Alcohol:

Screening, assessment and management in general practice

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Talking about alcohol

Before we examine the role of alcohol in our patients' lives it is helpful to look at how we talk about drinking. How we construct our understanding of alcohol, its benefits and problems, defines not only what we look for in our patients' drinking but also how we address alcohol use with our patients, what we record in the notes, and how we communicate about it with other professionals. Recording alcohol use and related concerns can be difficult. It doesn't fit tidily into existing general practice classifications like the Read code, nor into screening terms as a specific measurement like smoking. How we define alcohol use also impacts on the referral choices we make – think of the different concepts around drinking involved in an AA referral, an A&D clinic referral, a counselling referral or a rehab referral.

Alcohol diagnoses

The formal diagnoses of alcohol use are drawn from disease classifications. The DSM includes alcohol diagnoses within a psychiatric classification system (alcohol abuse and dependence) and the ICD within a disease coding system originally developed to classify causes of death (harmful drinking and alcohol dependence). Both these systems place alcohol dependence as the major alcohol diagnosis. Alcohol research generally uses either DSM or ICD systems for coding and alcohol population surveys may report people's drinking using these formal codes.

It can be helpful to use classification models – they can provide a framework to understand and discuss alcohol in health care – but neither of these classification systems fit well into general practice, based as they are on a disease model. The traditional disease model describes alcohol abuse and dependence in terms of the disease alcoholism. Supporters of this model point to identified genetic factors in alcoholism, the common pathophysiological features and the nature of alcoholism as a chronic progressive condition. Most alcohol-related problems however occur in people who do not meet criteria for a formal alcohol diagnosis. This is because for alcohol, as for other health risk factors such as cholesterol, most complications occur in the larger group of lower risk people rather than the small group at high risk. In practical terms this means that the larger group drinking at borderline to intermediate levels of consumption are more likely to impact on the health system and on our alcohol-related caseload than the smaller very heavy drinking group.

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An alternative model developed originally within the UK primary care system is the problem drinking model which defines alcohol use in terms of consumption levels and associated problems rather than dependence and disease. This model looks at alcohol use for the individual as a learned behaviour and within the population as a socio-cultural phenomenon.

It is helpful to remember that before the disease model, alcohol problems were described as the result of moral or character weaknesses and considered a vice, a sin or a crime. An attitude of blame was hardly conducive to successful intervention and the development of the disease model and the influence of Alcoholics Anonymous was an important step towards humane treatment. Alcoholism as a disease involved the key features of loss of control over drinking and the necessity for abstinence

as a therapeutic goal. To be alcoholic was to be different from other drinkers and treatment required acceptance of the disease label and the goal of abstinence. The attachment of a disease label to a patient's drinking allowed for the development of therapy rather than blame, and for pathways for funding and treatment programmes.

As an alternative to looking at a defined group of drinkers as alcoholic, the problem drinking model considers everyone's alcohol use along a continuum from harm-free to harmful drinking with the particular individual's drinking learned and modified by experience. The level of drinking for any one person is considered to be determined by a balance of advantages and disadvantages, pleasures and harms of drinking, and everyone has the choice to move forward or backward along the continuum. In this model, problem drinkers are not any different from non-problem drinkers but rather, for them, the benefits of drinking outweigh any problems.

There are practical implications of these models for general practice. The disease model leads to a focus on the clinical identification of physical complications of alcohol use and referral of those accepting the alcoholic diagnosis to treatment and rehabilitation programmes. The treatment goal is abstinence. In the problem drinking model alcohol use is screened for all patients, much as we screen for lipids or blood pressure. Alcohol consumption, patterns of drinking and indicators of alcohol-related problems are included in screening and other health checks with advice and management based on a patient-centred approach with personalised safe drinking the goal.

A general practice model

In practical terms, there are features of both models that are helpful and they can be put together with alcohol use being considered either as a health risk factor, as a cause of current harm, or as alcohol dependence.

In the literature, alcohol as a risk factor variably involves the terms risky drinking, hazardous drinking, alcohol-related risk, alcohol use or consumption, and binge drinking. In practice it refers to weekly consumption for men of over 20 and for women of over 14 standard drinks/week. The exact level at which risk occurs is also dependent on individual vulnerability (e.g. affected by body mass, genetic factors, occupation, medical history, pregnancy etc). In any case, an interview assessment of consumption is only an approximation, although the use of questionnaires does increase the accuracy and repeatability of information obtained. Binge drinking as a health risk is particularly important in New Zealand as it is a common feature in our drinking patterns.

