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. . . men who drink more than 4 standard drinks in a day (or more than 14 per week) and women who drink more than 3 in a day (or more than 7 per week) are at increased risk for alcohol-related problems.

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 more than 4 standard drinks in a day (or more than 14 per week) and women who drink more than 3 in a day (or more than 7 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.**

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.^{11,12}

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 a likely 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.

Before You Begin...

Decide on a screening method

The *Guide* provides two methods for screening: a single question (about heavy drinking days) to use during a clinical interview and a written self-report instrument (the AUDIT—see page 11). The single interview question can be used at any time, either in conjunction with the AUDIT or alone. Some practices may prefer to have patients fill out the AUDIT before they see the clinician. It takes less than 5 minutes to complete and can be copied or incorporated into a health history.

Think about clinical indications for screening

Key opportunities include

- As part of a **routine examination**
- Before **prescribing a medication** that interacts with alcohol (see box on page 29)
- In the **emergency department** or urgent care center
- When seeing patients who
 - are **pregnant** or trying to conceive
 - are **likely to drink heavily**, such as smokers, adolescents, and young adults
 - have **health problems that might be alcohol induced**, such as

cardiac arrhythmia	dyspepsia	liver disease
depression or anxiety	insomnia	trauma
 - have a chronic **illness that isn't responding to treatment as expected**, such as

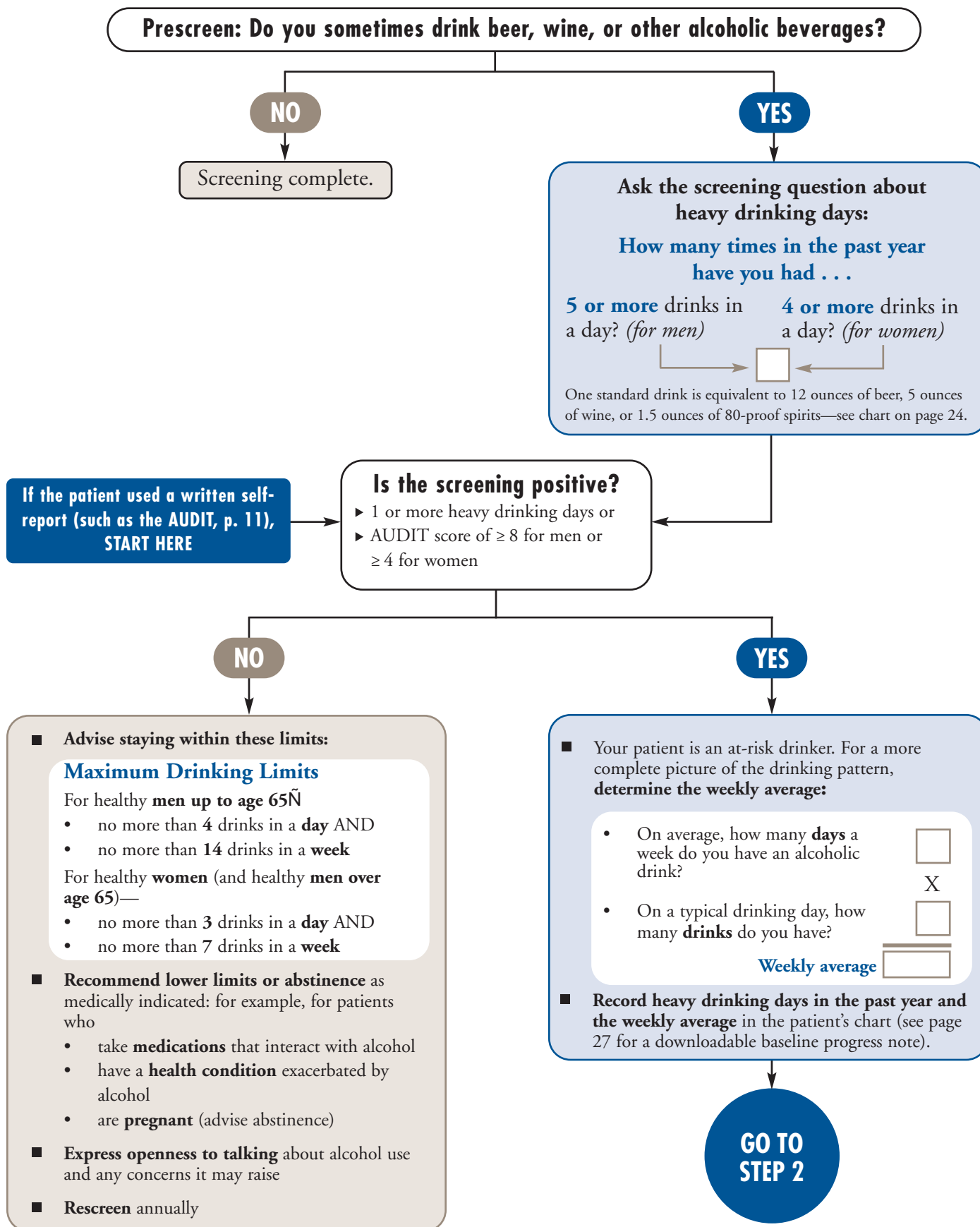
chronic pain	diabetes	gastrointestinal disorders
depression	heart disease	hypertension

Set up your practice to simplify the process

- Decide who will conduct the screening (you, other clinical personnel, the receptionist who hands out the AUDIT)
- Use preformatted progress notes (see “Online Materials” on page 27)
- Use computer reminders (if using electronic medical records)
- Keep copies of the pocket guide (provided) and referral information in your examination rooms
- Monitor your performance through practice audits

How to Help Patients Who Drink Too Much: A Clinical Approach

STEP 1 Ask About Alcohol Use



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)

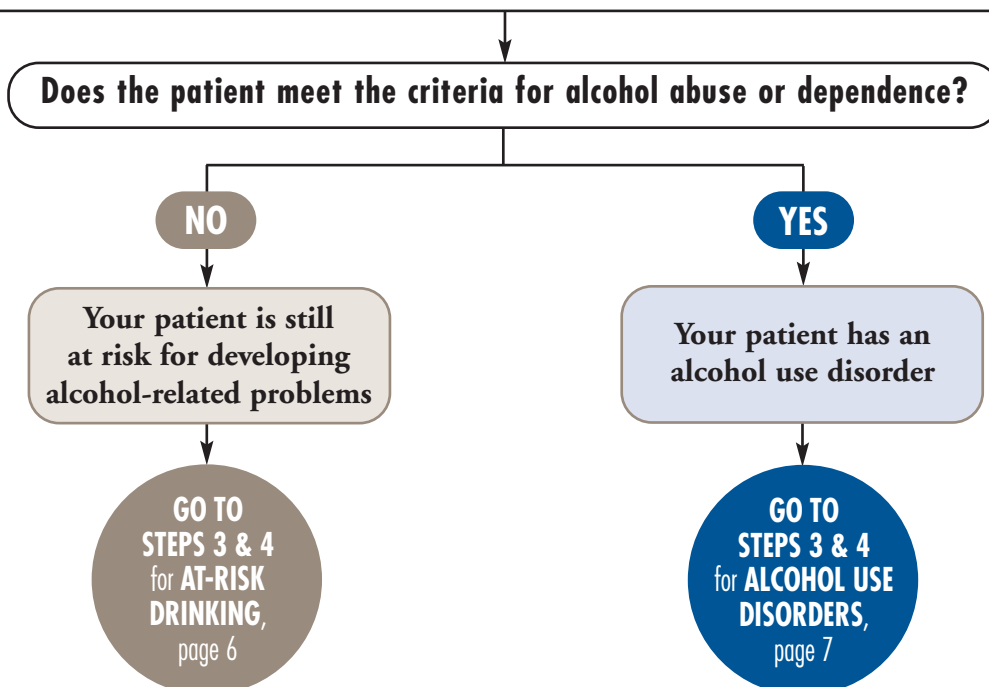
If yes to **one or more** → your patient has **alcohol abuse**.

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**.



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.

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.

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

Your practice may choose to have patients fill out a written screening instrument before they see a clinician. In this *Guide*, the AUDIT is provided in both English and Spanish for this purpose. It takes only about 5 minutes to complete, has been tested internationally in primary care settings, and has high levels of validity and reliability.¹³ You may photocopy these pages or download them from www.niaaa.nih.gov/guide.

Scoring the AUDIT

Record the score for each response in the blank box at the end of each line, then total these numbers. The maximum possible total is 40.

Total scores of 8 or more for men up to age 60 or 4 or more for women, adolescents, and men over 60 are considered positive screens.^{14,15,16} For patients with totals near the cut-points, clinicians may wish to examine individual responses to questions and clarify them during the clinical examination.

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

Continuing with screening and assessment

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

