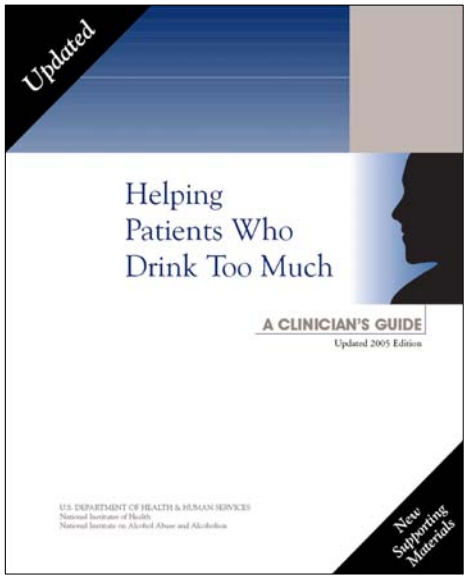
Using the NIAAA *Clinician's Guide*

A note to Instructors:

This slide show is a companion to the NIAAA Clinician's Guide. For best results, distribute the full text of the Guide for students to review in conjunction with the presentation.

Order free copies or download the PDF at ***www.niaaa.nih.gov/guide***.



NIAAA introduces a new free online training resource:

Video Case Scenarios

based on the NIAAA *Clinician's Guide*

- **CME/CE credits available from *Medscape.com***
- **For details and links, visit *www.niaaa.nih.gov/guide***

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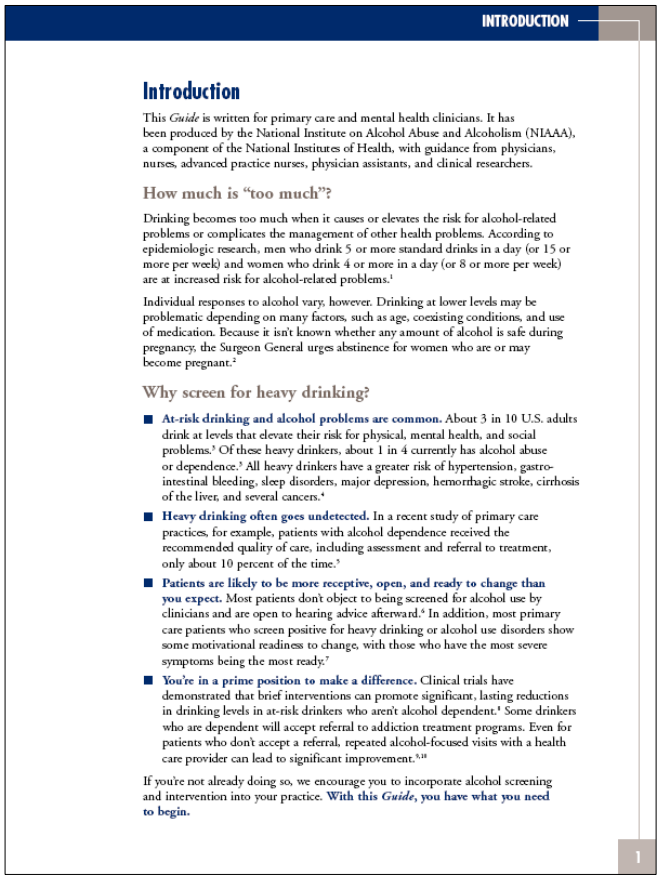
The *Guide's* Table of Contents

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

Introduction

This *Guide* is written for primary care and mental health clinicians. It has been 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. According to epidemiologic research, men who drink 5 or more standard drinks in a day (or 15 or more per week) and women who drink 4 or more in a day (or 8 or more per week) are at increased risk for alcohol-related problems.[1]

Individual responses to alcohol vary, however. Drinking at lower levels may be problematic depending on many factors, such as age, coexisting conditions, and use of medication. Because it isn't known whether any amount of alcohol is safe during pregnancy, the Surgeon General urges abstinence for women who are or may become pregnant.[2]

Why screen for heavy drinking?

- **At-risk drinking and alcohol problems are common.** About 3 in 10 U.S. adults drink at levels that elevate their risk for physical, mental health, and social problems.[3] Of these heavy drinkers, about 1 in 4 currently has alcohol abuse or dependence.[3] All heavy drinkers have a greater risk of hypertension, gastrointestinal bleeding, sleep disorders, major depression, hemorrhagic stroke, cirrhosis of the liver, and several cancers.[4]
- **Heavy drinking often goes undetected.** In a recent study of primary care practices, for example, patients with alcohol dependence received the recommended quality of care, including assessment and referral to treatment, only about 10 percent of the time.[5]
- **Patients are likely to be more receptive, open, and ready to change than you expect.** Most patients don't object to being screened for alcohol use by clinicians and are open to hearing advice afterward.[6] In addition, most primary care patients who screen positive for heavy drinking or alcohol use disorders show some motivational readiness to change, with those who have the most severe symptoms being the most ready.[7]
- **You're in a prime position to make a difference.** Clinical trials have demonstrated that brief interventions can promote significant, lasting reductions in drinking levels in at-risk drinkers who aren't alcohol dependent.[8] Some drinkers who are dependent will accept referral to addiction treatment programs. Even for patients who don't accept a referral, repeated alcohol-focused visits with a health care provider can lead to significant improvement.[9,10]

If you're not already doing so, we encourage you to incorporate alcohol screening and intervention into your practice. **With this *Guide*, you have what you need to begin.**

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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
* Use of medication

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.

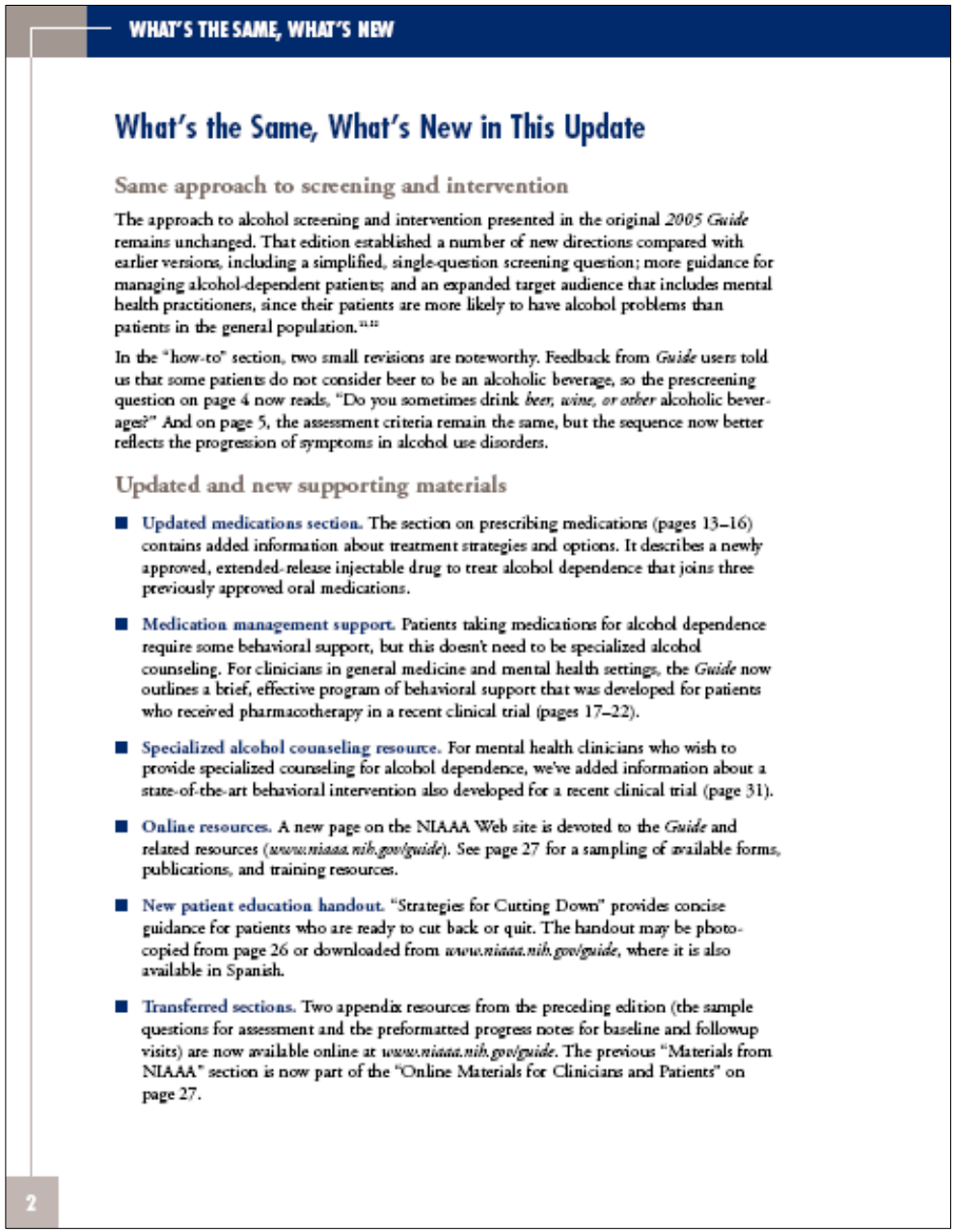
You are in a prime position to make a difference

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

What's the Same, What's New

Same approach to screening and intervention

*The approach presented in the original *2005 Guide* remains unchanged



What's the Same, What's New in This Update

Same approach to screening and intervention

The approach to alcohol screening and intervention presented in the original *2005 Guide* remains unchanged. That edition established a number of new directions compared with earlier versions, including a simplified, single-question screening question; more guidance for managing alcohol-dependent patients; and an expanded target audience that includes mental health practitioners, since their patients are more likely to have alcohol problems than patients in the general population."[1]

In the "how-to" section, two small revisions are noteworthy. Feedback from *Guide* users told us that some patients do not consider beer to be an alcoholic beverage, so the prescreening question on page 4 now reads, "Do you sometimes drink *beer, wine, or other* alcoholic beverages?" And on page 5, the assessment criteria remain the same, but the sequence now better reflects the progression of symptoms in alcohol use disorders.

Updated and new supporting materials

- **Updated medications section.** The section on prescribing medications (pages 13–16) contains added information about treatment strategies and options. It describes a newly approved, extended-release injectable drug to treat alcohol dependence that joins three previously approved oral medications.
- **Medication management support.** Patients taking medications for alcohol dependence require some behavioral support, but this doesn't need to be specialized alcohol counseling. For clinicians in general medicine and mental health settings, the *Guide* now outlines a brief, effective program of behavioral support that was developed for patients who received pharmacotherapy in a recent clinical trial (pages 17–22).
- **Specialized alcohol counseling resource.** For mental health clinicians who wish to provide specialized counseling for alcohol dependence, we've added information about a state-of-the-art behavioral intervention also developed for a recent clinical trial (page 31).
- **Online resources.** A new page on the NIAAA Web site is devoted to the *Guide* and related resources (*www.niaaa.nih.gov/guide*). See page 27 for a sampling of available forms, publications, and training resources.
- **New patient education handout.** "Strategies for Cutting Down" provides concise guidance for patients who are ready to cut back or quit. The handout may be photocopied from page 26 or downloaded from *www.niaaa.nih.gov/guide*, where it is also available in Spanish.
- **Transferred sections.** Two appendix resources from the preceding edition (the sample questions for assessment and the preformatted progress notes for baseline and followup visits) are now available online at *www.niaaa.nih.gov/guide*. The previous "Materials from NIAAA" section is now part of the "Online Materials for Clinicians and Patients" on page 27.

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What's the Same, What's New

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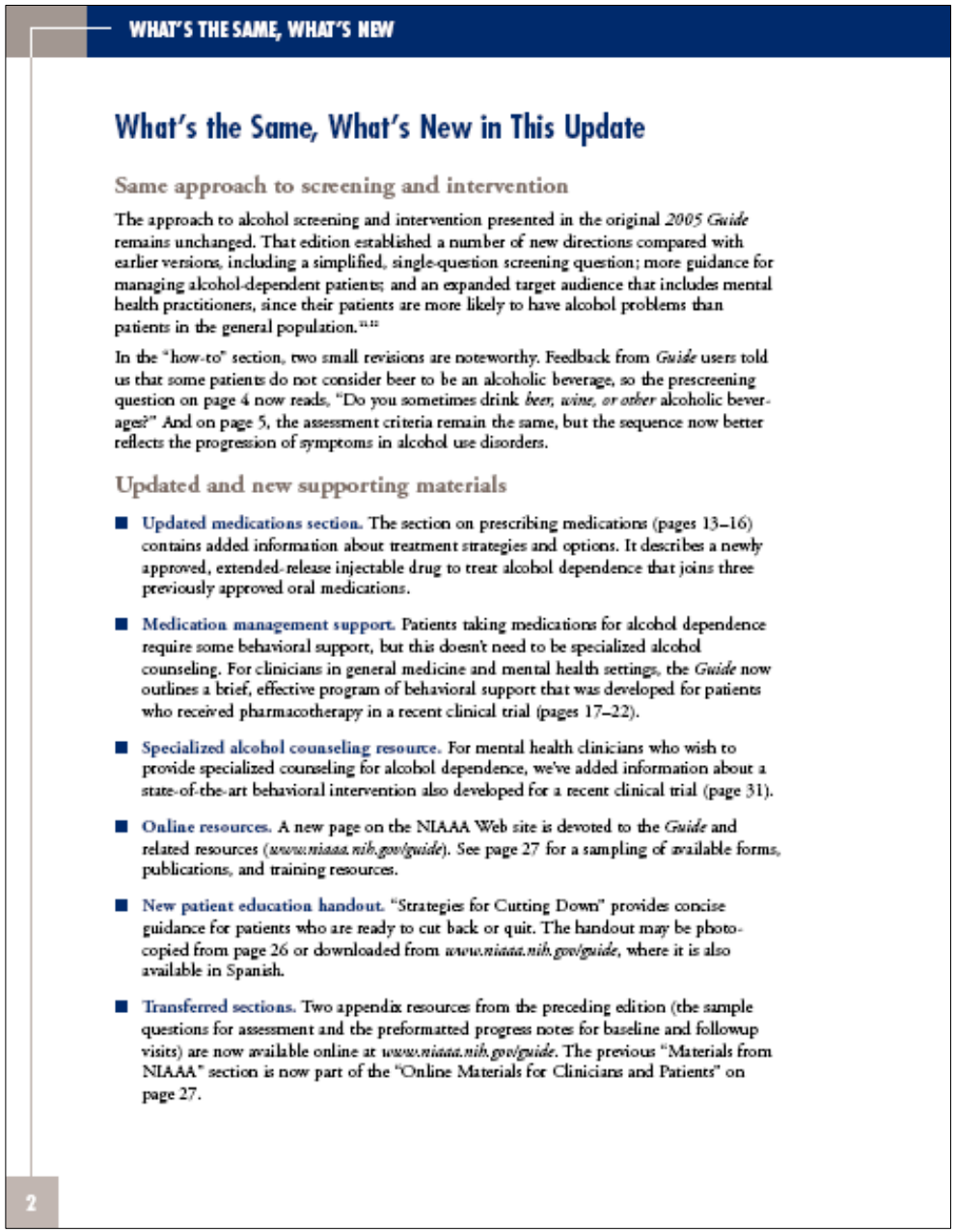

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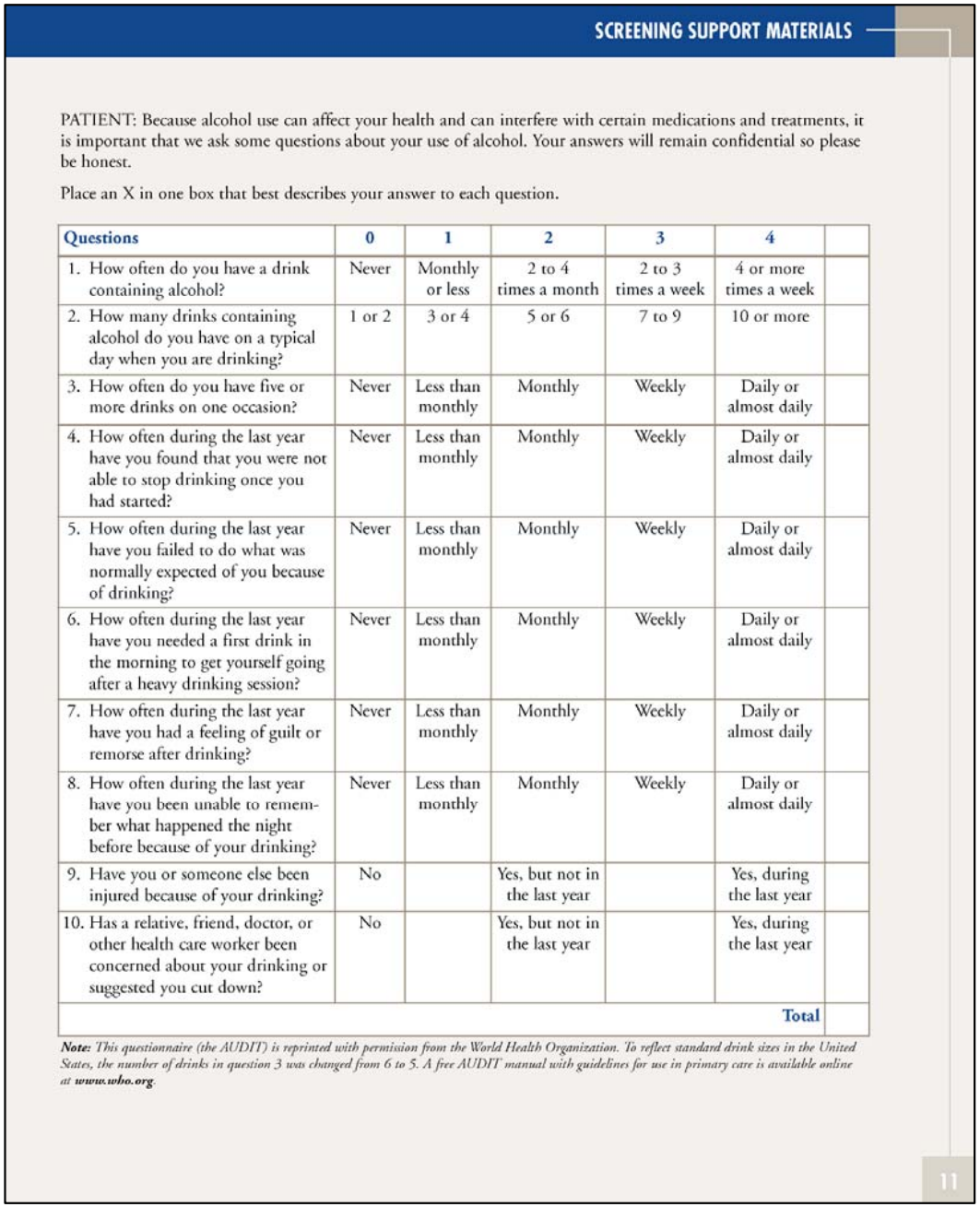
Before You Begin…

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.*



SCREENING SUPPORT MATERIALS

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****.*

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The AUDIT is found on page 11…

…and a Spanish translation is found on page 12.

For a complete Spanish translation of the full text of the Clinician's Guide, visit www.niaaa.nih.gov/guide

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 remordimientos 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.

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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

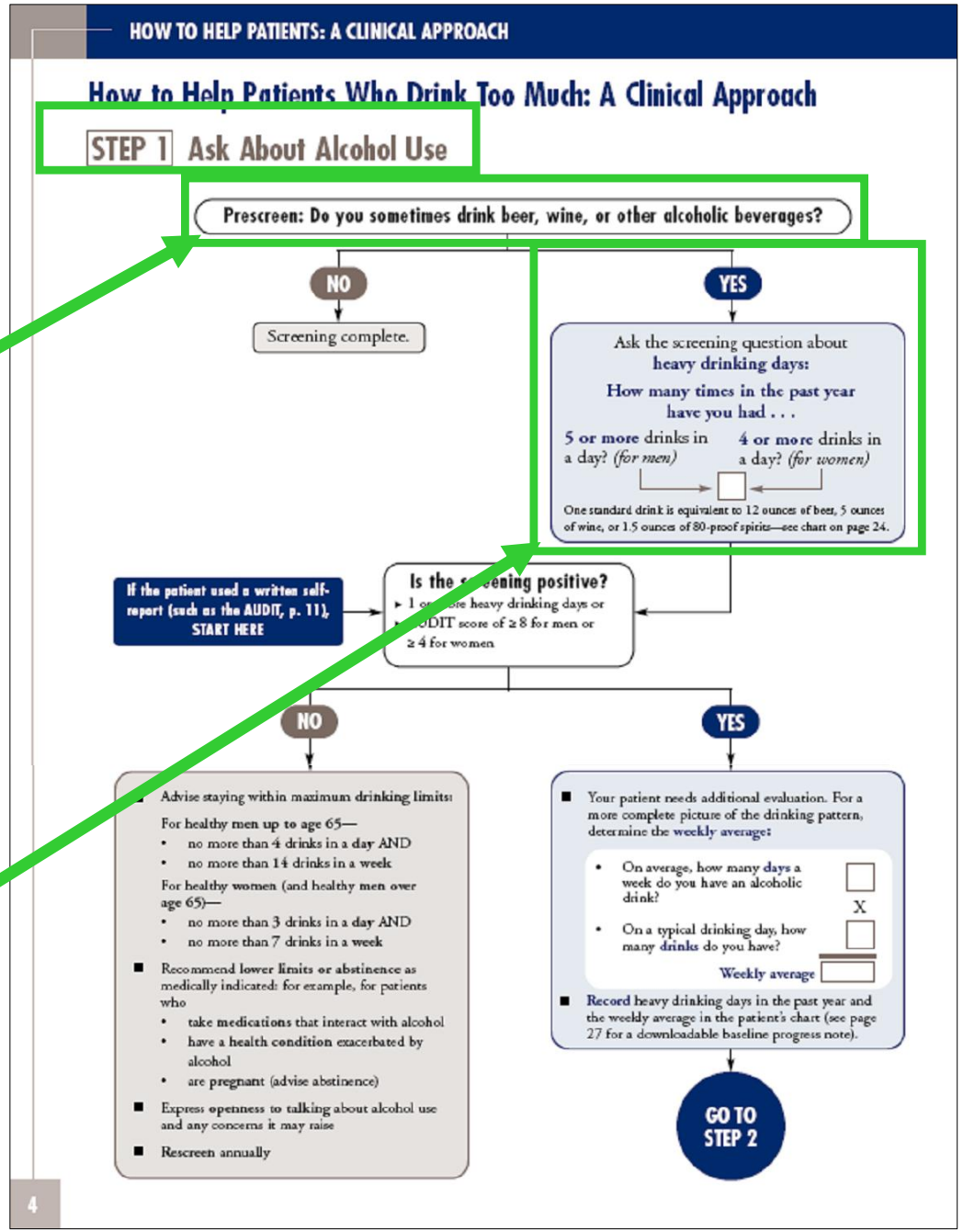
* Decide who will conduct the screening or administer the AUDIT.
* Use preformatted progress notes (pages 22–23).
* Use computer reminders.
* Keep copies of the Pocket Guide and referral information.
* Monitor your performance through practice audits

STEP 1:
Ask About Alcohol Use

*** Prescreen: Do you sometimes drink beer, wine, or other alcoholic beverages?**

*** If the prescreen is positive:**

Ask the screening question about heavy drinking days



For patients who drink:

Ask the screening question about heavy drinking days:

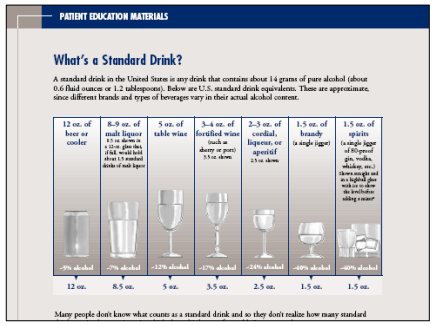
How many times in the past year have you had...

