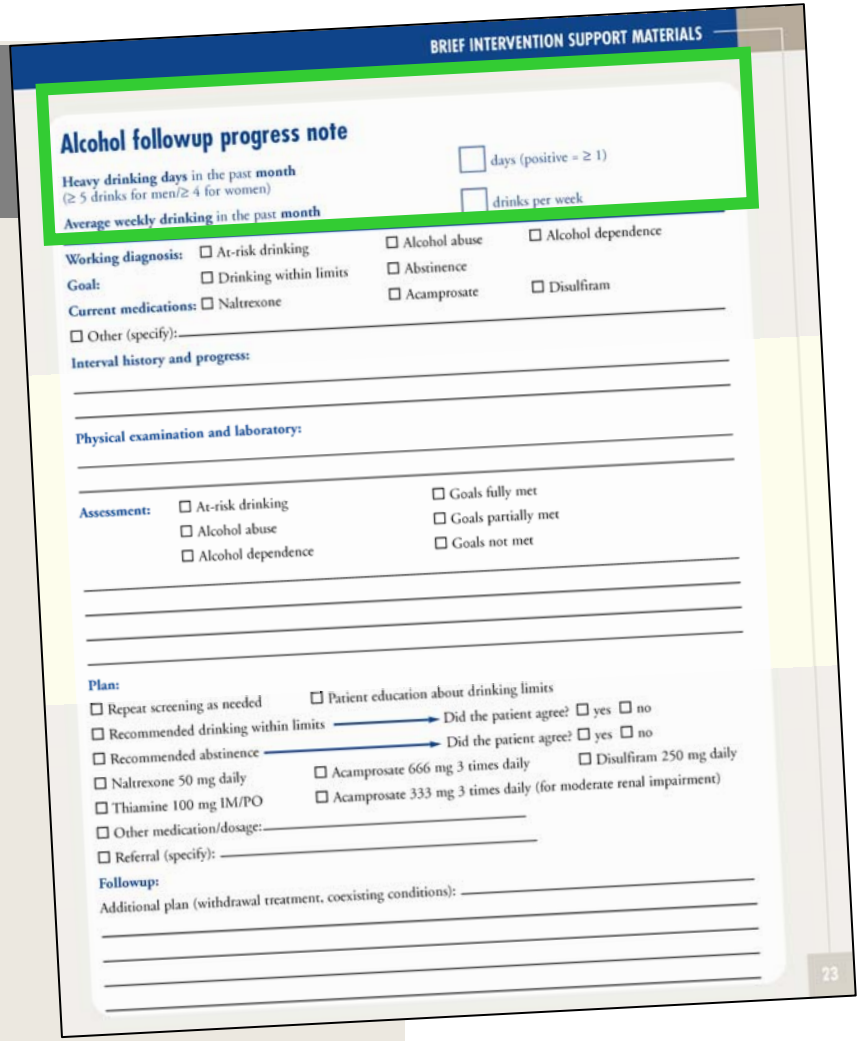
FOR **AT-RISK DRINKING** (**no** abuse or dependence)

STEP 4: At Followup: Continue Support

Obtain the drinking quantity and frequency at each followup visit.

See the suggested questions and form on **Page 23.**



BRIEF INTERVENTION SUPPORT MATERIALS

Alcohol followup progress note

Heavy drinking days in the past **month** (≥ 5 drinks for men/≥ 4 for women) ☐ days (positive = ≥ 1)

Average weekly drinking in the past **month** ☐ drinks per week

Working diagnosis: ☐ At-risk drinking ☐ Alcohol abuse ☐ Alcohol dependence

Goal: ☐ Drinking within limits ☐ Abstinence

Current medications: ☐ Naltrexone ☐ Acamprosate ☐ Disulfiram

☐ Other (specify):

Interval history and progress:

Physical examination and laboratory:

Assessment: ☐ At-risk drinking ☐ Alcohol abuse ☐ Alcohol dependence ☐ Goals fully met ☐ Goals partially met ☐ Goals not met

Plan:

☐ Repeat screening as needed ☐ Patient education about drinking limits

☐ Recommended drinking within limits → Did the patient agree? ☐ yes ☐ no

☐ Recommended abstinence → Did the patient agree? ☐ yes ☐ no

☐ Naltrexone 50 mg daily ☐ Acamprosate 666 mg 3 times daily ☐ Disulfiram 250 mg daily

☐ Thiamine 100 mg IM/PO ☐ Acamprosate 333 mg 3 times daily (for moderate renal impairment)

☐ Other medication/dosage:

☐ Referral (specify):

Followup:

Additional plan (withdrawal treatment, coexisting conditions):

23

FOR **AT-RISK DRINKING** (**no** abuse or dependence)

STEP 4: Followup

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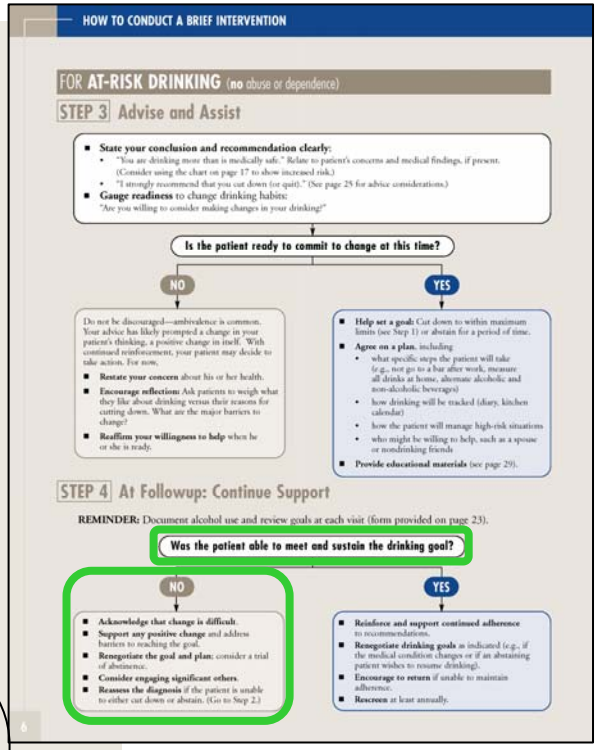
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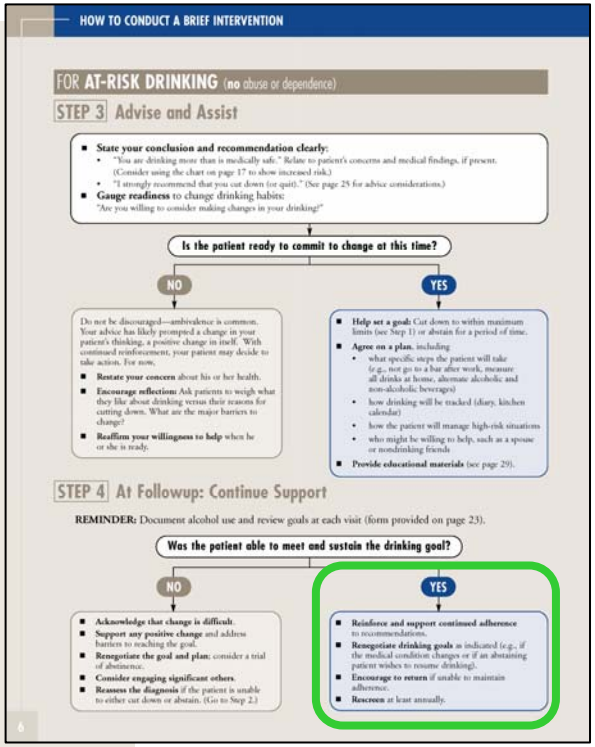
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- Provide educational materials (see page 29).

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (form provided on page 23).

Was the patient able to meet and sustain the drinking goal?

NO

- Acknowledge that change is difficult.
- Support any positive change and address barriers to reaching the goal.
- Renegotiate the goal and plan: consider a trial of abstinence.
- Consider engaging significant others.
- Reassess the diagnosis if the patient is unable to either cut down or abstain. (Go to Step 2.)

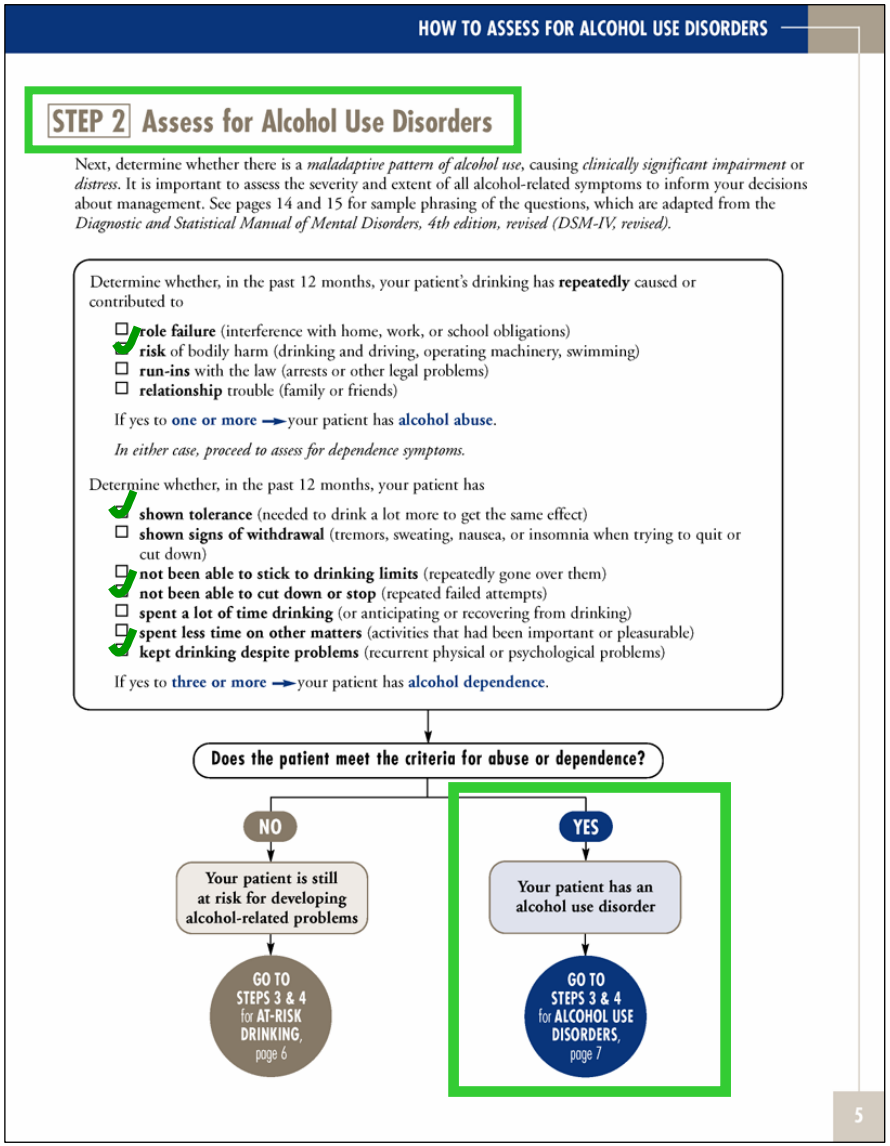
YES

- Reinforce and support continued adherence to recommendations.
- Renegotiate drinking goals as indicated (e.g., if the medical condition changes or if an abstaining patient wishes to resume drinking).
- Encourage to return if unable to maintain adherence.
- Rescreen at least annually.

This completes Steps 3 and 4 for the first example, a patient with *At-Risk Drinking*.

However, if a patient's assessment in Step 2 indicates an *Alcohol Use Disorder:*

Go to Steps 3 and 4 presented on page 7, as follows…



HOW TO ASSESS FOR ALCOHOL USE DISORDERS

STEP 2 Assess for Alcohol Use Disorders

Next, determine whether there is a *maladaptive pattern of alcohol use*, causing *clinically significant impairment* or *distress*. It is important to assess the severity and extent of all alcohol-related symptoms to inform your decisions about management. See pages 14 and 15 for sample phrasing of the questions, which are adapted from the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, revised (DSM-IV, revised)*.

Determine whether, in the past 12 months, your patient's drinking has **repeatedly** caused or contributed to

- ☐ **role failure** (interference with home, work, or school obligations)
- ☑ **risk** of bodily harm (drinking and driving, operating machinery, swimming)
- ☐ **run-ins** with the law (arrests or other legal problems)
- ☐ **relationship** trouble (family or friends)

If yes to **one or more** → your patient has **alcohol abuse**.

