

# Unhealthy Drinking in Adults Screening and Intervention Guideline

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**Last guideline approval:** October 2023

**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.

# Changes as of October 2023

- **Baclofen** is now recommended as a second-line alternative for treating alcohol use disorder (AUD) for patients who are interested in abstinence.
- **Gabapentin** is now recommended as a second-line alternative for treating AUD in patients who are interested in reducing their drinking.
- Considerations for **transgender/nonbinary individuals** were added to the section on recommended drinking limits.

## 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 have risky drinking. 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 prior evidence from observational studies indicated that light to moderate alcohol consumption was associated with decreased risk of coronary heart disease and ischemic stroke, more recent evidence suggests the association is not causal and could be confounded by other characteristics of patients with low-level alcohol use. Therefore, patients should **not** be advised to drink alcohol for health or cardiovascular benefits (WHO 2023).

### **Pregnancy**

Alcohol is a known teratogen. Any alcohol that a pregnant person 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 during lactation results in reduced milk consumption, decreased growth, and altered sleep patterns in infants (ACOG 2011). Lactating patients 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, patients 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 (with Alcohol Symptom Check List), 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, referral to Mental Health and Wellness (MHW) is recommended for assessment for appropriate treatment intervention. For patients who are not interested in treatment, repeated motivational brief alcohol interventions provided by Primary Care or IMH social work, 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 (part of the Annual Mental Health Questionnaire, Maternal Mental Health Questionnaire, and Mental Health Monitoring Tool)
- Assessment for alcohol use disorder (AUD) with the Alcohol Symptom Check List if **any** alcohol intake since learning of pregnancy (and/or AUDIT-C score 3–12 before pregnancy)
- Brief interventions

### Mental Health and Wellness and IMH Social Work in consultation with Ob/Gyn and Midwifery

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

## 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. KP HealthConnect (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** considered 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 patients 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.

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

Drinking above either the daily or weekly limits is risky.

**Recommended drinking limits for transgender and nonbinary individuals**

While there are no consensus guidelines for recommended drinking limits for transgender and nonbinary adults, the following points may be helpful in discussing recommended drinking limits with these individuals:

- Alcohol is water-soluble, so women typically achieve higher blood-alcohol concentration (BAC) because they have less body water. The smaller the patient’s size, the lower the total body water. Finally, total body water also decreases with age. **Consider advising smaller and older patients to follow recommended drinking limits for women.**
- Alcohol has many different **risks**. It is unknown how transgender surgeries or prescription medications taken by transgender patients (e.g., estrogen, testosterone, and anti-androgen medications) change these risks.
  - Alcohol use is associated with development of **hormone-sensitive tumors (e.g., breast and prostate cancers)**, with breast cancer risk increased with any alcohol use (Shield 2016, Zhao 2016). For this reason, the presence or absence of breast and prostate tissue is an important consideration.
  - **Cirrhosis:** Women have increased risk of cirrhosis at more than 1 drink daily and men have increased risk of cirrhosis at more than 2 drinks daily.
  - **Death:** Women have increased risk of death at more than 1 drink daily and men have increased risk of death at more than 2 drinks daily.

