SBI for Alcohol misuse in Australia: The state of play

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The Australian Group

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The Australian Context

- Population: 20,012,948 (ABS, 2003).
- Indigenous Australians number 386,000 (approx. 2% of the population).
- Australia's national health care delivery system covers all permanent residents of Australia, and is largely financed by general taxes.

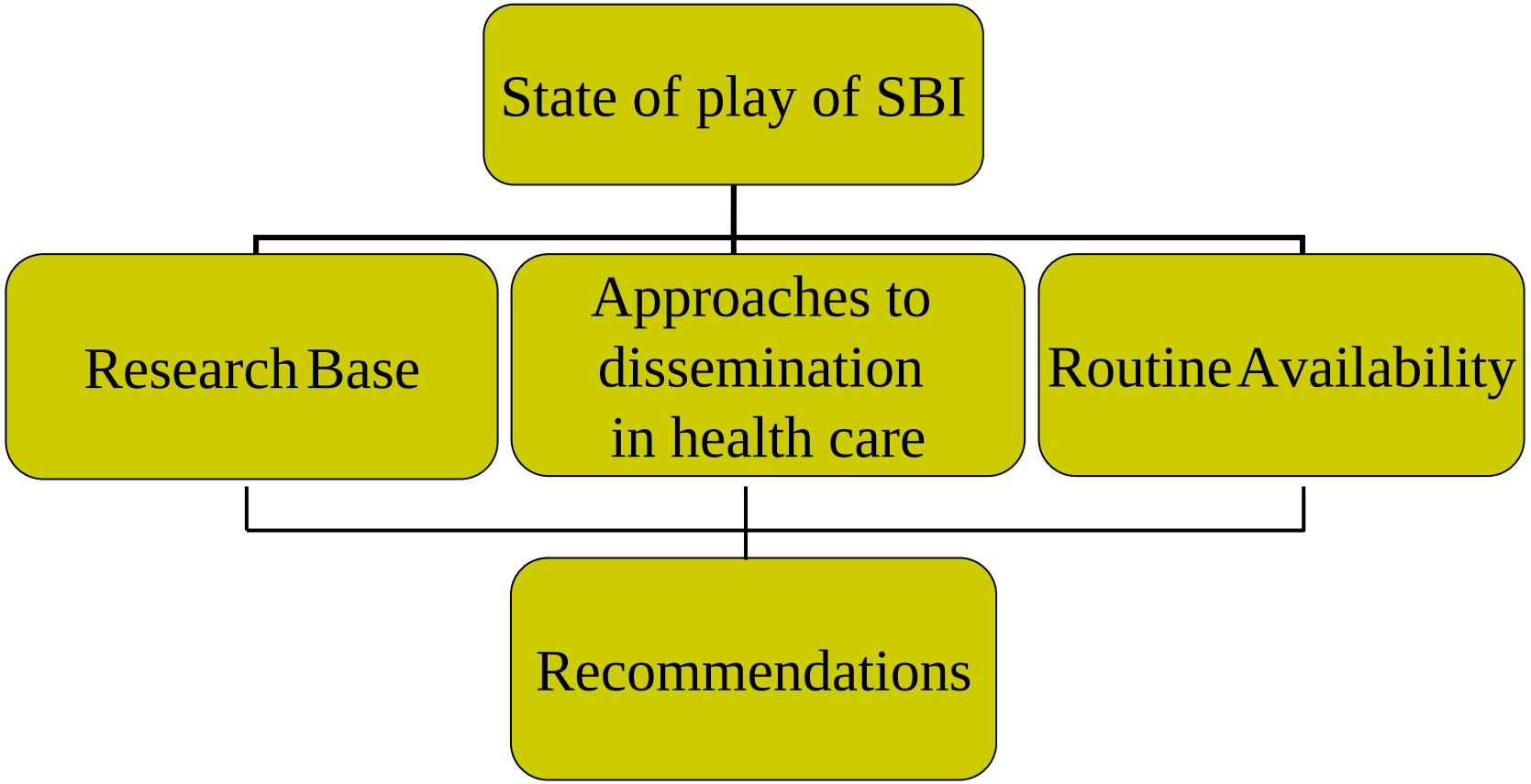
Alcohol Problems in Australia

