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OHSU HEALTH SYSTEM

OFFICE OF CLINICAL INTEGRATION AND EVIDENCE-BASED PRACTICE

GUIDANCE ON THE MANAGEMENT OF ALCOHOL USE DISORDER

Background: Alcohol use disorder (AUD) is associated with substantial burden of disease in terms of years of life lost to premature mortality, disability-adjusted life years, and years lived with disability. [1] Despite its high prevalence and numerous negative consequences, AUD remains undertreated. Effective interventions are available, and treatment is associated with reductions in the risk of relapse [2] and AUD-associated mortality. [3] Most treatment is currently delivered in specialty settings rather than in primary care settings. [4, 5] The goal of this guidance is to implement evidence-based interventions for AUD in the primary care setting to improve quality of care and treatment outcomes for patients with AUD.

Prevalence: In 2014, an estimated 6.4% of the U.S. population was affected by alcohol use disorder (AUD). [6] AUD has estimated values for 12-month and lifetime prevalence of 13.9% and 29.1%, respectively, with approximately half of individuals with lifetime AUD having a severe disorder. [7]

Risks: Alcohol use disorder (AUD) causes substantial morbidity and mortality—threefold to fourfold increased rates of early mortality. [5, 8-10]AUD is associated with hypertension, heart disease, stroke, cancer, liver cirrhosis, amnesias, cognitive impairment, sleep problems, peripheral neuropathy, gastritis and gastric ulcers, pancreatitis, decreased bone density, anemia, depression, insomnia, anxiety, suicide, and fetal alcohol syndrome. [5, 11, 12] Excessive alcohol consumption is also a major factor in injury and violence. [13] Acute alcohol-related harm can be the result of fires, drowning, falls, homicide, suicide, motor vehicle crashes, child maltreatment, and pedestrian injuries. [14] In addition, AUDs can complicate the assessment and treatment of other medical and psychiatric problems. [11]

Definitions:
Alcohol withdrawal – A characteristic syndrome that develops within several hours to a few days after the cessation of (or reduction in) heavy and prolonged alcohol use.
Moderate to severe alcohol use disorder (AUD) – An alcohol use disorder as defined by DSM-5 criteria that is associated with the presence of 4-5 symptoms for moderate AUD and 6 or more symptoms for severe AUD.
Renal impairment – Inability of the kidney(s) to function normally, typically described in terms of reductions in creatinine clearance or estimated glomerular filtration rate (eGFR).
Acute Hepatitis – An acute illness characterized by inflammation of the liver. In addition to a pattern of hepatocellular injury, individuals with hepatitis have either jaundice or elevated serum alanine aminotransferase (ALT) or aspartate aminotransferase (AST) levels. Hepatitis can be asymptomatic or associated with fatigue, anorexia, nausea, and abdominal pain. Depending on the cause of the hepatitis, fever, headache, vomiting, or diarrhea can also be present
Delirium tremens – Acute confusional state occurring during withdrawal from alcohol, characterized by rapid pulse, clouding of consciousness, dehydration, delirium, elevated body temperature, sweating, extreme fear, hypertension, tachycardia, tremor, and hallucinations.
Alcohol withdrawal seizures – Occurring early (usually 7-24 hours after the last drink). Grand mal in type and usually occur as a single episode.

Guideline Eligibility Criteria:
- Adolescents and adults
- A diagnosis of alcohol use disorder defined by DSM-5 criteria

Guideline Exclusion Criteria:
- Children less than 10 years old

Clinical Practice Recommendations:

Screening
Pre-screen for risky use of alcohol using Screening, Brief Intervention and Referral to Treatment (SBIRT) **(Strong Recommendation, Moderate Quality Evidence)**. [15-20]

For patients who screen positive using the SBIRT, complete Alcohol Use Disorders Identification Test (AUDIT) or Alcohol Use Disorders Identification Test-Concise (AUDIT-C) to assess severity of alcohol misuse. **(Strong Recommendation, Moderate Quality Evidence)**. [21-28]

The CRAFFT screening tool is intended to be developmentally appropriate and is recommended for adolescents starting ages 10-12 **(Consensus based on external guidelines)**.

