SCREENING AND BRIEF INTERVENTION FOR ALCOHOL PROBLEMS

- **Ask every patient about alcohol using a simple 4-question screening tool (CAGE-AID).**
- **Provide clear, personalized advice and set mutually acceptable goals.**
- **Offer information and treatment referrals.**

5 STEPS OF BRIEF INTERVENTION

(1) Healthy or unhealthy drinking?

- Ask every patient, regardless of age, gender, race/ethnicity, pregnancy, health status, or income, about alcohol use as part of routine health care.
- Be direct and non-judgmental.
- Use screening instruments to probe for alcohol problems. (SEE BACK)

(2) Give clear, personalized advice on how to cut down or abstain.

- Listen reflectively - summarize and repeat what your patient says.
- Show concern and avoid confrontation – be on your patient's side.
- When possible, link alcohol use to a specific medical condition, such as liver disease, insomnia or depression.

(3) Set mutually acceptable goals – involve your patient.

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

(4) Offer information and treatment referrals.

- Help patients identify drinking triggers such as job stress, money worries, chronic illness, family problems, depression, anxiety or social isolation, and suggest practical ways to cope.
- Provide patient education materials and resources.
- Offer treatment referrals and recommend self-help groups when necessary. Many alcohol-dependent patients will benefit from specialized chemical dependency services, such as outpatient rehabilitation or residential programs as well as self-help groups such as Alcoholics Anonymous (AA).

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

- 3 or 4 follow-up visits increase the effectiveness of brief intervention.
- Reinforce by visits with, or phone calls from, health educators, nurse practitioners, physician assistants, alcohol counselors, and others.

Adapted from: Petit J, Sederer, LI. Brief Intervention for Alcohol Problems. City Health Information, 2006; 25(10)71-78.

The New York City Department of Health and Mental Hygiene

SCREENING INSTRUMENTS FOR ALCOHOL PROBLEMS

CAGE-AID (Adapted to Include Drugs)

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

CAGE-AID for Adults

Have you ever:	
Thought you should...	**C**ut down on your drinking or drug use?
Become...	**A**nnoyed when people criticized your drinking or drug use?
Felt bad or...	**G**uilty about your drinking or drug use?
Needed an...	**E**ye-opener drink or used a drug to feel better in the morning?

***YES** to 1 or 2 questions = Possible alcohol/drug use problem*
***YES** to 3 or 4 questions = Probable alcohol/drug dependence*

CRAFFT FOR ADOLESCENTS

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

***YES** to 2 questions = Possible alcohol problem*

AUDIT-C — ALCOHOL USE DISORDERS IDENTIFICATION TEST-C

This screening instrument has a high sensitivity and specificity for identifying high-risk drinking.

1. How often did you have a drink containing alcohol in the past year?
- Never = 0
- Monthly or less = 1
- 2 to 4 times per month = 2
- 2 to 3 times per week = 3
- 4 or more times per week = 4

2. How many drinks did you have on a typical day when you were drinking in the past year?
- 1 or 2 = 0
- 3 or 4 = 1
- 5 or 6 = 2
- 7 to 9 = 3
- 10 or more = 4

3. How often did you have 6 or more drinks on one occasion during the past year?
- Never = 0
- Less than monthly = 1
- Monthly = 2
- Weekly = 3
- Daily or almost daily = 4

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

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