CME Activity Inside and Online

City Health Information

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BRIEF INTERVENTION FOR ALCOHOL PROBLEMS

Primary care providers can identify and help people with problem drinking.

1. **Ask every patient about alcohol using a simple 4-question screening tool (CAGE-AID).**
2. **For patients with unhealthy drinking levels, provide clear, personalized advice about cutting down or abstaining.**
3. **Set mutually acceptable goals – involve your patient.**
4. **Offer advice, information, and treatment referrals. Prescribe medication if indicated.**
5. **Provide regular follow-up to support efforts to reduce or stop drinking.**

While most adults drink safely or not at all, alcohol problems are common. Every year, about 25,000 New Yorkers are hospitalized and more than 1,500 die from alcohol-related injuries and illnesses.[1]

Alcohol abuse leads to motor vehicle crashes and other preventable injuries. It also contributes to social problems, including poor work or school performance and family, financial, or legal difficulties. Excessive drinking causes or complicates illnesses and conditions including chronic headaches, gastrointestinal disorders, infections, liver and heart disease, cancer, and psychiatric problems.

Alcohol use in pregnancy can cause miscarriage, premature birth, and developmental impairments including fetal alcohol syndrome. Alcohol use also increases sexual risk-taking, fueling the spread of HIV and other sexually transmitted infections.

An estimated 15% of adult New Yorkers – nearly 900,000 people – report excessive drinking.[1] Few consult alcohol treatment specialists, but most (about 70%) see a physician regularly. Therefore, each medical visit is an opportunity to reduce problem drinking.[2]

USE BRIEF INTERVENTION

Brief intervention is a counseling technique that helps patients reduce risky behavior. It can be used in many health care settings including primary care, pediatrics and adolescent medicine, family medicine, student health centers, psychiatric and social services, emergency departments, and trauma centers.

Compelling evidence supports the effectiveness of brief intervention. Some studies suggest that it may be as effective as specialized treatment for patients who drink heavily.[2-5]

This publication features a 5-step version of brief intervention. In a 5- to 10-minute office visit, clinicians can help their patients reduce drinking. This issue includes:

- Short, evidence-based screening instruments (2 for adults, one for adolescents) (**Tables 1 and 2**);
- Recommendations for special populations including pregnant women, children and adolescents, and older adults (**Table 3**);
- Patient education materials (**Resources**).

Brief counseling can also:

- Improve adherence to treatment for illnesses such as asthma, hypertension, diabetes, HIV, cancer, and depression;[2-5]
- Identify alcohol-dependent people who could benefit from specialized treatment.

TAKE CARE NEW YORK

Brief Intervention: 5 Steps

1. Healthy or unhealthy drinking?

Ask every patient, including adolescents and seniors, about alcohol use as part of routine health care, and/or when you suspect an alcohol problem.

Be direct and non-judgmental. Ask all patients regardless of age, gender, race/ethnicity, pregnancy, health status, or income:

"Over the course of a week, about how many drinks (beer, wine, liquor) do you have?"

"On the days you drink, how many drinks do you usually have?"

What Is "One Drink?"[2]

Each of the following contains about 0.6 fluid oz. (14 g) of pure alcohol and is considered one drink.

Beer or wine cooler	12 oz glass, bottle, or can
Malt liquor	8.5 oz glass, bottle, or can
Table wine	5 oz glass
Fortified wine (eg, port, sherry)	3.5 oz glass
Cordial, liqueur or aperitif	2.5 oz glass
Distilled spirits, brandy	1.5 oz "shot"

Adapted from: National Institute on Alcohol Abuse and Alcoholism

Screening and Brief Interventions for Alcoholism*

SCREEN:

Routinely ask about alcohol use:

- Assess total drinks during a usual week
- Assess average drinks per occasion

USE SCREENING INSTRUMENTS TO PROBE FOR ALCOHOL PROBLEMS (Tables 1 and 2).