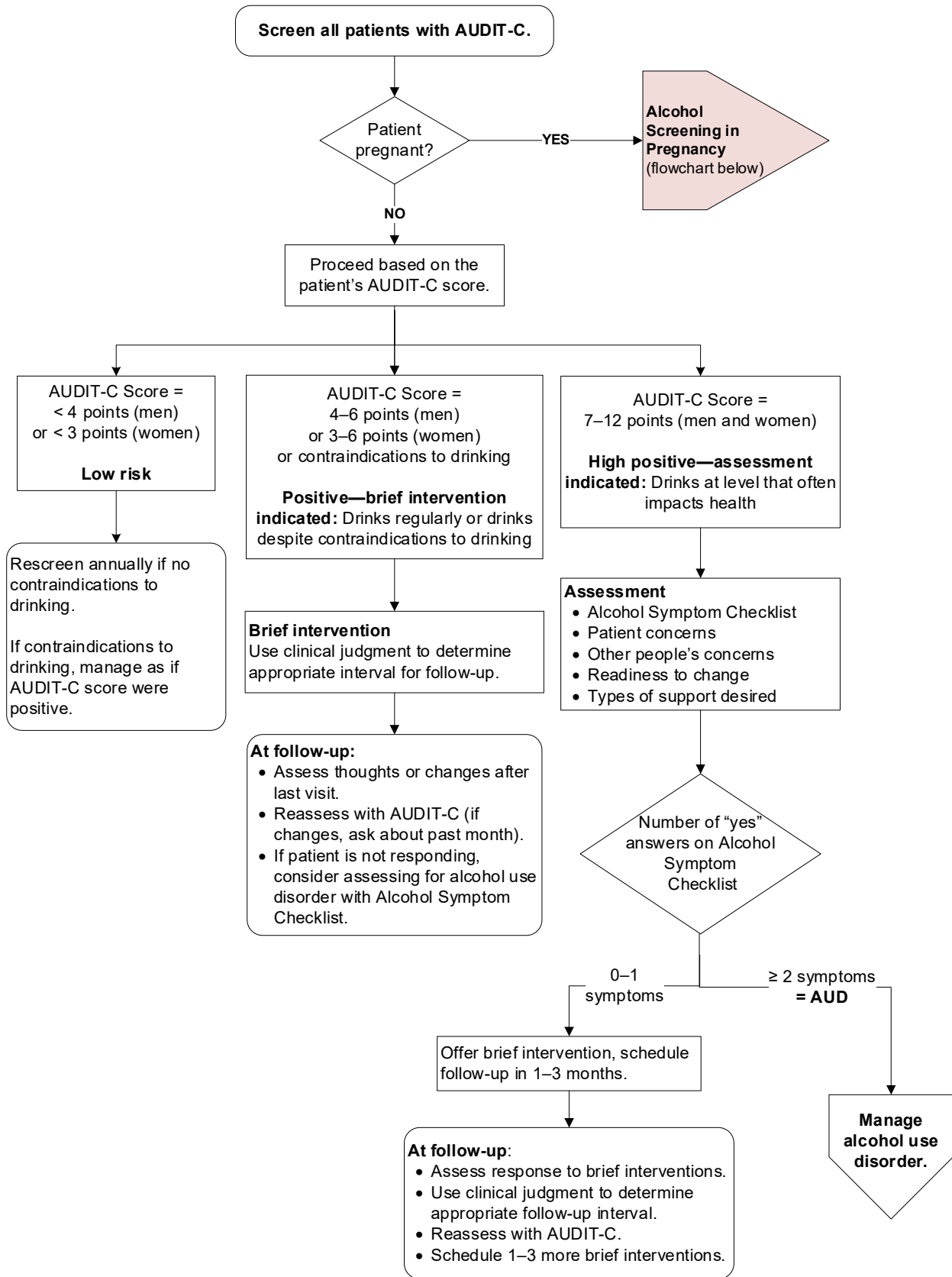
**One standard drink equals:**

- 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

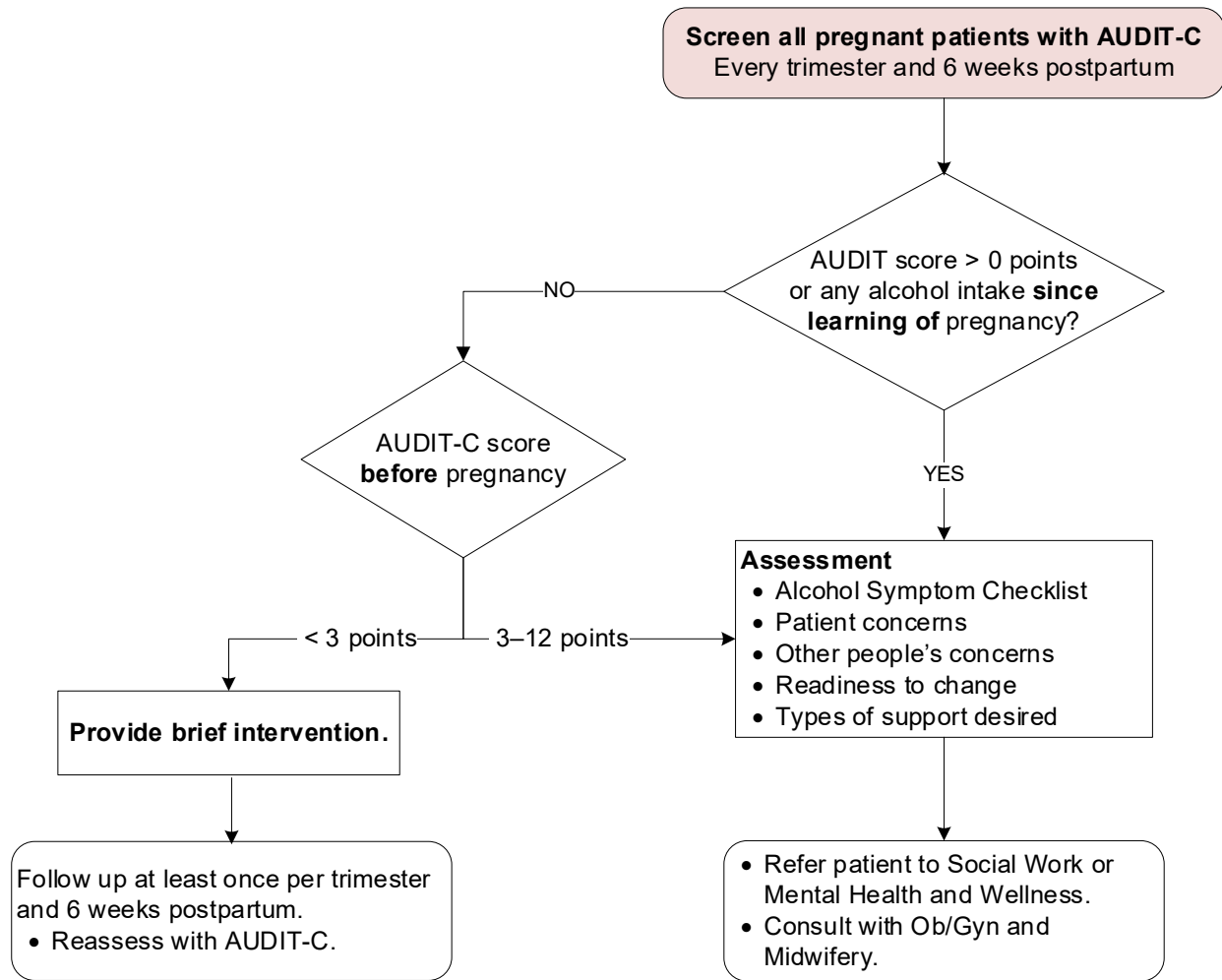
**Pregnancy**

Abstinence is recommended for people who are pregnant or planning pregnancy, as there is no safe level of alcohol consumption during pregnancy. Individuals who are drinking during pregnancy should have the risks of alcohol use—particularly the risk drinking poses to the fetus—explained to them and be advised to abstain and asked if they'd be willing to talk to someone about their drinking. It's recommended that an integrated mental health consultant be invited in for a warm handoff to offer shared decision-making about alcohol treatment options to support abstinence. If unable to make real-time handoff, internal referral to MHW is recommended for assessment and referral to appropriate level of care.