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

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

?

Tip: It may be useful to show the **Standard Drinks** chart on page 24.


PATIENT EDUCATION MATERIALS

What's a Standard Drink?

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

12 oz. of beer or cooler

8–9 oz. of malt liquor

5 oz. of table wine

3–4 oz. of fortified wine (such as sherry or port)

2–3 oz. of cordial, liqueur, or aperitif

1.5 oz. of brandy (a single jigger)

1.5 oz. of spirits (a single jigger of 80-proof gin, vodka, whiskey, etc.)

12 oz. 8.5 oz. 5 oz. 3.5 oz. 2.5 oz. 1.5 oz. 1.5 oz.

Many people don't know what counts as a standard drink and so they don't realize how many standard

What's 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.**

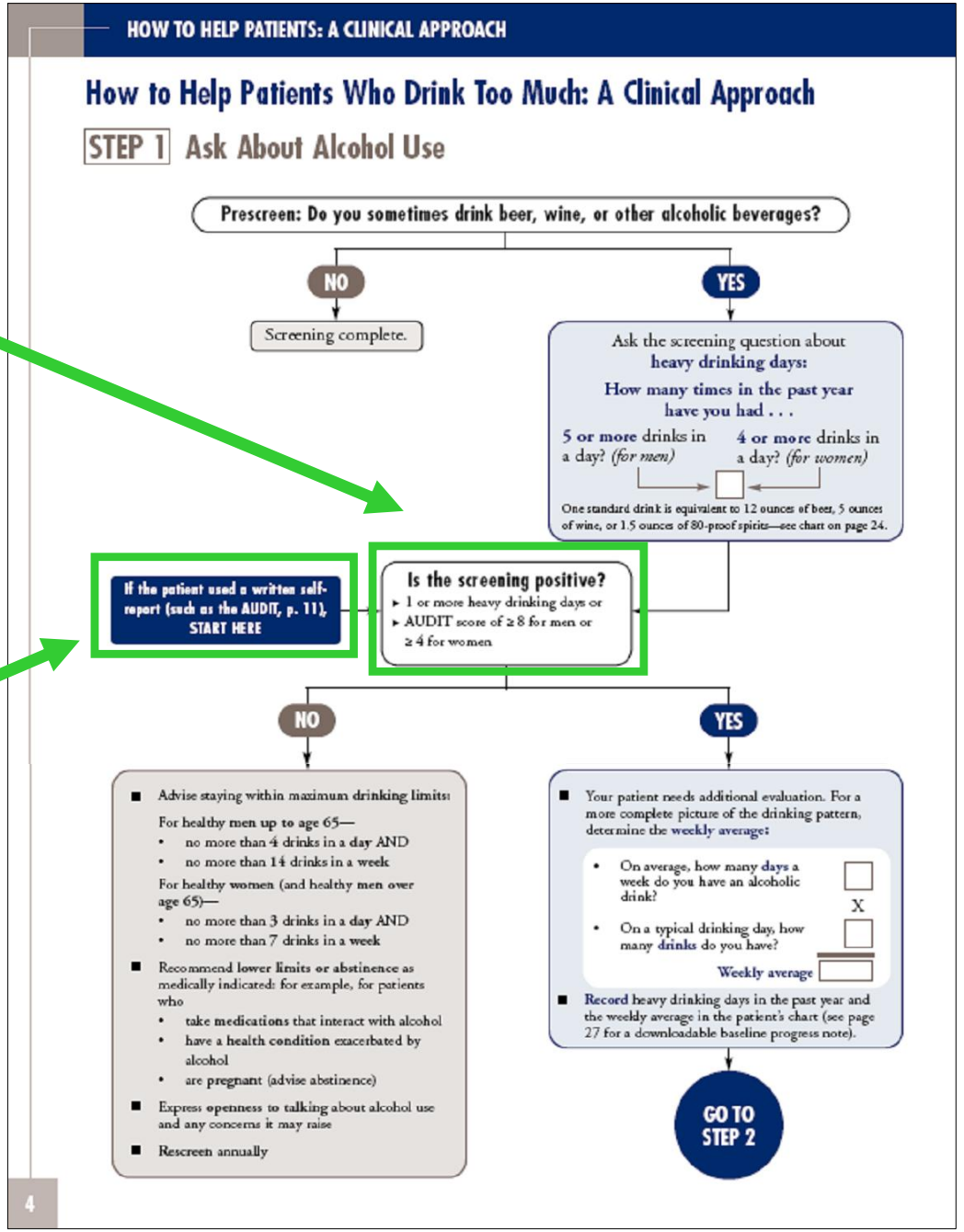
STEP 1 (continued):

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?

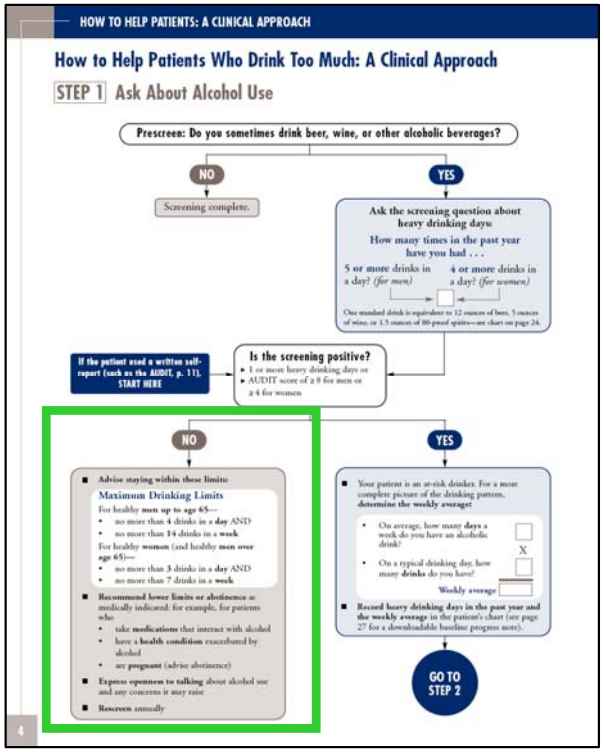
If NO, then…

*Advise staying within these limits:

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**

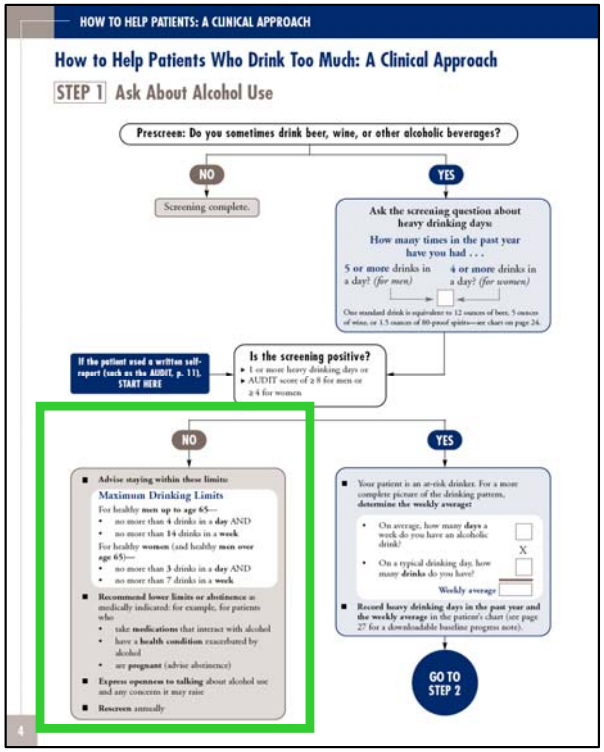
For healthy **women** (and healthy **men over age 65) -**
*no more than **3** drinks in a **day** AND
*no more than **7** drinks in a **week**



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



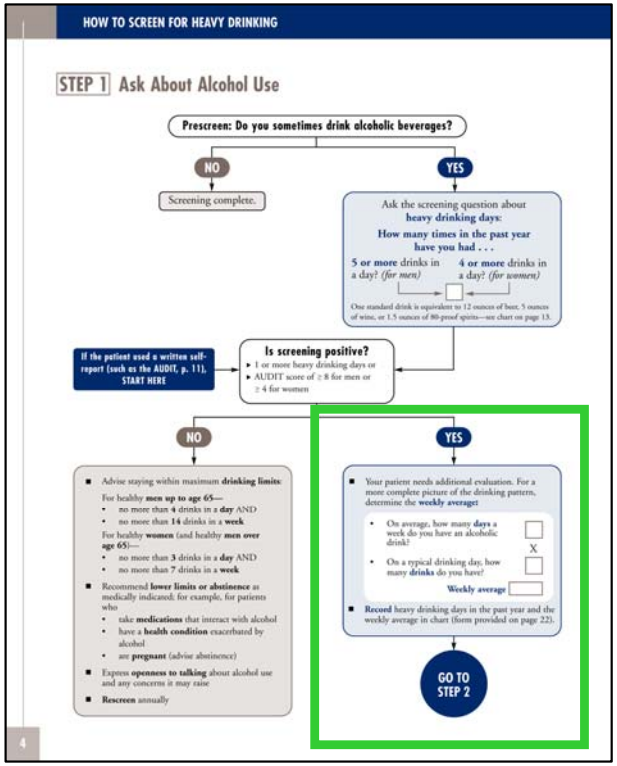
STEP 1: Is the Screening Positive?

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? ☐

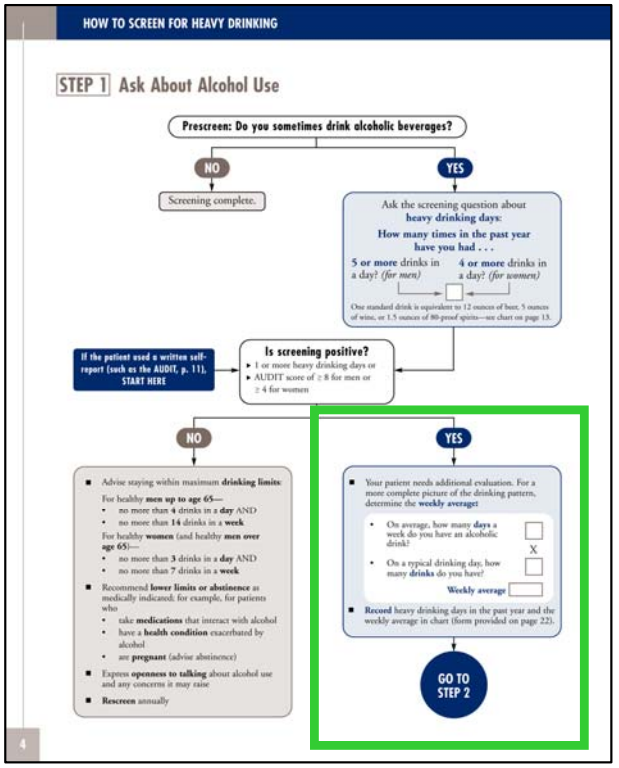
Weekly average ☐



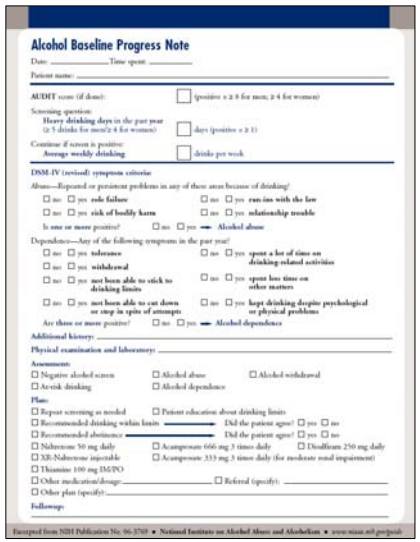
STEP 1: Is the Screening Positive?

If YES, then…

* **Record**
  * heavy drinking days in the past year and
  * the weekly average



TIP: Download **preformatted progress notes** and templates from NIAAA at www.niaaa.nih.gov/guide (see resources on page 27)

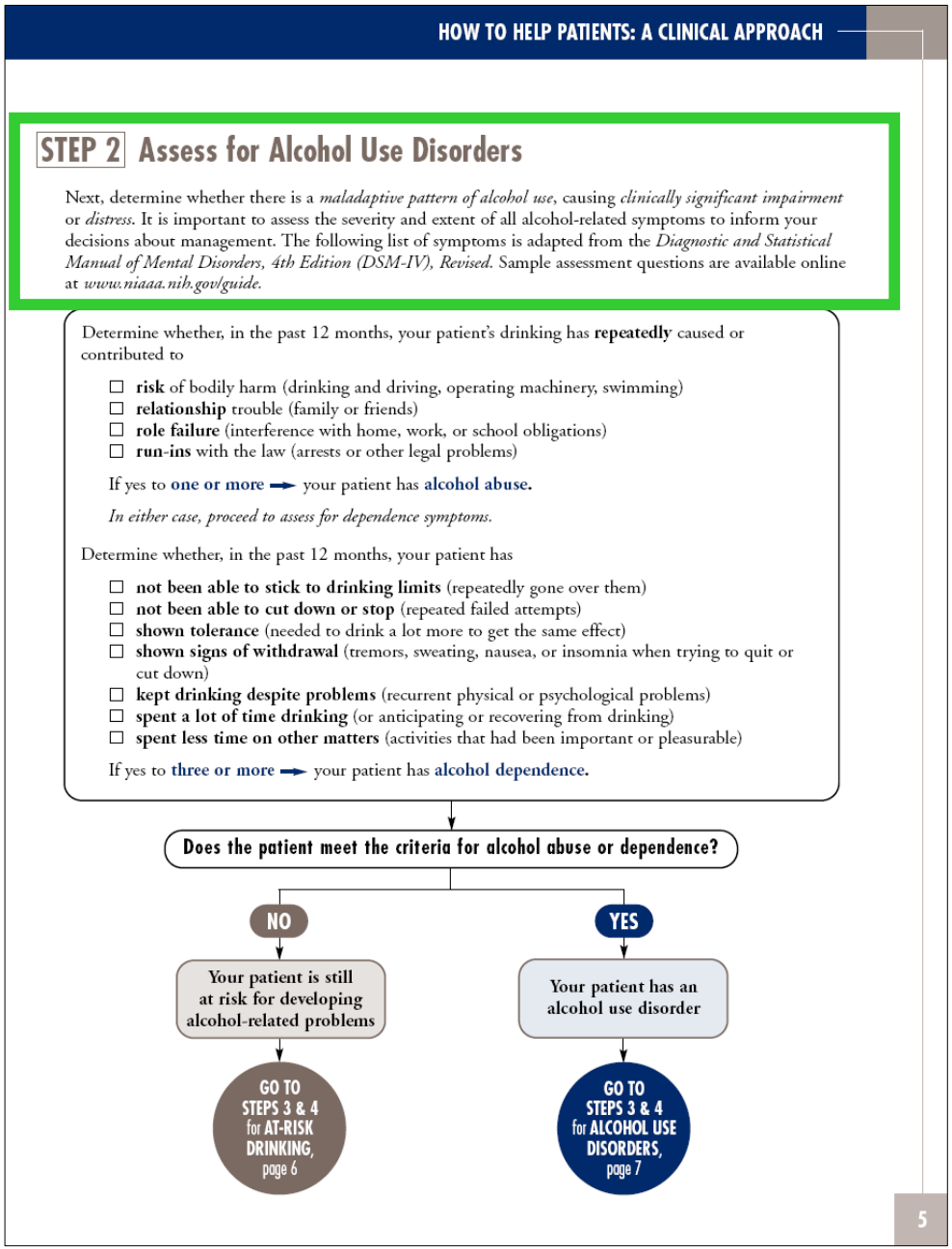


GO TO STEP 2

STEP 2:
Assess for Alcohol Use Disorders (AUDs)

Determine if there is—

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



HOW TO HELP PATIENTS: A CLINICAL APPROACH

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. The following list of symptoms is adapted from the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV), Revised*. Sample assessment questions are available online at *www.niaaa.nih.gov/guide*.

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

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

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

- ☐ **not been able to stick to drinking limits** (repeatedly gone over them)
- ☐ **not been able to cut down or stop** (repeated failed attempts)
- ☐ **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)
- ☐ **kept drinking despite problems** (recurrent physical or psychological problems)
- ☐ **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)

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

Does the patient meet the criteria for alcohol 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)

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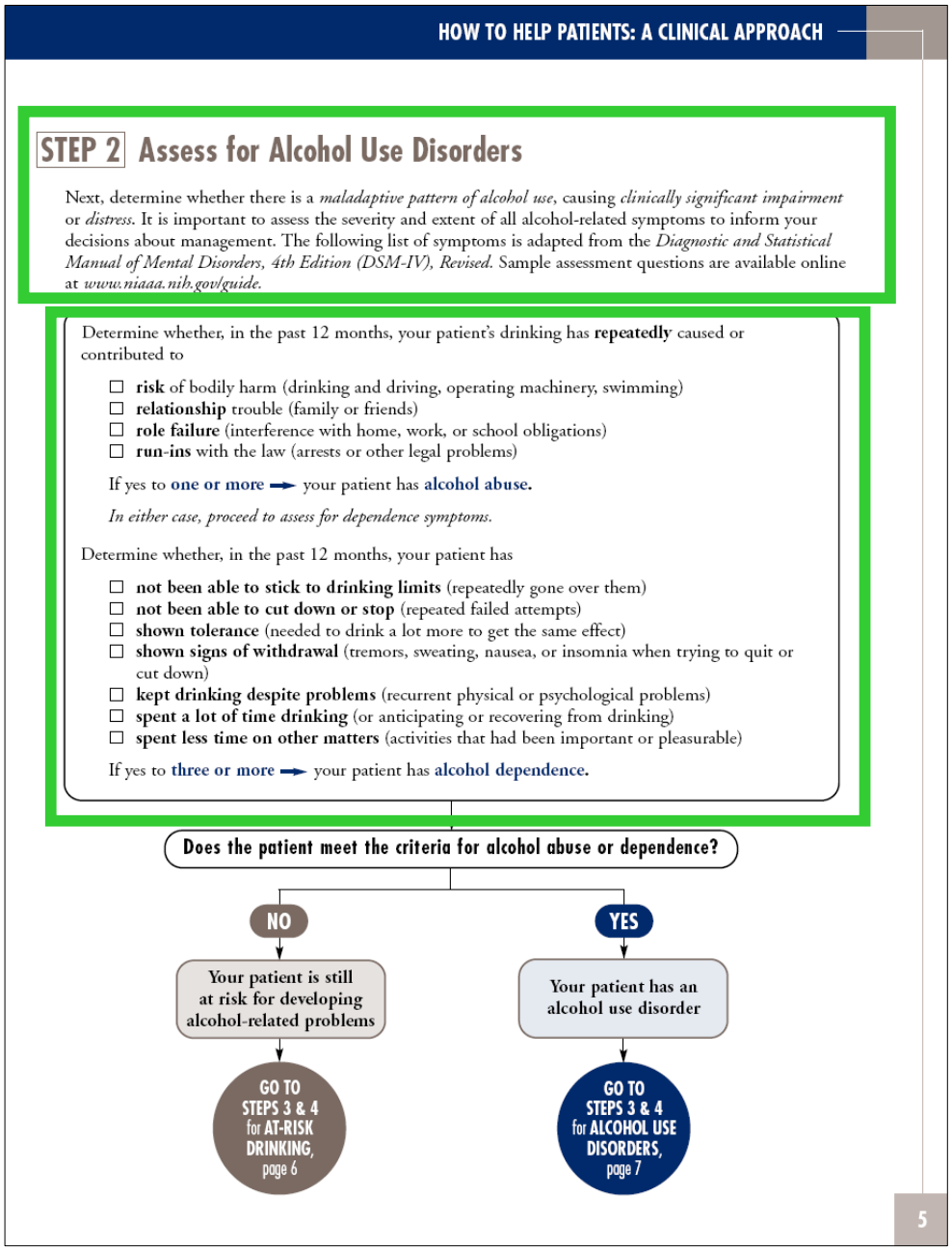
The Clinician's Guide presents a list of symptoms adapted from the *DSM-IV, Revised*.



HOW TO HELP PATIENTS: A CLINICAL APPROACH

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. The following list of symptoms is adapted from the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV), Revised*. Sample assessment questions are available online at *www.niaaa.nih.gov/guide*.

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

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

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

- ☐ **not been able to stick to drinking limits** (repeatedly gone over them)
- ☐ **not been able to cut down or stop** (repeated failed attempts)
- ☐ **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)
- ☐ **kept drinking despite problems** (recurrent physical or psychological problems)
- ☐ **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)

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

Does the patient meet the criteria for alcohol 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

5

STEP 2:
Assess for Alcohol Use Disorders (AUDs)

Sample assessment questions are available online at www.niaaa.nih.gov/guide

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…"

- **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?
- **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?
- **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 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?