Diagnosis of alcohol use disorder should be defined by DSM-5 criteria that is associated with the presence of 2-3 criteria for mild AUD, 4-5 criteria for moderate AUD and 6 or more criteria for severe AUD **(Consensus)**. [29]

Determination of Treatment Setting
For patients with alcohol use disorder who are attempting to cut down or quit alcohol use, suggest using standardized measures to assess the severity of withdrawal symptoms such as Clinical Institute Withdrawal Assessment for Alcohol (revised version) (CIWA-Ar) **(Conditional Recommendation, Low Quality Evidence)**. [21]

Outpatient Care
Outpatient care can be appropriate for patients with mild or moderate alcohol withdrawal syndrome (AWS), with no indicators of more complicated withdrawal (as outlined below) and with a CIWA-Ar <15. **(Conditional Recommendation, Low Quality Evidence)**. [21, 27, 30, 31]

Stages of Alcohol Withdrawal Syndrome: [31]

- Stage 1 (mild) - Anxiety, tremor, insomnia, headache, palpitations, gastrointestinal disturbances
- Stage 2 (moderate) - Mild symptoms and diaphoresis, increased systolic blood pressure, tachypnea, tachycardia, confusion, mild hyperthermia
- Stage 3 (delirium tremens) - Moderate symptoms and disorientation, impaired attention, visual and/or auditory hallucinations, seizures

For patients seen in outpatient clinic, monitor at least every 24 hours for at least 72 hours after last drink. Additionally, in the case of mild AWS with the presence of risk factors for the development of severe forms of AWS, pharmacological outpatient treatment should to be started **(Consensus)**.

Inpatient Care
Consider referral to inpatient treatment (medically managed withdrawal facility or hospital, ASAM criteria 3.7 or greater) if: **(Consensus based on external guidelines)** **[21, 27, 30, 31]**

- History of delirium tremens or withdrawal seizures
- Severe alcohol withdrawal (i.e., Clinical Institute Withdrawal Assessment for Alcohol [revised version] [CIWA-Ar] score ≥20)
- Co-occurring medical conditions that would pose serious risk for ambulatory withdrawal management (e.g., severe coronary artery disease, congestive heart failure, liver cirrhosis)
- Risk of withdrawal from other substances in addition to alcohol (e.g., sedative hypnotics)
- Recurrent unsuccessful attempts at ambulatory withdrawal management
- Active psychosis or severe cognitive impairment
- Pregnancy
- Inability to tolerate oral medication
- Absence of support network
- Abnormal laboratory results if available (severe hyponatremia, transaminitis >3x ULN with pain or worsening transaminitis above baseline, elevated lipase to suggest pancreatitis)
- Long-term intake of greater than or equal to 17 standard drinks daily (which is equivalent to a fifth (750 mL) of hard liquor, 3-3.5 750mL bottles of wine, or 17 12-oz bottles/cans of regular beer)

Practice Implication:
When inpatient care is not available, weigh the possible benefits and harms with patient and use shared decision making to determine if outpatient care is a possibility.

Outpatient Management of Alcohol Withdrawal Syndrome

Stabilization and Withdrawal in the Outpatient Setting
Benzodiazepines are the preferred medication for treating AWS in the outpatient setting **(Strong Recommendation, Moderate Quality Evidence)**. [21, 30-32]

