

# Screening for High Risk and Dependent Alcohol Use among Psychiatric Inpatients

## The Joint Commission's SUB-1

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# Screening for Alcohol Use among Psychiatric Inpatients

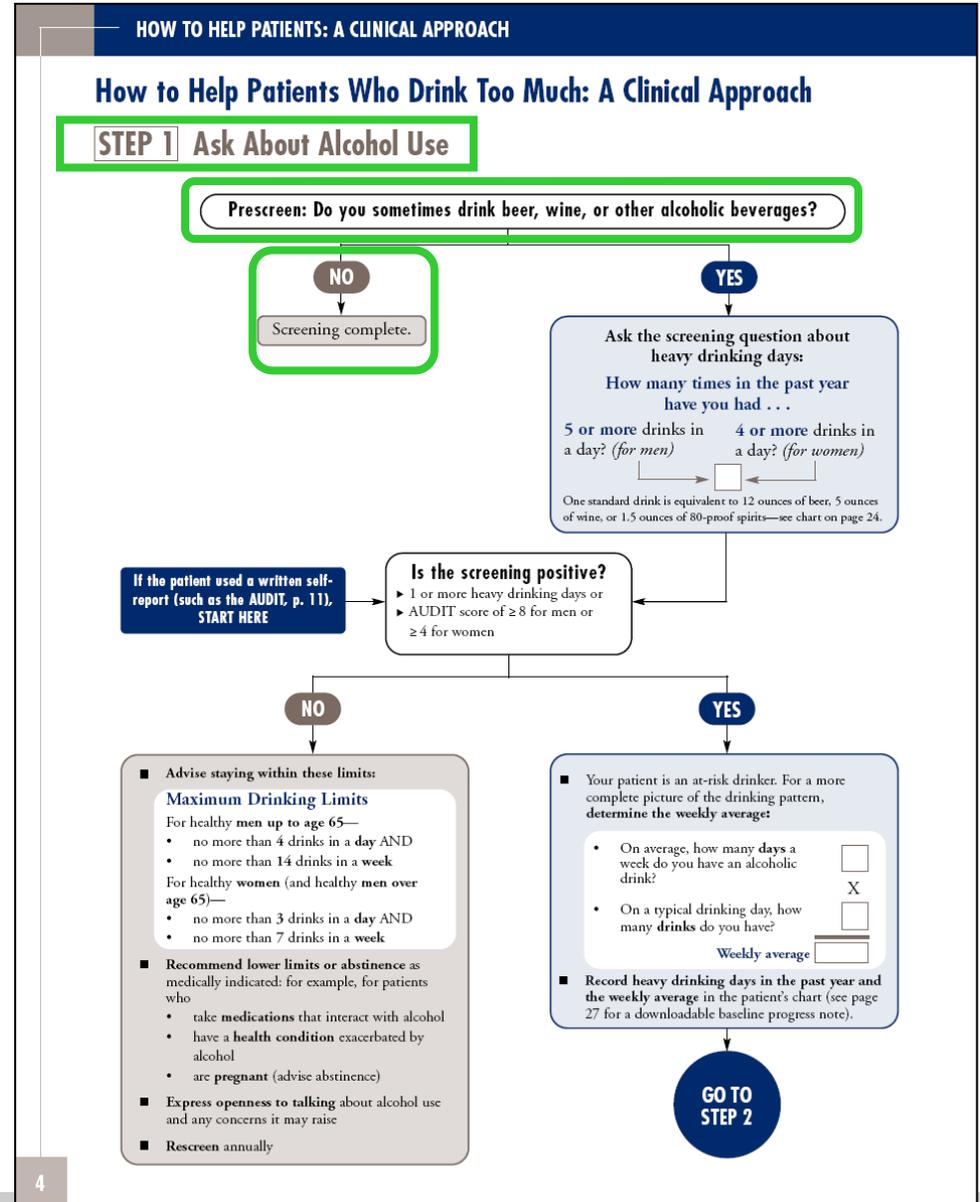
- Screening refers to a tool – usually a brief questionnaire – that finds subjects who have or are at high risk for a disorder in a population of interest.
- Screening does not establish a diagnosis. Instead, it identifies people at risk for or likely to have a disorder
- The Joint Commission SUB-1 measure specifies a “validated” screening instrument

# STEP 1: Ask About Alcohol Use

Prescreen: *Do you sometimes drink beer, wine, or other alcoholic beverages?*

If NO... the screening is complete.

