



Reducing Hazardous Alcohol Use: How Can Screening and Brief Intervention in Health Care Settings be Expanded?

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About this Paper

A recent proposal by college presidents to lower the drinking age to 18 has spotlighted the hazards of binge drinking among college students. The nation's alcohol problem is also underscored by this statistic: 17 million Americans age 12 or older are heavy drinkers.

A clinical tool called screening and brief intervention (SBI) is a tested and successful method for reducing college binge drinking. Offering SBI services more broadly — in primary care offices, emergency rooms, trauma centers and other clinical settings — is a proven strategy for identifying individuals with alcohol problems and influencing their drinking behavior, and there is a growing willingness among public and private insurers to pay for it.

But use still lags. The efforts of pediatricians and family practitioners to provide SBI “were typically inconsistent, not in enough depth, and they failed to incorporate the most effective educational methods,” according to one survey. A continuing commitment to expand reimbursement, educate physicians, and provide resources to encourage the use of effective SBI techniques can be expected to influence the nation's troubling problem of alcohol misuse.

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About the Rapid Public Health Policy Response Project

The Rapid Public Health Policy Response Project of the School of Public Health and Health Services at The George Washington University presents data and other background information on breaking public health stories. The goal is to educate the public, policymakers, legislators, health care providers, the media and others in order to promote informed decision making.

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In August 2008, more than 100 college presidents called for lowering the legal drinking age, claiming that current restrictions encourage binge drinking among students.¹ While the proposal sparked widespread controversy, it also called attention to a broad public health problem: 43.6 percent of college students engage in binge drinking, defined as five or more drinks on the same occasion at least once over the past 30 days; some 17 percent of students engage in that behavior at least five days in a month.²

The hazards of alcohol misuse at all ages are well-documented, and the value of standardized screening and brief intervention (SBI) services has been repeatedly demonstrated, not only as a tool to reduce college binge drinking but to identify at-risk individuals and facilitate changes in their behavior. As a result, many federal agencies, managed care companies, professional medical associations, and health care providers have endorsed the use of SBI in clinical settings, and many public and private insurers will pay for it.

Nonetheless, screening and brief intervention for alcohol misuse has not become a routine part of most clinical practices. Given the personal and social costs of the problem, the benefits to widening the use of SBI seem clear. What can be done to make that happen?

Alcohol Misuse and Access to Treatment

A few statistics from the extensive literature on the consequences of alcohol misuse only hint at the threat:

- ▶ Seventeen million Americans age 12 or older — 6.9 percent of the population — are heavy drinkers, according to the Substance Abuse and Mental Health Services Administration.² That is more than the number who suffer from high blood pressure, asthma, or arthritis. And almost 80,000 adults die every year from alcohol-related events, making excessive drinking the third leading preventable cause of death in the United States.³
- ▶ Alcohol is the drug of choice among young people, who use it more widely than either cigarettes or marijuana.⁴ More than one-third (35.7 percent) of individuals 18 to 20 are binge drinkers, as are 19.4 percent of 16 and 17-year-olds and 7.8 percent of 14 and 15-year-olds.² Some 4,600 people under age 21 die every year from alcohol-related injuries.³ Underage drinking is associated with risky sexual behavior, academic failure, and the use of tobacco and illicit drugs, and it is a risk factor for heavy drinking later in life.⁴
- ▶ Every year, alcohol drains \$186 billion from the American economy and contributes to 500 million lost work days. Employers pay twice as much to cover the health care costs of employees with alcohol problems as they do for other employees.⁵

Despite the evident need, less than 10 percent of working adults with alcohol or drug disorders are identified and treated, according to the Center for Integrated Behavioral Health Policy, part of the Department of Health Policy in the School of Public Health and Health Services at The George Washington University, which works to reduce the burden of alcohol misuse.⁵