Oral Medications Used to Treat Mild and Moderate AWS

Medications	Typical Dosing	Comments
Nonbenzodiazepine anticonvulsants		Appropriate monotherapy in **mild** AWS
Gabapentin (Neurontin)	Loading dose: 1,200 mg Days 1 through 3: 600 mg to 1,200 mg per day Days 4 through 7: taper to 300 mg to 600 mg per day	Adjunctive therapy dosing: 400 mg every 6 to 8 hours Consider in those with continuing treatment for AUD (1,200 mg per day)
Benzodiazepines (choose only one of the below agents)		First-line treatment for **moderate** AWS. Longer-acting types are preferred; if concern for liver disease, use benzodiazepines with less hepatic metabolism
Chlordiazepoxide (Librium)	50 mg to 100 mg	Single dose of 50 mg to 100 mg or symptom-triggered dose every 4 to 6 hours
Diazepam (Valium)	10 mg to 20 mg	10 mg to 20 mg every 6 to 12 hours for the first 24 hours, then reduce to 5 mg to 10 mg every 6 to 12 hours for the next 3 to 5 days Alternative front-loading regimen of 20 mg every 1 to 2 hours for 3 doses, then proceed to symptom-triggered regimen
Lorazepam (Ativan)	0.5 mg to 2 mg	0.5 mg to 1 mg every 6 to 8 hours on a scheduled basis, plus 1 mg every 4 hours if needed for mild symptoms or plus 2 mg every 2 hours if needed for moderate symptoms Lorazepam has less hepatic clearance and should be used in patients with liver disease.
Beta blockers	Atenolol: 25 mg to 50 mg daily Metoprolol tartrate: 25 mg to 50 mg every 12 hours	For persistent hypertension and tachycardia Use with caution in patients at risk for bradycardia or hypotension.
Clonidine	0.1 mg to 0.2 mg every 8 to 12 hours	For autonomic hyperactivity or anxiety Use with caution in patients at risk for hypotension.
Gabapentin	400 mg every 6 to 8 hours	For additional control; reduces craving

*Adapted from 2021 American Academy of Family Physician's Alcohol Withdrawal Syndrome: Outpatient Management Recommendations

Consider symptom-triggered therapy where patients are given medications only when signs or symptoms of withdrawal occur ***See Appendix B for dosing considerations*** **(Conditional Recommendation, Low Quality Evidence)**. [21, 33]

For patients with mild to moderate alcohol withdrawal for whom risks of benzodiazepines outweigh benefits (e.g. inadequate monitoring available, abuse liability, or allergy/adverse reactions), suggest considering gabapentin or valproic acid **(Conditional Recommendation, Low Quality Evidence)**. [21]

Consider thiamine (100 mg daily) and folic acid (1 mg daily) routinely, because patients often nutritionally depleted **(Consensus based on external guidelines)**. [31]

Alcohol Use Disorder

Determination of Initial Treatment Goals

Initial goals of treatment of alcohol use disorder (e.g., abstinence from alcohol use, reduction or moderation of alcohol use, other elements of harm reduction) should be agreed on between the patient and clinician **(Consensus based on external guidelines)**. [Reus, 2019 #41][Charlet, 2017 #7324]

Behavioral Interventions

Offer one or more of the following interventions considering patient preference and provider training/competence:

- For brief interventions:
  - Motivational Interviewing **(Strong Recommendation, Moderate Quality Evidence)**. [20, 22, 34-43]
- For comprehensive interventions:
  - Cognitive Behavioral Therapy (CBT) **(Conditional Recommendation, Low Quality Evidence)**. [21, 27, 44, 45]
  - Mutual Aid (SMART Recovery, 12-Step approach) **(Conditional Recommendation, Moderate Quality Evidence)**. [21, 27, 46-48]

Pharmacotherapy

To assist patients and providers in choosing pharmacologic agents for AUD, OHSU Health has developed a tiered approach. The tier 1 options are chosen because the evidence has shown them to be efficacious, but have contraindications for use. The tier 2 includes options for patients for which tier 1 options are contraindicated, and when patient preference needs to be weighed.