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

Excerpted from NIH Publication No. 06-3769 ■ **National Institute on Alcohol Abuse and Alcoholism** ■ *www.niaaa.nih.gov/guide*

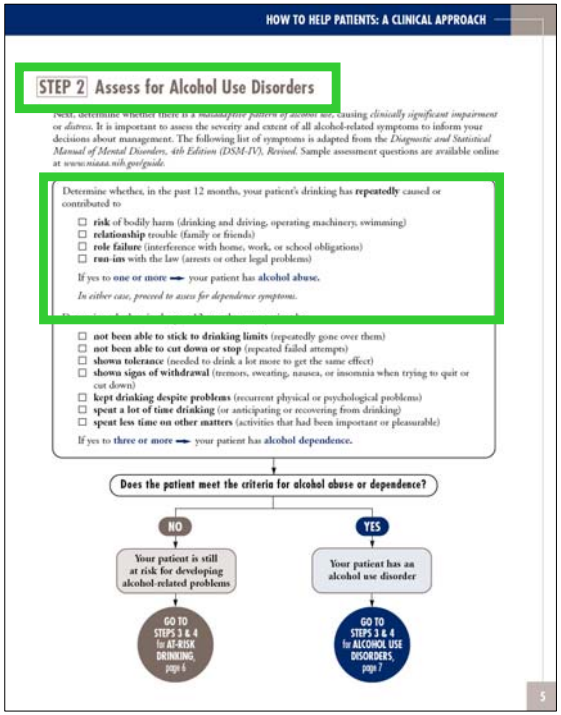
STEP 2: Assess for AUDs:

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

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

Yes to one or more → your patient has 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…

- ✓* **Not been able to stick to drinking limits** (repeatedly gone over them)
- ✓* **Not been able to cut down or stop** (repeated failed attempts)
- ✓* **Shown tolerance** (needed to drink a lot more to get the same effect)
- * **Shown signs of withdrawal** (tremors, sweating, nausea, insomnia when trying to quit or cut down)
- * **Kept drinking despite problems** (recurrent physical or psychological problems)
- * **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)

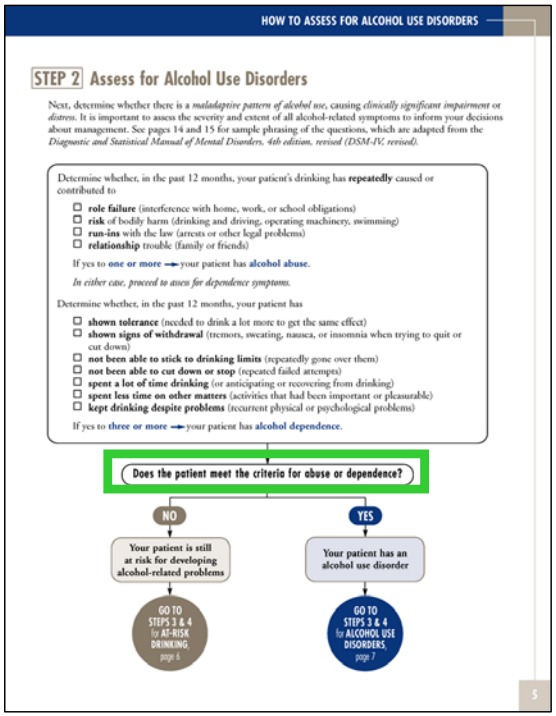
Yes to 3 or more ➡ your patient has Alcohol dependence

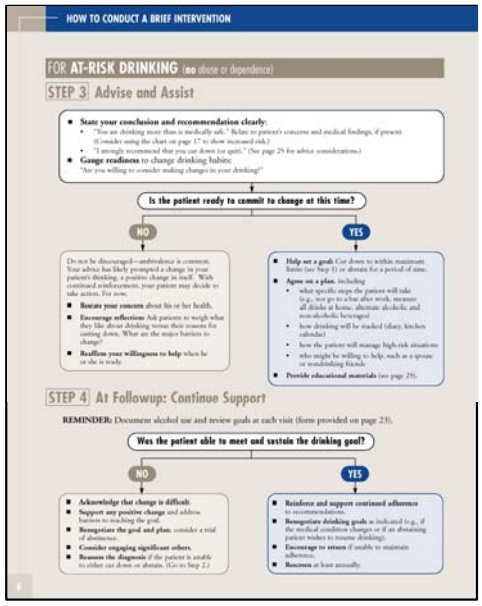
STEP 2: Assess for AUDs

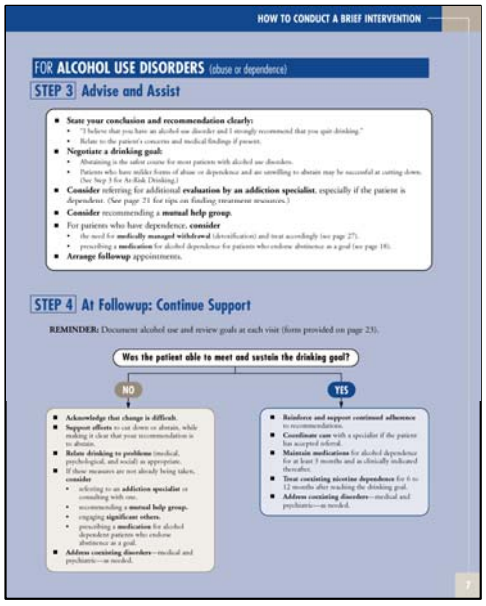
Does the patient meet the criteria for abuse or dependence?

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)



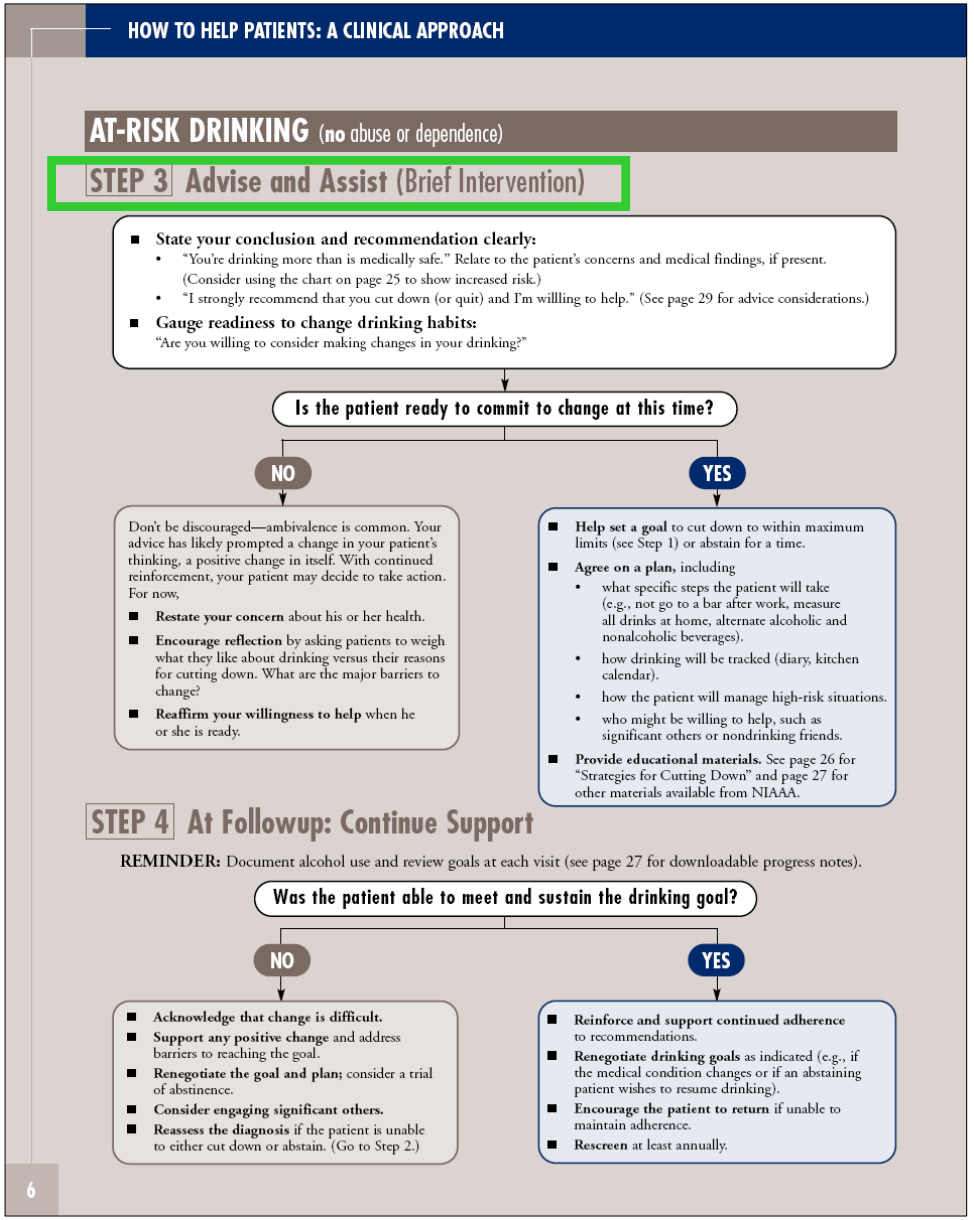




Page 6
First Example--
For a Patient with

AT-RISK DRINKING
(no abuse or dependence)

STEP 3:
Advise and Assist
(Brief Intervention



HOW TO HELP PATIENTS: A CLINICAL APPROACH

AT-RISK DRINKING (no abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

- **State your conclusion and recommendation clearly:**
  - "You're drinking more than is medically safe." Relate to the patient's concerns and medical findings, if present. (Consider using the chart on page 25 to show increased risk.)
  - "I strongly recommend that you cut down (or quit) and I'm willling to help." (See page 29 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

Don't 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** by asking 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** to cut down to within maximum limits (see Step 1) or abstain for a 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 nonalcoholic 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 significant others or nondrinking friends.
- **Provide educational materials.** See page 26 for "Strategies for Cutting Down" and page 27 for other materials available from NIAAA.

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes).

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 the patient to return** if unable to maintain adherence.
- **Rescreen** at least annually.

6

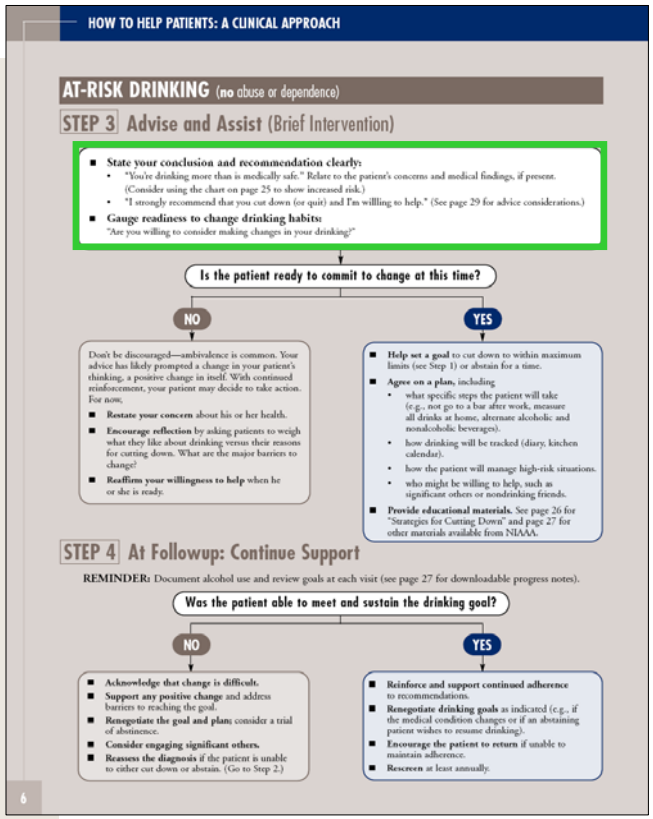
AT-RISK DRINKING
(**no** abuse or dependence)

STEP 3: Advise and Assist

*** State your conclusion and recommendations clearly**

image credit: Comstock

You are drinking more than is medically safe.


HOW TO HELP PATIENTS: A CLINICAL APPROACH

AT-RISK DRINKING (no abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

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YES

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REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes).

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

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- Reassess the diagnosis if the patient is unable to either cut down or abstain. (Go to Step 2.)

YES

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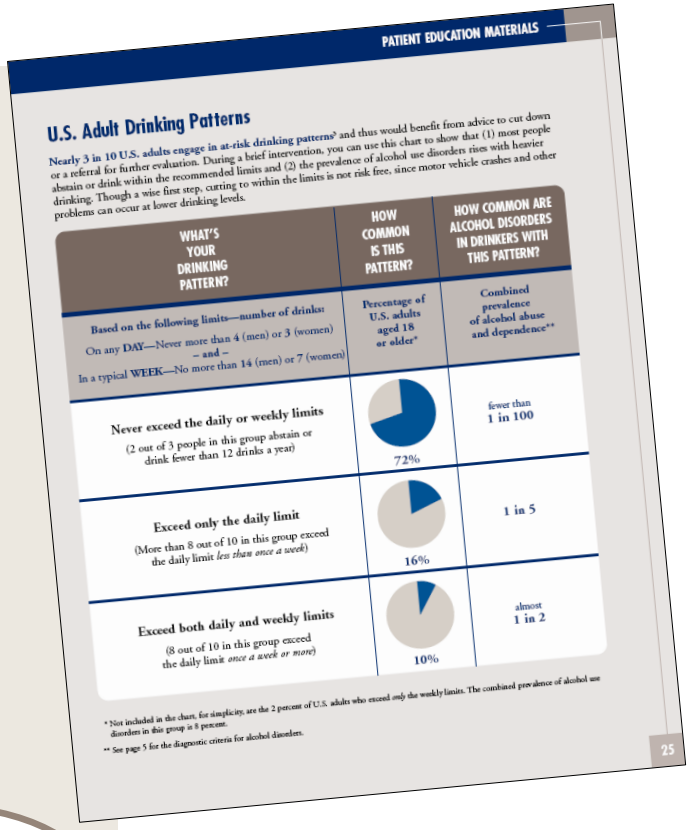
6

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

STEP 3: Advise and Assist

*** State your conclusion and recommendations clearly**



PATIENT EDUCATION MATERIALS

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) 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'S 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%	fewer 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 page 5 for the diagnostic criteria for alcohol disorders.

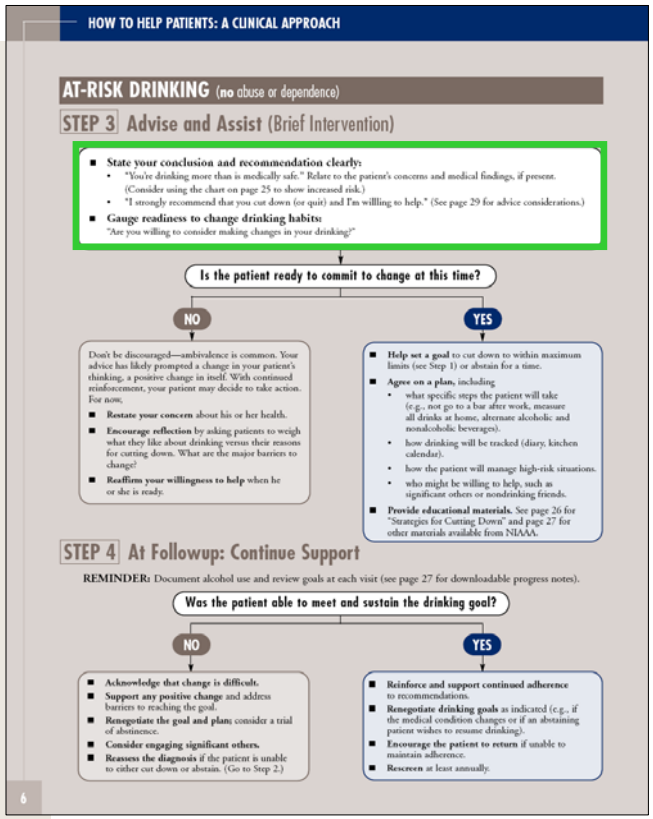
25

image credit: Comstock

I strongly recommend that you cut down (or quit) and I'm willing to help.

Consider using the chart on page 25 to show increased risk.

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



STEP 3: Advise and Assist

* State your conclusion and recommendations clearly
* **Gauge readiness to change drinking habits**

Are you willing to consider making changes in your drinking?

image credit: Comstock

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

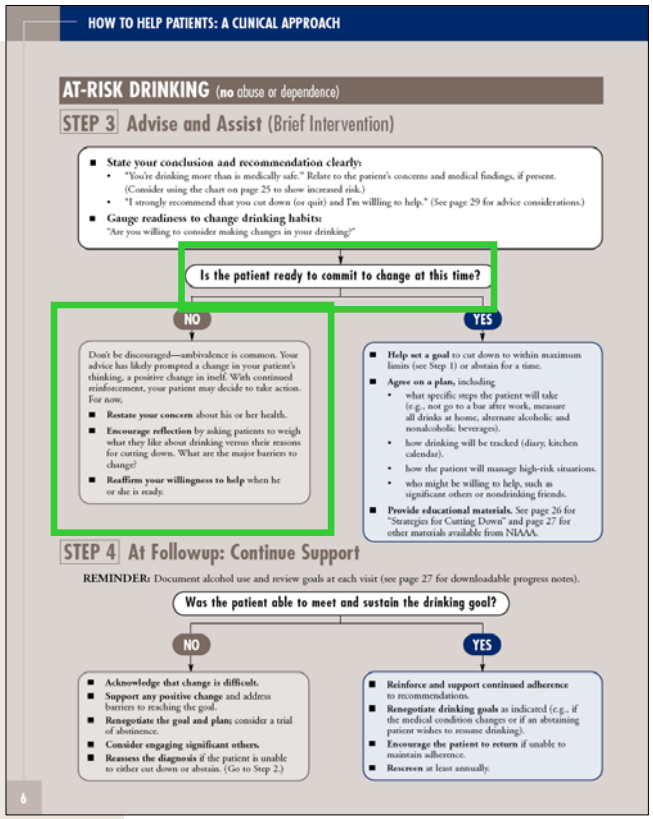
STEP 3: Advise and Assist

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.



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

STEP 3: Advise and Assist

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

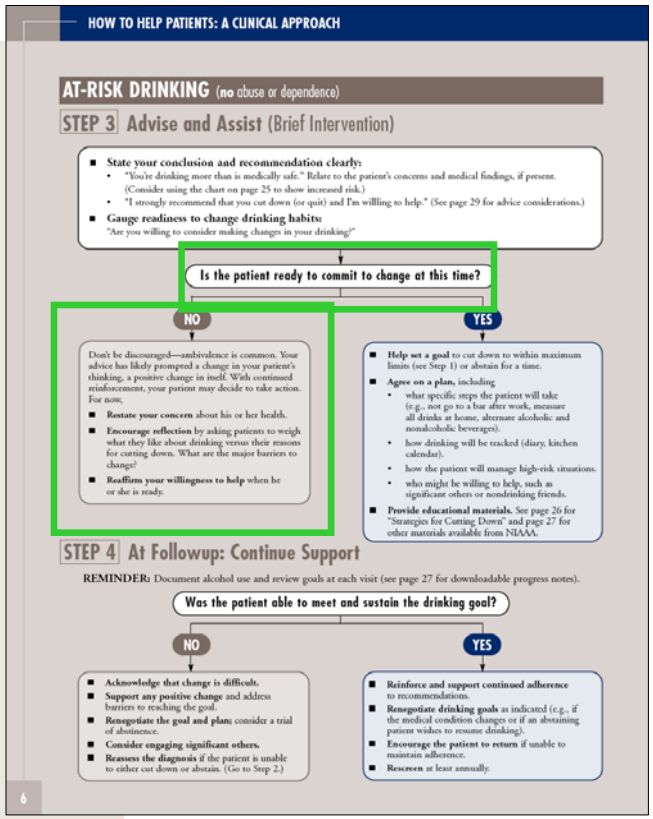
↓

NO

↓

For now…

* **Restate your concern** about his or her health.


HOW TO HELP PATIENTS: A CLINICAL APPROACH

AT-RISK DRINKING (no abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

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- Reaffirm your willingness to help when he or she is ready.

YES

- Help set a goal to cut down to within maximum limits (see Step 1) or abstain for a time.
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STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes).

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 the patient to return if unable to maintain adherence.
- Rescreen at least annually.

6

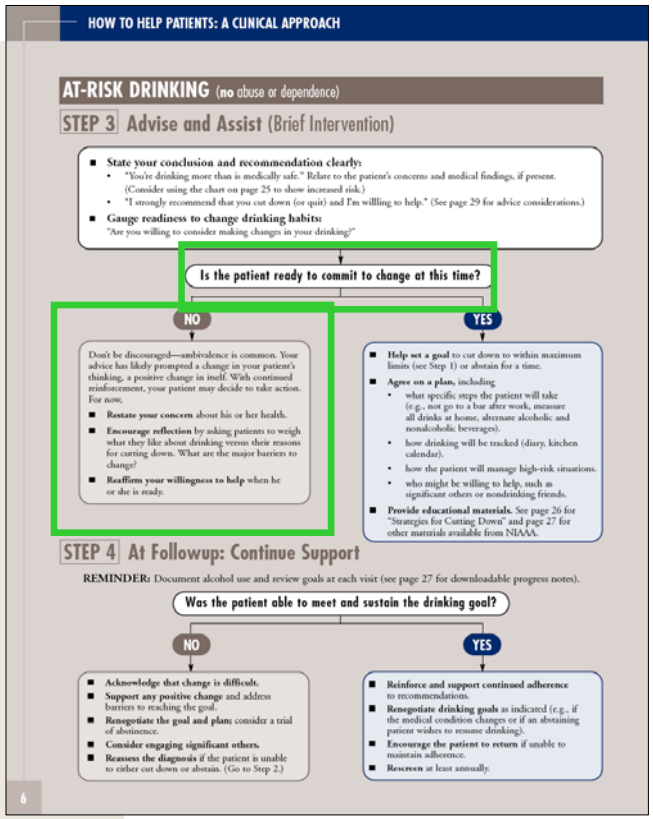
AT-RISK DRINKING
(**no** abuse or dependence)

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?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- Rescreen at least annually.

6

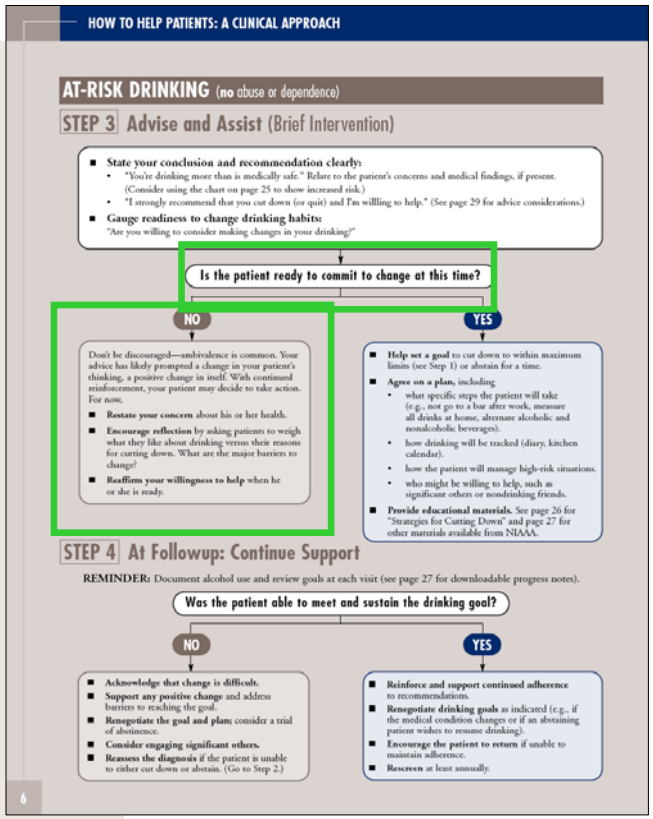
AT-RISK DRINKING
(**no** abuse or dependence)

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.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STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes).

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 the patient to return if unable to maintain adherence.
- Rescreen at least annually.

