

Unhealthy Drinking in Adults Screening and Intervention Guideline

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Guidelines are systematically developed statements to assist patients and providers in choosing appropriate health care for specific clinical conditions. While guidelines are useful aids to assist providers in determining appropriate practices for many patients with specific clinical problems or prevention issues, guidelines are not meant to replace the clinical judgment of the individual provider or establish a standard of care. The recommendations contained in the guidelines may not be appropriate for use in all circumstances. The inclusion of a recommendation in a guideline does not imply coverage. A decision to adopt any particular recommendation must be made by the provider in light of the circumstances presented by the individual patient.

Summary of Changes as of October 2016

Added recommendations for screening and intervention for **PREGNANT WOMEN:**

- Abstinence is recommended for pregnant women and for women planning pregnancy.
- Pregnant women should be screened with the AUDIT-C at least once per trimester and at the 6-week postpartum visit.
 - The timeframe for the questions should be the last 3 months rather than the last year.
 - The threshold for “binge drinking” in the third question is 4 or more drinks on one occasion.
- Pregnant women should be screened for alcohol use disorder (AUD) using the Alcohol Symptom Checklist if:
 - They score a 3 or greater on the AUDIT-C, or
 - They are currently drinking at any level since learning of their pregnancy, regardless of their AUDIT-C score.
- Pregnant women who are negative for AUD should receive brief behavioral interventions focused on abstinence in Primary Care. Talking points for these brief interventions are provided in Appendix 1b.
- Pregnant women who are positive for AUD should be referred to Behavioral Health or introduced to Social Work at the time of the visit in the women’s clinic or Primary Care, rather than be managed in Primary Care.

Added recommendations for **LACTATING WOMEN:**

- Abstinence is recommended for lactating women.
- If a lactating woman is currently drinking, breastfeeding is still recommended unless the risks clearly outweigh the benefits.
- Risks to the infant can be mitigated by the mother waiting at least 2 hours to breastfeed after one standard drink, or 4–8 hours after consuming more than one drink.

Added new tool for assessing the **SEVERITY OF ALCOHOL WITHDRAWAL:**

- The Short Alcohol Withdrawal Scale (SAWS) can be used to assess the severity of alcohol withdrawal and help determine the appropriate setting for management of withdrawal symptoms and the need for medical management.
- For most patients, alcohol withdrawal may be managed within Primary Care in an outpatient setting, provided the patient has a reliable support network.
- Pharmacologic treatment of alcohol withdrawal may be considered for patients with moderate or severe withdrawal symptoms, including increased systolic blood pressure, fever, tachycardia, agitation, insomnia, and tremors.

Background

In the United States, the estimated prevalence of unhealthy drinking—which includes risky drinking and alcohol use disorder—is up to 30%. The majority of people in the unhealthy drinking group are considered risky drinkers. In primary care, studies suggest that approximately 21% of patients report risky drinking (Jonas 2012).

Alcohol use has a number of adverse effects on health, even in patients who do not have alcohol use disorder. In 2010, alcohol use accounted for 5.5% of the global burden of disease, making it the third strongest contributor to disease worldwide (Lim 2012). Moreover, on a population level, the majority of adverse health effects of alcohol use are experienced by people who do not have alcohol use disorder (i.e., those not “addicted” to alcohol). Alcohol consumption contributes to the risk of pancreatitis, hepatitis, cirrhosis, gastrointestinal bleeding, injuries, hypertension, and atrial fibrillation. It also contributes to risk of certain cancers, including breast, prostate, and oral cancers (Corrao 2004), as well as depression, anxiety, suicide, and other mental health conditions. Excessive alcohol consumption accounts for 10% of deaths among working-age adults in the United States (Stahre 2014).

Recommended drinking limits differ for men and women. Women become more impaired than men do after drinking the same amount of alcohol, even when differences in body weight are taken into account. Alcohol is water soluble, so women typically achieve higher blood-alcohol concentration (BAC) because they have less body water.

Although some evidence from observational studies indicates that light to moderate alcohol consumption is associated with decreased risk of coronary heart disease and ischemic stroke, the association may not be causal and could be confounded by other characteristics of patients with low-level alcohol use. (This pitfall of observational data was demonstrated by the extensive observational literature showing a “benefit” of hormone replacement therapy in the 1980s that was disproven by later randomized controlled trials.) Therefore, patients should **not** be advised to drink alcohol for cardiovascular benefits.

Pregnancy

Alcohol is a known teratogen. Any alcohol that a pregnant woman drinks passes quickly through the placenta to the fetus, which can result in physical, psychological, behavioral, and cognitive problems for the child. There is no safe amount of alcohol in pregnancy. The risk of fetal alcohol syndrome increases with increasing alcohol consumption (ACOG 2013).

Lactation

Alcohol consumption by lactating women results in reduced milk consumption, decreased growth, and altered sleep patterns in their infants (ACOG 2011). Lactating women should be encouraged and supported to stop drinking; however, breastfeeding is still recommended unless the risks clearly outweigh the benefits (WHO 2014). The risk to the infant can be somewhat mitigated by waiting to breastfeed for at least 2 hours after one standard drink or 4–8 hours after consuming more than one drink. During this waiting period, women should be encouraged to use alternative sources of milk, such as frozen breast milk or formula (WHO 2014).

Role of Primary Care

Primary care physicians (PCPs) and their teams have two key roles to play in addressing and minimizing disability due to alcohol use: prevention and treatment.

- **Prevention:** Brief interventions are recommended by the U.S. Preventive Services Task Force (USPSTF) because they decrease drinking in patients who screen positive for unhealthy drinking. Many patients with positive screens do not have alcohol use disorder, but can benefit from preventive interventions. Primary care teams are often the only medical providers who interact with adults who drink at unhealthy levels, placing them in a prime position to identify and counsel these patients and to help prevent alcohol-related morbidity and mortality.
- **Treatment:** When patients have alcohol use disorder or other alcohol-related conditions, primary care management includes assessment, diagnosis, shared decision making regarding treatment options, management of withdrawal if patients choose abstinence, and prescription of medications for AUD. Once a patient is diagnosed with AUD, treatment in Behavioral Health Services (BHS) is recommended. For patients who are not interested in treatment, repeated

motivational brief alcohol interventions, like those used for prevention, are effective for alcohol use disorders, and may be used to increase patient readiness.

Pregnancy: Roles of Primary Care and Specialty

Primary Care

- Screening with AUDIT-C
- Assessment for alcohol use disorder (AUD) if **any** alcohol intake since learning of pregnancy, and/or AUDIT-C score 3–12
- Brief interventions

► Behavioral Health Services/Social Work in consultation with Women’s Health

- Management of AUD
- Medication management of alcohol craving or AUD
- Management of alcohol withdrawal

A note about Behavioral Health Integration (BHI): Kaiser Permanente working to improve access, reliability, and quality of care for patients with mental health and substance use concerns by integrating behavioral health into primary care clinics. The goal of BHI is to create a welcoming environment for primary care patients to address common problems—unhealthy alcohol use, as well as depression—with their primary care teams. A major element of BHI is transitioning primary care social workers to a new role—that of integrated behavioral health clinician—in which they will be able to address patient needs without disrupting patient flow and team cycle time. BHI will be implemented in all Kaiser Foundation Health Plan of Washington clinics by mid-2018.

Definitions

Alcohol use disorder (AUD) is a problematic pattern of alcohol use leading to clinically significant impairment or distress with at least 2 symptoms over the last 12-month period. AUD is a DSM-5 diagnosis that ranges in severity from mild (2–3 symptoms) to moderate (4–5 symptoms) to severe (6–11 symptoms); for a list of DSM-5 diagnostic criteria, see Table 6, p. 12. Epic questionnaires have corresponding questions.

Previously, DSM-IV used the terms “alcohol abuse” and “alcohol dependence,” but research showed that symptoms of abuse and dependence were all symptoms of a single disorder.

Unhealthy drinking is drinking alcohol at levels that are associated with adverse health effects and/or alcohol use disorder. The following behaviors are considered unhealthy drinking, although they are **not** AUDs according to DSM-5:

Risky drinking is exceeding recommended drinking limits (see below). It not only increases the risk of alcohol use disorder, but also puts patients at increased risk for harms associated with alcohol use, including injuries and alcohol-related medical conditions. Risky drinking includes binge drinking.

Binge drinking is a pattern of drinking alcohol that is associated with adverse consequences, irrespective of average consumption. Consuming 5 or more drinks for men and 4 or more drinks for women within a single day is considered binge drinking.

Recommended drinking limits (Table 1) are levels at or above which drinkers are more likely to experience AUD or other adverse consequences. Patients who drink regularly, are identified by screening, or have problems due to drinking should be advised about recommended limits.

Table 1. Recommended drinking limits include BOTH daily and weekly limits: ¹

Population	Maximum drinks ² in 1 day		Maximum drinks ² in 1 week
Healthy adults ≤ 65 years old			
Men	4 or fewer	and	14 or fewer
Women	3 or fewer	and	7 or fewer
Healthy adults over 65 years old			
	3 or fewer	and	7 or fewer
People who should abstain			
Women who are pregnant or planning pregnancy	0	and	0
Those with history of alcohol or drug use disorders	0	and	0
Those with liver disease or other contraindications	0	and	0
Patients under the legal drinking age of 21 years	0	and	0
¹ Drinking levels defined by the National Institute on Alcohol Abuse and Alcoholism. ² One “drink” refers to a “standard drink” as defined below.			

Both daily and weekly maximums define recommended drinking limits. Daily limits address binge drinking, and weekly limits address chronic heavy drinking.