SCREEN IS POSITIVE IF:

- Consumption is > 14 drinks/week or > 4 drinks/occasion (men)
- Consumption is > 7 drinks/week or > 3 drinks/occasion (women)

Or

- AUDIT-C ≥ 3 (for women) or ≥ 4 (for men) or CAGE-AID ≥ 1 or CRAFFT ≥ 2

THEN ASSESS FOR:

- **Medical problems:** blackouts, depression, hypertension, trauma, abdominal pain, liver dysfunction, sexual problems, sleep disorders
- **Laboratory:** elevated gamma glutamyl transpeptidase (GGTP) or other liver enzymes, elevated mean corpuscular volume (MCV), and blood alcohol concentration (BAC)
- **Behavioral problems:** work, family, school, accidents
- **Alcohol dependence:** 3+ on CAGE-AID (**Table 2**) or one or more of: compulsion to drink, impaired control, withdrawal symptoms, increased tolerance, relief drinking

GIVE SPECIFIC FEEDBACK TO PATIENT, THEN ADVISE — BE FIRM BUT EMPATHIC:

If diagnosed as at risk:

- Advise patient of risk
- Advise abstinence/moderation
- Set drinking goals
- Schedule follow-up to discuss progress

If diagnosed as alcohol dependent:

- Advise patient of objective evidence
- Assess acute risk of intoxication/withdrawal
- Assess medical/psychiatric comorbidities
- Advise/agree on plan of action (below)

PLAN OF ACTION:

- Refer the patient to an addiction medicine specialist for formal assessment and development of a treatment plan.
- Educate the patient, significant others, and family about the nature of addiction, the effectiveness of treatment, and the prospects for recovery.
- Remain engaged in care of the patient by addressing medical issues as needed and supporting the patient's commitment to the treatment process.

*Reprinted and adapted with permission from the American Society of Addiction Medicine (ASAM), Inc. For further information consult ASAM's *Principles of Addiction Medicine,* Third Edition, 2003, and the National Institute on Alcohol Abuse and Alcoholism's Pocket Guide, Alcohol Screening and Brief Intervention: pubs.niaaa.nih.gov/publications/Practitioner/PocketGuide/pocket_guide.htm

Ask how much and how often. Moderate drinking levels generally considered healthy for most adults[2] are defined as:

Men: No more than 4 drinks on a single occasion, and no more than 14 drinks/week.

Women and people over 65: No more than 3 drinks on a single occasion and no more than 7 drinks/week.

Also ask about binge drinking, especially in young adults. Binge drinking is defined as 5-6 or more drinks on one occasion in the past year. The 3-question Alcohol Use Disorders Identification Test-C (AUDIT-C) has high sensitivity and specificity for identifying high-risk drinking (**Table 1**).[6]

Assess current drinkers with a rapid screening instrument (**Table 2**). No amount of alcohol is considered safe for women who are pregnant or planning pregnancy, people under 21, anyone driving or operating heavy machinery, and people with a history of alcohol dependence. Other populations (adults 65 and older, people taking certain medications, and people with a family history of alcoholism) should be advised that if they consume alcohol, they should do so with caution (**Table 3**).

If you suspect a patient is drinking heavily despite denials, elevated laboratory tests for markers such as gamma glutamyl transpeptidase (GGTP) can indicate recent heavy alcohol consumption.[7,10]

Table 1. Alcohol Use Disorders Identification Test-C (AUDIT-C)[6]

1. How often did you have a drink containing alcohol in the past year?

Never = 0
Monthly or less = 1
2 to 4 times per month = 2
2 to 3 times per week = 3
4 or more times per week = 4

2. How many drinks did you have on a typical day when you were drinking in the past year?

1 or 2 = 0
3 or 4 = 1
5 or 6 = 2
7 to 9 = 3
10 or more = 4

3. How often did you have 6 or more drinks on one occasion during the past year?

Never = 0
Less than monthly = 1
Monthly = 2
Weekly = 3
Daily or almost daily = 4

The AUDIT-C is scored on a scale of 0–12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.

Table 2. CAGE-AID (Adapted to Include Drugs) AND CRAFFT

CAGE-AID can be used to screen for both alcohol and drug-related problems; this publication refers to CAGE-AID throughout, but only addresses alcohol problems.

CAGE-AID for adults[8]

Have you ever:

1. Thought you should…	**C**ut down on your drinking or drug use?
2. Become…	**A**nnoyed when people criticized your drinking or drug use?
3. Felt bad or…	**G**uilty about your drinking or drug use?
4. Needed an…	**E**ye-opener drink or used a drug to feel better in the morning?
YES to 1 or 2 questions =	Possible alcohol/drug use problem
YES to 3 or 4 questions =	Probable alcohol/drug dependence

CRAFFT for adolescents[7,9]

1. Did you ever ride in a…	**C**ar driven by someone (including you) who was using alcohol?
2. Do you ever drink to…	**R**elax, feel better, or fit in?
3. Do you ever drink…	**A**lone?
4. Do you ever…	**F**orget what you do when you drink?
5. Does your drinking worry…	**F**amily or friends?
6. Have you ever gotten in…	**T**rouble while using alcohol?
YES to 2 questions =	Possible alcohol problem