6

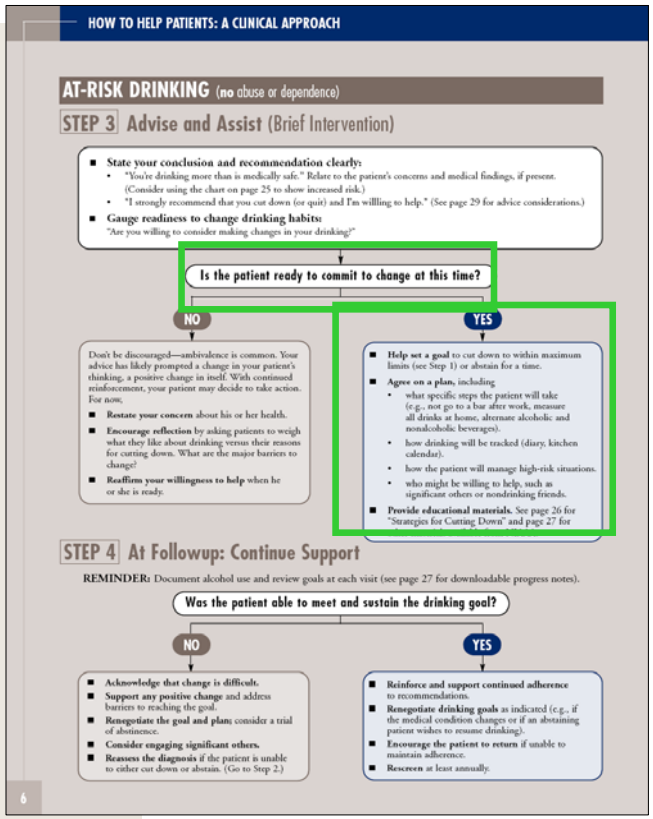
AT-RISK DRINKING
(**no** abuse or dependence)

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.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STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes).

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

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AT-RISK DRINKING
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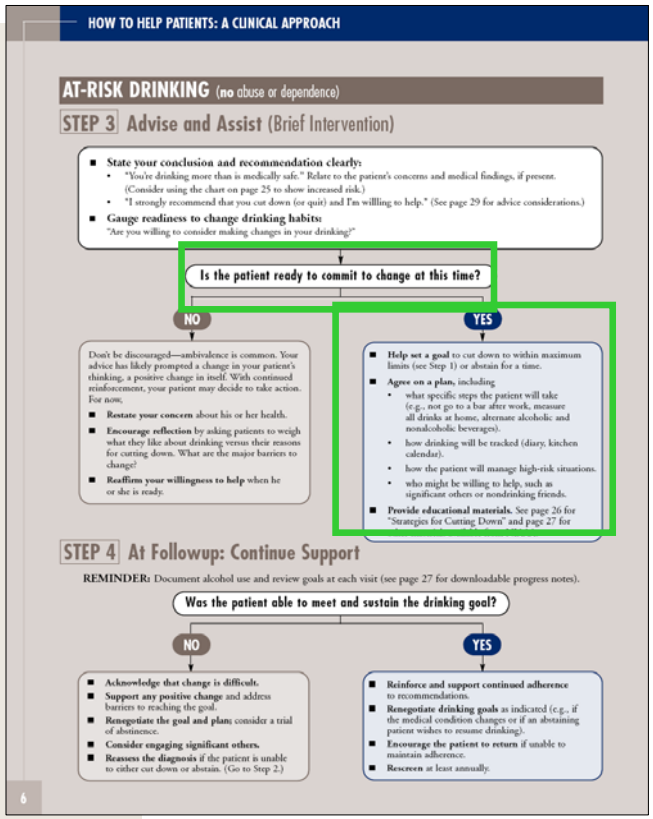
STEP 3: Advise and Assist

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)


HOW TO HELP PATIENTS: A CLINICAL APPROACH

AT-RISK DRINKING (no abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

- State your conclusion and recommendation clearly:
  - "You're drinking more than is medically safe." Relate to the patient's concerns and medical findings, if present. (Consider using the chart on page 25 to show increased risk.)
  - "I strongly recommend that you cut down (or quit) and I'm willling to help." (See page 29 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

Don't 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 by asking 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 to cut down to within maximum limits (see Step 1) or abstain for a 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 nonalcoholic 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 significant others or nondrinking friends.
- Provide educational materials. See page 26 for "Strategies for Cutting Down" and page 27 for

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes).

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

NO

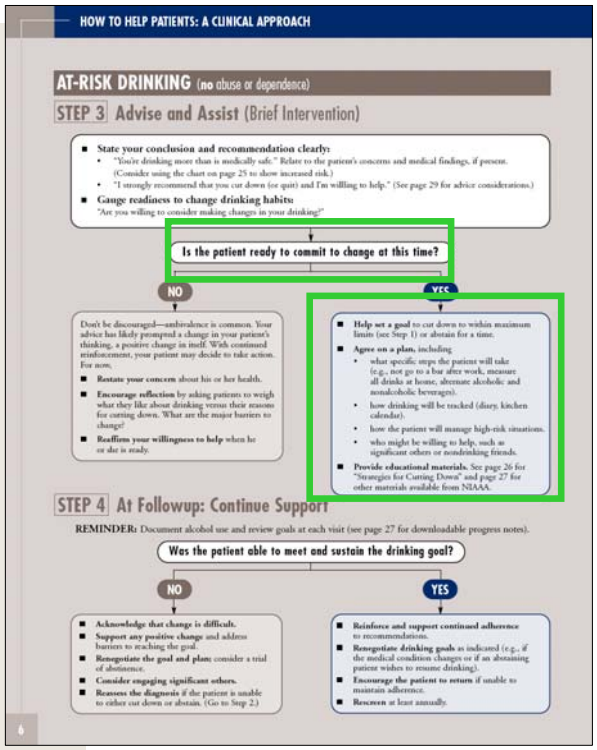
- Acknowledge that change is difficult.
- Support any positive change and address barriers to reaching the goal.
- Renegotiate the goal and plan; consider a trial of abstinence.
- Consider engaging significant others.
- Reassess the diagnosis if the patient is unable to either cut down or abstain. (Go 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 the patient to return if unable to maintain adherence.
- Rescreen at least annually.

6

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


HOW TO HELP PATIENTS: A CLINICAL APPROACH

AT-RISK DRINKING (no abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

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

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- Encourage reflection by asking 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 to cut down to within maximum limits (see Step 1) or abstain for a 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 nonalcoholic 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 significant others or nondrinking friends.
- Provide educational materials. See page 26 for "Strategies for Cutting Down" and page 27 for other materials available from NIAAA.

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes).

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 the patient to return if unable to maintain adherence.
- Rescreen at least annually.

6

STEP 3: Advise and Assist

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

YES

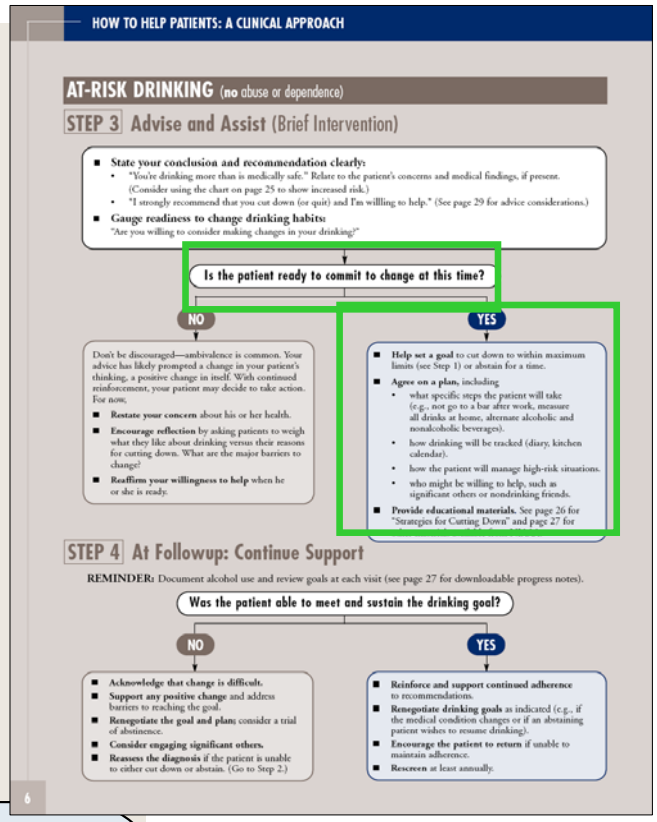
* **Agree on a plan** (cont'd) including-
  * how drinking will be tracked
  * how the patient will manage high-risk situations
  * who might be willing to help, such as a spouse or nondrinking friends

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

STEP 3: Advise and Assist

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

YES


HOW TO HELP PATIENTS: A CLINICAL APPROACH

AT-RISK DRINKING (no abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

- State your conclusion and recommendation clearly:
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- 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?

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- Restate your concern about his or her health.
- Encourage reflection by asking 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 to cut down to within maximum limits (see Step 1) or abstain for a 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 nonalcoholic 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 significant others or nondrinking friends.
- Provide educational materials. See page 26 for "Strategies for Cutting Down" and page 27 for

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes).

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 the patient to return if unable to maintain adherence.
- Rescreen at least annually.

6

* **Provide educational materials -**See Page 26, **Strategies for Cutting Down**, and see online materials at ***www.niaaa.nih.gov/guide***

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

STEP 4: At Followup: Continue Support

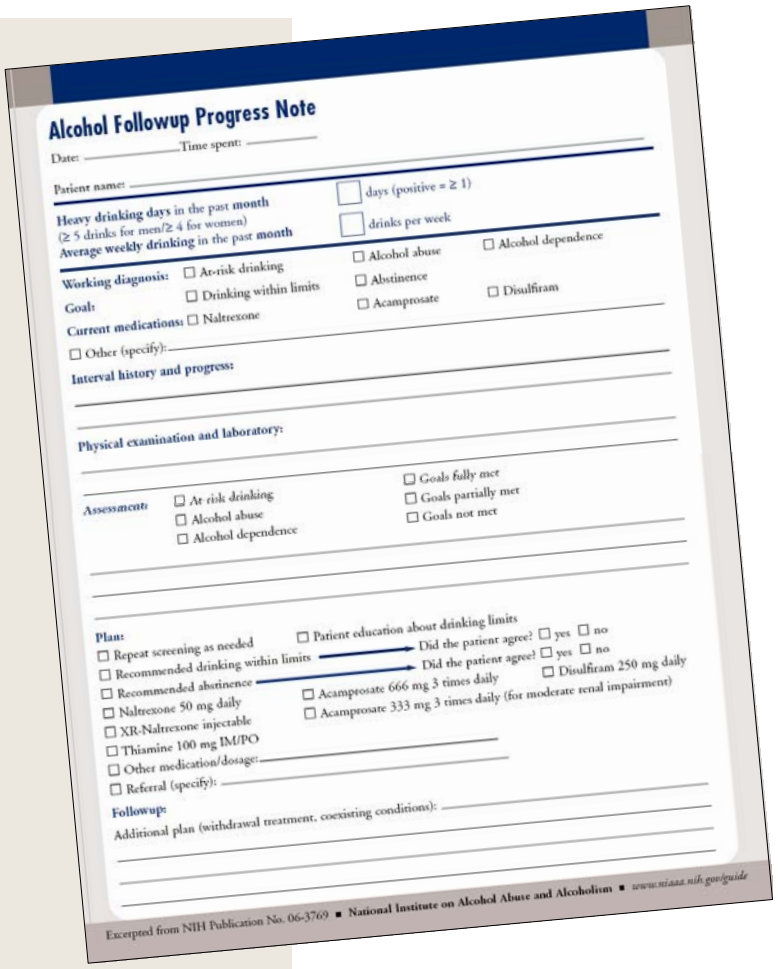
REMINDER:

***Document alcohol use, and**

*** review goals at each visit.**

-Obtain the drinking quantity and frequency at followup visits

-Download preformatted progress notes from *www.niaa.nih.gov*.
See page 27 for details.



Alcohol Followup Progress Note

Date: _____ Time spent: _____

Patient name: _____

Heavy drinking days in the past **month** _____ days (positive = ≥ 1)
(≥ 5 drinks for men/≥ 4 for women)
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
☐ XR-Naltrexone injectable ☐ Acamprosate 333 mg 3 times daily (for moderate renal impairment)
☐ Thiamine 100 mg IM/PO
☐ Other medication/dosage: _____
☐ Referral (specify): _____

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

Excerpted from NIH Publication No. 06-3769 ▪ National Institute on Alcohol Abuse and Alcoholism ▪ *www.niaaa.nih.gov/guide*

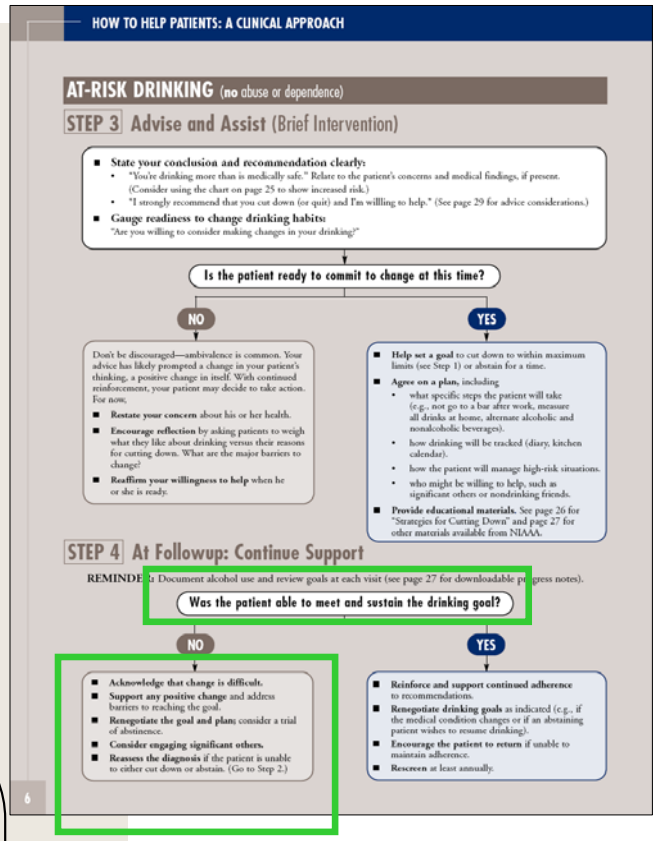
AT-RISK DRINKING
(**no** abuse or dependence)

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.)



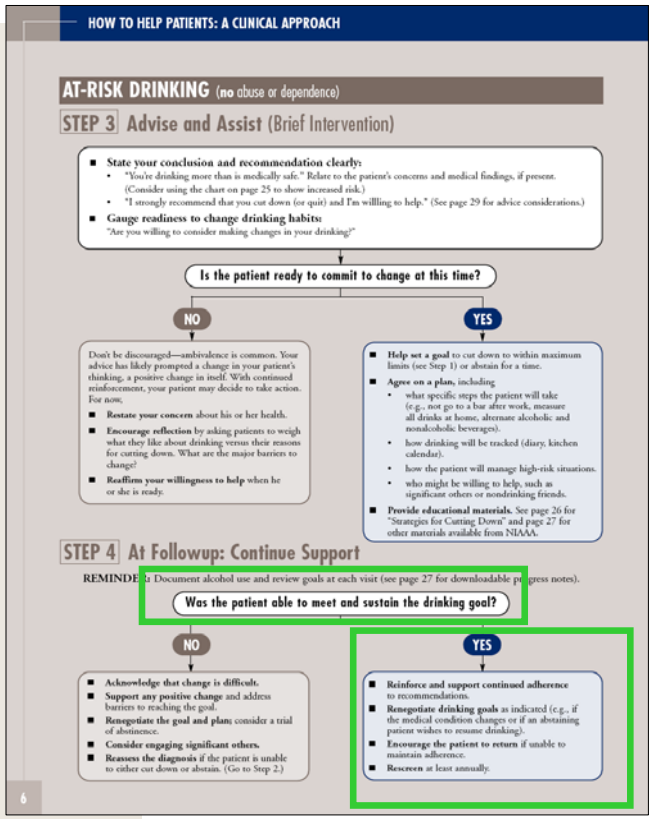
AT-RISK DRINKING
(**no** abuse or dependence)

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.


HOW TO HELP PATIENTS: A CLINICAL APPROACH

AT-RISK DRINKING (no abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

- State your conclusion and recommendation clearly:
  - "You're drinking more than is medically safe." Relate to the patient's concerns and medical findings, if present. (Consider using the chart on page 25 to show increased risk.)
  - "I strongly recommend that you cut down (or quit) and I'm willing to help." (See page 29 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

Don't 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 by asking 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 to cut down to within maximum limits (see Step 1) or abstain for a 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 nonalcoholic 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 significant others or nondrinking friends.
- Provide educational materials. See page 26 for "Strategies for Cutting Down" and page 27 for other materials available from NIAAA.

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes).

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

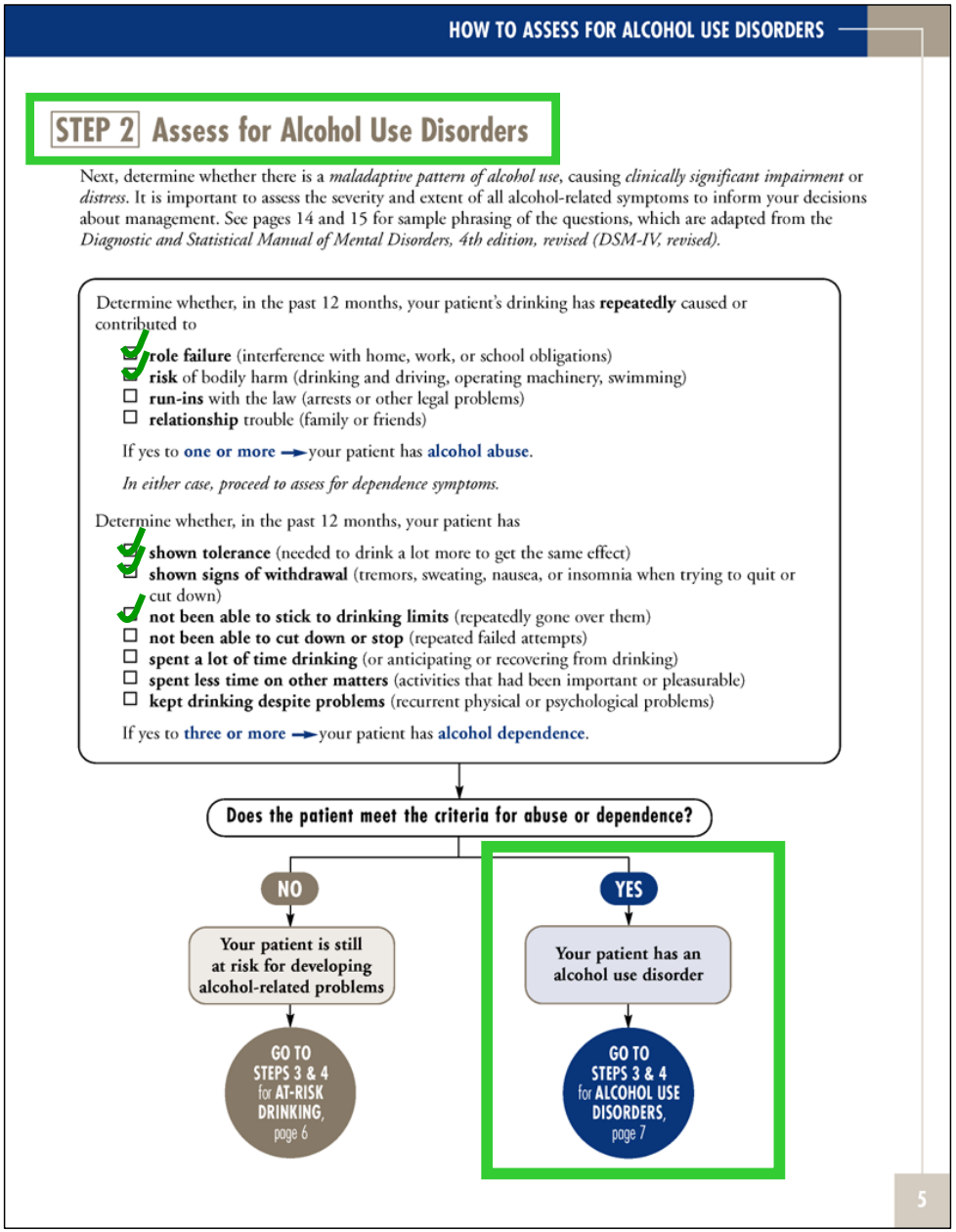
- Reinforce and support continued adherence to recommendations.
- Renegotiate drinking goals as indicated (e.g., if the medical condition changes or if an abstaining patient wishes to resume drinking).
- Encourage the patient to return if unable to maintain adherence.
- Rescreen at least annually.

6

This completes **Example 1**, a patient with ***At-Risk Drinking***.

However, if the patient assessment completed in Step 2 indicates an *Alcohol Use Disorder:*

GO TO Steps 3 and 4 (page 7)



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

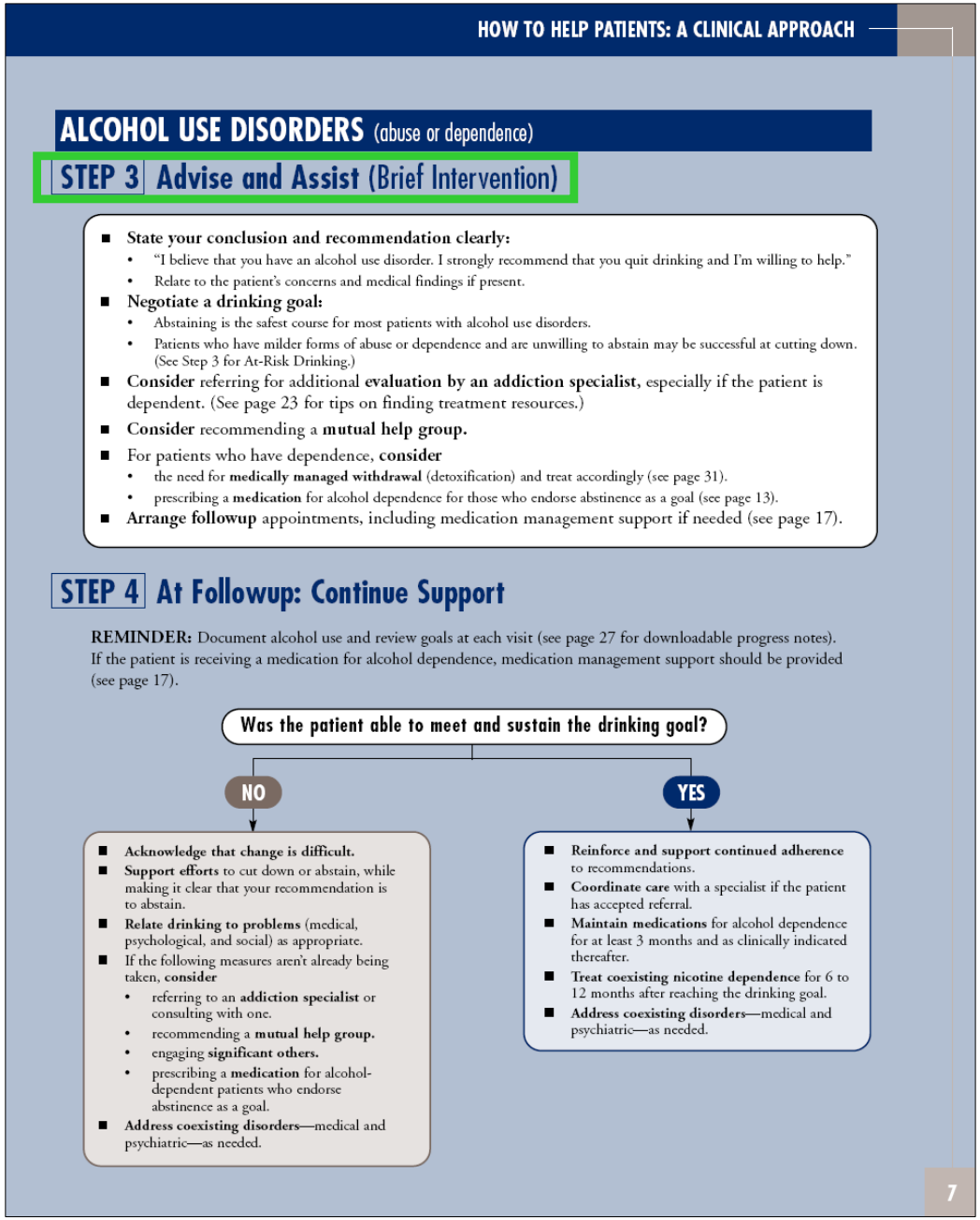
YES → Your patient has an alcohol use disorder → GO TO STEPS 3 & 4 for ALCOHOL USE DISORDERS, page 7

5

Example 2 -- For patients who meet the criteria for

Alcohol Use Disorders (abuse or dependence)

STEP 3: Advise and Assist (Brief Intervention)



HOW TO HELP PATIENTS: A CLINICAL APPROACH

ALCOHOL USE DISORDERS (abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

- **State your conclusion and recommendation clearly:**
  - "I believe that you have an alcohol use disorder. I strongly recommend that you quit drinking and I'm willing to help."
  - 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 23 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 31).
  - prescribing a **medication** for alcohol dependence for those who endorse abstinence as a goal (see page 13).
- **Arrange followup** appointments, including medication management support if needed (see page 17).