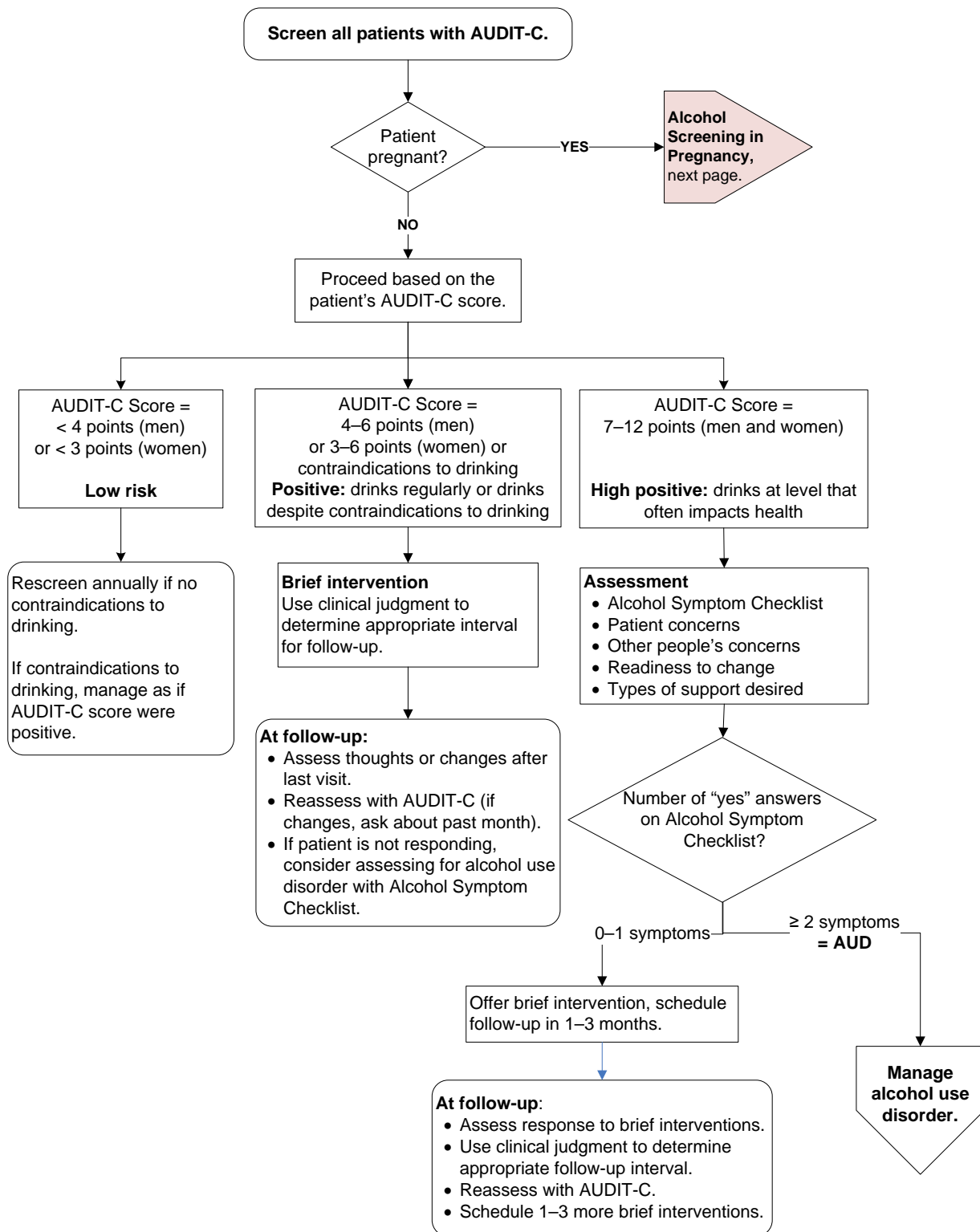
One standard drink equals:

- 12 ounces of beer or malt beverage
- 1.5 ounces of 80-proof distilled spirits
- 5 ounces of wine
- 4 ounces of liqueur, sherry, or aperitif

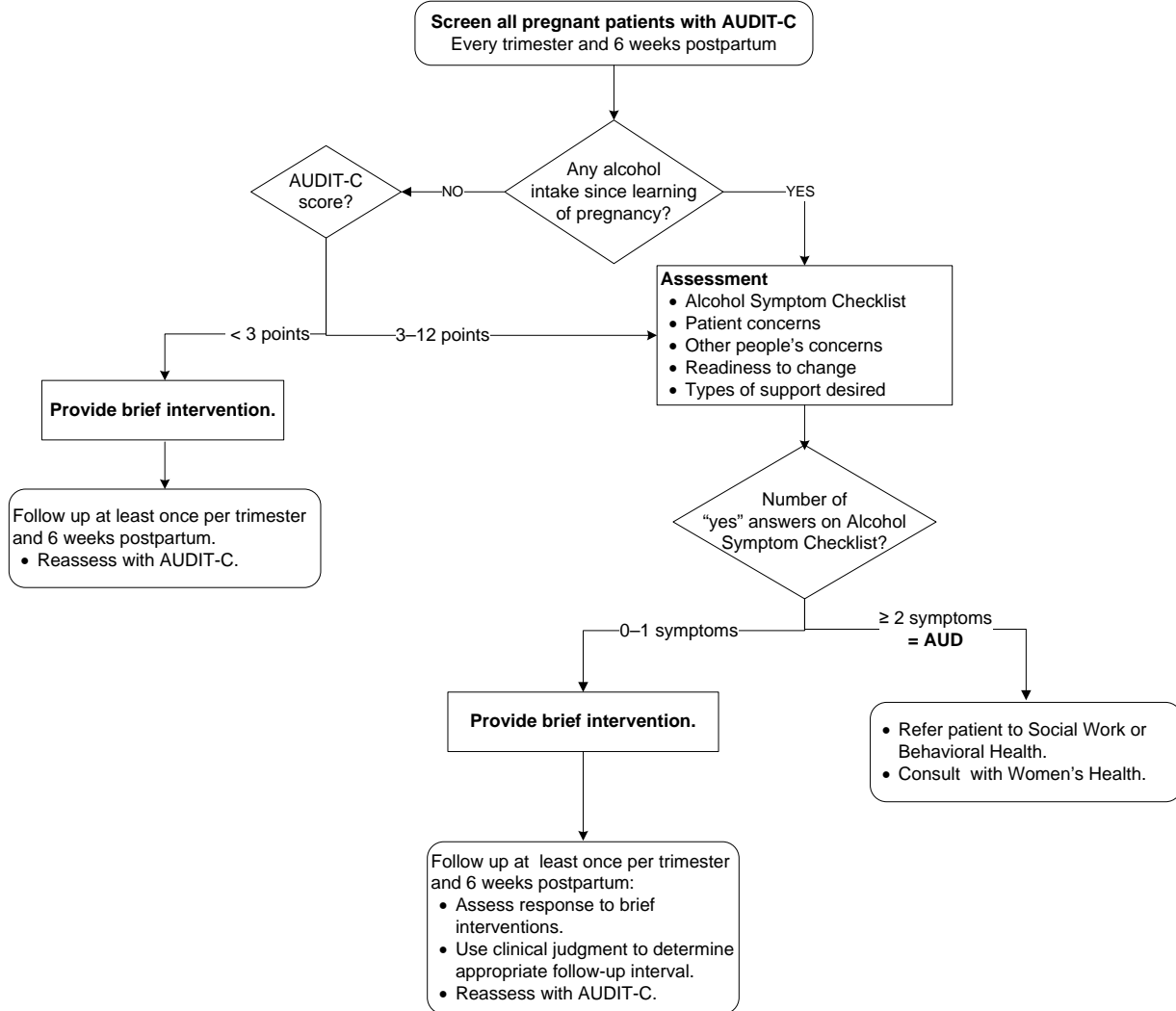
Pregnancy

Abstinence is recommended for pregnant women and women planning pregnancy, as there is no safe level of alcohol consumption during pregnancy.

Alcohol Screening and Brief Interventions in Primary Care



Alcohol Screening and Brief Interventions: Pregnant Women



Screening with the AUDIT-C

Eligible population	Recommended screening tool	Recommended frequency
Adult patients aged 18 and older	AUDIT-C	Annually
Pregnant women	AUDIT-C	At least once per trimester and at 6 weeks postpartum

AUDIT-C

The AUDIT-C (Alcohol Use Disorders Identification Test-Consumption) is a tool designed to screen for unhealthy drinking and is composed of the first three questions from the full AUDIT tool. Studies have shown that the AUDIT-C has comparable accuracy to the AUDIT and is faster to administer (Jonas 2012).

The AUDIT-C is available as an Epic flowsheet and is included on the wellness questionnaire that is administered as part of the standard well visit, as well as on the annual Health Profile.

The AUDIT-C and AUDIT are for screening only. Diagnosis of AUD can only be made using the Alcohol Symptom Checklist, which is based on DSM-5 criteria (Table 6, p. 12).

Pregnancy

The process of AUDIT-C screening is the same for pregnant women as for the rest of the adult population, with two exceptions:

- The timeframe for all three questions should be the last 3 months rather than the last year.
- The threshold for “binge drinking” in the third question is 4 or more drinks on one occasion. In women, using 4 drinks as the threshold instead of 6 increases the sensitivity of the screen by 4% (Bradley 2003). While the difference in sensitivity is slight, the serious risks posed by alcohol use during pregnancy warrant heightened efforts to ensure that potentially problematic drinking is not overlooked.

Scoring and interpretation of the AUDIT-C, however, are different for pregnant women. (See Table 4b.)

How often did you have 1 drink containing alcohol in the last year?	Never	0 points
	Monthly or less	1 point
	2 to 4 times per month	2 points
Pregnant women: How often did you have 1 drink containing alcohol in the last 3 months?	2 or 3 times per week	3 points
	4 or more times per week	4 points
How many drinks containing alcohol did you have on a typical day when you were drinking in the last year?	I don't drink alcohol	0 points
	1 to 2 drinks	0 points
	3 to 4 drinks	1 point
	5 to 6 drinks	2 points
Pregnant women: How many drinks containing alcohol did you have on a typical day when you were drinking in the last 3 months?	7 to 9 drinks	3 points
	10 or more drinks	4 points
How often did you have 6 or more drinks on one occasion in the last year?	Never	0 points
	Less than monthly	1 point
	Monthly	2 points
Pregnant women: How often did you have 4 or more drinks on one occasion in the last 3 months?	Weekly	3 points
	Daily or almost daily	4 points

Interpreting the AUDIT-C score

The AUDIT-C has been validated in many different settings and populations as a screen for the full spectrum of unhealthy drinking (risky drinking and alcohol use disorder).

Note: Patients can screen positive on the AUDIT-C despite reporting drinking below recommended limits—a result that can be confusing to both patients and providers. AUDIT-C scoring allows for the possibility that patients will underreport their drinking.

Score	Interpretation	Management	Follow-up
Men < 4 points Women < 3 points	Low risk due to drinking if no contraindications to drinking alcohol.	No intervention, unless contraindications to drinking alcohol.	Rescreen in 1 year, or sooner if contraindications to drinking alcohol.
Men 4–6 points Women 3–6 points	Positive: Drinks regularly. <i>Note:</i> Patients can screen positive despite reporting drinking below recommended limits, as AUDIT-C scoring allows for the possibility of underreporting.	Brief intervention (see p. 10).	Use clinical judgment to determine appropriate follow-up interval.
Men and women 7–12 points	High positive: Drinks at level that often impacts health. The higher the score, the greater the potential for health risks.	Assessment for alcohol use disorder using DSM-5 criteria (see Table 6, p. 12), comorbidities, and readiness to change.	If alcohol use disorder , manage AUD (see p. 13). If no alcohol use disorder , offer brief intervention (see p. 10) and use clinical judgment to determine appropriate follow-up interval.

