Alcohol Assessment and Intervention – Pediatric/Adult – Primary Care Clinical Practice Guideline

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Release Date: August 2014
Next Review: August 2016
Executive Summary

Guideline Overview
The 2005 NIAAA Physician’s Guide\(^1\) as well as the 2011 American Academy of Pediatrics Policy Statement\(^2\) served as a primary outline to this document.

Key Practice Recommendations
1. Perform Screening for Alcohol Use
2. Complete Assessment for Positive Screens
3. Perform Brief Intervention
4. Provide Treatment

Companion Documents
1. NIAAA Standard Drink Chart
2. Alcohol Assessment and Intervention Algorithm
3. Alcohol Intervention and Referral Algorithm

Additional & External Resources:
1. Substance Abuse and Mental Health Services Administration- Facility Locator (http://findtreatment.samhsa.gov/)

Scope

Disease/Condition(s): Alcoholism, Risky Behavior

Clinical Specialty: Primary Care

Intended Users: Primary Care Physicians, Physician Assistants, Medical Assistants, Registered Nurses, Nurse Practitioners

CPG objective(s):
- Reduce current practice variation and provide evidence-based recommendations to help improve patient outcomes.
- Identify tools which providers may use to assess a patient’s alcohol intake habits.
- Provide providers with recommended interventions.

Target Population:
Adolescent (11-17 years) and adult (18 years and older) primary care patients.

Methodology
Methods Used to Collect/Select the Evidence and Formulate the Recommendations: The workgroup reviewed previous guideline recommendations, and conducted electronic searches of PubMed and other databases to update and verify content. Consensus was obtained among the working group members regarding the types of recommendations included in this guideline.

Methods Used to Assess the Quality and Strength of the Evidence and Recommendations: The workgroup used the Grading of Recommendations Assessment, Development and Evaluation (GRADE) algorithm\(^3\) below to establish grades for evidence/recommendations not included in the U.S. Preventive Services Task Force (USPSTF) review.\(^4\)

Rating Scheme for the Strength of the Evidence: Evidence which was included in the USPSTF review was rated using the scheme found in Table 1. Any additional evidence outside of the USPSTF report, which was reviewed by the workgroup was rated using the GRADE scheme in Table 2.

Table 1. USPSTF Ranking of Evidence

<table>
<thead>
<tr>
<th>Level of Certainty*</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.</td>
</tr>
</tbody>
</table>
| Moderate           | The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as:  
  - The number, size, or quality of individual studies.  
  - Inconsistency of findings across individual studies.  
  - Limited generalizability of findings to routine primary care practice.  
  - Lack of coherence in the chain of evidence.  
  As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion. |
| Low                | The available evidence is insufficient to assess effects on health outcomes. Evidence is |

\(^*\)The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies. 

\(^\)The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as: the number, size, or quality of individual studies, inconsistency of findings across individual studies, limited generalizability of findings to routine primary care practice, lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion. 

\(^\)The available evidence is insufficient to assess effects on health outcomes. Evidence is
insufficient because of:

- The limited number or size of studies.
- Important flaws in study design or methods.
- Inconsistency of findings across individual studies.
- Gaps in the chain of evidence.
- Findings not generalizable to routine primary care practice.
- Lack of information on important health outcomes.

More information may allow estimation of effects on health outcomes.

* The USPSTF defines certainty as “likelihood that the USPSTF assessment of the net benefit of a preventive service is correct.” The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

**Table 2. GRADE Ranking of Evidence**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>We are confident that the effect in the study reflects the actual effect.</td>
</tr>
<tr>
<td>Moderate</td>
<td>We are quite confident that the effect in the study is close to the true effect, but it is also possible it is substantially different.</td>
</tr>
<tr>
<td>Low</td>
<td>The true effect may differ significantly from the estimate.</td>
</tr>
<tr>
<td>Very Low</td>
<td>The true effect is likely to be substantially different from the estimated effect.</td>
</tr>
</tbody>
</table>

**Rating Scheme for the Strength of the Recommendations:** The USPSTF grading scheme was used (Table 3) otherwise any recommendations not provided directly by the USPSTF were rated using the GRADE continuum (Table 4).