Tier 1

Recommend naltrexone or acamprosate be offered to patients with moderate to severe AUD with a goal of reducing alcohol consumption or achieving abstinence, prefer pharmacotherapy or have not responded to nonpharmacological treatment, have no contraindications to use of these drugs **(Strong Recommendation, Moderate Quality Evidence)**. [5, 21, 27, 49-52]

Contraindications

- Recommend against using acamprosate for patients with severe renal impairment. [49]
- Recommend against use of naltrexone for patients who have acute hepatitis or hepatic failure. [49]
- Recommend against use of naltrexone for patients with AUD and who use opioids or who have an anticipated need for opioids. [49]

Tier 2

Suggest disulfiram be offered to patients with moderate or severe alcohol use disorder who have a goal of achieving abstinence, prefer disulfiram or an intolerant to or have no responded to naltrexone and acamprosate, are capable of understanding the risks of alcohol consumption while taking disulfiram, and have no contraindications to the use of this medication **(Conditional Recommendation, Low Quality Evidence)**. [5, 21, 27, 49, 51, 53]

Suggest that gabapentin be offered to patients with moderate or severe alcohol use disorder who have a goal of reducing alcohol consumption or achieving abstinence, prefer gabapentin or are intolerant to or have not responded to naltrexone or acamprosate, have no contraindications to the use of these medications **(Conditional Recommendation, Low Quality Evidence)**. [21, 49, 54, 55]

Recommendations against use

Do not recommend use of antidepressant medications to treat alcohol use disorder (unless co-occurring disorder for which is indicated) **(Strong Recommendation, Moderate Quality Evidence)**. [5, 27, 49, 56]

Do not recommend use of benzodiazepines (unless treating acute alcohol withdrawal or co-occurring disorder exists for which benzodiazepines is indicated) **(Strong Recommendation, Low Quality Evidence)**. [27, 49]

Summary of Pharmacotherapy Recommendations for Alcohol Use Disorder

Medication	Considerations	Level of Evidence

Tier 1		
Naltrexone	Not be used as a treatment for alcohol use disorder by individuals who use opioids or who have an anticipated need for opioids. In patients with alcohol use disorder and co-occurring opioid use disorder, naltrexone can be prescribed to individuals who wish to abstain from opioid use and either abstain from or reduce alcohol use and are able to abstain from opioid use for a clinically appropriate time prior to naltrexone initiation. [49] Not be used by patients who have acute hepatitis. For patients with hepatic failure, both harms and benefits should be weighed before considering use. Use with caution in patients with liver function tests (LFTs) 3-5 times the upper limit of normal. Monitoring: check LFTs 7-14 days after starting naltrexone, with regular follow up testing every 6-12 months thereafter. [49]	Moderate
Acamprosate	Reduce the dose of acamprosate for patients with renal disease compared with recommended doses in individuals with normal renal function. [49] Patients with hepatic disease or those are being treated with opioids for pain or addiction. Acamprosate is eliminated renally and does not affect endogenous or exogenous opioids. [49] Patients who are coping with multiple medical issues and who are taking many other medications. There are no clinically significant drug interactions with acamprosate, so it can be a safe medication for many patients taking other medications. [51]	Moderate
Tier 2		
Gabapentin	For patients with moderate-severe alcohol use disorder for whom tier 1 pharmacotherapy is contraindicated or ineffective, suggest considering gabapentin. [21, 49]	Low
Topiramate	Consider for patients who have not responded to naltrexone and acamprosate, and have no contraindications to the use of these medications. [49] Caution use in patients at risk for falls, including the elderly [41]	Moderate
Recommend against use for the treatment of AUD		
Antidepressant medications	Unless there is evidence of a co-occurring disorder for which an antidepressant is an indicated treatment. [49]	Moderate
Benzodiazepines	Unless treating acute alcohol withdrawal or unless a co-occurring disorder exists for which a benzodiazepine is an indicated treatment. [49]	Low

Co-occurring substance use disorders

Actively treat all substance use disorders concurrently **(Consensus based on external guidelines)**. [27]