The Value of Screening and Brief Intervention

Routinely screening all patients in a clinical setting for a particular health risk, regardless of what brought them to that setting in the first place, is an established technique for identifying those who need medical care. In 1990, the Institute of Medicine created the framework for widespread alcohol screening with its recommendation that “patients in all medical settings be screened for the full spectrum of problems that can accompany alcohol use.”⁶

Because the majority of screened patients are *not* likely to have the condition of concern, screening generally needs to be fast and easy. Several validated alcohol screening tools take no more than five or 10 minutes to administer, including the CAGE questionnaire, with just four questions, and the 10-question Alcohol Use Disorder Identification Test (AUDIT).⁷ According to one study, problem drinking can even be identified by a single question: “When was the last time you had more than X drinks in one day?” [where x=4 for women and x=5 for men].⁸

A brief intervention for those who screen positive typically involves a series of one to four short counseling sessions with a trained clinician, such as a physician, psychologist or social worker, according to the National Institute on Alcohol Abuse and Alcoholism.⁹ Each session lasts between five and 15 minutes, with the total intervention taking no more than an hour. (The clinical settings that can readily offer routine screening for alcohol abuse, such as primary care offices, hospital emergency rooms, and trauma centers, are not typically prepared to address chronic alcohol dependence, but they can provide appropriate referrals.)

Given the relative ease of alcohol screening and a brief intervention, its value is striking. Among the persuasive research:

- ▶ The U.S. Preventive Services Task Force reviewed the body of available evidence on SBI and concluded that “good-quality brief multicontact behavior counseling interventions reduced risky and harmful alcohol use by primary care patients.”¹¹ While most studies found that benefits lingered for six to 12 months after an intervention, at least one showed improved drinking behavior 48 months later.¹²
- ▶ A brief intervention was the most effective of 48 alcohol treatment modalities, according to an analysis of 381 clinical trials by the Mesa Grande project. Mesa Grande periodically reviews and compiles the outcomes of comparison treatment trials (and derives its names from the large table format in which it presents the findings).¹³
- ▶ Based on four years of follow-up, researchers concluded that a single-session preventive intervention with college students reduced the amounts they drank, and the negative consequences of their drinking.¹⁴

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- ▶ Responding to concerns that some research studies did not reflect the “real world” of clinical practice, researchers analyzed a subset of studies conducted in primary care settings and reached a consistent conclusion — “overall, brief interventions lowered alcohol consumption.”¹⁵
- ▶ Although the weight of the evidence supporting SBI’s success at reducing drinking is greater than for improving health or longevity, a meta-analysis of 32 studies involving some 7,500 subjects found “clear indications that brief interventions have an effect on mortality.” While flagging a variety of methodological limitations, researchers estimated that a brief intervention reduces the mortality of problem drinkers by a considerable 23–36 percent.¹⁶
- ▶ Alcohol screening, followed by a brief intervention, can reduce health care costs in primary care, emergency departments, trauma centers and behavioral health settings, with an average return on \$2 for every dollar invested.¹⁷

A Consensus Emerges, but Compliance Lags

Reflecting these findings, many professional associations and public health advocates have recommended that screening and brief intervention services become a routine part of primary care:

- ▶ The U.S. Preventive Services Task Force “recommends screening and behavioral counseling intervention to reduce alcohol misuse by adults, including pregnant women, in primary care settings.”¹⁸
- ▶ The National Quality Forum, with 365 membership organizations from all parts of the health care system, has endorsed a set of voluntary evidence-based standards for treating substance use problems. The consensus recommendations call for screening all patients at least annually for at-risk drinking, followed by a brief intervention where appropriate.¹⁹
- ▶ SBI is also recommended by the American Medical Association (AMA), the American Society of Addiction Medicine, and the Canadian Task Force on Preventive Health Care, among others. The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics (AAP) have made similar recommendations for pregnant women, and the AAP and the AMA recommend screening children and adolescents.²⁰

Despite these recommendations, the use of screening and a brief intervention for alcohol problems falls far short of its potential. One survey found that while most primary care physicians and psychiatrists do ask their new patients whether they drink alcohol, less than half (47 percent) ask about their maximum consumption on a given occasion, and only 13 percent use a formal screening tool.²¹