**Table 3. USPSTF Grades for Recommendations**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is substantial.</td>
</tr>
<tr>
<td>B</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.</td>
</tr>
<tr>
<td>C</td>
<td>The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.</td>
</tr>
<tr>
<td>D</td>
<td>The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.</td>
</tr>
<tr>
<td>I Statement</td>
<td>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.</td>
</tr>
</tbody>
</table>

**Table 4. GRADE Ratings for Recommendations**

<table>
<thead>
<tr>
<th>Strength for using/Against using</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong for using/Strong against using</td>
<td>The net benefit of the treatment is clear, patient values and circumstances are unlikely to affect the decision.</td>
</tr>
<tr>
<td>Weak for using/Weak against using</td>
<td>The evidence is weak or the balance of positive and negative effects is vague.</td>
</tr>
</tbody>
</table>
Definitions:

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

One standard drink = 12 oz. regular beer = 8-9 oz. malt liquor = 5 oz. table wine = 1.5 oz. 80-proof hard liquor.¹

Figure 1. NIAAA Standard Drink Chart¹

<table>
<thead>
<tr>
<th>12 oz. of beer or cooler</th>
<th>8–9 oz. of malt liquor</th>
<th>5 oz. of table wine</th>
<th>3–4 oz. of fortified wine (such as sherry or port)</th>
<th>2–3 oz. of cordial, liqueur, or aperitif</th>
<th>1.5 oz. of brandy (a single jigger)</th>
<th>1.5 oz. of spirits (a single jigger of 80-proof gin, vodka, whiskey, etc.) shown roughed out in a highball glass with ice to show dilution before adding a mixer</th>
</tr>
</thead>
<tbody>
<tr>
<td>-5% alcohol</td>
<td>-7% alcohol</td>
<td>-12% alcohol</td>
<td>-17% alcohol</td>
<td>-24% alcohol</td>
<td>40% alcohol</td>
<td>&lt;40% alcohol</td>
</tr>
<tr>
<td>12 oz.</td>
<td>8.5 oz.</td>
<td>5 oz.</td>
<td>3.5 oz.</td>
<td>2.5 oz.</td>
<td>1.5 oz.</td>
<td>1.5 oz.</td>
</tr>
</tbody>
</table>

- **Alcohol Use Disorder**: A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two diagnostic criteria occurring within a 12-month period.⁵

- **At Risk Use**: Consuming the equivalent of more than 4 standard drinks in a day or more than 14 in a week, for men and the equivalent of more than 3 standard drinks in a day or more than 7 in a week for women who do not meet criteria for alcohol dependence or abuse. Some literature also uses the term "hazardous drinking" for drinking that runs the risk of causing serious problems.

- **Harmful Drinking (Alcohol Abuse)**: Drinking amounts that cause serious problems. These problems include motor vehicle crashes, physical health and/or mental health problems, violence, injuries, unsafe sex, and serious issues in areas of life such as work, school, family, social relationships, and finances.

**Introduction**

Excessive alcohol consumption accounted for nearly 1 in 10 deaths and over 1 in 10 years of potential life lost among working-age adults in the United States between 2006-2010.⁶ In addition, it has been estimated that 37% of U.S. adolescents aged 12-17 years used alcohol or drugs within the previous year, and 7.9% met criteria for a substance-related disorder.⁷ The 2005 NIAAA Physician’s Guide¹ as well as the 2011 American Academy of Pediatrics Policy Statement² served as a primary outline to this document.
Alcohol Screening and Assessment Algorithm

Adolescents (age 11-17 yrs.)

Perform Screening
During the past 12 months, did you:
1. Drink any alcohol (more than a few sips)?
   (Do not count sips of alcohol taken during family or religious events)
2. Smoke any marijuana or hashish?
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things you sniff or "huff")

<table>
<thead>
<tr>
<th>Patient Response</th>
<th>Complete CAR question of CRAFFT Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Complete CAR question of CRAFFT Assessment</td>
</tr>
<tr>
<td>No</td>
<td>Provide patient education regarding safe driving habits.</td>
</tr>
</tbody>
</table>

Perform Screening
1. Did you drink alcohol before you knew you were pregnant?
2. Have you been able to stop or cut down since you found out you were pregnant?