In either case, proceed to assess for dependence symptoms.

Determine whether, in the past 12 months, your patient has

- ☑ **shown tolerance** (needed to drink a lot more to get the same effect)
- ☐ **shown signs of withdrawal** (tremors, sweating, nausea, or insomnia when trying to quit or cut down)
- ☐ **not been able to stick to drinking limits** (repeatedly gone over them)
- ☑ **not been able to cut down or stop** (repeated failed attempts)
- ☐ **spent a lot of time drinking** (or anticipating or recovering from drinking)
- ☐ **spent less time on other matters** (activities that had been important or pleasurable)
- ☑ **kept drinking despite problems** (recurrent physical or psychological problems)

If yes to **three or more** → your patient has **alcohol dependence**.

Does the patient meet the criteria for abuse or dependence?

NO → Your patient is still at risk for developing alcohol-related problems → GO TO STEPS 3 & 4 for AT-RISK DRINKING, page 6

YES → Your patient has an alcohol use disorder → GO TO STEPS 3 & 4 for ALCOHOL USE DISORDERS, page 7

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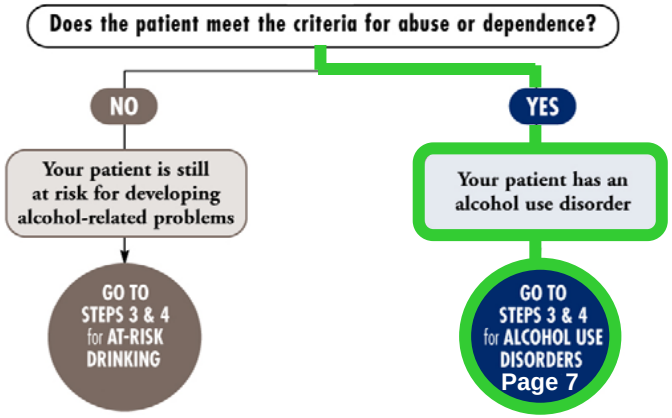
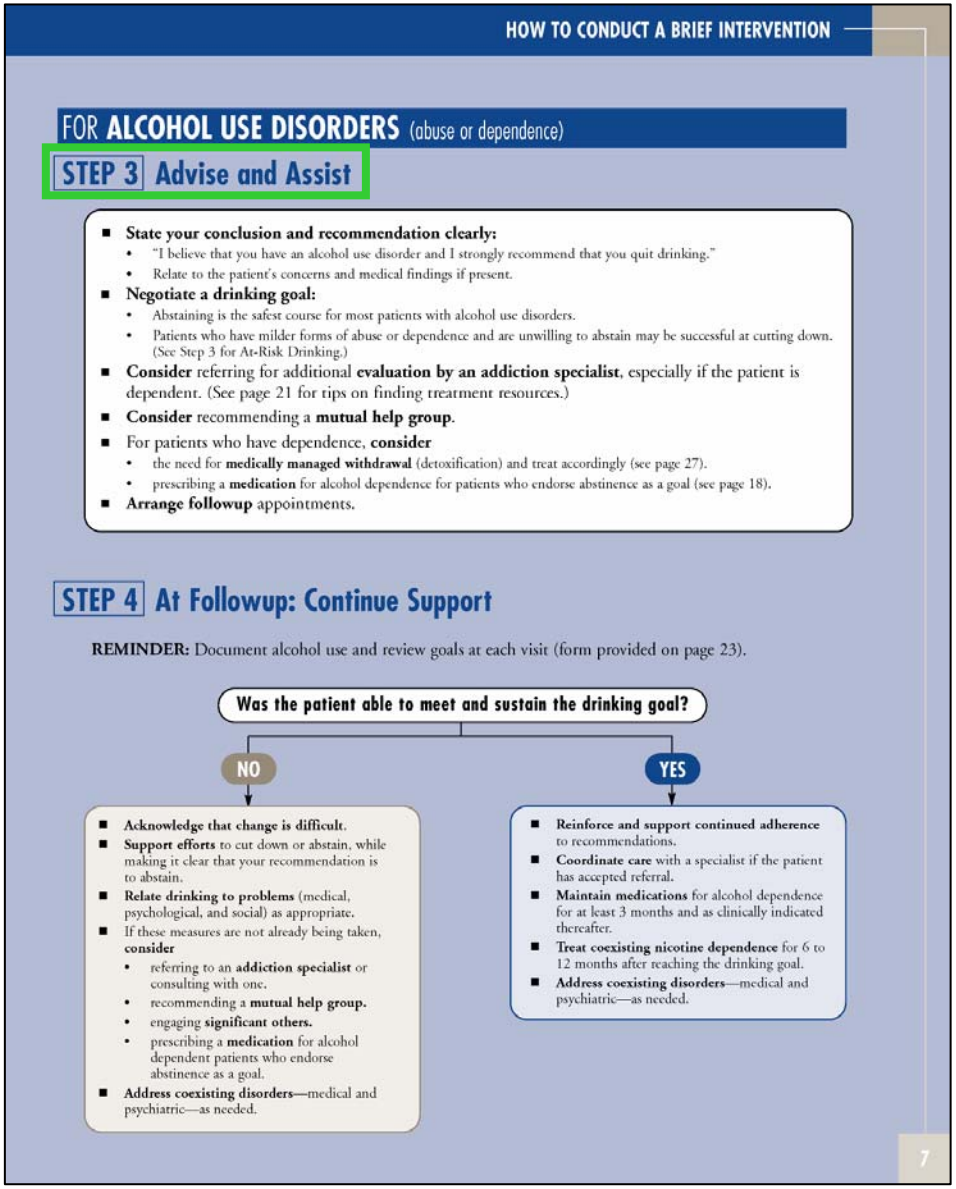




HOW TO CONDUCT A BRIEF INTERVENTION

FOR **ALCOHOL USE DISORDERS** (abuse or dependence)

STEP 3 Advise and Assist

- **State your conclusion and recommendation clearly:**
  - "I believe that you have an alcohol use disorder and I strongly recommend that you quit drinking."
  - Relate to the patient's concerns and medical findings if present.
- **Negotiate a drinking goal:**
  - Abstaining is the safest course for most patients with alcohol use disorders.
  - Patients who have milder forms of abuse or dependence and are unwilling to abstain may be successful at cutting down. (See Step 3 for At-Risk Drinking.)
- **Consider** referring for additional **evaluation by an addiction specialist**, especially if the patient is dependent. (See page 21 for tips on finding treatment resources.)
- **Consider** recommending a **mutual help group**.
- For patients who have dependence, **consider**
  - the need for **medically managed withdrawal** (detoxification) and treat accordingly (see page 27).
  - prescribing a **medication** for alcohol dependence for patients who endorse abstinence as a goal (see page 18).
- **Arrange followup** appointments.

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (form provided on page 23).

Was the patient able to meet and sustain the drinking goal?

NO

- **Acknowledge that change is difficult.**
- **Support efforts** to cut down or abstain, while making it clear that your recommendation is to abstain.
- **Relate drinking to problems** (medical, psychological, and social) as appropriate.
- If these measures are not already being taken, **consider**
  - referring to an **addiction specialist** or consulting with one.
  - recommending a **mutual help group.**
  - engaging **significant others.**
  - prescribing a **medication** for alcohol dependent patients who endorse abstinence as a goal.
- **Address coexisting disorders**—medical and psychiatric—as needed.

YES

- **Reinforce and support continued adherence** to recommendations.
- **Coordinate care** with a specialist if the patient has accepted referral.
- **Maintain medications** for alcohol dependence for at least 3 months and as clinically indicated thereafter.
- **Treat coexisting nicotine dependence** for 6 to 12 months after reaching the drinking goal.
- **Address coexisting disorders**—medical and psychiatric—as needed.

7

Page 7

Second Example--

For a Patient with an

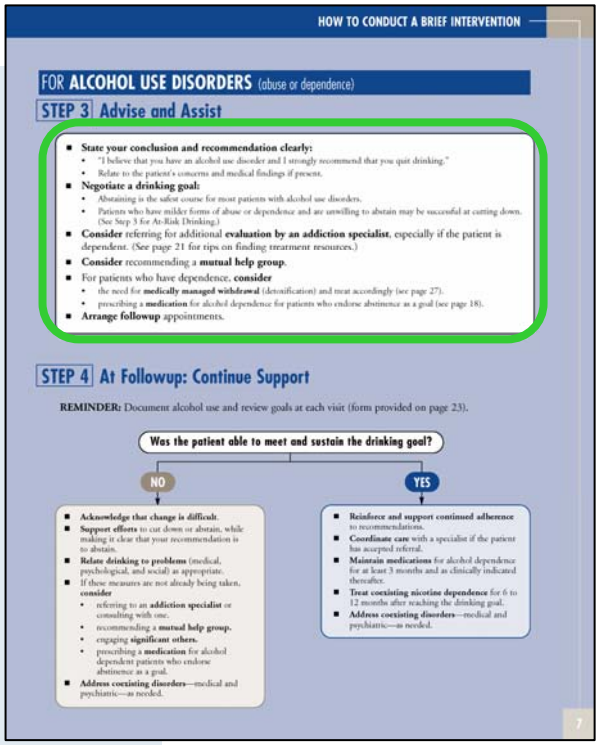
Alcohol Use Disorder (abuse or dependence)

FOR **ALCOHOL USE DISORDERS** (abuse or dependence)

STEP 3: Advise and Assist

* State your conclusion and recommendations clearly.
* Relate to the patient's concerns and medical findings if present.

"I believe that you have an alcohol use disorder and I strongly recommend that you quit drinking."



HOW TO CONDUCT A BRIEF INTERVENTION

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YES

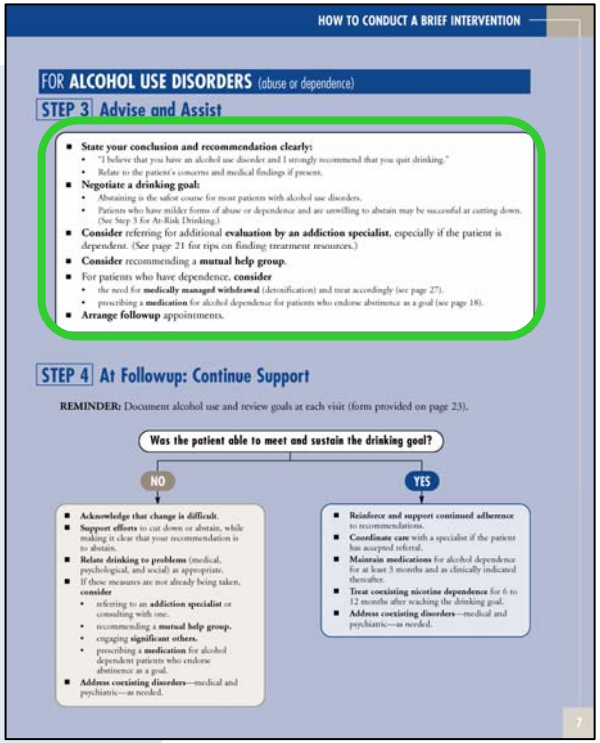
- **Reinforce and support continued adherence** to recommendations.
- **Coordinate care** with a specialist if the patient has accepted referral.
- **Maintain medications** for alcohol dependence for at least 3 months and as clinically indicated thereafter.
- **Treat coexisting nicotine dependence** for 6 to 12 months after reaching the drinking goal.
- **Address coexisting disorders**—medical and psychiatric—as needed.

image credit: Comstock

FOR **ALCOHOL USE DISORDERS** (abuse or dependence)

STEP 3: Advise and Assist

* **Negotiate a drinking goal.**
  * **Abstaining is the safest course for most patients with AUDs.**
  * **Patients who have milder forms of abuse or dependence and are unwilling to abstain may be successful at cutting down.** (See **Step 3 for *At-Risk Drinking***, page 6.)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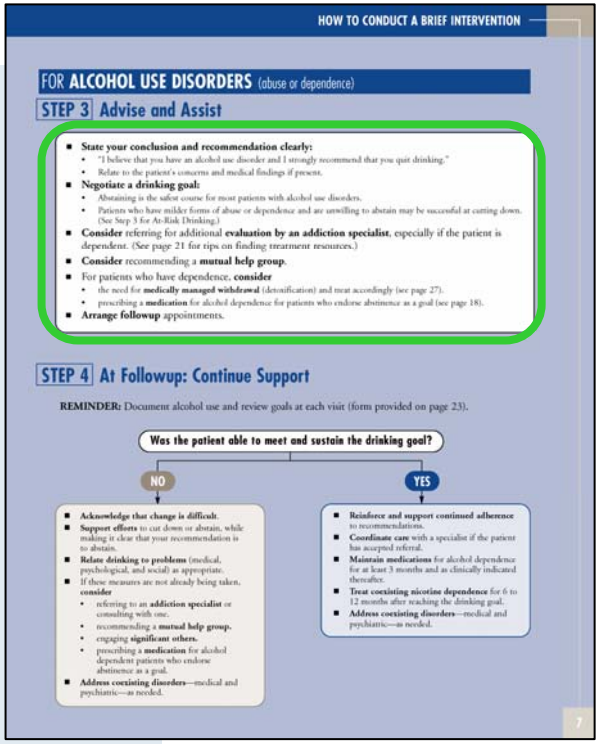
FOR **ALCOHOL USE DISORDERS** (abuse or dependence)

STEP 3: Advise and Assist

* **Consider referring for additional evaluation by an addiction specialist.** (See tips on finding treatment resources, page 21.)