Pregnancy

For pregnant women who report **any** alcohol intake since learning of their pregnancy, screen for alcohol use disorder, regardless of AUDIT-C score.

Score	Interpretation	Management	Follow-up
< 3 points	Potential risk to fetus.	Brief intervention (see p. 10).	Rescreen every trimester and at the 6-week postpartum visit.
3–12 points	High risk. The higher the score, the greater the potential for harm to the fetus.	Assessment for alcohol use disorder using DSM-5 criteria (see Table 6, p. 12), comorbidities, and readiness to change.	If alcohol use disorder , refer to Behavioral Health or introduce to Social Work at time of visit in the women's clinic or Primary Care. If no alcohol use disorder , offer brief intervention (see p. 10) and rescreen at least once per trimester and at the 6-week postpartum visit.

Brief Interventions

Care providers can help patients to decrease unhealthy drinking. For patients who screen positive for unhealthy drinking, there is good evidence from randomized controlled trials and meta-analyses that brief counseling interventions provided by primary care physicians or other clinical staff (who are not specialists in addiction or counseling) are associated with a significant decrease in alcohol consumption compared with usual care (Jonas 2012).

Pregnancy

In pregnant women, there is fair evidence that even a single behavioral intervention is more beneficial than no intervention in reducing alcohol consumption, increasing rates of abstinence, and improving newborn outcomes (Stade 2009).

Overview

Table 5a. Characteristics of brief interventions

Table 5b. Content of brief interventions

Table 5a. Characteristics of brief interventions	
Duration	5 to 15 minutes.
Number of sessions	1 to 4. Repeated sessions are more effective than a one-time intervention, and higher AUDIT-C scores warrant more concern. Use clinical judgment to determine the appropriate follow-up interval. The sessions may take place in person or by phone.
Clinicians	Primary care physicians, advanced practice providers, nurses, social workers, and midwives.
Target population	People who score positive on the AUDIT-C. Single brief interventions are most effective for patients with unhealthy alcohol use, compared with patients with alcohol use disorder. For single brief interventions, the number needed to treat (NNT) to resolve unhealthy alcohol use in 1 person is 7–9 (Jonas 2012, Kaner 2009); for four brief interventions, the NNT is ~4 (Fleming 1997).

Table 5b. Content of brief interventions

Express concern	<p>Discuss with patients in an empathetic, patient-centered manner that—based on the screen—you are concerned they “may be” or “are” drinking at an unhealthy level.</p> <p>Use “may be” if the patient screens positive but is not reporting drinking above recommended limits.</p>
Provide feedback linking drinking to health	<p>Describe how the drinking might impact the patient’s medical conditions (e.g., hypertension, hepatitis C, depression), symptoms (e.g., insomnia, dyspepsia), or risks (e.g., breast cancer, liver disease).</p>
Offer advice	<p>Advise the patient to</p> <ul style="list-style-type: none">▪ Drink below recommended drinking limits (see Table 1), and educate the patient about those limits, or▪ Abstain from drinking. <p>Patients should be advised to abstain if they have alcohol use disorder or other contraindications to drinking (e.g., pregnancy, liver disease) or are taking medications that may interact with alcohol (e.g., benzodiazepines, warfarin). For more information about specific alcohol-drug reactions, see: pubs.niaaa.nih.gov/publications/Medicine/medicine.htm.</p>
Elicit response, assess readiness to change, and support goal setting if ready	<p>Support the patient in selecting a goal (e.g., monitoring drinking or filling out a drinking diary, decreasing drinking, or identifying triggers). The NIAAA Rethinking Drinking website can be useful: rethinkingdrinking.niaaa.nih.gov.</p> <p>For those with alcohol use disorder, the ideal goal is abstinence, but patients should be engaged in thinking about their drinking even if they are not interested in making changes now. Discussions of alcohol use can lead to later changes.</p>
Offer referral	<p>Offer to refer the patient to a behavioral health professional for assessment of alcohol use (which would include motivational interviewing if indicated) and/or a potential other mental health comorbidity, or for treatment of alcohol use disorder, if appropriate.</p>

Conducting a brief intervention

Offering patient-centered brief interventions can be done very briefly, but the tone is important. Easy ways to make alcohol-related discussions comfortable include:

- Framing the discussion as part of routine care of all patients who drink regularly.
- Asking permission to discuss alcohol use and/or provide information.
- Using open-ended questions to elicit patients’ perspectives and concerns.
- Devoting over half of the discussion to eliciting and listening to the patient’s perspectives.
- Giving information if the patient is interested.
- Conveying all information nonjudgmentally, stressing that the patient must choose what is best for him/her.

Talking points for brief interventions

Appendix 1a. Patients with positive AUDIT-C scores (≥ 3 points for non-pregnant/non-lactating women and ≥ 4 points for men)

Appendix 1b. Pregnant and lactating women

Gauging responses to one or more brief interventions

Patients are responding positively to brief interventions if they are increasing their readiness to change their drinking and/or are reducing unhealthy drinking.

If patients with positive AUDIT-C scores (men 4–6, women 3–6) are not responding to brief interventions, consider assessing for alcohol use disorder (see next section).

Assessment for Alcohol Use Disorder

Pregnancy

For pregnant women who indicate **any** ongoing alcohol use, assess for AUD regardless of AUDIT-C score.

Use the Alcohol Symptom Checklist (Table 6, and available as an Epic flowsheet) for diagnosing alcohol use disorder; do **not** use AUDIT-C or AUDIT scores.

If you are unsure of the diagnosis, consider consultation via Mind Phone.

Table 6. Alcohol Symptom Checklist

Based on DSM-5 criteria. 2 or more “yes” responses are diagnostic of AUD.

- Do you find that drinking the same amount of alcohol has less effect than it used to, or do you have to drink more alcohol to get intoxicated?
- When you cut down or stop drinking, do you get sweaty or nervous, or have an upset stomach or shaky hands? Do you drink alcohol or take other substances to avoid these symptoms?
- When you drink, do you drink more or for longer than you planned to?
- Have you wanted to or tried to cut back or stop drinking alcohol, but been unable to do so?
- Do you spend a lot of time obtaining alcohol, drinking alcohol, or recovering from drinking?
- Have you continued to drink even though you know or suspect it creates or worsens mental or physical problems?
- Has drinking interfered with your responsibilities at work, school, or home?
- Have you been intoxicated more than once in situations where it was dangerous, such as driving a car or operating machinery?
- Do you drink alcohol even though you knew or suspected it causes problems with your family or other people?
- Do you experience strong desires or cravings to drink alcohol?
- Do you spend less time working, enjoying hobbies, or being with others because of your drinking?

AUD severity is defined as:

Mild: 2–3 DSM-5 symptoms present

Moderate: 4–5 DSM-5 symptoms present

Severe: 6 or more DSM-5 symptoms present

Management of Alcohol Use Disorder in Primary Care

Pregnancy ►

Pregnant women with AUD should be referred to Behavioral Health or introduced to Social Work at the time of the visit in the women's clinic or Primary Care, rather than managed in Primary Care.

Overview

Management of alcohol use disorder in Primary Care can include shared decision making about treatment options, emotional support, prescription of medications for cravings, and management of withdrawal for patients who choose abstinence. At any time, patients with AUD may be referred to a behavioral health professional if they would prefer to receive their treatment in BHS or have severe mental health comorbidities (e.g., schizophrenia, bipolar disorder).

Patients with moderate or severe AUD (4 or more symptoms) can benefit from medications (see Table 7) when added to behavioral therapies (Jonas 2014). Patients with milder AUD are more likely to be able to change with less intensive behavioral interventions than those with more severe AUD. The more severe the AUD, the more likely a patient is to have severe withdrawal.

To begin reducing harms and improving outcomes, begin addressing AUD as soon after a new diagnosis as possible and ensure that the patient gets some ongoing care.

Visits following a new AUD diagnosis

HEDIS® targets for AUD diagnosis follow-up are: one visit no later than 14 days after initial diagnosis, and at least two more visits in the 30 days following the first visit. (Note: If the first follow-up visit takes place the same day as diagnosis, for HEDIS purposes that follow-up visit needs to be with a different provider than the one who made the diagnosis.)

Approach these shared-decision making conversations as “meeting the patients where they are,” letting them know they have options even if they are not interested in stopping drinking. Explain that it is up to the patient to decide if they want to consider reducing or stopping drinking. For patients who are not at all ready to change, the focus should be on engaging them in care (i.e., focus on health issues they are concerned about).

Over the course of several visits:

Develop a relationship with the patient so they want to engage in alcohol-related care and return for further discussion. Ask permission to explore their drinking further, then ask about their health goals and priorities and their history of alcohol use. Assess how alcohol fits into and affects the patient's life with questions like:

- “When did you start drinking?”
- “How has your drinking changed over time?”
- “Has your drinking ever been a problem?”
- “What are the good things about drinking? The not-so-good things?”
- “Who would be disappointed if you changed your drinking? Who would support change?”

Discuss any medical conditions the patient has that can be complicated by drinking, such as hypertension, gastroesophageal reflux disease, gout, atrial fibrillation, hepatitis C or other liver disease, insomnia, or medication interactions.

Assess for mental health and other substance use disorders

- Depression: Assess with the PHQ-9. See the Depression Guideline for additional guidance.
- Anxiety: Assess with the GAD-7.

- Bipolar disorder, schizophrenia, or other serious mental illness: Refer the patient to BHS if there are concerns that these conditions might be present.
- Other substance use: Assess with two-item screen.
 1. How often have you used marijuana in the last year?
 2. How often have you used recreational drugs (such as heroin, cocaine, or methamphetamine) or used a prescription medicine for non-medical reasons in the last year?

Responses: Never, Less than monthly, Monthly, Weekly, Almost daily, Daily.

If the patient answers "Daily" to Question 1, or anything but "Never" to Question 2, use the Substance Use Disorder Symptom Checklist Flowsheet in Epic and/or contact the BHS Mind Phone for a consultation.

For patients with four or more DSM-5 symptoms of AUD, **offer information on medications** that can make it easier to stop or decrease drinking, such as naltrexone or acamprosate (see p. 17).

Engage patients in self-assessment, and inform them about resources that might help them change their drinking if they decide to (see p. 16).

Consider assessing with:

- The Short Inventory of Problems (SIP) to help the patient identify and assess alcohol-related symptoms (Miller 1995).
- The Penn Alcohol Craving Scale (PACS) to assess how much time they spend thinking about alcohol (Flannery 1999).
- Readiness rulers to assess patients' readiness for change, the importance they place on making a change, and their confidence in their ability to change.