Table 3. Pregnancy, Age, Medication and Family History: Recommendations for Certain Populations

Population	Problems	Recommendation
Women who are pregnant or planning pregnancy[11,12]	• Reproductive problems associated with alcohol include infertility, increased risk of miscarriage, and impaired fetal growth and development. • Every year, more than 40,000 infants in the US are born with alcohol-related problems ranging from mild learning and behavior problems to growth deficiencies and severe mental and physical impairment. • Some women are not aware of these risks, while others drink before they realize they're pregnant. Because safe limits in pregnancy have not been established, the best course is no alcohol at all.	No alcohol
Children and adolescents[13,14] *To screen for current and future substance abuse risk, the American Academy of Pediatrics recommends a routine, age-appropriate psychosocial history beginning at age 8.*	• Substance abuse can start at a very young age. • Adolescent substance abuse may be the most commonly missed pediatric diagnosis. • Nearly half of 8th graders in the US have had at least 1 drink, and 1 in 5 have been drunk. • About a third of high school seniors have engaged in binge drinking (5–6 or more drinks on a single occasion) at least once. • In addition to being illegal, underage drinking poses serious health risks: motor-vehicle crashes, increased risk of sexually transmitted diseases, vulnerability to alcohol-related brain damage, and an increased likelihood of alcohol dependence and drug addiction in adulthood.	No alcohol
Older adults[2]	• Lower limits for older adults are recommended for several reasons, including less efficient liver metabolism, loss of lean body mass, and a higher likelihood of adverse alcohol-medication reactions. • Even at low drinking levels, older adults are more likely to experience impaired motor skills, making driving especially dangerous. • Sleep disorders and the risk of injury, including falls, increase in elderly people who drink. • Excessive drinking raises the risk of stroke.	Caution. No alcohol for those who are frail or taking certain medications.
People taking certain medications[15,16]	• Alcohol can cause adverse reactions with hundreds of prescription, over-the-counter, and herbal medications. • Chronic alcohol use can make acetaminophen toxic even in standard therapeutic amounts. • Combining alcohol with opioids, such as heroin or narcotic analgesics, enhances the sedative effects of both, increasing the risk of death from overdose. • Adverse reactions vary widely among individuals for many reasons including age, gender, drinking patterns, and genetics. Always ask about alcohol use before prescribing medication.	No alcohol/caution
People with a family history of alcoholism[17]	• People with a family history of alcoholism are more vulnerable than others to alcohol problems. • Research suggests that at least half of the risk for alcoholism may be genetically determined. • Like diabetes and heart disease, alcoholism is genetically complex (many genes may play a role), so individual risk is hard to predict.	Caution

2. For patients with unhealthy drinking levels, provide clear, personalized advice to cut down or abstain.

Listen reflectively – summarize and repeat what your patient says. Show concern and avoid confrontation – be on your patient's side. When possible, link alcohol use to a specific medical condition:

"Your blood tests show liver damage from alcohol."

"I think drinking is making your depression worse."

"When people forget what they did while drinking, it's called a blackout. Blackouts are almost always a sign of an alcohol problem."

"Your drinking level would be fine if you weren't trying to become pregnant."

Give clear, personalized advice to cut down or abstain:

"Even one drink a day can cause liver damage in people with hepatitis C. It's important for your health that you stop drinking. Are you willing to give it a try?"

"This medicine can be dangerous if taken with alcohol. You'll need to stop drinking while you're on it."

"Your father died early of a stroke. You'll be at much less risk of an early stroke if you cut down on drinking."

"There is no safe level of drinking when you're pregnant. Some babies are born with problems even when their mothers drink just a little."

3. Set mutually acceptable goals — involve your patient.

Patients may be unwilling to abstain from drinking completely, but may agree to reduce alcohol consumption.

"For the next 30 days, would you be willing to try to limit yourself to 2 drinks a day?"

"Alcoholics Anonymous has helped many of my patients. There are hundreds of meetings in New York City – how would you feel about checking out a meeting?"

"I'd like you to keep track of your drinking in a notebook, and bring it with you next time so we can look at it together."

4. Offer advice, information, and treatment referrals.

Help patients identify drinking triggers and practical ways to cope. Common triggers include job stress, money worries, chronic illness, family problems, depression, anxiety, and social isolation.

"Stressful situations can sometimes trigger drinking urges. Let's talk about some ways to avoid them or deal with them differently."