# Alcohol Screening and Brief Interventions in Primary Care



# Alcohol Screening and Brief Interventions: Pregnancy



# Screening with the AUDIT-C

Eligible population	Recommended screening tool	Recommended frequency
Adult patients aged 18 and older	AUDIT-C	Annually
Pregnant patients	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 a KP HealthConnect flowsheet and is included on the mental health questionnaire that is administered annually in Primary Care, 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).**

<b>Pregnancy</b>
<p>The process of AUDIT-C screening is the same for pregnant patients as for the rest of the adult population, with two exceptions:</p> <ul style="list-style-type: none"> <li>• The timeframe for all three questions should be the last 3 months rather than the last year.</li> <li>• 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.</li> </ul> <p>Scoring and interpretation of the AUDIT-C, however, are different for pregnant patients. (See Table 4b, p. 10.)</p>

How often did you have 1 drink containing alcohol in the last year?	Never Monthly or less 2 to 4 times per month 2 or 3 times per week 4 or more times per week	0 points 1 point 2 points 3 points 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 1 to 2 drinks 3 to 4 drinks 5 to 6 drinks 7 to 9 drinks 10 or more drinks	0 points 0 points 1 point 2 points 3 points 4 points
How often did you have 6 or more drinks on one occasion in the last year?	Never Less than monthly Monthly Weekly Daily or almost daily	0 points 1 point 2 points 3 points 4 points



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

Table 4a. AUDIT-C score interpretation for non-pregnant adults			
Score	Interpretation	Management	Follow-up
<b>Men</b> < 4 points <b>Women</b> < 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.
<b>Men</b> 4–6 points <b>Women</b> 3–6 points	Positive—brief intervention indicated. 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.
<b>Men and women</b> 7–12 points	High positive—assessment indicated. 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	<b>If alcohol use disorder,</b> manage AUD (see p. 13).  <b>If no alcohol use disorder,</b> offer brief intervention (see p. 10) <b>and</b> use clinical judgment to determine appropriate follow-up interval.

**Pregnancy**

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

**Table 4b. AUDIT-C score interpretation for pregnant adults**

Score	Interpretation	Management	Follow-up
1–3 points prior to learning of pregnancy	Potential risk to fetus	Brief intervention focused on the importance of abstinence for the fetus (see p. 10)	Rescreen every trimester and at the 6-week postpartum visit.
3–12 points prior to learning of pregnancy <b>or</b> 1–12 points indicating any alcohol use since learning of pregnancy	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	Refer to Mental Health and Wellness or introduce to Social Work at time of visit in Ob/Gyn and Midwifery or Primary Care.

## 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 pregnancy, 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: Characteristics and content of brief interventions

**Table 5a. Characteristics of brief interventions**

<b>Duration</b>	5 to 15 minutes
<b>Number of sessions</b>	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.
<b>Clinicians</b>	Primary Care physicians, advanced practice providers, nurses, social workers, and midwives
<b>Target population</b>	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).

<b>Express concern</b>	<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>
<b>Provide feedback linking drinking to health</b>	<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> <p>Consider use of the “Alcohol and Health” brochure to help facilitate these discussions: <a href="https://wa.kaiserpermanente.org/static/pdf/public/health-wellness/drink.pdf">https://wa.kaiserpermanente.org/static/pdf/public/health-wellness/drink.pdf</a>.</p>
<b>Offer advice</b>	<p>Advise the patient to</p> <ul style="list-style-type: none"> <li>▪ Drink below recommended drinking limits (see Table 1), and educate the patient about those limits, or</li> <li>▪ Abstain from drinking.</li> </ul> <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: <a href="https://pubs.niaaa.nih.gov/publications/Medicine/medicine.htm">pubs.niaaa.nih.gov/publications/Medicine/medicine.htm</a>.</p>
<b>Elicit response, assess readiness to change, and support goal setting if ready</b>	<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: <a href="https://rethinkingdrinking.niaaa.nih.gov">rethinkingdrinking.niaaa.nih.gov</a>.</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>
<b>Offer referral</b>	<p>Offer to refer the patient to a mental health professional for assessment of alcohol use (which would include motivational interviewing if indicated) and/or another potential 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 (e.g., “Can you tell me more about that?”) 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 ( $\geq 3$  points for non-pregnant/non-lactating women and  $\geq 4$  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 patients who indicate **any** ongoing alcohol use, assess for AUD regardless of AUDIT-C score.

Use the Alcohol Symptom Checklist (Table 6 and available as a HealthConnect flowsheet) to support diagnosis of alcohol use disorder; do **not** use AUDIT-C or AUDIT scores.

If you are unsure of the diagnosis, consider consultation via Mind Phone or use E-Consult Mental Health.

### Table 6. Alcohol Symptom Checklist

Based on DSM-5 criteria. Two or more “yes” responses are diagnostic of alcohol use disorder if they are recurrent in the past year.