<table>
<thead>
<tr>
<th>Patient Response to Question 1</th>
<th>1. Did you drink alcohol before you knew you were pregnant?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2. Have you been able to stop or cut down since you found out you were pregnant?</td>
</tr>
<tr>
<td>No</td>
<td>Complete TWEAK Assessment</td>
</tr>
</tbody>
</table>

Perform Screening
Females (all ages)/Men >65 yrs.:
How often do you drink 4 or more drinks in a single occasion within the last year?

Men < 65 yrs.:
How often do you drink 5 or more drinks in a single occasion within the last year?

Answer Options:
- Never
- Once or Twice
- 6-20 times
- More than 20 times

<table>
<thead>
<tr>
<th>Patient Response to Question 2</th>
<th>Complete TWEAK Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Complete TWEAK Assessment</td>
</tr>
<tr>
<td>No</td>
<td>Provide patient education regarding safe driving habits.</td>
</tr>
</tbody>
</table>

Perform Screening
Adults

Perform Screening
Pregnant Adults

Perform Screening
1. Did you drink alcohol before you knew you were pregnant?
2. Have you been able to stop or cut down since you found out you were pregnant?

<table>
<thead>
<tr>
<th>Patient Response to Question 1</th>
<th>Complete TWEAK Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Complete TWEAK Assessment</td>
</tr>
<tr>
<td>No</td>
<td>Provide patient education regarding safe driving habits.</td>
</tr>
</tbody>
</table>

Perform Screening
Females (all ages)/Men >65 yrs.:
How often do you drink 4 or more drinks in a single occasion within the last year?

Men < 65 yrs.:
How often do you drink 5 or more drinks in a single occasion within the last year?

Answer Options:
- Never
- Once or Twice
- 6-20 times
- More than 20 times

<table>
<thead>
<tr>
<th>Patient Response to Question 2</th>
<th>Complete TWEAK Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Complete TWEAK Assessment</td>
</tr>
<tr>
<td>No</td>
<td>Provide patient education regarding safe driving habits.</td>
</tr>
</tbody>
</table>

Complete Physician-Patient Interview
Document number of risky drinking days in prior month
Proceed to Intervention/Referral Algorithm
1. Perform Screening for Alcohol Use

Screening of alcohol use status is the first critical step in determining problem drinking. Screening success is enhanced if:

- Annual alcohol screening is established as standard of care at each clinic site;
- A system such as an electronic medical record prompt or vital sign stamp is used to indicate alcohol use status;
- The receptionist or the person taking vital signs may ask patients to complete a written questionnaire or to respond orally to a few questions about their drinking.

Screening should be performed in asymptomatic or average risk patients.  

(USPSTF B Recommendation) Refer to Table 5 below for screening questions based upon patient age, gender, and scenario. Those patients with a current diagnosis of alcohol use disorder do not need to be screened. (High quality of evidence, Strong recommendation)

Table 5. Screening Question(s) Based Upon Patient Scenario

<table>
<thead>
<tr>
<th>Single Screening Question (Adults)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female patients or males &gt; 65 years:</strong></td>
</tr>
<tr>
<td>How often do you drink 4 or more drinks in a day within the last year?*</td>
</tr>
<tr>
<td><strong>Male patients &lt; 65 years:</strong></td>
</tr>
<tr>
<td>How often do you drink 5 or more drinks in a single day within the last year?*</td>
</tr>
<tr>
<td>*Answer Options: Never; Once or twice; 6-20 times; More than 20 times.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Screening Questions (Adolescents)</th>
</tr>
</thead>
</table>
| During the past 12 months, did you:  
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)  
2. Smoke any marijuana or hashish?  
3. Use anything else to get high? (“anything else” includes illegal drugs, over the counter and prescription drugs, and things that you sniff or “huff”) |

