

CAGE

In the past have you ever:

C—tried to Cut down or Change your pattern of drinking or drug use?

A—been Annoyed or Angry because of others' concern about your drinking or drug use?

G—felt Guilty about the consequences of your drinking or drug use?

E—had a drink or used a drug in the morning (as an “Eye-opener”) to decrease hangover or withdrawal symptoms?

Two or more positive responses indicate misuse or dependence and suggest patients need further assessment.

AUDIT-C and the Full AUDIT

1. What is the AUDIT-C?

The AUDIT-C is an alcohol screen that can help identify patients who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C questions are:

Q#1: How often did you have a drink containing alcohol in the past year?

- Never (0 points)
- Monthly or less (1 point)
- Two to four times a month (2 points)
- Two to three times per week (3 points)
- Four or more times a week (4 points)

Q#2: How many drinks did you have on a typical day when you were drinking in the past year?

- 1 or 2 (0 points)
- 3 or 4 (1 point)
- 5 or 6 (2 points)
- 7 to 9 (3 points)
- 10 or more (4 points)

Q#3: How often did you have six or more drinks on one occasion in the past year?

- Never (0 points)
- Less than monthly (1 point)
- Monthly (2 points)
- Weekly (3 points)
- Daily or almost daily (4 points)

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

2. What does a positive AUDIT-C score mean?

A positive score means the patient has a higher likelihood for at risk drinking or active alcohol abuse or dependence.

3. Why don't we use the CAGE anymore?

The CAGE fails to identify many patients with at risk drinking who are not alcohol dependent.[2] It is important to identify at risk drinkers because they may also benefit from advice from primary care providers about their drinking.[3]

4. What is at risk drinking?

At risk drinking is drinking above recommended limits that increases a patient's risk of injury and/or medical problems. Most patients who report at risk drinking are not alcohol dependent. However, there are so many of these non-dependent, at risk drinkers that they account for most of the morbidity and mortality that is attributed to drinking.[4]

5. If a patient screens positive on the AUDIT-C, is it likely they are alcohol dependent?

Most patients who screen positive on the AUDIT-C will be at risk drinkers who are not alcohol dependent. By using both the AUDIT-C score, and the patient's history of alcohol treatment, it is possible to identify those most likely to be alcohol dependent. For patients who have never been in alcohol treatment (or attended AA), scores ≥ 8 are associated with relatively high rates of dependence. Patients who have had past alcohol treatment are at high risk of dependence with any positive AUDIT-C score.

6. What is appropriate follow-up for a positive AUDIT-C screen?

See recommendations under Interpretation/Follow-up of AUDIT-C Scores.

7. Does everyone who screens positive on the AUDIT-C need a full assessment or referral?

Not everyone needs a full assessment or referral. Since the AUDIT-C reflects severity, the raw score can be used to assess the likelihood that the patient has alcohol dependence. For patients with AUDIT-C scores 4-7 and no prior alcohol treatment, the provider should offer a brief intervention as follows:

- 1). Express concern about the patient's drinking, if drinking above recommended limits;
- 2) Provide feedback linking the patient's drinking to his/her health concerns, noting that patient is drinking above recommended limits, and
- 3) Offer explicit advice to stay below recommended limits

Patients with more severe problems due to drinking who are do not to accept referral can also be offered brief intervention. If providers want more information on specific symptoms due to drinking, questions #4-10 of the full AUDIT can be used as a brief assessment or patients can be referred to a mental health specialist.

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8. Why do patients who have only one drink a day screen positive on the AUDIT-C?

The optimal screening thresholds are based on studies that used in-depth interviews to assess the patient's drinking and problems due to drinking. These studies found that scores of 4 for men (3 for women) were optimal for identifying those with hazardous drinking or active alcohol use disorders.[5, 6] However, like all screening tests, the AUDIT-C does give some false positives.

A score of 4 points for men (3 for women) is used as the threshold for potentially hazardous drinking. However, when the points are all from question #1 alone (questions #2 & #3 score are zero), it can be assumed that the patient is drinking below recommended limits. In this situation, we recommend that the provider review the patient's alcohol intake over the past few months to confirm accuracy (e.g. "Has this been your consistent pattern over the past 2-3 months?"), review the problem list to ensure there are no medical contraindications due to drinking (e.g. hepatitis C, prior alcohol treatment), and advise the patient to stay below recommended limits.

Recommended limits:

Men: No more than 14 drinks a week, 4 drinks per occasion

Women: No more than 7 drinks a week, 3 drinks per occasion

9. Will the AUDIT-C miss alcohol dependence?

In validation studies that compared the AUDIT-C to in-depth interviews, the AUDIT-C was as good as the CAGE Questionnaire for identifying male patients with active alcohol abuse or dependence.[2, 5] It was also an effective screening test for active alcohol abuse or dependence in women [6] and more effective than the TWEAK (an adaptation of the CAGE for women). [7]

10. Why is the AUDIT-C cut-off higher for men than women?

The recommended cut-off for women is based on a study of female VA patients, which used in-depth interviews to assess their drinking patterns and problems due to drinking.[6] Women develop problems due to drinking at lower levels of alcohol consumption than men. This reflects their lower total body water as well as possible differences in metabolism. Alcohol use is also more stigmatized for women compared to men, so women may be more likely to under-report their drinking.

Recommended Limits: [1]

Men: No more than 14 drinks a week, and 4 drinks on any single occasion

Women: No more than 7 drinks a week, and 3 drinks on any single occasion

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The FULL AUDIT -- AUDIT QUESTIONS #4-10:

Q#4: How often during the last year have you found that you were not able to stop drinking once you had started?