For patients with alcohol use disorder and co-occurring opioid use disorder, do not consider naltrexone for individuals already on buprenorphine or methadone or for those who are interested in continuing use of opioids. Naltrexone can be considered for treatment of both alcohol and opioid use disorders in individuals who are not currently being treated with partial or full agonist opioids and are able to abstain from opioid use for 7-14 days as to prevent precipitated opioid withdrawal if naltrexone is given too soon after opioid use **(Strong Recommendation, Low Quality Evidence)**. [49, 51]

Consider injectable naltrexone for patients seeking treatment for alcohol use disorder while in recovery from co-occurring opioid use disorder. Before starting naltrexone in either its oral or long-acting injectable formulation, outpatients must be abstinent from opioids for 7–

14 days (depending on the duration of action of the opioid) because of the risk for precipitating opioid withdrawal. **(Strong Recommendation, Moderate Quality Evidence)**. [49, 51]

Pregnant and Breastfeeding women with alcohol use disorder

Empirical evidence for pharmacologic treatments for pregnant and breastfeeding women with AUD is limited, therefore if considering pharmacologic treatment, utilize a shared-decision making approach with patient, and provide a comprehensive overview of the benefits and harms that need to be weighed when determining if pharmacologic treatment should be used. Consider referral to a higher level of specialty care **(Consensus)**. [Reus, 2019 #41; ACOG, 2011 #13857; Thibaut, 2019 #7323]

Practice Implication:

For women of reproductive age, consider referring to Family Planning service or recommending a pregnancy test and contraceptive counseling prior to pharmacologic treatment.

Adolescents

Behavioral interventions should be first-line treatment for adolescent patients in need of treatment for alcohol use disorder. If patient is unresponsive to behavioral interventions, proceed with caution when considering pharmacologic agents, as empirical validation of the value of medication-assisted treatment in adolescents is lacking. Moreover, none of the available medications are approved by the FDA for use in patients younger than 18 years old. Therefore, adolescents in need of treatment should be referred to a clinician or program specializing in adolescent addiction **(Consensus based on external guidelines)**. [Reus, 2019 #41][(SAMSHA), 2015 #43]

Quality Measures:

Process:

- # of patients who are screened for AUD
- # of patients who receive behavioral intervention
- # of medication prescribed
- Type of medication prescribed

Outcome:

- # of patients with AUD diagnosis
- % of patients who reduce alcohol use
- % of patients who receive treatment for AWS in outpatient setting

Guideline Preparation

This guideline was prepared by **XX** in collaboration with the Office of Clinical Integration (CI) and Evidence-Based Practice (EBP) at Oregon Health and Science University.

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Development Process

This guideline was developed using the process outlined in the CI and EBP Manual (2016). The review summary documents the following steps: 1. Review Preparation - PICO questions established - Evidence search confirmed with content experts 2. Review of Existing Internal and External Guidelines - Literature Review of Relevant Evidence 3. Critically Analyze the Evidence 4. Summarize the Evidence by preparing the guideline, and order sets - Materials used in the development of the guidelines, review summaries are maintained in a Management of Pediatric to Adult Health Care Transition EB review manual with the Office of CI and EBP.

Evaluating the Quality of the Evidence

Published clinical guidelines were evaluated for this review using the **University of Pennsylvania's Trustworthy Guideline Rating Scale**. The summary of these guidelines are included in the evidence summary. The rating scale is based on the Institute of Medicine's "Standards for Developing Trustworthy Clinical Practice Guidelines" (IOM), as well as a review of the AGREE Enterprise and Guidelines International Network domains. This scale evaluates a guideline's transparency, conflict of interest, development group, systematic review, supporting evidence, recommendations, external review and currency and updates. The purpose of this scale is to focus on the weaknesses of a guideline that may reduce the trust a clinical user can have in the guideline, and distinguish weaknesses in documentation (e.g. guideline does not have a documented updating process) from weaknesses in the guidance itself (e.g. recommendations are outdated).

The **GRADE (Grading of Recommendations, Assessment, Development and Evaluation)** criteria were utilized to evaluate the body of evidence used to make clinical recommendations. The table below defines how the quality of the evidence is rated and how a strong versus conditional recommendation is established. The evidence summary reflects the critical points of evidence.