<table>
<thead>
<tr>
<th>Screening Question (Pregnant Adult Women)</th>
</tr>
</thead>
</table>
| 1. Did you drink alcohol before you knew you were pregnant?  
(If yes to Question 1)  
2. Have you been able to stop or cut down since you found out you were pregnant? |

Adults and Alcohol Use

Adult patients age 18 years or older, who are not pregnant, should be screened for their alcohol use (USPSTF B Recommendation) annually using the single screening question based upon age and gender. Patients who report excessive alcohol use one or more times in the last year are considered a positive screen and should complete a brief assessment and appropriate intervention services.
Pregnancy and Alcohol Use
Women who are pregnant should be screened using the pregnancy screening questions. Any women who answers “yes” to Question 1 (or no to Question 2) should be assessed using the TWEAK tool. (Moderate quality evidence, strong recommendation)

The Surgeon General of the United States and the Secretary of Health and Human Services recommend abstinence from alcohol for women planning pregnancy, at conception, and during pregnancy because a safe level of prenatal alcohol consumption has not been determined. (High quality of evidence, strong recommendation)

Alcohol appears to have negative effects throughout pregnancy, not just during the first trimester. These effects include impaired growth problems, facial dysmorphia, and central nervous system abnormalities (structural abnormalities, neurological problems, below normal cognitive performance).

Adolescents and Alcohol Use
It is recommended that adolescent patients are screened for alcohol use annually using the adolescent screening questions. (Low quality of evidence, strong recommendation)

If the patient responds “yes” to any of the screening questions, all 6 CRAFFT questions should be asked. The CAR question should be asked regardless of patient response to screening questions.

2. Complete Assessment
A positive patient response to the screening question(s) determines the need for further assessment for at risk drinking behavior or signs of alcohol substance use disorder. (USPSTF B Recommendation) The following assessment tools should be completed by the patient based upon age or pregnancy status.

AUDIT-C (Alcohol Use Disorders Identification Test- C): All non-pregnant adults with positive alcohol screens should complete the AUDIT-C questionnaire or the full AUDIT. (High quality of evidence, strong recommendation)

If a patient scores 3 points or greater on the AUDIT-C, the patient should complete the additional questions within the full AUDIT. (Moderate quality of evidence, strong recommendation)

<table>
<thead>
<tr>
<th>AUDIT-C Assessment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td>Non-pregnant Adults (18 years or older)</td>
</tr>
<tr>
<td><strong>Number of Questions</strong></td>
<td>3</td>
</tr>
<tr>
<td><strong>Administrator</strong></td>
<td>Staff or self-administered by patient</td>
</tr>
<tr>
<td><strong>Scoring</strong></td>
<td>Max Score Positive Threshold (At-Risk)* 12 3 points or greater</td>
</tr>
<tr>
<td></td>
<td>*Complete full AUDIT assessment</td>
</tr>
</tbody>
</table>
AUDIT (Alcohol Use Disorders Identification Test)\(^1,20\): The AUDIT was developed by the World Health Organization (WHO) to screen patients for excessive drinking behavior and to assist in brief assessment. Those patients who score 3 points or greater on the AUDIT-C should complete the full AUDIT assessment. (Moderate quality of evidence, strong recommendation)

<table>
<thead>
<tr>
<th>AUDIT Assessment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td>Non-pregnant Adults (18 years or older)</td>
</tr>
<tr>
<td><strong>Number of Questions</strong></td>
<td>10</td>
</tr>
<tr>
<td><strong>Administrator</strong></td>
<td>Staff or self-administered by patient</td>
</tr>
<tr>
<td><strong>Scoring:</strong></td>
<td>Max Score 40 points</td>
</tr>
<tr>
<td></td>
<td>Positive Threshold (At-Risk) 8 points or greater(^20)</td>
</tr>
<tr>
<td></td>
<td>Positive Threshold (Alcohol Dependence) 13 (women), 15 (men) points or greater(^20)</td>
</tr>
</tbody>
</table>

