Annex 5

Additional deliverables

GUIDE: HOW TO MANAGE RISKY DRINKERS IN PRIMARY HEALTH CARE

This guide has been written in accordance with the criteria of the PHEPA Training Programme on identification and brief interventions and the PHEPA Clinical Guidelines on identification and brief interventions. It is also inspired in 'Helping patients who drink too much. A clinician's guide. 2005 Edition' from the NIAAA.

Introduction

Alcohol increases the risk of a wide range of medical and social problems in a dose dependent manner, with no evidence for a threshold effect. Generally the more serious the crime or injury, the more likely alcohol is to be involved. Harm to others is a powerful to reason to intervene for hazardous and harmful alcohol consumption.

Apart from being a drug of dependence, alcohol is a cause of 60 or so different types of disease, including injuries, mental and behavioural disorders, gastrointestinal conditions, cancers, cardiovascular diseases, immunological disorders, skeletal diseases, reproductive disorders and pre-natal harm. For the individual drinker, alcohol increases the risk of these diseases and injuries in a dose dependent manner, with no evidence for a threshold effect. The higher the alcohol consumption, the greater is the risk.

The risk of death from alcohol is a balance between the risk of diseases and injuries that alcohol increases and the risk of heart disease that in small amounts alcohol decreases. This balance shows that, except for older people, the consumption of alcohol is not risk free. The level of alcohol consumption with the lowest risk of death is zero or near zero for women under the age of 65, and less than 5g of alcohol a day for women aged 65 years or older. For men, the level of alcohol consumption with the lowest risk of death is zero under 35 years of age, about 5g a day in middle age, and less than 10g a day when aged 65 years or older.

Throughout the European Union as a whole, alcohol is one of the most important causes of ill-health and premature death. It is less important than smoking and raised blood pressure, but more important than high cholesterol levels and overweight.

There are health benefits from reducing or stopping alcohol consumption. All acute risks can be completely reversed if alcohol is removed. Even amongst chronic diseases, such as liver cirrhosis and depression, reducing or stopping alcohol consumption are associated with rapid improvements in health. Primary Health Care (PHC) providers play a crucial role in this field since they are in a pivotal position inside Health Systems.

Key questions and recommendations

KEY QUESTIONS	RECOMMENDATIONS
Should hazardous and harmful alcohol use be identified? Since alcohol is implicated in a wide variety of physical and mental health problems in a dose dependent manner, there is an opportunity for PHC providers to identify adult patients with hazardous and harmful alcohol consumption. Numerous studies have shown that most patients with hazardous and harmful alcohol consumption are not known to their health care provider.	The identification of hazardous and harmful alcohol consumption and episodic heavy drinking should be offered to all adult patients of PHC facilities.

In which groups of patients should hazardous and harmful alcohol use be identified? A truly preventive approach can only be reached if all adult patients are screened for hazardous and harmful alcohol consumption, including patterns of episodic heavy drinking. If such an approach is not feasible, limiting screening to high risk groups or to some specific situations may be a feasible option. Such groups could include young to middle aged males and special health clinics (e.g. for hypertension).	All adult patients should be routinely screened for hazardous and harmful alcohol consumption at least every 2 years
What are the best questions or screening instruments to identify hazardous and harmful alcohol use? The simplest questions to use are those that ask about alcohol consumption. The first three questions of the World Health Organization's Alcohol Use Disorders Identification Test, which was designed to identify hazardous and harmful alcohol consumption in primary care settings, have been well tested and validated. The first question asks about frequency of drinking; the second the amount of alcohol consumed on an average drinking day; and the third the frequency of episodic heavy drinking.	The use of the first three alcohol consumption questions of the AUDIT is one preferred method to identify hazardous and harmful alcohol consumption.
How should questions or screening instruments be administered? The identification of hazardous and harmful alcohol consumption works best when it is incorporated into routine clinical practices and systems, such as systematically asking all new patients when they register; all patients when they attend for a health check; or all men aged 18-44 years, when they attend for a consultation. There is no evidence available to suggest that systematic identification of hazardous and harmful alcohol consumption lead to adverse effects, such as discomfort or dissatisfaction amongst patients.	The identification of hazardous and harmful alcohol consumption works best when it is incorporated into routine clinical practices and systems
Are biochemical tests useful for screening? Biochemical tests for alcohol use disorders such as liver enzymes (e.g. serum γ-glutamyl transferase (GGT) and the aminotransferases), carbohydrate deficient transferrin (CDT) and mean corpuscular volume (MCV) are not useful for screening because elevated results have poor sensitivity, identifying only a small proportion of patients with hazardous or harmful alcohol consumption.	Biochemical tests should not be relied on for routine screening for hazardous or harmful alcohol consumption or alcohol dependence in PHC.
Are brief interventions effective in reducing hazardous and harmful alcohol consumption and alcohol related problems? Brief interventions are effective in PHC settings in reducing hazardous and harmful alcohol consumption and alcohol related problems in patients without alcohol dependence. Eight patients need to be advised for one patient to benefit. There is little evidence for a dose response effect and it does not seem that extended interventions are any more effective than brief interventions. The effectiveness is certainly maintained for up to one year. Brief interventions are also effective in reducing mortality. 282 patients need to receive advice to prevent one death within one year.	PHC physicians and other PHC professionals should offer at least a very brief (5 minute) intervention to all patients identified with hazardous or harmful alcohol consumption.
What are the components of effectiveness? Based on the contents of evaluated interventions, three	Interventions can be