Provide patient education materials and resources. For reinforcement, give your patients informational literature on alcohol use and its associated problems, how to cut down or abstain, and support services and networks (**Resources**).

While most patients with alcohol abuse can be treated effectively by their primary care provider, many alcohol-dependent people need specialized care. Patients who have a history of alcohol withdrawal seizures or delirium tremens may require a brief hospitalization for detoxification. Many alcohol-dependent patients will benefit from referral to specialized chemical dependency services, such as outpatient, rehabilitation, residential programs, or self-help groups such as Alcoholics Anonymous (AA) (**Resources**).

"This treatment program is covered by your insurance. We can make an appointment for you now if you want."

Three medications that can help alcohol-dependent patients abstain from or reduce their use of alcohol have been approved for the treatment of alcohol dependence (**Table 4**). If appropriate, **naltrexone, acamprosate,** and **disulfiram** should be prescribed as an adjunct to participation in a self-help group or other psychosocial treatments.

"Some people find that certain medications help them stop drinking. We can make an appointment with a specialist to see if these medications might help you."

Don't give up on patients who refuse referral. Don't be discouraged, and don't shame or blame. The decision to stop often takes time.

"I hope you'll read this booklet and call one of the numbers I gave you. Or just come back and talk. When you're ready, we can help."

5. Provide regular follow-up to support efforts to reduce or stop drinking.

Three or 4 follow-up visits (or a combination of visits and phone support) increase the effectiveness of brief intervention.[3] Brief counseling may be further reinforced by visits with or phone calls from health educators, nurse practitioners, physician assistants, alcohol counselors, and others.

Table 4. Medications for Treating Alcohol Dependence*†[2]

	Usual Dosage	Action	Contraindications	Precautions	Serious Adverse Reactions	Comments
Naltrexone (ReVia®)	• 50 mg daily • Establish opioid abstinence before prescribing	• Blocks opioid receptors • Reduces alcohol craving • Reduces reward in response to drinking	• Current opioid use • Acute opioid withdrawal • Anticipated need for opioid analgesics • Acute hepatitis or liver failure	• Other hepatic disease • Renal impairment • History of suicide attempts	• Severe withdrawal if patient is opioid-dependent • Hepatoxicity at large doses (monitor liver enzyme tests periodically)	• Opioid antagonist • Can reduce chance of relapse into heavy drinking[18]
Naltrexone* (Vivitrol®)	• 380 mg IM every 4 weeks in the buttocks, alternating every month	• Blocks opioid receptors • Reduces alcohol craving • Reduces reward in response to drinking	• Acute hepatic or renal impairment • Patients receiving opiate analgesics	• Other hepatic disease • Renal impairment • History of suicide attempts	• Eosinophilic pneumonia • Patients allergic to polylactide-co-glycolide (PLG) or carboxy-methylcellulose	• Opioid antagonist • Can reduce chance of relapse into heavy drinking[18]
Acamprosate (Campral®)	• 666 mg (two 333 mg tablets) 3x/day • For patients with moderate renal impairment, reduce to 333 mg (one tablet) 3x/day • Some indication for increased efficacy after detoxification	• Reduces unpleasant symptoms associated with protracted alcohol abstinence • Alcohol-related action is unclear	• Severe renal impairment	• Moderate renal impairment • Depression or suicidality	• Anxiety • Depression • Rarely: suicide attempts, acute kidney failure, heart failure, or other acute cardiovascular symptoms	• Helps maintain alcohol abstinence[19]
Disulfiram (Antabuse®)	• 250 mg daily (range: 125–500 mg) • Warn patient against any alcohol consumption or use of products containing alcohol (eg, perfumes, colognes)	• Causes unpleasant reactions with alcohol (flushing, sweating, nausea, tachycardia)	• Continued alcohol use (including medications and foods containing alcohol) • Use of metronidazole • Coronary artery disease • Severe myocardial disease	• High impulsivity (more likely to drink while using it) • Psychoses (current or history) • Diabetes mellitus • Epilepsy • Hepatic dysfunction • Hypothyroidism • Renal impairment • Rubber/latex contact dermatitis	• Hepatitis (monitor liver enzyme tests periodically) • Optic neuritis • Peripheral neuropathy • Psychotic reactions	• Can help patients remain abstinent when administered in supervised setting[20] • Effectiveness limited in patients who are unsupervised[19]