TWEAK (Tolerance, Worried, Eye-Opener, Amnesia, Cut Down)\(^21-25\): This assessment tool is recommended to screen women who are pregnant for risky drinking behavior. (High quality of evidence, strong recommendation) It is recommended that Question 1A is used during screening, due to differences in patient interpretation of “passing out”. (Low quality of evidence, weak recommendation)

<table>
<thead>
<tr>
<th>TWEAK Assessment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td>Pregnant women (18 years or older)</td>
</tr>
<tr>
<td><strong>Number of Questions</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Administrator</strong></td>
<td>Staff or self-administered by patient</td>
</tr>
<tr>
<td><strong>Scoring:</strong></td>
<td>Max Score 7 points</td>
</tr>
<tr>
<td></td>
<td>Positive Threshold (Risky drinking) 2 points or greater(^25)</td>
</tr>
</tbody>
</table>

CRAFFT (Car, Relax, Alone, Forget, Family/Friends, Trouble)\(^14,15,26-28\): This assessment tool is recommended by the American Academy of Pediatrics’ Committee on Substance Abuse\(^2,16\) to screen adolescents (age 11-17 years) for risky drinking behavior annually, especially during their well-adolescent visit.\(^2\) (USPSTF I Statement)

Adolescents should be screened using the screening questions outlined in the previous section. Further assessment (CAR question only vs. full CRAFFT assessment) may be completed based upon a patient’s responses to the initial screening questions.

<table>
<thead>
<tr>
<th>CRAFFT Assessment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td>Adolescents (age 11-17 years)</td>
</tr>
<tr>
<td><strong>Number of Questions</strong></td>
<td>6</td>
</tr>
<tr>
<td><strong>Administrator</strong></td>
<td>Staff or self-administered by patient</td>
</tr>
<tr>
<td><strong>Scoring:</strong></td>
<td>Max Score 6 points</td>
</tr>
<tr>
<td></td>
<td>Positive Threshold 2 points or greater(^14,16)</td>
</tr>
</tbody>
</table>
Higher scores on all of the standardized assessment tools typically correspond with a greater likelihood of having a substance use disorder. The following questions are included as examples for physicians and primary care providers to further assess a potential alcohol problem via a semi-structured interview following use of the previously described assessment tools.

**Physician-Patient Interview:**

1. Have you ever missed an important family event due to your drinking? (i.e., one of your children’s birthdays, a sporting event, or a school activity?)
2. Has anyone ever asked you to cut down or stop your drinking?
3. Have you ever tried to cut down on your drinking for a while?
4. What made you cut down?
5. Have you ever driven a car while under the influence of alcohol?
6. Has drinking affected your work or school?
7. What are some things you like about drinking? What don’t you like?
8. How many risky drinking days have you had in the last month? (Risky defined as more than 4 (women, men > 65 yrs.) or 5 (men < 65 yrs.) drinks/day).¹

Based upon the answers provided during the interview and on the formal assessment, a physician may consider establishing a diagnosis for alcohol use disorder (see Figure 5). It may also be beneficial to consider adding a diagnosis to the problem list, to alert colleagues to the potential for additional health complications and for higher risk of misuse of potentially addictive prescription medications. (Low quality of evidence, strong recommendation)

**NOTE:** Following diagnosis, patients are subject to follow requirements established by the Healthcare Effectiveness Data and Information Set (HEDIS) for initiating and engaging patients in treatment. For more information, see Appendix A.
The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) considers the following diagnostic criteria (manifested by at least two of the following within a 12-month period) indicative of an alcohol use disorder:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which it is physically hazardous.
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for alcohol (refer to Criteria A and B of the criteria set for alcohol withdrawal).
    b. Alcohol (or a closely related substance, such as benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

**Mild:** Presence of 2-3 symptoms

**Moderate:** Presence of 4-5 symptoms

**Severe:** Presence of 6 or more symptoms.
Figure 5. Alcohol Intervention and Referral Algorithm

Alcohol Intervention and Referral Algorithm

All Patients (Adolescent – Pregnant Adults – Adults)

Document number of risky drinking days in prior month

CRAFFT score < 4 points?

OR

AUDIT score < 20 points?