These tools can provide objective feedback for patients for self-assessment and monitoring changes over time. For example, a reduction in craving symptoms documented by a lower score on the PACS can provide objective data that the cravings medication is effective. Likewise, a decrease in SIP score over time may provide encouragement for patients who may not otherwise feel that they are making progress. The SIP may also help patients who are unaware that they are having any alcohol-related problems to recognize the impact that their alcohol use is having on themselves and others.

The change in score on any of these assessment tools is more important than the magnitude of the score (there are no cut-points), since the tools are not being used for diagnosis.

See Appendix 3, p. 37, for more detail about each of these self-assessment tools. The SIP and PACS are also available as Epic flowsheets.

Use shared decision making to help patients decide if they are ready to make any changes and explore their treatment options.

Options for changing alcohol use

Options for changing alcohol use fall into three categories: “not interested,” reduced drinking, and abstinence. At the end of each visit, check in with the patient to see how they’re responding and whether they’re interested in changing their goals.

If the patient is **NOT INTERESTED** in changing alcohol use at this time:

1. Ask if the patient would be willing to monitor drinking (drinking diary for 1–2 weeks).
2. Order lab tests to assess for health risks: Check AST, ALT, GGT and CBC. Repeat every 3–6 months if abnormal while patient is still drinking.
3. Schedule follow-up visit(s).

If the patient is interested in **REDUCED DRINKING**:

1. Elicit patient’s reasons to change and reasons not to change.
2. Ask patient to set a specific goal(s) for changing drinking behavior.
3. Ask patient to self-monitor alcohol consumption.
4. Outline treatment options for patient to consider (now or in the future):
 - Counseling to address comorbid mental health issues
 - Medications (if ≥ 4 DSM-5 criteria): naltrexone, acamprostate, topiramate
5. Even if they are not ready to stop drinking altogether, patients can be referred to Alcoholics Anonymous or addiction treatment in order to learn more about AUD and options for treatment.
6. Order lab tests to assess for health risks: Check AST, ALT, GGT and CBC every 3–6 months while patient is still drinking.
7. Arrange a follow-up visit to reassess with AUDIT-C and other tools (e.g., SIP).

If the patient is interested in **ABSTINENCE**:

1. Plan for and treat withdrawal.
 - Assess the patient’s withdrawal risk (see p. 21) and determine whether patient needs medical management of withdrawal.
 - Select setting for withdrawal (see p. 22).
 - For questions about managing medications for alcohol withdrawal or craving, the Mind Phone is available for consultation.
2. Discuss treatment options.
 - Specialty chemical dependency treatment (referral via Behavioral Health Access)
 - Outpatient group/individual
 - Residential followed by outpatient group/individual
 - Outpatient mental health treatment for co-occurring conditions (referral via Behavioral Health Access)
 - Alcoholics Anonymous (to learn about AUD and how some people have found AA helpful)
3. As needed, prescribe medications for craving and AUD, as appropriate.
 - Naltrexone
 - Acamprostate
 - Topiramate (second-line)
 - Disulfiram (second-line)
4. Consider addiction medicine referral for patients with complex medical or psychiatric needs who have failed to respond to previous treatments in primary care.
5. Order lab monitoring to assess for health risks: Check AST, ALT, GGT and CBC every 12 months.
6. Reassess the patient using the AUDIT-C.

Resources for changing alcohol use

Patients need education and emotional support to reduce or stop drinking.

Staff and contracted behavioral health providers include psychiatrists, psychologists, psychotherapists, addiction and chemical dependency counselors, social workers, and nurses.

The following services are available:

In Primary Care

- Social Work and Behavioral Health can assist in assessments/engagement.
- Ambulatory treatment/management of alcohol withdrawal.
- Medications for managing alcohol craving and alcohol use disorder.

In Behavioral Health

- Mental health care: individual and group psychotherapy, psychiatric care and psychological testing.
- Chemical dependency care (through a contracted network of providers): assessment and evaluation, chemical dependency counseling, and residential treatment.
- Inpatient detoxification (through a contracted network of providers) when determined medically necessary.

Outside resources that can help patients to reduce or stop drinking include:

- Alcoholics Anonymous: AA organizes meetings to help those who want to stop drinking. The groups are made up of people who have had alcohol use problems, and participants may stay anonymous. (www.aa.org provides phone numbers and information on local chapters.)
- Smart Recovery®: www.smartrecovery.org is a face-to-face and/or online program rooted in research on how people change behaviors and addictions. It is an alternative to 12-step programs.
- Washington Recovery Help Line: 1-866-789-1511 or www.warecoveryhelpline.org. Anonymous and confidential help line that provides crisis intervention and referral services for Washington State residents.
- Women for Sobriety: www.womenforsobriety.org. A nonprofit organization dedicated to helping women overcome alcoholism and other addictions.
- Al-Anon/Alateen: www.al-anon.alateen.org. Al-Anon offers group meetings for families and friends of alcoholics. Alateen offers group meetings for younger family members and friends of alcoholics.
- Celebrate Recovery® Ministry: A Christ-Centered Recovery Program: www.celebraterecovery.com.

Emerging technologies offer the potential to improve the effectiveness and accessibility of treatment services for AUD. In general, the types of screenings and interventions that are used in face-to-face settings mirror those found online or electronically. These alternative modes of delivery are, in some ways, more convenient and readily accessible compared with standard treatment and have the potential to engage young or underserved patients who may be more inclined to access support through these channels. Currently, the literature addresses a variety of these electronic screenings and interventions in a variety of settings amidst different populations. While they show promise, the literature base is not yet conclusive, with many of the studies suffering from methodological limitations.

- AlcoholScreening.org is a free service of Join Together, a project of the Partnership at Drugfree.org and Boston University School of Public Health: www.alcoholscreening.org.
- Drinker's Checkup™ (requires registration): www.drinkerscheckup.com.
- Alcohol Help Center (requires registration): www.alcoholhelpcenter.net. Includes the Check Your Drinking (CYD) Survey, which can be taken without registering: www.alcoholhelpcenter.net/cyd/CYDScreenerP1_0.aspx.
- Down Your Drink is based at the University College London (requires registration): www.downyourdrink.org.uk.
- NIAAA Rethinking Drinking: <http://rethinkingdrinking.niaaa.nih.gov>. The *Rethinking Drinking* website and [booklet](#) have been produced by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), a part of the National Institutes of Health. The content of *Rethinking Drinking* draws largely from the results of major NIAAA population studies and clinical trials.

Medication Management of Alcohol Craving and Alcohol Use Disorder

Pregnancy ►

Pregnant women should be referred to specialty chemical dependency treatment (via BHS) in consultation with Women’s Health for medication management of alcohol craving and AUD.

Primary care providers or established behavioral health providers should prescribe medications for AUD when patients are interested. Patients do not need to be referred to Behavioral Health Services for these medications.

The goals of pharmacologic management of alcohol craving and alcohol use disorder are to prolong abstinence or to reduce unhealthy drinking. In addition, primary care providers should continue brief interventions, as well as monitor for medication side effects.

Pharmacologic options for alcohol craving and alcohol use disorder

Medications are used to manage alcohol craving and alcohol use disorder. They are most effective as an adjunct to chemical dependency counseling, or—if patients decline counseling—with medication monitoring by a nurse or pharmacist and referral to Alcoholics Anonymous (Anton 2006).

Note: Abstinence from alcohol is not required before initiating pharmacologic therapy, with the exception of disulfiram, which requires a minimum period of 24 hours abstinence.

Table 7. Medications for alcohol craving and alcohol use disorder

Medication (See “Prescribing notes” on next page)	Initial dose	Therapeutic dose	Treatment duration
1st line			
Naltrexone	50 mg daily. ¹	Titration to 100 mg daily may be beneficial if patient is only partially responsive to 50 mg.	<ul style="list-style-type: none"> Continue for at least 3 months to assess benefit, if possible. For patients who respond, an additional 6 months of naltrexone improves outcomes. No need to taper at discontinuation. Patients may benefit from 12–24 months of treatment to thoroughly integrate recovery practices into their lives. Can be given for short periods of time in anticipation of periods of increased cravings and exposure to alcohol in the environment (e.g., holidays).
Acamprosate	333 mg or 666 mg three times daily. ¹ Most effective when started immediately after cessation of drinking.	666 mg (2 x 333 mg tablets) three times daily.	<ul style="list-style-type: none"> Continue for at least 3 months to assess benefit. Patients may benefit from 12–24 months of treatment to thoroughly integrate recovery practices into their lives.
2nd line			
Topiramate (off-label use)	25 mg daily.	Increase weekly by 25–50 mg daily divided into two doses as tolerated up to a maximum of 300 mg daily. Typical therapeutic	<ul style="list-style-type: none"> Continue for 6–12 months to thoroughly integrate recovery practices into patient’s life. Taper to discontinue.

		range is 100–200 mg daily.	
Disulfiram	250 mg daily at least 24 hours after last drink and/or patient has BAC of 0.00. A small percentage of people rapidly metabolize this medication and may need 500 mg daily dosing.	Continue 250 mg daily for maintenance. 500 mg is daily maximum dose.	<ul style="list-style-type: none"> ▪ Monitored disulfiram improves outcomes over unmonitored disulfiram. ▪ No need to taper on discontinuation. ▪ Patients may benefit from 12–24 months of treatment to thoroughly integrate recovery practices into their lives. ▪ Can be given for short periods of time in anticipation of periods of increased cravings and exposure to alcohol in the environment (e.g., holidays).
¹ Some patients may prefer naloxone to acamprosate because of its once-daily dosing schedule.			

Prescribing notes for Table 7. Medications for alcohol craving and alcohol use disorder

Naltrexone

Advantages

- Once-daily dosing.
- First-line agent based on efficacy and safety for patients not taking or needing opioids.
- Useful for patients with a history of opioid dependence but not currently using/abusing opioids.
- Relatively inexpensive.

Disadvantages

- Not for patients taking or needing opioids.
- Not for patients with liver failure or acute hepatitis.

Acamprosate

Advantages

- Useful for patients who have significant liver disease.
- Useful for patients with protracted withdrawal symptoms.

Disadvantages

- Not for patients with renal failure.
- Three times–daily dosing.

Topiramate

Advantages

- Useful for decreasing heavy drinking in patients with a goal of reducing drinking.

Disadvantages

- Not FDA-approved for this indication.
- Tapering up to effective dose, which is required to minimize side effects, takes 6–10 weeks.
- Potential side effects include dizziness, ataxia, somnolence, memory difficulties, depression, anxiousness, confusion, nystagmus, weight loss, and nausea.
- Many patients cannot tolerate.
- Avoid in patients with history of renal calculi.

