

Screening and Behavioral Counseling Interventions in Primary Care To Reduce Alcohol Misuse: Recommendation Statement

U.S. Preventive Services Task Force*

This statement summarizes the U.S. Preventive Services Task Force (USPSTF) recommendations on behavioral counseling interventions to reduce alcohol misuse in primary care patients and updates the 1996 recommendations on this topic. The complete information on which this statement is based, including evidence tables and references, is available in the accompanying article in this issue and in the systematic evidence review on this topic. The complete USPSTF recommendation statement (which includes a brief review of the supporting evidence), the accompanying journal article, and the complete systematic evidence review are avail-

able through the USPSTF Web site (www.preventiveservices.ahrq.gov). The journal article and the USPSTF recommendation statement are available in print through the Agency for Healthcare Research and Quality Publications Clearinghouse (telephone, 800-358-9295; e-mail, ahrqpubs@ahrq.gov).

Ann Intern Med. 2004;140:554-556.

www.annals.org

See related article on pp 557-568.

*For a list of the members of the U.S. Preventive Services Task Force, see the Appendix.

SUMMARY OF THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) recommends screening and behavioral counseling interventions to reduce alcohol misuse (see Clinical Considerations) by adults, including pregnant women, in primary care settings. This is a **grade B recommendation**. (See Appendix Table 1 for a description of the USPSTF classification of recommendations.)

The USPSTF found good evidence that screening in primary care settings can accurately identify patients whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence, but place them at risk for increased morbidity and mortality, and good evidence that brief behavioral counseling interventions with follow-up produce small to moderate reductions in alcohol consumption that are sustained over 6- to 12-month periods or longer. (See Appendix Table 2 for a description of the USPSTF classification of levels of evidence.) The USPSTF found some evidence that interventions lead to positive health outcomes 4 or more years post-intervention, but found limited evidence that screening and behavioral counseling reduce alcohol-related morbidity. The evidence on the effectiveness of counseling to reduce alcohol consumption during pregnancy is limited; however, studies in the general adult population show that behavioral counseling interventions are effective among women of childbearing age. The USPSTF concluded that the benefits of behavioral counseling interventions to reduce alcohol misuse by adults outweigh any potential harms.

The USPSTF concludes that the evidence is insufficient to recommend for or against screening and behavioral counseling interventions to prevent or reduce alcohol misuse by adolescents in primary care settings. This is a **grade I recommendation**.

The USPSTF found limited evidence evaluating the effectiveness of screening and behavioral counseling interventions in primary care settings to prevent or reduce alcohol misuse by adolescents. The USPSTF concluded that the evidence is in-

sufficient to assess the potential benefits and harms of screening and behavioral counseling interventions in this population.

CLINICAL CONSIDERATIONS

Alcohol misuse includes “risky/hazardous” and “harmful” drinking that places individuals at risk for future problems. “Risky” or “hazardous” drinking has been defined in the United States as more than 7 drinks per week or more than 3 drinks per occasion for women and more than 14 drinks per week or more than 4 drinks per occasion for men. “Harmful drinking” describes persons who are currently experiencing physical, social, or psychological harm from alcohol use but do not meet criteria for dependence (1, 2). Alcohol abuse and dependence are associated with repeated, negative physical, psychological, and social effects from alcohol (3). The USPSTF did not evaluate the effectiveness of interventions for alcohol dependence because the benefits of these interventions are well established and referral or specialty treatment is recommended for those meeting the diagnostic criteria for dependence.

Light to moderate alcohol consumption in middle-aged or older adults has been associated with some health benefits, such as reduced risk for coronary heart disease (4). Moderate drinking has been defined as 2 standard drinks (for example, 12 ounces of beer) or less per day for men and 1 drink or less per day for women and persons older than 65 years of age (5), but recent data suggest comparable benefits from as little as 1 drink 3 to 4 times a week (6).

The Alcohol Use Disorders Identification Test (AUDIT) is the most studied screening tool for detecting alcohol-related problems in primary care settings. It is sensitive for detecting alcohol misuse and abuse or dependence, and can be used alone or embedded in broader health risk or lifestyle assessments (7, 8). The 4-item CAGE (feeling the need to Cut down, Annoyed by criti-

cism, Guilty about drinking, and need for an Eye-opener in the morning) is the most popular screening test for detecting alcohol abuse or dependence in primary care (9). The TWEAK, a 5-item scale, and the T-ACE are designed to screen pregnant women for alcohol misuse. They detect lower levels of alcohol consumption that may pose risks during pregnancy (10). Clinicians can choose screening strategies that are appropriate for their clinical population and setting (8, 11–14). Screening tools are available at the National Institute on Alcohol Abuse and Alcoholism Web site: www.niaaa.nih.gov/publications/instable.htm.