OR

TWEAK score < 2 points?

Yes

Perform Brief Intervention and Education

No

Provide Referral

Yes

Manage patient within primary care, and consider pharmacotherapy treatment

No

Patient Acceptance?

Yes

Provide Referral and consider pharmacotherapy treatment

No

Complete Follow-up in 4-8 weeks

Document number of risky drinking days in prior month to assess decrease in drinking behavior
3. Perform Brief Intervention for Non-Dependent, At-Risk or Problem Drinkers

Motivating patients to reduce or stop drinking is the essence of a brief intervention. The intervention includes providing feedback on alcohol use and harms, identification of high risk situations for drinking and coping strategies, as well as motivating patients to develop a personal plan to reduce drinking. A brief intervention can be as short as five minutes in the primary care clinical setting.29

Brief intervention is recommended for all patients identified as at risk alcohol users via the screening question or assessments.1,4 (USPSTF B Recommendation) Below are specific statements and messages clinicians may want to utilize with patients who use alcohol above recommended limits.

1. **Direct feedback:**
   “As your primary care clinician I am concerned about how much you drink and how it is affecting your health.”
   “You are drinking alcohol at a level that puts you at serious risk for a number of alcohol related problems, especially accidents, injuries or a worsening of your health problems.”

2. **Discuss how their alcohol use is affecting their health:**
   “As your physician I am concerned about how your alcohol use is affecting our ability to treat your ___________ (mention additional conditions, e.g. hypertension, diabetes, depression).”
   “All of your previous suicide attempts were associated with heavy drinking.”
   “Your __________ (other stated) medication will work better if you cut down or stop drinking.”

**NOTE:** If a patient reports drinking 10 or more drinks per day, provide brief anticipatory guidance for possible withdrawal symptoms and consider providing the patient with educational materials. (Low quality of evidence, strong recommendation)

3. **Negotiate and set goals:**
   “As your physician, I would recommend for you to [abstain from or reduce] your drinking.” (if the physician recommends abstaining, such as in alcoholism, it is beneficial to add: “However, if you are unable to abstain, even if you reduce your drinking it will be beneficial for your health”)
   “What do you think about cutting down to three drinks 2 to 3 times per week?”
   “Can you reduce your drinking for the next month?”

4. **Behavioral modification strategies:**
   “There are some situations when people drink and sometimes lose control of their drinking. These situations include going out to dinner with friends, having difficulty sleeping or during times of stress. Let’s talk about ways you can avoid these situations.”
   “Can you identify a family member or a friend who can help you?”
“What are the things you like about drinking?”
“What are some of the things you don’t like about your alcohol use?”
“Let’s practice what you will say to your friends or family members when they offer you a drink.”

5. **Self-help directed bibliotherapy : (when available)**
“I would like you to review this booklet on ways to reduce your alcohol use and bring it with you to our next visit.”
“It would be very helpful if you would complete some of the exercises in this guide.”

6. **Follow-up and reinforcement**
“I would like you to return to see me in one month to see how you are doing.”
“Someone from my office will call you in two weeks to check in with you.”
“Please make an appointment to see me in 2 weeks.”
“Sometimes people, despite best intentions, are not able to achieve the goals they set for themselves. I hope you’ll be successful, but if you have problems with it, please come and talk to me, and we’ll start from there.”

As with most kinds of behavioral therapy, Brief Intervention works best when delivered in a non-judgmental, caring, empathetic manner.

4. **Provide Treatment and/or Referral for Alcohol-Dependent Patients**

**Referral for AODA Counseling**
It is recommended that patients who score above 4 points on the CRAFFT, 20 points on the AUDIT, or 2 points on the TWEAK should be referred for AODA counseling. (Moderate quality of evidence, strong recommendation)

Those patients who do not accept a referral should be followed and managed within the primary care setting. While brief intervention is known to be effective in reducing alcohol consumption among at-risk drinkers, it may not be as effective among those with alcohol dependence. Consider immediate referral to specialist treatment in this situation (High quality of evidence, strong recommendation); however, if the patient is unwilling or unable to seek specialized AODA services, implementing all the steps of screening and brief intervention (SBI) is recommended. (Moderate quality of evidence, strong recommendation)

