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Problem Drinking Part 2 - Brief Intervention

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Scope

This guideline provides practitioners with practical information on how to conduct brief intervention for problem drinking in adults aged ≥ years and can be used after a positive screen occurs when using the BC Guideline *"Screening for Problem Drinking"*.* Once screening is complete and a patient is deemed at-risk, physicians may perform a brief intervention. Problem drinking is a behaviour that can be changed through intervention, and physicians in primary and hospital based care are in a key position to make a difference.[1-5] A study of two minute brief intervention screenings concluded that "self reported patient status at 6 months indicated significant improvements over baseline for illicit drug use and heavy alcohol use."[6]

Brief interventions motivate patients to lower their risk for alcohol related problems and are often successful in addressing other medical issues including medication adherence, weight loss, smoking cessation and dietary habits. If your patient is seeing you for another problem, it may be necessary for screening to be done at the first appointment and intervention done at a follow up appointment.

The following steps are outlined in this guideline:

- Brief intervention
- Follow-up and support

Diagnostic Code

303: Alcohol dependence syndrome
305: Non dependent use of drugs

Intervention Selection

Selected interventions should be based on the assessment completed during the screening (See *Problem Drinking Part 1 - Screening and Assessment)*. Although alcohol misuse is a spectrum disorder, positive screens will fall into one of three categories.

1. **At-risk drinking:** Men - 5 or more drinks on one or more days in the last year.
   Women - 4 or more drinks on one or more days in the last year.
2. **Alcohol abuse:** Patient meets 1 or more Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for abuse in the last 12 months.
3. **Alcohol dependence:** Patient meets 3 or more DSM IV criteria for dependence in the last 12 months.

Practitioners may wish to use the *"Brief Intervention Follow-up Note"* provided with this guideline.

* *Significant portions of this guideline were adapted from the National Institute on Alcohol Abuse and Alcoholism (NIAAA), "Helping Patients Who Drink Too Much", A Clinicians' Guide, Updated 2005 Edition, and should be fully acknowledged for developing this useful clinical tool. A full copy of their guideline and reference materials can be found on NIAAA's website at* http://pubs.niaaa.nih.gov

Brief Intervention for At-Risk Drinking (no abuse or dependence)

First – state your conclusion and recommendations clearly:

1. **"You are drinking more than is medically safe. I think your drinking is putting your health at risk and is not good for you."** Relate to patient's concerns and medical findings (e.g., anxiety, gastroesophageal reflux disease (GERD)).
2. **"I strongly recommend that you cut down or quit."**
   (Note: Only about 20% of alcohol dependent drinkers require medically managed withdrawal.[14] See *Problem Drinking Part 3 - Office Based Management of Alcohol Withdrawal and Prescribing Medications for Alcohol Dependence.)*

Second – gauge readiness to change drinking habits by asking one of the following:

Q: "Are you willing to consider making changes in your drinking?"

Q: "Do you want to do anything about your drinking?"

Q: "How do you feel about my recommendation? Do you have any questions?"

Q: "What do you think? Would that work for you? Does that make sense?"

Is the patient ready to commit to change at this time?

Yes

- **Help set a goal**
  Cut down to within maximum drinking limits or abstain.
- **Agree on a plan**
  - specific steps.
  - how drinking will be tracked (e.g., diary, kitchen calendar).
  - how the patient will manage high-risk situations (e.g., social events).
  - who might be willing to help, such as a spouse or non-drinking friends.
- **Provide educational materials**
  See Resource section in *Problem Drinking Part 1 - Screening and Assessment*.

No

A. Repeat screen regularly (annually / semi-annually).

B. Link related health concerns to alcohol use.

- **Do not be discouraged**
  Ambivalence is common. Your advice has likely prompted a change in your patient's thinking, a positive change in itself. With continued reinforcement, your patient may decide to take action. For now:
  - **Restate your concern** about his or her health.
  - **Encourage reflection:** Ask patients to think about it. Assess the major barriers to change.
  - **Reaffirm your willingness to help** when he or she is ready.
  - **Follow-up and support.**

Intervention for Alcohol Abuse

Physicians are advised to take the following steps when conducting an intervention:

1. State your conclusion and recommendation clearly:

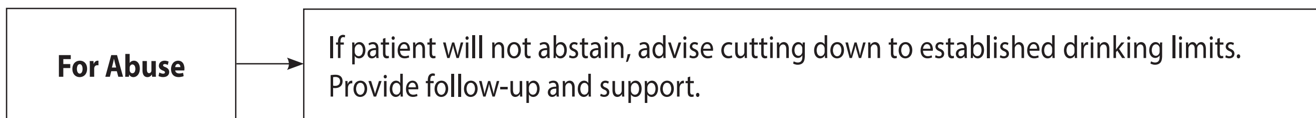
- "I believe that you have an alcohol use disorder. I strongly recommend that you stop drinking and I'm willing to help."
- Relate to the patient's concerns and medical findings if present.

2. Negotiate a goal and develop a plan:

- Abstaining is the safest course for most patients with alcohol use disorders.
- Patients who have milder forms of abuse or dependence and are unwilling to abstain may be successful at cutting down.

3. Consider referring to external or community resources:

- Alcohol and drug counselor, addiction medicine physician.
- Community groups such as Alcoholics Anonymous (AA).
- See Community Health and Resource Directory (CHARD).



Intervention for Alcohol Dependence

For dependence, complete the following in addition to steps 1-3 above:

4. For patients who have dependence:

Monitor for withdrawal - Only about 20% of alcohol dependent drinkers require medically managed withdrawal.[14] Refer to *Problem Drinking Part 3 - Office Based Management of Alcohol Withdrawal and Prescribing Medications for Alcohol Dependence.*

5. Prescribing medications for alcohol dependence:

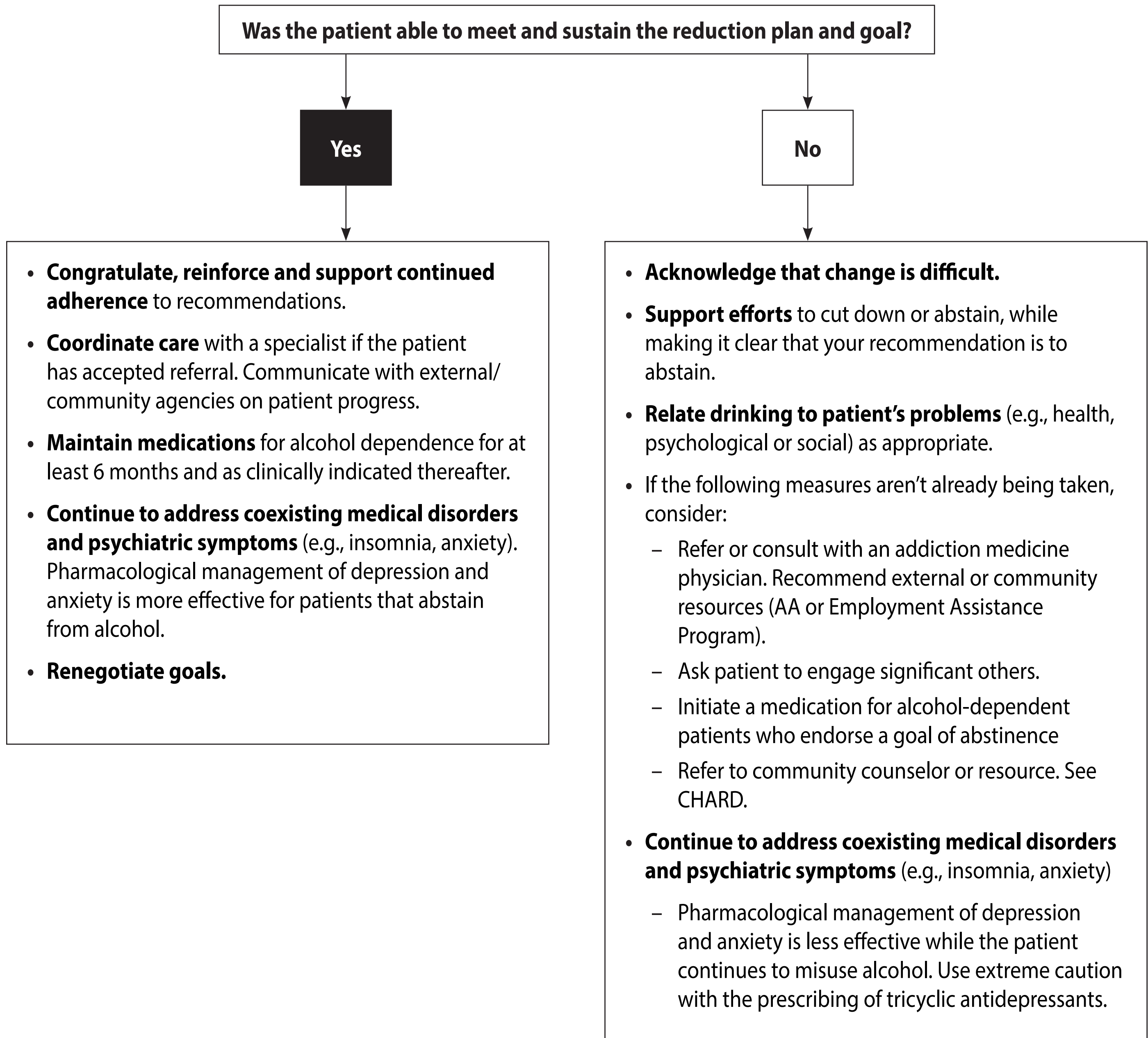
Medication, in conjunction with psychosocial interventions, can play a valuable part in the management of alcohol dependence. See *Part 3 - Office Based Management of Alcohol Withdrawal and Prescribing Medications for Alcohol Dependence* for more information on prescribing medications.

