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Screening and Initial Management of Alcohol Misuse in Primary Care

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ABSTRACT

Nurse practitioners play a vital role in the screening and management of alcohol use disorders in primary care. Despite the prevalence and health impact of alcohol misuse, and recommendations for use of regular screening, many providers report lack of preparation and confidence in the identification, treatment, and referral. Several validated and evidence-based screening, assessment, intervention, and treatment options are available, including the Alcohol Use Disorders Identification Test, Alcohol Use Disorders Identification Test-Consumption, and the single-question screen. Similar to screening for other adverse health behaviors, screening and brief intervention for alcohol misuse is a preventive service that nurse practitioners can provide to their patients.

Keywords: alcohol misuse, alcohol use disorder, SBIRT, screening and brief intervention, primary care

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INTRODUCTION

The primary care provider (PCP) is often the first and most integral player in the initial assessment of patients at risk for alcohol misuse. This could be because of an already established PCP/patient relationship, making the PCP a trusted source of information and/or initial intervention for the patient misusing alcohol or at risk for misuse.[1,2] Nurse practitioners (NPs) play a vital role in the screening and management of alcohol use disorders in primary care, and in urgent, emergency, and acute care settings. Despite the prevalence and health impact of alcohol misuse, and recommendations for use of regular screening by many entities (eg, National Institute on Alcohol Abuse and Alcoholism [NIAAA], American Academy of Family Physicians [AAFP], American Society of Addiction Medicine, United States Preventive Services Task Force [USPSTF], etc), many providers report lack of preparation and confidence in the identification, treatment, and referral of patients with alcohol use disorders.[3]

SCOPE OF PROBLEM AND DEFINITION OF TERMS

According to the 2015 National Survey on Drug Use and Health, > 70% of Americans surveyed reported drinking in the past year; 56% reported that they drank in the past month.[4] It is estimated that > 9.8 million men (8%) and 5.6 million women (4%) in the United States have had an alcohol use disorder, making alcohol-related events the fourth leading cause of preventable death in the US.[5] In 2014, 31% of all driving fatalities (88,000 deaths) were caused by alcohol-impaired driving.[6,7]

To clarify terms, moderate drinking, as defined by the *Dietary Guidelines for Americans, 2015-2020*, is up to 1 drink per day for women and up to 2 drinks per day for men, with a drink defined as 0.6 fluid ounce of pure alcohol.[8] For example, 1 alcoholic drink-equivalent can include, 12 fluid ounces of regular beer (5% alcohol), 5 fluid ounces of wine (12% alcohol), or 1.5 fluid ounces of 80 proof distilled spirits (40% alcohol).[8] Risky alcohol use includes all levels of drinking above these recommended limits. Of special interest to new clinicians, terms such as risky drinking, moderate drinking, hazardous

drinking, binge drinking, alcohol misuse, alcohol abuse, and alcohol dependence often cause confusion in the assessment of patients who use alcohol. Previously, the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fourth edition* (*DSM-IV*) described 2 distinct disorders—alcohol abuse and alcohol dependence—with specific criteria for each. The fifth edition, *DSM-5*, integrates these 2 disorders into a single one, called alcohol use disorder (AUD), with mild, moderate, and severe subclassifications.[9]

Although the term alcohol misuse can include mild to extreme levels of alcohol use, AUD is a pattern of alcohol use that can involve difficulty in controlling drinking, a preoccupation with alcohol, continuing to use alcohol even when it causes problems, having to drink more to get the same effect, or having withdrawal symptoms when rapidly decreasing or stopping drinking.[10] Although abstinence has been shown to produce the best health outcomes, reducing the amount of drinking can also greatly improve quality of life and other lead to other improvements in health status.[11]

Risky/hazardous drinking is considered to be any drinking behavior that increases risk to a person's health or well being or that of others, and this usually occurs with drinking above the suggested limits as set forth by the *Dietary Guidelines*.[11] Binge drinking is the most common pattern of risky drinking behavior and is clinically defined as an AUD that leads to a blood alcohol level of $\geq$ 0.08 g/dL.[12] This level of blood alcohol is usually reached by the consumption of > 4 drinks/day for women, or > 5 drinks/day for men at the same time or within a couple of hours of each other; consuming this much alcohol on at least 1 day in the past month also qualifies the patient for a diagnosis of AUD.[13] Binge drinking is associated with increased morbidity and mortality.[14,15]

EPIDEMIOLOGY AND PATHOPHYSIOLOGY

A review of the epidemiology and pathophysiology is also helpful in gaining a clear perspective of this complex disorder. A wide range of health disorders are associated with AUDs, including depression, anxiety, cognitive impairment, cancer, pancreatitis, liver disease, hypertension, stroke, gastritis and gastric ulcers, osteopenia/osteoporosis, cirrhosis, and birth defects.[11] These disorders are also a major factor in morbidity and mortality associated with accidents, homicide, suicide, child abuse/neglect, and major trauma.[16] AUDs can also complicate the assessment and treatment of these and other medical and psychiatric conditions.[16]

Although it is common knowledge that alcohol consumption can lead to dependence and dose tolerance, many notable studies have also shown that light to moderate alcohol consumption can have some health benefits, although this is not always true for everyone.[17] In regard to heart disease risk, regular light drinkers tend to have more advantage over infrequent light drinkers, and binge drinking, no matter how infrequent, has been shown to produce more adverse characteristics over nonbinge drinking, even when weekly consumptions are similar.[18] For this and other reasons, the US Centers for Disease Control and Prevention (CDC) does not encourage nondrinkers to start drinking for health reasons.[17]

SCREENING FOR ALCOHOL MISUSE

Several good screening, assessment, intervention, and treatment options are available and recommended by the US Department of Health and Human Services, National Institute of Health, and NIAAA. These entities' most recent 2005 edition of *The Clinician's Guide to Helping Patients Who Drink Too Much* offers several suggestions for initial screening and assessment of patients in the primary care clinic. Two methods of initial screening are suggested: (1) a single question about heavy drinking days; and/or (2) a written self-report instrument, the Alcohol Use Disorders Identification Test (AUDIT). The USPSTF also recommends the AUDIT, the abbreviated AUDIT-Consumption (AUDIT-C), and single-question screening, such as "How many times in the past year have you had 5 (4 for women and all adults over age 65 years) or more drinks a day?"[19]

For over 30 years, research has shown that alcohol screening and brief intervention has been effective at reducing risky drinking, leading the USPSTF to recommend that screening, brief intervention, and referral to treatment (SBIRT) be implemented in primary care.[19,20] It follows (and newer research is active in this direction) that SBIRT may be useful in

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