

Problem alcohol drinkers: Detecting and intervening

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Over the last decade, general practitioners (GPs) in New Zealand have become increasingly active in detecting and helping risky and problematic drinkers in their practices, not just those with dependency. In this respect New Zealand GPs could be said to lead the world.

Alcohol drinkers are often categorised using the Alcohol Use Disorders Identification Test (AUDIT).¹ The AUDIT assigns a score out of 40 to 10 questions about: drinking behaviour, problems associated with alcohol use and signs of dependency.

An AUDIT score less than eight is associated with safer drinking. This group of people includes either non-drinkers or social drinkers.

Social drinkers usually drink within recommended guidelines for safer use of alcohol (less than 14 units per week for women and less than 21 units for men) and don't indulge in binge-drinking sessions (more than four units in a short session for women and more than six units for men). Social drinkers have the advantage that when they are older they may reduce their cardiovascular risk.² A unit is 10g of alcohol. This corresponds to around one nip of spirits such as whiskey, one small glass of wine or a glass or can of beer.

An AUDIT score of eight to 12 is associated with risky or early problematic alcohol drinking. People in this category usually drink more than the recommended guidelines and are often binge drinkers.

An AUDIT score higher than 12 is associated with severe problem

alcohol drinking, and sometimes with the ICD10 or DSMIV diagnosis of alcohol dependency (alcoholism).

Dependent and severe problem use of alcohol affects every major body system, and has been causally linked to over 60 health consequences including:³

- Coronary heart disease
- Stroke
- Cancer
- Cirrhosis of the liver.

The consequences are particularly prevalent in older people (aged 55 and older). However, problematic alcohol consumption is also responsible for morbidity and mortality among younger people.⁴ In particular this involves:

- Road traffic accidents^{5,6}
- Suicide⁷⁻⁹
- Violence and assaults.¹⁰⁻¹³

The risks associated with risky and problematic alcohol drinking make it worth trying to identify and manage as many of these patients as possible. After all, if alcohol related problems continue unchecked they can lead to recurrent presentations at medical services with cost and workload consequences for your practice.

Who experiences problems with alcohol drinking?

Sixteen per cent of people attending their GP are defined as risky, problematic, or dependent drinkers using the AUDIT.¹⁴ Forty per cent of attendances at accident and emergency departments are related to alcohol, rising to over 70% at peak times.¹⁵ Cross-sectional surveys have indicated that

up to 36% of all acute hospital admissions in the UK are related to alcohol consumption.¹⁶⁻¹⁸

General practice attendee figures depend on age and gender:¹⁴

- Around 12% of boys and 12% of girls aged 14-15 years attending a GP have AUDIT scores between eight and 12. That is, they are risky or early problematic drinkers.
- Around 28% of men and 21% of women aged 16-19 years attending GPs have AUDIT scores between eight and 12.
- In people older than 19 years attending GPs, risky or early problematic drinking behaviour drops almost linearly with age, until at age 65 and older only about 6% of men and 2% women fit this category.

Detecting patients with problem alcohol drinking

Do GPs ask questions about alcohol consumption? Worldwide surveys indicate they ask 'some of the time'.¹⁹ However, few ask these questions routinely.

Why is this? According to Beich and colleagues, screening all patients for excessive alcohol use creates more problems than it solves; although it was important to counsel patients about their drinking, they found that GPs were discouraged by the increase in workload and low rate of detection.^{20,21} For these reasons we don't recommend routine screening, rather we suggest a pragmatic approach, based on opportunistic patient encounters and an awareness of pres-

entations that are likely to be related to excessive alcohol consumption.²²

Israel et al. tested a system where doctors asked only patients with previous trauma about alcohol use and alcohol-related problems.²³ This system detected over 62% of practice patients with problem use of alcohol.

However, any practice may have local knowledge and populations that would suggest using indicators other than trauma. For example, a practice may decide to ask one of the following groups about their alcohol use:

- Students presenting for a sick note on Mondays
- Women presenting more than once for emergency contraception
- People with gastritis
- People with poorly controlled hypertension.

This process could be called systematic opportunistic detection of problem users of alcohol.

Short screening tools

Sometimes short screening tools can be valuable. This approach suits nurses, and many practice nurses are keen to detect and assist problem alcohol drinkers.

The AUDIT is the best alternative to a diagnostic interview, but because of its length it is impractical in a busy general practice. A useful alternative is the Shortened AUDIT²⁴ where a score of three or more has 87% sensitivity and 65% specificity:

1. How often do you have a drink containing alcohol?
2. How many drinks containing alcohol do you have on a typical day?
3. How often do you have six or more drinks on one occasion?

The 'one minute' Paddington Alcohol Test (PAT), designed for use in busy medical settings, ascertains quantity and frequency of consumption, and in addition asks the patient to consider whether their attendance might have been related to their drinking.²⁵ This sets the agenda for further intervention and helps move the patient towards a contemplative stage of change.

What can you do to help problem alcohol users?

The biggest difficulty is that almost all risky and problem drinkers found will be unaware they are problem alcohol users, or will be aware of their problem but unprepared to do anything about it. Motivational interviewing theory describes such people as pre-contemplators.²⁶

In alcohol and drug clinics the doctor or nurse would offer a 'brief intervention'. This could be one or a series of, say, 15-minute discussions

between a counsellor and a patient with the design of each discussion based on counselling principles or using motivational interviewing.

A Cochrane review suggested that brief counselling would produce reductions of up to 65% in subsequent motor vehicle crashes and related injuries, falls, suicide attempts, domestic violence, assaults and child abuse, alcohol-related trauma, hospitalisations, and deaths.²⁷ The

definition of 'counselling' varied between the trials selected for review, but included primary care interventions.

To be time effective in primary care and general practice it is better to use 'opportunistic interventions' rather than clinic style counselling. The nurse or doctor initiates a series of conversations or brief comments over a series of serendipitous patient contacts.²⁸⁻³⁰ Because the opportunistic intervention occurs within a range of other activities it is time effective. It makes use of that well-known advantage of primary care – continuity of care.

Having determined that a problem or dependent drinker might benefit from an intervention, you could simply refer them to a local alcohol

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service. A recent report in the *Lancet* suggests that this approach can lower levels of alcohol consumption and reduce the number of subsequent presentations, even if the patient doesn't attend.³¹ Here, the referral alone is acting as a good example of an opportunistic intervention.

What happens when the patient decides to change?

It's only when a patient decides to change that you should begin to discuss change strategies. A premature intervention probably won't change the patient's behaviour and is likely to make the doctor frustrated and the patient annoyed.²⁶ Change strategies should include dealing with risk situations and soliciting support networks. Provided you have read the literature around it, using naltrexone opens new opportunities to help. If the patient is alcohol dependent or has multiple issues (such as depression or underlying anxiety), refer them to a local community alcohol service.

Do brief interventions work?

Moyer et al. carried out a meta-analysis of brief interventions versus control conditions in non-treatment-seeking populations.³² The effect sizes identified were small to medium. They comment that the effect sizes were largest at the earliest follow-up points, arguing that health care providers should continue to monitor their patient's drinking behaviour and be prepared to intervene again with a brief intervention should their drinking relapse toward unsafe levels.

Fleming calculated that for every US\$10,000 spent on primary care screening and brief intervention for risky and problem use of alcohol, US\$43,000 were saved in health and society costs.³³

A literature review suggested that for every seven brief interventions, one patient will cut their drinking down to safer levels.³⁴ Obviously, if you continue year by year the numbers helped will increase. This will lead to a consequent reduction in patient morbidity, practice workload, and practice costs.

What research doesn't tell us is how many brief primary care conversations or comments lead a pre-contemplative patient to feel ambivalent about their behaviour. This is an important intermediate step that theory and clinical practice suggest makes the next discussion you have with that person about problem use of alcohol more likely to lead to behaviour change.²⁶ This is a useful area for future research.

Available resources and courses

General practitioners and practice nurses may want to up-skill in this area. There are two key resources that are available: the TADS programme and the RNZCGP workshop on alcohol.

TADS is a Goodfellow Unit programme that began in 1995 as a 'Tobacco, Alcohol and other Drugs' project to train general practitioners, practice nurses and 'other' primary health care personnel about screening and brief intervention for problem use of alcohol and drugs. It has evolved into a programme about generic lifestyle issues with an emphasis on training all primary health care professionals about enabling patients to discuss the lifestyle issues that most matter to them. Its workshops last one to two days.

The evidence TADS has accumulated since 1995 has helped inform what are pragmatic interventions for problem lifestyle behaviours (including problem use of alcohol) for each type of professional, in particular doctors and nurses. TADS findings bear considerable similarity to recent theoretical work in the United Kingdom. Heather et al.³⁵ describe:

- The need for a National Alcohol Strategy in the UK
- That brief intervention and screening should be a multi-disciplinary process including nurses and dieticians

- That brief interventions should be tailored to meet the needs of differing groups
- That the process should be led by the patient's own agenda
- That training should be offered for screening and brief intervention
- And 'the need for realism all round'.

Another example where New Zealand leads the world?

General practitioners who want a good brief refresher course about detection of and intervention for risky and problem use of alcohol should visit the RNZCGP on-line workshop on alcohol – www.rnzcgp.org.nz/alac/homePage.htm. This is an interactive learning programme covering screening, assessment and management of alcohol problems in general practice. It uses case studies and formative quizzes, can be completed wherever and whenever you wish (provided you have a computer!) and is worth six RNZCGP re-accreditation points on completion.

You could argue that practice specific detection of and appropriate intervention for problem use of alcohol should be as much a part of our routine practice as is detection of ab-

normal cholesterol levels. After all the numbers needed to treat to achieve a reduction in problem drinking levels in one person are less than using cholesterol lowering drugs in some patient categories. And the consequent reduction in morbidity by helping risky and

problem drinkers may save us, and our patients, a lot of anguish, time and resources.

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'As an enthusiastically modern general practitioner I had thought that "evidence based" meant "less uncertain" or more certain uncertainty. I wonder if evidence based really means more uncertain certainty. I certainly do not feel able to provide a lead for the NHS with this quantity of uncertainty about some of the most thoroughly researched clinical conditions that make up the rich fabric of my daily work.'

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