1. Did drinking the same amount have less effect than it used to? Or did you have to drink more alcohol to feel the effect you wanted? *Please answer “yes” if either is true for you.*
2. Did you have an upset stomach or get sweaty or nervous when you weren’t drinking or tried to cut down? Did you drink alcohol or take something to help you feel better? *Please answer “yes” if either is true for you.*
3. Did you have times when you drank more or for longer than you wanted to?
4. Did you want to cut back or stop drinking alcohol, but couldn’t?
5. Did you spend a lot of time getting alcohol, drinking, or feeling hungover?
6. Did you continue to drink even though you thought it might be causing physical or mental problems—or making them worse?
7. Did drinking make it harder for you to keep up with your responsibilities at work, school, or home?
8. Did you do dangerous things more than once after drinking, like drive a car or operate machinery?
9. Did you drink alcohol even though you thought it might be causing problems with your family or other people?
10. Did you have strong desires or cravings for alcohol?
11. Did 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 patients with AUD should be referred to Mental Health and Wellness or introduced to Social Work at the time of the visit in Ob/Gyn and Midwifery or Primary Care, rather than be 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 mental health professional if they would prefer to receive their treatment in MHW 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, p. 18) 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 or medications prescribed for AUD no later than 14 days after initial diagnosis, and at least two more visits or continued medications for AUD in the 34 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; for example an integrated mental health clinician could see a patient after a Primary Care provider makes a 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). Consider offering patients the “Options for People Who Are Thinking About Their Drinking” decision aid/booklet.

### Over the course of several visits:

**Initiate the discussion of alcohol use in such a way** that they will 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 [KPWA Depression Guideline](#) for additional guidance.
- Anxiety: Assess with the GAD-7.
- Bipolar disorder, schizophrenia, or other serious mental illness: Refer the patient to MHW if there are concerns that these conditions might be present.

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 **Penn Alcohol Craving Scale (PACS)** to assess how much time they spend thinking about alcohol (Flannery 1999). The PACS is available as a KP HealthConnect flowsheet.
- **Readiness ruler** to assess patients' readiness for change, the importance they place on making a change, and their confidence in their ability to change. 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.

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.

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.

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

- Order the "Options booklet" through Print Services: ("Options for patients who are thinking about their drinking") to support shared decision-making about AUD. Staff can also request to have a copy mailed to a patient's home through Order activity in Epic by searching on "alcohol use" (previous title displays as "Alcohol Use Disorder Booklet").
- Suggest that patient look at stories in Part 1, the option grid (page 40), any other parts that look interesting, and complete the worksheet at the end of the booklet (page 41).
- Schedule a follow-up visit to discuss. At the visit, review the worksheet about the patient's goals and treatment(s) they may be interested in (and the option grid if necessary).

## Drinking goals: make no change, cut down, or stop?

Patients can arrive at three different goals regarding changing alcohol use: making no changes right now, reducing their drinking, and abstaining from drinking. 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  $\geq 4$  DSM-5 criteria): naltrexone, acamprosate, gabapentin (second-line)
  - Consider use of intermittent dosing of oral naltrexone taken just prior to drinking to reduce alcohol consumption (often referred to as "The Sinclair Method"). While there is insufficient evidence of effectiveness, this approach could be considered for patients who are not ready to quit drinking completely but are ready to decrease their consumption.
5. Even if they are not ready to stop drinking altogether, patients can be referred to Alcoholics Anonymous, Smart Recovery, 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.

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

1. Plan for and treat withdrawal.
  - Assess the patient's withdrawal risk (see p. 22) and determine whether patient needs medical management of withdrawal.
  - Select setting for withdrawal (see p. 23).
  - 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 Mental Health Access)
    - Outpatient group/individual
    - Residential followed by outpatient group/individual
  - Outpatient mental health treatment for co-occurring conditions (referral via Mental Health Access)
  - Alcoholics Anonymous or Smart Recovery (to learn about AUD and how some people have found support groups helpful)
3. As needed, prescribe medications for craving and AUD, as appropriate.
  - Naltrexone (oral or injectable)
  - Acamprosate
  - Topiramate (second-line)
  - Baclofen (second-line)
  - **Note:** Disulfiram, previously recommended as a second-line option, is no longer routinely recommended for treatment of AUD, as new evidence shows that its harms outweigh its benefits. If a patient expresses an interest in starting disulfiram, a virtual consult with Addiction Medicine is recommended.
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. For patients who want accountability for alcohol abstinence, a stand-alone test for alcohol biomarkers in urine can be ordered: ethyl glucuronide (EtG), which can detect low levels of alcohol up to 5 days after consumption. Positive EtG tests will reflex to ethyl sulfate (EtS) tests for confirmation.
7. 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 mental health providers include psychiatrists, psychologists, psychotherapists, addiction and chemical dependency counselors, social workers, and nurses.

The following services are available:

### In Primary Care

- Ambulatory treatment/management of alcohol withdrawal.
- Medications for managing alcohol craving and alcohol use disorder.
- Consultation with social workers for assessment and engagement.
- [“Options for people who are thinking about their drinking”](#) booklet.

### In MHW

- 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](http://www.aa.org) provides phone numbers and information on local chapters.)
- Smart Recovery®: [www.smartrecovery.org](http://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](http://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](http://www.womenforsobriety.org). A nonprofit organization dedicated to helping women overcome alcoholism and other addictions.
- Al-Anon/Alateen: [www.al-anon.alateen.org](http://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](http://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.