If YES...



# Pre-Screen: The NIAAA – Recommended Single Question Alcohol Screener

	None	1 or more
<b>MEN: How many times in the past year have you had 5 or more drinks in a day?</b>		
<b>WOMEN: How many times in the past year have you had 4 or more drinks in a day?</b>		

This question was sensitive (87.9%) but less specific (66.8%) for the detection of a current alcohol use disorder.

Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. Primary care validation of a single-question alcohol screening test. *J Gen Intern Med.* 2009;24:783–788.

Supplemented by two-item screener: **(1) recurrent drinking in hazardous situations** and **(2) drinking more than intended**. If either answered yes, the sensitivity of current SUD varies from 77% to 95% and the specificity from 62% to 86%.

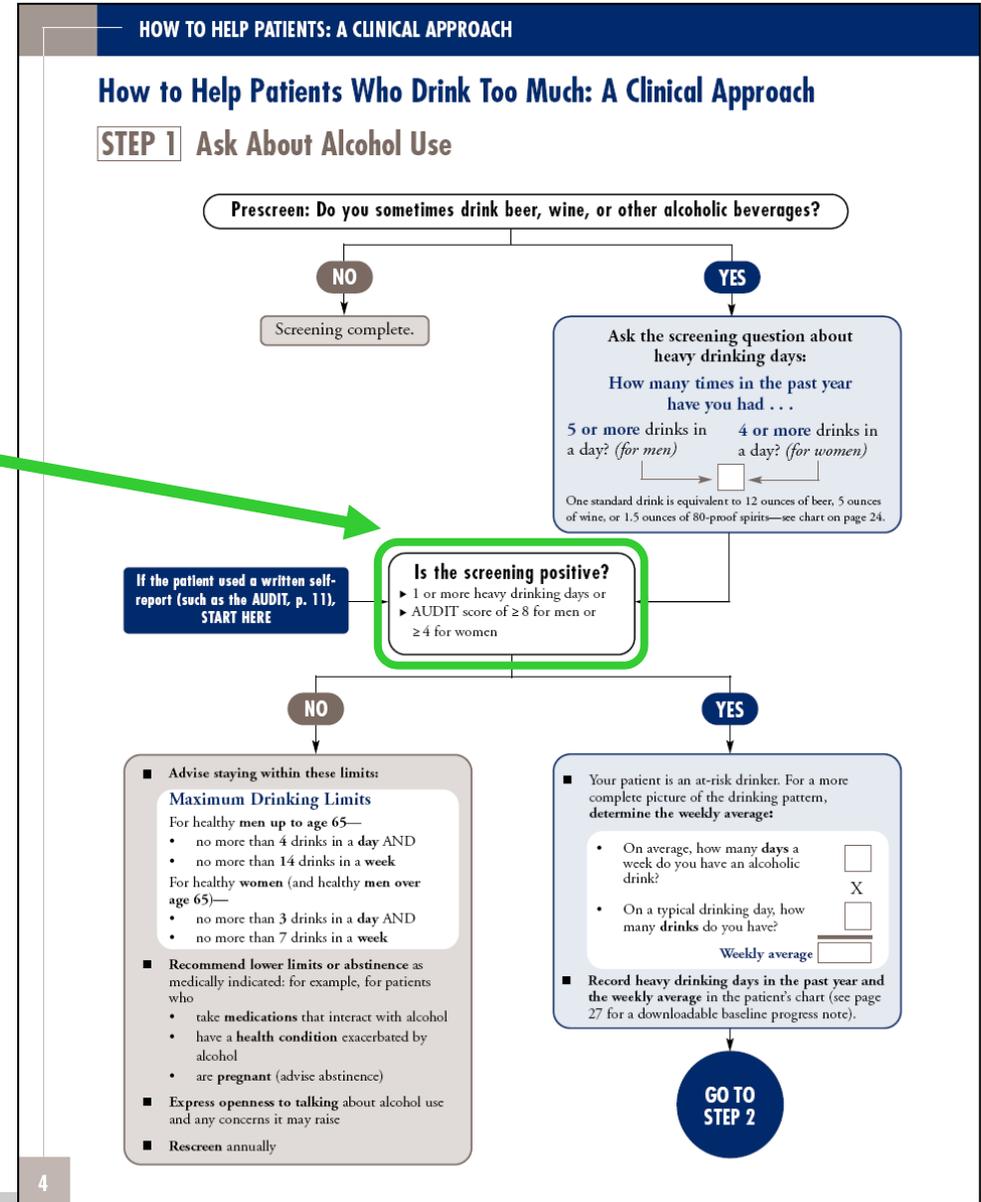
# Why We Recommend the AUDIT

- ✓ Valid
- ✓ Reliable
- ✓ Brief
- ✓ Public domain
- ✓ Free
- ✓ Multiple languages
- ✓ Widely used in the U.S. and Canada
- ✓ Identifies unhealthy and dependent drinking patterns
- ✓ Results guide treatment
- ✓ Monitors change in use
- ✓ Fits with other screeners (e.g. PHQ-9 for depression)
- ✓ Multiple ways to administer (verbally, in person or over the phone, on paper or online)

# STEP 1: Is the Screening Positive?

Positive Screening =

- 1 or more heavy drinking days





If YES...

Ask the screening question about heavy drinking days:  
 How many times in the past year have you had...

5 or more drinks in a day? (for men)

4 or more drinks in a day? (for women)

How to Help Patients Who Drink Too Much: A Clinical Approach

STEP 1 Ask About Alcohol Use

Do you sometimes drink beer, wine, or other alcoholic beverages?