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes). If the patient is receiving a medication for alcohol dependence, medication management support should be provided (see page 17).

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 the following measures aren't 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.

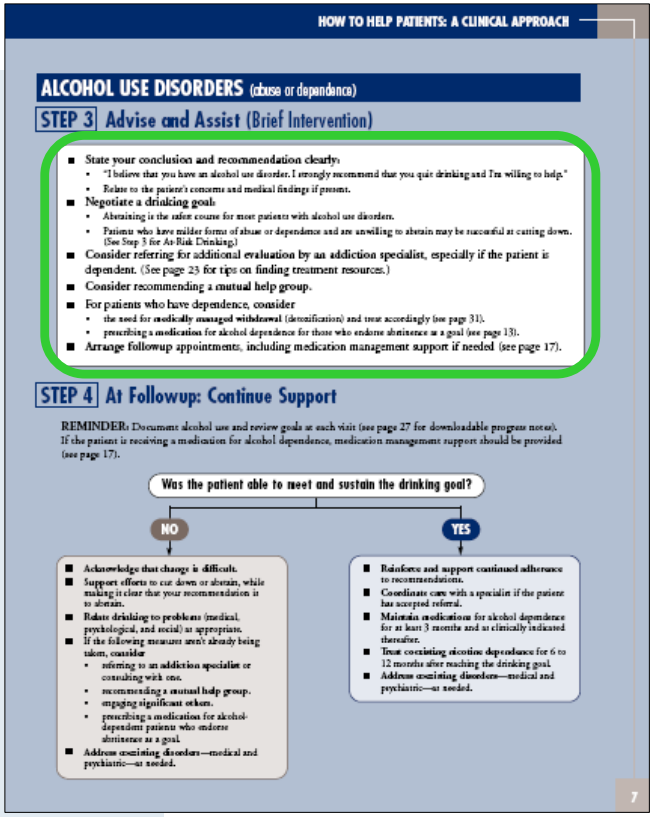
7

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. I strongly recommend that you quit drinking and I'm willing to help.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ALCOHOL USE DISORDERS (abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

- State your conclusion and recommendation clearly:
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  - 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 23 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 31).
  - prescribing a medication for alcohol dependence for those who endorse abstinence as a goal (see page 13).
- Arrange followup appointments, including medication management support if needed (see page 17).

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes). If the patient is receiving a medication for alcohol dependence, medication management support should be provided (see page 17).

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 the following measures aren't 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.

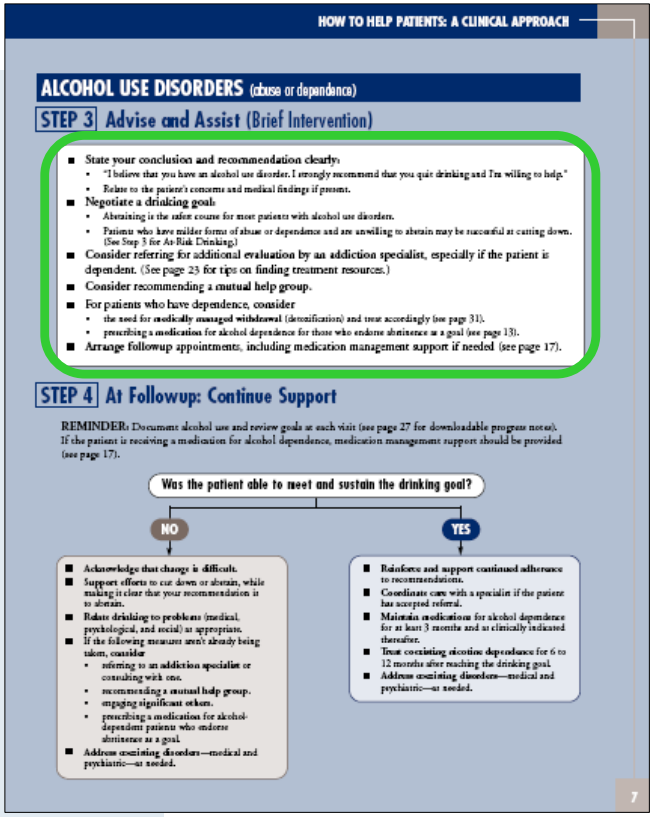
YES

- 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


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.**

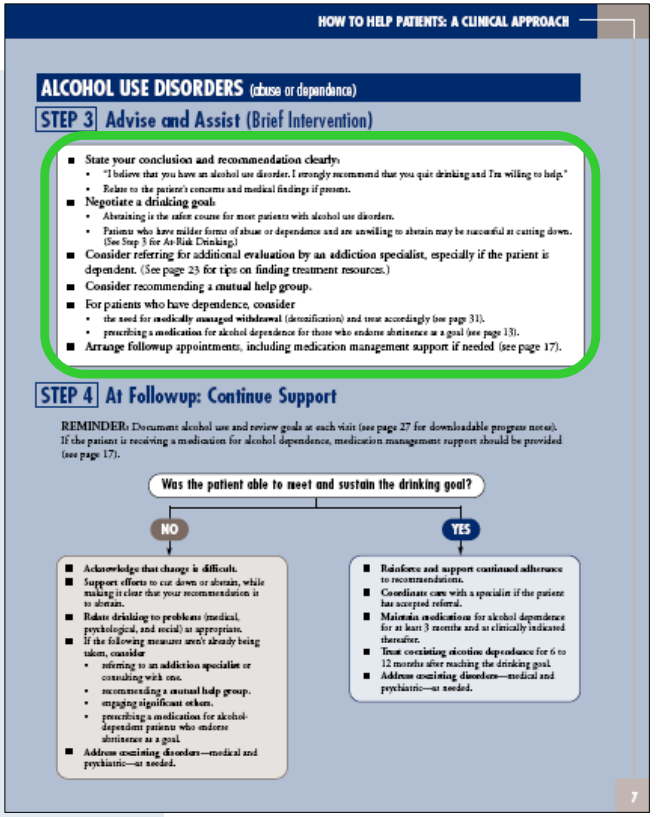
  * **Patients who have milder forms of abuse or dependence and are unwilling to abstain may be successful at cutting down.** (See **Step 3 for *At-Risk Drinking***, page 6.)

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

STEP 3: Advise and Assist

* **Consider referring for additional evaluation by an addiction specialist, especially for dependence.** (See tips on finding treatment resources, page 23.)

* **Consider recommending a mutual help group.**


HOW TO HELP PATIENTS: A CLINICAL APPROACH

ALCOHOL USE DISORDERS (abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

- State your conclusion and recommendation clearly.
  - "I believe that you have an alcohol use disorder. I strongly recommend that you quit drinking and I'm willing to help."
  - 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 23 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 31).
  - prescribing a medication for alcohol dependence for those who endorse abstinence as a goal (see page 13).
- Arrange followup appointments, including medication management support if needed (see page 17).

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes). If the patient is receiving a medication for alcohol dependence, medication management support should be provided (see page 17).

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 the following measures aren't 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

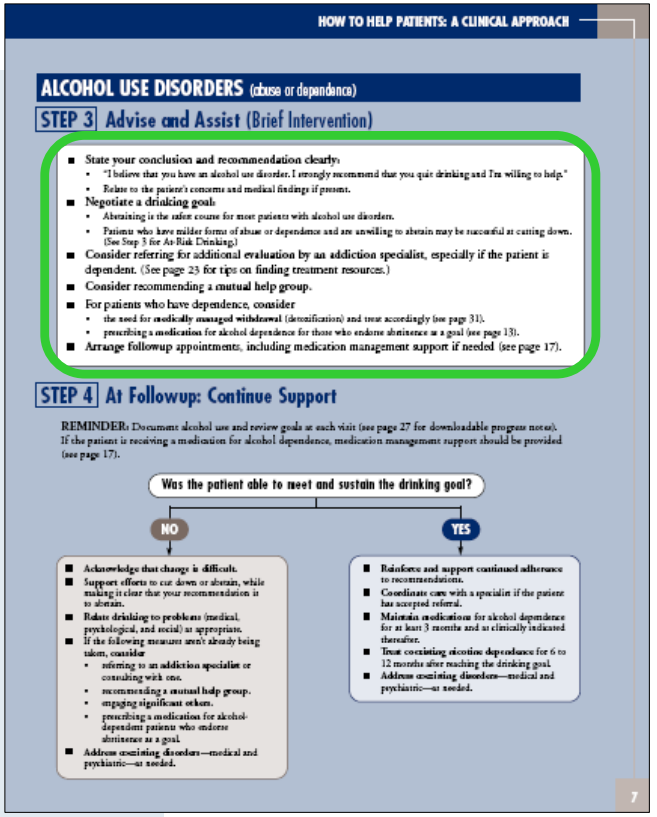
- Reinforce and support continued adherence to recommendations.
- Coordinate care with a specialist if the patient has accepted referral.
- Maintain medications for alcohol dependence for at least 3 months and as clinically indicated thereafter.
- Treat coexisting nicotine dependence for 6 to 12 months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

7

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 31)



HOW TO HELP PATIENTS: A CLINICAL APPROACH

ALCOHOL USE DISORDERS (abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

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- Consider recommending a mutual help group.
- For patients who have dependence, consider
  - the need for medically managed withdrawal (detoxification) and treat accordingly (see page 31).
  - prescribing a medication for alcohol dependence for those who endorse abstinence as a goal (see page 13).
- Arrange followup appointments, including medication management support if needed (see page 17).

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes). If the patient is receiving a medication for alcohol dependence, medication management support should be provided (see page 17).

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 the following measures aren't 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.

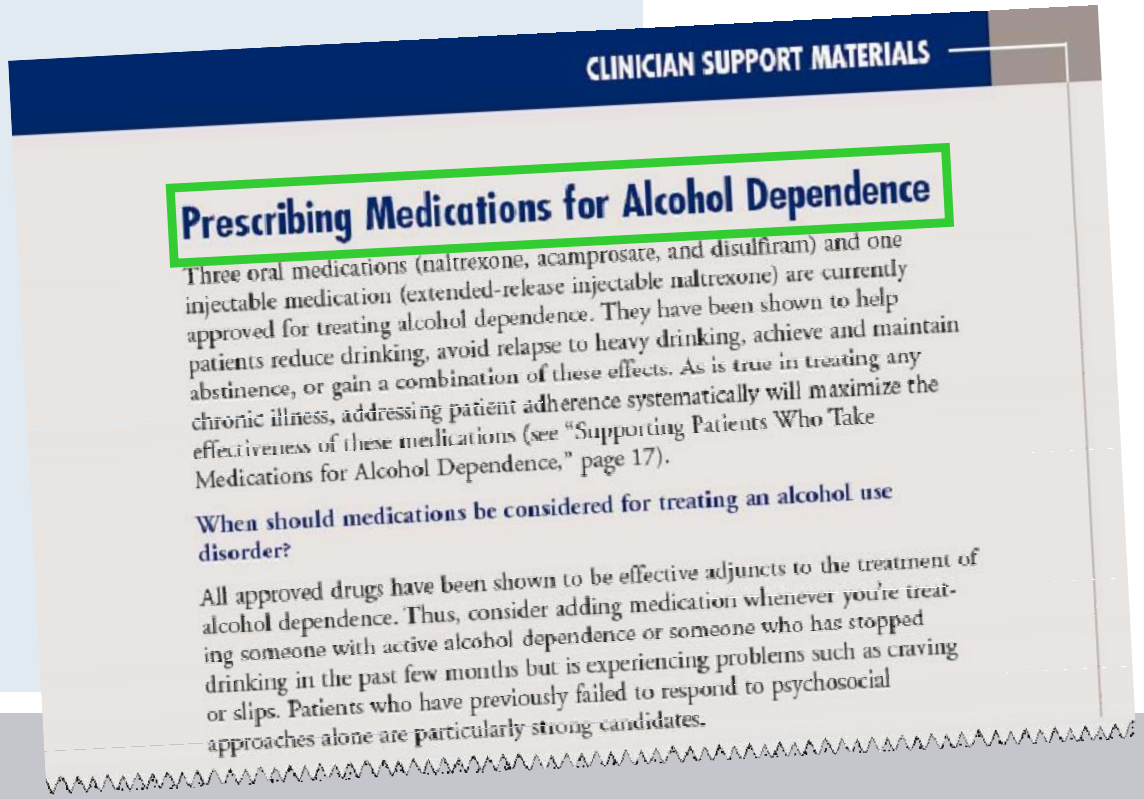
7

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

STEP 3: Advise and Assist

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

* **prescribing medications** for patients who endorse abstinence as a goal (see page 13)



CLINICIAN SUPPORT MATERIALS

Prescribing Medications for Alcohol Dependence

Three oral medications (naltrexone, acamprosate, and disulfiram) and one injectable medication (extended-release injectable naltrexone) are currently approved for treating alcohol dependence. They have been shown to help patients reduce drinking, avoid relapse to heavy drinking, achieve and maintain abstinence, or gain a combination of these effects. As is true in treating any chronic illness, addressing patient adherence systematically will maximize the effectiveness of these medications (see "Supporting Patients Who Take Medications for Alcohol Dependence," page 17).

When should medications be considered for treating an alcohol use disorder?

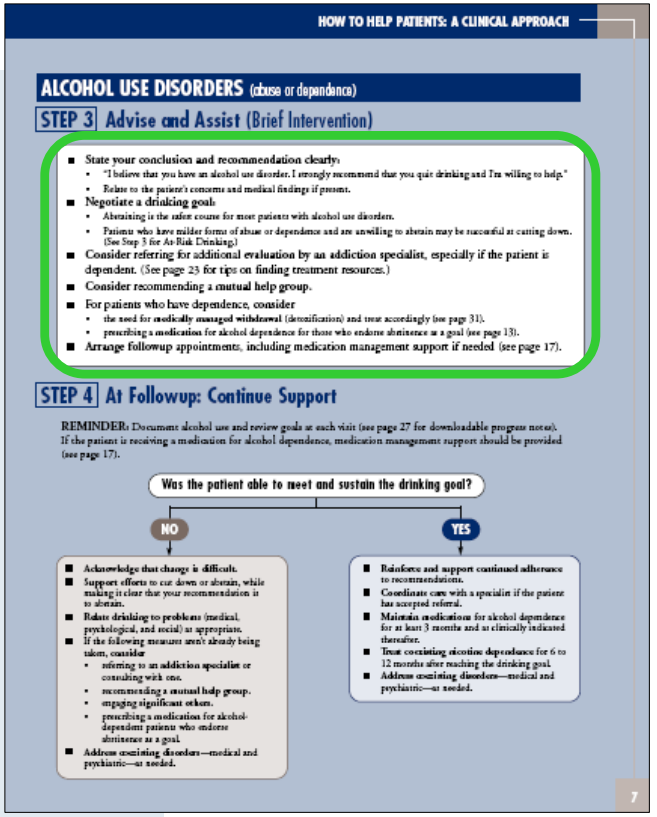
All approved drugs have been shown to be effective adjuncts to the treatment of alcohol dependence. Thus, consider adding medication whenever you're treating someone with active alcohol dependence or someone who has stopped drinking in the past few months but is experiencing problems such as craving or slips. Patients who have previously failed to respond to psychosocial approaches alone are particularly strong candidates.

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

STEP 3: Advise and Assist

***Arrange followup appointments.**

*Include **medication management support** if needed (see Page 17)


HOW TO HELP PATIENTS: A CLINICAL APPROACH

ALCOHOL USE DISORDERS (abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

- State your conclusion and recommendation clearly.
  - "I believe that you have an alcohol use disorder. I strongly recommend that you quit drinking and I'm willing to help."
  - 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 23 for tips on finding treatment resources.)
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STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable program notes). If the patient is receiving a medication for alcohol dependence, medication management support should be provided (see page 17).

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.
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- If the following measures aren't already being taken, consider
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  - 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

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- Treat coexisting nicotine dependence for 6 to 12 months after reaching the drinking goal.
- Address coexisting disorders—medical and psychiatric—as needed.

7

FOR ALCOHOL USE DISORDERS

STEP 4: At Followup
Continue Support

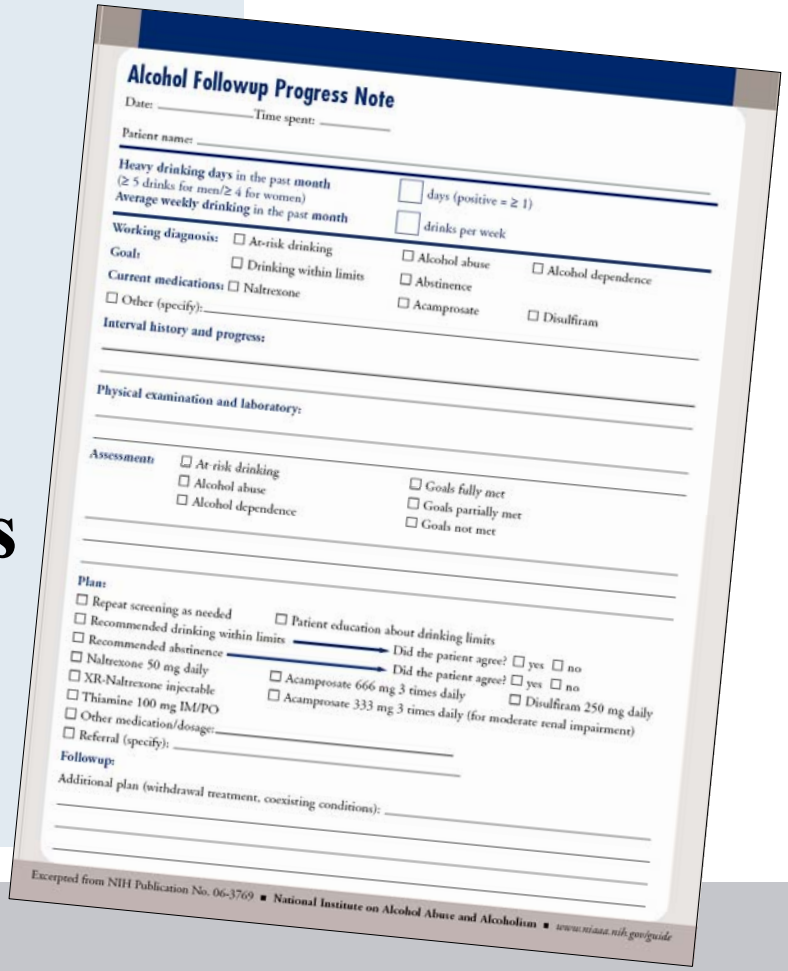
REMINDER:

***Document alcohol use, and**

*** review goals at each visit.**

-Obtain the drinking quantity and frequency at followup visits

-Download preformatted progress notes from *www.niaa.nih.gov* (See materials listed at page 27)



Alcohol Followup Progress Note

Date: _____ Time spent: _____

Patient name: _____

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

☐ Recommended drinking within limits → ☐ Patient education about drinking 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

☐ XR-Naltrexone injectable ☐ Acamprosate 333 mg 3 times daily (for moderate renal impairment)

☐ Thiamine 100 mg IM/PO

☐ Other medication/dosage: _____

☐ Referral (specify): _____

Followup:

Additional plan (withdrawal treatment, coexisting conditions): _____

Excerpted from NIH Publication No. 06-3769 ■ National Institute on Alcohol Abuse and Alcoholism ■ www.niaaa.nih.gov/guide

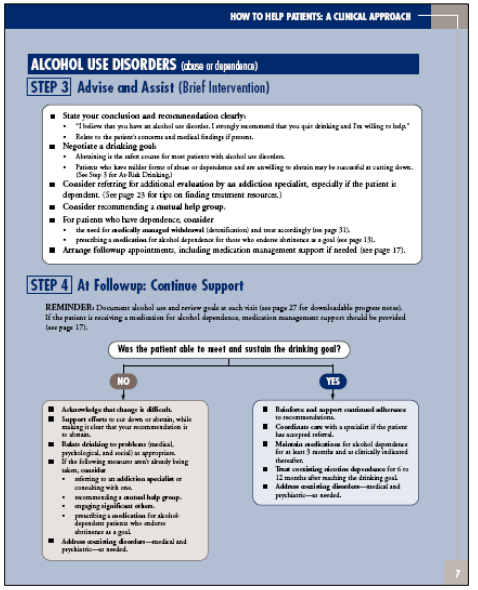
FOR **ALCOHOL USE DISORDERS**

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.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ALCOHOL USE DISORDERS (abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

- State your conclusion and recommendation clearly.
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  - 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 23 for tips on finding treatment resources.)
- Consider recommending a mutual help group.
- For patients who have dependence, consider
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  - 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

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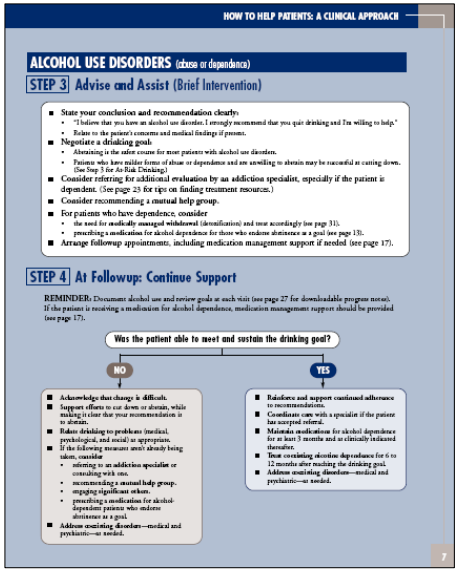
STEP 4: At Followup

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

NO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- Address coexisting disorders—medical and psychiatric—as needed.