**Pharmacotherapy**
Medications may be used to assist adult patients in their recovery from alcohol dependence, whether or not they are receiving specialty-based treatment. Use is indicated for patients motivated to reduce alcohol intake. (High quality of evidence, strong recommendation) The following table (Table 6) provides information on the contraindications, adverse effects, and recommended doses for FDA-approved medications.
Table 6. Pharmacotherapy Options for Alcohol Dependence

<table>
<thead>
<tr>
<th>Medication</th>
<th>Contraindications/Precautions</th>
<th>Adverse Effects</th>
<th>Dosage</th>
<th>Initiation</th>
<th>Discontinuation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naltrexone (ReVia® - tablet)</td>
<td>- Concurrent use of opioids&lt;br&gt;- Opioid withdrawal&lt;br&gt;- Pregnancy Category C&lt;br&gt;- Active liver disease</td>
<td>Nausea, headache, dizziness, abdominal discomfort, increased liver function tests and CK, injection site reactions</td>
<td>Tab – 50 mg PO daily&lt;br&gt;Injection – 380 mg IM every 28 days</td>
<td>3+ days abstinence&lt;br&gt;Initial LFTs and urine drug screen</td>
<td>Duration: 3-12 months&lt;br&gt;No withdrawal effects; no need to taper</td>
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<td>Acamprosate (Campral®)</td>
<td>- Severe renal impairment (creatinine clearance &lt; 30 mL/min)&lt;br&gt;- Suicide ideation&lt;br&gt;- Pregnancy Category C&lt;br&gt;- Age &gt; 65 yrs.</td>
<td>Diarrhea, insomnia, anxiety, fatigue</td>
<td>333mg TID for 3-5 days (initiation)&lt;br&gt;666 mg PO three times daily (maintenance)</td>
<td>5 days abstinence&lt;br&gt;Initial renal function tests</td>
<td>Duration: &gt; 12 months&lt;br&gt;No withdrawal; no need to taper</td>
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<td>Disulfuram (Antabuse®)</td>
<td>- Myocardial disease&lt;br&gt;- Alcohol-containing cough preparations&lt;br&gt;- Psychosis&lt;br&gt;- Pregnancy Category B2&lt;br&gt;- Age &gt; 60 yrs.</td>
<td>Dermatitis, flushing with alcohol ingestion, increase in liver function tests, metallic taste</td>
<td>500 mg PO daily for 1 – 2 weeks, then 250 mg daily</td>
<td>12+ hours abstinence and/or BAC = 0&lt;br&gt;Baseline LFTs, urine HCG&lt;br&gt;ECG if clinically indicated</td>
<td>Duration: Up to 20 months&lt;br&gt;No withdrawal; no need to taper&lt;br&gt;Reaction with alcohol up to 2 weeks after discontinuation</td>
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<tr>
<td>Topiramate (Topamax®)</td>
<td>- Conditions or medications that predispose to metabolic acidosis&lt;br&gt;- Psychiatric or behavior disturbances&lt;br&gt;- Pregnancy Category B3</td>
<td>Dizziness, cognitive impairment, anorexia, weight loss, somnolence, abnormal serum bicarbonate</td>
<td>Initiate at 50 mg daily and increase dose over several weeks to 150 mg twice daily</td>
<td>Initiate at 50 mg daily, increase by 50 mg weekly to 100 mg twice daily. If cravings persist, doses can be titrated up to 150 mg twice daily.</td>
<td>Taper by decreasing daily dose by 50 mg each week, unless safety considerations warrant more rapid withdrawal.</td>
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</table>
Disclaimer
CPGs are described to assist clinicians by providing a framework for the evaluation and treatment of patients. This Clinical Practice Guideline outlines the preferred approach for most patients. It is not intended to replace a clinician’s judgment or to establish a protocol for all patients. It is understood that some patients will not fit the clinical condition contemplated by a guideline and that a guideline will rarely establish the only appropriate approach to a problem.

References