YES

Ask the screening question about heavy drinking days:  
 How many times in the past year have you had ...

5 or more drinks in a day? (for men)

4 or more drinks in a day? (for women)

One standard drink is equivalent to 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits—see chart on page 24.

Is the screening positive?  
 1 or more heavy drinking days or  
 AUDIT score of ≥ 8 for men or  
 ≥ 4 for women

YES

Your patient is an at-risk drinker. For a more complete picture of the drinking pattern, determine the weekly average:

- On average, how many days a week do you have an alcoholic drink?
- On a typical drinking day, how many drinks do you have?

Weekly average

Record heavy drinking days in the past year and the weekly average in the patient's chart (see page 27 for a downloadable baseline progress note).

GO TO STEP 2

These limits:

**Drinking Limits**

For healthy men up to age 65—

- no more than 4 drinks in a day AND
- no more than 14 drinks in a week

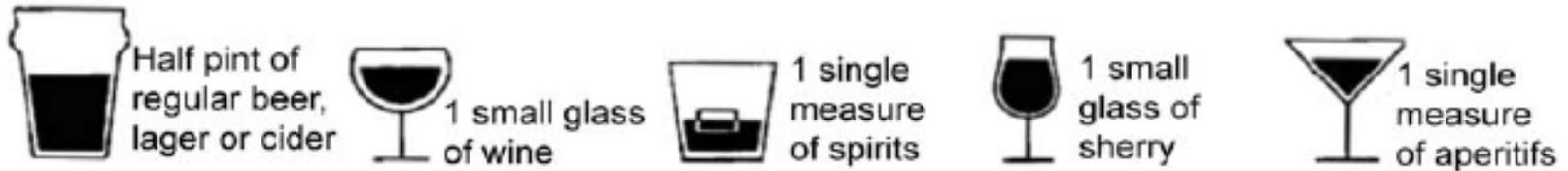
For healthy women (and healthy men over age 65)—

- no more than 3 drinks in a day AND
- no more than 7 drinks in a week

- Recommend lower limits or abstinence as medically indicated: for example, for patients who
  - take medications that interact with alcohol
  - have a health condition exacerbated by alcohol
  - are pregnant (advise abstinence)
- Express openness to talking about alcohol use and any concerns it may raise
- Rescreen annually

# How much is a drink?

**This is one unit of alcohol...**



**...and each of these is more than one unit**



## STEP 1: Is the Screening Positive?

If **NO** then...