7

* 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

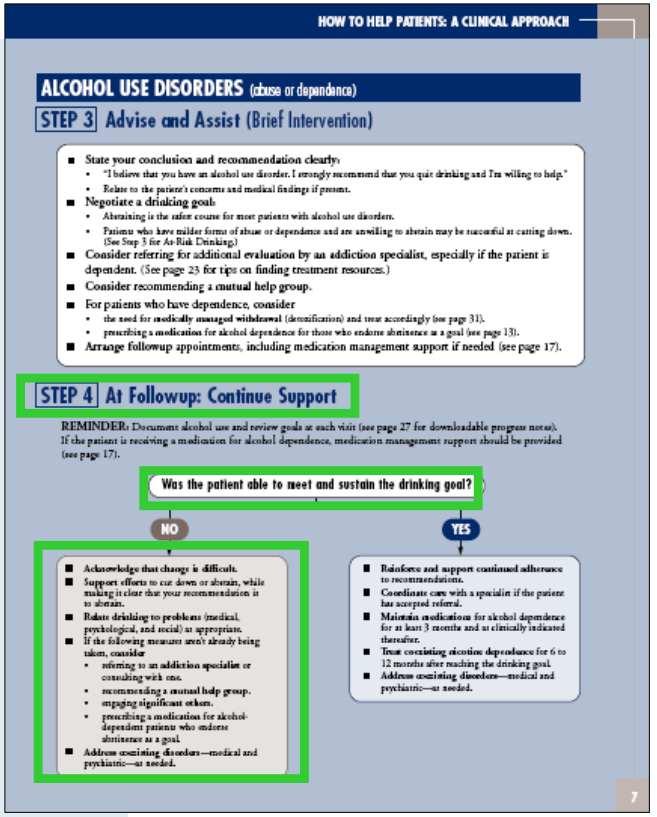
FOR **ALCOHOL USE DISORDERS**

STEP 4: At 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?

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* **Reinforce and support continued adherence** to recommendations.

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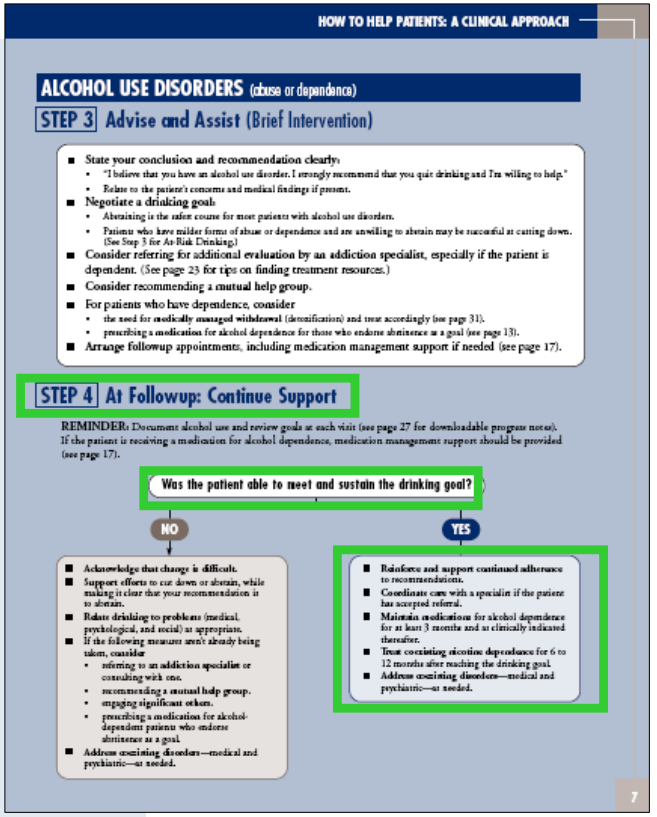


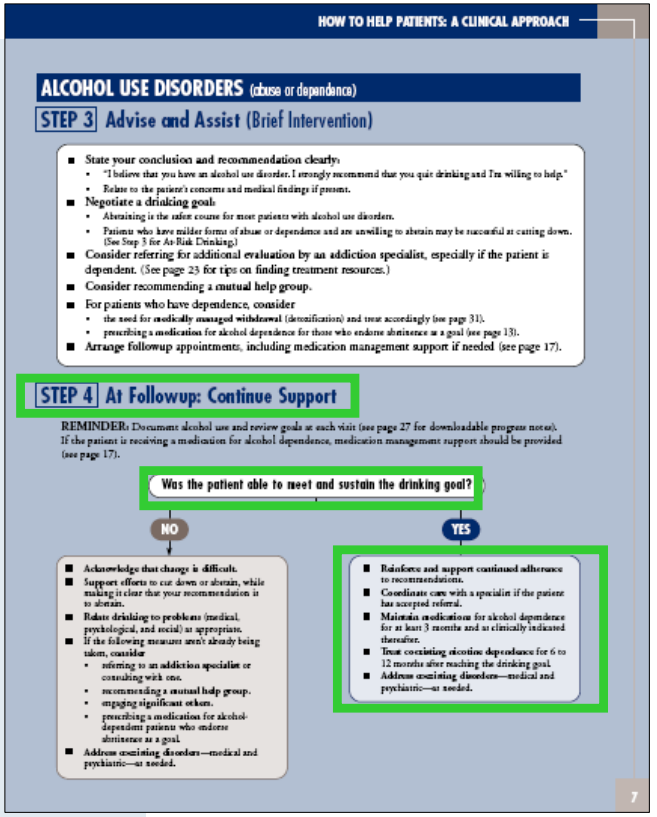
FOR **ALCOHOL USE DISORDERS**

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.



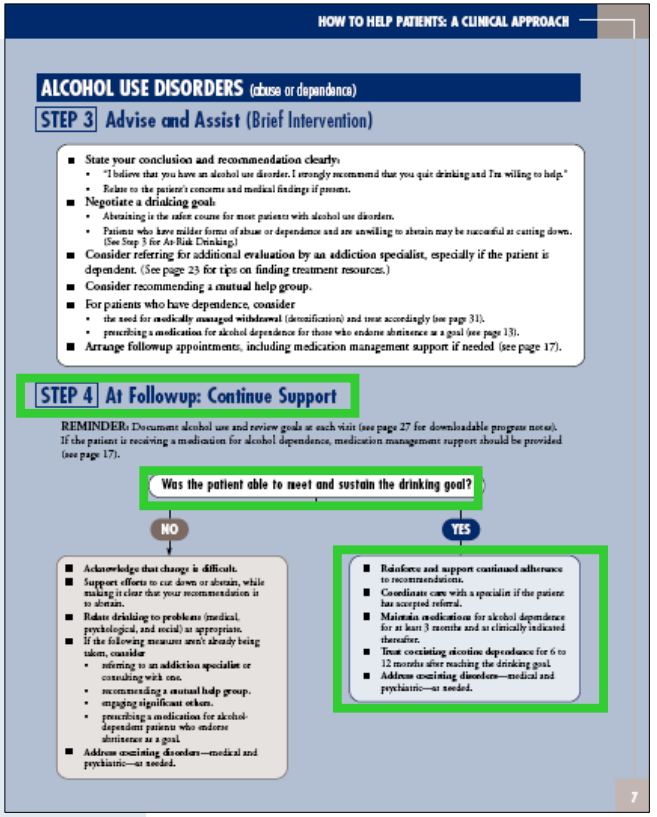
FOR **ALCOHOL USE DISORDERS**

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.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STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes). If the patient is receiving a medication for alcohol dependence, medication management support should be provided (see page 17).

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

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7

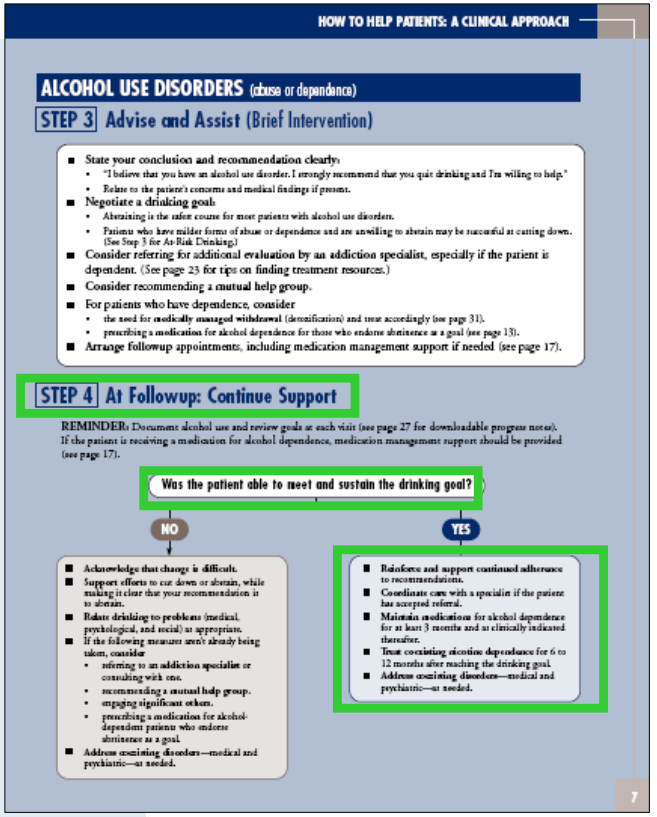
FOR **ALCOHOL USE DISORDERS**

STEP 4: At Followup

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

YES

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



Following the clinical approach outlined on pages 6-7, the Guide provides additional resources featured in the

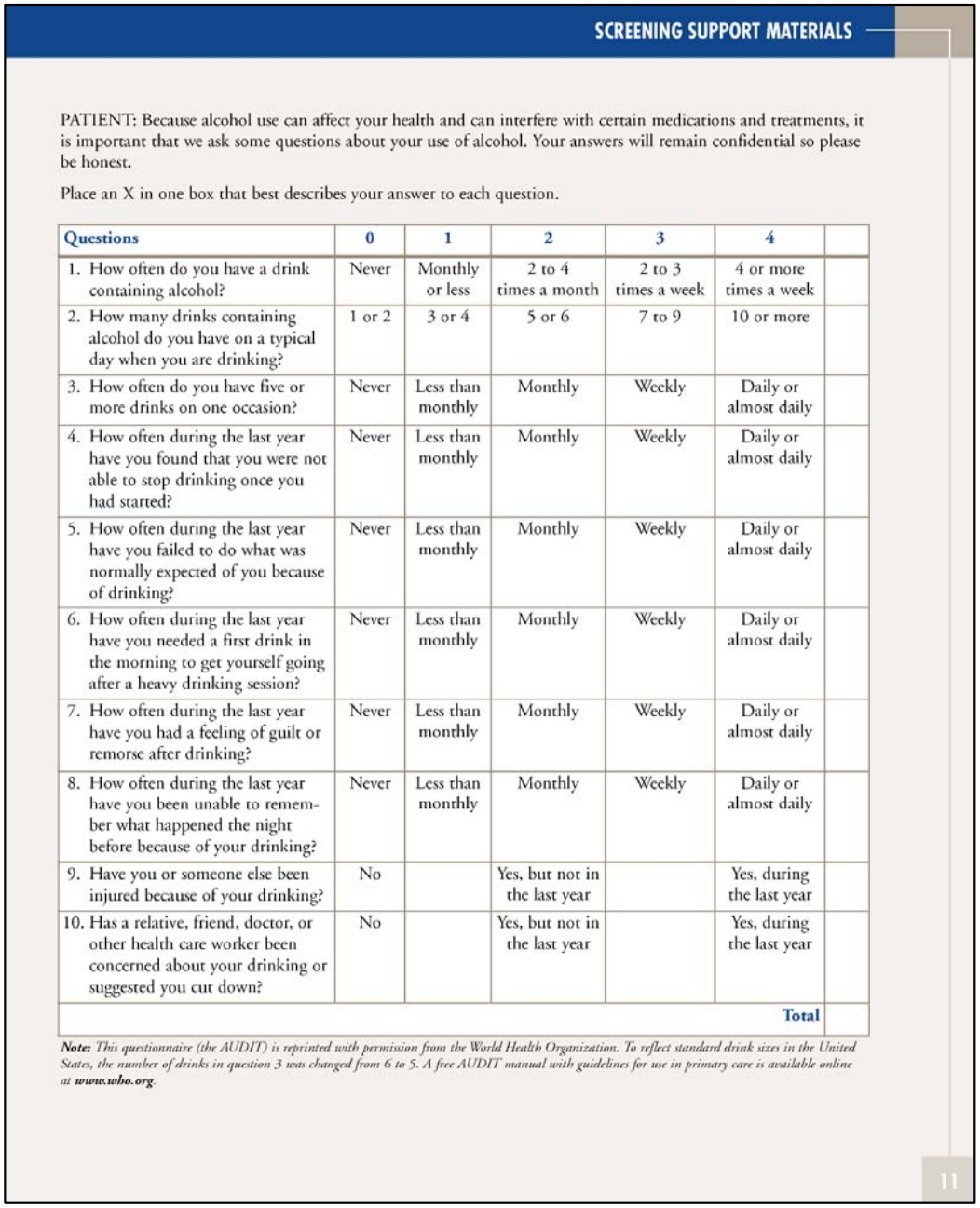
Appendix

* Clinician Support Materials: pages 10-23
* Patient Education Support Materials: pages 24-26
* Online Materials for Clinicians and Patients: page 27
* Frequently Asked Questions: pages 28-32

Appendix

Appendix – Clinician Support Materials

***Screening Instrument: the AUDIT: pages 10-12**



SCREENING SUPPORT MATERIALS

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****.*

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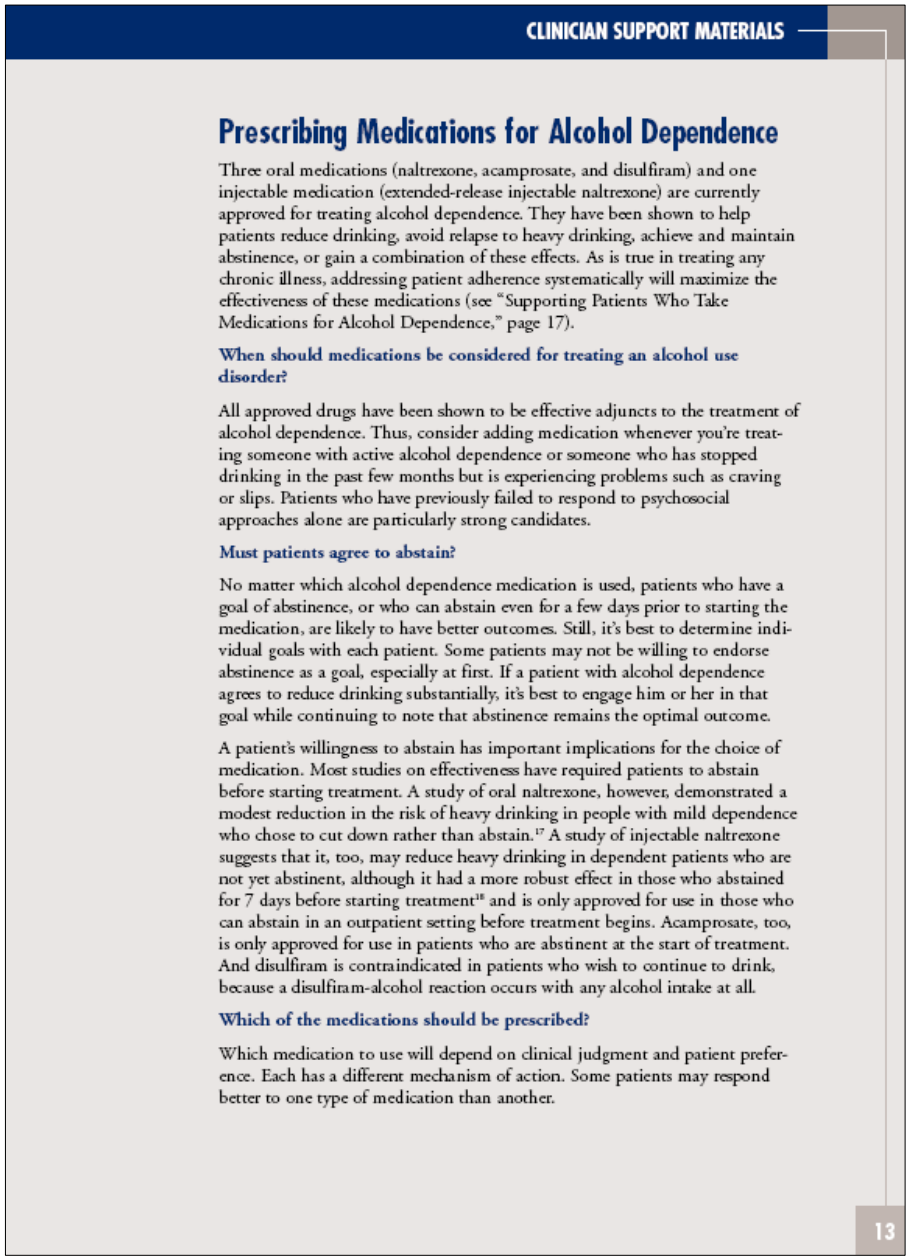
Appendix

*Prescribing Medications for Alcohol Dependence: pages 13-16

Featuring a Medications Chart with additional details about--

- *Naltrexone – available in 2 forms: oral and extended-release injectable
- *Acamprosate
- *Disulfiram



CLINICIAN SUPPORT MATERIALS

Prescribing Medications for Alcohol Dependence

Three oral medications (naltrexone, acamprosate, and disulfiram) and one injectable medication (extended-release injectable naltrexone) are currently approved for treating alcohol dependence. They have been shown to help patients reduce drinking, avoid relapse to heavy drinking, achieve and maintain abstinence, or gain a combination of these effects. As is true in treating any chronic illness, addressing patient adherence systematically will maximize the effectiveness of these medications (see "Supporting Patients Who Take Medications for Alcohol Dependence," page 17).

When should medications be considered for treating 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're 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. Patients who have previously failed to respond to psychosocial approaches alone are particularly strong candidates.

Must patients agree to abstain?

No matter which alcohol dependence medication is used, patients who have a goal of abstinence, or who can abstain even for a few days prior to starting the medication, are likely to have better outcomes. Still, it's best to determine individual goals with each patient. Some patients may not be willing to endorse abstinence as a goal, especially at first. If a patient with alcohol dependence agrees to reduce drinking substantially, it's best to engage him or her in that goal while continuing to note that abstinence remains the optimal outcome.

A patient's willingness to abstain has important implications for the choice of medication. Most studies on effectiveness have required patients to abstain before starting treatment. A study of oral naltrexone, however, demonstrated a modest reduction in the risk of heavy drinking in people with mild dependence who chose to cut down rather than abstain.[17] A study of injectable naltrexone suggests that it, too, may reduce heavy drinking in dependent patients who are not yet abstinent, although it had a more robust effect in those who abstained for 7 days before starting treatment[18] and is only approved for use in those who can abstain in an outpatient setting before treatment begins. Acamprosate, too, is only approved for use in patients who are abstinent at the start of treatment. And disulfiram is contraindicated in patients who wish to continue to drink, because a disulfiram-alcohol reaction occurs with any alcohol intake at all.

Which of the medications should be prescribed?

Which medication to use will depend on clinical judgment and patient preference. Each has a different mechanism of action. Some patients may respond better to one type of medication than another.

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Appendix:

Oral form Naltrexone | Extended-release injectable Naltrexone | Acamprosate | Disulfiram

Medications Chart for Treating Alcohol Dependence, page 16

16

Medications for Treating Alcohol Dependence

	Naltrexone (Depade®, ReVia®)	Extended-Release Injectable Naltrexone (Vivitrol®)	Acamprosate (Campral®)	Disulfiram (Antabuse®)
Action	Blocks opioid receptors, resulting in reduced craving and reduced reward in response to drinking.	Same as oral naltrexone; 30-day duration.	Affects glutamate and GABA neurotransmitter systems, but its alcohol-related action is unclear.	Inhibits intermediate metabolism of alcohol, causing a buildup of acetaldehyde and a reaction of flushing, sweating, nausea, and tachycardia if a patient drinks alcohol.
Contraindications	Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analgesics; acute hepatitis or liver failure.	Same as oral naltrexone, plus inadequate muscle mass for deep intramuscular injection; rash or infection at the injection site.	Severe renal impairment (CrCl ≤ 30 mL/min).	Concomitant use of alcohol or alcohol-containing preparations or metronidazole; coronary artery disease; severe myocardial disease; hypersensitivity to rubber (thiuram) derivatives.
Precautions	Other hepatic disease; renal impairment; history of suicide attempts or depression. If opioid analgesia is needed, larger doses may be required and respiratory depression may be deeper and more prolonged. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see *www.niaaa.nih.gov/guide*.	Same as oral naltrexone, plus hemophilia or other bleeding problems.	Moderate renal impairment (dose adjustment for CrCl between 30 and 50 mL/min); depression or suicidal ideation and behavior. Pregnancy Category C.	Hepatic cirrhosis or insufficiency; cerebrovascular disease or cerebral damage; psychoses (current or history); diabetes mellitus; epilepsy; hypothyroidism; renal impairment. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see *www.niaaa.nih.gov/guide*.
Serious adverse reactions	Will precipitate severe withdrawal if the patient is dependent on opioids; hepatotoxicity (although does not appear to be a hepatotoxin at the recommended doses).	Same as oral naltrexone, plus infection at the injection site; depression; and rare events including allergic pneumonia and suicidal ideation and behavior.	Rare events include suicidal ideation and behavior.	Disulfiram-alcohol reaction, hepatotoxicity, optic neuritis, peripheral neuropathy, psychotic reactions.
Common side effects	Nausea, vomiting, decreased appetite, headache, dizziness, fatigue, somnolence, anxiety.	Same as oral naltrexone, plus a reaction at the injection site; joint pain; muscle aches or cramps.	Diarrhea, somnolence.	Metallic after-taste, dermatitis, transient mild drowsiness.
Examples of drug interactions	Opioid medications (blocks action).	Same as oral naltrexone.	No clinically relevant interactions known.	Anticoagulants such as warfarin; isoniazid; metronidazole; phenytoin; any nonprescription drug containing alcohol.
Usual adult dosage	*Oral dose:* 50 mg daily. *Before prescribing:* Patients must be opioid-free for a minimum of 7 to 10 days before starting. If you feel that there's a risk of precipitating an opioid withdrawal reaction, administer a naloxone challenge test. Evaluate liver function. *Laboratory followup:* Monitor liver function.	*IM dose:* 380 mg given as a deep intramuscular gluteal injection, once monthly. *Before prescribing:* Same as oral naltrexone, plus examine the injection site for adequate muscle mass and skin condition. *Laboratory followup:* Monitor liver function.	*Oral dose:* 666 mg (two 333-mg tablets) three times daily; *or* for patients with moderate renal impairment (CrCl 30 to 50 mL/min), reduce to 333 mg (one tablet) three times daily. *Before prescribing:* Evaluate renal function. Establish abstinence.	*Oral dose:* 250 mg daily (range 125 mg to 500 mg). *Before prescribing:* Evaluate liver function. Warn the patient (1) not to 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) to avoid alcohol in the diet (e.g., sauces and vinegars), over-the-counter medications (e.g., cough syrups), and toiletries (e.g., cologne, mouthwash). *Laboratory followup:* Monitor liver function.

