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.
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.
The AUDIT is found on page 11...

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.

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

Total

Note: This questionnaire (the AUDIT) is reproduced 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.addo.org.
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.

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

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:

Prescreen: Do you sometimes drink alcoholic beverages?

**NO**

Screening complete.

**YES**

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).

<table>
<thead>
<tr>
<th>12 oz. of beer or cooler</th>
<th>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</th>
<th>5 oz. of table wine</th>
<th>3-4 oz. of fortified wine (such as sherry or port) 3.5 oz. shown</th>
<th>2-3 oz. of cordial, liqueur, or aperitif 2.5 oz. shown</th>
<th>1.5 oz. of brandy (a single jigger)</th>
<th>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*</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 oz.</td>
<td>8.5 oz.</td>
<td>5 oz.</td>
<td>3.5 oz.</td>
<td>2.5 oz.</td>
<td>1.5 oz.</td>
<td>1.5 oz.</td>
</tr>
</tbody>
</table>
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).
STEP 2: Assess for Alcohol Use Disorders (AUDs)

Determine if there is—

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

**How to 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 8**
- **YES**
  - Your patient has an alcohol use disorder
  - **GO TO STEPS 3 & 4 for ALCOHOL USE DISORDERS, page 7**
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 (AUDs)

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

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**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?
STEP 2: Assess for AUDs:
Determine whether, in the past 12 months, your patient’s drinking has repeatedly caused or contributed to…

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

Yes to one or more in past year: **Alcohol abuse**

In either case, 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
STEP 2: Assess for AUDs

Does the patient meet the criteria for abuse or dependence?

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)
Page 6

First Example--For a Patient with At-Risk Drinking (no abuse or dependence)

STEP 3: Advise and Assist

**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 for good.” (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 drinking, a positive change in itself. With reinforced reinforcement, your patient may decide to take action, for now.
  - Restrate your concerns 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?
  - Realize 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 abstinence 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 alcoholics and non-alcoholic beverages)
    - how drinking will be tracked (daily, kitchen calendar)
    - how the patient will manage high-risk situations
  - Who might be willing to help, such as a spouse or non-drinking friends
  - Provide educational materials (see page 29).

**STEP 4** At Followup: Continue Support

REMEMBER: 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.
  - Rerigaret the goal and plan; consider a trial of abstinence.
  - Consider engaging significant others.
  - Reasons 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.
  - Recognize 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.
  - Reexamine at least annually.
FOR AT-RISK DRINKING (no abuse or dependence)

STEP 3: Advise and Assist

* State your conclusion and recommendations clearly

“You are drinking more than is medically safe.”
FOR AT-RISK DRINKING (no abuse or dependence)

STEP 3: Advise and Assist

* State your conclusion and recommendations clearly

“I strongly recommend that you cut down or quit.”
FOR AT-RISK DRINKING (no abuse or dependence)

STEP 3: Advise and Assist

* State your conclusion and recommendations clearly

* Gauge readiness to change

“Are you willing to consider making changes to your drinking?”
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

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, patients may decide to take action.
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

For now…

* Restate your concern about his or her health.
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

* Encourage reflection: Ask patients to weigh what they like about drinking versus their reasons for cutting down. What are the major barriers to change?
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

* Reaffirm your willingness to help when he or she is ready.
FOR AT-RISK DRINKING (no abuse or dependence)

STEP 3: Advise and Assist

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

**YES**

* Help set a goal: Cut down to within maximum limits (see Step 1) or abstain for a period of time.
FOR AT-RISK DRINKING (no abuse or dependence)

STEP 3: Advise and Assist

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

YES

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

STEP 3: Advise and Assist

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

YES

* **Agree on a plan** (cont’d) including-
  * how drinking will be tracked
  * how the patient will manage high-risk situations
  * who might be willing to help, such as a spouse or nondrinking friends
FOR AT-RISK DRINKING (no abuse or dependence)

STEP 3: Advise and Assist

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

**YES**

* Provide educational materials (see appendix, page 29).
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**
FOR AT-RISK DRINKING (no abuse or dependence)

STEP 4: At Followup: Continue Support

REMININDER: Document alcohol use and review goals at each visit.
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.
FOR AT-RISK DRINKING (no abuse or dependence)