* **Consider recommending a mutual help group.**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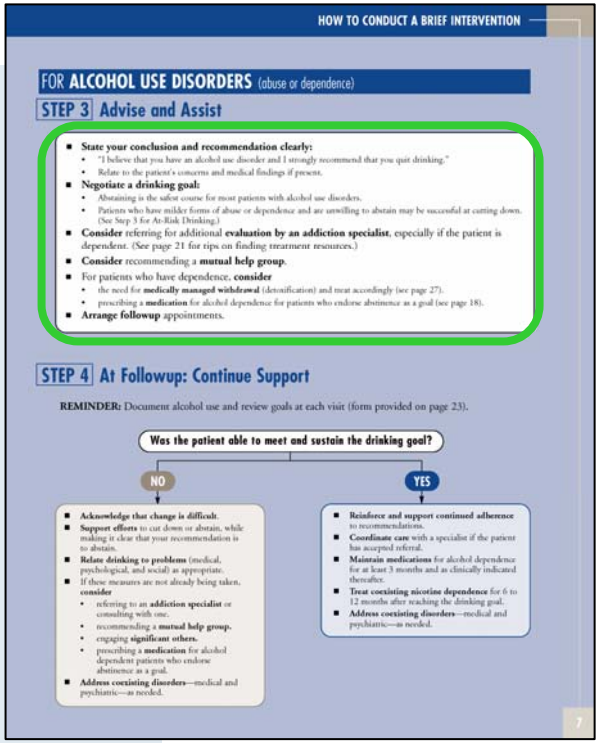
FOR **ALCOHOL USE DISORDERS** (abuse or dependence)

STEP 3: Advise and Assist

*** For patients who have alcohol <u>dependence</u>, consider…**

- **the need for medically managed withdrawal (detoxification) and treat accordingly** (see page 27)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FOR **ALCOHOL USE DISOR**
(abuse or dependence)

STEP 3: Advise and As

*** For patients who have**
<u>dependence</u>, consider.

- **Prescribing medications** for patients who endorse abstinence as a goal (see pages 18-21)

BRIEF INTERVENTION SUPPORT MATERIALS

Medications for Treating Alcohol Dependence

The chart below highlights some of the properties of each medication. It does not provide complete information and is not meant to be a substitute for the package inserts or other drug reference sources used by clinicians. For patient information about these and other drugs, the National Library of Medicine provides Medline Plus (**http://medlineplus.gov**).

Whether or not a medication should be prescribed and in what amount is a matter between individuals and their health care providers. The prescribing information provided here is not a substitute for a provider's judgment in an individual circumstance, and the NIH accepts no liability or responsibility for use of the information with regard to particular patients.

	Disulfiram (Antabuse®)	**Naltrexone** (ReVia®)	**Acamprosate** (Campral®)
Action	Inhibits intermediate metabolism of alcohol, causing a build-up of acetaldehyde and a reaction of flushing, sweating, nausea, and tachycardia if a patient drinks alcohol	Blocks opioid receptors, resulting in reduced craving and reduced reward in response to drinking	Affects glutamate and GABA neurotransmitter systems, but its alcohol-related action is unclear
Contraindications	Concomitant use of alcohol or alcohol-containing preparations or metronidazole; coronary artery disease; severe myocardial disease	Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analgesics; acute hepatitis or liver failure	Severe renal impairment (CrCl ≤ 30 mL/min)
Precautions	High impulsivity—likely to drink while using it; psychoses (current or history); diabetes mellitus; epilepsy; hepatic dysfunction; hypothyroidism; renal impairment; rubber contact dermatitis	Other hepatic disease; renal impairment; history of suicide attempts. If opioid analgesia is required, larger doses may be required, and respiratory depression may be deeper and more prolonged.	Moderate renal impairment (dose adjustment for CrCl between 30–50 mL/min); depression or suicidality
Serious adverse reactions	Hepatitis; optic neuritis; peripheral neuropathy; psychotic reactions. Pregnancy Category C.	Will precipitate severe withdrawal if patient is dependent on opioids; hepatotoxicity (uncommon at usual doses). Pregnancy Category C.	Anxiety; depression. Rare events include the following: suicide attempt, acute kidney failure, heart failure, mesenteric arterial occlusion, cardiomyopathy, deep thrombophlebitis, and shock. Pregnancy Category C.
Common side effects	Metallic after-taste; dermatitis	Nausea; abdominal pain; constipation; dizziness; headache; anxiety; fatigue	Diarrhea; flatulence; nausea; abdominal pain; headache; back pain; infection; flu syndrome; chills; somnolence; decreased libido; amnesia; confusion
Examples of drug interactions	Amitryptyline; anticoagulants such as warfarin; diazepam; isoniazid; metronidazole; phenytoin; theophylline; warfarin; any nonprescription drug containing alcohol	Opioid analgesics (blocks action); yohimbine (use with naltrexone increases negative drug effects)	No clinically relevant interactions known
Usual adult dosage	*Oral dose:* 250 mg daily (range 125 mg to 500 mg) *Before prescribing:* (1) warn that patient should not take disulfiram for at least 12 hours after drinking and that a disulfiram-alcohol reaction can occur up to 2 weeks after the last dose; and (2) warn about alcohol in the diet (e.g., sauces and vinegars) and in medications and toiletries *Followup:* Monitor liver function tests periodically	*Oral dose:* 50 mg daily *Before prescribing:* Evaluate for possible current opioid use; consider a urine toxicology screen for opioids, including synthetic opioids. Obtain liver function tests. *Followup:* Monitor liver function tests periodically	*Oral dose:* 666 mg (two 333-mg tablets) three times daily *or*, for patients with moderate renal impairment (CrCl 30–50 mL/min), reduce to 333 mg (one tablet) three times daily *Before prescribing:* Establish abstinence

The information in this chart was drawn primarily from references 18 and 23 (see page 30).

JULY 2005

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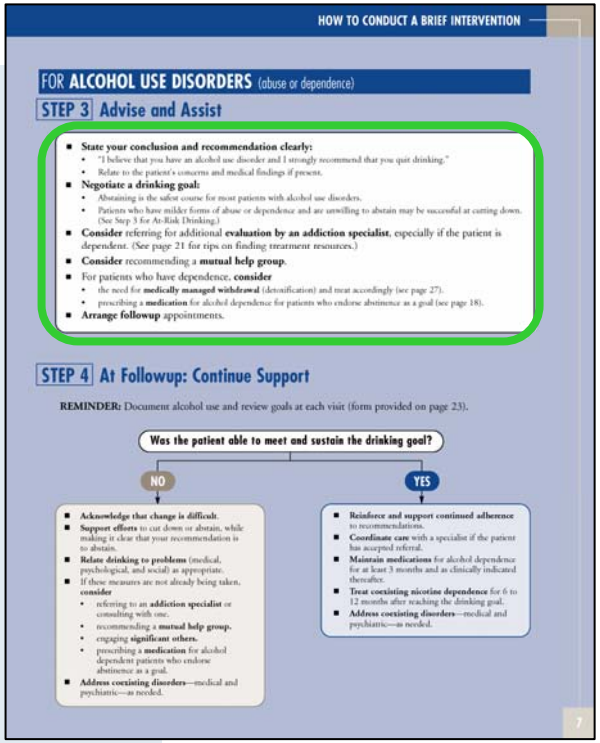
FOR **ALCOHOL USE DISORDERS** (abuse or dependence)

STEP 3: Advise and Assist

* **Arrange followup appointments.**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STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (form provided on page 23).

Was the patient able to meet and sustain the drinking goal?

NO

- **Acknowledge that change is difficult.**
- **Support efforts** to cut down or abstain, while making it clear that your recommendation is to abstain.
- **Relate drinking to problems** (medical, psychological, and social) as appropriate.
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FOR ALCOHOL USE DISORDERS

STEP 4: At Followup

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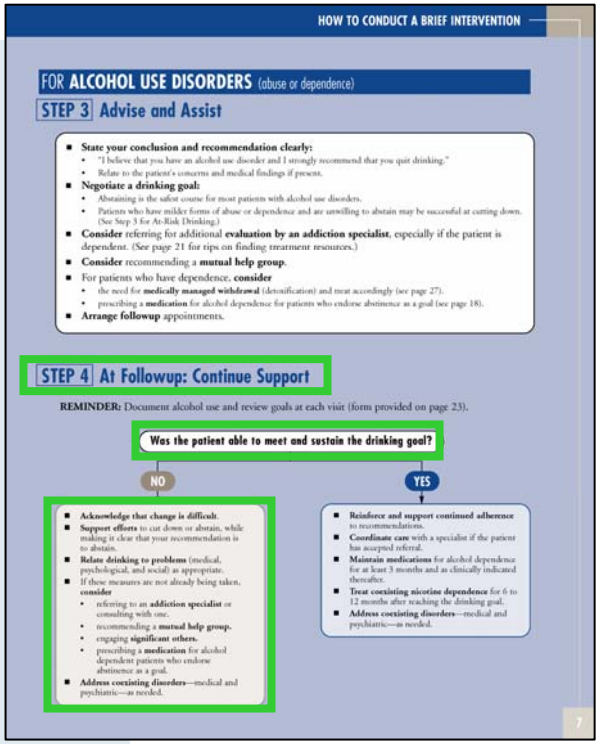
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7

FOR **ALCOHOL USE DISORDERS**

STEP 4: At Followup

Was the patient able to meet and sustain the drinking goal?

NO

* If these measures are not already being taken, **consider**
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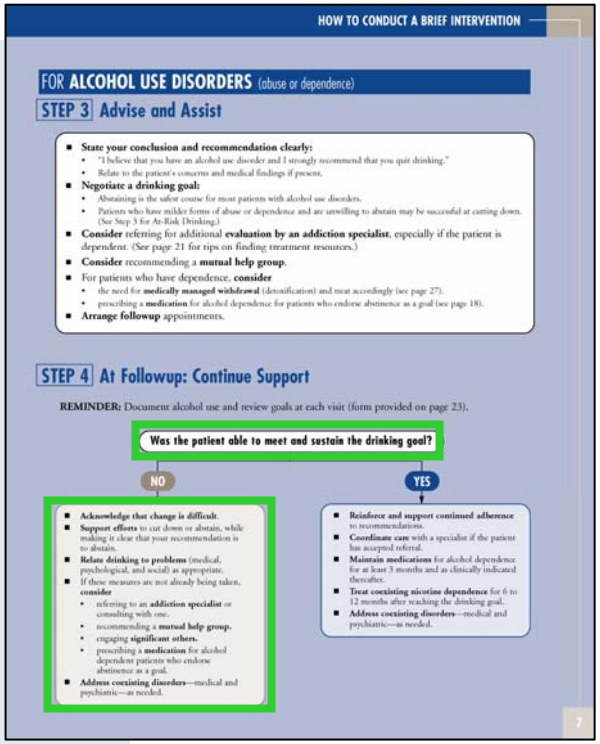
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- **Support efforts** to cut down or abstain, while making it clear that your recommendation is to abstain.
- **Relate drinking to problems** (medical, psychological, and social) as appropriate.
- If these measures are not already being taken, **consider**
  - referring to an **addiction specialist** or consulting with one.
  - recommending a **mutual help group.**
  - engaging **significant others.**
  - prescribing a **medication** for alcohol dependent patients who endorse abstinence as a goal.
- **Address coexisting disorders**—medical and psychiatric—as needed.