Moderate evidence suggests that electronic interventions (via computer or mobile device) are effective in decreasing alcohol consumption, but no specific apps are recommended. The components of electronic interventions that are most effective are behavior substitution, problem solving, and being perceived as a credible source. Low-quality evidence suggests no difference in alcohol consumption between digital interventions and face-to-face interventions.



**External websites that may be helpful to patients interested in reducing or stopping drinking include:**

- 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](http://www.alcoholscreening.org).
- Drinker’s Checkup™ (requires registration): [www.drinkerscheckup.com](http://www.drinkerscheckup.com).
- Alcohol Help Center (requires registration): <https://evolutionhealth.care/index> Includes the Check Your Drinking (CYD) Survey, which can be taken without registering: <https://evolutionhealth.care/cyd>
- NIAAA Rethinking Drinking: <http://rethinkingdrinking.niaaa.nih.gov>. The *Rethinking Drinking* website has 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.
- [Let’s Rethink How We Drink](https://player.vimeo.com/video/119979917) video <https://player.vimeo.com/video/119979917>

## Medication Management of Alcohol Craving and Alcohol Use Disorder

### **Pregnancy**

Pregnant patients should be referred to specialty chemical dependency treatment (via MHW) in consultation with Ob/Gyn and Midwifery for medication management of alcohol craving and AUD.

Primary Care providers or established mental health providers should prescribe medications for AUD when patients are interested. Patients do not need to be referred to MHW 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.

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, pharmacist, or social worker and referral to Alcoholics Anonymous (Anton 2006). Abstinence from alcohol is **not** required before initiating any of these recommended pharmacologic therapies.

\* Not all patients relate to the term *craving*. To assess craving, try asking patients if they “have a hard time thinking of anything else” or “find it hard to get their mind off drinking,” or use the Penn Alcohol Craving Scale.

**Table 7. Medications for alcohol craving and alcohol use disorder**

See "Prescribing notes" below.

Medication	Initial dose	Therapeutic dose	Treatment duration
<b>1<sup>st</sup> line</b>			
Naltrexone (oral)	50 mg daily <sup>1</sup>	Titration to 100 mg daily may be beneficial if patient is only partially responsive to 50 mg	<ul style="list-style-type: none"> <li>Continue for at least 3 months to assess benefit, if possible.</li> <li>For patients who respond, an additional 6 months of naltrexone improves outcomes.</li> <li>No need to taper at discontinuation.</li> <li>Patients may benefit from 12–24 months of treatment to thoroughly integrate recovery practices into their lives.</li> <li>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).</li> </ul>
Acamprosate	333 mg or 666 mg three times daily <sup>1</sup>  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"> <li>Continue for at least 3 months to assess benefit.</li> <li>Patients may benefit from 12–24 months of treatment to thoroughly integrate recovery practices into their lives.</li> </ul>
<b>2<sup>nd</sup> line</b>			
Topiramate (off-label use)	25 mg daily	Increase weekly by 25–50 mg daily divided into two doses as tolerated up to maximum 300 mg daily.  Typical therapeutic range 100–200 mg daily	<ul style="list-style-type: none"> <li>Continue for 6–12 months to thoroughly integrate recovery practices into patient's life.</li> <li>Taper to discontinue.</li> </ul>
Naltrexone (injectable) <sup>2</sup>	380 mg IM every 4 weeks (or once a month)  A trial of oral naltrexone is recommended first to establish tolerability	380 mg every 4 weeks (or once a month)	<ul style="list-style-type: none"> <li>Continue for at least 3 months to assess benefit, if possible.</li> <li>For patients who respond, an additional 6 months of naltrexone improves outcomes.</li> <li>No need to taper at discontinuation.</li> <li>Patients may benefit from 12–24 months of treatment to thoroughly integrate recovery practices into their lives.</li> <li>No need to taper at discontinuation</li> </ul>
Baclofen	5 mg three times daily, then 10 mg three times daily	30–60 mg daily	<ul style="list-style-type: none"> <li>Taper to discontinue.</li> </ul>
Gabapentin	300 mg at bedtime	Therapeutic dosing 900–1800 mg daily in three divided doses  Start with 300 mg at bedtime and increase by 300 mg increments every day to target 600 mg three times daily. Can titrate more slowly if side effects <sup>3</sup>	<ul style="list-style-type: none"> <li>Linear dose effect on improved abstinence and reduced heavy drinking.</li> <li>Gabapentin added to naltrexone during early abstinence period may improve drinking outcomes over naltrexone alone.</li> <li>Taper to discontinue.</li> </ul>
<sup>1</sup> Some patients may prefer naltrexone to acamprosate because of its once-daily dosing schedule. <sup>2</sup> Recommended for patients who may have trouble with adherence to the daily oral formulation. <sup>3</sup> Sample gabapentin titration schedule used in studies (Mason 2014): Day 1: 300 mg at bedtime. Day 2: 300 mg in the morning and at bedtime. Day 3 and 4: 300 mg in the morning, at noon, and at bedtime. Day 5 onward: 300 mg in the morning, 300 mg at noon, and 600 mg at bedtime.			

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

### ***Naltrexone (oral)***

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#### 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 opioids or having an anticipated need for opioids.
- Contraindicated in patients with liver failure or acute hepatitis.

### ***Naltrexone (injectable)***

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#### Advantages

- Dosed once a month.
- May improve compliance in patients who may have trouble adhering to the oral formulation.
- Useful for patients with a history of opioid dependence but not currently using/abusing opioids.