Effective interventions to reduce alcohol misuse include an initial counseling session of about 15 minutes, feedback, advice, and goal-setting. Most also include further assistance and follow-up. Multicontact interventions for patients ranging widely in age (12 to 75 years) are shown to reduce mean alcohol consumption by 3 to 9 drinks per week, with effects lasting up to 6 to 12 months after the intervention. They can be delivered wholly or in part in the primary care setting, and by 1 or more members of the health care team, including physician and nonphysician practitioners. Resources that help clinicians deliver effective interventions include brief provider training or access to specially trained primary care practitioners or health educators, and the presence of office-level systems supports (prompts, reminders, counseling algorithms, and patient education materials).

Primary care screening and behavioral counseling interventions for alcohol misuse can be described with reference to the 5 A's behavioral counseling framework: *assess* alcohol consumption with a brief screening tool followed by clinical assessment as needed; *advise* patients to reduce alcohol consumption to moderate levels; *agree* on individual goals for reducing alcohol use or abstinence (if indicated); *assist* patients with acquiring the motivations, self-help skills, or supports needed for behavior change; and *arrange* follow-up support and repeated counseling, including referring dependent drinkers for specialty treatment (15). Common practices that complement this framework include motivational interviewing (16), the 5 R's used to treat tobacco use (17), and assessing readiness to change (18).

The optimal interval for screening and intervention is unknown. Patients with past alcohol problems, young adults, and other high-risk groups (such as smokers) may benefit most from frequent screening.

All pregnant women and women contemplating pregnancy should be informed of the harmful effects of alcohol on the fetus. Safe levels of alcohol consumption during pregnancy are not known; therefore, pregnant women are advised to abstain from drinking alcohol. More research into the efficacy of primary care screening and behavioral intervention for alcohol misuse among pregnant women is needed.

The benefits of behavioral intervention for preventing

or reducing alcohol misuse in adolescents are not known. The CRAFFT questionnaire was recently validated for screening adolescents for substance abuse in the primary care setting (19). The benefits of screening this population will need to be evaluated as more effective interventions become available in the primary care setting.

The brief review of the evidence that is normally included in USPSTF recommendations is available in the complete recommendation statement on the USPSTF Web site (www.preventiveservices.ahrq.gov).

RECOMMENDATIONS OF OTHERS

Professional groups such as the American Medical Association (AMA) (www.ama-assn.org/ama/pub/article/2036-2393.html), the American Society of Addiction Medicine (www.asam.org/ppol/screen.htm), and the Canadian Task Force on Preventive Health Care (<http://ctfphc.org/>) recommend routine screening for alcohol misuse in primary care and brief counseling interventions for individuals who screen positive. The American College of Obstetricians and Gynecologists (<http://acog.org/>) and the American Academy of Pediatrics (AAP) (http://aappolicy.aappublications.org/policy_statement/index.dtl) recommend counseling all women who are pregnant or are planning pregnancy about the harmful effects of drinking to the fetus and that abstinence is the safest policy. The AAP and the AMA guidelines for Adolescent Preventive Services (www.ama-assn.org/ama/upload/mm/39/gapsmono.pdf) recommend that clinicians routinely screen children and adolescents for alcohol use and advise patients to abstain from alcohol. The AAP also recommends that physicians discuss the hazards of alcohol and other drug use with parents during routine risk behavior assessment (<http://aappolicy.aappublications.org/cgi/content/full/pediatrics/;108/1/185>).

APPENDIX

Members of the U.S. Preventive Services Task Force are Alfred O. Berg, MD, MPH, *Chair* (University of Washington, Seattle, Washington); Janet D. Allan, PhD, RN, CS, *Vice-Chair* (University of Maryland Baltimore, Baltimore, Maryland); Paul Frame, MD (Tri-County Family Medicine, Cohocton, and University of Rochester, Rochester, New York); Charles J. Homer, MD, MPH (National Initiative for Children's Healthcare Quality, Boston, Massachusetts); Mark S. Johnson, MD, MPH (University of Medicine and Dentistry of New Jersey–New Jersey Medical School, Newark, New Jersey); Jonathan D. Klein, MD, MPH (University of Rochester School of Medicine, Rochester, New York); Tracy A. Lieu, MD, MPH (Harvard Pilgrim Health Care and Harvard Medical School, Boston, Massachusetts); C. Tracy Orleans, PhD (The Robert Wood Johnson Foundation, Princeton, New Jersey); Jeffrey F. Peipert, MD, MPH (Women and Infants' Hospital, Providence, Rhode Island); Nola J. Pender, PhD, RN (University of Michigan, Ann Arbor, Michi-

Appendix Table 1. U.S. Preventive Services Task Force Recommendations and Ratings*

Grade	Recommendation
A	The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. <i>The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.</i>
B	The USPSTF recommends that clinicians provide [the service] to eligible patients. <i>The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.</i>
C	The USPSTF makes no recommendation for or against routine provision of [the service]. <i>The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.</i>
D	The USPSTF recommends against routinely providing [the service] to asymptomatic patients. <i>The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.</i>
I	The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. <i>Evidence that [the service] is effective is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.</i>