YES

- **Reinforce and support continued adherence** to recommendations.
- **Coordinate care** with a specialist if the patient has accepted referral.
- **Maintain medications** for alcohol dependence for at least 3 months and as clinically indicated thereafter.
- **Treat coexisting nicotine dependence** for 6 to 12 months after reaching the drinking goal.
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7

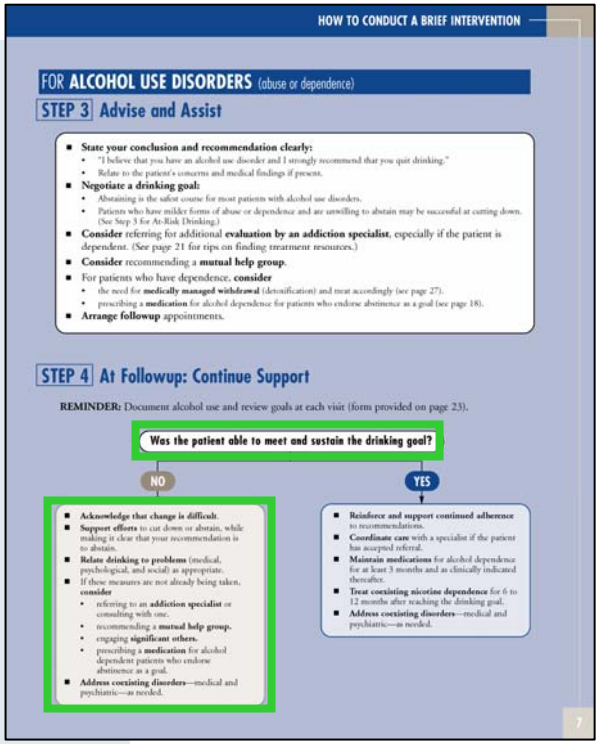
FOR **ALCOHOL USE DISORDERS**

STEP 4: Followup

Was the patient able to meet and sustain the drinking goal?

NO

***Address coexisting disorders**—medical and psychiatric—as needed.



HOW TO CONDUCT A BRIEF INTERVENTION

FOR **ALCOHOL USE DISORDERS** (abuse or dependence)

STEP 3 Advise and Assist

- **State your conclusion and recommendation clearly:**
  - "I believe that you have an alcohol use disorder and I strongly recommend that you quit drinking."
  - Relate to the patient's concerns and medical findings if present.
- **Negotiate a drinking goal:**
  - Abstaining is the safest course for most patients with alcohol use disorders.
  - Patients who have milder forms of abuse or dependence and are unwilling to abstain may be successful at cutting down. (See Step 5 for At-Risk Drinking.)
- **Consider** referring for additional **evaluation by an addiction specialist**, especially if the patient is dependent. (See page 21 for tips on finding treatment resources.)
- **Consider** recommending a **mutual help group**.
- For patients who have dependence, **consider**
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STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (form provided on page 23).

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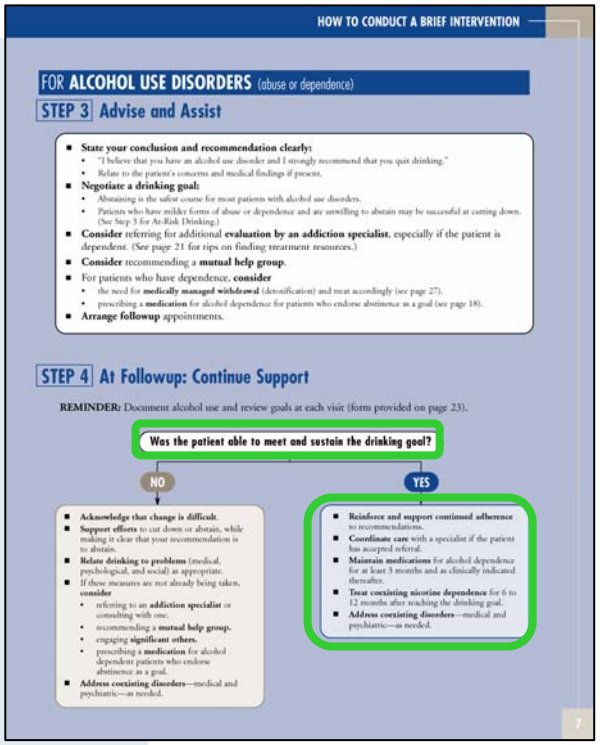
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STEP 4: At Followup

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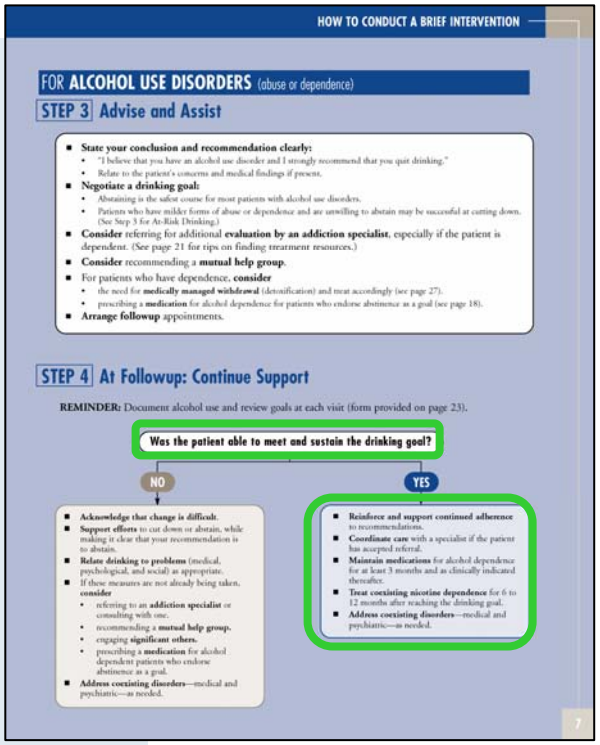
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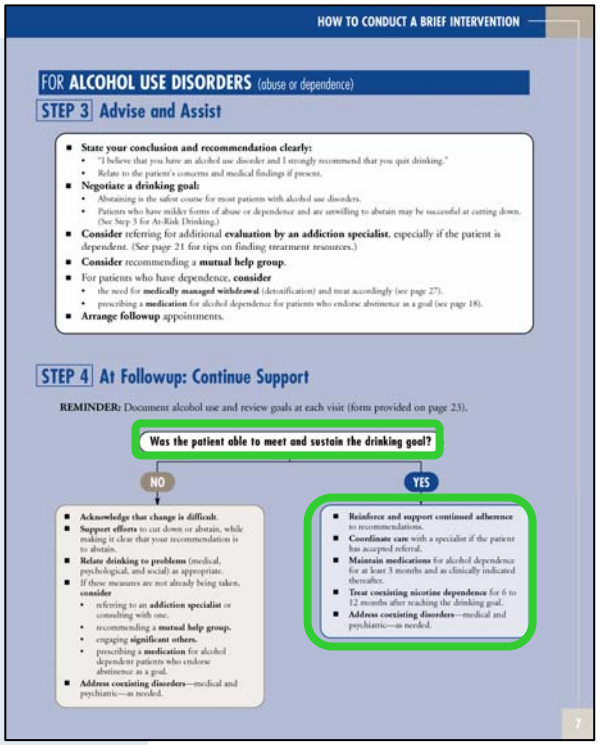
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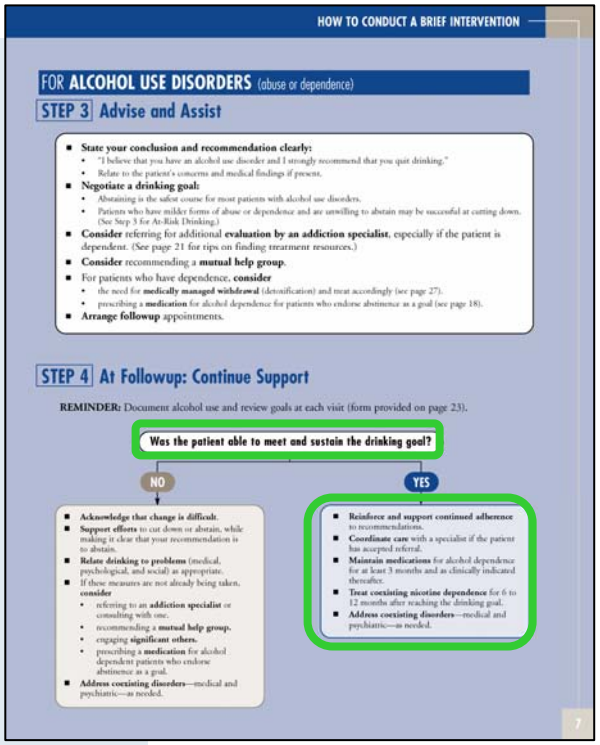
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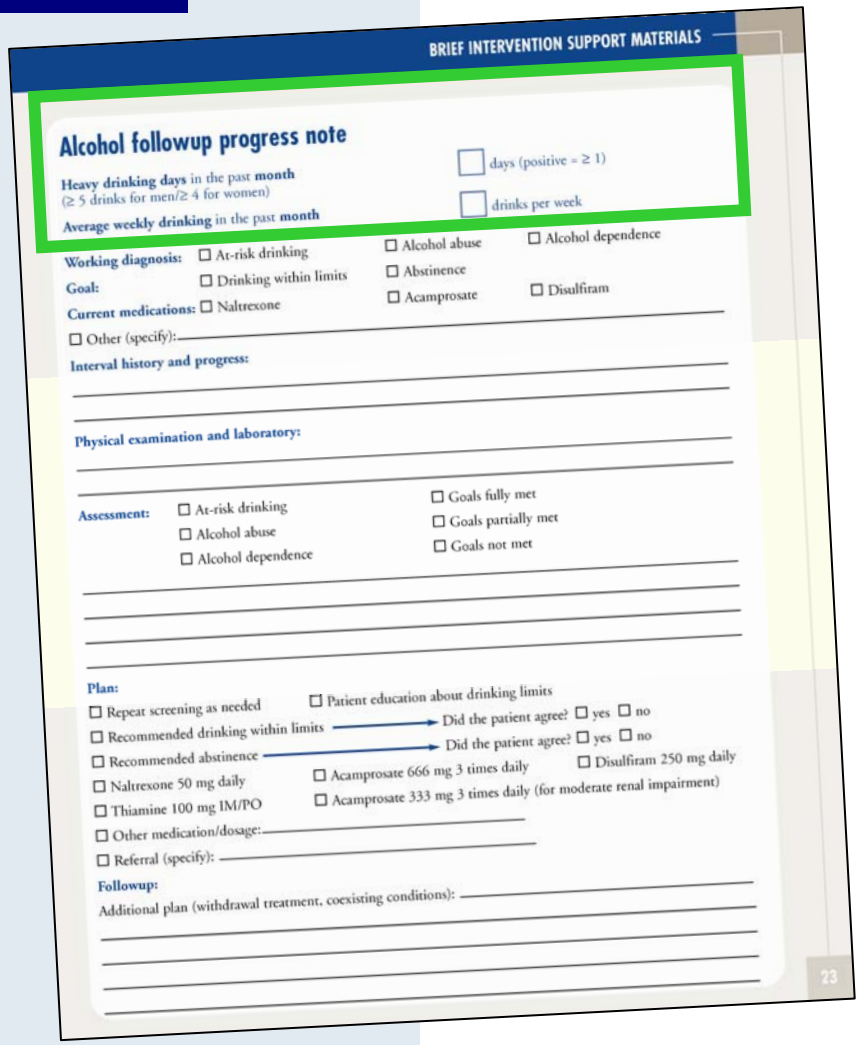
FOR ALCOHOL USE DISORDERS

STEP 4: At Followup

REMINDER: Document alcohol use and review goals at each visit.

To obtain the patient's drinking quantity and frequency at each followup, see the suggested questions and form on page 23.