#### Disadvantages

- Requires administration by a health care professional.
- Not for patients taking opioids or having an anticipated need for opioids within the next 30 days (longer than with oral naltrexone).
- Injection site reactions.
- Contraindicated in patients with liver failure or acute hepatitis.
- Higher cost.

### ***Acamprosate***

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#### Advantages

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

#### Disadvantages

- Contraindicated in patients with severe renal failure (CrCl < 30 ml/min).
- For patients with mild to moderate renal impairment, acamprosate may be used as a second-line treatment at a reduced dose (max dose of 333 mg three times daily for CrCl 30–50 ml/min).
- Three times–daily dosing.

### ***Topiramate***

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#### 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.
- Paresthesia, taste perversion, anorexia, insomnia, difficulty concentrating, nervousness, psychomotor slowing and pruritus.
- Many patients cannot tolerate.
- Avoid in patients with history of renal calculi.

### ***Baclofen***

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#### Advantages

- Significantly reduces the risk of relapse (moderate evidence) and increases the percentage of abstinent days.

#### Disadvantages

- Increased chance of side effects such as vertigo, somnolence, dry mouth, paresthesia, and muscle rigidity.
- Does not reduce heavy drinking or number of drinks per drinking day.
- Can cause CNS depression.

### ***Gabapentin***

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#### Advantages

- Useful for decreasing days of heavy drinking and extending time to relapse.
- Can be helpful in patients with co-occurring neuropathic pain.

#### Disadvantages

- Can cause CNS depression.
- Has risk for misuse/abuse when taken in excess of a therapeutic dose.

## Medications **not** recommended for alcohol craving and alcohol use disorder

The following medications are **not recommended** for reducing alcohol consumption, reducing cravings, or preventing relapse in adults:

- **Disulfiram** is not routinely recommended as it has no effect on reducing cravings and new evidence shows that its harms outweigh its benefits. If a patient requests disulfiram, virtual consultation with Addiction Medicine is recommended.
- **Valproic acid** is not recommended due to insufficient evidence of efficacy in reducing alcohol consumption or improving health outcomes in patients with AUD.

## 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.

<b>Medication</b>	<b>Monitoring parameters</b>	<b>Frequency</b> <sup>1</sup>
All medications for alcohol craving or AUD	PHQ-9 and Columbia Suicide Risk Assessment	At baseline, then every 3–6 months <b>or</b> 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 <b>or</b> if there are symptoms of acidosis
Baclofen	Creatinine clearance	At baseline
	Adherence, side effects	At 2–4 weeks, then every 3–6 months
Gabapentin	Creatinine clearance	At baseline
	Adherence, side effects, and misuse/abuse <sup>2</sup>	At 2–4 weeks, then every 3–6 months
<sup>1</sup> 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 before 1 month has passed, 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.		
<sup>2</sup> Gabapentin has abuse potential when taken in excess of a therapeutic dose. Monitor quantities prescribed, refill and usage pattern, early fills, etc.		

# Management of Alcohol Withdrawal

## Pregnancy

Pregnant patients should be referred to specialty chemical dependency treatment (via MHW) in consultation with Ob/Gyn and Midwifery 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 or urgent care** to assess the need for inpatient medical or psychiatric treatment or outpatient detox and withdrawal medications, 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 (p. 22, and SmartPhrase **.saws**) to evaluate the severity of withdrawal symptoms and call the 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 use.
- 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 KP HealthConnect.

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 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 the 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. 22) should be considered for inpatient treatment (Sachdeva 2015).

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

Inpatient treatment may also be recommended for patients who are pregnant or 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 MHW 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.

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 MHW 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

<b>Table 9a. Medications for alcohol withdrawal (See “Prescribing notes” below.)</b>			
<b>1<sup>st</sup> line: Benzodiazepines</b>			
<b>Medication</b>	<b>Dosing and taper schedule</b>		
	<b>Day</b>	<b>Dose</b>	<b>Schedule</b>
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 <sup>1</sup> (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
<b>2<sup>nd</sup> line: Anticonvulsants</b>			
Use anticonvulsants only in patients with contraindications to benzodiazepines or risk of addiction.			
<b>Medication</b>	<b>Dosing and taper schedule</b>		
Valproic acid or divalproex sodium-EC	500 mg three times daily for 5 days		
Gabapentin	400 mg three times daily for 5 days		
<sup>1</sup> 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	Disadvantages



- Renally cleared, so safer in patients with hepatic impairment or in elderly.
- Shorter half-life also makes it less prone to oversedation.
- 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).
- Has risk for misuse/abuse when taken in excess of a therapeutic dose.

<b>Table 9b. Adjunctive therapeutics for alcohol withdrawal if not already prescribed</b>		
<b>Medication</b>	<b>Dosing</b>	<b>Benefit</b>
Thiamine	100 mg IM <b>one time</b>	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.

<b>Class</b>	<b>Target symptoms</b>	<b>Medication</b>	<b>Dosing</b>
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
		Ondansetron	4 mg every 8 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.

As part of our improvement process, the Kaiser Permanente Washington guideline team is working towards developing new clinical guidelines and updating the current guidelines regularly. To achieve this goal, we are adapting evidence-based recommendations from high-quality national and international external guidelines, if available and appropriate. The external guidelines should meet several quality standards to be considered for adaptation. They must: be developed by a multidisciplinary team with no or minimal conflicts of interest; be evidence-based; address a population that is reasonably similar to our population; and be transparent about the frequency of updates and the date the current version was completed.