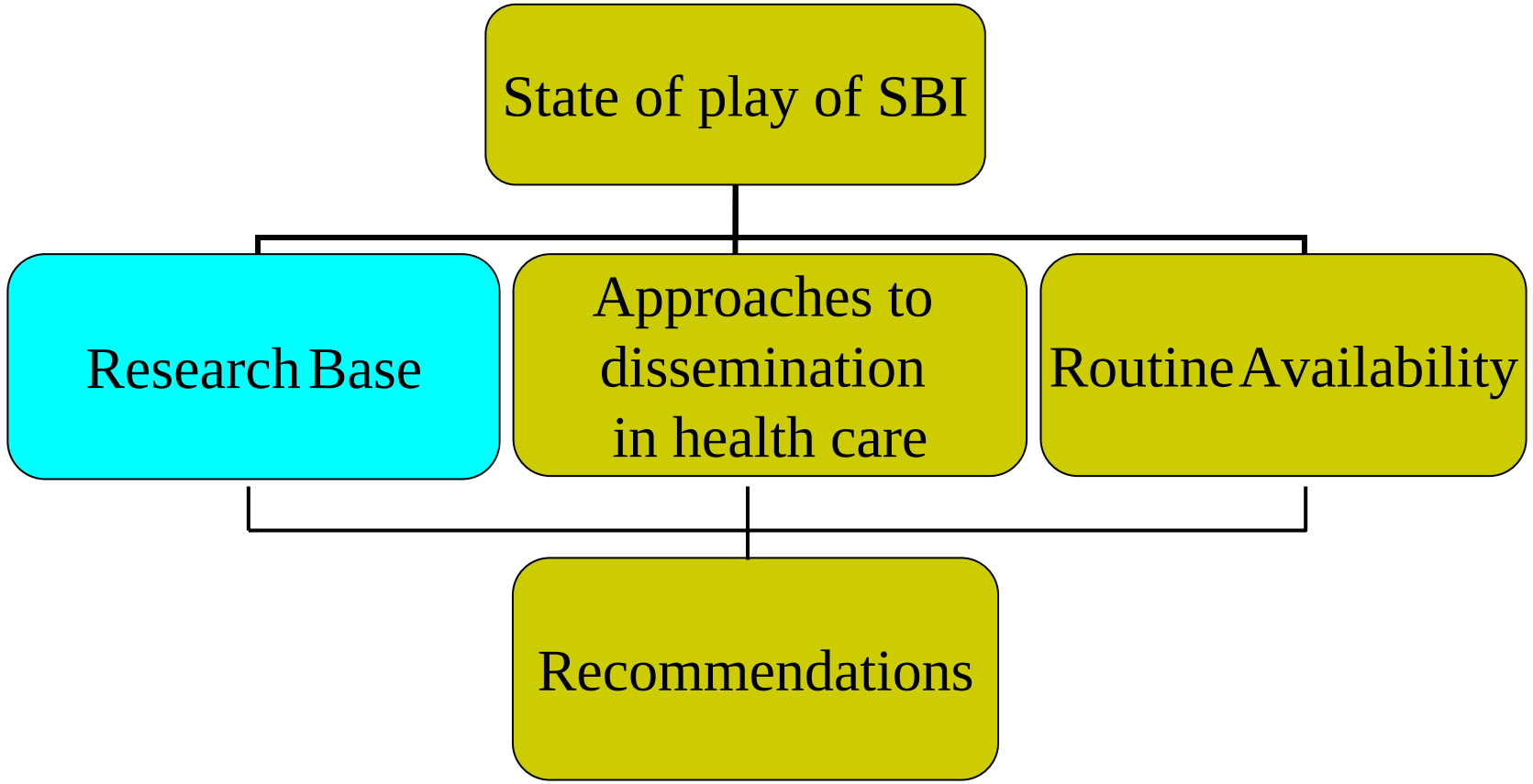
- 85% > of Australians drink alcohol at least occasionally.
- Drinking is not restricted to specific population groups or geographical areas.
- Ranked 17th in the world (2nd/English speaking countries) for total consumption.
- Remains one of the 2 major causes of substance-related mortality in Australia, accounting for approximately 5% of all deaths. It is a contributing or exacerbating factor for many health problems, including injury, mental health, & cancer.

Brief Intervention

- Brief interventions have been developed for several forms of substance use, most notably alcohol.
- The emphasis has been on opportunistic brief intervention within a general medical practice setting. The rationale being:
  - GPs and are often the initial and most frequent point of contact between the general community &d the health care system.
  - hazardous and harmful drinkers present twice as often to primary health care as other patients.
  - GPs are accepted as an authoritative source of health advice

State of play of SBI: Australia

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Research Base

- In the WHO Brief Intervention trials, conducted in Australia and internationally, a 5-minute intervention reduced hazardous consumption by 27-30% compared to no intervention control (WHO Brief Intervention Study Group, 1996; Saunders et al., 1998).
- Several meta-analyses of SBI have been published (Kahan et al., 1995; Wilk et al., 1997; Moyer et al., 2002).
- Moyer et al (2002) showed a significant positive effect of brief intervention compared with control, with an average reduction in alcohol intake of 20%.

Electronic SBI: Kypri et al (in press)

- **Aim:** determine the efficacy of a web-based SBI to reduce hazardous drinking.
- **Setting:** a university student health service.
- **Participants:** 167 students (17-26 years) completed a 3-min web-based screen (inc. AUDIT questionnaire). 112 tested positive, and 104 (52 females) who consented to follow-up were included in the trial.
- **Measurements:** drinking frequency, typical occasion quantity, total volume, heavy episode frequency (f >80g ethanol, m >120g ethanol), number of personal problems, an academic problems score.
- **Intervention:** Participants randomised to:
  - Intervention group: 10-15 minutes of web-based assessment and personalised feedback on their drinking (n=51),
  - Control Group: leaflet-only (n=53).

Electronic SBI (Cont).

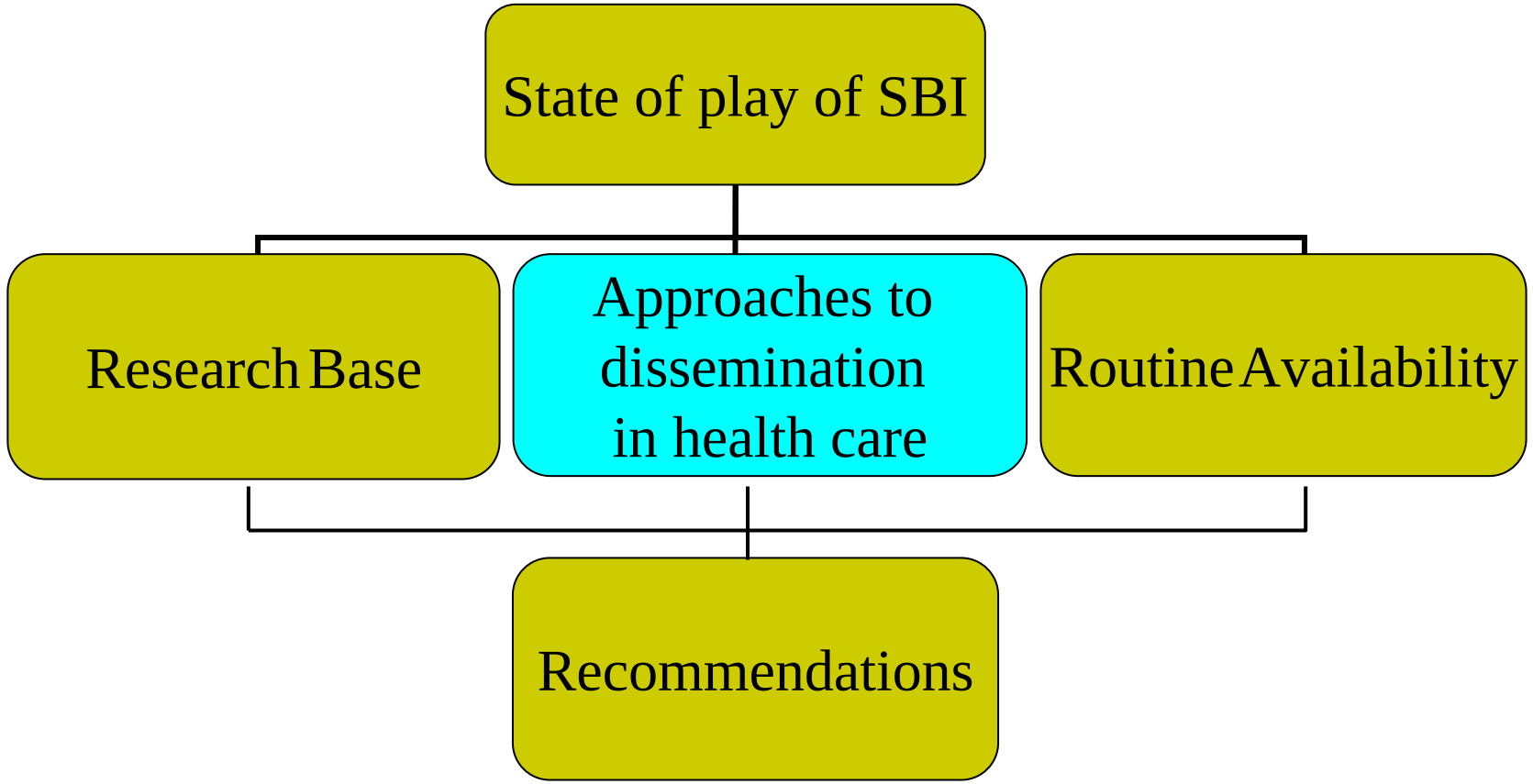
- **Findings:**

At 6 weeks compared to control, participants receiving e-SBI reported significantly reduced:

- total consumption
- heavy drinking episode frequency
- fewer personal problems

At 6 months (compared to control):

- personal problems remained lower
- consumption did not differ significantly
- academic problems were lower in the intervention group relative to controls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Efforts to promote & disseminate SBI in the health care system

- SBI for hazardous & harmful drinking is supported within the framework of the Smoking, Nutrition, Alcohol and Physical activity (SNAP) framework (Commonwealth Dept of Health & Ageing).
- Mass media - occasional magazine articles (AUDIT linked to advice based on score)
- NHMRC guidelines on responsible alcohol consumption
- Australian Mental Health Initiative (AIMHi): Disseminate sustainable methods to improve the mental, physical, social & community health of people with mental disorders
- SBI dissemination for indigenous & non-indigenous in rural & remote communities
- WHO Phase III
  - Determination of effective dissemination methods
  - Onsite training, with the provision of user-friendly resource material, was found to be the most acceptable, achievable and cost effective approach.
- WHO Phase IV
  - Revision of Drink-Less Package (2001-2003)
  - Lead organisations
  - NSW RTA

Lead Organisation & Alliances

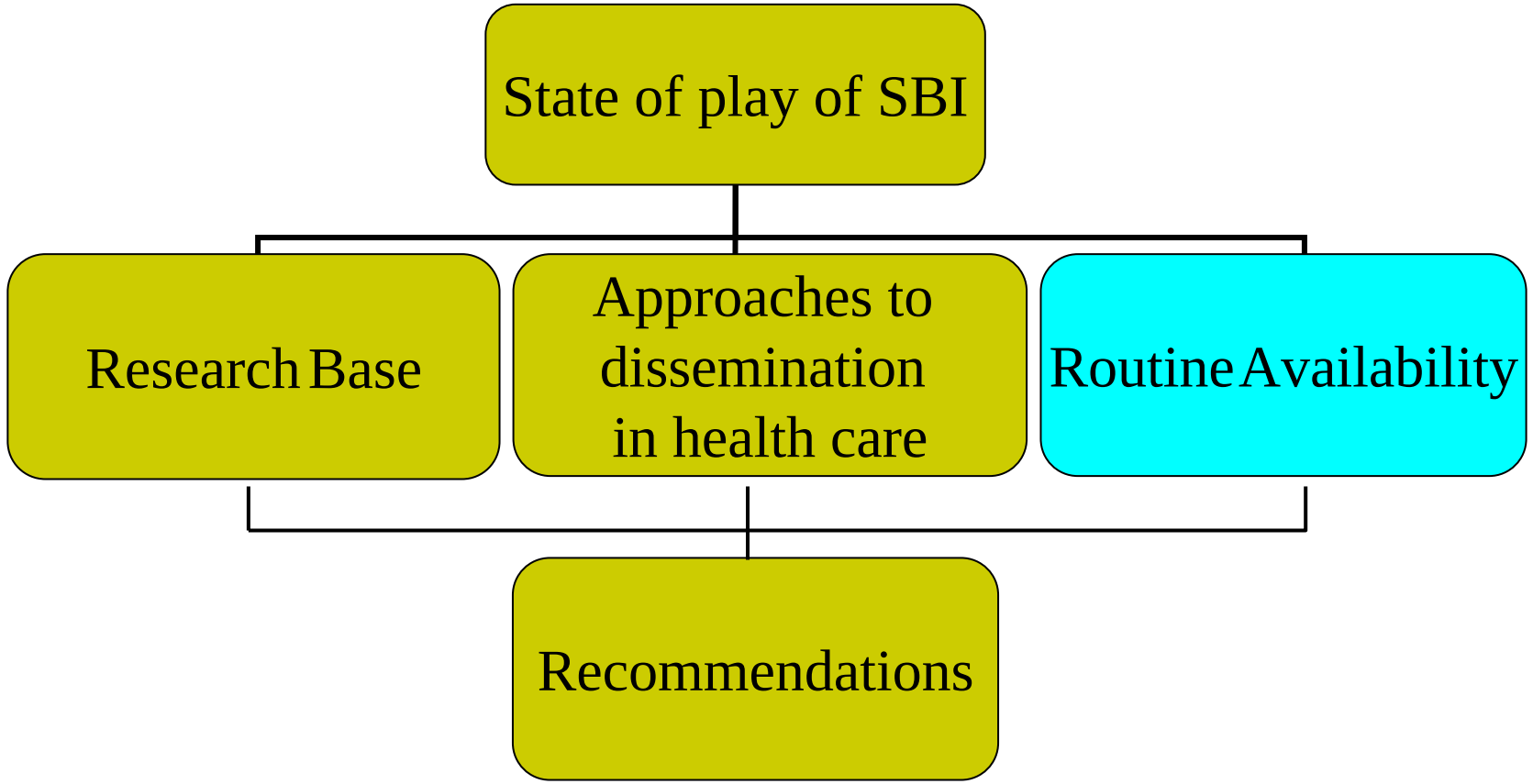
- The Centre for Drug & Alcohol Studies (CDAS), School of Medicine, University of Queensland
- Alcohol and Drug Service (The Prince Charles Hospital and District Health Service – Queensland Health)
- Colleagues in the University of Sydney.
- Alliances are formed with the following organisations:
  - Central & local government agencies linked to primary health care.
  - Divisions of General Practice
  - The Roads and Traffic Authority (NSW)
  - Key educational & research institutions with expertise in SBI &/or in the development of intervention and training materials and methods
  - Professional associations with the power to set the agenda for particular service sectors, such as Colleges of GPs, nurses, medical social workers, psychologists
  - Charities, volunteer organisations, community groups & community leaders that can contribute to the implementation

NSW Roads & Traffic Authority - 2003

- GP Liaison Officers at all Divisions of General Practice in NSW were invited to participate in training sessions for Drink-Less. The Drink-Less program was presented at one of their meetings by:
  - Prof John B. Saunders
  - A/Prof Kate Conigrave
  - A/Prof Paul Haber
  - Dr Elizabeth Proude
  - Dr Hester Wilce
  - Dr Rose Neild
- The purpose of this initiative is to train GPs in SBI for drink-drivers.
- GPs received continuing professional development (CPD) practice points from the Royal Australian College of General Practitioners for attending the training session.
- A secondary aim is for GPs to identify & provide BI for hazardous drinkers in their practice.
- This initiative also saw the revision of the Drinkless-Package

WHO Phase IV work: Demonstration project

- Funding found to be very difficult
  - NHMRC
  - AERF
  - ATODS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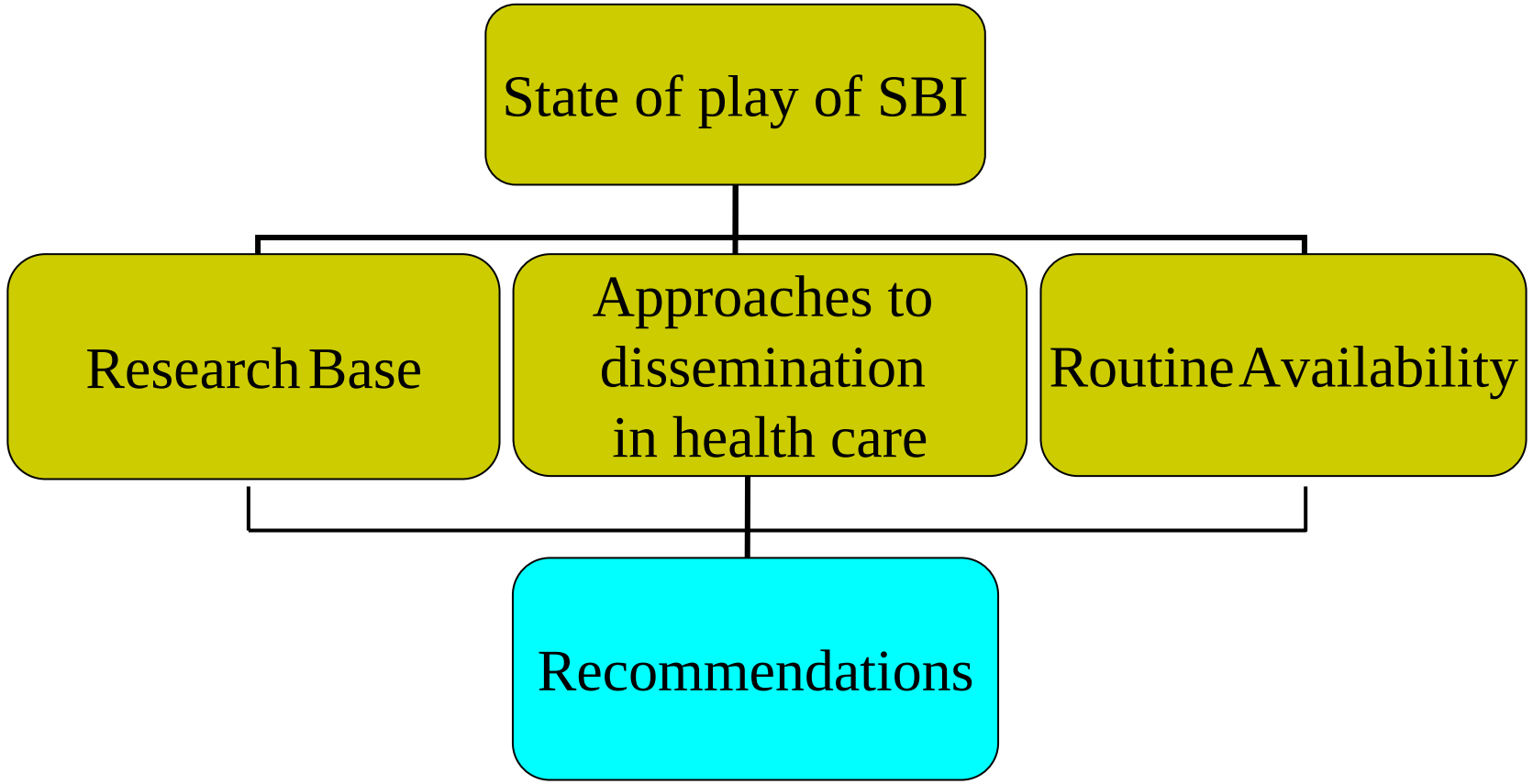
Routine Availability of Screening & Intervention?

