

UC San Diego

UC San Diego Previously Published Works

Title

Screening and Brief Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adults 18 Years and Older, Including Pregnant Women.

Permalink

<https://escholarship.org/uc/item/36s7b4hz>

Journal

JAMA Psychiatry, 76(1)

ISSN

2168-622X

Author

Schuckit, Marc A

Publication Date

2019

DOI

10.1001/jamapsychiatry.2018.3278

Peer reviewed

EDITORIAL

Screening and Brief Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adults 18 Years and Older, Including Pregnant Women

Marc A. Schuckit, MD

This editorial offers thoughts about the 2018 update¹ of the 2013 recommendation statement regarding screening and behavioral counseling for unhealthy alcohol use in adults and adolescents and the updated evidence report and systematic



Related articles at

jama.com

jamainternalmedicine.com

jamapediatrics.com

review² issued by the US Preventive Services Task Force (USPSTF) and published in this week's issue of *JAMA*.

The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use (B recommendation). The official recommendation statement also discusses these issues in pregnant women and adolescents, but my commentary focuses on adults in general because recommendations regarding pregnancy are similar to adults (with the addition of absolute abstinence during pregnancy), and issues regarding adolescent drinkers are commented on elsewhere.³ The original recommendations are aimed at primary care settings, but the material seems equally appropriate for psychiatrists.

The USPSTF did not find sufficient evidence to assess the balance of benefits and harms of screening and counseling for alcohol use in primary care settings in adolescents (I statement). In this recommendation statement, unhealthy alcohol use encompasses what the National Institute on Alcohol and Alcoholism considers to be risky drinking, as well as heavy use episodes, any alcohol consumption during pregnancy, and alcohol use disorders (AUDs) as defined in major diagnostic manuals. Risky drinking is defined as men aged 21 to 64 years should drink no more than 4 drinks per day and no more than 14 drinks per week; women of all ages and men 65 years and older should drink no more than 3 drinks per day and no more than 7 drinks per week. It is commendable that the recommendations emphasize that unhealthy alcohol intake is not limited to individuals with AUDs, just as the dangers of having overweight are not limited to persons with morbid obesity.

The preponderance of data in this recommendation statement support the conclusion that clinicians should screen for unhealthy drinking in all adults and pregnant women by incorporating a standardized self-administered questionnaire. The USPSTF highlight several instruments, including the times in the past year a man consumed 5 or more drinks or a woman, 4

or more in a day (Single Alcohol Screening Question)⁴; a 3-item instrument asking about drinking frequency, usual quantities, and frequency of consuming 6 or more drinks per occasion⁵ (Alcohol Use Disorders Identification Test-Consumption [AUDIT-C]); and the 10-item AUDIT asking 7 additional questions about inability to stop drinking, interference with activities, needing a morning drink, feeling guilty after drinking, alcohol-related blackouts, drinking-related injuries, and drinking-related concerns expressed by others.⁶ These measures and similar instruments have acceptable validities and reliabilities, take less than 5 minutes to complete, and can be filled out in a waiting room before being seen by a clinician. I prefer the AUDIT because it gives the clinician more information and can take as little as 2 minutes to complete. Despite their ease of implementation and clinical usefulness, the recommendations found that the majority of clinicians do not consistently use any of these screening tools, and I believe this is likely to be equally true for psychiatrists. The latter is unfortunate because heavier drinking can mimic many psychiatric symptoms, including clinically relevant alcohol-induced depressive, anxiety, and psychotic symptoms that usually disappear within a month of abstinence and often sooner.⁷

I believe that the specific instrument chosen is not as important as taking steps to screen all patients during initial appointments and when psychiatric symptoms intensify or recur. Individuals engaged in unhealthy drinking probably represent 20% to 25% of patients, regardless of the person's age, sex, or socioeconomic stratum and whether the person fits the general, inaccurate stereotype of an individual with an AUD.⁸ While there are some theoretical dangers of screening for unhealthy alcohol use (eg, anxiety from discovering risks associated with a person's own drinking), these problems are rare and the dangers of unhealthy alcohol use are serious.

These brief screening instruments are only the initial step in identifying unhealthy alcohol use. While not emphasized in the USPSTF recommendations, I believe that clinicians should also look at the pattern of blood test results to identify patients consuming about 5 or more drinks per day.⁹ Special attention should be paid to easily available and relatively inexpensive laboratory tests such as γ -glutamyl transferase values of 35 units per liter or higher, high normal or larger red cell sizes (mean corpuscular volume), or high normal uric acid. Other tests can be ordered to screen specifically for heavier drinking (eg, carbohydrate-deficient transferrin), but my focus here is on steps clinicians can take using the most easily available tests.

Another useful step in screening for unhealthy alcohol use is to consider the patient's recent history, symptoms, and physical signs. Heavier and unhealthy drinking is often associated with modest and fluctuating hypertension, insomnia, moodiness, repetitive male impotence, unintentional injuries, and interpersonal problems.