In addition to identifying the recently published guidelines that meet the above standards, a literature search was conducted to identify studies relevant to the key questions that are not addressed by the external guidelines.

## External guidelines eligible for adapting

[2018 United States Preventive Services Task Force \(USPSTF\) Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions](#)

[2021 VA/DoD Clinical Practice Guidelines for the Management of Substance Use Disorders](#)

[2021 Australian Guidelines to Reduce Health Risks from Drinking Alcohol](#)

[2020 ASAM Clinical Practice Guideline on Alcohol Withdrawal Management](#)

## Key questions addressed in the KPWA evidence review

1. **What is the effectiveness and safety of baclofen, gabapentin, and valproic acid for reducing alcohol consumption, reducing craving, and/or preventing relapse in adults (excluding pregnant women)?**

### ***Baclofen***

A systematic review and meta-analysis (Agabio 2023) of 17 randomized controlled trials (RCTs) represented 1,818 participants who were diagnosed with alcohol dependence compared baclofen to placebo. Patients were 46.5 years old on average, received psychosocial treatments, and most were detoxified. Treatment duration was 12 weeks in most studies. Baclofen significantly reduced the risk to relapse (RR 0.87 [0.77 to 0.99]; moderate-quality evidence; 12 RCTs). Findings were similar in detoxified patients. Baclofen increased the percentage of abstinent days (MD 9.07 higher [3.3 higher to 14.85 higher]; high-quality evidence; 16 RCTs). Effects were marked in detoxified compared to non-detoxified patients. However, baclofen may not reduce heavy drinking, does not reduce the number of drinks per drinking day, does not increase the number of participants with  $\geq 1$  adverse event at the end of treatment, does not increase the number of participants who drop out at the end of treatment, and does not increase the number of dropouts due to adverse events. (Evidence quality is moderate to high).

Compared to acamprosate or naltrexone, few studies, of very low quality, were evaluated. Therefore, the evidence is insufficient. There were no differences in craving, anxiety, or depression severity. Regarding fatigue, vertigo, sleepiness, dry mouth, numbness, and muscle spasm, baclofen may increase these adverse effects. No differences between baclofen and placebo for other adverse events were reported.

### ***Gabapentin***

In a meta-analysis of 7 RCTs, Kranzler 2019 showed that gabapentin significantly reduces heavy drinking days ( $g = -0.64$ ; 95% CI, -1.22 to -0.06;  $P=0.03$ ). It is the only outcome that showed a clear benefit. No benefit was reported for other alcohol-related outcomes—abstinence, relapse to heavy drinking, percentage of days abstinent, drinks/day, GGT concentration. No serious adverse events were reported. The quality of the included studies is good according to the authors.

### **Valproic acid**

No high-quality studies were identified for this iteration. There is still insufficient evidence to assess valproic acid for the treatment of AUD.

## **2. What is the effectiveness of psychological interventions to reduce alcohol consumption among pregnant and postpartum women?**

Three systematic reviews and meta-analyses were the basis for determining the efficacy of psychosocial interventions in pregnancy. The evidence on the psychosocial interventions evaluated is limited, of low quality, or insufficient in quality.

The first systematic review (Gomez 2012) included 20 studies that assessed a variety of interventions, but the most frequently studied were brief interventions and motivational approaches. The odds of achieving abstinence in pregnancy were 2.3 times higher in the intervention groups than the control groups (OR 2.31 [1.61, 3.32];  $P < 0.001$ ;  $n = 6$ ). However, 14 studies that were not included in the meta-analysis showed inconsistent findings for brief intervention efficacy. With regard to the effectiveness of intervention in motherhood, the findings are indicative of a significant but small effect in favor of intervention groups [SMD = -0.20 [-0.38, -0.02];  $P = 0.03$ ;  $n = 4$  studies; 536 participants]. The body of evidence is of very low quality owing to high risk of bias of individual studies and to inconsistencies.

Another review (Stade 2009) of 4 RCTs (715 participants) reported no significant differences between groups, and mixed results with regard to abstinence or reduction of alcohol consumption. There was a lack of data on the effects of interventions on the health of mothers and babies.

Next, Popova 2023 aimed to investigate the effect of brief interventions (BIs) in a systematic review of 26 studies. Patients with any level of alcohol consumption were included and the studies occurred in any setting. Most interventions included motivational interviewing (MI). Other interventions involved motivational enhancement therapy (MET) combined with cognitive behavioral therapy (CBT), MET alone, and MI + CBT. The authors reported that BIs may result in abstinence (OR=1.56 [1.15–2.13];  $I^2 = 46.75\%$ ;  $P = 0.04$ ;  $n = 12$ ; 2620 patients) in pregnancy and reduce pre-term birth (OR 0.67 [0.46–0.98];  $P = 0.58$ ). The magnitude of the effect is small, and the body of evidence is of low quality according to the authors. The remainder of the outcomes showed no significant differences.

## **3. Do peer support programs increase engagement in AUD treatment?**

Kelly 2020: This is a systematic review and meta-analysis of RCTs/quasi-RCTs and non-randomized trials including 27 studies representing 10,565 participants. Patients were adults with AUD, alcohol abuse, or alcohol dependence, with mean age ranging from 34.2 to 51 years. High-quality evidence indicated that Alcoholics Anonymous/Twelve-Step Facilitation (AA/TSF) (manualized) improved the rate of continuous abstinence (RR 1.21; CI, 1.03 to 1.42;  $N = 2$  studies; 1,936 participants). Effect remained consistent at 24 and 36 months. Moderate-quality evidence suggested that AA/TSF (manualized) was as effective as other clinical interventions in terms of drinking intensity measured by drinks per drinking day (MD -0.17; 95% CI, -1.11 to 0.77; 1 study; 1,516 participants), and for alcohol-related consequences (MD -2.88; 95% CI, -6.81 to 1.04; 3 studies; 1,762 participants). The evidence for the remainder of alcohol-related outcomes was of low quality, but AA/TSF may perform as well as other clinical interventions for percentage of days abstinent, longest period of abstinence, percentage of days heavy drinking, and alcohol addiction severity.