Recommendation	
STRONG	Desirable effects clearly outweigh undesirable effects or vice versa
CONDITIONAL	Desirable effects closely balanced with undesirable effects
Quality	**Type of Evidence**
High	Consistent evidence from well-performed RCTs or exceptionally strong evidence from unbiased observational studies
Moderate	Evidence from RCTs with important limitations (e.g., inconsistent results, methodological flaws, indirect evidence, or

	imprecise results) or unusually strong evidence from unbiased observational studies
Low	Evidence for at least 1 critical outcome from observational studies, from RCTs with serious flaws or indirect evidence
Very Low	Evidence for at least 1 critical outcome from unsystematic clinical observations or very indirect evidence

Recommendations

Recommendations for the guidelines were directed by the existing evidence, content experts, and consensus. Patient and family preference were included when possible. When evidence is lacking, options in care are provided in the guideline and the order sets that accompany the guideline.

Approval Process

Guidelines are reviewed and approved by the Content Expert Team, Office of CI and EBP, Knowledge Management and Therapeutics Committee, Professional Board, and other appropriate hospital committees as deemed appropriate for the guideline's intended use. Guidelines are reviewed and updated as necessary every 2 to 3 years within the Office of CI and EBP at OHSU. Content Expert Teams will be involved with every review and update.

Disclaimer

Guideline recommendations are made from the best evidence, clinical expertise and consensus, in addition to thoughtful consideration for the patients and families cared for within the Integrated Delivery System. When evidence was lacking or inconclusive, content experts made recommendations based on consensus. Expert consensus is implied when a reference is not otherwise indicated.

The guideline is not intended to impose standards of care preventing selective variation in practice that is necessary to meet the unique needs of individual patients. The physician must consider each patient and family's circumstance to make the ultimate judgment regarding best care.

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Appendix A: The Alcohol Use Disorder Identification Test [28, 57]

Box 4

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?
   (0) Never [Skip to Qs 9-10]
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
   Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?
    (0) No
    (2) Yes, but not in the last year
    (4) Yes, during the last year

Record total of specific items here

If total is greater than recommended cut-off, consult User's Manual.

Babor, T.F., et al., 2001, *WHO*

Box 10

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.
Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Babor, T.F., et al., 2001, *WHO*

AUDIT-C ASSESSMENT TOOL

The AUDIT-C assessment tool[i] can be used to provide a quick assessment of how much and often a woman is drinking alcohol. AUDIT-C is the first three questions of the longer AUDIT tool, which is a more comprehensive assessment of problem drinking. Both tools are internationally recognised and widely used.

Questions	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total	

Bush, K., et al., 1998, *Archives of Internal Medicine*

DATE: June 2022

The CRAFFT Interview (version 2.0)

To be orally administered by the clinician

Begin: "*I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential.*"

Part A

During the PAST 12 MONTHS, on how many days did you:

1.	Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Say "0" if none.	☐ # of days
2.	Use any **marijuana** (pot, weed, hash, or in foods) or "**synthetic marijuana**" (like "K2" or "Spice")? Say "0" if none.	☐ # of days
3.	Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff or "huff")? Say "0" if none.	☐ # of days

Did the patient answer "0" for all questions in Part A?

Yes ☐ → **Ask CAR question only, then stop**

No ☐ → **Ask all six CRAFFT* questions below**

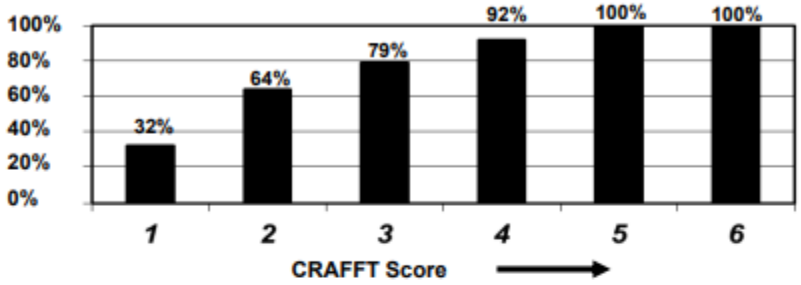
Part B		**No**	**Yes**
C	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
R	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
A	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
F	Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
F	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
T	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

