This pocket guide is condensed from the 30-page NIAAA guide, *Helping Patients Who Drink Too Much: A Clinician’s Guide*.

For copies of the full guide or more copies of this pocket version, contact:

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A standard drink is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are standard drink equivalents as well as the number of standard drinks in different container sizes for each beverage. These are approximate, as different brands and types of beverages vary in their actual alcohol content.

<table>
<thead>
<tr>
<th>STANDARD DRINK EQUIVALENTS</th>
<th>APPROXIMATE NUMBER OF STANDARD DRINKS IN:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BEER or COOLER</strong></td>
<td></td>
</tr>
<tr>
<td>12 oz.</td>
<td>• 12 oz. = 1</td>
</tr>
<tr>
<td></td>
<td>• 16 oz. = 1.3</td>
</tr>
<tr>
<td></td>
<td>• 22 oz. = 2</td>
</tr>
<tr>
<td></td>
<td>• 40 oz. = 3.3</td>
</tr>
<tr>
<td>8–9 oz.</td>
<td>• 12 oz. = 1.5</td>
</tr>
<tr>
<td></td>
<td>• 16 oz. = 2</td>
</tr>
<tr>
<td></td>
<td>• 22 oz. = 2.5</td>
</tr>
<tr>
<td></td>
<td>• 40 oz. = 4.5</td>
</tr>
<tr>
<td>750 mL (25 oz.) bottle</td>
<td>• a 750 mL (25 oz.) bottle = 5</td>
</tr>
<tr>
<td><strong>MALT LIQUOR</strong></td>
<td></td>
</tr>
<tr>
<td>5 oz.</td>
<td>• a mixed drink = 1 or more*</td>
</tr>
<tr>
<td></td>
<td>• a pint (16 oz.) = 11</td>
</tr>
<tr>
<td></td>
<td>• a fifth (25 oz.) = 17</td>
</tr>
<tr>
<td></td>
<td>• 1.75 L (59 oz.) = 39</td>
</tr>
</tbody>
</table>

*Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.
# Drinking Patterns

## What is your drinking pattern?

- **Never exceed the daily or weekly limits**
  - (2 out of 3 people in this group abstain or drink fewer than 12 drinks a year)
  - Percentage of U.S. adults aged 18 or older: **72%**
  - Combined prevalence of alcohol abuse and dependence: **less than 1 in 100**

- **Exceed only the daily limit**
  - (More than 8 out of 10 in this group exceed the daily limit less than once a week)
  - Percentage of U.S. adults aged 18 or older: **16%**
  - Combined prevalence of alcohol abuse and dependence: **1 in 5**

- **Exceed both daily and weekly limits**
  - (8 out of 10 in this group exceed the daily limit once a week or more)
  - Percentage of U.S. adults aged 18 or older: **10%**
  - Combined prevalence of alcohol abuse and dependence: **almost 1 in 2**

*Not included in the chart, for simplicity, are the 2 percent of U.S. adults who exceed only the weekly limits. The combined prevalence of alcohol use disorders in this group is 8 percent.*

**Source:** 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a nationwide survey sponsored by the National Institute on Alcohol Abuse and Alcoholism of 43,093 U.S. adults aged 18 or older.
The chart below contains excerpts from page 20 of NIAAA’s *Helping Patients Who Drink Too Much: A Clinician’s Guide*. It does not provide complete information and is not meant to be a substitute for the patient package inserts or other drug references used by clinicians. For patient information, visit [http://medlineplus.gov](http://medlineplus.gov).

<table>
<thead>
<tr>
<th>Disulfiram</th>
<th>Naltrexone</th>
<th>Acamprosate</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(Antabuse®)</em></td>
<td><em>(ReVia®)</em></td>
<td><em>(Campral®)</em></td>
</tr>
<tr>
<td><strong>Contraindications</strong></td>
<td>Concomitant use of alcohol or alcohol-containing preparations or metronidazole; coronary artery disease; severe myocardial disease</td>
<td>Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analogues; acute hepatitis or liver failure</td>
</tr>
<tr>
<td><strong>Key precautions</strong></td>
<td>High impulsivity; likely to drink while using it; psychoses (current or history); hepatic dysfunction</td>
<td>Other hepatic disease. If opioid analgesia is required, larger doses may be required, and respiratory depression may be deeper and more prolonged.</td>
</tr>
<tr>
<td><strong>More common serious adverse reactions</strong></td>
<td>Disulfiram-ethanol reaction; hepatitis; peripheral neuropathy; psychotic reactions; pregnancy Category C</td>
<td>Will precipitate severe withdrawal if patient is dependent on opioids; hepatotoxicity (uncommon at usual doses); pregnancy Category C</td>
</tr>
<tr>
<td><strong>Common side effects</strong></td>
<td>Metallic after-taste; dermatitis</td>
<td>Nausea; abdominal pain; constipation; dizziness; headache; anxiety and fatigue</td>
</tr>
<tr>
<td><strong>Examples of drug interactions</strong></td>
<td>Warfarin; isoniazid; metronidazole; any nonprescription drug containing alcohol</td>
<td>Opioid analogues (blocks action)</td>
</tr>
</tbody>
</table>
| **How to prescribe** | Oral dose: 250 mg daily (range 125 mg to 500 mg)  
**Before prescribing:** (1) warn that patient should not take disulfiram for at least 12 hours after drinking and that a disulfiram-alcohol reaction can occur up to 2 weeks after the last dose; and (2) warn about alcohol in the diet (e.g., sauces and vinegars) and in medications and toiletries  
**Followup:** Monitor liver function tests periodically | Oral dose: 50 mg daily  
**Before prescribing:** Evaluate for possible current opioid use; consider a urine toxicology screen for opioids, including synthetic opioids. Obtain liver function tests.  
**Followup:** Monitor liver function tests periodically | Oral dose: 666 mg (two 333-mg tablets) three times daily or, for patients with moderate renal impairment (CrCl 30-50 mL/min), reduce to 333 mg (one tablet) three times daily  
**Before prescribing:** Establish abstinence |