- Advise staying within these limits:

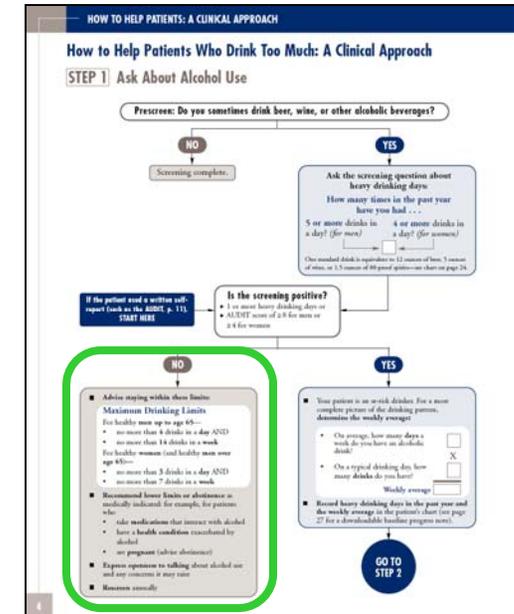
### Maximum Drinking Limits

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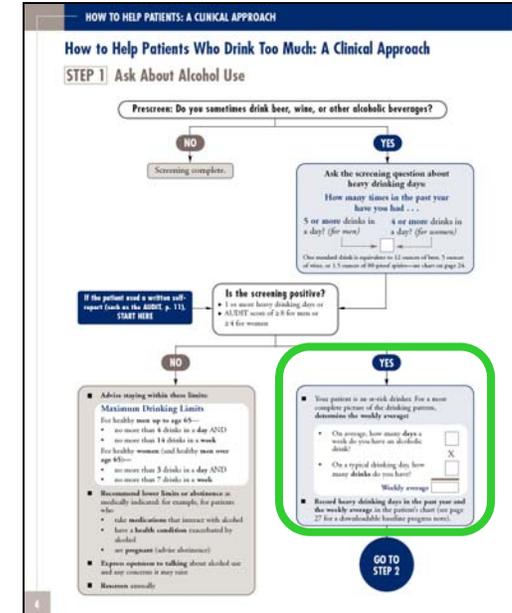


# STEP 1: Is the Screening Positive?

If **YES** then...

- Your patient is an at-risk drinker. For a more complete picture of the drinking pattern, **determine the weekly average:**

- On average, how many **days** a week do you have an alcoholic drink?
  - On a typical drinking day, how many **drinks** do you have?
- Weekly Average**



# Using the AUDIT –C: Consumption Questions

Questions	0	1	2	3	4	Score
<b>1. How often do you have a drink containing alcohol?</b>	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	
<b>2. How many drinks containing alcohol do you have on a typical day of drinking?</b>	1 or 2	3 or 4	5 or 6	7 to 9	10 +	
<b>3. How often do you have 5 (for men under age 65)/4 (for women and men over age 65) or more drinks on one occasion?</b>	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
<b>AUDIT-C Score (add items 1-3)</b>						
<b>Positive screen = 4 for men/3 for women and men over age 65. If positive, ask the next 7 questions to administer the full AUDIT.</b>						