Disulfiram

Advantages

- Useful for patients committed to **abstinence from alcohol**.
- Useful for patients who have support to monitor taking the medication.
- Useful for patients who also have cocaine dependence.
- Short-term use for abstinent patients who will be in a time-limited, high-risk situation.

Disadvantages

- Not for patients with significant active psychosis.
- Not for patients with severe heart disease.
- Not for pregnant or nursing women.
- No effect on cravings.

Medication monitoring for alcohol craving and alcohol use disorder

Medications for AUD have been proven effective only when accompanied by behavioral support. The least intensive type of behavioral support is medication monitoring, which includes:

- Assessing side effects and adherence,
- Tracking lab results,
- Encouraging patients to use mutual help groups,
- Helping patients to set goals and track their progress, and
- Determining whether patients might need a more intensive form of behavioral treatment than they are currently receiving.

Table 8. Monitoring for medication side effects

Medication	Monitoring parameters	Frequency ¹
All medications for alcohol craving or AUD	PHQ-9 and Columbia Suicide Risk Assessment	At baseline, then every 3–6 months or if there are symptoms of depression
Naltrexone	AST, ALT, alkaline phosphatase, adherence, side effects	At baseline, at 1 month, then periodically
Acamprosate	Creatinine clearance	At baseline
	Adherence, side effects	At 1 month, then periodically
Topiramate	Creatinine and bicarbonate, adherence, side effects	At baseline, then every 3–6 months or if there are symptoms of acidosis
Disulfiram	AST, ALT, alkaline phosphatase, adherence, side effects	At baseline, at week 2, at months 1–6, then quarterly
¹ The available evidence does not suggest an ideal monitoring frequency. Generally assess by phone 1 week after baseline and again at 1 month. If the patient has any side effects or other problems with the medications early, consider monitoring more frequently. Tapering up more slowly can decrease side effects. Some patients will need to try a different medication. If the patient declines formal behavioral treatment for AUD, consider increasing the frequency of medication monitoring.		

Management of Alcohol Withdrawal

Pregnancy ►

Pregnant women should be referred to specialty chemical dependency treatment (via BHS) in consultation with Women's Health for management of alcohol withdrawal.

When a patient is going to stop or greatly reduce drinking, the risk of developing alcohol withdrawal and the need for treatment should be assessed. Treatment of withdrawal ameliorates unpleasant symptoms and helps to prevent severe complications (e.g., seizures and delirium), but it is not a treatment for the patient's underlying alcohol use disorder. Treatment of withdrawal should only be initiated when there is a plan to engage in further assessment and treatment or a credible plan for self-management and support to abstain from alcohol use.

Many patients will require several episodes of medically managed withdrawal throughout their lifetime, just as patients with other chronic medical conditions will require periodic episodes of intensive treatment when they have an exacerbation of their conditions.

The **role of the Primary Care provider** in assessing and treating alcohol withdrawal is to determine:

1. Is medication management of withdrawal necessary?
2. Can it safely be done at home?
 - If yes, Primary Care provides this treatment.
3. Is there a plan for further assessment and treatment, or a viable plan for self-management?
 - If no, consider linking patient with Social Work to help develop this plan.

Emergent situations: unplanned, acute withdrawal

Occasionally, patients may stop drinking on their own. Consider directing a patient to an **emergency department** for possible inpatient medical or psychiatric treatment if the patient presents with:

- Acute toxicity (e.g., altered mental status) that cannot be safely managed in an outpatient setting.
- A coexisting medical condition that indicates a need for inpatient management (e.g., acute pancreatitis).
- Acute psychiatric presentation with suicidal or homicidal thoughts.

Use the Short Alcohol Withdrawal Scale (SmartPhrase **.saws**) to evaluate the severity of withdrawal symptoms and call the BHS Mind Phone for consultation.

Withdrawal signs and symptoms

The autonomic signs and symptoms of withdrawal may begin soon after cessation of drinking, peaking over the first 2 days, and then begin to diminish over approximately 4 days. Symptoms of alcohol withdrawal include anxiety, restlessness, tremor, insomnia, headache, palpitations, gastrointestinal disturbances, sweating, increased systolic blood pressure, rapid breathing, tachycardia, mild fever, problems with memory, and confusion.

Withdrawal seizures, when they occur, begin within 48 hours of cessation of alcohol use. Delirium tremens—the most severe form of withdrawal—has a later onset, at 3–5 days after cessation of drinking. If untreated, delirium is associated with high mortality. Treatment greatly reduces mortality. Delirium typically lasts 2–3 days but may persist for 1–2 weeks, even with treatment.

Risk factors for developing complicated withdrawal

Complicated withdrawal is severe withdrawal, often including development of seizures and/or delirium. Risk factors include:

- Prior complicated withdrawal that included seizures and/or delirium.
- Repeated withdrawal episodes with severe symptoms.
- Multiple-substance abuse.
- Comorbid medical conditions that are destabilized by alcohol withdrawal (e.g., heart failure, epilepsy, structural brain lesions, infection, chronic renal failure, recent surgical procedure).
- Older age.
- Comorbid psychiatric disorders that would be destabilized by alcohol withdrawal.
- Dehydration.
- Laboratory abnormalities, such as electrolyte disturbance (hyponatremia or hypokalemia) or abnormal liver enzymes.

Short Alcohol Withdrawal Scale (SAWS) (source: Muncie 2013)

The SAWS is a clinician- or self-administered subjective measure of withdrawal symptoms over the past 24 hours, which can be helpful in the assessment, management, and ongoing monitoring of withdrawal.

Available as **.saws** in Epic.

Instructions: Indicate how you have felt in the last 24 hours.

	None (0 points)	Mild (1 point)	Moderate (2 points)	Severe (3 points)
Anxious				
Feeling confused				
Restless				
Miserable				
Problems with memory				
Tremor (shakes)				
Nausea				
Heart pounding				
Sleep disturbance				
Sweating				

SAWS Scoring

Mild withdrawal: < 12 points

Moderate to severe withdrawal: ≥ 12 points (requires medical management)

In treating withdrawal, a target for response to treatment is SAWS < 6 points.

Determining whether medical management is necessary

Most cases of mild alcohol withdrawal do not require medical intervention (Kattimani 2013). Unnecessary prophylaxis or treatment of may lead to unintentional consequences including excessive sedation, falls, respiratory depression, propylene glycol toxicity, and delirium.

To determine whether medication management is needed:

- Evaluate withdrawal symptoms using SAWS.
- Obtain vital signs.
- Assess for history of risk factors for complicated withdrawal.

Pharmacotherapy is recommended (Kattimani 2013) when:

- Systolic blood pressure exceeds 150 mm Hg,
- Diastolic blood pressure exceeds 90 mm Hg,
- Body temperature is greater than 37.7°C,
- Pulse exceeds 100 beats per minute, or
- Other withdrawal symptoms such as agitation, insomnia, or tremulousness are present without other medical or neurological illness.

Determining the setting for withdrawal treatment

There is insufficient evidence from published studies to determine the optimal setting for alcohol detoxification. However, there is a consensus that patients with risk factors for complicated withdrawal (see p. 21) should be considered for inpatient treatment based on the following predictors of severe alcohol withdrawal symptoms (Sachdeva 2015).

For most patients with alcohol use disorder, withdrawal can be safely and effectively managed in an outpatient setting, provided the patient is reliable and/or has an adequate support network.

Inpatient treatment may also be recommended for pregnant women, and for patients who lack a reliable support network.

Use **Mind Phone** for a consultation on a preferred treatment approach, as needed.

For patients for whom inpatient treatment is indicated, contact BHS to arrange treatment.

Determining the follow-up plan for treatment or self-management of alcohol use disorder

Without a follow-up plan to manage alcohol use disorder, treatment of withdrawal may do more harm than good, as patients are highly likely to relapse without some support to remain abstinent. Discuss with the patient whether they have made plans for further evaluation and management of their alcohol use disorder. This could include:

- Assessment and/or treatment with a chemical dependency provider – outpatient or residential treatment.
- Engagement in mental health counseling.
- Treatment with anti-craving medications.
- Engagement in peer support groups.

Consider referral to Social Work to help patients better determine which approach is best for them.

Pharmacologic management of alcohol withdrawal

Benzodiazepines are the gold standard for treatment of alcohol withdrawal, prevention of seizures and delirium, and alleviation of withdrawal symptoms.

However, anticonvulsants are a better option in patients who are using other centrally acting depressants (e.g., opioids), and there is a risk of polysubstance overdose, especially if patients drink while taking medications for withdrawal. Anticonvulsants are also an option for patients with intolerance to benzodiazepines or some other contraindication for benzodiazepines.

Monitoring should ideally be done daily while patients are receiving medication as part of outpatient treatment for withdrawal. Patients should self-administer the SAWS each morning. Clinical assessment may be done by in-person assessment with a physician or nurse or by phone if clinically appropriate (i.e., if withdrawal symptoms are well controlled, with SAWS < 12). Patients whose withdrawal symptoms are not adequately responding (i.e., SAWS ≥ 12) should be reassessed and/or their treatment should be adjusted to better manage withdrawal symptoms.

If assessment by the Primary Care team is not available (e.g., over weekends), patients should be monitored by family, friends, or supporters in the community (e.g., AA sponsor) and instructed to contact a consulting nurse and potentially go to Urgent Care if they have worsening symptoms or adverse effects of medication treatment.

Monitoring consists of the following:

- Assessing for alcohol and drug use, withdrawal symptoms, response to treatment, and motivation for abstinence/recovery.
- Asking patients:
 - If they have had contact with Behavioral Health regarding referral for chemical dependency assessment and, if not, what barriers have prevented this from occurring.
 - If they are involved in recovery/treatment and/or AA or another 12-step group.
 - If they are interested in trying medications that can make it easier to stop drinking.

Table 9a. Medications for alcohol withdrawal

Table 9b. Adjunctive therapeutics for alcohol withdrawal

Table 9c. Adjunctive medications used as needed to alleviate symptoms during withdrawal

Table 9a. Medications for alcohol withdrawal (See “Prescribing notes” following table.)			
1st line: Benzodiazepines			
Medication	Dosing and taper schedule		
	Day	Dose	Schedule
Lorazepam (short-acting)	1	2 mg	Every 6 hours for 4 doses
	2	1 mg	Every 6 hours for 4 doses
	3	1 mg	Three times daily
	4	1 mg	Twice daily
	5	0.5 mg	Twice daily
Chlordiazepoxide ¹ (long-acting)	1	25 mg	Every 6 hours for 4 doses
	2	25 mg	Three times daily
	3	25 mg	Twice daily
	4	25 mg	Once daily
Anticonvulsants			
Use anticonvulsants only in patients with contraindications to benzodiazepines or risk of addiction.			
Medication	Dosing and taper schedule		
Valproic acid or divalproex sodium-EC	500 mg three times daily for 5 days		
Gabapentin	400 mg three times daily for 5 days		
¹ Chlordiazepoxide dosing: Many common protocols include an additional day and start patients at 50 mg every 6 hours for the first day. For most patients receiving outpatient management, this dose would be too sedating.			

