### 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

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<th>Step</th>
<th>Description</th>
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| 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.  |
| 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... Cut down on your drinking or drug use?
- Become... Annoyed when people criticized your drinking or drug use?
- Felt bad or... Guilty about your drinking or drug use?
- Needed an... Eye-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... Car driven by someone (including you) who was using alcohol?
2. Do you ever drink to... Relax, feel better, or fit in?
3. Do you ever drink... Alone?
4. Do you ever... Forget what you do when you drink?
5. Does your drinking worry... Family or friends?
6. Have you ever gotten in... Trouble 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.

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<th>Question</th>
<th>Possible Response</th>
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| 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  
- Monthly = 2  
- Less than monthly = 1  
- 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.