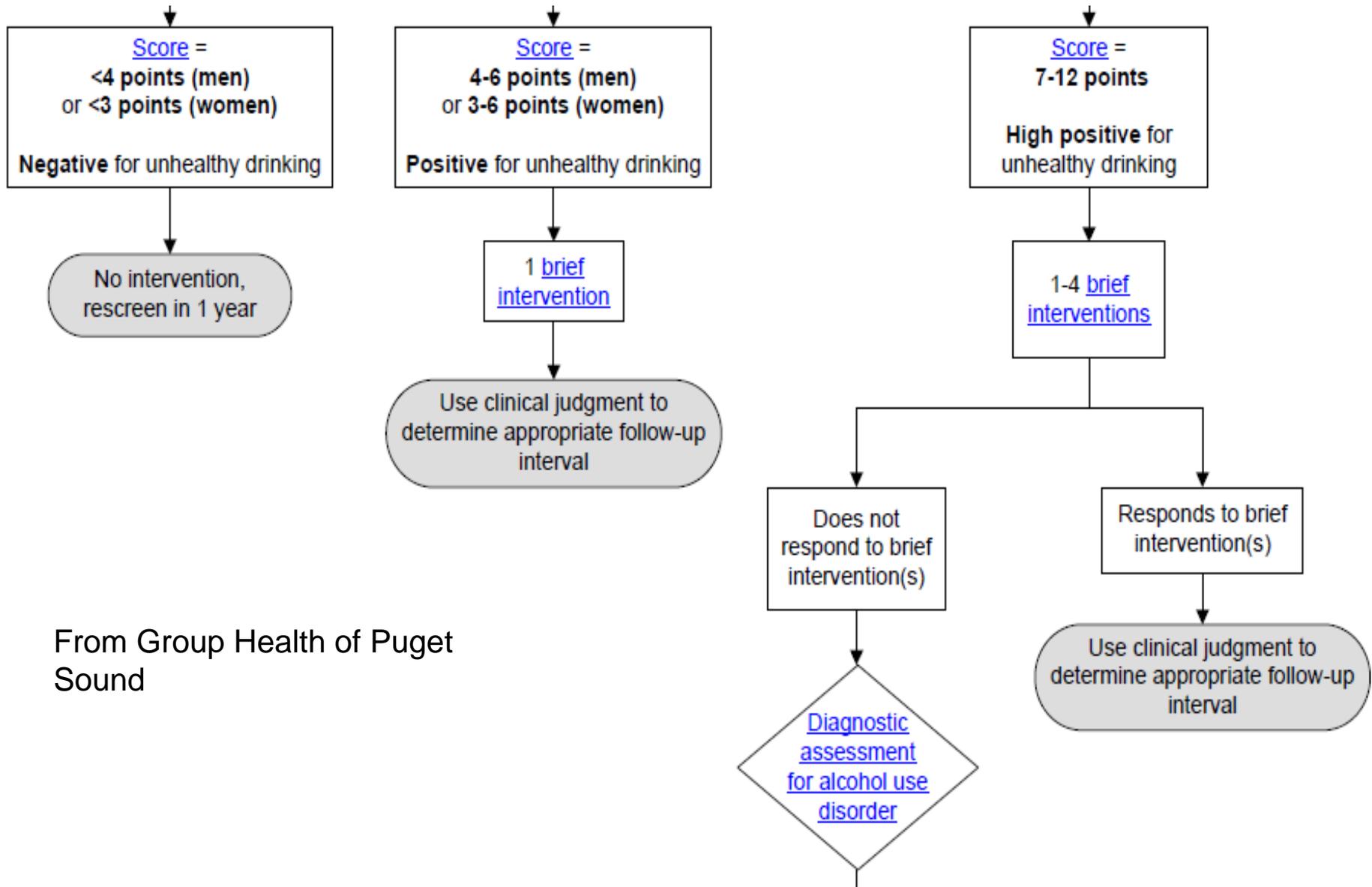
## Scoring the AUDIT-C

The AUDIT-C has been validated as a screen for the full spectrum of unhealthy drinking (risky drinking and alcohol use disorders).

**Table 4. AUDIT-C scoring**

Score	Interpretation	Management	Follow-up
<b>Men</b> Fewer than 4 points  <b>Women</b> Fewer than 3 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> 4–6 points  <b>Women</b> 3–6 points	Positive for unhealthy drinking.	Brief intervention (see <a href="#">Table 6a</a> ).	Use clinical judgment to determine appropriate follow-up interval.
<b>Men and women</b> 7–12 points	High positive for unhealthy drinking.  The higher the score, the greater the potential for health risks.	Brief intervention (see <a href="#">Table 6b</a> ). <b>and</b> If not responding to BI, diagnostic assessment for alcohol use disorder (see <a href="#">Table 7</a> ).	Use clinical judgment to determine appropriate follow-up interval.