STEP 4: Followup

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

**NO**

* Acknowledge change is difficult.
* Support any positive change.
* Renegotiate the goal and plan: Consider a trial of abstinence.
* Consider engaging significant others.
* Reassess the diagnosis. (Go to Step 2.)
FOR AT-RISK DRINKING
(no abuse or dependence)

STEP 4: Followup

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

**YES**

* Reinforce and support adherence.
* Renegotiate drinking goals as indicated.
* 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…
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.”
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.)
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.
FOR ALCOHOL USE DISORDERS (abuse or dependence)

STEP 3: Advise and Assist

* For patients who have alcohol dependence, consider…

  • the need for medically managed withdrawal (detoxification) and treat accordingly (see page 27)
FOR ALCOHOL USE DISORDERS

(abuse or dependence)

STEP 3: Advise and Assist

* For patients who have alcohol dependence, consider:

- Prescribing medications for patients who endorse abstinence as a goal (see pages 18-21)
FOR ALCOHOL USE DISORDERS (abuse or dependence)

STEP 3: Advise and Assist

* Arrange followup appointments.
FOR ALCOHOL USE DISORDERS

STEP 4: At Followup

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.
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
  * 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.
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.
FOR ALCOHOL USE DISORDERS

STEP 4: At Followup

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

YES

* Reinforce and support continued adherence to recommendations.

* Coordinate care with a specialist if the patient has accepted referral.
FOR ALCOHOL USE DISORDERS

STEP 4: At Followup

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

YES

* Maintain medications for alcohol dependence for at least 3 months and as clinically indicated thereafter.
FOR ALCOHOL USE DISORDERS

STEP 4: At Followup

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

**YES**

* Treat coexisting nicotine dependence for 6 to 12 months after reaching the drinking goal.
FOR ALCOHOL USE DISORDERS

STEP 4: At Followup

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

YES

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

* Screening Support Materials
* Assessment Support Materials
* Brief Intervention Support Materials
* Frequently Asked Questions
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. 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 (five nondrinkers) is 0 and the maximum possible score is 40. Scores of 8 or more for men (up to age 60) or 5 or more for women, adolescents, and men over the age of 60 are considered positive screens.

For patients who have scores near the cutoff 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 cutoff points increases sensitivity (the proportion of 'true positive' cases) while increasing the number of false positives. Thus, it may be easier to use a cutoff 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.

---

**Questionnaire:**

**Questions:**

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

**Total**

*Note: This questionnaire (the AUDIT) is adapted with permission from the World Health Organization. To reflect national drink sizes in the United States, the number of drinks in questions 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at www.niaaa.org.*
# Screening, Assessment, and Brief Intervention Support Materials: Pages 12-13

## Screening Support Materials

**PAGE 1**

**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 no tiene porque ser honesto por favor.

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

<table>
<thead>
<tr>
<th>Preguntas</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ¿Con qué frecuencia consume alguna bebida alcohólica?</td>
<td>Nunca</td>
<td>Una o menos veces al mes</td>
<td>De 2 a 4 veces al mes</td>
<td>De 2 a 3 veces al mes</td>
<td>4 o más veces al mes</td>
</tr>
<tr>
<td>2. ¿Cuántas consumiciones de bebidas alcohólicas suele realizar en un día de consumo normal?</td>
<td>1 o 2</td>
<td>3 o 4</td>
<td>5 o 6</td>
<td>7 o 9</td>
<td>10 o más</td>
</tr>
<tr>
<td>3. ¿Con qué frecuencia toma 5 o más bebidas alcohólicas en un solo día?</td>
<td>Nunca</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
</tr>
<tr>
<td>4. ¿Con qué frecuencia en el curso del último año ha sido incapaz de pasar de beber una vez habiendo emprendido?</td>
<td>Nunca</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
</tr>
<tr>
<td>5. ¿Con qué frecuencia en el curso del último año no pudo hacer lo que se esperaba de usted porque había bebido?</td>
<td>Nunca</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
</tr>
<tr>
<td>6. ¿Con qué frecuencia en el curso del último año ha necesitado beber en aytunas para recuperarse después de haber bebido mucho el día anterior?</td>
<td>Nunca</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
</tr>
<tr>
<td>7. ¿Con qué frecuencia en el curso del último año ha tenido remordimientos o sentimientos de culpa después de haber bebido?</td>
<td>Nunca</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
</tr>
<tr>
<td>8. ¿Con qué frecuencia en el curso del último año no ha podido recordar lo que sucedió la noche anterior porque había estado bebiendo?</td>
<td>Nunca</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
<td>Menos de una vez al mes</td>
</tr>
<tr>
<td>9. ¿Usaste o algún otra persona ha resultado herido porque usted había bebido?</td>
<td>No</td>
<td>Sí, pero no en el curso del último año</td>
<td>Sí, en el curso del último año</td>
<td>Sí, en el curso del último año</td>
<td>Sí, en el curso del último año</td>
</tr>
<tr>
<td>10. ¿Alguna vez después de beber, ha tenido preocupaciones por no consumir de bebidas alcohólicas o te ha sugerido que deje de beber?</td>
<td>No</td>
<td>Sí, pero no en el curso del último año</td>
<td>Sí, en el curso del último año</td>
<td>Sí, en el curso del último año</td>
<td>Sí, en el curso del último año</td>
</tr>
</tbody>
</table>