Prescribing notes for Table 9a. Medications for alcohol withdrawal

Lorazepam (short-acting)

Advantages

- Renally cleared, so safer in patients with hepatic impairment or in elderly.
- Shorter half-life also makes it less prone to oversedation.

Disadvantages

- Patients who are not likely to adhere to dosing schedule may have more withdrawal symptoms.

Chlordiazepoxide (long-acting)

Advantages

- Long half-life provides smooth taper and adequate seizure prophylaxis for those who are not likely to adhere to dosing schedule.

Disadvantages

- Potential oversedation and respiratory depression in slow metabolizers or those with hepatic impairment or in elderly.

Valproic acid or divalproex sodium-EC

Advantages

—

Disadvantages

- Avoid with hepatic impairment.
- May cause GI side effects.

Gabapentin

Advantages

- Renally cleared, so safer with hepatic impairment.

Disadvantages

- Does not provide reliable seizure prophylaxis (i.e., use for withdrawal symptoms when it is not safe to use benzodiazepines and patient is at relatively low risk for seizures).

Table 9b. Adjunctive therapeutics for alcohol withdrawal if not already prescribed

Medication	Dosing	Benefit
Thiamine	100 mg IM one time	Prevents encephalopathy and amnestic disorder.
Multivitamin with folate	1 tablet daily	Corrects common vitamin deficiencies.

Table 9c. Adjunctive medications used as needed to alleviate symptoms during withdrawal

These medications do not prevent development of seizures or delirium. They may be used in addition to benzodiazepines for symptomatic treatment typically lasting 3–7 days.

Class	Target symptoms	Medication	Dosing
Beta-blocker	Tachycardia, hypertension, tremors, sweats, anxiety, restlessness	Propranolol	10 mg three times daily as needed for 3 days
Alpha-adrenergic agonist	Hypertension, tremors, sweats, anxiety, restlessness	Clonidine	0.1 mg three times daily as needed for 3 days
Antihistamine	Anxiety, restlessness	Hydroxyzine	25 mg every 6 hours as needed
		Diphenhydramine	25 mg every 6 hours as needed
Antihistamine	Insomnia	Hydroxyzine	25–50 mg once daily at night as needed
		Diphenhydramine	25–50 mg once daily at night as needed
Antiemetic	Nausea	Promethazine	25 mg every 6 hours as needed
		Metoclopramide	10 mg every 6 hours as needed
Antacids	Dyspepsia	Calcium carbonate	500 mg 1–2 tabs every 8 hours as needed
		Mylanta	Follow package instructions
Pain reliever	Pain, fever	Acetaminophen	500 mg every 4 hours as needed not to exceed 3 g in 24 hours

Evidence Summary

The Unhealthy Drinking in Adults Screening and Intervention Guideline was developed using an evidence-based process, including systematic literature search, critical appraisal, and evidence synthesis.

Screening for unhealthy drinking

According to the U.S. Preventive Services Task Force (USPSTF), there is moderate-level evidence that screening adults in primary care settings can accurately identify individuals whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence but do place them at risk for increased morbidity and mortality (USPSTF 2013). There is insufficient evidence to determine the most appropriate screening frequency for unhealthy drinking in adults.

Screening tests

In 2012, the Agency for Healthcare Research and Quality (AHRQ) evaluated the sensitivity and specificity of several screening tests for detecting unhealthy drinking. After taking into account time burden, sensitivity, and specificity, AHRQ found that a single-question screen [How many times in the past year have you had X or more drinks in a day? (X = 4 for women and 5 for men)], the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) and the Alcohol Use Disorders Identification Test (AUDIT) were the best overall tools for screening adults for the full spectrum of unhealthy drinking in primary care.

Findings from the review suggest that for the AUDIT-C, using a cutoff score of greater than or equal to 2 or 3 for women and greater than or equal to 4 for men provides the best balance between sensitivity and specificity. For the AUDIT, using a cutoff score of 4 or 5 provides the best balance between sensitivity and specificity (Jonas 2012).

Sensitivity and specificity of screening tests for detecting unhealthy drinking in primary care (Jonas 2012)

Instrument/ Cutoff score	All adults		Women only		Men only	
	Sensitivity	Specificity	Sensitivity	Specificity	Sensitivity	Specificity
AUDIT ≥4	0.84 to 0.85	0.77 to 0.84	0.47 to 0.65	0.92 to 0.93	0.87 to 0.91	0.69 to 0.80
AUDIT ≥5	0.70 to 0.92	0.73 to 0.94	0.35 to 0.53	0.95 to 0.98	0.77 to 0.81	0.84 to 0.90
AUDIT ≥8	0.44 to 0.51	0.96 to 0.97	0.27	0.98	0.54 to 0.58	0.95 to 0.96
AUDIT-C ≥2	0.96	0.32	0.81 to 0.89	0.78 to 0.86	0.98	0.63
AUDIT-C ≥3	0.74 to 0.88	0.64 to 0.83	0.60 to 0.73	0.91 to 0.96	0.92 to 0.95	0.60 to 0.79
AUDIT-C ≥4	0.74 to 0.76	0.80 to 0.83	0.38 to 0.57	0.96 to 0.98	0.86	0.72 to 0.89
Single question: Past 12 months*	0.82 to 0.87	0.61 to 0.79	0.81	0.84	0.83	0.72

The reference standard was a structured diagnostic interview.

*Greater than or equal to 1 is a positive screen.

Behavioral interventions for adults with unhealthy drinking

The USPSTF found adequate evidence that brief behavioral counseling interventions can positively affect unhealthy drinking behaviors in adults engaging in risky or hazardous drinking (USPSTF 2013). While it is recognized that the specific components of behavioral interventions may vary, the strongest evidence supports the effectiveness of brief multi-contact behavioral counseling. These interventions generally lasted 10 to 15 minutes per contact and were delivered by primary care physicians, although some also included additional follow-up with a health educator or nurse (Jonas 2013).

Pharmacologic therapies for alcohol dependence

FDA-approved drugs

A recent systematic review and meta-analysis prepared by the AHRQ (Jonas 2014) assessed the benefits and harms of medications for adults with AUD. The review included medications approved by the U.S. Food and Drug Administration as well as other medications. The AHRQ identifies acamprosate and oral naltrexone as effective medications for improving alcohol consumption outcomes. Head-to-head comparisons of these medications do not favor one over the other. The efficacy of disulfiram in reducing alcohol consumption was not supported by the literature.

Off-label-use medications

Anticonvulsants

A Cochrane review (Pani 2014) and meta-analysis of 17 trials evaluated the efficacy and acceptability of anticonvulsants used alone or in combination with another medication or a psychosocial intervention for the treatment of alcohol dependence. The anticonvulsants assessed in the trials included topiramate, gabapentin, pregablin, valproate, oxacarbazine, levetiracetam, zonisamide and carbamazine. Comparisons were made versus placebo or active therapies with naltrexone, acamprosate, or disulfiram. Overall, the meta-analysis does not provide sufficient evidence on the effectiveness of anticonvulsants to treat alcohol dependence. The studies included were small and had wide variations in quality, design, and rating instruments. The specific medication most supported by evidence of efficacy was topiramate (6 RCTs [n = 970] versus placebo and 3 [n = 380] versus naltrexone).

Topiramate

There is fair evidence from meta-analyses (Jonas 2014, Bodget 2012, and Pani 2014) that topiramate has a moderate overall effect on improving alcohol consumption outcomes (abstinence and heavy drinking) in individuals with AUD. However, it is associated with a significantly higher dropout rate than placebo due to side effects (12.3% versus 4.6%), which include increased risk of paresthesia, taste perversion, anorexia, insomnia, difficulty concentrating, nervousness, psychomotor slowing, dizziness, and pruritus.

Gabapentin and valproic acid

There is insufficient evidence to determine the efficacy of valproic acid or gabapentin on alcohol consumption or health outcomes patients with AUD.

Nalmefene

There is moderate evidence from meta-analyses pooling results from trials conducted mainly in Europe that nalmefene used off-label may be more effective than placebo in reducing relapse to heavy drinking and number of heavy drinking days in alcohol-dependent patients treated in an inpatient setting (Soyka 2016, Palpacuer 2015, and Jonas 2014).

Alcohol withdrawal syndrome (AWS): diagnosis and management

The literature search identified at least 20 validated tools/rating scales for predicting and/or managing alcohol withdrawal syndrome (AWS). There are wide variations between these tools in the signs and symptoms included as well as length and ease of using them. The great majority were developed among patients hospitalized for alcohol detoxification or for other medical illnesses. In addition, many have subjective items, which may lead to inter-rater variability.

CIWA/CIWA-Ar

The Clinical Institute Withdrawal Assessment for Alcohol (CIWA-A) is the most commonly studied and used tool for assessing severity as well as monitoring patients undergoing alcohol detoxification. It is a 15-item tool that was developed among hospitalized chronic alcoholic patients (Shaw 1981). In 1989, Sullivan and colleagues shortened the scale to include 10 items, renaming it the Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised (CIWA-Ar) (Sullivan 1989). Both the CIWA and CIWA-Ar are validated tools that guide benzodiazepine dosing as part of symptom-triggered dosing regimens.

Short Alcohol Withdrawal Scale (SAWS)

SAWS is a 10-item tool that has been validated in the outpatient setting. In the SAWS, patients indicate how they felt in the previous 24 hours (Gossop 2002, Elholm 2010).

The first five items represent psychological symptoms, and the next five items represent physical symptoms:

- Anxious
- Feeling confused
- Restless
- Miserable
- Problems with memory
- Tremor
- Nausea
- Heart pounding
- Sleep disturbance
- Sweating

Each item is scored on a 4-point scale: 0 = no symptoms, 1 = mild symptoms, 2 = moderate symptoms, and 3 = severe symptoms. The scores are summed up to give a total score.

- A total score < 12 points = mild withdrawal
- A total score \geq 12 points = moderate to severe withdrawal

Setting for management of AWS

There is insufficient evidence from published studies to determine the optimal setting for alcohol detoxification. However, there is a consensus that certain patients should be considered for inpatient treatment based on the following predictors of severe alcohol withdrawal syndrome (Sachdeva 2015).

- Older age
- History of severe withdrawal symptoms
- History of withdrawal seizures or delirium tremens
- Multiple previous detoxifications
- Comorbid psychiatric, surgical, or medical illness
- Recent high levels of alcohol consumption
- Dehydration
- Electrolyte disturbance (hyponatremia or hypokalemia)
- Abnormal liver enzymes
- Structural brain lesions

Inpatient treatment may also be recommended for pregnant women, and for patients who lack a reliable support network.