6. Arrange follow-up:

Arrange follow-up appointments, including medication management support if needed. See *Problem Drinking Part 3 - Office Based Management of Alcohol Withdrawal and Prescribing Medications for Alcohol Dependence*. To support behaviour change, consider seeing patient at least once every 14 days in initial period.

Follow-up and Support

REMINDER: Document alcohol use and review goals at each visit (use *Brief Intervention Follow-up Note*). If the patient is receiving a medication for alcohol dependence, medication management support should be provided.



Rationale

Every health care practitioner will encounter patients with alcohol problems in their practice. It is therefore important that all adolescent and adult patients be screened for problem drinking at some time. In BC as many as one in 10 visits to Vancouver General Hospital Emergency Room was for substance abuse.[7] As well, the number of patients staying at Vancouver General and University of British Columbia Hospitals due to substance abuse increased by 44% between 2005 and 2008 (from 1,317 to 1,896).[8] Screening and brief intervention are effective ways to reduce alcohol use as well as reduce acute care utilization. Research shows:

- Screening, Brief Intervention and Referral to Treatment (SBIRT) can cut hospitalization costs by $1,000 per person screened and save $4 for every $1 invested in trauma center and emergency department screening.[9-11]
- Comparing the results of those who received brief counseling with those who did not, researchers found that counseling resulted in a 40 to 50% decrease in alcohol consumption, a 42% drop in emergency room visits, a 55% decline in motor vehicle crashes, and a 100% reduction in arrests for alcohol or other substance violations.[12]

Research has also shown that many screened patients cut down on their drinking simply because they were asked about their alcohol use; likewise, brief interventions have been shown to effectively reduce alcohol and other drug use. [13]

Resources

References

1 Fleming MF, Manwell LB, Barry KL, et al. Brief physician advise for alcohol problems in older adults: a randomized community-based trial. J Family Pract. 1999 May; 48(5):378-84.

2 Wood MD, Fairlie AM, Fernandez AC, et al. Brief motivational and parent interventions for college students: a randomized factorial study. J Consult Clin Psychol. 2010 June;78(3):349-61.

3 Hermansson U, Helander A, Brandt L, et al. Screening and brief intervention for risky alcohol consumption in the workplace: results of a 1-year randomized controlled study. Alcohol Alcohol. 2010 May-June;45(3):252-7.

4 Kaner EF, Dickinson HO, Beyer FR, et al. Effectiveness of brief alcohol interventions in primary care populations (Review). The Cochrane Collaboration 2009, Issue 3.

5 Henry-Edwards S, Humeniuk R, Ali R, et al. Brief intervention for substance use: A manual for use in primary care. (Draft version 1.1 for field testing). Geneva, World Health Organization, 2003.

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7 Brubacher JR, Mabie A, Ngo M, et al. Substance-related problems in patients visiting an urban Canadian emergency department. Can J Emerg Med. 2008;10:198-204.