essential elements of advice have been proposed, including feedback, the giving of advice and goal setting. There is mixed evidence to suggest interventions with more than one session are any more effective than one session alone. Motivational interviewing appears to be an effective intervention technique.	described with reference to the 5-As counselling framework: **assess** alcohol consumption; **advise** patients to reduce alcohol consumption; **agree** on individual goals; **assist** patients for behaviour change; and **arrange** follow-up.
What is the cost effectiveness of brief interventions? At a cost of €1960 per year of ill-health and premature death prevented, PHC brief interventions for hazardous and harmful alcohol consumption are amongst the cheapest of all medical interventions that lead to health gain. In other words, if a primary health care provider is going to undertake a new activity, giving brief advice to patients with hazardous and harmful alcohol consumption will give one of the best health benefits for the practice population than spending ten minutes doing anything else.	Within PHC activity and within the alcohol treatment field, there should be an urgent reorientation of resources to deliver identification and brief intervention programmes for hazardous and harmful alcohol consumption.

Key concepts

Hazardous Alcohol Consumption. Hazardous drinking is a pattern of alcohol consumption that increases the risk of harmful consequences for the user or others. Hazardous drinking patterns are of public health significance despite the absence of any current disorder in the individual user.

Harmful Alcohol Consumption. Harmful use refers to alcohol consumption that results in consequences to physical and mental health. Some would also consider social consequences among the harms caused by alcohol.

Risky drinking. This term is used as a synonimous of Hazardous Alcohol Consumption and is gaining increasing popularity even though it is not an accepted term by the WHO.

Alcohol Dependence. Alcohol dependence is a cluster of behavioural, cognitive, and physiological phenomena that may develop after repeated alcohol use4. Typically, these phenomena include a strong desire to consume alcohol, impaired control over its use, persistent drinking despite harmful consequences, a higher priority given to drinking than to other activities and obligations, increased alcohol tolerance, and a physical withdrawal reaction when alcohol use is discontinued.

Standard Drink Unit. A volume of beverage alcohol (e.g. a glass of wine, a can of beer, or a mixed drink containing distilled spirits) that contains approximately the same amounts (in grams) of ethanol regardless of the type of beverage. The term is often used to educate alcohol users about the similar effects associated with consuming different alcoholic beverages served in standard-sized glasses or containers (e.g. the effects of one glass of beer are equal to those of one glass of wine). In Europe, the term ''unit" is employed, where one unit of an alcoholic beverage contains approximately 10 grams of ethanol; in North American literature, ''a drink" contains about 12 grams of ethanol.

AUDIT. The Alcohol Use Disorders Identification Test is a questionnaire which consists of 10 questions about recent alcohol use, alcohol dependence symptoms, and alcohol-related problems. As the first screening test designed specifically for use in primary care it was developed and