*Adapted with modifications from 2005 National Institute of Alcohol Abuse and Alcoholism Guidelines.[2]
†Patients who need acute pain management will need regional analgesia and sedation with benzodiazepines.
NOTE: Benzodiazepines are not a treatment for alcohol dependence, but are the preferred treatment for acute alcohol withdrawal. Patients physically dependent on alcohol may require a closely supervised benzodiazepine taper over 3–7 days to reduce alcohol withdrawal symptoms and prevent delirium tremens, depending on the patient's level of dependence and response to the medication. Hospitalization is often required, but some patients can be safely detoxified from alcohol on an outpatient basis under close supervision and monitoring. Psychosocial treatment for alcohol dependence should begin during or immediately following supervised withdrawal.[21]
Use of brand names is for informational purposes only and does not imply endorsement by the New York City Department of Health and Mental Hygiene.

Resources

Treatment Referrals:

LIFENET
Telephone interpretation in 170 languages
- English: 800-LIFENET (800) 543-3638
- Spanish: 877-AYUDESE (877) 298-3373
- Chinese: (Asian LifeNet) (877) 990-8585
- Other languages: (800) 543-3638 (ask for an interpreter)
- TTY (hearing-impaired): (212) 982-5284
- Or call 311 and ask for LIFENET

New York State Office of Alcoholism and Substance Abuse (OASAS): (800) 522-5353 or www.oasas.state.ny.us

American Society of Addiction Medicine (ASAM)
(301) 656-3920 or www.asam.org

12-Step/Self-Help Groups:

Alcoholics Anonymous (AA)
(212) 870-3400
www.alcoholics-anonymous.org

Narcotics Anonymous (NA)
(212) 929-6262
www.nycasc.org

Support for Families and Friends:

The Greater NY Al-Anon Family Intergroup, Inc
350 Broadway, Suite 404
New York, NY 10013
(212) 941-0094 or www.nycalanon.org
e-mail: intergroup@nycalanon.org

Intergrupal Hispano de Al-Anon y Al-Teen (Spanish)
P.O. Box 231376
New York, NY 10023
(800) 939-2770 or www.nycalanon.org/meetings/espanol.html

Online Treatment Locator

Substance Abuse and Mental Health Services Administration (SAMHSA) National Drug and Alcohol Treatment Referral Routing Service
(800) 662-HELP (4357) or www.findtreatment.samhsa.gov

28-day Addiction Treatment Centers:

- **Brooklyn**
  Kingsboro Addiction Treatment Center
  754 Lexington Avenue
  Brooklyn, NY 11221
  (718) 453-3200
- **Bronx**
  Bronx Addiction Treatment Center
  1500 Waters Place, Building 13
  Bronx, NY 10461-2723
  (718) 904-0026
- **Manhattan**
  Manhattan Addiction Treatment Center
  Meyer Building, 11th Floor
  600 East 125th Street, Wards Island
  New York, NY 10035
  (646) 672-6120
- **Queens**
  Creedmoor Addiction Treatment Center
  Building #19 – CBU, 15 80-45 Winchester Blvd.
  Queens Village, NY 11427
  (718) 264-3740
- **Staten Island**
  South Beach Addiction Treatment Center
  Building 1, 2nd Floor, 777 Seaview Avenue
  Staten Island, NY 10305-3499
  (718) 667-2551

PATIENT EDUCATION

New York City Department of Health and Mental Hygiene
Health Bulletin: Alcohol – Risks and Benefits
www.nyc.gov/html/doh/downloads/pdf/public/dohmhnews2-05.pdf (English)
www.nyc.gov/html/doh/downloads/pdf/public/dohmhnews2-05-sp.pdf (Spanish)

National Institute on Alcohol Abuse and Alcoholism
English Language Pamphlets/Brochures/Posters
www.niaaa.nih.gov/Publications/PamphletsBrochuresPosters/English/default.htm

GUIDELINES FOR ALCOHOL TREATMENT

National Institute on Alcohol Abuse and Alcoholism
Helping Patients Who Drink Too Much: A Clinician's Guide
pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm

U.S. Preventive Services Task Force Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse: Recommendation Statement, 2004.
www.aafp.org/afp/20040715/us.html

American Medical Association
Screening and Brief Interventions for Alcohol Problems
www.ama-assn.org/ama1/pub/upload/mm/443/csai-99.pdf

Center for Substance Abuse Treatment
Brief Interventions and Brief Therapies for Substance Abuse
ncadi.samhsa.gov/govpubs/BKD341

American Society of Addiction Medicine Screening for Addiction in Primary Care Settings. Public Policy Statement, 2006. Go to www.asam.org and type the title in "Search."