BRIEF INTERVENTION SUPPORT MATERIALS

Alcohol followup progress note

Heavy drinking days in the past **month** (≥ 5 drinks for men/≥ 4 for women) ☐ days (positive = ≥ 1)

Average weekly drinking in the past **month** ☐ drinks per week

Working diagnosis: ☐ At-risk drinking ☐ Alcohol abuse ☐ Alcohol dependence

Goal: ☐ Drinking within limits ☐ Abstinence

Current medications: ☐ Naltrexone ☐ Acamprosate ☐ Disulfiram

☐ Other (specify):

Interval history and progress:

Physical examination and laboratory:

Assessment: ☐ At-risk drinking ☐ Alcohol abuse ☐ Alcohol dependence ☐ Goals fully met ☐ Goals partially met ☐ Goals not met

Plan:

☐ Repeat screening as needed ☐ Patient education about drinking limits

☐ Recommended drinking within limits → Did the patient agree? ☐ yes ☐ no

☐ Recommended abstinence → Did the patient agree? ☐ yes ☐ no

☐ Naltrexone 50 mg daily ☐ Acamprosate 666 mg 3 times daily ☐ Disulfiram 250 mg daily

☐ Thiamine 100 mg IM/PO ☐ Acamprosate 333 mg 3 times daily (for moderate renal impairment)

☐ Other medication/dosage:

☐ Referral (specify):

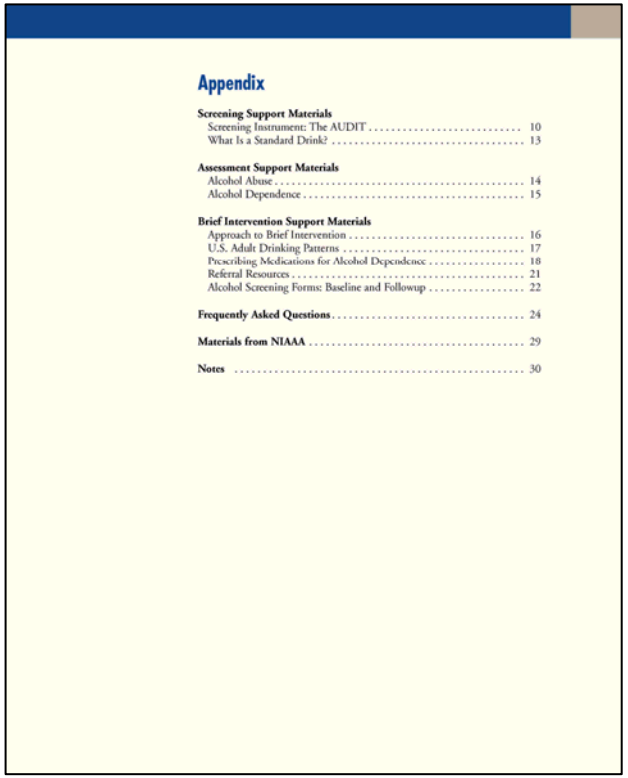
Followup:

Additional plan (withdrawal treatment, coexisting conditions):

23

Appendix

* Screening Support Materials
* Assessment Support Materials
* Brief Intervention Support Materials
* Frequently Asked Questions



Appendix

Screening, Assessment, and Brief Intervention Support Materials: Pages 10-11

Screening Instrument: The Alcohol Use Disorders Identification Test (AUDIT)

Your practice may choose to have patients fill out a written screening instrument before they see a clinician. In this *Guide*, the AUDIT is provided in both English and Spanish for this purpose. It takes only about 5 minutes to complete, has been tested internationally in primary care settings, and has high levels of validity and reliability.[11] You may photocopy these pages or print them as individual pages from the PDF download version of the *Guide* at **www.niaaa.nih.gov**.

Scoring the AUDIT

A minimum score (for nondrinkers) is 0 and the maximum possible score is 40.

Scores of 8 or more for men (up to age 60) or 4 or more for women, adolescents, and men over the age of 60 are considered positive screens.[12,13,14] For patients who have scores near the cut-points, clinicians may wish to examine individual responses to questions and clarify them during the clinical examination.

Note: The AUDIT's sensitivity and specificity for detecting heavy drinking and alcohol use disorders varies across different populations. Lowering the cut-points increases sensitivity (the proportion of "true positive" cases) while increasing the number of false positives. Thus, it may be easiest to use a cut-point of 4 for all patients, recognizing that more false positives may be identified among adult men.

Continuing with screening and assessment

After the AUDIT is completed, continue with Step 1, page 4.

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
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	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: *This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect standard drink sizes in the United States, the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at* ***www.who.org****.*

Screening, Assessment, and Brief Intervention Support Materials: Pages 12-13

PACIENTE: Debido a que el uso del alcohol puede afectar su salud e interferir con ciertos medicamentos y tratamientos, es importante que le hagamos algunas preguntas sobre su uso del alcohol. Sus respuestas serán confidenciales, así que sea honesto por favor.

Marque una X en el cuadro que mejor describa su respuesta a cada pregunta.

Preguntas	0	1	2	3	4	
1. ¿Con qué frecuencia consume alguna bebida alcohólica?	Nunca	Una o menos veces al mes	De 2 a 4 veces al mes	De 2 a 3 más veces a la semana	4 o más veces a la semana	
2. ¿Cuantas consumiciones de bebidas alcohólicas suele realizar en un día de consumo normal?	1 o 2	3 o 4	5 o 6	De 7 a 9	10 o más	
3. ¿Con qué frecuencia toma 5 o más bebidas alcohólicas en un solo día?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
4. ¿Con qué frecuencia en el curso del último año ha sido incapaz de parar de beber una vez había empezado?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
5. ¿Con qué frecuencia en el curso del último año no pudo hacer lo que se esperaba de usted porque había bebido?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
6. ¿Con qué frecuencia en el curso del último año ha necesitado beber en ayunas para recuperarse después de haber bebido mucho el día anterior?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
7. ¿Con qué frecuencia en el curso del último año ha tenido remor-dimientos o sentimientos de culpa después de haber bebido?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
8. ¿Con qué frecuencia en el curso del último año no ha podido recordar lo que sucedió la noche anterior porque había estado bebiendo?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
9. ¿Usted o alguna otra persona ha resultado herido porque usted había bebido?	No		Sí, pero no en el curso del último año		Sí, el último año	
10. ¿Algún familiar, amigo, médico o profesional sanitario ha mostrado preocupación por un consumo de bebidas alcohólicas o le ha sugerido que deje de beber?	No		Sí, pero no en el curso del último año		Sí, el último año	
					Total	

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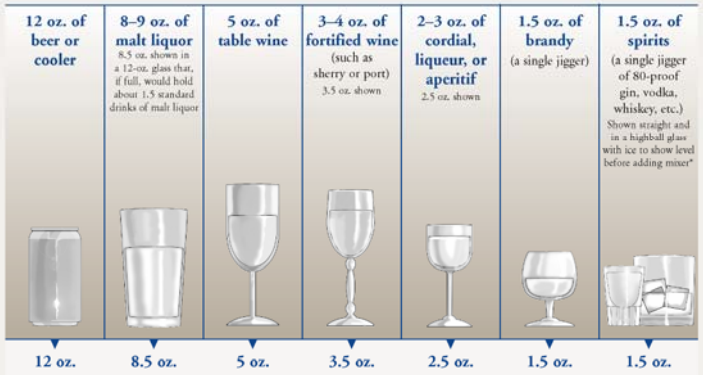
What Is a Standard Drink?

A standard drink is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are standard drink equivalents. These are approximate, as different brands and types of beverages vary in their actual alcohol content.



Many people do not know what counts as a standard drink, and thus are unaware of how many standard drinks are held in the containers in which these drinks are often sold. Some examples:

- For **beer**, the approximate number of standard drinks in
  - 12 oz. = 1
  - 16 oz. = 1.3
  - 22 oz. = 2
  - 40 oz. = 3.3
- For **malt liquor**, the approximate number of standard drinks in
  - 12 oz. = 1.5
  - 16 oz. = 2
  - 22 oz. = 2.5
  - 40 oz. = 4.5
- For **table wine**, the approximate number of standard drinks in
  - a standard 750 mL (25 oz.) bottle = 5
- For **80-proof spirits**, or "hard liquor," the approximate number of standard drinks in
  - a mixed drink = 1 or more*
  - a pint (16 oz.) = 11
  - a fifth (25 oz.) = 17
  - 1.75 L (59 oz.) = 39

Note: It can be difficult to estimate the number of standard drinks served in a single mixed drink made with hard liquor. Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

Screening, Assessment, and Brief Intervention Support Materials: Pages 14-15

Alcohol Abuse:

Sample Questions for Assessment Based on Diagnostic Criteria*

A diagnosis of alcohol **abuse** requires that the patient meet **one** or more of the following criteria, occurring at any time in the same 12-month period, and **not** meet the criteria for alcohol dependence.

All questions are prefaced by "In the past 12 months…"

- **Failure to fulfill major role obligations at work, school, or home because of recurrent drinking:**
  Have you had a period when your drinking—or being sick from drinking—often interfered with taking care of your home or family? Caused job troubles? School problems?
- **Recurrent drinking in hazardous situations:**
  - Have you more than once driven a car or other vehicle while you were drinking? Or after having had too much to drink?
  - Have you gotten into situations while drinking or after drinking that increased your chances of getting hurt—like swimming, using machinery, or walking in a dangerous area or around heavy traffic?
- **Recurrent legal problems related to alcohol:**
  Have you gotten arrested, been held at a police station, or had any other legal problems because of your drinking?
- **Continued use despite recurrent interpersonal or social problems:**
  - Have you continued to drink even though you knew it was causing you trouble with your family or friends?
  - Have you gotten into physical fights while drinking or right after drinking?

*Adapted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Copyright 2000 American Psychiatric Association.

ASSESSMENT SUPPORT MATERIALS

Alcohol Dependence:

Sample Questions for Assessment Based on Diagnostic Criteria*

A diagnosis of alcohol **dependence** requires that the patient meet **three** or more of the following criteria, occurring at any time in the same 12-month period.

All questions are prefaced by "In the past 12 months…"

- **Tolerance:**
  Have you found that you have to drink much more than you once did to get the effect you want? Or that your usual number of drinks has much less effect on you than it once did?
- **Withdrawal syndrome or drinking to relieve withdrawal:**
  - When the effects of alcohol are wearing off, have you had trouble sleeping? Found yourself shaking? Nervous? Nauseous? Restless? Sweating or with your heart beating fast? Have you sensed things that aren't really there? Had seizures?
  - Have you taken a drink or used any drug or medicine (other than over-the-counter pain relievers) to keep from having bad aftereffects of drinking? Or to get over them?
- **Impaired control:**
  Have you more than once wanted to stop or cut down on your drinking? Or tried more than once to stop or cut down but found you couldn't?
- **Drinking more or longer than intended:**
  Have you had times when you ended up drinking more than you meant to? Or kept on drinking for longer than you intended?
- **Neglect of activities:**
  In order to drink, have you given up or cut down on activities that were important or interesting to you or gave you pleasure?
- **Time spent related to drinking or recovering:**
  Have you had a period when you spent a lot of time drinking? Or being sick or getting over the bad aftereffects of drinking?
- **Continued use despite recurrent psychological or physical problems:**
  Have you continued to drink even though you knew it was making you feel depressed or anxious? Or causing a health problem or making one worse? Or after having had a blackout?

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Screening, Assessment, and Brief Intervention Support Materials: Pages 16-17

This section contains guidance and materials to help practitioners conduct brief interventions. Included are the following:

- Approach to Brief Intervention
- U.S. Adult Drinking Patterns
- Prescribing Medications for Alcohol Dependence
- Referral Resources
- Patient Progress Notes (for photocopying)

Approach to Brief Intervention

Keep in mind that changing health-related behaviors is often a difficult process, with progress interrupted by relapse to less healthy behaviors. Providing reinforcement, support, and thoughtful reflection during an office visit can often make the difference between long-term success and failure.

General approach to brief intervention—things to remember:

- Use a health education approach
  - Be matter-of-fact and nonconfrontational
  - Provide patient education materials (see page 29)
- Offer choices on how to make changes
- Emphasize your patient's responsibility for changing drinking behavior
- Convey confidence in your patient's ability to change drinking behavior

U.S. Adult Drinking Patterns

Nearly 3 in 10 U.S. adults engage in at-risk drinking patterns[3] and thus would benefit from advice to cut down or a referral for further evaluation. During a brief intervention, you can use this chart to show that (1) most people abstain or drink within the recommended limits and (2) the prevalence of alcohol use disorders rises with heavier drinking. Though a wise first step, cutting to within the limits is not risk free, since motor vehicle crashes and other problems can occur at lower drinking levels.