***Two or more YES answers suggest a serious problem and need for further assessment. See back for further instructions →**

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:
The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

1. Show your patient his/her score on this graph and discuss level of risk for a substance use disorder.

Percent with a DSM-5 Substance Use Disorder by CRAFFT score*



*Data source: Mitchell SG, Kelly SM, Gryczynski J, Myers CP, O'Grady KE, Kirk AS, & Schwartz RP. (2014). The CRAFFT cut-points and DSM-5 criteria for alcohol and other drugs: a reevaluation and reexamination. Substance Abuse, 35(4), 376–80.

2. Use these talking points for brief counseling.

1. **REVIEW** screening results
   For each "yes" response: *"Can you tell me more about that?"*
2. **RECOMMEND** not to use
   "As your doctor (nurse/health care provider), my recommendation is not to use any alcohol, marijuana or other drug because they can: 1) Harm your developing brain; 2) Interfere with learning and memory, and 3) Put you in embarrassing or dangerous situations."
3. **RIDING/DRIVING** risk counseling
   "Motor vehicle crashes are the leading cause of death for young people. I give all my patients the Contract for Life. Please take it home and discuss it with your parents/guardians to create a plan for safe rides home."
4. **RESPONSE** elicit self-motivational statements
   Non-users: *"If someone asked you why you don't drink or use drugs, what would you say?"* Users: *"What would be some of the benefits of not using?"*
5. **REINFORCE** self-efficacy
   "I believe you have what it takes to keep alcohol and drugs from getting in the way of achieving your goals."

3. Give patient Contract for Life. Available at www.crafft.org/contract

Appendix B: Dosing Tables

Sample Fixed and Symptom-Triggered Dosing for Oral Alcohol Withdrawal Medications Pick ONE agent (diazepam, chlordiazepoxide, OR lorazepam), and follow either a fixed or symptom triggered dosing schedule		
Medication	*Fixed Schedule*	*Symptom-Triggered Schedule**
Day 1		
Diazepam (Valium)	10 mg every 6 hours	10 mg every 4 hours
Chlordiazepoxide (Librium)	25 to 50 mg every 6 hours	25 to 50 mg every 4 hours
Lorazepam (Ativan)	2 mg every 8 hours	2 mg every 6 hours
Day 2		
Diazepam (Valium)	10 mg every 8 hours	10 mg every 6 hours
Chlordiazepoxide (Librium)	25 to 50 mg every 8 hours	25 to 50 mg every 6 hours
Lorazepam (Ativan)	2 mg every 8 hours	2 mg every 6 hours
Day 3		
Diazepam (Valium)	10 mg every 12 hours	10 mg every 6 hours
Chlordiazepoxide (Librium)	25 to 50 mg every 12 hours	25 to 50 mg every 6 hours
Lorazepam (Ativan)	1 mg every 8 hours	1 mg every 8 hours
Day 4		
Diazepam (Valium)	10 mg at bedtime	10 mg every 12 hours
Chlordiazepoxide (Librium)	25 to 50 mg at bedtime	25 to 50 mg every 12 hours
Lorazepam (Ativan)	1 mg every 12 hours	1 mg every 12 hours
Day 5		
Diazepam (Valium)	10 mg at bedtime	10 mg every 12 hours
Chlordiazepoxide (Librium)	25 to 50 mg at bedtime	25 to 50 mg every 6 hours
Lorazepam (Ativan)	1 mg at bedtime	1 mg every 12 hours

**For patients with a CIWA-Ar score > 9*

***Adapted from 2013 American Academy of Family Physician's Outpatient Management of Alcohol Withdrawal Syndrome Recommendations*