**Note:** The questionnaire (the AUDIT) is approved with permission from the World Health Organization and the European Valencian Conselleria De Sanitat Publica. To reflect standard drink sizes in the United States, the number of drinks in question 5 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at www.anadh.org

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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.

<table>
<thead>
<tr>
<th>12 oz. of beer or cooler</th>
<th>8-9 oz. of malt liquor</th>
<th>5 oz. of table wine</th>
<th>3-4 oz. of fortified wine (such as sherry or port)</th>
<th>2-3 oz. of hard liquor, liqueur, or aperitif</th>
<th>1.5 oz. of brandy (in a single shot)</th>
<th>1.5 oz. of spirits (in a single shot of 80-proof gin, vodka, whiskey, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12 oz.</td>
</tr>
</tbody>
</table>

Many people do not know what counts as a standard drink, and thus are unaware of how many standard drinks are being consumed in a course where these drinks are often sold. Some examples:

- **For beer:** The approximate number of standard drinks in
  - 12 oz. = 1
  - 22 oz. = 2

- **For malt liquor:** The approximate number of standard drinks in
  - 12 oz. = 1.5
  - 22 oz. = 2.5

- **For table wine:** The approximate number of standard drinks in
  - 12 oz. = 1.5
  - 22 oz. = 2.5

- **For 80-proof spirits:** The approximate number of standard drinks in
  - 1 oz. = 1
  - 1.5 oz. = 1.5

*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.
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—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 gone 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.

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? Felt you had to have a drink? Nervous? Anxious? Restless? Sweating or with your heart beating fast? Have you been irritable or restless? Had tremors?
  - 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?

*Adapted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Copyright 2000 American Psychiatric Association.
Screening, Assessment, and Brief Intervention Support Materials: Pages 16-17

**U.S. Adult Drinking Patterns**

Nearly 3 in 10 U.S. adults engage in at-risk drinking patterns* 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) more 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.

<table>
<thead>
<tr>
<th>WHAT IS YOUR DRINKING PATTERN?</th>
<th>HOW COMMON IS THIS PATTERN?</th>
<th>HOW COMMON ARE ALCOHOL DISORDERS IN DRINKERS WITH THIS PATTERN?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on the following limits—number of drinks:</td>
<td>Percentage of U.S. adults aged 18 or older*</td>
<td>Combined prevalence of alcohol abuse and dependence**</td>
</tr>
<tr>
<td>On any DAY—Never more than 4 (men) or 3 (women) and—</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a typical WEEK—No more than 14 (men) or 7 (women)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 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 more than once a week)
  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 3 percent.

** See page 14 and 15 for the diagnostic criteria for alcohol disorders.
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 those 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. 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 fleeting 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. 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 tell 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. 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. Several studies also demonstrated a positive interaction between naltrexone and cognitive-behavioral therapy for alcohol dependence.

- **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 irritability, 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. In most positive studies, patients were fully withdrawn from alcohol for at least several days to weeks prior to initiating use.