WHAT IS YOUR DRINKING PATTERN?	HOW COMMON IS THIS PATTERN?	HOW COMMON ARE ALCOHOL DISORDERS IN DRINKERS WITH THIS PATTERN?
Based on the following limits—number of drinks: On any **DAY**—Never more than **4** (men) or **3** (women) – **and** – In a typical **WEEK**—No more than **14** (men) or **7** (women)	**Percentage of U.S. adults aged 18 or older***	**Combined prevalence of alcohol abuse and dependence****
***Never* exceed the daily *or* weekly limits** (2 out of 3 people in this group abstain or drink fewer than 12 drinks a year)	 72%	less than **1 in 100**
Exceed *only* the *daily* limit (More than 8 out of 10 in this group exceed the daily limit *less than once a week*)	 16%	**1 in 5**
Exceed *both daily and weekly* limits (8 out of 10 in this group exceed the daily limit *once a week or more*)	 10%	almost **1 in 2**

* Not included in the chart, for simplicity, are the 2 percent of U.S. adults who exceed *only* the weekly limits. The combined prevalence of alcohol use disorders in this group is 8 percent.

** See pages 14 and 15 for the diagnostic criteria for alcohol disorders.

Brief Intervention Support Materials – Prescribing Medications: Pages 18-19

Prescribing Medications for Alcohol Dependence

Three approved medications—disulfiram, naltrexone, and acamprosate—are currently available to treat alcohol dependence. They have been shown to be helpful to patients in reducing drinking, reducing relapse to heavy drinking, achieving and maintaining abstinence, or a combination of these effects.

When should I consider prescribing medication for an alcohol use disorder?

All approved drugs have been shown to be effective adjuncts to the treatment of alcohol dependence. Thus, consider adding medication whenever you are treating someone with active alcohol dependence or someone who has stopped drinking in the past few months but is experiencing problems such as craving or slips.

Will medications allow my patients who are alcohol dependent to drink socially?

If someone has developed dependence, the safest course is abstinence, and that would be the usual clinical recommendation. Still, it is best to determine individualized goals with each patient. Some patients may not be willing to endorse abstinence as a goal, especially at first. If an alcohol-dependent patient agrees to reduce drinking substantially, it is best to engage them in that goal while continuing to note that abstinence remains the optimal outcome.

Regarding medications, disulfiram, of course, would be contraindicated in patients who wish to continue to drink, because a disulfiram-alcohol reaction would occur with any alcohol intake at all. In a recent study, naltrexone had a modest effect in reducing the risk of heavy drinking in drinkers with mild to moderate alcohol dependence who had a choice of cutting down or abstaining.[15] At this point, less is known about using acamprosate for this purpose.

Which of the medications should I prescribe?

Which medication to use will be determined by clinical judgment and patient preference. Each works through a different mechanism of action. Some patients may respond better to one type of medication rather than another.

- **Disulfiram** (Antabuse®) produces an unpleasant flushing reaction whenever the patient drinks alcohol. Thus, it produces a disincentive to drinking alcohol and provides some external controls on drinking behavior. Disulfiram has been shown to be most effective when given in a monitored fashion, such as in a clinic or by a spouse.[16] If a spouse or other family member is the monitor, instruct the patient and the monitor that the patient should be taking the medication and asking the monitor to simply observe. Instruct the monitor to call you if the patient does not adhere to this schedule for 2 days. Some patients will respond to self-administered disulfiram, especially if they are highly motivated to abstain.

- **Naltrexone** (ReVia®) blocks opiate receptors that are involved in the rewarding effects of drinking alcohol and the craving for alcohol after establishing abstinence. Naltrexone's efficacy in reducing relapse to heavy drinking has been demonstrated in multiple studies, a finding now confirmed by meta-analyses.[17,18] Although predictors of treatment response have not been clearly demonstrated, research suggests that patients with a family history of alcohol dependence may have a higher rate of response.[19] Several studies also demonstrated a positive interaction between naltrexone and cognitive-behavioral therapy for alcohol dependence.[20]
- **Acamprosate** (Campral®) has been used to treat alcohol dependence in Europe for more than a decade and was approved in the United States for this indication in 2004. Although its mode of action has not been clearly established, it may work by reducing symptoms of protracted abstinence such as insomnia, anxiety, and restlessness. Acamprosate's efficacy in increasing the proportion of dependent drinkers who maintain abstinence for several weeks to months has been demonstrated in multiple studies, a finding confirmed by a meta-analysis of 17 clinical trials.[21] In most positive studies, patients were fully withdrawn from alcohol for at least several days to weeks prior to initiating use.[22]

See the chart on the next page for a summary of the properties of each medication and prescribing information.

Brief Intervention Support Materials – Medications, Referrals: Pages 20-21

Medications for Treating Alcohol Dependence

The chart below highlights some of the properties of each medication. It does not provide complete information and is not meant to be a substitute for the package inserts or other drug reference sources used by clinicians. For patient information about these and other drugs, the National Library of Medicine provides Medline Plus (**http://medlineplus.gov**).

Whether or not a medication should be prescribed and in what amount is a matter between individuals and their health care providers. The prescribing information provided here is not a substitute for a provider's judgment in an individual circumstance, and the NIH accepts no liability or responsibility for use of the information with regard to particular patients.

	Disulfiram (Antabuse®)	**Naltrexone** (ReVia®)	**Acamprosate** (Campral®)
Action	Inhibits intermediate metabolism of alcohol, causing a build-up of acetaldehyde and a reaction of flushing, sweating, nausea, and tachycardia if a patient drinks alcohol	Blocks opioid receptors, resulting in reduced craving and reduced reward in response to drinking	Affects glutamate and GABA neurotransmitter systems, but its alcohol-related action is unclear
Contraindications	Concomitant use of alcohol or alcohol-containing preparations or metronidazole; coronary artery disease; severe myocardial disease	Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analgesics; acute hepatitis or liver failure	Severe renal impairment (CrCl ≤ 30 mL/min)
Precautions	High impulsivity—likely to drink while using it; psychoses (current or history); diabetes mellitus; epilepsy; hepatic dysfunction; hypothyroidism; renal impairment; rubber contact dermatitis	Other hepatic disease; renal impairment; history of suicide attempts. If opioid analgesia is required, larger doses may be required, and respiratory depression may be deeper and more prolonged.	Moderate renal impairment (dose adjustment for CrCl between 30–50 mL/min); depression or suicidality
Serious adverse reactions	Hepatitis; optic neuritis; peripheral neuropathy; psychotic reactions. Pregnancy Category C.	Will precipitate severe withdrawal if patient is dependent on opioids; hepatotoxicity (uncommon at usual doses). Pregnancy Category C.	Anxiety; depression. Rare events include the following: suicide attempt, acute kidney failure, heart failure, mesenteric arterial occlusion, cardiomyopathy, deep thrombophlebitis, and shock. Pregnancy Category C.
Common side effects	Metallic after-taste; dermatitis	Nausea; abdominal pain; constipation; dizziness; headache; anxiety; fatigue	Diarrhea; flatulence; nausea; abdominal pain; headache; back pain; infection; flu syndrome; chills; somnolence; decreased libido; amnesia; confusion
Examples of drug interactions	Amitryptyline; anticoagulants such as warfarin; diazepam; isoniazid; metronidazole; phenytoin; theophylline; warfarin; any nonprescription drug containing alcohol	Opioid analgesics (blocks action); yohimbine (use with naltrexone increases negative drug effects)	No clinically relevant interactions known
Usual adult dosage	*Oral dose:* 250 mg daily (range 125 mg to 500 mg) *Before prescribing:* (1) warn that patient should not take disulfiram for at least 12 hours after drinking and that a disulfiram-alcohol reaction can occur up to 2 weeks after the last dose; and (2) warn about alcohol in the diet (e.g., sauces and vinegars) and in medications and toiletries *Followup:* Monitor liver function tests periodically	*Oral dose:* 50 mg daily *Before prescribing:* Evaluate for possible current opioid use; consider a urine toxicology screen for opioids, including synthetic opioids. Obtain liver function tests. *Followup:* Monitor liver function tests periodically	*Oral dose:* 666 mg (two 333-mg tablets) three times daily or, for patients with moderate renal impairment (CrCl 30–50 mL/min), reduce to 333 mg (one tablet) three times daily *Before prescribing:* Establish abstinence

The information in this chart was drawn primarily from references 18 and 23 (see page 30).

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Referral Resources

When making referrals, involve your patient in the decisions and schedule a referral appointment while he or she is in your office.

Finding evaluation and treatment options

- For patients with insurance, contact a behavioral health case manager at the insurance company for a referral.
- For patients who are underinsured or uninsured, contact your local health department about addiction services.
- For patients who are employed, ask whether they have access to an Employee Assistance Program with addiction counseling.
- To locate treatment options in your area:
  - Call local hospitals to see which ones offer addiction services.
  - Call the National Drug and Alcohol Treatment Referral Routing Service (1-800-662-HELP) or visit the Substance Abuse Facility Treatment Locator Web site at **http://findtreatment.samhsa.gov**.

Finding support groups

- Alcoholics Anonymous (AA) offers free, widely available groups of volunteers in recovery from alcohol dependence. Volunteers are often willing to work with professionals who refer patients. For contact information for your region, visit **www.aa.org**.
- Other self-help organizations that offer secular approaches, groups for women only, or support for family members can be found on the National Clearinghouse for Alcohol and Drug Information Web site (**www.health.org**) under "Resources."

Local resources

Use the space below for contact information for resources in your area (treatment centers, support groups such as AA, local government services, the closest Veterans Affairs medical center, shelters, churches).

Forms for Baseline and Followup Progress Notes: Pages 22-23

Alcohol screening form—baseline

AUDIT score (if done): ☐ (positive = ≥ 8 for men; ≥ 4 for women)

Screening question:
Heavy drinking days in the past **year** (≥ 5 drinks for men/≥ 4 for women) ☐ days (positive = ≥ 1)

Continue if screen is positive:
Average weekly drinking ☐ drinks per week

DSM-IV (revised) symptom criteria:

Abuse—Repeated or persistent problems in any of these areas because of drinking?

☐ no ☐ yes **role failure**
☐ no ☐ yes **risk of bodily harm**
☐ no ☐ yes **run-ins with the law**
☐ no ☐ yes **relationship trouble**

Is **one or more** positive? ☐ no ☐ yes → **Alcohol abuse**

Dependence—Any of the following symptoms in the past year?