8 Vancouver Coastal Health Authority. Acute inpatients for Vancouver General Hospital and University of BC Hospital data for fiscal years 2005/2006, 2006/2007, and 2007/2008, mental and behavioural disorders due to psychoactive substance use (F10-F16, F18-F19) diagnosis types: most responsible diagnosis (type M) and pre-admit comorbidity diagnosis (type1).

9 Richard Brown, M.D., associate professor at the University of Wisconsin School of Medicine and Public Health. "Taking Burden Off Physicians Key to SBI Growth" Join Together Project, Boston School of Public Health.

10 Gentilello LM, Ebel BE, Wickizer TM, et al. Alcohol interventions for trauma patients treated in emergency departments and hospitals. A cost benefit analysis. Ann Surg. 2005 April;241(4): 541-550.

11 Longnecker MP, MacMahon B. Associations between alcoholic beverage consumption and hospitalization, 1983 National Health Interview Survey. Am J of Public Health. 1988 Feb;78(2):153-6.

12 Grossberg PM, Brown DD, Fleming MF. Brief physician advice for high-risk drinking young adults. Ann Fam Med. 2004;2:474-480.

13 Anderson P, Aromaa S, Rosenbloom D, et al. Screening and Brief Intervention: Making a Public Health Difference. Published 2008 by Join Together with support from the Robert Wood Johnson Foundation.

14 Bayard M, McIntyre J, Hill KR, et al. Alcohol withdrawal syndrome. Am Fam Physician. 2004 Mar 15;69(6):1443-1450.

Associated Documents

Brief Intervention Follow-up Note (HLTH 2825)

This guideline is based on scientific evidence current as of the Effective Date.

This guideline was developed by the Guidelines and Protocols Advisory Committee, approved by the British Columbia Medical Association, and adopted by the Medical Services Commission.

THE GUIDELINES AND PROTOCOLS ADVISORY COMMITTEE

The principles of the Guidelines and Protocols Advisory Committee are to:

- encourage appropriate responses to common medical situations
- recommend actions that are sufficient and efficient, neither excessive nor deficient
- permit exceptions when justified by clinical circumstances

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Disclaimer

The Clinical Practice Guidelines (the "Guidelines") have been developed by the Guidelines and Protocols Advisory Committee on behalf of the Medical Services Commission. The Guidelines are intended to give an understanding of a clinical problem, and outline one or more preferred approaches to the investigation and management of the problem. The Guidelines are not intended as a substitute for the advice or professional judgment of a health care professional, nor are they intended to be the only approach to the management of clinical problem.

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BRIEF INTERVENTION FOLLOW-UP NOTE

This followup note is meant to accompany the Guideline for Problem Drinking www.BCGuidelines.ca

DATE	NAME OF PATIENT	TIME SPENT

Q2. Heavy drinking days in the past **month:**
(≥ 5 drinks for men / ≥ 4 for women)

If screen is positive determine weekly

	days (positive ≥ 1)
	drinks per week (drinking days per week x typical number of drinks)

Working diagnosis:		At-risk drinking		Alcohol abuse		Alcohol dependence
Goal:		Drinking within limits		Abstinence		
Current medications:		Naltrexone		Acamprosate		Disulfiram
		Other (specify):				

Interval history and progress:

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Physical examination and laboratory:

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Current Assessment:

	At-risk drinking		Goals fully met
	Alcohol abuse		Goals partially met
	Alcohol dependence		Goals not met

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Plan:

	Repeat screening as needed		Patient education about drinking limits					
	Recommend drinking within limits				Did the patient agree?		No		Yes
	Recommend abstinence				Did the patient agree?		No		Yes
	Naltrexone 50 mg daily		Acamprosate 666 mg 3 times daily		Disulfiram 250 mg daily			
	Thiamine 100 mg IM/PO * (daily x 5)		Acamprosate 333 mg 3 times daily (for moderate renal impairment) (CrCl 30-50 mL/min)					
	Other medication/dosage:							
	Referral (specify):							

* Continue thiamine while patient is drinking and continue for 1 week after patient stops

Followup:

Additional plan (withdrawal treatment, coexisting conditions, etc) : ____________________

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BILLING CODE: DIAGNOSTIC CODE: BILLING: DATE: DATE: