Screening for Alcohol Use in Adult Primary Care

The Society of Trauma Nurses believes:

- Alcohol abuse screenings and brief behavioral counseling interventions (SBIs) should be done in emergency departments and trauma centers to identify at risk patients for morbidity and mortality related to their alcohol consumption.
- The Uniform Policy Provision Law which allows insurers to refuse to pay medical costs for patients injured while under the influence should be repealed in all states.
- Alcohol screening and alcohol education should be integrated into curricula, continuing education, and standards for all health care professionals.
- Nurses should participate in collaborative research, education, and data gathering to improve the care of patients with alcohol use problems.

The US Preventive Services Task Force (USPSTF) has suggested guidelines, based on numerous data sources, to help reduce risky/harmful alcohol use by adults.[1] Their public health approach would include screening and brief behavioral counseling interventions (SBIs) in primary care settings that would identify patients whose alcohol consumption do not meet criteria for alcohol dependence, but places them at risk for morbidity and mortality. These brief interventions can be as short as five minutes and often incorporate six elements summarized by the acronym FRAMES: feedback, responsibility, advice, menu of strategies, empathy and self-efficacy.[2] It is hoped, based on these studies, that future research would include implementing these strategies into the practice of routine health care.

The history of research in this area can easily date back three decades ago with the publication of the landmark *Accidental Death and Disability* in 1970,[3] that was the precursor to significant advances in development of trauma centers and their systems in the management of patients with severe injuries. In contrast, those clinicians who treat those injured in alcohol-related events do very little to disrupt one of the major pathways to traumatic injury -----the abuse of alcohol and drugs. Trauma centers are in a unique position to implement screening programs that would also include intervention and referral to appropriate agencies. The tendency not to intervene includes physician training that focuses primarily on critical care management of the trauma patient, an aversion to behaviors of intoxicated patients, limited resources, and assuming that the intoxicated episode in a spurious episode, not a marker of an underlying problem.[4]

Two decades of evidence supports effectiveness of brief interventions that includes 40 controlled studies. Meta-analysis of 12 randomized controlled trials showed that those receiving brief interventions were twice as likely to have moderated their drinking at 6-12 months post intervention as those who did not receive any intervention.[5] Other studies on the success of screening and brief interventions include a recent evidence-based review that revealed 39 published studies that included 30 randomized controlled and 9 cohort studies. A positive effect was demonstrated in 32 of these studies.[6]

Besides the primary care setting, emergency departments also offer a potential "teaching moment" to those patients who have experienced a negative consequence to their alcohol problem.[7,8] Cherpitel [9]found that ED patients were one and half to three times more likely to report heavy drinking, alcohol dependence, and consequences of past drinking than those patients in a primary care setting. Project ASSERT, an ED based intervention to increase access to primary care, preventive services and substance abuse treatment systems, found that 50% of patients with alcohol and drug dependence reported follow-up with the treatment referral.[10] A 2001 study by D'Onofrio et al, using Project ASSERT, reported similar positive results.[6]

Screening tools recommended by the National Institute of Alcohol Abuse and Alcoholism (NIAAA) include the use of quantity and frequency questions (Q & F) as well as the CAGE questionnaire. The Q and F questions can determine if the responses exceed the "moderate" drinking levels and are therefore "at risk" for illness and injury. The CAGE questions are better for determining dependence and for those patients who present intoxicated, since it eliminates the need to ask the patient to quantity their drinking, which can be met with resistance.[11] Other screening tools used in the detention of alcohol-dependent individuals include the MAST, TWEAK, and the TACE. and the FAST.

Benefit-cost analysis studies of brief interventions have been few and the methods of conducting the analysis have been inconsistent because brief interventions are not homogeneous entities. The interventions vary in length, structure, targets, and personnel involved. Clearer delineation of the intervention design can alleviate this problem. One study within a managed care setting estimated that for every $10,000 spent on brief interventions for alcohol or drug abuse, $13,500-$25,000 is saved in medical care spending.[12] This study, the first quantitative one, was based on the baseline, 6-month and 12-month follow-up data from Project TREAT in Wisconsin. The study found a decreased use of ERD and inpt hospitalizations at savings of $195,000 and a decrease in and crime and motor vehicle crashes amounting to $228,000. The total benefit was equal to $1,151 per study patient. In determining the benefits relative to costs, the total cost of the intervention was $80,000, or $205/subject. The net benefit was $947 per study pt. The benefit-cost ratio was equivalent to $56,263 in benefits for every $10,000 spent on the brief intervention.

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