Advances in Pharmacotherapy for Alcohol Dependence
www.extendmed.com/alcoholdependence2

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CME Activity Brief Intervention for Alcohol Problems

1. **All of the following statements about the consequences of excessive alcohol use are correct EXCEPT:**
   A. Every year, about 25,000 adult New Yorkers are hospitalized and more than 1,500 die from alcohol-related injuries and illnesses.
   B. Excessive alcohol use can lead to an increased risk for HIV and other sexually transmitted infections by contributing to sexual risk-taking.
   C. Excessive alcohol use can cause or worsen liver and heart disease, cancer, and psychiatric problems.
   D. Excessive drinking does not affect the treatment outcome for illnesses like headache, infections, or cancer.
2. **All of the following statements about brief intervention for alcohol problems are correct EXCEPT:**
   A. Health providers can help their patients reduce risky drinking behavior by performing a brief intervention.
   B. Health providers should ask all patients about their alcohol use.
   C. Men who average more than 14 drinks per week and women who average more than 7 drinks per week may be drinking excessively.
   D. Alcohol problems can usually be addressed in a single office visit; follow-up is not necessary.
3. **All of the following statements related to alcohol use in pregnancy are true EXCEPT:**
   A. Safe alcohol limits in pregnancy have not been established.
   B. Pregnant women should be advised to abstain from drinking alcohol.
   C. Alcohol use in pregnancy can increase the likelihood of a premature birth.
   D. Pregnant women should be advised that moderate use of alcohol will not harm the fetus.
4. **All of the following statements about medications for treating alcohol dependence are true EXCEPT:**
   A. Naltrexone can precipitate opioid withdrawal symptoms if taken by someone who is physically dependent on opioids.
   B. Alcohol abstinence should be established before prescribing acamprosate.
   C. Alcohol use will lead to an unpleasant flushing reaction in patients who take disulfiram.
   D. Counseling and other psychosocial treatments are unnecessary if patients are taking a medication for alcohol dependence.
5. **How well did this continuing education activity achieve its educational objectives?**
   ❑ A. Very well ❑ B. Adequately ❑ C. Poorly

PLEASE PRINT LEGIBLY.

Name _____ Degree _____

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Continuing Education Activity

This issue of *City Health Information*, including the continuing education activity, can be downloaded from the publications section at nyc.gov/health. To access *City Health Information* and Continuing Medical Education online, visit www.nyc.gov/html/doh/html/chi/chi.shtml.

Instructions

Read this issue of *City Health Information* for the correct answers to questions. To receive continuing education credit, you must answer 3 of the first 4 questions correctly.

To Submit by Mail

1. Complete all information on the response card, including your name, degree, mailing address, telephone number, and e-mail address. PLEASE PRINT LEGIBLY.

2. Select your answers to the questions and check the corresponding boxes on the response card.

3. Return the response card (or a photocopy) postmarked *no later than December 31, 2007.* Mail to:
CME Administrator, NYC Dept. of Health and Mental Hygiene,
2 Lafayette Street, CN-65, New York, NY 10277-1632.

To Submit Online

Visit www.nyc.gov/html/doh/html/chi/chi.shtml to complete this activity online. Your responses will be graded immediately, and you can print out your certificate.

Continuing Education Activity

Brief Intervention for Alcohol Problems

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CITY HEALTH INFORMATION
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Objectives

At the conclusion of the course, the participants should be able to:

1. Screen all patients for risky drinking.
2. Define safe alcohol consumption limits.
3. Provide information about how to change drinking patterns.
4. Negotiate goals and strategies for change.

Accreditation

The DOHMH is accredited by the Medical Society of the State of New York to sponsor continuing medical education for physicians. The DOHMH designates this educational activity for a maximum of one *AMA PRA Category 1 Credit*™. Each physician should claim only those hours of credit that were spent on the educational activity.

Participants are required to submit name, address, and professional degree. This information will be maintained in the Department's CME program database. If you request, the CME Program will verify your participation and whether you passed the exam.

We will *not* share information with other organizations without your permission, except in certain emergencies when communication with health care providers is deemed by the public health agencies to be essential or when required by law. Participants who provide e-mail addresses may receive electronic announcements from the Department about future CME activities as well as other public health information.

Participants must submit the accompanying exam by December 31, 2007.

CME Activity Faculty:
Hugh Cummings, MD; Jorge R. Petit, MD; Lloyd I. Sederer, MD

All faculty are affiliated with the New York City DOHMH, Division of Mental Hygiene.

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