**Note:** Whether or not a medication should be prescribed and in what amount is a matter between individuals and their health care providers. The prescribing information provided here is not a substitute for a provider’s judgment in an individual circumstance and the NIH accepts no liability or responsibility for use of the information with regard to particular patients.

**JULY 2005**
**STEP 1  Ask About Alcohol Use**

**Ask:** Do you sometimes drink alcoholic beverages?

- **NO**
  - Screening complete.

- **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.
  - **Is the answer 1 or more times?**

  - **NO**
    - Advise staying within maximum 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 indicated; for example, for patients who take medications that interact with alcohol, have a health condition exacerbated by alcohol, or are pregnant (advise abstinence)
    - **Rescreen** annually
  - **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 past year and weekly average in chart.

*GO TO STEP 2*
Next, determine if there is a maladaptive pattern of alcohol use, causing clinically significant impairment or distress.

Determine whether, in the past 12 months, your patient’s drinking has repeatedly caused or contributed to

- role failure (interference with home, work, or school obligations)
- risk of bodily harm (drinking and driving, operating machinery, swimming)
- run-ins with the law (arrests or other legal problems)
- relationship trouble (family or friends)

If yes to one or more ➡️ your patient has alcohol abuse.

In either case, proceed to assess for dependence symptoms.

Determine whether, in the past 12 months, your patient has

- shown tolerance (needed to drink a lot more to get the same effect)
- shown signs of withdrawal (tremors, sweating, nausea, or insomnia when trying to quit or cut down)
- not been able to stick to drinking limits (repeatedly gone over them)
- not been able to cut down or stop (repeated failed attempts)
- spent a lot of time drinking (or anticipating or recovering from drinking)
- spent less time on other matters (activities that had been important or pleasurable)
- kept drinking despite problems (recurrent physical or psychological problems)

If yes to three or more ➡️ your patient has alcohol dependence.

Does patient meet criteria for abuse or dependence?

NO
GO TO STEPS 3 & 4 for AT-RISK DRINKING

YES
GO TO STEPS 3 & 4 for ALCOHOL USE DISORDERS
FOR AT-RISK DRINKING (no abuse or dependence)

**STEP 3 Advise and Assist**

- **Is patient ready to commit to change?**
  - **NO**
    - Restate your concern.
    - Encourage reflection.
    - Address barriers to change.
    - Reaffirm your willingness to help.
  - **YES**
    - Help set a goal.
    - Agree on a plan.
    - Provide educational materials.

**STEP 4 At Followup: Continue Support**

**REMEMBER:** Document alcohol use and review goals at each visit.

- **Was patient able to meet and sustain drinking goal?**
  - **NO**
    - Acknowledge that change is difficult.
    - Support positive change and address barriers.
    - Renegotiate goal and plan; consider a trial of abstinence.
    - Consider engaging significant others.
    - Reassess diagnosis if patient is unable to either cut down or abstain.
  - **YES**
    - Reinforce and support continued adherence to recommendations.
    - Renegotiate drinking goals as indicated (e.g., if the medical condition changes or if an abstaining patient wishes to resume drinking).
    - Encourage to return if unable to maintain adherence.
    - Rescreen at least annually.
BRIEF INTERVENTION
FOR ALCOHOL USE DISORDERS (abuse or dependence)

**STEP 3** Advise and Assist

- State your conclusion and recommendation clearly and relate them to medical concerns or findings.
- Negotiate a drinking goal.
- Consider evaluation by an addiction specialist.
- Consider recommending a mutual help group.
- For patients who have dependence, consider:
  - the need for **medically managed withdrawal** (detoxification) and treat accordingly.
  - prescribing a **medication** for alcohol dependence for patients who endorse abstinence as a goal.
- Arrange followup appointments.

**STEP 4** At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit.

**Was patient able to meet and sustain drinking goal?**

- **NO**
  - Acknowledge that change is difficult.
  - Support efforts to cut down or abstain.
  - Relate drinking to ongoing problems as appropriate.
  - Consider (if not yet done):
    - consulting with an **addiction specialist**.
    - recommending a **mutual help group**.
    - engaging **significant others**.
    - prescribing a **medication** for alcohol dependent patients who endorse abstinence as a goal.
  - Address coexisting disorders as needed.

- **YES**
  - Reinforce and support continued adherence.
  - Coordinate care with specialists as appropriate.
  - Maintain medications for alcohol dependence for at least 3 months and as clinically indicated thereafter.
  - Treat coexisting nicotine dependence.
  - Address coexisting disorders as needed.