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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Action</th>
<th>Contraindications</th>
<th>Precautions</th>
<th>Serious adverse reactions</th>
<th>Common side effects</th>
<th>Examples of drug interactions</th>
<th>Usual adult dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disulfiram (Antabuse®)</td>
<td>Blocks acetal dehydrogenase, resulting in reduced mas of alcohol in the body</td>
<td>None</td>
<td>History of alcohol dehydrogenase deficiency</td>
<td>Moderate hepatic enzyme dysfunction, dose-related nausea &amp; vomiting</td>
<td>Nausea, headache, malaise, flushing</td>
<td>Acute alcohol use after discontinuation of use or slow withdrawal of alcohol</td>
<td>2 or 500 mg daily, up to 15 mg to 500 mg before drinking</td>
</tr>
<tr>
<td>Naltrexone (ReVia®)</td>
<td>Blocks opioid receptors, resulting in reduced craving and relapse in response to drinking</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Nausea, vomiting, headache, distraction</td>
<td>Moderate alcohol use after discontinuation of use or slow withdrawal of alcohol</td>
<td>50 mg daily, up to 150 mg daily</td>
</tr>
<tr>
<td>Acamprosate (Campral®)</td>
<td>Alters glutamate and NMDA-receptor function systems, but its alcohol-related action is unclear</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Nausea, vomiting, headache</td>
<td>Moderate alcohol use after discontinuation of use or slow withdrawal of alcohol</td>
<td>333 mg three times daily, up to 1667 mg three times daily</td>
</tr>
</tbody>
</table>

Referral Resources

When making referrals, involve your patient in the discussion 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 uninsured or ineligible, 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 Locate 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.gov) 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, clinics, churches).
The Guide answers Frequently Asked Questions, such as...
How effective are brief interventions?

- 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 presenting the alcohol questions with a soothing rather than an accusatory phrase, such as “Do you enjoy a drink now and then?” can encourage honest responses. 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 “Who Has a Standard Drink?” chart in the appendix of the AUDIT and then count drinking quantities, or ask them how much they usually drink on a given evening. The AUDIT can be used with 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 method is to conduct it at each patient visit. The 10-item AUDIT-C has been shown to be effective in primary care settings. This form (provided on page 11) is also recommended for use in clinics and hospice settings. It is a quick and easy way to identify patients who need further assessment and management.

- 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. 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 contribute to the treatment response. Thus, it is important that all mental health clinicians conduct routine screening for heavy drinking.

- 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. Achieving

About drinking levels and advice

- When should I recommend abstinence versus cutting down? Certain conditions warrant advice to abstain as opposed to cutting down. These include when:
  - Use or may become pregnant.
  - Are taking a cardioprotective 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. If this is the case, the clinician should discuss the potential benefits of cutting down versus abstaining. It may be useful to discuss different options, such as cutting down to recommended limits or abstaining completely for a period of time, then reconsidering future drinking. If cutting down is the initial strategy but the patient is unable to stay within limits, recommended abstinence.

R. 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 medications can interact with alcohol, including beta blockers, anticoagulants, antidepressants, anticonvulsants, benzodiazepines, beta-blockers, calcium channel blockers, corticosteroids, hormone replacement therapy, hormone reuptake inhibitors, muscled relaxants, non-steroidal anti-inflammatory agents, opioids, and warfarin. In addition, over-the-counter medications and herbal preparations can cause negative side effects when taken with alcohol.
When should I recommend abstaining versus cutting down?

### Frequently Asked Questions

#### About alcohol screening and brief interventions

- **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 presenting the alcohol questions with a soothing, reassuring manner such as “Do you enjoy a drink now and then?” can encourage honest answers. Patients may feel that a less confrontational self-report version of the AUDIT is less intrusive 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 15. 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 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% 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. Follow-up periods typically range from 6 to 24 months, although one recent study reported sustained reductions in alcohol use over 48 months. 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, separate brief interventions are approximately equally useful for 1 to 2 years can lead to significant reductions in or cessation of drinking.  

### 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 medications can interact with alcohol, including antibiotics, antidiuretics, antihistamines, barbiturates, benzodiazepines, beta-blockers, histamine H2 receptor antagonists, muscle relaxants, non-steroidal anti-inflammatory drugs, opioids, and warfarin. In addition, many over-the-counter medications and herbal preparations can cause negative side effects when taken with alcohol.
What if a patient reports some symptoms of an alcohol use disorder but not enough to qualify for a diagnosis?

About diagnosing and helping patients with alcohol use disorders

- What if a patient reports some symptoms of an alcohol use disorder but not enough to qualify for a diagnosis for a disease?

Alcohol use disorders are similar to other medical disorders such as hypertension, diabetes, or depression in having "gray zones" of diagnosis. For example, a patient might report a single arrest for driving while intoxicated and no other symptoms. Since a diagnosis of alcohol abuse requires repetitive problems, that diagnosis could not be made. Similarly, a patient might report one or two symptoms of alcohol dependence, but there are needed to qualify for a diagnosis. Any symptoms of abuse or dependence are a cause for concern and should be addressed, as an alcohol use disorder may be present or developing. These patients may be more successful with abstaining as opposed to using down to recommended limits. Close followup is indicated, as well as reconsidering the diagnosis as more information becomes available.

- If I refer a patient for alcohol treatment, what are the chances for recovery?

A review of seven large studies of alcoholism treatment found that about one-third of patients either abstained or drank moderately without negative consequences or dependence in the year following treatment. Although the other patients thought they had periods of heavy drinking, on average they reduced consumption and alcohol-related problems by more than half. These reductions appear to last at least 3 years. This substantial improvement in patients who do not attain complete abstinence or problem-free reduced drinking is often overlooked. These patients may...
FREQUENTLY ASKED QUESTIONS

Should I recommend any particular behavioral therapy for patients with alcohol use disorders?

A balance between the risks and benefits of alcohol consumption remains difficult, however, because each person has a different susceptibility to diseases potentially caused or prevented by alcohol. Your advice to a young person with a family history of alcoholism, for example, would differ from the advice you would give to a middle-aged patient with a family history of premature heart disease. Most experts do not recommend advising nondrinking patients to begin drinking to reduce their cardiovascular risk. However, if a patient is considering this, discuss safe drinking limits and ways to avoid alcohol-induced harm.

Why are the recommended drinking limits lower for some patients?
The limits are lower for women because they have proportionally less body water than men do and thus achieve higher blood alcohol concentrations after drinking the same amount of alcohol. Older adults also have less lean body mass and greater sensitivity to alcohol effects. In addition, there are many clinical situations where abstinence or lower limits are indicated, due to a greater risk of harm associated with drinking. Examples include women who are or may become pregnant, patients taking medications that may interact with alcohol, young people with a family history of alcohol dependence, and those with physical or psychiatric problems that are caused or exacerbated by use of alcohol.

Some of my patients who drink heavily believe that this is normal. What percentage of people drink at levels above those recommended by ASAM? About 7 to 10 adults abstain, drink rarely, or drink within the daily and weekly limits listed in Step 1. The next excess the daily limits, the weekly limits, or both. The Drinking Patterns chart on page 17 shows the percentage of drinkers in each category, as well as the prevalence of alcohol use disorders in each group. Because heavy drinkers often believe that most people drink as much as and as frequently as they do, providing normative data about U.S. drinking patterns and related risks can provide a helpful reality check. In particular, those who believe that it is fine to drink moderately during the week and heavily on the weekends need to know that they have a higher chance not only of immediate alcohol-related injuries, but also of developing alcohol use disorders and other alcohol-related medical and psychiatric disorders.

Some of my patients who are pregnant do not see any harm in having an occasional drink. What is the latest advice? Some pregnant women may not be aware of the risks involved with drinking, while others may drink before they realize they are pregnant. A recent survey estimates that 1 in 16 pregnant women in the United States drinks alcohol. In addition, among sexually active women who are not using birth control, more than half drink and 12% report binge drinking, placing them at particularly high risk for an alcohol-exposed pregnancy. Each year in the United States, an estimated 2,000 to 8,000 infants are born with fetal alcohol syndrome and many thousands more are born with some degree of alcohol-related effects. These problems range from mild learning and behavioral problems to growth deficiencies to severe mental and physical impairment. Together, these adverse effects comprise Fetal Alcohol Spectrum Disorders. Because it is not known what, if any, amount of alcohol is safe during pregnancy, the Surgeon General recently released an advisory that urges women who are or may become pregnant to abstain from drinking alcohol. The advisory also recommends that pregnant women who have already consumed alcohol stop to minimize further risks, and that health professionals inquire routinely about alcohol consumption by women of childbearing age.

