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▶ Different methods of early identification of risky drinking: a review of clinical signs.

Reinholdz H.K., Bendtsen P., Spak F. Request reprint
Alcohol and Alcoholism: 2011, 46(3), p. 283–291.

A national project in Sweden advocates replacing standard screening with what are seen as more natural ways to identify risky drinkers among primary care patients, but can these work as well as tools like the AUDIT questionnaire, and what are the pros and cons?

Summary The review's starting point was a national project in Sweden which advocates replacing systematic and standardised screening with what are seen as more patient-centred and 'natural' ways to identify risky drinkers among primary care patients.

Approaches to early identification of possible or actual drinking problems can be categorised as:
• *Systematic screening* Routinely probing every patient (or a substantial number) for early signs of a possible problem even when they do not exhibit these signs or the symptoms of a current problem. If this happens during the course of consultations for other conditions, it is called 'opportunistic screening'. When all or nearly all patients are screened, it is termed 'universal screening'. 'Targeted screening' is systematic but not universal because only patients in certain categories are screened, such as those with high blood pressure or who are visiting the practice for the first time.
• *Semi-systematic method* The care provider raises the issue of drinking among patients who exhibit one or more of a set list of physical, social and psychological signs of risky drinking. This is systematic in the sense that all patients can be considered for questioning about their drinking even if only some actually are questioned.
• *Non-systematic* The practitioner raises the issue of drinking when they feel it is 'natural' to do so on the basis of their clinical judgement, even if this is assisted by training in which conditions or symptoms should make the practitioner particularly alert to alcohol as a possible cause. While not systematic, probably neither is this a completely random process, but one influenced by personal and other variable factors.

The reviewers aim was to find research relating to whether there are specific clinical

signs apparent in the everyday clinical encounter which could make a semi-systematic or non-systematic method a feasible alternative to systematic screening.

Results and conclusions

The review found 15 articles which identified signs of risky drinking. Psychological and social factors were considered to be earlier indicators than physical or psychiatric conditions, which emerge relatively late in a drinking career. No single sign could be relied on and it was argued that such signs could not substitute for screening, but only be used as indicators or clues to alert physicians to which patients should be screened. On this basis the reviewers believe the most important signs are: depression; hypertension; work problems; insomnia; anxiety; legal problems; trauma; and family problems.

No studies compared a semi-systematic method with systematic screening, but some did compare different screening methods and compare these against clinical assessment. They clearly show that more risky drinkers can be identified by systematic screening, but still more evidence is needed on how many, and on how this compares with non-systematic methods.

Arguments against systematic screening include the point that some patients are not identified because they under-report their drinking, that patient sensitivity about drinking makes systematic screening awkward, that screening is not compatible with a patient-centred consultation, and that many patients need to be screened to find a case of risky drinking. The featured review argues that it is not *whether* drinking is asked about but *how* which might mean the consultation is not client-centred. Whether screening tools interfere with the consultation depends on how the discussion is handled, and this can be trained. Moreover, it seems that staff rather than patients worry that screening would erode the patient-centredness of the consultation.

On the other hand, semi-systematic methods have been criticised on the basis that the 'signs' are not truly early indicators of risky drinking, that assessments can be time consuming and therefore expensive, and that accuracy depends on the skills of the practitioner. Some studies have found that GPs mainly detected obvious cases and that non-systematic clinical examination findings were often weakly and non-significantly related to daily alcohol intake. However, no study has tested a well-defined semi-systematic method.

There are also ethical issues in spending time identifying and giving advice on risky drinking when the patient has come for another purpose. A focus on risky drinking might leave less time for other important issues. Screening might be effective from a public health perspective, but it is not self-evident that each individual will benefit. On the other hand, it may be considered unethical to take the risk of failing to identify a drinking problem both from the point of view of the individual patient's welfare, and because this failure might lead to higher societal costs later which will divert resources from other health problems.

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