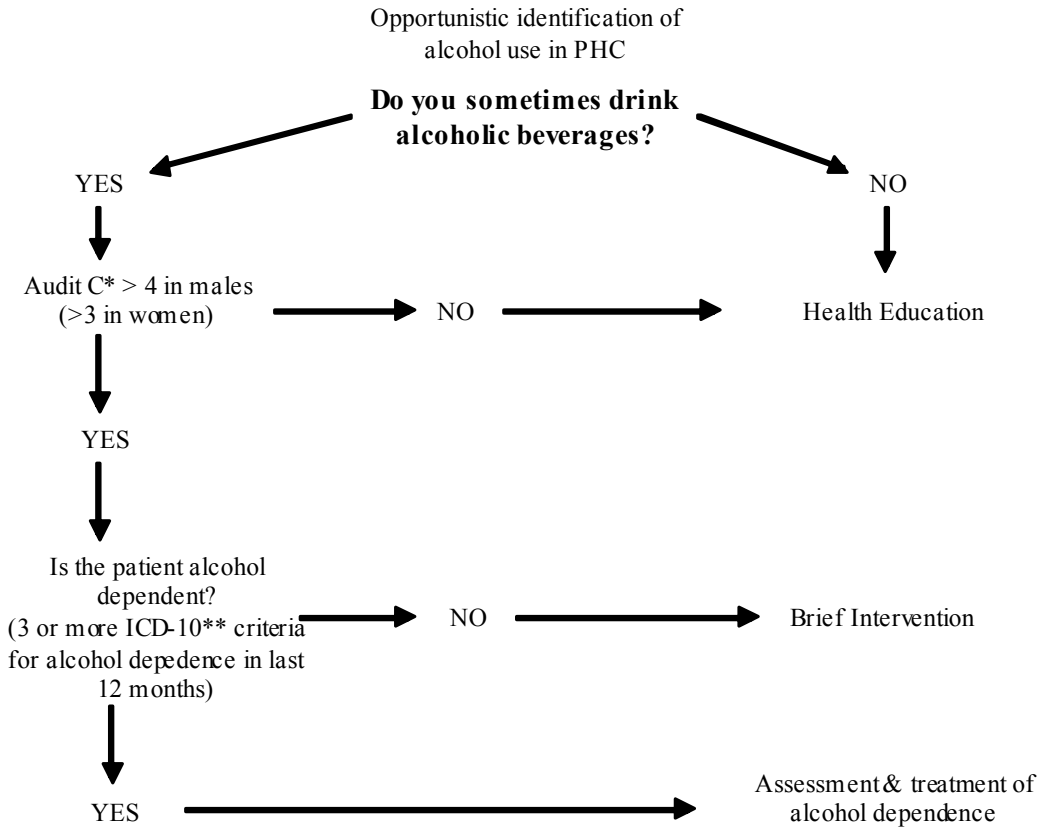
evaluated over a period of two decades, and it has been found to provide an accurate measure of risk across gender, age, and cultures settings.

AUDIT-C. It contains the first 3 questions of the Audit. Reliable to screen hazardous drinking in primary health care settings.

Brief Intervention. A treatment strategy in which structured therapy of short duration (typically 5-30 minutes) is offered with the aim of assisting an individual to cease or reduce the use of alcohol. It is designed in particular for general practitioners and other PHC workers. Also known as minimal intervention. Brief intervention is often linked to systematic screening testing for hazardous and harmful alcohol use.

How to do it

Step 1. SCREENING



*** AUDIT-C**

1: How often did you have a drink containing alcohol in the past year?
(0) Never; (1) Monthly or less; (2) 2-4 times a month; (3) 2-3 times per week; (4) 4 or more times a week.