* The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to 1 of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

Appendix Table 2. U.S. Preventive Services Task Force Strength of Overall Evidence*

Grade	Definition
Good	Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes
Fair	Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies; generalizability to routine practice; or indirect nature of the evidence on health outcomes
Poor	Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes

* The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor).

gan); Albert L. Siu, MD, MSPH (Mount Sinai School of Medicine, New York, New York); Steven M. Teutsch, MD, MPH (Merck & Co., Inc., West Point, Pennsylvania); Carolyn Westhoff, MD, MSc (Columbia University, New York, New York); and Steven H. Woolf, MD, MPH (Virginia Commonwealth University, Fairfax, Virginia). This list includes members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to www.ahrq.gov/clinic/uspstfab.htm.

From the U.S. Preventive Services Task Force, Agency for Healthcare Research and Quality, Rockville, Maryland.

Disclaimer: The USPSTF recommendations are independent of the U.S. government. They do not represent the views of the Agency for Healthcare Research and Quality, the U.S. Department of Health and Human Services, or the U.S. Public Health Service.

Requests for Single Reprints: Reprints are available from the USPSTF Web site (www.preventiveservices.ahrq.gov) and in print through the Agency for Healthcare Research and Quality Publications Clearinghouse (800-358-9295).

References

1. Reid MC, Fiellin DA, O'Connor PG. Hazardous and harmful alcohol consumption in primary care. *Arch Intern Med.* 1999;159:1681-9. [PMID: 10448769]
2. The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines. Geneva, Switzerland: World Health Organization; 1992.
3. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, DC: American Psychiatric Assoc; 1994.
4. Tenth Special Report to the U.S. Congress on Alcohol and Health from the Secretary of Health and Human Services. U.S. Department of Health and Human Services. Washington, DC: National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism (NIAAA); June 2000. NIH publication no. 00-1583.
5. The Physician's Guide to Helping Patients with Alcohol Problems. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism (NIAAA); 1995. NIH publication no. 95-3769.
6. Mukamal KJ, Conigrave KM, Mittleman MA, Camargo CA Jr, Stampfer MJ, Willett WC, et al. Roles of drinking pattern and type of alcohol consumed in coronary heart disease in men. *N Engl J Med.* 2003;348:109-18. [PMID: 12519921]
7. Saunders JB, Aasland OG, Babor TF, de la Fuente JR, Grant M. Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption—II. *Addiction.* 1993;88:791-804. [PMID: 8329970]
8. Fiellin DA, Reid MC, O'Connor PG. Screening for alcohol problems in primary care: a systematic review. *Arch Intern Med.* 2000;160:1977-89. [PMID: 10888972]
9. Ewing JA. Detecting alcoholism. The CAGE questionnaire. *JAMA.* 1984;252:1905-7. [PMID: 6471323]
10. Chang G. Alcohol-screening instruments for pregnant women. *Alcohol Res Health.* 2001;25:204-9. [PMID: 11810959]
11. Babor TF, Higgins-Biddle JC. Brief intervention for hazardous and harmful drinking. A manual for use in primary care. Geneva, Switzerland: World Health Organization; 2001.
12. Training Physicians in Techniques for Alcohol Screening and Brief Intervention. Bethesda, MD: National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism; 1997.
13. Whaley SE, O'Connor MJ. Increasing the report of alcohol use among low-income pregnant women. *Am J Health Promot.* 2003;17:369-72. [PMID: 12858616]
14. Fleming MF. Identification of at-risk drinking and intervention with women of childbearing age: guide for primary care providers. Bethesda, MD: National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism; 2000.
15. Whitlock EP, Orleans CT, Pender N, Allan J. Evaluating primary care behavioral counseling interventions: an evidence-based approach. *Am J Prev Med.* 2002;22:267-84. [PMID: 11988383]
16. Miller WR, Rollnick S. Motivational Interviewing: Preparing People for Change. 2nd ed. New York: Guilford Pr; 2002.
17. Anderson JE, Jorenby DE, Scott WJ, Fiore MC. Treating tobacco use and dependence: an evidence-based clinical practice guideline for tobacco cessation. *Chest.* 2002;121:932-41. [PMID: 11888979]
18. Prochaska JO, Velicer WF. The transtheoretical model of health behavior change. *Am J Health Promot.* 1997;12:38-48. [PMID: 10170434]
19. Knight JR, Sherritt L, Harris SK, Gates EC, Chang G. Validity of brief alcohol screening tests among adolescents: a comparison of the AUDIT, POSIT, CAGE, and CRAFFT. *Alcohol Clin Exp Res.* 2003;27:67-73. [PMID: 12544008]