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Alcohol causing harm is also known as harmful drinking (ICD10), problem drinking, alcohol abuse (DSMIV), or alcohol-related problems and may include physical, mental and social consequences of alcohol use. There is an association between laboratory markers of heavy alcohol use (e.g. GGT, AST, ALT) and harmful consequences, both physical (e.g. gastrointestinal, gout, hypertension, obesity, injuries, hospital admissions), social (e.g. accidents, relationship problems, occupational) and mental (depression, suicide).

Alcohol dependence requiring the key features of increasing use and loss of control over drinking is a formal diagnosis within both international classification systems (ICD10 and DSMIV) and is also termed addiction, alcoholism and alcohol use disorder.

The practical implications for us within general practice is that it is desirable to screen all patients for alcohol use as a risk factor, to remain alert in clinical situations to identify when alcohol is causing harm, and to recognise alcohol dependence when it occurs as a complication of heavy drinking.

Clinical alertness to alcohol

How then can we identify alcohol risk, harm and dependence in general practice? Alcohol may impact on many clinical situations and alertness to its role is helpful. Commonly listed health consequences include among others: cardiovascular disorders (hypertension, ischaemic heart disease variably related to actual consumption level and pattern, cardiomyopathy, cardiac arrhythmias, and stroke); gastrointestinal disorders (cholelithiasis, pancreatitis, liver disease); cancers (oropharyngeal, laryngeal, oesophageal cancer; liver cancer, a contribution to breast cancer); mental health disorders (depression, suicide, neuropsychiatric disorders); pregnancy complications; injuries including road traffic injuries, alcohol poisoning, falls, drownings and other unintentional injuries.

During physical examinations, potential indicators of heavy drinking include obesity, nicotine staining on fingers from smoking (often associated with heavy drinking), scars which may indicate previous trauma and facial erythema which is sometimes present as a result of chronic heavy drinking.

Alcohol screening

However, most alcohol problems will remain undetected unless alcohol is included as part of a systematic prac-

tice screening programme. There are three useful types of screening tests. Measuring consumption alone will readily classify the level of risk for most patients. The addition of specific alcohol questions will help identify patients with problems or dependence, and selected laboratory testing is a helpful supplementary screen.

The simplest way to measure consumption is to use a quantity/frequency calculation – multiplying the amount consumed per session by the frequency of sessions per week. This provides an approximate measure only but sufficient for screening purposes. More accuracy can be obtained by going through each session in a typical or retrospective period and summating the alcohol consumed as standard drinks. The main difficulty with weekly consumption in standard drinks is that it doesn't distinguish regular safe drinking from binge drinking. For example, 18 standard drinks per week for a man might be within safe limits consumed on six days but is associated with increased risk if consumed in a single binge.

A quantity/frequency calculation can be used to indicate a risk level for problems related to alcohol use (in standard drinks per week, low risk is M<21, F<15; intermediate risk M 21–50, F 15–35; high risk M>50, F>35) but this assessment does not indicate the actual presence of problems.

A number of questionnaires have been developed to determine problem drinking, most of which are too long to be practical. The best validated shorter questionnaire is the AUDIT, which has 10 questions (three of which quantify alcohol use, the remainder indicating possible problems or dependence). This is a very useful tool that can be given as a self-administered questionnaire or used as an interview. The on-line version is particularly useful (http://www.alac.org.nz/DrinkCheck.aspx). This on-line questionnaire can be completed with the patient and an individualised report reviewed and printed. Certain questions have been shown to be most predictive of problem drinking and two in particular can be used along with consumption questions in a very brief screen; these are:

- Have you ever felt the need to cut down on your drinking? and
- Do close relatives ever worry or complain about your drinking?

The performance characteristics of questionnaires as screening tools are well documented but in practice they are most helpful when considered an entry points for further assessment.

The most practical laboratory screening items remain the liver enzymes (GGT, AST and ALT) and the MCV. A number of other biochemical tests have shown promise but none have become readily available for general practice. Again, the main advantage of liver enzymes and MCV are as indicators of heavy alcohol use. Along with measures of consumption and concern questions about drinking they indicate the need for further assessment.

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Alcohol assessment

Formal assessment of drinking requires an alcohol clinical interview, which gives detailed insight into a patient's alcohol use and provides opportunity for intervention. A sample interview is available on the RNZCGP alcohol workshop website (http://www.rnzcgp.org.nz/). A detailed alcohol history provides useful information, allows for a diagnosis and guides management. A patient-centred interview about alcohol use readily leads on to a motivational framework for management. Sometimes however it is neither feasible nor desirable to arrange a detailed assessment. Just entering into a discussion about alcohol use can open the issue for many patients and lead to healthy changes. A brief overview of a patient's drinking can be obtained using the 5Ls mnemonic:

- Liver (physical health)
- Lover (relationships)
- Livelihood (work)
- Law (legal problems)
- Losing it (emotional difficulties).