- Despite (i) better awareness, (ii) better skill base, (iii) evidence supporting the effectiveness of SBI, & (iv) the large number of hazardous drinkers attending general practice, an appropriate intervention is rarely offered.
  - In a 2000-01 examination of GP activity in Australia, alcohol was rarely addressed within the practice encounter, with an intervention comprising 0.4% of all encounters.
  - Within the study, the AUDIT was administered to 31,543 individuals aged 18+ years. 24.1% of patients 'at risk' levels of alcohol use (Britt et al., 2001).
- Routine health checks funded by Medicare ceased in 1990s
- Possibly SNAP initiative will lead to Medicare remuneration items for SBI

Limitations on GPs

- Saunders & Wutzke (1998) identified barriers to provision of SBI by GPs, which include:
  - Educational limitations: limited awareness of SBI effectiveness, & of the conditions/problems (excluding physical ones) that could arise from harmful alcohol use
  - Lack of resource materials: questionnaires, intervention guidelines & patient self-instructional materials
  - Logistical barriers: time & heavy workloads. 3-4 Kilos of materials p/mth on effectiveness & cost-effectiveness of interventions > GPs provide preventive interventions in a variable manner.
  - Attitudinal barriers: lack of self-confidence & self-efficacy in delivering effective interventions.
  - Who owns the consultation? Patients are not allocated to a GP in Australia. Patients akin to consumers & can pick GP according to need. > GPs may be driven by the patient's primary concerns.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Recommendations for implementing SBI in Australia

Having considered some of the issues faced by GPs, the following recommendations have been made:

Education Programs

- Skills development: Training courses that are available face-to-face & in electronic form need to be promoted to GPs to impart the knowledge and skills needed for SBI.
- Education courses should also address the issue of ownership of the consultation. Perhaps a view that emphasises mutual responsibility & conjoint ownership of the consultation would facilitate SBI.

Recommendations (cont.)

National Government and Peak Bodies

- GP workload & inundation of preventive medicine opportunities: It is recommended that a list of prioritised issues be developed for GPs to manage as part of their core role (based on mortality & morbidity statistics).
- National government bodies should carefully monitor trends in alcohol consumption and misuse, & examine the priority given to alcohol interventions.
- Examine whether incentives for PHC practitioners to promote brief interventions should be incorporated into relevant policies & practices.
- To enhance role legitimacy, SBI should be promoted to the general community (patients), with the aim of "their setting the agenda" of the consultation. The media could be engaged to develop communication strategies to emphasise the hazards of risky drinking, and the role of the GP in discussing these issues.