# AUDIT-C Intervention guide



From Group Health of Puget Sound

# AUDIT-PC: Consumption, Problems – predicts hospital withdrawal risk

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

# Remaining AUDIT Questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	

## Other Screening Instruments

Adolescents: CRAFFT

Geriatric – MAST-G

Alcohol and other Drugs – ASSIST

Behavioral health and AUDs – GAIN-SS

SIP-A

ASI – Alcohol Subscale

~~CAGE?~~

## Adolescent Screener: CRAFFT

- C Have you ever ridden in a *car* driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
- R Do you ever use alcohol or drugs to *relax*, feel better about yourself, or fit in?
- A Do you ever use alcohol or drugs while you are by yourself, *alone*?
- F Do you ever *forget* things you did while using alcohol or drugs?
- F Do your family or *friends* ever tell you that you should cut down on your drinking or drug use?
- T Have you ever gotten into *trouble* while you were using alcohol or drugs?

Arch Pediatr Adolesc Med. 2002;156(6):607-614. doi:10.1001/archpedi.156.6.607

# The ASSIST - Alcohol, Smoking and Substance Involvement Screening Test (WHO)

In your life, which of the following substances have you <u>ever used</u> ? <i>(NON-MEDICAL USE ONLY)</i>	No	Yes
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

Probe if all answers are negative:  
 "Not even when you were in school?"

*If "No" to all items, stop interview.*

*If "Yes" to any of these items, ask Question 2 for each substance ever used.*

# Global Appraisal of Individual Needs Short Screener (GAIN-SS) -- Substance Use Scale

**When was the last time that...**

you used alcohol or other drugs weekly or more often?

you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?

you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?

your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?

you had withdrawal problems like shaky hands, throwing up, having trouble sitting still or sleeping, or used to stop being sick?

# SIP-A Short Index of Problems - Alcohol

<b>I have been unhappy because of..</b>	<b>I had money problems because of</b>
<b>I have not eaten properly because of</b>	<b>My physical appearance was harmed by</b>
<b>I failed to do what was expected because of</b>	<b>My family was hurt by</b>
<b>I felt guilty because of</b>	<b>My friendships have been damaged by</b>
<b>I have taken foolish risks because of</b>	<b>Alcohol has gotten in the way of my growth</b>
<b>I have done impulsive things when</b>	<b>Alcohol damaged my social life</b>
<b>My physical health was harmed by</b>	<b>I spent too much time because of</b>
<b>I have had an accident while.</b>	

Feinn R, Tennen H, Kranzler HR. Psychometric properties of the Short Index of Problems as a measure of recent alcohol-related problems. *Alcsm Clin Exp Res.* 2003;27:1436–41  
 Alterman AI, Cacciola JS, Ivey MA, Habing B, Lynch KG. Reliability and validity of the alcohol SIP and a newly constructed drug Short Index of Problems. *J Stud Alcohol Drugs.* 2009;70:304–7 **20**

# Addiction Severity Index – 6; Alcohol Scale

**Drank more/longer than intended**

**Time spent drinking**

**Impaired control (stop/cut down)**

**Use despite interpersonal problems**

**Hazardous use**

**Failure to fulfill role obligations**

**Withdrawal**

**Activities given up**

**Tolerance**

**Legal problems**

**Use despite physical/psychological problems**

Cacciola, J. S., Alterman, A. I., Habing, B., & McLellan, A. T. (2011). Recent status scores for version 6 of the Addiction Severity Index (ASI-6). *Addiction*, 106(9), 1588-1602. **21**

## CAGE – not recommended, insensitive to risky use

- (1) “Have you ever felt you ought to **C**ut down on your drinking?”;
- (2) “Have people **A**nnoyed you by criticizing your drinking?”;
- (3) “Have you ever felt bad or **G**uilty about your drinking?”; and
- (4) “Have you ever had a drink in the morning to steady your nerves or get rid of a hangover (**E**ye opener)?”.