- Never (0 points)
- Less than monthly (1 point)
- Monthly (2 points)
- Weekly (3 points)
- Daily or almost daily (4 points)

Q#5: How often during the last year have you failed to do what was normally expected from you because of drinking?

- Never (0 points)
- Less than monthly (1 point)
- Monthly (2 points)
- Weekly (3 points)
- Daily or almost daily (4 points)

Q#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 (0 points)
- Less than monthly (1 point)
- Monthly (2 points)
- Weekly (3 points)
- Daily or almost daily (4 points)

Q#7: How often during the last year have you had a feeling of guilt or remorse after drinking?

- Never (0 points)
- Less than monthly (1 point)
- Monthly (2 points)
- Weekly (3 points)
- Daily or almost daily (4 points)

Q#8: How often during the last year have you been unable to remember what happened the night before because you had been drinking?

- Never (0 points)
- Less than monthly (1 point)
- Monthly (2 points)
- Weekly (3 points)
- Daily or almost daily (4 points)

Q#9: Have you, or has someone else, been injured as a result of your drinking?

- No (0 points)
- Yes, but not in the last year (2 points)
- Yes, during the last year (4 points)

Q#10: Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?

- No (0 points)
- Yes, but not in the last year (2 points)
- Yes, during the last year (4 points)

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Substance Abuse Screening Instrument (O4/05)

The Drug Abuse Screening Test (DAST) was developed in 1982 and is still an excellent screening tool. It is a 28-item self-report scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has “exhibited valid psychometric properties” and has been found to be “a sensitive screening instrument for the abuse of drugs other than alcohol.

The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or “over-the-counter” drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

	YES	NO
1. Have you used drugs other than those required for medical reasons?	___	___
2. Have you abused prescription drugs?	___	___
3. Do you abuse more than one drug at a time?	___	___
4. Can you get through the week without using drugs (other than those required for medical reasons)?	___	___
5. Are you always able to stop using drugs when you want to?	___	___
6. Do you abuse drugs on a continuous basis?	___	___
7. Do you try to limit your drug use to certain situations?	___	___
8. Have you had “blackouts” or “flashbacks” as a result of drug use?	___	___
9. Do you ever feel bad about your drug abuse?	___	___
10. Does your spouse (or parents) ever complain about your involvement with drugs?	___	___
11. Do your friends or relatives know or suspect you abuse drugs?	___	___
12. Has drug abuse ever created problems between you and your spouse?	___	___
13. Has any family member ever sought help for problems related to your drug use?	___	___
14. Have you ever lost friends because of your use of drugs?	___	___
15. Have you ever neglected your family or missed work because of your use of drugs?	___	___
16. Have you ever been in trouble at work because of drug abuse?	___	___
17. Have you ever lost a job because of drug abuse?	___	___
18. Have you gotten into fights when under the influence of drugs?	___	___
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?	___	___
20. Have you ever been arrested for driving while under the influence of drugs?	___	___
21. Have you engaged in illegal activities in order to obtain drug?	___	___
22. Have you ever been arrested for possession of illegal drugs?	___	___
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	___	___
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	___	___
25. Have you ever gone to anyone for help for a drug problem?	___	___
26. Have you ever been in a hospital for medical problems related to your drug use?	___	___
27. Have you ever been involved in a treatment program specifically related to drug use?	___	___
28. Have you been treated as an outpatient for problems related to drug abuse?	___	___

Scoring and interpretation: A score of “1” is given for each YES response, except for items 4,5, and 7, for which a NO response is given a score of “1.” Based on data from a heterogeneous psychiatric patient population, cutoff scores of 6 through 11 are considered to be optimal for screening for substance use disorders. Using a cutoff score of 6 has been found to provide excellent sensitivity for identifying patients with substance use disorders as well as satisfactory specificity (i.e., identification of patients who do not have substance use disorders). Using a cutoff score of <11 somewhat reduces the sensitivity for identifying patients with substance use disorders, but more accurately identifies the patients who do not have a substance use disorders. Over 12 is definitely a substance abuse problem. In a heterogeneous psychiatric patient population, most items have been shown to correlate at least moderately well with the total scale scores. The items that correlate poorly with the total scale scores appear to be items 4,7,16,20, and 22.

References Cited:

1. National Institute on Alcohol Abuse and Alcoholism, U.D.o.H.a.H.s. and National Institute of Health, *Helping patients with alcohol problems: A practitioner's guide*. 2003.
2. Bradley KA, et al., *Screening for problem drinking: comparison of CAGE and AUDIT*. J Gen Intern Med, 1998. 13(6): p. 379-388.
3. Fleming MF, et al., *Brief physician advice for problem alcohol drinkers: a randomized controlled trial in community-based primary care practices*. JAMA, 1997. 277(13): p. 1039-1045.
4. Institute of Medicine, *Broadening the Base of Treatment for Alcohol Problems: A Report of the Committee for the Study of Treatment and Rehabilitation for Alcoholism*. 1990, Washington DC: National Academy Press. 1-629.
5. Bush K, et al., *The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking*. Arch Intern Med, 1998. 158: p. 1789-1795.
6. Bradley KA, et al., *Two brief alcohol screening tests from the Alcohol Use Disorders Identification Test (AUDIT): validation in a female VA patient population*. Arch Intern Med, 2003. 163: p. 821-839.
7. Bush KR, et al., *The TWEAK is weak for alcohol screening among female VA outpatients*. Alcoholism: Clinical and Experimental Research, In press 2003.

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