The information in this chart was drawn primarily from package inserts and references 18, 20, 22, and 26 (see pages 33–34).
January 2007

Note: This chart 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 MedlinePlus (*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.

Appendix – Clinician Support Materials

***Supporting Patients Who Take Medications for Alcohol Dependence: pages 17-18**

Supporting Patients Who Take Medications for Alcohol Dependence

Pharmacotherapy for alcohol dependence is most effective when combined with some behavioral support, but this doesn't need to be specialized, intensive alcohol counseling. Nurses and physicians in general medical and mental health settings, as well as counselors, can offer brief but effective behavioral support that promotes recovery. Applying this medication management approach in such settings would greatly expand access to effective treatment, given that many patients with alcohol dependence either don't have access to specialty treatment or refuse a referral.

How can general medical and mental health clinicians support patients who take medication for alcohol dependence?

Managing the care of patients who take medication for alcohol dependence is similar to other disease management strategies such as initiating insulin therapy in patients with diabetes mellitus. In the recent Combining Medications and Behavioral Interventions (COMBINE) clinical trial, physicians, nurses, and other health care professionals in outpatient settings delivered a series of brief behavioral support sessions for patients taking medications for alcohol dependence.[22] The sessions promoted recovery by increasing adherence to medication and supporting abstinence through education and referral to support groups.[22] This *Guide* offers a set of how-to templates outlining this program (see pages 19–22). It was designed for easy implementation in nonspecialty settings, in keeping with the national trend toward integrating the treatment of substance use disorders into medical practice.

What are the components of medication management support?

Medication management support consists of brief, structured outpatient sessions conducted by a health care professional. The initial session starts by reviewing the medical evaluation results with the patient as well as the negative consequences from drinking. This information frames a discussion about the diagnosis of alcohol dependence, the recommendation for abstinence, and the rationale for medication. The clinician then provides information on the medication itself and adherence strategies, and encourages participation in a mutual support group such as Alcoholics Anonymous (AA).

In subsequent visits, the clinician assesses the patient's drinking, overall functioning, medication adherence, and any side effects from the medication. Session structure varies according to the patient's drinking status and treatment compliance, as outlined on page 22. When a patient doesn't adhere to the medication regimen, it's important to evaluate the reasons and help the patient devise plans to address them. A helpful summary of strategies for handling nonadherence is provided in the "Medical Management Treatment Manual" from Project COMBINE, available online at *www.niaaa.nih.gov/guide.*

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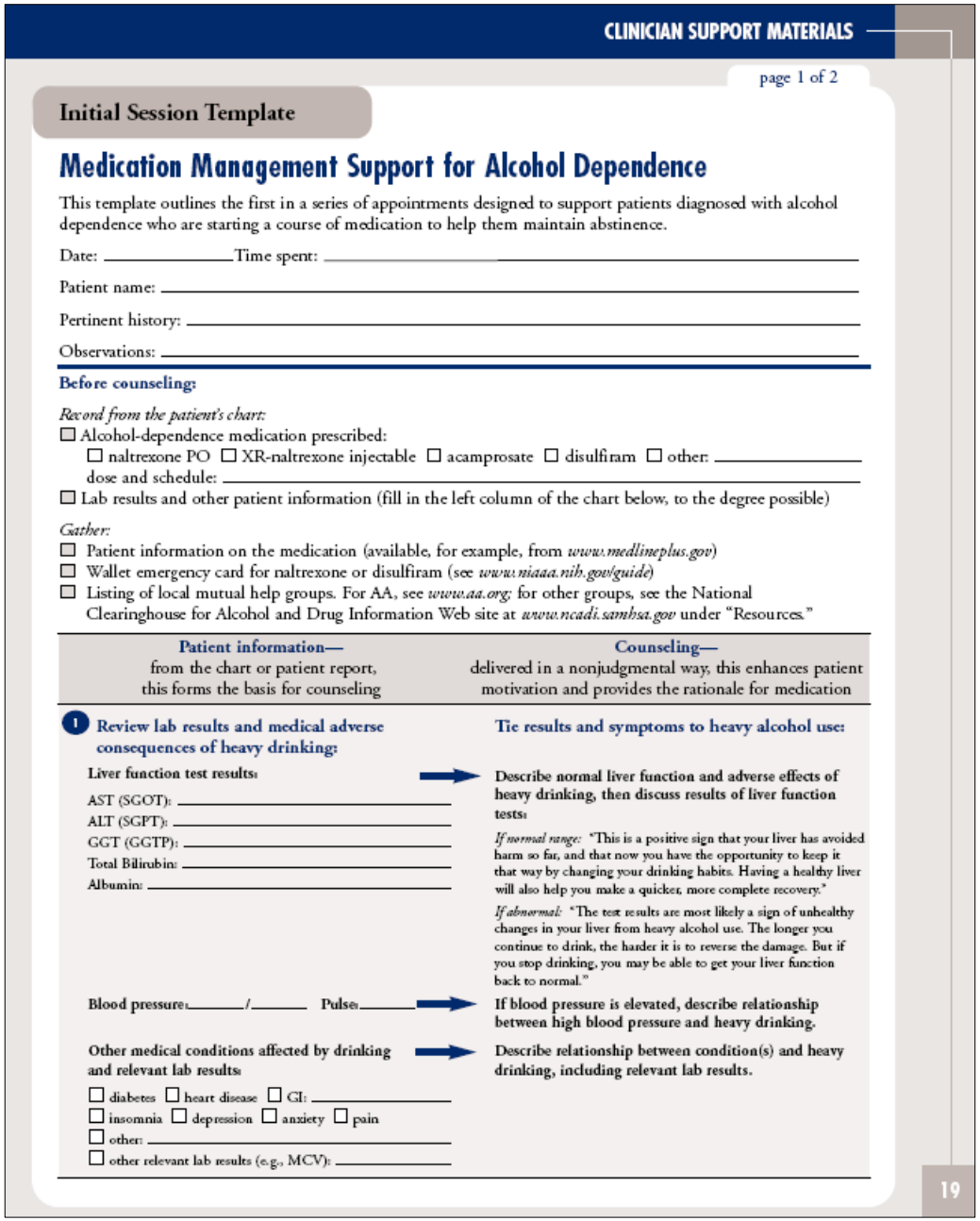
Appendix – Clinician Support Materials

*Medication Management Support for Alcohol Dependence

*Initial Session Template…….19-20



CLINICIAN SUPPORT MATERIALS

page 1 of 2

Initial Session Template

Medication Management Support for Alcohol Dependence

This template outlines the first in a series of appointments designed to support patients diagnosed with alcohol dependence who are starting a course of medication to help them maintain abstinence.

Date: _____ Time spent: _____

Patient name: _____

Pertinent history: _____

Observations: _____

Before counseling:

Record from the patient's chart:

☐ Alcohol-dependence medication prescribed:
☐ naltrexone PO ☐ XR-naltrexone injectable ☐ acamprosate ☐ disulfiram ☐ other: _____
dose and schedule: _____
☐ Lab results and other patient information (fill in the left column of the chart below, to the degree possible)

Gather:

☐ Patient information on the medication (available, for example, from *www.medlineplus.gov*)
☐ Wallet emergency card for naltrexone or disulfiram (see *www.niaaa.nih.gov/guide*)
☐ Listing of local mutual help groups. For AA, see *www.aa.org;* for other groups, see the National Clearinghouse for Alcohol and Drug Information Web site at *www.ncadi.samhsa.gov* under "Resources."

Patient information— from the chart or patient report, this forms the basis for counseling	**Counseling—** delivered in a nonjudgmental way, this enhances patient motivation and provides the rationale for medication
1 Review lab results and medical adverse consequences of heavy drinking:	**Tie results and symptoms to heavy alcohol use:**
Liver function test results: AST (SGOT): _____ ALT (SGPT): _____ GGT (GGTP): _____ Total Bilirubin: _____ Albumin: _____	→ **Describe normal liver function and adverse effects of heavy drinking, then discuss results of liver function tests:** *If normal range:* "This is a positive sign that your liver has avoided harm so far, and that now you have the opportunity to keep it that way by changing your drinking habits. Having a healthy liver will also help you make a quicker, more complete recovery." *If abnormal:* "The test results are most likely a sign of unhealthy changes in your liver from heavy alcohol use. The longer you continue to drink, the harder it is to reverse the damage. But if you stop drinking, you may be able to get your liver function back to normal."
Blood pressure: ____/____ **Pulse:** ____	→ **If blood pressure is elevated, describe relationship between high blood pressure and heavy drinking.**
Other medical conditions affected by drinking and relevant lab results: ☐ diabetes ☐ heart disease ☐ GI: _____ ☐ insomnia ☐ depression ☐ anxiety ☐ pain ☐ other: _____ ☐ other relevant lab results (e.g., MCV): _____	→ **Describe relationship between condition(s) and heavy drinking, including relevant lab results.**

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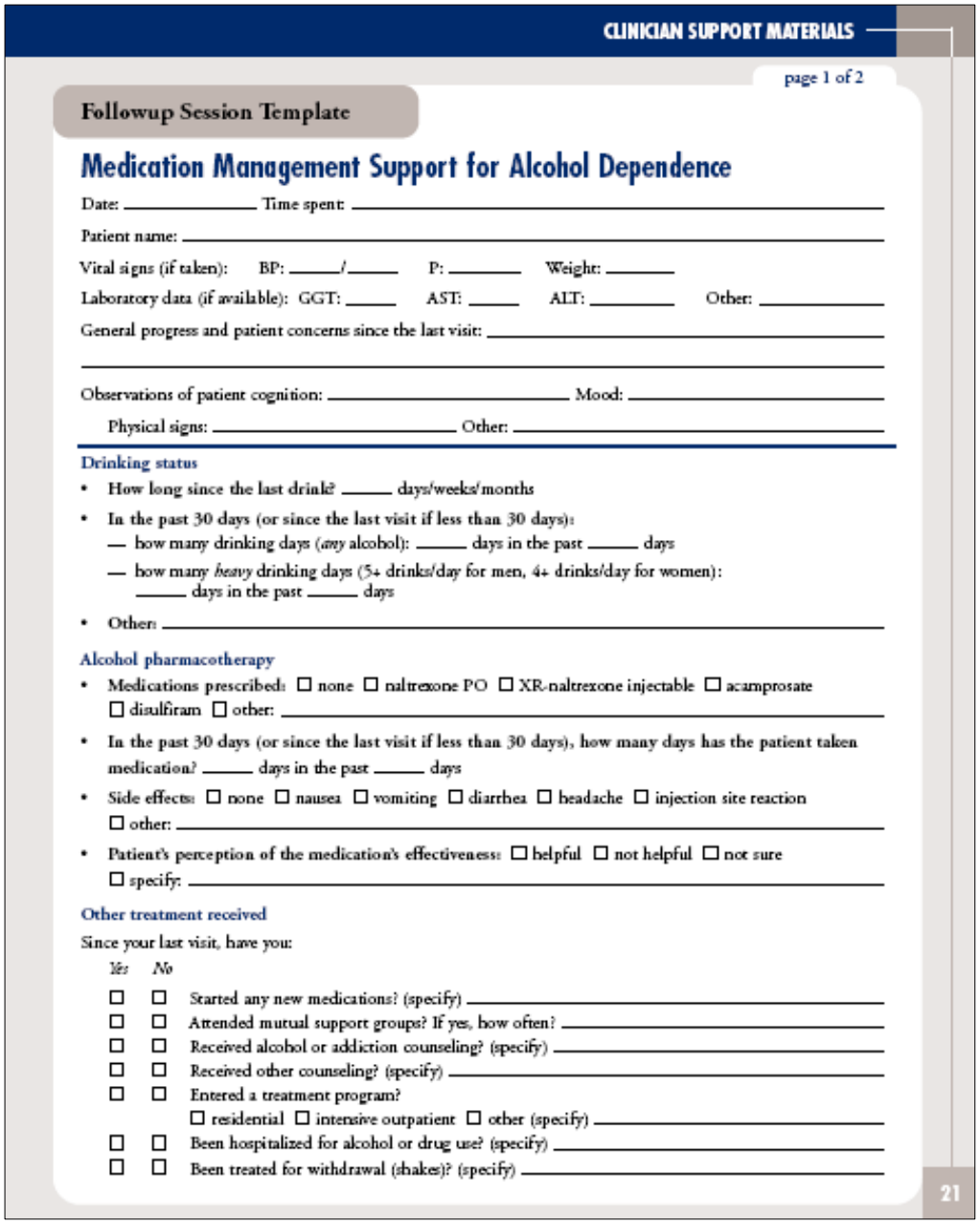
Appendix – Clinician Support Materials

*Medication Management Support for Alcohol Dependence

*Followup Session Template…….page 21-22



CLINICIAN SUPPORT MATERIALS

page 1 of 2

Followup Session Template

Medication Management Support for Alcohol Dependence

Date: _____ Time spent: _____

Patient name: _____

Vital signs (if taken): BP: ____/____ P: _____ Weight: _____

Laboratory data (if available): GGT: _____ AST: _____ ALT: _____ Other: _____

General progress and patient concerns since the last visit: _____

_____

Observations of patient cognition: _____ Mood: _____

Physical signs: _____ Other: _____

Drinking status

- How long since the last drink? _____ days/weeks/months
- In the past 30 days (or since the last visit if less than 30 days):
  - how many drinking days (*any* alcohol): _____ days in the past _____ days
  - how many *heavy* drinking days (5+ drinks/day for men, 4+ drinks/day for women): _____ days in the past _____ days
- Other: _____

Alcohol pharmacotherapy

- Medications prescribed: ☐ none ☐ naltrexone PO ☐ XR-naltrexone injectable ☐ acamprosate ☐ disulfiram ☐ other: _____
- In the past 30 days (or since the last visit if less than 30 days), how many days has the patient taken medication? _____ days in the past _____ days
- Side effects: ☐ none ☐ nausea ☐ vomiting ☐ diarrhea ☐ headache ☐ injection site reaction ☐ other: _____
- Patient's perception of the medication's effectiveness: ☐ helpful ☐ not helpful ☐ not sure ☐ specify: _____

Other treatment received

Since your last visit, have you:

Yes	*No*	
☐	☐	Started any new medications? (specify) _____
☐	☐	Attended mutual support groups? If yes, how often? _____
☐	☐	Received alcohol or addiction counseling? (specify) _____
☐	☐	Received other counseling? (specify) _____
☐	☐	Entered a treatment program? ☐ residential ☐ intensive outpatient ☐ other (specify) _____
☐	☐	Been hospitalized for alcohol or drug use? (specify) _____
☐	☐	Been treated for withdrawal (shakes)? (specify) _____

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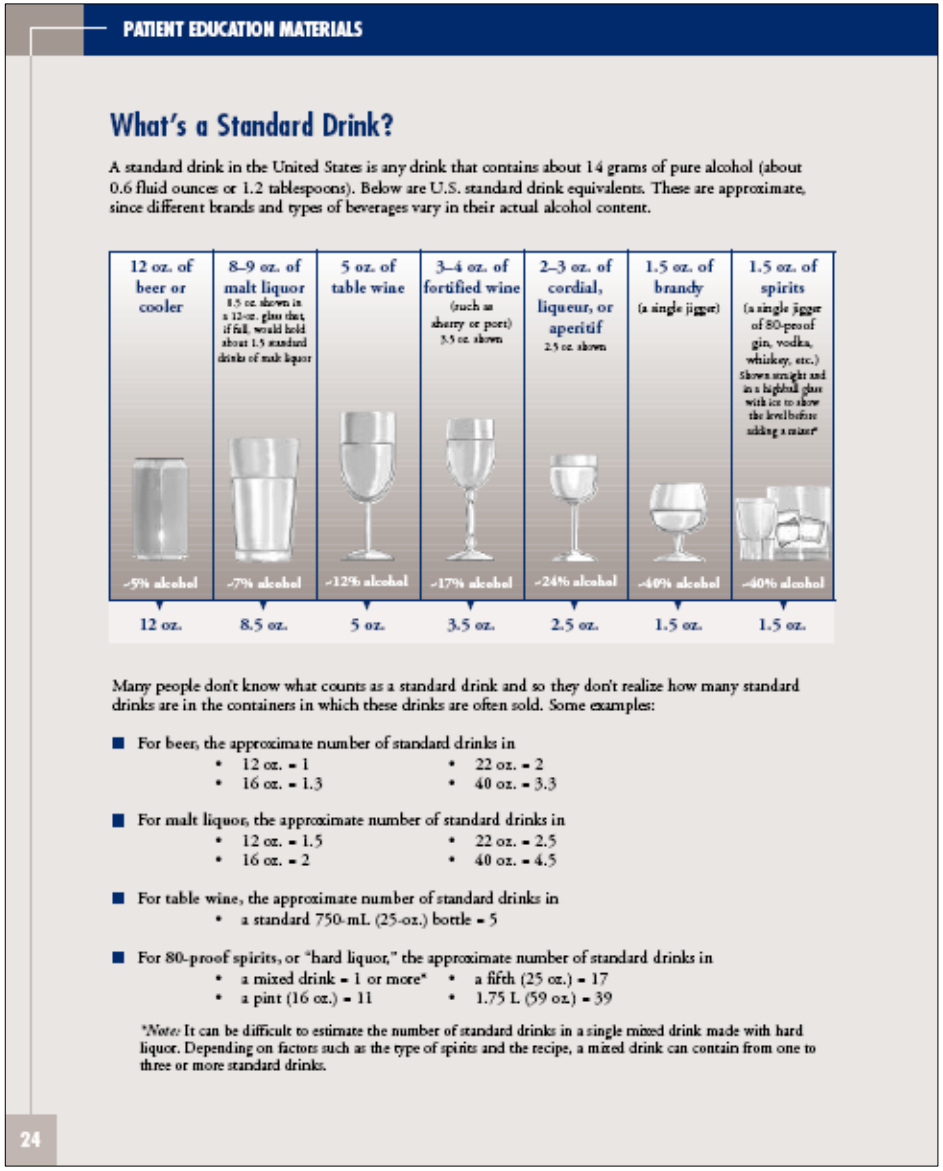
Appendix – Patient Education Support Materials

***What's a Standard Drink: page 24**



PATIENT EDUCATION MATERIALS

What's a Standard Drink?

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

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 the level before adding a mixer*
~5% alcohol	~7% alcohol	~12% alcohol	~17% alcohol	~24% alcohol	~40% alcohol	~40% alcohol
12 oz.	8.5 oz.	5 oz.	3.5 oz.	2.5 oz.	1.5 oz.	1.5 oz.

Many people don't know what counts as a standard drink and so they don't realize how many standard drinks are 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 in a single mixed drink made with hard liquor. Depending on factors such as the type of spirits and the recipe, a mixed drink can contain from one to three or more standard drinks.

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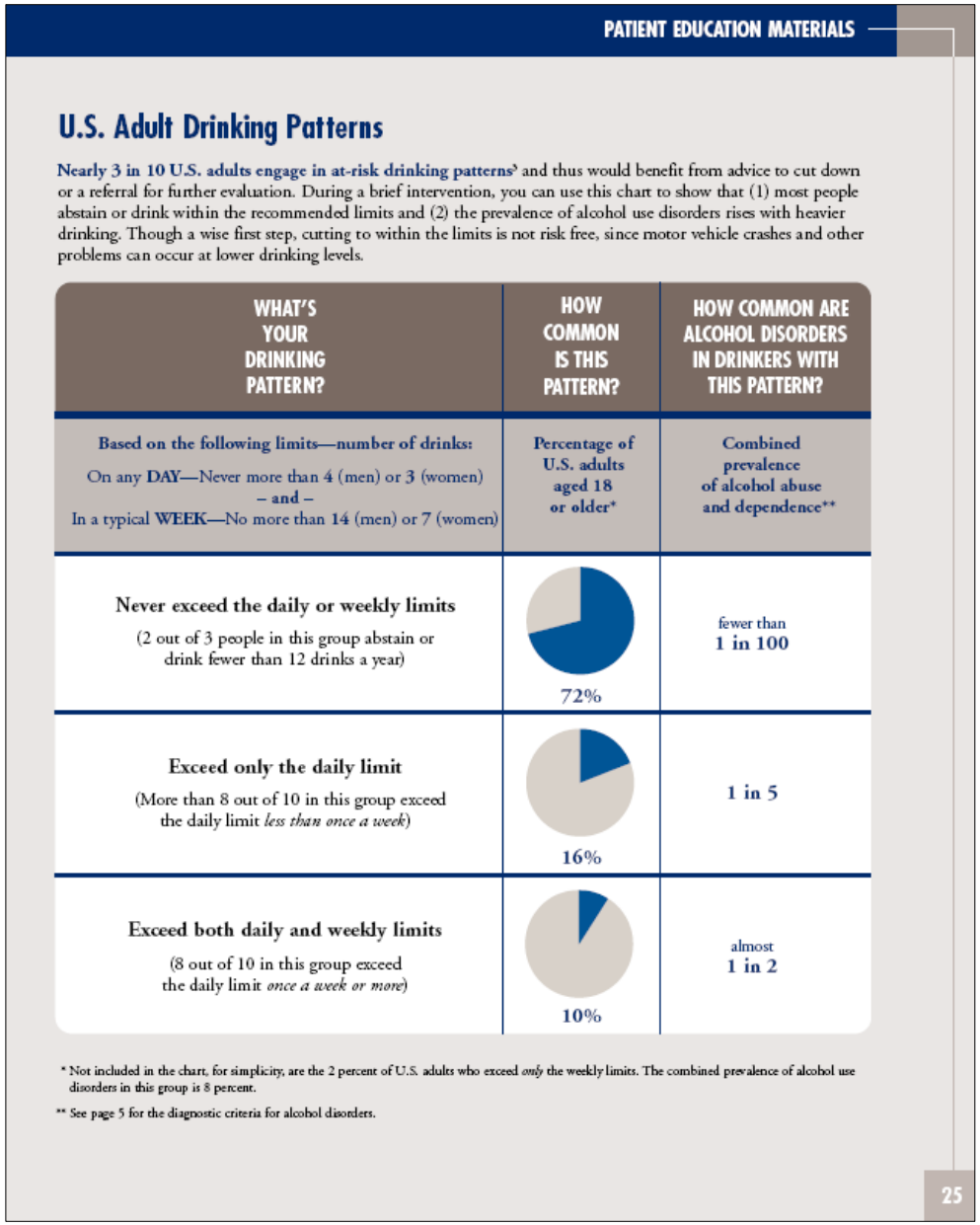
Appendix – Patient Education Support Materials

***U.S. Adult Drinking Patterns: page 25**



PATIENT EDUCATION MATERIALS

U.S. Adult Drinking Patterns

Nearly 3 in 10 U.S. adults engage in at-risk drinking patterns[1] 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'S 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%	fewer 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 page 5 for the diagnostic criteria for alcohol disorders.