2021 VA Guidelines recommend peer linkage, network support, and 12-step facilitation.

## **4. What is the efficacy and safety of outpatient management of alcohol withdrawal (benzodiazepines, gabapentin, and valproic acid or any treatment regimens)?**

The findings of this update did not challenge the current KPWA recommendations. Four systematic reviews (Bahji 2022, Ghosh 2021, Umar 2023, and Lai 2022) were considered, but only one was extensively appraised (Bahji 2022).

Bahji 2022: A systematic review and meta-analysis of 149 trials (10,692 participants) occurring in any setting (mostly in inpatient settings) and with different degrees of alcohol withdrawal severity indicated

that benzodiazepines are the only agents showing consistent findings across efficacy, safety, and secondary outcomes (length of hospital stay, use of additional medications, total benzodiazepine requirements, and death). Valproate and carbamazepine improved some efficacy outcomes (seizures and CIWA-Ar scores).

With regard to efficacy outcomes, the following medications (on fixed schedule) were all more effective than placebo at reducing incident alcohol withdrawal seizures:

Chlormethiazole	OR, 0.16; 95% CI, 0.04–0.65
Diazepam	OR, 0.16; 95% CI, 0.04–0.59
Lorazepam	OR, 0.19; 95% CI, 0.08–0.45
Chlordiazepoxide	OR, 0.21; 95% CI, 0.08–0.53
Divalproex	OR, 0.22; 95% CI, 0.05–0.86

Only fixed-schedule diazepam (OR = 0.19; 95% CI, 0.05–0.76) reduced incident delirium tremens.

Oxcarbazepine (d = -3.69; 95% CI, -6.21 to -1.17), carbamazepine (d = -2.76; 95% CI, -4.13 to -1.40), fixed-schedule oxazepam (d = -2.55; 95% CI, -4.26 to -0.83), and  $\gamma$ -droxybutyrate (GHB) (d = -1.80; 95% CI, -3.35 to -0.26) improved endpoint CIWA-Ar scores over placebo. There was no evidence for gabapentin.

In addition, benzodiazepines, propranolol, adjunctive lamotrigine, topiramate, and adjunctive baclofen reduced proportion of participants requiring additional alcohol withdrawal medications (ORs varied from 0.01 to 0.12).

Promazine and carbamazepine were the only medications significantly associated with greater dropouts because of adverse events. None of the medications reduced mortality.

The quality of the body of evidence is low.

The other reviews found very low–quality to low-quality evidence for the medications assessed.

## 5. Are there effective digital therapeutics/apps to treat alcohol use disorder in adults?

Staiger 2020 conducted a review to evaluate mobile app interventions for concerning tobacco, alcohol, and illicit drug use. Twenty studies were included, of which 11 focused on alcohol. Patients were recruited from the general community. Content of the apps was considerably diverse, from stand-alone apps to multicomponent apps with interactive features and audio content or used as adjuncts with face-to-face treatment. Duration of intervention was in general 1 to 8 weeks. Notifications varied from none to 4 times per day. Only three apps targeting alcohol (A-CHESS, TeleCoach, and CampusGANDR) showed a low to moderate reduction in alcohol. The overall risk of bias is high according to the authors (owing to high risk of bias for allocation concealment and blinding of participants and personnel, small sample sizes, and short intervention duration). In sum, there is insufficient evidence in quality to make a firm conclusion about the efficacy of mobile apps to reduce alcohol consumption.

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# 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 2023.

## Team

The Unhealthy Drinking in Adults Screening and Intervention Guideline development team included representatives from the following specialties: Adolescent Health, Addiction and Recovery Services, Family Medicine, Kaiser Permanente Washington Health Research Institute, Mental Health and Wellness, Ob/Gyn and Midwifery, Patient Safety, Pediatrics, Pharmacy, and Urgent Care.

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## Appendix 1a. Talking Points for Brief Interventions: Non-Pregnant Adults

### 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](http://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 mental 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 Patients

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

## **Talking points for pregnant patients**

- Patients who are pregnant or planning pregnancy should refrain from drinking alcohol to keep the risks to the baby minimal.
- Patients 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 patients**

- Abstinence is recommended for lactating patients.
- If a lactating patient 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 patients 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.
- Patients 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

### 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
<b>Men and women</b> < 5 points	Negative for unhealthy drinking.	No intervention, unless contraindications to drinking alcohol.	Rescreen in 1 year, or sooner if contraindications to drinking alcohol.
<b>Men</b> 5–10 points  <b>Women</b> 5–8 points	Positive for unhealthy drinking.	Brief intervention.	Use clinical judgment to determine appropriate follow-up interval.
<b>Men</b> 11–40 points  <b>Women</b> 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 Alcohol Symptom Checklist (Table 6, p. 12).	If patient has AUD, manage AUD.  If patient does not have AUD, provide brief intervention <b>and</b> use clinical judgment to determine appropriate follow-up interval.