Likewise, most pediatricians and family practitioners who treat adolescents provide some level of alcohol prevention services, but according to researchers, “their efforts were typically

inconsistent, not in enough depth, and they failed to incorporate the most effective educational methods.”²²

Among other trends that emerged from these surveys:^{20,21}

- ▶ Younger physicians were more likely than older ones to screen patients in their practices.
- ▶ Internists and family medicine physicians were more likely to offer alcohol intervention than obstetrician-gynecologists.
- ▶ Female physicians were more likely to screen adolescents than male physicians.
- ▶ Older adolescents were significantly more likely to receive prevention services than younger ones.

Expanding SBI: More Reimbursement, More Resources, More Education

In order to bring physician practice in line with clinical guidelines, policymakers and advocates at a number of federal agencies and not-for-profit organizations have emphasized the importance of appropriate reimbursement for SBI services. The cumulative effect of those efforts suggests that 2008 will be “the year of SBI,” according to Eric Goplerud, director of the Center for Integrated Behavioral Health Policy, who helped to create a reimbursement framework.

An early building block came in January 2007, when the Centers for Medicare and Medicaid Services added new codes to allow physicians to be compensated for identifying and treating Medicaid patients with alcohol problems. The American Medical Association provided further momentum by approving SBI reimbursement codes in January 2008.²³

Increasingly, private health plans are stepping forward as well. According to an annual survey conducted in 2008 by the National Business Coalition on Health, 58 percent of the 150 health plans surveyed now cover substance use screening and brief intervention services. Plans offering nationwide coverage include AETNA, Blue Cross/Blue Shield and CIGNA.²⁴

Continuing the trend, SBI became a reimbursable service to all 5.6 million federal employees with federal health insurance in April 2008.²⁵ And in July, the White House Office of National Drug Control Policy announced that ten states had agreed to reimburse physicians for providing SBI-related services to Medicaid patients; an essential step since the states share Medicaid costs with the federal government.²⁶

But reimbursement alone does not guarantee that health care providers will expand their use of screening and brief intervention services. Other obstacles remain, according to published research, including “stigmatizing attitudes toward substance-using patients, physicians’ lack of self-efficacy in managing these disorders, pessimism about the effectiveness of intervention and time constraints.”²⁰

Survey findings point to opportunities to increase the use of SBI. For example, primary care physicians and psychiatrists say they are more likely to offer the services if they:

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- ▶ Are familiar with guidelines developed by the National Institute on Alcohol Abuse and Alcoholism.
- ▶ Feel confident in their capacity to take a patient history of alcohol use.
- ▶ Disagree with the statements that “patients don’t want to be asked about substance use” and “patients refuse to accept the diagnosis of alcohol abuse.”²⁰

Likewise, “perceived skills were the single best predictor of service quality for all groups” among adolescent primary care providers, yet they frequently report “feeling they do not have adequate knowledge and skills for addressing and counseling patients about behavior issues such as alcohol use, smoking or sexual behavior.”¹⁹

All of that suggests a possible role for provider training, either as part of initial medical education or in continuing education venues. Other research has underscored the value of strategies to improve care without adding new burdens in primary care environments — for example, the availability of a health educator in a pediatric setting increased screening for risky behavior,²⁷ as did the perception by physicians that they could refer adolescent patients with serious alcohol problems to other services.¹⁹

New funding from the National Institute on Drug Abuse and the Substance Abuse and Mental Health Services Administration should further advance knowledge of what works. These grants will promote the development and testing of models for integrating screening, brief intervention and referrals into primary care and other general medical settings.²⁸

While much remains unknown about how best to motivate health care providers to expand screening and brief intervention services, a clear course has been set — the need to combat alcohol misuse is obvious, the value of a standardized intervention technique has been extensively documented, and reimbursement is increasingly available. More activity in primary care settings across the country will be the real indicator that SBI is catching on.

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