Should I recommend any particular behavioral therapy for patients with alcohol use disorders? Several types of behavioral therapy are used to treat alcohol use disorders. These may be based on cognitive-behavioral techniques, enhancing motivation, the 12 steps of Alcoholics Anonymous (e.g., the Minnesota Model), or a combination of these and other psychosocial approaches. All seem to be equally effective, suggesting that seeking help in itself is more important than which particular approach is used.

In addition to more formal treatment approaches, mutual-help groups such as Alcoholics Anonymous (AA) appear to be very beneficial for patients who seek them. AA is widely available, free, and requires no commitment other than a desire to stop drinking. If you have never attended a meeting, consider doing so as an observer and supporter. To learn more, 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 website (www.health.org) under “Resources.”

How should alcohol withdrawal be managed? Alcohol withdrawal results when a person who is alcohol dependent suddenly stops drinking. Symptoms usually start within a few hours, and consist of tremor, sweating, elevated pulse and blood pressure, nausea, insomnia, and anxiety. Generalized seizures may also occur. A second syndrome, alcohol withdrawal delirium, sometimes follows. Beginning after 1 to 3 days and lasting 2 to 10 days, it consists of an altered sensorium, disorientation, poor short-term memory, altered sleep-wake cycle, and hallucinations. Management typically consists of administering thiamine and benzodiazepines, sometimes together with anticonvulsants, beta adrenergic blockers, or antipsychotics as indicated. Mild withdrawal can be managed successfully in the outpatient setting, but more complicated or severe cases require hospitalization. Consult references 32 and 33 on page 30 for additional information.

Are laboratory tests available to screen for or monitor alcohol problems? For screening purposes in primary care settings, interviews and questionnaires have greater sensitivity and specificity than blood tests for biochemical markers, which identify only about 10 to 30 percent of heavy drinkers. Nevertheless, biochemical markers may be useful if heavy drinking is suspected but the patient denies it. The most sensitive and widely available test for this purpose is the gamma-glutamyl transferase (GGT) assay. However, GGT is not very specific, so reasons for GGT elevation other than excessive alcohol use need to be eliminated. GGT and other transaminases may also be helpful for monitoring progress and identifying relapse if elevated at baseline, and serial values can provide valuable feedback to patients after an intervention. Other blood tests include the mean corpuscular volume (MCV) of red blood cells, which is often elevated in alcohol-dependent persons, and the carbohydrate-deficient transferrin (CDT) assay. The CDT assay is not as sensitive as GGT and has the advantage that it is not affected by liver disease. It is not, however, widely available in the United States.

If I refer a patient for alcohol treatment, what are the chances for recovery? A review of seven large studies of alcoholism treatment found that about one-third of patients either were abstinent or drank moderately without negative consequences or dependence in the year following treatment. Although the other two-thirds had some periods of heavy drinking, on average they reduced consumption and alcohol-related problems by more than half. These reductions appear to last at least 3 years. This substantial improvement in patients who do not attain complete abstinence or who have reduced drinking is often overlooked. These patients may...
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A recent survey estimates that 1 in 16 pregnant women in the United States drinks alcohol. In addition, among sexually active women who are not using birth control, more than half drink an average of 2 to 4 drinks per week. Blood-alcohol concentrations may be higher in pregnant women, with some studies estimating higher levels of alcohol than in nonpregnant women.

Each year in the United States, an estimated 2,000 to 8,000 infants are born with fetal alcohol syndrome and many thousands more born with some degree of alcohol-related effects. These problems range from mild learning and behavioral problems to growth difficulties to severe mental and physical impairment. Together, these adverse effects comprise Fetal Alcohol Spectrum Disorders. Because it is not known what, if any, amount of alcohol is safe during pregnancy, the Surgeon General recently released an advisory that urges women who are or may become pregnant to abstain from drinking alcohol. The advisory also recommends that pregnant women who have already consumed alcohol stop to minimize further risks, and that health professionals inquire routinely about alcohol consumption by women of childbearing age.