☐ no ☐ yes **tolerance**
☐ no ☐ yes **withdrawal**
☐ no ☐ yes **not been able to stick to drinking limits**
☐ no ☐ yes **not been able to cut down or stop in spite of attempts**
☐ no ☐ yes **spent a lot of time on drinking-related activities**
☐ no ☐ yes **spent less time on other matters**
☐ no ☐ yes **kept drinking despite psychological or physical problems**

Are **three or more** positive? ☐ no ☐ yes → **Alcohol dependence**

Additional history: _____

Physical examination and laboratory: _____

Assessment:

☐ Negative alcohol screen ☐ Alcohol abuse ☐ Alcohol withdrawal
☐ At-risk drinking ☐ Alcohol dependence

Plan:

☐ Repeat screening as needed ☐ Patient education about drinking limits
☐ Recommended drinking within limits → Did the patient agree? ☐ yes ☐ no
☐ Recommended abstinence → Did the patient agree? ☐ yes ☐ no
☐ Naltrexone 50 mg daily ☐ Acamprosate 666 mg 3 times daily ☐ Disulfiram 250 mg daily
☐ Thiamine 100 mg IM/PO ☐ Acamprosate 333 mg 3 times daily (for moderate renal impairment)
☐ Other medication/dosage: _____ ☐ Referral (specify): _____

Followup:

Additional plan (withdrawal treatment, coexisting conditions): _____

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Alcohol followup progress note

Heavy drinking days in the past **month** (≥ 5 drinks for men/≥ 4 for women) ☐ days (positive = ≥ 1)

Average weekly drinking in the past **month** ☐ drinks per week

Working diagnosis: ☐ At-risk drinking ☐ Alcohol abuse ☐ Alcohol dependence
Goal: ☐ Drinking within limits ☐ Abstinence
Current medications: ☐ Naltrexone ☐ Acamprosate ☐ Disulfiram
☐ Other (specify): _____

Interval history and progress:

_____

Physical examination and laboratory:

_____

Assessment:

☐ At-risk drinking ☐ Goals fully met
☐ Alcohol abuse ☐ Goals partially met
☐ Alcohol dependence ☐ Goals not met

_____

Plan:

☐ Repeat screening as needed ☐ Patient education about drinking limits
☐ Recommended drinking within limits → Did the patient agree? ☐ yes ☐ no
☐ Recommended abstinence → Did the patient agree? ☐ yes ☐ no
☐ Naltrexone 50 mg daily ☐ Acamprosate 666 mg 3 times daily ☐ Disulfiram 250 mg daily
☐ Thiamine 100 mg IM/PO ☐ Acamprosate 333 mg 3 times daily (for moderate renal impairment)
☐ Other medication/dosage: _____
☐ Referral (specify): _____

Followup:

Additional plan (withdrawal treatment, coexisting conditions): _____

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The Guide answers Frequently Asked Questions, such as…

Frequently Asked Questions

About alcohol screening and brief interventions

- **How effective is screening for heavy drinking?**
  Studies have demonstrated that screening is sensitive and that patients are willing to give honest information about their drinking to health practitioners when appropriate methods are used.[13] Several methods have been shown to work, including quantity-frequency interview questions and questionnaires such as the CAGE, the AUDIT, the shorter AUDIT-C, the TWEAK (for pregnant women), and others.[24,25] In this *Guide*, the single screening question about heavy drinking days was chosen for its simplicity and because almost all people with alcohol use disorders report drinking 5 or more drinks in a day (for men) or 4 or more (for women) at least occasionally. This *Guide* also recommends the AUDIT (provided on page 11) as a self-administered screening tool because of its high levels of validity and reliability.[13]

- **How effective are brief interventions?**
  Randomized, controlled clinical trials in a variety of populations and settings have shown that brief interventions can decrease alcohol use significantly among people who drink above the recommended limits but are not dependent. Studies have found reductions of up to 30 percent in consumption and binge drinking over 12 months, as well as significant decreases in blood pressure readings, levels of gamma-glutamyl transferase (GGT), psychosocial problems, hospital days, and hospital readmissions for alcohol-related trauma.[6] Followup periods typically range from 6 to 24 months, although one recent study reported sustained reductions in alcohol use over 48 months.[6] A cost-benefit analysis in this study showed that each dollar invested in brief physician intervention could reap more than fourfold savings in future health care costs. Other research shows that for alcohol-dependent patients with an alcohol-related medical illness, repeated brief interventions at approximately monthly intervals for 1 to 2 years can lead to significant reductions in or cessation of drinking.[7,8]

- **What can I do to encourage my patients to give honest and accurate answers to the screening questions?**
  It is often best to ask about alcohol consumption at the same time as other health behaviors, such as smoking, diet, and exercise. Using an empathic, nonconfrontational approach can help put patients at ease. Some clinicians have found that prefacing the alcohol questions with a nonthreatening opener such as "Do you enjoy a drink now and then?" can encourage reserved patients to talk. Patients may feel that a written or computerized self-report version of the AUDIT is less confrontational as well. To improve the accuracy of estimated drinking quantities, you could ask patients to look at the "What Is a Standard Drink?" chart on page 13. Many people do not know what counts as a single standard drink, especially for beverages with a higher alcohol content such as malt liquors, fortified wines, and spirits.

- **How can a clinic- or office-based screening system be implemented?**
  The best studied method, which is both easy and efficient, is to ask patients to fill out the 10-item AUDIT before seeing the doctor. This form (provided on page 11) can be added to others that patients fill out. The full AUDIT or the 3-item AUDIT-C can also be incorporated into a larger health history form. The AUDIT-C consists of the first three consumption-related items of the AUDIT; a score of 6 or more for men and 4 or more for women[26] indicates a positive screen. Alternatively, the single-item screen in Step 1 of this *Guide* could be incorporated into a health history form. Screening can also be done in person by a nurse during patient check-in. (See also "Set Up Your Practice to Simplify the Process" on page 3.)

- **Are there any specific considerations for implementing screening in mental health settings?**
  Studies have demonstrated a strong relationship between alcohol use disorders and other mental disorders.[27] Heavy drinking can cause psychiatric symptoms such as depression, anxiety, insomnia, cognitive dysfunction, and interpersonal conflict. For patients who have an independent psychiatric disorder, heavy drinking may compromise the treatment response. Thus, it is important that all mental health clinicians conduct routine screening for heavy drinking.

  Less is known about the performance of screening methods or brief interventions in mental health settings than in primary care settings. Still, the single-question screener in this *Guide* is likely to work reasonably well, since almost all persons with alcohol use disorders report drinking above the recommended daily limits at least occasionally.

  Mental health clinicians may need to conduct a more thorough assessment to determine whether an alcohol use disorder is present and how it might be interacting with other mental or substance use disorders. The recommended limits for drinking may need to be lowered depending on coexisting problems and prescribed medications.

  Similarly, a more extended behavioral intervention may be needed to address coexisting alcohol use disorders, either delivered as part of mental health treatment or through referral to an addiction specialist.

About drinking levels and advice

- **When should I recommend abstaining versus cutting down?**
  Certain conditions warrant advice to abstain as opposed to cutting down. These include when drinkers:
  - are or may become pregnant,
  - are taking a contraindicated medication (see box, below),
  - have a medical or psychiatric disorder caused or exacerbated by drinking, or
  - have an alcohol use disorder.

  If patients with alcohol use disorders are unwilling to commit to abstinence, they may be willing to cut down on their drinking. This should be encouraged while noting that abstinence, the safest strategy, has a greater chance of long-term success.

  For heavy drinkers who do not have an alcohol use disorder, use professional judgment to determine whether cutting down or abstaining is more appropriate, based on factors such as these:
  - a family history of alcohol problems
  - advanced age
  - injuries related to drinking
  - symptoms such as sleep disorders or sexual dysfunction

  It may be useful to discuss different options, such as cutting down to recommended limits or abstaining completely for perhaps 2 months, then reconsidering future drinking. If cutting down is the initial strategy but the patient is unable to stay within limits, recommend abstinence.

- **How do I factor the potential benefits of moderate drinking into my advice to patients who drink rarely or not at all?**
  Moderate consumption of alcohol (defined by U.S. Dietary Guidelines as up to two drinks a day for men and one for women) has been associated with a reduced risk of coronary heart disease.[28] Achieving

℞ Interactions Between Alcohol and Medications

Alcohol can interact negatively with medications either by interfering with the metabolism of the medication (generally in the liver) or by enhancing the effects of the medication (particularly in the central nervous system). Many classes of prescription medicines can interact with alcohol, including antibiotics, antidepressants, antihistamines, barbiturates, benzodiazepines, histamine H2 receptor agonists, muscle relaxants, non-opioid pain medications and anti-inflammatory agents, opioids, and warfarin. In addition, many over-the-counter medications and herbal preparations can cause negative side effects when taken with alcohol.

How effective are brief interventions?

Frequently Asked Questions

About alcohol screening and brief interventions

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Studies have demonstrated that screening is sensitive and that patients are willing to give honest information about their drinking to health practitioners when appropriate methods are used.[13] Several methods have been shown to work, including quantity-frequency interview questions and questionnaires such as the CAGE, the AUDIT, the shorter AUDIT-C, the TWEAK (for pregnant women), and others.[24,25] In this *Guide*, the single screening question about heavy drinking days was chosen for its simplicity and because almost all people with alcohol use disorders report drinking 5 or more drinks in a day (for men) or 4 or more (for women) at least occasionally. This *Guide* also recommends the AUDIT (provided on page 11) as a self-administered screening tool because of its high levels of validity and reliability.[13]

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It is often best to ask about alcohol consumption at the same time as other health behaviors, such as smoking, diet, and exercise. Using an empathic, nonconfrontational approach can help put patients at ease. Some clinicians have found that prefacing the alcohol questions with a nonthreatening opener such as "Do you enjoy a drink now and then?" can encourage reserved patients to talk. Patients may feel that a written or computerized self-report version of the AUDIT is less confrontational as well. To improve the accuracy of estimated drinking quantities, you could ask patients to look at the "What Is a Standard Drink?" chart on page 13. Many people do not know what counts as a single standard drink, especially for beverages with a higher alcohol content such as malt liquors, fortified wines, and spirits.

- **How can a clinic- or office-based screening system be implemented?**

The best studied method, which is both easy and efficient, is to ask patients to fill out the 10-item AUDIT before seeing the doctor. This form (provided on page 11) can be added to others that patients fill out. The full AUDIT or the 3-item AUDIT-C can also be incorporated into a larger health history form. The AUDIT-C consists of the first three consumption-related items of the AUDIT; a score of 6 or more for men and 4 or more for women[26] indicates a positive screen. Alternatively, the single-item screen in Step 1 of this *Guide* could be incorporated into a health history form. Screening can also be done in person by a nurse during patient check-in. (See also "Set Up Your Practice to Simplify the Process" on page 3.)

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Mental health clinicians may need to conduct a more thorough assessment to determine whether an alcohol use disorder is present and how it might be interacting with other mental or substance use disorders. The recommended limits for drinking may need to be lowered depending on coexisting problems and prescribed medications.

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- **When should I recommend abstaining versus cutting down?**

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- are or may become pregnant,
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- have an alcohol use disorder.

If patients with alcohol use disorders are unwilling to commit to abstinence, they may be willing to cut down on their drinking. This should be encouraged while noting that abstinence, the safest strategy, has a greater chance of long-term success.

For heavy drinkers who do not have an alcohol use disorder, use professional judgment to determine whether cutting down or abstaining is more appropriate, based on factors such as these:

- a family history of alcohol problems
- advanced age
- injuries related to drinking
- symptoms such as sleep disorders or sexual dysfunction

It may be useful to discuss different options, such as cutting down to recommended limits or abstaining completely for perhaps 2 months, then reconsidering future drinking. If cutting down is the initial strategy but the patient is unable to stay within limits, recommend abstinence.

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  Moderate consumption of alcohol (defined by U.S. Dietary Guidelines as up to two drinks a day for men and one for women) has been associated with a reduced risk of coronary heart disease.[28] Achieving

Rx Interactions Between Alcohol and Medications

Alcohol can interact negatively with medications either by interfering with the metabolism of the medication (generally in the liver) or by enhancing the effects of the medication (particularly in the central nervous system). Many classes of prescription medicines can interact with alcohol, including antibiotics, antidepressants, antihistamines, barbiturates, benzodiazepines, histamine H2 receptor agonists, muscle relaxants, non-opioid pain medications and anti-inflammatory agents, opioids, and warfarin. In addition, many over-the-counter medications and herbal preparations can cause negative side effects when taken with alcohol.

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require further treatment, and their chances of benefiting the next time do not appear to be influenced significantly by having had prior treatments.[37] As is true for other medical disorders, some patients have more severe forms of alcohol dependence that may require long-term management.

■ **What can I do to help patients who struggle to remain abstinent or who relapse?**

Changing drinking behavior is a challenge, especially for those who are alcohol dependent. The first 12 months of abstinence are especially difficult, and relapse is most common during this time. If patients do relapse, recognize that they have a chronic disorder that requires continuing care, just like patients who have asthma, hypertension, or diabetes. Recurrence of symptoms is common and similar across each of these disorders,[38] perhaps because they require the patient to change health behaviors to maintain gains.

For patients who struggle to abstain or who relapse:

- Treat depression or anxiety disorders if they are present more than 2 to 4 weeks after abstinence is established.
- Assess and address other possible triggers for struggle or relapse, including stressful events, interpersonal conflict, insomnia, chronic pain, craving, or high-temptation situations such as a wedding or convention.
- If the patient is not taking medication for alcohol dependence, consider prescribing one (see page 18).
- If the patient is not attending a mutual-help group or is not receiving behavioral therapy, consider recommending these support measures.
- Encourage those who have relapsed by noting that relapse is common and by pointing out the value of the recovery that was achieved.
- Provide followup care and advise patients to contact you if they are concerned about relapse.

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Materials from NIAAA

These materials can be ordered from the NIAAA Publications Distribution Center, P.O. Box 10686, Rockville, MD 20849–0686; phone: (301) 443–3860. They are also available in full text on NIAAA's Web site (**www.niaaa.nih.gov**). NIAAA continually develops and updates materials for practitioners and patients; please check the Web site for new offerings.