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Appendix – Patient Education Support Materials

*Strategies for Cutting Down: page 26

PATIENT EDUCATION MATERIALS

Strategies for Cutting Down

Small changes can make a big difference in reducing your chances of having alcohol-related problems. Here are some strategies to try. Check off some to try the first week, and add some others the next.

☐ **Keeping track**
Keep track of how much you drink. Find a way that works for you, such as a 3x5" card in your wallet, check marks on a kitchen calendar, or a personal digital assistant. If you make note of each drink before you drink it, this will help you slow down when needed.

☐ **Counting and measuring**
Know the standard drink sizes so you can count your drinks accurately. One standard drink is 12 ounces of regular beer, 8 to 9 ounces of malt liquor, 5 ounces of table wine, or 1.5 ounces of 80-proof spirits. Measure drinks at home. Away from home, it can be hard to know the number of standard drinks in mixed drinks. To keep track, you may need to ask the server or bartender about the recipe.

☐ **Setting goals**
Decide how many days a week you want to drink and how many drinks you'll have on those days. You can reduce your risk of alcohol dependence and related problems by drinking within the limits in the box to the right. It's a good idea to have some days when you don't drink.

MAXIMUM DRINKING LIMITS FOR HEALTHY ADULTS*

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**

* Depending on your health status, your doctor may advise you to drink less or abstain.

☐ **Pacing and spacing**
When you do drink, pace yourself. Sip slowly. Have no more than one drink with alcohol per hour. Alternate "drink spacers"—nonalcoholic drinks such as water, soda, or juice—with drinks containing alcohol.

☐ **Including food**
Don't drink on an empty stomach. Have some food so the alcohol will be absorbed more slowly into your system.

☐ **Avoiding "triggers"**
What triggers your urge to drink? If certain people or places make you drink even when you don't want to, try to avoid them. If certain activities, times of day, or feelings trigger the urge, plan what you'll do instead of drinking. If drinking at home is a problem, keep little or no alcohol there.

☐ **Planning to handle urges**
When an urge hits, consider these options: Remind yourself of your reasons for changing. Or talk it through with someone you trust. Or get involved with a healthy, distracting activity. Or "urge surf"—instead of fighting the feeling, accept it and ride it out, knowing that it will soon crest like a wave and pass.

☐ **Knowing your "no"**
You're likely to be offered a drink at times when you don't want one. Have a polite, convincing "no, thanks" ready. The faster you can say no to these offers, the less likely you are to give in. If you hesitate, it allows you time to think of excuses to go along.

Additional tips for quitting

If you want to quit drinking altogether, the last three strategies can help. In addition, you may wish to ask for support from people who might be willing to help, such as a significant other or nondrinking friends. Joining Alcoholics Anonymous or another mutual support group is a way to acquire a network of friends who have found ways to live without alcohol. If you're dependent on alcohol and decide to stop drinking completely, don't go it alone. Sudden withdrawal from heavy drinking can cause dangerous side effects such as seizures. See a doctor to plan a safe recovery.

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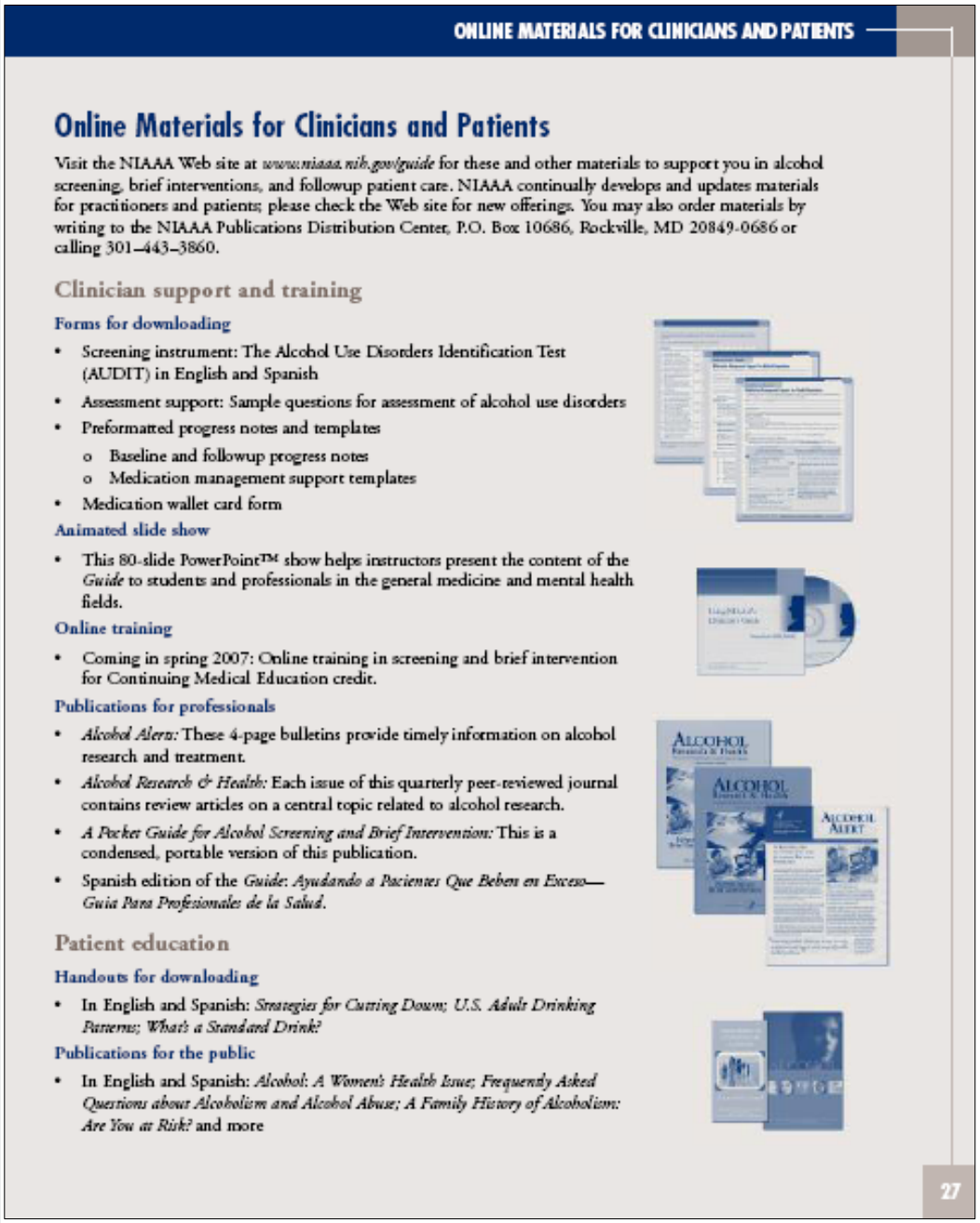

ONLINE MATERIALS FOR CLINICIANS AND PATIENTS

Online Materials for Clinicians and Patients

Visit the NIAAA Web site at *www.niaaa.nih.gov/guide* for these and other materials to support you in alcohol screening, brief interventions, and followup patient care. NIAAA continually develops and updates materials for practitioners and patients; please check the Web site for new offerings. You may also order materials by writing to the NIAAA Publications Distribution Center, P.O. Box 10686, Rockville, MD 20849-0686 or calling 301–443–3860.

Clinician support and training

Forms for downloading

- Screening instrument: The Alcohol Use Disorders Identification Test (AUDIT) in English and Spanish
- Assessment support: Sample questions for assessment of alcohol use disorders
- Preformatted progress notes and templates
  - Baseline and followup progress notes
  - Medication management support templates
- Medication wallet card form

Animated slide show

- This 80-slide PowerPoint™ show helps instructors present the content of the *Guide* to students and professionals in the general medicine and mental health fields.

Online training

- Coming in spring 2007: Online training in screening and brief intervention for Continuing Medical Education credit.

Publications for professionals

- *Alcohol Alert:* 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.
- *A Pocket Guide for Alcohol Screening and Brief Intervention:* This is a condensed, portable version of this publication.
- Spanish edition of the *Guide: Ayudando a Pacientes Que Beben en Exceso—Guia Para Profesionales de la Salud.*

Patient education

Handouts for downloading

- In English and Spanish: *Strategies for Cutting Down; U.S. Adult Drinking Patterns; What's a Standard Drink?*

Publications for the public

- In English and Spanish: *Alcohol: A Women's Health Issue; Frequently Asked Questions about Alcoholism and Alcohol Abuse; A Family History of Alcoholism: Are You at Risk?* and more

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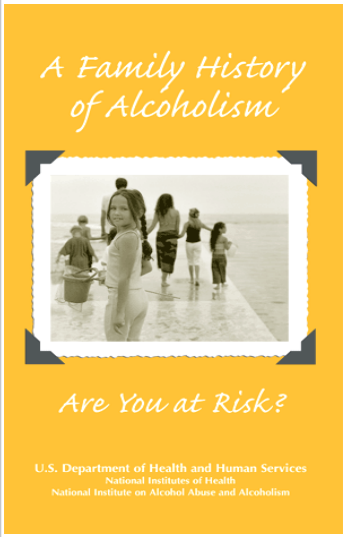
Appendix – Online Materials

*Visit NIAAA's Web site www.niaaa.nih.gov/guide for other materials to support alcohol screening, brief interventions, and followup patient care.

*Check the Website for updates.

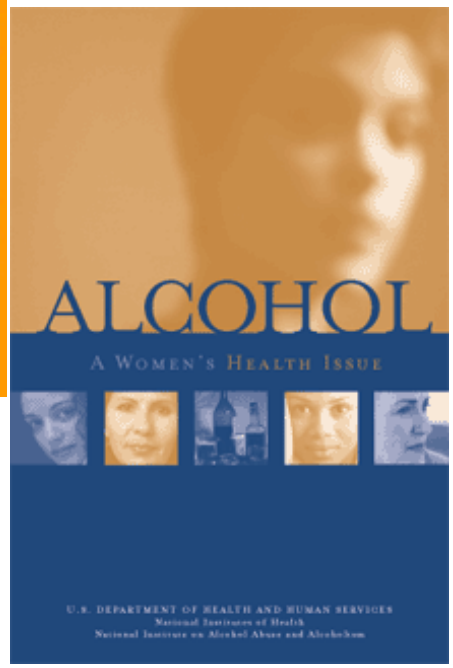
*Order materials by phone or mail

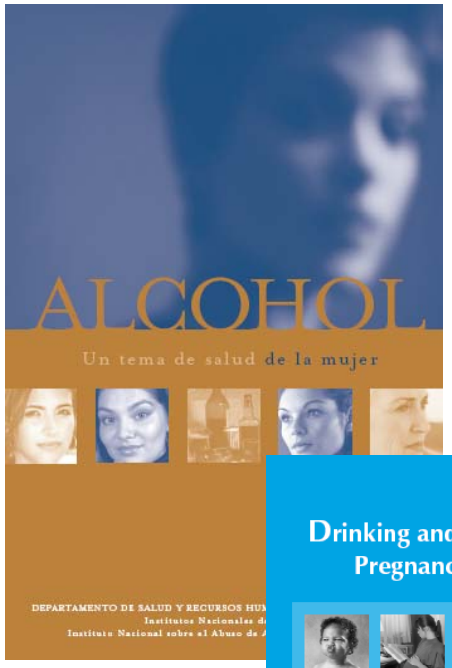
Examples of Free Patient Education Materials from NIAAA – in English and Spanish



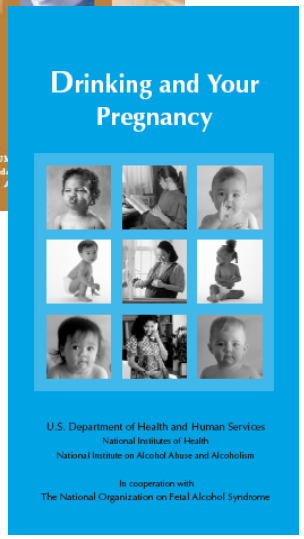
A Family History of Alcoholism: Are You at Risk?

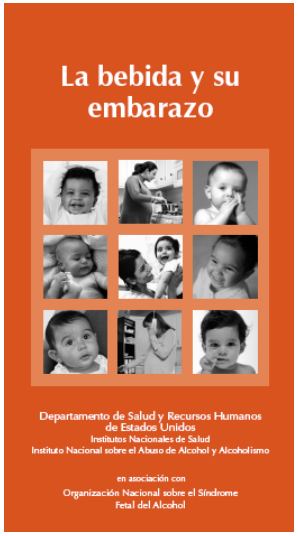
Alcohol: A Women's Health Issue





Drinking and Your Pregnancy





FREQUENTLY ASKED QUESTIONS

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 care practitioners when appropriate methods are used.[6,15] 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.[28,29] 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.[15]

■ **With the single interview question, screening is positive with just one heavy drinking day in the past year. Isn't that casting a very broad net?**
A common reaction to the screening question is, "Everybody's going to meet this, at least occasionally." A large national survey by NIAAA, however, showed that nearly three-fourths of U.S. adults never exceed the limits in the screening question.[3] Even if patients report that they only drink heavily on rare occasions, screening provides an opportunity to educate them about safe drinking limits so that heavy drinking doesn't become more frequent. The risk for alcohol-related problems rises with the number of heavy drinking days,[1] and some problems, such as driving while intoxicated or trauma, can occur with a single occasion.

■ **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 aren't dependent. In several intervention trials with multiple brief contacts, for example, heavy drinkers cut an average of three to nine drinks per week, for a 13 to 34 percent net reduction in consumption.[30] Even relatively modest reductions in drinking can have important health benefits when spread across a large number of people. Brief intervention trials have also reported significant decreases in blood pressure readings, levels of gamma-glutamyl transferase (GGT), psychosocial problems, hospital days, and hospital readmissions for alcohol-related trauma.[8] Followup periods typically range from 6 to 24 months, although one recent study reported sustained reductions in alcohol use over 48 months.[8] 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.[9,10]

■ **What can I do to encourage my patients to give honest and accurate answers to the screening questions?**
It's 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's a Standard Drink?" chart on page 24. Many people are surprised to learn what counts as a single standard drink, especially for beverages with a higher alcohol content such as malt liquors, fortified wines, and spirits. The chart also lists the number of standard drinks in commonly purchased beverage containers. In some situations, you may consider adding the questions "How often do you buy alcohol?" and "How much do you buy?" to help build an accurate estimate.

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The Guide provides answers to important Frequently Asked Questions regarding…

* **Screening and brief interventions**
* **Drinking levels and advice**
* ***Diagnosing and helping patients with AUDs**

For example…

Frequently Asked Questions

About alcohol screening and brief interventions

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How effective are brief interventions?

When should I recommend abstaining versus cutting down?

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

■ **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[31] 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.[32] 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 everyone with an alcohol use disorder reports 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 by or exacerbated by drinking
- 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 don't have an alcohol use disorder, use professional judgment to determine whether cutting down or abstaining is more appropriate, based on factors such as these:

℞ 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, nonopioid 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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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 care practitioners when appropriate methods are used.[6,15] 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.[28,29] 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.[15]

- **With the single interview question, screening is positive with just one heavy drinking day in the past year. Isn't that casting a very broad net?**
  A common reaction to the screening question is, "Everybody's going to meet this, at least occasionally." A large national survey by NIAAA, however, showed that nearly three-fourths of U.S. adults never exceed the limits in the screening question.[3] Even if patients report that they only drink heavily on rare occasions, screening provides an opportunity to educate them about safe drinking limits so that heavy drinking doesn't become more frequent. The risk for alcohol-related problems rises with the number of heavy drinking days,[1] and some problems, such as driving while intoxicated or trauma, can occur with a single occasion.

- **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 aren't dependent. In several intervention trials with multiple brief contacts, for example, heavy drinkers cut an average of three to nine drinks per week, for a 13 to 34 percent net reduction in consumption.[30] Even relatively modest reductions in drinking can have important health benefits when spread across a large number of people. Brief intervention trials have also reported significant decreases in blood pressure readings, levels of gamma-glutamyl transferase (GGT), psychosocial problems, hospital days, and hospital readmissions for alcohol-related trauma.[8] Followup periods typically range from 6 to 24 months, although one recent study reported sustained reductions in alcohol use over 48 months.[8] 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.[9,10]

- **What can I do to encourage my patients to give honest and accurate answers to the screening questions?**
  It's 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's a Standard Drink?" chart on page 24. Many people are surprised to learn what counts as a single standard drink, especially for beverages with a higher alcohol content such as malt liquors, fortified wines, and spirits. The chart also lists the number of standard drinks in commonly purchased beverage containers. In some situations, you may consider adding the questions "How often do you buy alcohol?" and "How much do you buy?" to help build an accurate estimate.

How should alcohol withdrawal be managed?

Are laboratory tests available to screen for or monitor alcohol problems?

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

■ **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[31] 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?**

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NIAAA also offers a condensed Pocket Guide

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A POCKET GUIDE FOR

Alcohol Screening and Brief Intervention

Updated 2005 Edition

This pocket guide is condensed from the 34-page NIAAA guide, *Helping Patients Who Drink Too Much: A Clinician's Guide.*

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HOW TO SCREEN FOR HEAVY DRINKING

STEP 1 Ask About Alcohol Use

Ask: Do you sometimes drink beer, wine, or other 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? ☐
  - 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:

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

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:

- ☐ not been able to cut down or stop (repeated failed attempts)
- ☐ not been able to stick to drinking limits (repeatedly gone over them)
- ☐ 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)
- ☐ kept drinking despite problems (recurrent physical or psychological problems)
- ☐ 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)

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. (See *www.niaaa.nih.gov/guide.*)

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, including medication management support if needed.

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—medical and psychiatric—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—medical and psychiatric—as needed.

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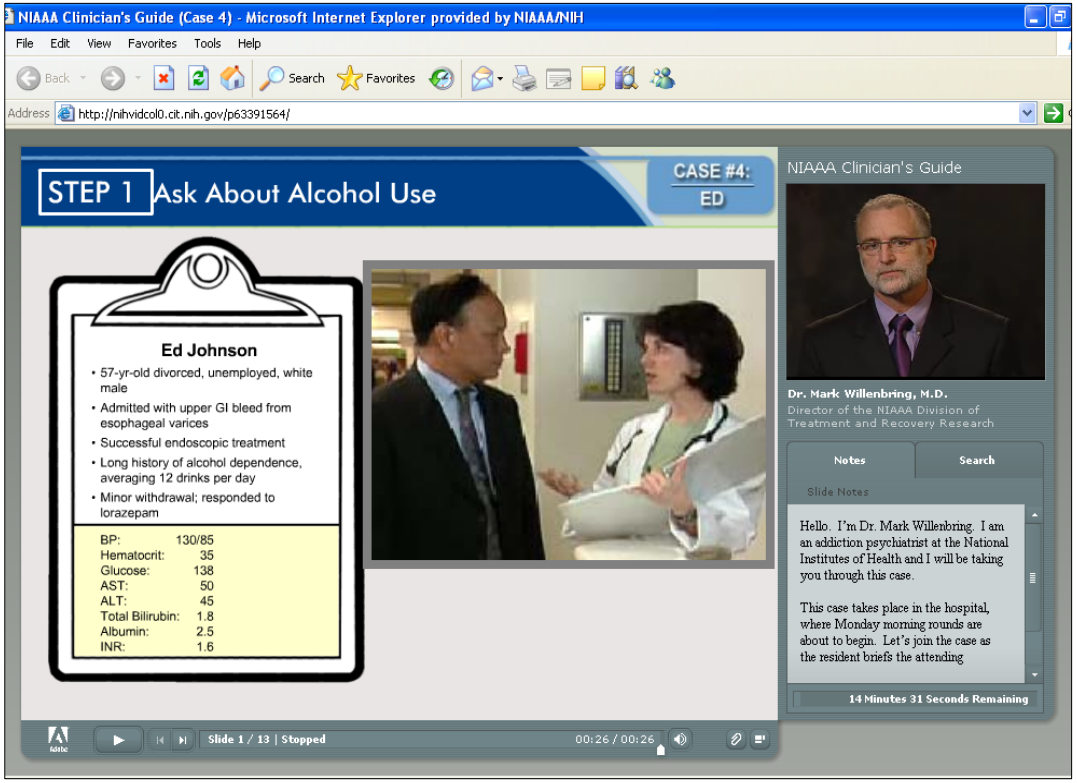

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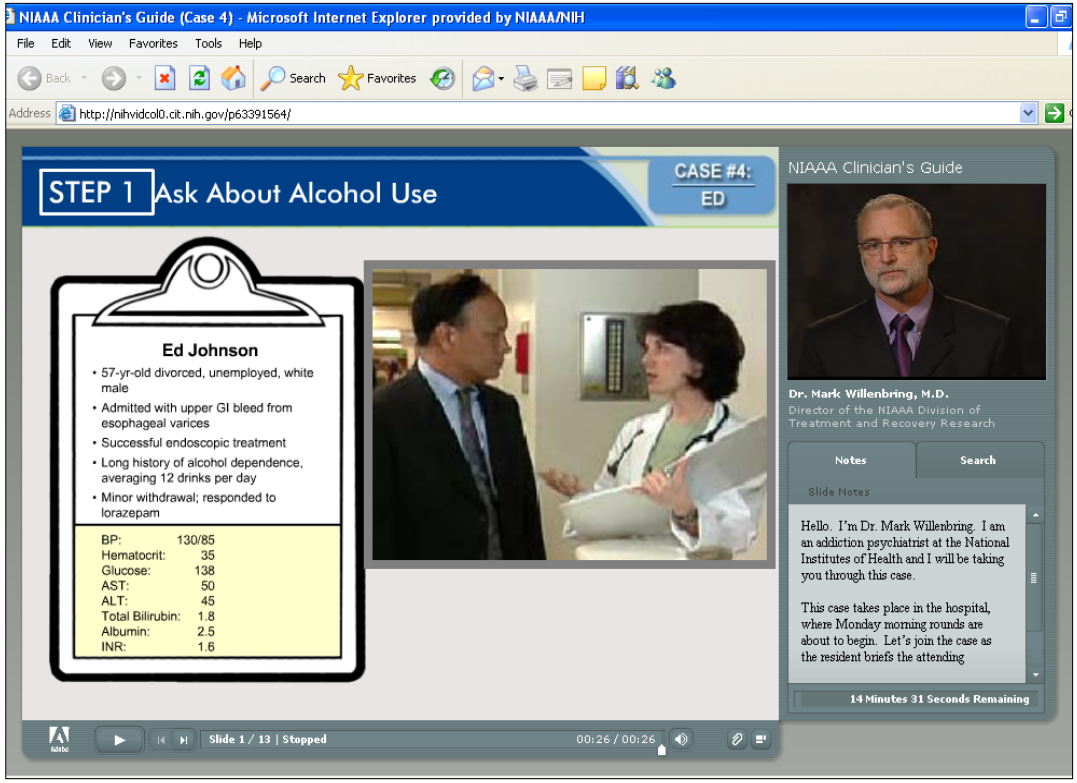

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