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How should alcohol withdrawal be managed?

Alcohol withdrawal symptoms are generally divided into two parts: the alcohol withdrawal syndrome and the delirium tremens. The alcohol withdrawal syndrome is characterized by a variety of symptoms, including tremors, sweating, tachycardia, and diaphoresis. The delirium tremens is a more severe form of alcohol withdrawal, characterized by confusion, agitation, hallucinations, and delusions. Management typically consists of administering thiamine and benzoate, sometimes together with benzodiazepines, beta adrenergic blockers, or antipsychotics as indicated. Mild withdrawal can be managed successfully in the outpatient setting, but more complicated or severe cases require hospitalization. (Consult references 32 and 33 on page 30 for additional information.)

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

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 conflicts, insomnia, chronic pain, craving, or high-stress situations such as a wedding or a 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 follow-up care and advise patients to contact you if they are concerned about relapse.

The substantial improvement in patients who do not attain complete abstinence or problem-free reduced drinking is often overlooked.
NIAAA also offers a condensed Pocket Guide
The Pocket Guide features the same steps...
...and many of the supporting materials.

<table>
<thead>
<tr>
<th>WHAT IS A STANDARD DRINK?</th>
<th>DRINKING PATTERNS</th>
<th>PRESCRIBING MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A standard drink is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons).</td>
<td>Based on the following limit—number of drinks On any day: More than 4 drinks for men or 3 drinks for women and in a typical week: No more than 14 drinks for women or 21 drinks for men</td>
<td>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 <a href="https://medlineplus.gov">https://medlineplus.gov</a>.</td>
</tr>
<tr>
<td>STANDARD DRINK EQUIVALENTS</td>
<td>APPROXIMATE NUMBER OF STANDARDS DRINKS IN:</td>
<td></td>
</tr>
<tr>
<td><strong>BEER OR COCKTAILS</strong></td>
<td></td>
<td>Divalproex (Valproate)</td>
</tr>
<tr>
<td>12 oz.</td>
<td>0.35% alcohol</td>
<td></td>
</tr>
<tr>
<td>• 12 oz. = 1</td>
<td></td>
<td>Currently used in addition to or without medications to treat alcohol dependence.</td>
</tr>
<tr>
<td>• 16 oz. = 1.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 22 oz. = 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 40 oz. = 3.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MALT LIQUOR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.9% abv.</td>
<td>0.35% alcohol</td>
<td></td>
</tr>
<tr>
<td>• 12 oz. = 1.5</td>
<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>• 40 oz. = 4.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TABLE WINE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 oz.</td>
<td>12% alcohol</td>
<td></td>
</tr>
<tr>
<td>• a 750 ml (25 oz.) bottle = 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>40 proof SPIRITS (hard liquor)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5 oz.</td>
<td>40% alcohol</td>
<td></td>
</tr>
<tr>
<td>• a mixed drink = 1 or more*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• a beer (12 oz.) = 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• a shot (1.5 oz.) = 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1.75 L (59 oz.) = 39</td>
<td></td>
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</tr>
</tbody>
</table>

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

**WHAT IS YOUR DRINKING PATTERN?**

- On any day: More than 4 drinks for men or 3 drinks for women and in a typical week: No more than 14 drinks for women or 21 drinks for men

**HOW COMMON ARE ALCOHOL DRINKERS IN THIS PATTERN?**

- Percentage of U.S. adults aged 18 or older

**COMBINED PREVALENCE of alcohol abuse and dependence**

- Based on the following limits—number of drinks On any day: More than 4 drinks for men or 3 drinks for women and in a typical week: No more than 14 drinks for women or 21 drinks for men

**A POCKET GUIDE FOR Alcohol Screening and Brief Intervention**

This pocket guide is condensed from the 30-page NIAAA guide, Helping Patients Who Drink Too Much: A Clinician’s Guide. For copies of the full guide or more copies of this pocket guide, contact NIAAA Publications Distribution Center. PO. Box 10686, Rockville, MD 20849-0686 (301) 443-3560 [www.niaaa.nih.gov](http://www.niaaa.nih.gov).
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