Helpful entry points into a discussion about alcohol include using a motivational approach asking about the 'enjoyable' and 'less good' aspects of the person's drinking and using this information to explore ambivalence and facilitate change.

Alcohol management

There is good evidence for the effectiveness of brief interventions in general practice based on a motivational approach using the transtheoretical model of change concept. Brief treatment intervention is a term used to describe a series of alcohol focused consultations involving a mix of motivational interviewing and other communication skills and strategies. Within a patient-centred framework it may include feedback on questionnaire information and laboratory results and simple advice-giving, but the effectiveness is dependent on patients being actively involved in the change process.

Brief opportunistic interventions refers to the use of opportunities that arise in clinical practice to facilitate change in drinking behaviour. It is a style of intervention that uses open-ended questions and reflective listening techniques, checking with the patient the importance of the issues being discussed, ensuring patient confidence in the process, and seeks to raise ambivalence about current behaviour, encourage self-motivating statements and support self-initiated change.

If alcohol use is normalised within a practice as a legitimate issue for discussion and approached in a non-threatening motivational style, it can be raised for review at any

appropriate patient contact. Permission to discuss alcohol as a health issue is seldom declined and opportunities to support change may present over long periods of time. Most changes in human behaviour occur over months or years and it is useful to maintain a long-term view.

Alcohol may of course be only one aspect of a patient's lifestyle and health risks. Alcohol risk or problems may change at times simply because other health issues have been addressed. For example, alcohol abuse might be a symptom of other problems such as stress, anxiety or depression and support in these areas may be all that is required.

Within most practices we will experience some patients for whom alcohol is a continuing problem, causing damage to them and creating problems for others. Some patients apparently remain resistant to change and it is easy to develop a sense of therapeutic nihilism and just ignore this aspect of their health.

There are other therapeutic models that we can draw on to explore and manage problem drinking. Solutions-focused therapy for example explores the resources patients have already developed to make life changes focusing on what they want to achieve rather than on the identified problems. The patient is invited to envision their preferred future and the therapeutic process encouarges moves towards it, whether these are small increments or large changes. This approach is based on the belief that if patients can describe something as a problem, they can also describe what life would be like if it was better, and they also have the resources needed to make it happen.

Another model is narrative therapy, which recognises that patients may have preferred or alternative life stories that are not dominated by alcohol problems. Patients are helped to identify the aspects of their life that are unaffected by their drinking – the focus is not so much on what the impact of alcohol is on their lives but on where alcohol is not affecting them. It explores a patient's contradictory experiences, seeking to shape preferred alternatives to drinking. The process explores what skills and knowledge patients currently possess to combat the problem and establish new ways to strengthen these skills. Identifying the desire for a better life can also give insights into previous successes, as well as views on how they would like their life story to turn out. Narrative therapy externalises the problem, allowing people to consider their relationship with alcohol as a problem rather than the person actually being the problem (alcoholic, problem-drinker).

In these models, there is much less emphasis on gathering information that leads to formal classification, rather a focus on the patient's perception and experience of alcohol use and themselves as the authors of change. As such, these approaches sit very comfortably in patient-centred practice with its recognition of the patient as expert and awareness of the experience of illness as important as the diagnosis of disease.

Summary

In summary, patient use of alcohol is an important consideration in general practice. Within clinical consultations, alertness to a patient's drinking will help identify alcohol-related problems, but many problems will go undetected unless we actively screen our practice population for alcohol risk, problems and dependence. It may be helpful to formally assess and classify alcohol problems, especially if we want to record alcohol use as a clinical problem and maintain surveillance, or if we want to refer to other services. For many patients however, simply providing the opportunity to discuss drinking may be sufficient to open up the issue and allow for successful interventions. Sustained change in patient behaviour requires ownership by the patient and, in the end, a patient-centred management strategy is more important than a diagnosis.

Competing interests

None declared.

Integration of addiction treatment and medical care

'The segregation of addiction treatment and medical care is an unfortunate consequence of policies and practices that have developed in the United States over many years. New research points toward the benefits of integrating these two systems of care, and the development of new behavioral and pharmacologic treatments for addiction is destined to render their separation increasingly untenable. However, movement toward integration faces substantial regulatory and political obstacles...

...The movement toward integration of addiction treatment and medical care is impeded by rigid regulatory policies, the paucity of addiction education for physicians, and the lack of parity in insurance coverage for addictions. However, progress is being made toward an era of managing addiction as a chronic medical disease, and physicians can be increasingly confident that their ministrations, while providing no certain cure, can have important and measurable benefits for their patients' struggle toward recovery.'

Merrill JO. Integrating Medical Care and Addiction Treatment. J Gen Intern Med. 2003 January; 18(1): 68-69.