Updated

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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- patient education handouts
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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 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**

- **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? ☐ x
  - 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)

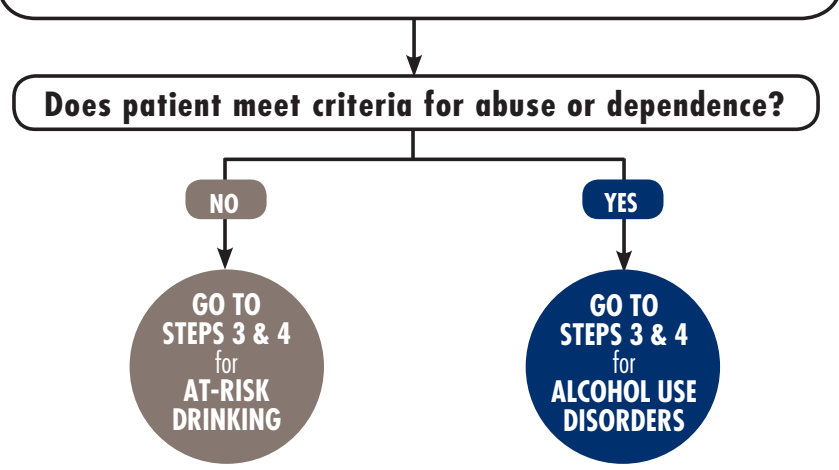
If yes to **one or more** → your patient has **alcohol abuse**.

In either case, proceed to assess for dependence symptoms.

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

- ☐ **not been able to 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**.



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.

HOW TO CONDUCT A BRIEF INTERVENTION

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.

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 as well as the number of standard drinks in different container sizes for each beverage. These are approximate, since different brands and types of beverages vary in their actual alcohol content.

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

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

Although the "standard" drink amounts are helpful for following health guidelines, they may not reflect customary serving sizes. In addition, while the alcohol concentrations listed are "typical," there is considerable variability in alcohol content within each type of beverage (e.g., beer, wine, distilled spirits).

DRINKING PATTERNS

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.

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

PRESCRIBING MEDICATIONS

The chart below contains excerpts from page 16 of NIAAA's *Helping Patients Who Drink Too Much: A Clinician's Guide*. It does *not* provide complete information and is not meant to be a substitute for the patient package inserts or other drug references used by clinicians. For patient information, visit *http://medlineplus.gov*.

	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, a naloxone challenge test should be employed. 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.

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

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