For patients

Alcohol: A Women's Health Issue—Describes the effects of alcohol on women's health at different stages in their lives. English version: NIH Publication No. 05–4956; Spanish version: NIH Publication No. 05–4956–S. Also available: a 12-minute video, with the same title, that describes the health consequences of heavy drinking in women.

Alcohol: What You Don't Know Can Harm You—Provides information on drinking and driving, alcohol-medication interactions, interpersonal problems, alcohol-related birth defects, long-term health problems, and current research issues. English version: NIH Publication No. 02–4323; Spanish version: NIH Publication No. 02–4323–S.

Alcoholism: Getting the Facts—Describes alcoholism and alcohol abuse and offers useful information on when and where to seek help. English version: NIH Publication No. 05–4153; Spanish version: NIH Publication No. 05–4153–S.

Drinking and Your Pregnancy—Briefly conveys the lifelong medical and behavioral problems associated with fetal alcohol syndrome and advises women not to drink during pregnancy. English version: NIH Publication No. 01–4101; Spanish version: NIH Publication No. 01–4102.

Frequently Asked Questions About Alcoholism and Alcohol Abuse—English version: NIH Publication No. 01–4735; Spanish version: NIH Publication No. 02–4735–S.

For health practitioners

A Pocket Guide for Alcohol Screening and Brief Intervention—a condensed, portable version of this publication.

Alcohol Alerts—These 4-page bulletins provide timely information on alcohol research and treatment.

Alcohol Research & Health—Each issue of this quarterly peer-reviewed journal contains review articles on a central topic related to alcohol research.

NIAAA also offers a condensed Pocket Guide

The Pocket Guide features the same steps…

HOW TO SCREEN FOR HEAVY DRINKING

STEP 1 Ask About Alcohol Use

Ask: Do you sometimes drink alcoholic beverages?

NO → Screening complete.

YES → Ask the screening question about **heavy drinking days**:

How many times in the past year have you had . . .

5 or more drinks in a day? *(for men)* — **4 or more** drinks in a day? *(for women)* → ☐

One standard drink is equivalent to 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

Is the answer 1 or more times?

NO →
- Advise staying within maximum **drinking limits**:

  For healthy **men up to age 65**—
  - no more than **4** drinks in a **day** AND
  - no more than **14** drinks in a **week**

  For healthy **women** (and healthy **men over age 65**)—
  - no more than **3** drinks in a **day** AND
  - no more than **7** drinks in a **week**
- Recommend **lower limits or abstinence** as indicated; for example, for patients who take **medications** that interact with alcohol, have a **health condition** exacerbated by alcohol, or are **pregnant** (advise abstinence)
- **Rescreen** annually

YES →
- Your patient is an at-risk drinker. For a more complete picture of the drinking pattern, **determine the weekly average:**
  - On average, how many **days** a week do you have an alcoholic drink? ☐
  - On a typical drinking day, how many **drinks** do you have? ☐

  x

  Weekly average ☐
- **Record** heavy drinking days in past year and weekly average in chart.

GO TO STEP 2

HOW TO ASSESS FOR ALCOHOL USE DISORDERS

STEP 2 Assess For Alcohol Use Disorders

Next, determine if there is a *maladaptive pattern of alcohol use*, causing *clinically significant impairment* or *distress*.

Determine whether, in the past 12 months, your patient's drinking has **repeatedly** caused or contributed to

- ☐ **role failure** (interference with home, work, or school obligations)
- ☐ **risk** of bodily harm (drinking and driving, operating machinery, swimming)
- ☐ **run-ins** with the law (arrests or other legal problems)
- ☐ **relationship** trouble (family or friends)

If yes to **one or more** → your patient has **alcohol abuse**.

In either case, proceed to assess for dependence symptoms.

Determine whether, in the past 12 months, your patient has

- ☐ **shown tolerance** (needed to drink a lot more to get the same effect)
- ☐ **shown signs of withdrawal** (tremors, sweating, nausea, or insomnia when trying to quit or cut down)
- ☐ **not been able to stick to drinking limits** (repeatedly gone over them)
- ☐ **not been able to cut down or stop** (repeated failed attempts)
- ☐ **spent a lot of time drinking** (or anticipating or recovering from drinking)
- ☐ **spent less time on other matters** (activities that had been important or pleasurable)
- ☐ **kept drinking despite problems** (recurrent physical or psychological problems)

If yes to **three or more** → your patient has **alcohol dependence**.

Does patient meet criteria for abuse or dependence?

NO → **GO TO STEPS 3 & 4 for AT-RISK DRINKING**

YES → **GO TO STEPS 3 & 4 for ALCOHOL USE DISORDERS**

HOW TO CONDUCT A BRIEF INTERVENTION

FOR AT-RISK DRINKING (no abuse or dependence)

STEP 3 Advise and Assist

- **State your conclusion and recommendation clearly** and relate them to medical concerns or findings.
- **Gauge readiness** to change drinking habits.

Is patient ready to commit to change?

NO →
- **Restate your concern.**
- **Encourage reflection.**
- **Address barriers to change.**
- **Reaffirm your willingness to help.**

YES →
- **Help set a goal.**
- **Agree on a plan.**
- **Provide educational materials.**

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit.

Was patient able to meet and sustain drinking goal?

NO →
- **Acknowledge that change is difficult.**
- **Support positive change** and address barriers.
- **Renegotiate goal and plan**; consider a trial of abstinence.
- **Consider engaging significant others.**
- **Reassess diagnosis** if patient is unable to either cut down or abstain.

YES →
- **Reinforce and support continued adherence** to recommendations.
- **Renegotiate drinking goals** as indicated (e.g., if the medical condition changes or if an abstaining patient wishes to resume drinking).
- **Encourage to return** if unable to maintain adherence.
- **Rescreen** at least annually.

FOR ALCOHOL USE DISORDERS (abuse or dependence)

STEP 3 Advise and Assist

- **State your conclusion and recommendation clearly** and relate them to medical concerns or findings.
- **Negotiate a drinking goal.**
- **Consider evaluation by an addiction specialist.**
- **Consider recommending a mutual help group.**
- For patients who have dependence, **consider**
  - the need for **medically managed withdrawal** (detoxification) and treat accordingly.
  - prescribing a **medication** for alcohol dependence for patients who endorse abstinence as a goal.
- **Arrange followup appointments.**

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit.

Was patient able to meet and sustain drinking goal?

NO →
- **Acknowledge that change is difficult.**
- **Support efforts** to cut down or abstain.
- **Relate drinking to ongoing problems** as appropriate.
- **Consider** (if not yet done):
  - consulting with an **addiction specialist.**
  - recommending a **mutual help group.**
  - engaging **significant others.**
  - prescribing a **medication** for alcohol dependent patients who endorse abstinence as a goal.
- **Address coexisting disorders** as needed.

YES →
- **Reinforce and support continued adherence.**
- **Coordinate care** with specialists as appropriate.
- **Maintain medications** for alcohol dependence for at least 3 months and as clinically indicated thereafter.
- **Treat coexisting nicotine dependence.**
- **Address coexisting disorders** as needed.

…and many of the supporting materials.

WHAT IS A STANDARD DRINK?

A standard drink is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are standard drink equivalents as well as the number of standard drinks in different container sizes for each beverage. These are approximate, as different brands and types of beverages vary in their actual alcohol content.

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
BEER or COOLER	
12 oz. ~5% alcohol	• 12 oz. = 1 • 16 oz. = 1.3 • 22 oz. = 2 • 40 oz. = 3.3
MALT LIQUOR	
8–9 oz. ~7% alcohol	• 12 oz. = 1.5 • 16 oz. = 2 • 22 oz. = 2.5 • 40 oz. = 4.5
TABLE WINE	
5 oz. ~12% alcohol	• a 750 mL (25 oz.) bottle = 5
80-proof SPIRITS (hard liquor)	
1.5 oz. ~40% alcohol	• a mixed drink = 1 or more* • a pint (16 oz.) = 11 • a fifth (25 oz.) = 17 • 1.75 L (59 oz.) = 39

*Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

DRINKING PATTERNS

WHAT IS YOUR DRINKING PATTERN?	HOW COMMON IS THIS PATTERN?	HOW COMMON ARE ALCOHOL DISORDERS IN DRINKERS WITH THIS PATTERN?
Based on the following limits—number of drinks: On any **DAY**—Never more than **4** (men) or **3** (women) —and— In a typical **WEEK**—No more than **14** (men) or **7** (women)	Percentage of U.S. adults aged 18 or older*	Combined prevalence of alcohol abuse and dependence
***Never* exceed the daily *or* weekly limits** (2 out of 3 people in this group abstain or drink fewer than 12 drinks a year)	72%	less than **1 in 100**
Exceed *only* the *daily* limit (More than 8 out of 10 in this group exceed the daily limit *less than once a week*)	16%	**1 in 5**
Exceed *both daily and weekly* limits (8 out of 10 in this group exceed the daily limit *once a week or more*)	10%	almost **1 in 2**

*Not included in the chart, for simplicity, are the 2 percent of U.S. adults who exceed *only* the weekly limits. The combined prevalence of alcohol use disorders in this group is 8 percent.

Source: 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a nationwide survey sponsored by the National Institute on Alcohol Abuse and Alcoholism of 43,093 U.S. adults aged 18 or older.

PRESCRIBING MEDICATIONS

The chart below contains excerpts from page 20 of NIAAA's *Helping Patients Who Drink Too Much: A Clinician's Guide*. It does *not* provide complete information and is not meant to be a substitute for the patient package inserts or other drug references used by clinicians. For patient information, visit **http://medlineplus.gov**.

	Disulfiram (Antabuse®)	Naltrexone (ReVia®)	Acamprosate (Campral®)
Contra-indications	Concomitant use of alcohol or alcohol-containing preparations or metronidazole; coronary artery disease; severe myocardial disease	Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analgesics; acute hepatitis or liver failure	Severe renal impairment (CrCl ≤ 30 mL/min)
Key precautions	High impulsivity; likely to drink while using it; psychoses (current or history); hepatic dysfunction	Other hepatic disease. If opioid analgesia is required, larger doses may be required, and respiratory depression may be deeper and more prolonged.	Moderate renal impairment (dose adjustment for CrCl between 30-50 mL/min); depression or suicidality
More common serious adverse reactions	Disulfiram-ethanol reaction; hepatitis; peripheral neuropathy; psychotic reactions; pregnancy Category C	Will precipitate severe withdrawal if patient is dependent on opioids; hepatotoxicity (uncommon at usual doses); pregnancy Category C	Anxiety; depression; suicide attempt (> 1%); pregnancy Category C
Common side effects	Metallic after-taste; dermatitis	Nausea; abdominal pain; constipation; dizziness; headache; anxiety and fatigue	Diarrhea; flatulence; nausea; abdominal pain; headache
Examples of drug inter-actions	Warfarin; isoniazid; metronidazole; any nonprescription drug containing alcohol	Opioid analgesics (blocks action)	No clinically relevant interactions known
How to prescribe	***Oral dose:*** 250 mg daily (range 125 mg to 500 mg) ***Before prescribing:*** (1) warn that patient should not take disulfiram for at least 12 hours after drinking and that a disulfiram-alcohol reaction can occur up to 2 weeks after the last dose; and (2) warn about alcohol in the diet (e.g., sauces and vinegars) and in medications and toiletries ***Followup:*** Monitor liver function tests periodically	***Oral dose:*** 50 mg daily ***Before prescribing:*** Evaluate for possible current opioid use; consider a urine toxicology screen for opioids, including synthetic opioids. Obtain liver function tests. ***Followup:*** Monitor liver function tests periodically	***Oral dose:*** 666 mg (two 333-mg tablets) three times daily or, for patients with moderate renal impairment (CrCl 30-50 mL/min), reduce to 333 mg (one tablet) three times daily ***Before prescribing:*** Establish abstinence

Note: Whether or not a medication should be prescribed and in what amount is a matter between individuals and their health care providers. The prescribing information provided here is not a substitute for a provider's judgment in an individual circumstance and the NIH accepts no liability or responsibility for use of the information with regard to particular patients. JULY 2005

A POCKET GUIDE FOR

Alcohol Screening and Brief Intervention

2005 Edition

This pocket guide is condensed from the 30-page NIAAA guide, *Helping Patients Who Drink Too Much: A Clinician's Guide.*

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