Medications/strategies for stabilizing adult patients at risk of AWS in an ambulatory outpatient setting

A systematic review by Kattimani and colleagues (2013) indicates that

- Mild AWS may not need pharmacotherapy.
- Outpatient treatment can be started for patients without risk factors (e.g., acute medical illness or past history of severe withdrawal) and is based on clinical withdrawal signs.
- Pharmacotherapy starts when systolic BP exceeds 150 mm Hg, diastolic BP exceeds 90 mm Hg, body temperature is greater than 37.7°C, or pulse exceeds 100 BPM, or when other withdrawal symptoms such as agitation, insomnia, or tremulousness are present without other medical or neurological illness.

Benzodiazepines

There is good evidence from a meta-analysis of 64 randomized controlled trials (RCTs) that, compared with placebo, oral benzodiazepines are safe and effective in reducing the risk of having an alcohol withdrawal seizure (Amato 2010). Choice of the benzodiazepine should take into consideration the pharmacokinetics of the agent, patient age, and presence of comorbidities.

Other drugs used for the treatment of AWS

There is insufficient evidence to recommend baclofen, sodium oxybate, dexmedetomidine, anticonvulsants, barbiturates, or magnesium for the treatment of alcohol withdrawal syndrome.

References

- Amato L, Minozzi S, Vecchi S, Davoli M. Benzodiazepines for alcohol withdrawal. *Cochrane Database Syst Rev*. 2010;(3):CD005063.
- American College of Obstetricians and Gynecologists (ACOG). At-risk drinking and alcohol dependence: obstetric and gynecologic implications. Committee Opinion No. 496. *Obstet Gynecol*. 2011;118:383-388.
- American College of Obstetricians and Gynecologists (ACOG). *Tobacco, Alcohol, Drugs, and Pregnancy*. Frequently Asked Questions FAQ170. 2013.
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA: American Psychiatric Association; 2013.
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR*. 4th ed., text revision. Washington, DC: 2000.
- Blodgett JC, Del Re AC, Maisel NC, Finney JW. A meta-analysis of topiramate's effects for individuals with alcohol use disorders. *Alcohol Clin Exp Res*. 2014 Jun; 38(6):1481-1488.
- Bradley KA, Bush KR, Epler AJ, et al. Two brief alcohol-screening tests from the Alcohol Use Disorders Identification Test (AUDIT): validation in a female Veterans Affairs patient population. *Arch Intern Med*. 2003;163(7):821-829.
- Corrao G, Bagnardi V, Zambon A, La Vecchia C. A meta-analysis of alcohol consumption and the risk of 15 diseases. *Prev Med*. 2004;38(5):613-619.
- Elholm B, Larsen K, Homnes N, Zierau F, Becker U. A psychometric validation of the Short Alcohol Withdrawal Scale (SAWS). *Alcohol Alcohol*. 2010 Jul-Aug; 45(4):361-365.
- Flannery BA, Volpicelli JR, Pettinati HM. Psychometric properties of the Penn Alcohol Craving Scale. *Alcohol Clin Exp Res*. 1999;23(8):1289-1295.
- Fleming MF, Barry KL, Manwell LB, Johnson K, London R. Brief physician advice for problem alcohol drinkers: a randomized controlled trial in community-based primary care practices. *JAMA*. 1997 Apr 2;277(13):1039-1045.
- Florez G, Saiz PA, Garcia-Portilla P, Alvarez S, Nogueiras L, Bobes J. Topiramate for the treatment of alcohol dependence: comparison with naltrexone. *Eur Addict Res*. 2011;17(1):29-36.
- Gossop M, Keaney F, Stewart D, Marshall EJ, Strang J. A Short Alcohol Withdrawal Scale (SAWS): development and psychometric properties. *Addict Biol*. 2002 Jan;7(1):37-43.
- Jonas DE, Amick HR, Feltner C, et al. Pharmacotherapy for adults with alcohol use disorders in outpatient settings: a systematic review and meta-analysis. *JAMA*. 2014 May 14;311(18):1889-1900.
- Jonas DE, Amick HR, Feltner C, et al. *Pharmacotherapy for adults with alcohol-use disorders in outpatient settings*. AHRQ Publication No.14-EHC029-EF. 134 Rockville, MD: Agency for Healthcare Research and Quality. May 2014. <http://effectivehealthcare.ahrq.gov/ehc/products/477/1907/alcohol-misuse-drug-therapy-executive-140513.pdf>
- Jonas DE, Garbutt JC, Brown JM, et al. *Screening, Behavioral Counseling, and Referral in Primary Care to Reduce Alcohol Misuse*. AHRQ Publication No. 12-EHC055-EF. Rockville, MD: Agency for Healthcare Research and Quality. July 2012. http://effectivehealthcare.ahrq.gov/ehc/products/269/1135/CER64_AlcoholMisuse_ExecSumm_20120608.pdf
- Jonas DE, Garbutt JC, Amick HR, et al. Behavioral counseling after screening for alcohol misuse in primary care: a systematic review and meta-analysis for the U.S. Preventive Services Task Force. *Ann Intern Med*. 2012 Nov 6;157(9):645-654.
- Kattimani S, Bharadwaj B. Clinical management of alcohol withdrawal: A systematic review. *Ind Psychiatry J*. 2013 Jul;22(2):100-108.
- Kenna GA, Longabaugh R, Gogineni A, et al. Can the short index of problems (SIP) be improved? Validity and reliability of the three-month SIP in an emergency department sample. *J Stud Alcohol*. 2005 May;66(3):433-437.
- Lim SS, Vos T, Flaxman AD, et al. A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet*. 2012;380:2224-2260. doi:10.1016/S0140-6736(12)61766-8.
- Miller WR, Tonigan JS, Longabaugh R. *The Drinker Inventory of Consequences (DrlnC): An Instrument for Assessing Adverse Consequences of Alcohol Abuse (Project MATCH Monograph Series) (NIH Publication No. 95-3911)*. Vol 4.

U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, Rockville: MD, 1995.

National Institute for Health and Clinical Excellence. *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence*. National Institute for Health and Clinical Excellence website. www.nice.org.uk/guidance/cg115. Published 2011.

Palpacuer C, Laviolle B, Boussageon R, Reymann JM, Bellissant E, Naudet F. Risks and Benefits of Nalmefene in the Treatment of Adult Alcohol Dependence: A Systematic Literature Review and Meta-Analysis of Published and Unpublished Double-Blind Randomized Controlled Trials. *PLoS Med*. 2015 Dec 22;12(12):e1001924.

Pani PP, Trogu E, Pacini M, Maremmi I. Anticonvulsants for alcohol dependence. *Cochrane Database Syst Rev*. 2014 Feb 13;(2):CD008544. doi: 10.1002/14651858.CD008544.pub2.

Sachdeva A, Choudhary M, Chandra M. Alcohol Withdrawal Syndrome: Benzodiazepines and Beyond. *J Clin Diagn Res*. 2015 Sep; 9(9):VE01-VE07.

Shaw JM, Kolesar GS, Sellers EM, Kaplan HL, Sandor P. Development of optimal treatment tactics for alcohol withdrawal. I. Assessment and effectiveness of supportive care. *J Clin Psychopharmacol*. 1981 Nov;1(6):382-389.

Soyka M. Nalmefene for the treatment of alcohol use disorders: recent data and clinical potential. *Expert Opin Pharmacother*. 2016;17(4):619-626.

Stahre M, Roeber J, Kanny D, Brewer RD, Zhang X. Contribution of excessive alcohol consumption to deaths and years of potential life lost in the United States. *Prev Chronic Dis*. 2014 Jun 26;11:E109. doi: 10.5888/pcd11.130293.

Sullivan JT, Sykora K, Schneiderman J, Naranjo CA, Sellers EM. Assessment of alcohol withdrawal: the revised clinical institute withdrawal assessment for alcohol scale (CIWA-Ar). *Br J Addict*. 1989 Nov;84(11):1353-1357.

UK Department of Health. *Alcohol Guidelines Review: Report from the Guidelines development group to the UK Chief Medical Officers*. 2016.

U.S. Preventive Services Task Force. Screening and behavioral counseling interventions in primary care to reduce alcohol misuse: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2013;159(3):210-218.

World Health Organization (WHO). *Guidelines for the identification and management of substance use and substance use disorders in pregnancy*. Geneva, Switzerland: World Health Organization, 2014.

Guideline Development Process and Team

Development process

The Unhealthy Drinking in Adults Screening and Intervention Guideline was developed using an evidence-based process, including systematic literature search, critical appraisal, and evidence synthesis.

This edition of the guideline was approved for publication by the Guideline Oversight Group in October 2016.

Team

The Unhealthy Drinking in Adults Screening and Intervention Guideline development team included representatives from the following specialties: adolescent health, behavioral health, family medicine, Group Health Research Institute, nursing, pharmacy, and women's health.

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Disclosure of conflict of interest

Kaiser Permanente requires that team members participating on a guideline team disclose and resolve all potential conflicts of interest that arise from financial relationships between a guideline team member or guideline team member's spouse or partner and any commercial interests or proprietary entity that provides or produces health care–related products and/or services relevant to the content of the guideline.

Team members listed above have disclosed that their participation on the Unhealthy Drinking in Adults Screening and Intervention Guideline team includes no promotion of any commercial products or services, and that they have no relationships with commercial entities to report.

Appendix 1a. Talking Points for Brief Interventions: Men and Non-pregnant, Non-lactating Women

Talking points for positive AUDIT-C score: 4–6 points (men) and 3–6 points (women)

Note: This content is also available as an AVS SmartPhrase (.avsauditcpositive).

- “We are now offering preventive advice about alcohol use to all patients who drink regularly. Would you mind if I provided some information on healthy alcohol use?”
- “Your answers suggest that you might be at risk for adverse health effects of drinking.”
- “Alcohol use while you take naproxen can cause stomach irritation and ulcers.”
- “I am concerned that your drinking might be contributing to raising your blood pressure. I know that you don’t like to take medication—would you be willing to try reducing your drinking to see if we can avoid using blood pressure medication?”
- **For men aged 18 through 65:** “I recommend you drink no more than 4 standard drinks in a single day and no more than 14 in a week.”
- **For all women, and for men aged 66 and older:** “I recommend you drink no more than 3 standard drinks in a single day and no more than 7 in a week.”
- “What do you make of this information? Is decreasing your drinking something you would consider?”
- “I can give you more information if you are interested.” Suggest the NIAAA Rethinking Drinking website (rethinkingdrinking.niaaa.nih.gov).

