Alcohol Screening and Brief Intervention in the Emergency Department

Alcohol use and abuse is a major preventable public health problem, contributing to over 100,000 deaths each year and costing society over 185 billion dollars annually.[1] Patients presenting to the ED represent the entire spectrum of alcohol-related problems. This includes drinkers "at-risk" for injury and illness, those presenting with "harmful/problem drinking" such as the impaired driver, all the way to those with signs and symptoms of alcohol dependence.

Fortunately, we now know several truths.

- **Brief intervention does work** There is compelling evidence in the literature that screening and brief intervention (SBI) for alcohol problems does work.[2] A recent evidence-based review on SBI revealed 39 published studies including 30 randomized controlled and 9 cohort studies. A positive effect was demonstrated in 32 of these studies.[3] Multiple studies have demonstrated the efficacy of brief intervention in a variety of settings, including general populations, primary care,[4] emergency departments [5, 6, 7,8] and inpatient trauma centers. [9]

- **The ED visit is an opportunity for intervention[10]** Patients presenting to the ED are more likely to have alcohol-related problems than those presenting to primary care. Cherpitel[11] recently compared patients presenting to an ED with those presenting to a primary care setting in the same metropolitan area. She found that ED patients were one and a half to three times more likely to report heavy drinking, consequences of drinking, alcohol dependence, or ever having treatment for an alcohol problem, than patients presenting to a primary care clinic. In addition, the ED visit offers a potential "teachable moment" due to the possible negative consequences associated with the event.[12, 13.]

- **Linking patients immediately to services has proven to be successful** As early as 1957 Chafetz[5] reported that 65% of patients with alcohol dependence who were directly referred to an alcohol clinic from the ED kept their initial appointment compared to 5.4% of the control group. Bernstein[8] found that 50% of patients with alcohol and drug dependence in Project ASSERT reported follow-up with the treatment referral. Recently, another institution using Project ASSERT[14] reported similar positive results. Of the 719 patients who received a direct referral for a specialized alcohol and drug treatment program during a one year period of time, 41% were contacted. Of these, 80% made contact with the treatment facility and 78% enrolled.

- **Emergency physicians have been reluctant to screen because of perceived barriers: lack of education, time and resources** This resource kit was developed to make the process as easy as possible. The resource kit includes recommended screening tools, an algorithm for providing brief intervention and a template for developing referrals in your community.

SCREENING

A variety of screening tools are available. Their effectiveness varies according to their availability, ease of administration, adverse consequences, and test characteristics. The National Institute of Alcohol Abuse and Alcoholism (NIAAA) recommends the use of quantity and frequency (Q&F) questions as well as the CAGE questionnaire. (See Quick Reference Card) The Q&F questions can elicit whether the patient is over the recommended levels for moderate drinking and therefore "at risk" for illness and injury. The CAGE questionnaire is better for identifying dependence with 90% specificity and 76% sensitivity when used in the ED.[15] Since the CAGE was originally designed for lifetime prevalence, it may be helpful to specify "during the past 12 months."

Asking Q&F questions, then adding the CAGE questions if the responses exceed moderate levels is one way to use the screens. Another approach is to jump to the CAGE questions for patients who present intoxicated with very high ethanol levels, or when dependence is suspected. This eliminates the negative connotations and resistance that can occur when the patient is asked to quantify their drinking.

BRIEF INTERVENTION

Brief interventions are short counseling sessions that can be as short as 5 minutes.[16] They often incorporate the six elements proposed by Miller and Sanchez summarized by the acronym FRAMES: feedback, responsibility, advice, menu of strategies, empathy and self-efficacy. ED DIRECT is an acronym that incorporates these concepts. For "at-risk" or "harmful" drinkers that are not dependent, goal setting within safe limits, discharge instructions and a referral to primary care is all that may be needed. For those patients who are dependent or that you are unsure of their position along the spectrum of alcohol problems, the brief intervention is a negotiation process to seek further assessment and referral to a specialized treatment program.

REFERRAL/AVAILABLE RESOURCES

Each ED must develop their own resource list for their community. Surprisingly there are often more referral sources than one would expect. Enclosed is a sample brochure and a template for developing a resource list and educational materials for your facility.

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ED DIRECT — Brief Intervention

Empathy

- Adopt a warm, reflective and understanding style. Avoid a blaming, confrontational or coercive style.

Directness

- Maintain eye contact and raise the subject, "I would like to take a few minutes to talk about your alcohol use."

Data

- Feedback: "I am concerned about your drinking." Our screening indicates that:
  1. You are above what we consider the safe limits of drinking; and
  2. You are at risk for alcohol-related illness, injury, and death."
- Offer comparison to national norms (See Quick Reference Card - Screening for Alcohol Problems in the ED)

Identify willingness to change

- "On a scale from 1-10 how ready are you to change your drinking patterns?"
- If the response is 6 or less, then ask, "Why not less?"
- If the response is greater than or equal to 7, then the patient is ready, move on to recommendations.
- The response will help the physician to identify discrepancies and assist the patient to move along the continuum from ambivalence to change.

Recommend action/advice

- All Patients:
  "We recommend that you never drive after drinking."
- At-Risk/Harnful Drinkers:
  Statement of recommended drinking limits (See Quick Reference Card - Screening for Alcohol Problems in the ED)
  Follow-up with your primary care physician
- Screen positive, but unsure if dependent drinker:
  Abstain from drinking, and refer for further assessment to social work, psychiatry or a specialized treatment facility or alcohol counselor.
- Dependent Drinkers:
  Abstain from drinking and refer to a detoxification center, specialized alcohol treatment facility, Alcoholics Anonymous (AA), and primary care.

Elicit response

- "How does this sound to you?" or "Where does this leave you?"

Clarify and confirm action

- Possible clarification:
  "We have just completed a screening test for a whole spectrum of alcohol problems that may lead to an increase risk of illness and injury. We are not attempting to label you as an 'alcoholic.' We are recommending what we know to be safe drinking limits. We want you to follow up with your primary care physician, just as we would with any patient who has screened positively for other health problems such as high blood pressure or a high sugar level."
- Possible confirmation:
  "We are very concerned about your drinking. In the interest of your health (and family) we recommend immediate referral for further assessment and treatment. We know that cutting back or abstaining from alcohol is very difficult to do on your own. We would like to offer you help."

Telephone referral

- "Would you be willing to speak with a counselor, social worker, etc. now?"
- "I'd like to call right now for an appointment or referral. What do you think?"