One positive response should raise the possibility of alcohol-related problems, but most researchers have used two or more positive responses. A pooled analysis of the CAGE in screening for alcohol abuse and dependence found a sensitivity of 0.87 in inpatients. Binge drinking and high risk use are often **not** captured by the CAGE.

# SUB-1 Training [www.SBIRTmentor.com](http://www.SBIRTmentor.com)



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- Immediate feedback from standardized patients and skill acquisition scores  
3 CMEs, continuing nurse education and counselor, social work, psychology CEUs

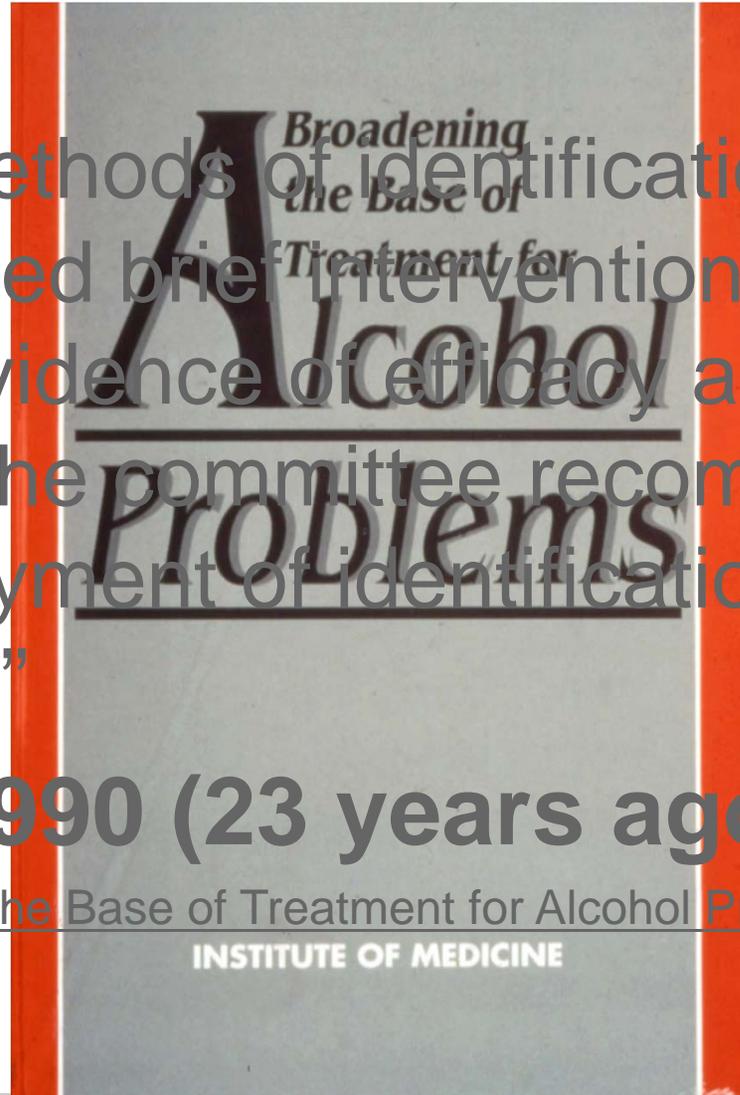
- For more information, 303.369.0039 x245 or [SBIRTinfo@PeerAssist.org](mailto:SBIRTinfo@PeerAssist.org)
- To access visit [www.SBIRTmentor.com](http://www.SBIRTmentor.com)

## Has enough time passed for SBI?

“Suitable methods of identification and readily learned brief intervention techniques with good evidence of efficacy are now available. The committee recommends... broad deployment of identification and brief intervention.”

**1990 (23 years ago!)**

(IOM, Broadening the Base of Treatment for Alcohol Problems, 1990, p. 8)



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# Thank You!

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