Talking points for high positive AUDIT-C score: 7–12 points (men and women)

This content is available as an AVS SmartPhrase (.avsauditcchighpositive).

- **Asking permission:** “Do you mind if we discuss your alcohol use for a moment?”
- **Expressing concern:** “I’m concerned that you are drinking at a level that will over time impact your health (or is worsening your insomnia, depression, heart failure, hypertension, GERD, gout, hepatitis C, diabetes, remembering to take your medications, falls, etc.).”
- **Exploring reasons for and against:** “Have you had concerns? Have any family members or friends had concerns?”
- “Can you tell me about some of the good things about drinking for you and some of the not so good things?”
- “How **important** is it to you to change (from 0–10, with 10 being the most)? How **confident** are you that you could change if you wanted (from 0–10, with 10 being the most)?” If a low number: “Why did you give it a 3 instead of a 0?” If a high number, “What makes you give it a 6 instead of a 3 or 4?” (Seek to have patients articulate for themselves their reasons for changing.)
- **Previous successes:**
 - “Have you ever tried to make a change in your drinking or another behavior like eating exercise or smoking? If yes, what worked for you then?”
 - “Have you ever been treated for an alcohol or drug problem? Tell me about that. What worked for you then?”
 - “Has there been a time in the past where you were successful at cutting down or did not drink at all? Can you tell me about that time? What helped you succeed?”
- **Optimism:** “I’m confident that you can change when you are ready.”
- “Reducing your drinking could markedly benefit your _____.”
- **Supporting patient autonomy:** “This choice is up to you. I know a decision to cut down can be difficult.”

- **Goal setting:** Help patients set a short-term goal that they are confident they can achieve, such as identifying triggers for heavy drinking or filling out a drinking diary in the coming weeks.
- “So where does this leave you now? Is there a small change you would like to make?”
- “Options that some patients have found helpful are monitoring your drinking, cutting down by _____, buying a limited amount, and alternating alcoholic drinks with non-alcoholic drinks.”
- **Plan follow-up:** “I’d like to check back with you in a few weeks. Would that be OK?”
- **Offer referral for self-assessment:** “Your score on this questionnaire was ____ points. People who have this score are often having problems due to drinking that they might not even have recognized. A systematic assessment can help. I’d like to check some labs today (GGT and MCV), and would you mind if we had you see our social worker (or behavioral health clinician) to help you assess your drinking?”
- **Inform about options:** “If you were having symptoms due to drinking, counseling, medications, and specialty addictions treatment are all options to help you make changes if you wanted.”

Appendix 1b. Talking Points for Brief Interventions: Pregnant and Lactating Women

Adapted in part from ACOG 2011, ACOG 2013, UK Department of Health 2016, and WHO 2014.

Talking points for pregnant women

- Women who are pregnant or planning pregnancy should refrain from drinking alcohol to keep the risks to the baby minimal.
- Women who learn they are pregnant after drinking at low levels in the early stages of their pregnancy should stop all consumption of alcohol for the duration of their pregnancy. They should be advised that in most cases the fetus is unlikely to have been affected by the earlier, low-level drinking.
- Fetal alcohol syndrome (FAS) is most likely to occur in infants whose mothers drank above the recommended limits prior to becoming pregnant (3 or more drinks per day or more than 7 drinks per week) and continued to drink heavily through pregnancy. However, FAS can occur with lower alcohol use.
- Drinking even one serving of alcohol per day—the recommended limit for non-pregnant women—can cause lifelong learning and behavioral problems in the child.
- **There is no safe amount of alcohol in pregnancy.**

Talking points for lactating women

- Abstinence is recommended for lactating women.
- If a lactating woman is currently drinking, breastfeeding is generally still recommended unless the risks clearly outweigh the benefits.
- Contrary to some popular belief, consuming alcohol does not enhance lactation.
- When lactating mothers drink alcohol, their infants consume less breast milk.
- Alcohol consumption during lactation is associated with altered growth, sleep patterns, and psychomotor patterns in the infant.
- Women should wait at least 2 hours after one standard drink to breastfeed their infants, and 4–8 hours after two or more drinks.

Appendix 2. AUDIT Tool

The full, 10-item AUDIT tool is available from the Patient Health Education page.

Interpreting AUDIT screening results from the full 10-item AUDIT

Use the Alcohol Symptom Checklist (Table 6, p. 12) for diagnosing alcohol use disorder, **not** AUDIT (or AUDIT-C) scores. Answers to questions on the full AUDIT can be used to facilitate initiation of an alcohol-related discussion with the patient.

Scoring and interpretation for the 10-item AUDIT			
Score	Interpretation	Management	Follow-up
Men and women < 5 points	Negative for unhealthy drinking.	No intervention, unless contraindications to drinking alcohol.	Rescreen in 1 year, or sooner if contraindications to drinking alcohol.
Men 5–10 points Women 5–8 points	Positive for unhealthy drinking.	Brief intervention.	Use clinical judgment to determine appropriate follow-up interval.
Men 11–40 points Women 9–40 points	High positive for unhealthy drinking. The higher the score, the greater the potential for health risks.	Diagnostic assessment for alcohol use disorder using the AUD symptom checklist (Table 6, p. 12).	If patient has AUD, manage AUD. If patient does not have AUD, provide brief intervention and use clinical judgment to determine appropriate follow-up interval.

Appendix 3. Self-Assessment Tools

The following self-assessment tools are recommended for use as part of engagement visits for patients diagnosed with AUD:

Short Inventory of Problems (SIP)

The 15-question SIP can be used to help the patient identify and assess alcohol-related symptoms and provide talking points for further discussion. The SIP can be used repeatedly and tracked over time as an objective way to measure the patient's progress. (See p. 38.) This tool is also available from the Patient Health Education page.

Penn Alcohol Craving Scale (PACS)

The 5-question PACS is helpful for assessing the level of cravings that the patient is experiencing. It can also inform decisions about whether to add or continue medications to the patient's treatment plan. The PACS can provide talking points for further discussion, and be used repeatedly and tracked over time as an objective way to measure the patient's progress. (See p. 39.) This tool is also available from the Patient Health Education page.

Readiness Rulers

Readiness rulers are helpful tools for motivational interviewing. Patients can be asked the following questions at every engagement visit:

On a scale from 0 to 10:

1. How **IMPORTANT** do you feel it would be to change your drinking?
2. How **CONFIDENT** do you feel that you can change your drinking?

The provider should ask follow-up questions about the patient's self-rating. Asking, "Why not a higher number?" gives the patient an opportunity to explore and articulate current **barriers** to changing drinking, while "Why not a lower number?" can elicit the patient's **motivations** to change or their self-efficacy. The actual number patients assign themselves is not important, but the discussion that follows is.

Short Inventory of Problems (SIP-2R)

DURING THE PAST 3 MONTHS, about how often has this happened to you? Circle one answer.	Never	Once or a few times	Once or twice a week	Daily or almost daily
1. I have been unhappy because of my drinking.	0	1	2	3
2. Because of my drinking, I have not eaten properly.	0	1	2	3
3. I have failed to do what is expected of me because of my drinking.	0	1	2	3
4. I have felt guilty or ashamed because of my drinking.	0	1	2	3
5. I have taken foolish risks when I have been drinking.	0	1	2	3
6. When drinking, I have done impulsive things that I regretted later.	0	1	2	3
7. My physical health has been harmed by my drinking.	0	1	2	3
8. I have had money problems because of my drinking.	0	1	2	3
9. My physical appearance has been harmed by my drinking.	0	1	2	3
10. My family has been hurt by my drinking.	0	1	2	3
11. A friendship or close relationship has been damaged by my drinking.	0	1	2	3
12. My drinking has gotten in the way of my growth as a person.	0	1	2	3
13. My drinking has damaged my social life, popularity, or reputation.	0	1	2	3
14. I have spent too much or lost a lot of money because of my drinking.	0	1	2	3

Has this happened to you DURING THE PAST 3 MONTHS? Circle one answer.	No	Almost	Yes, once	Yes, more than once
15. I have had an accident while drinking or intoxicated..	0	1	2	3

Source: Kenna GA, et al. Can the short index of problems (SIP) be improved? Validity and reliability of the three-month SIP in an emergency department sample. J Stud Alcohol. 2005;66(3):433–7.

Penn Alcohol Craving Scale

Date _____

Patient Name _____

Circle the number that best describes your craving during the past week.

1. During the past week how often have you thought about drinking or about how good a drink would make you feel?
 - 0 Never (0 times during the past week)
 - 1 Rarely (1 to 2 times during the past week)
 - 2 Occasionally (3 to 4 times during the past week)
 - 3 Sometimes (5 to 10 times during the past week or 1 to 2 times per day)
 - 4 Often (11 to 20 times during the past week or 2 to 3 times per day)
 - 5 Most of the time (20 to 40 times during the past week or 3 to 6 times per day)
 - 6 Nearly all of the time (more than 40 times during the past week or more than 6 times per day)
2. At its most severe point, how strong was your craving during the past week?
 - 0 None at all
 - 1 Slight, very mild urge
 - 2 Mild urge
 - 3 Moderate urge
 - 4 Strong urge, but easily controlled
 - 5 Strong urge and difficult to control
 - 6 Strong urge and would have drunk alcohol if it were available
3. During the past week how much time have you spent thinking about drinking or about how good a drink would make you feel?
 - 0 None at all
 - 1 Less than 20 minutes
 - 2 21 to 45 minutes
 - 3 46 to 90 minutes
 - 4 90 minutes to 3 hours
 - 5 Between 3 to 6 hours
 - 6 More than 6 hours
4. During the past week how difficult would it have been to resist taking a drink if you had known a bottle were in your house?
 - 0 None at all
 - 1 Very mildly difficult
 - 2 Mildly difficult
 - 3 Moderately difficult
 - 4 Very difficult
 - 5 Extremely difficult
 - 6 Would not be able to resist
5. Keeping in mind your responses to the previous questions, please rate your overall average alcohol craving for the past week.
 - 0 Never thought about drinking and never had the urge to drink
 - 1 Rarely thought about drinking and rarely had the urge to drink
 - 2 Occasionally thought about drinking and occasionally had the urge to drink
 - 3 Sometimes thought about drinking and sometimes had the urge to drink
 - 4 Often thought about drinking and often had the urge to drink
 - 5 Thought about drinking most of the time and had the urge to drink most of the time
 - 6 Thought about drinking nearly all of the time and had the urge to drink nearly all of the time

Source: Flannery BA, Volpicelli JR, Pettinati HM. Psychometric properties of the Penn Alcohol Craving Scale. *Alcoholism: Clinical and Experimental Research*. 1999;23(8):1289-1295.