The second major issue addressed in the recommendations is the importance of counseling a patient with unhealthy alcohol use regarding their problem and what they can do about it. Although I would add the need to stress abstinence and referral to more formal treatment in individuals who meet criteria for AUDs,¹⁰ the recommendation statement focused most on patients who did not meet AUD criteria. Recognizing the clinician's time limitations, the USPSTF^{1,2} emphasized brief behavioral interventions (ie, brief interventions). Most such discussions in clinical settings involve 1 or 2 sessions with a median length of 30 minutes each. The key elements are practical discussions based on the screening, brief intervention, and referral to treatment approach and include comparing the patient's alcohol consumption with both recommended limits and with the practices of most other drinkers (ie, personalized normative feedback) and suggesting ways to cut back on drinking. The latter could include teaching the definition of a standard drink, suggesting keeping a drinking diary, discussing life stresses and possible solutions other than drinking, sharing specific laboratory results and physical signs or symptoms that indicate unhealthy alcohol use, and teaching how having peers who drink heavily encourage a person's own heavy drinking.¹¹ Similar good responses to the screening, brief intervention, and referral to treatment approach are seen across sexes, races/ethnicities, and socioeconomic strata. Despite the availability of relatively easy-to-use counseling approaches, the recommendation statement found that most clinicians (potentially including psychiatrists) do not offer counseling for

unhealthy alcohol use. Although there are potential theoretical harms of these brief interventions (eg, investment in patient and clinician time), the recommendation statement found no evidence of even modest dangers to these approaches.

The USPSTF concluded that there was adequate evidence of "...a moderate beneficial effect of screening for unhealthy alcohol use followed by brief behavioral counseling interventions in adults"¹ and that these steps "can reduce unhealthy drinking behaviors...including heavy episodic drinking, high daily or weekly levels of alcohol consumption, and exceeding recommended drinking limits."¹ The data supported the conclusion that the harms associated with adequate screening and subsequent behavioral interventions were small to none. The incorporation of those steps should be relatively easy for clinicians already well trained for counseling and psychotherapy.

In closing, the USPSTF documented that heavier than recommended drinking and related problems are among the most prevalent causes of premature death in Western countries, and additional literature demonstrates that heavy drinking causes or exacerbates many common medical and psychiatric problems. To me, the ease of screening and the likely impact of brief interventions support a conclusion that all health care professionals should include 1 or more alcohol screening instruments for every patient. Medical schools and related academic institutions that train these clinicians and resident training programs can start this process by mandating a course on alcohol- and drug-related disorders and approaches to identifying these problems and helping patients avoid future problems. Hospital systems and insurers should work to monitor that screening and interventions are regular components of patient evaluations and should enforce these steps as vigorously as they do screening and interventions for tuberculosis and vaccinations.

ARTICLE INFORMATION

Author Affiliation: University of California, San Diego, School of Medicine, La Jolla.

Corresponding Author: Marc A. Schuckit, MD, University of California San Diego, Psychiatry, 8950 Villa La Jolla Dr, B-218, La Jolla, CA 92037 (mschuckit@ucsd.edu).

Published Online: November 13, 2018.
doi:10.1001/jamapsychiatry.2018.3278

Conflict of Interest Disclosures: Dr Schuckit is director of the Alcohol Medical Scholars Program (AMSP) that trains medical school faculty across the United States how to optimize their teaching skills and expand information presented at their school regarding alcohol and drugs. The Alcohol Medical Scholars Program is funded by a gift to the Regents of the University of California by the Anheuser Busch Foundation. Dr Schuckit has no other potential conflicts.

REFERENCES

1. US Preventive Services Task Force. Screening and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adults: US Preventive Services Task Force recommendation statement [published online November 13, 2018]. *JAMA*. doi:10.1001/jama.2018.16789
2. O'Connor EA, Perdue LA, Senger CA, et al. Screening and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adults: updated evidence report and systematic review for the US Preventive Services Task Force [published online November 13, 2018]. *JAMA*. doi:10.1001/jama.2018.12086
3. McCarty CA, Levy S, Harris SK. Alcohol use screening and behavioral counseling with adolescents in primary care: a call to action [published online November 13, 2018]. *JAMA Pediatr*. doi:10.1001/jamapediatrics.2018.4171
4. Substance Abuse and Mental Health Administration (SAMHSA)-Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions. Screening tools. SAMHSA website. <https://www.integration.samhsa.gov/clinical-practice/screening-tools>. Accessed October 23, 2018.
5. Humeniuk R, Henry-Edwards S, Ali R, Poznyak V, Monteiro M. *The ASSIST-Linked Brief Intervention for Hazardous and Harmful Substance Use: A Manual for Use in Primary Care*. Geneva, Switzerland: World Health Organization; 2010.
6. Bohn MJ, Babor TF, Kranzler HR. The Alcohol Use Disorders Identification Test (AUDIT): validation of a screening instrument for use in medical settings. *J Stud Alcohol*. 1995;56(4):423-432. doi:10.15288/jsa.1995.56.423
7. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Washington, DC: American Psychiatric Association; 2013.
8. Schuckit MA, Smith TL, Kalmijn JA. The patterns of drug and alcohol use and associated problems over 30 years in 397 men. *Alcohol Clin Exp Res*. 2014;38(1):227-234. doi:10.1111/acer.12220
9. Schuckit MA. Alcohol-use disorders. *Lancet*. 2009;373(9662):492-501. doi:10.1016/S0140-6736(09)60009-X
10. Allen JP, Sillanaukee P, Strid N, Litten RZ. Biomarkers of heavy drinking. In: Allen JP, Wilson VB, eds. *Assessing Alcohol Problems: a Guide for Clinicians and Researchers*. 2nd ed. Bethesda, MD: US Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism; 2003: 37-53.
11. Schuckit MA, Smith TL, Clausen P, et al. The low level of response to alcohol-based heavy drinking prevention program: one-year follow-up. *J Stud Alcohol Drugs*. 2016;77(1):25-37. doi:10.15288/jsad.2016.77.25