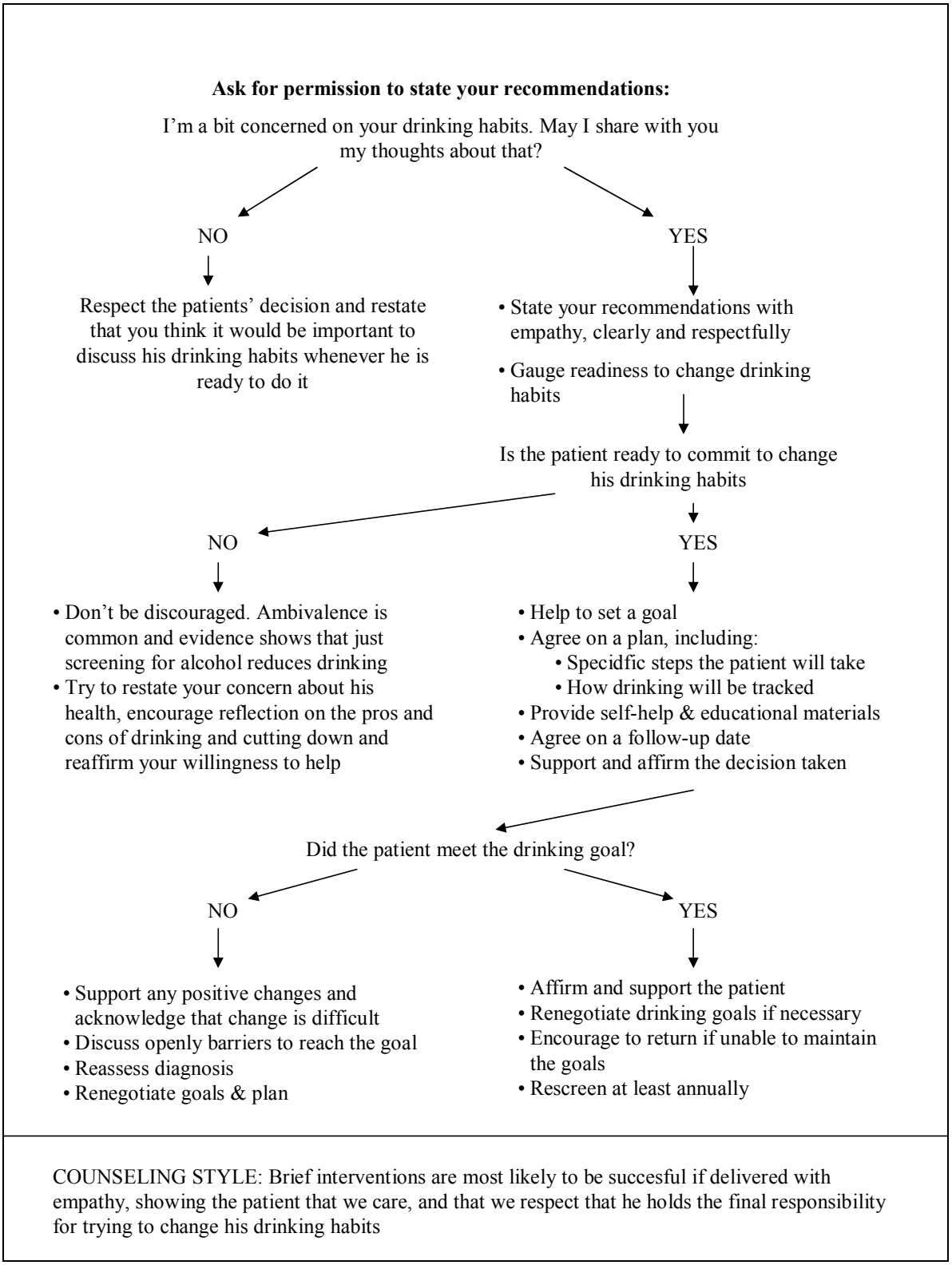
2: How many drinks did you have on a typical day when you were drinking in the past year?
(0) 1 or 2; (1) 3 or 4; (2) 5 or 6 ; (3) 7 to 9; (4) 10 or more.

3: How often did you have six or more drinks on one occasion in the past year?
(0) Never; (1) Less than monthly; (2) Monthly; (3) Weekly; (4) Daily or almost daily.

**** ICD-10 DEPENDENCE CRITERIA**
A definite diagnosis should be made only if 3 or more of the following have been present together at some time in the last 12 months:

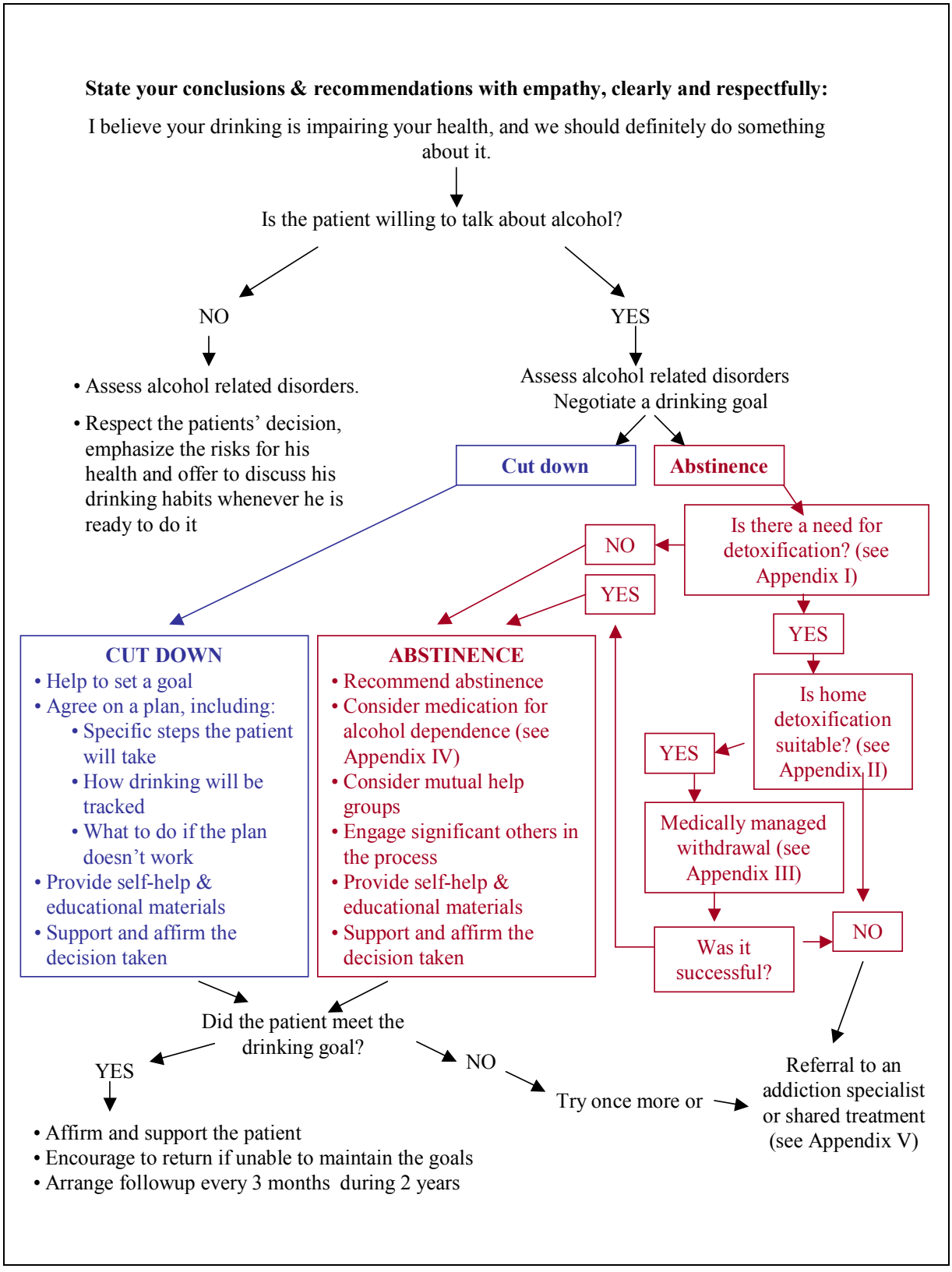
A strong desire or sense of compulsion to drink.
Difficulty in controlling drinking in terms of its onset, termination or level of use.
A physiological withdrawal state or drinking to relieve or avoid withdrawal symptoms.
Evidence of tolerance.
Progressive neglect of alternative pleasures or interests because of drinking.
Persisting with alcohol use despite awareness of overtly harmful consequences.

Step 2-A. BRIEF ADVICE FOR AT-RISK DRINKING



COUNSELING STYLE: Brief interventions are most likely to be succesful if delivered with empathy, showing the patient that we care, and that we respect that he holds the final responsibility for trying to change his drinking habits

Step 2-B. ASSESSMENT, TREATMENT AND REFERRAL FOR ALCOHOL DEPENDENCE



Appendix I. Is there a need for detoxification?

Detoxification Criteria

- Previous DT or seizures
- Morning withdrawal signs
- Drinking first thing in the morning
- Patient willing to take medication
- Actual withdrawal signs
- Severe physical condition

Appendix II. Is home detoxification suitable?

Conditions needed for outpatient detoxification

- Daily alcohol consumption below 25 standard drinks/day.
- No severe medical or psychiatric complications
- Patients commitment to:
- Alcohol abstinence during the detoxification.
- Staying at home
- Avoidance of risky activities.
- One relative without addictive problems must be responsible to control the medication and supervise the treatment.
- No availability of alcoholic beverages at home during the detoxification.
- Daily contact with GP or nurse (in person or by phone)

Contraindications for outpatient detoxification

- Confusion or hallucinations.
- History of previously complicated withdrawal.
- Epilepsy or history of fits.
- Poor nutritional state.
- Severe vomiting or diarrhoea.
- Risk of suicide.
- Severe dependence coupled with unwillingness to be seen daily.
- Failure of home-assisted withdrawal.
- Uncontrollable withdrawal symptoms.
- Acute physical or psychiatric illness.
- Polysubstance use.
- Home environment unsupportive of abstinence

Source: Scottish Intercollegiate Guidelines Network. The management of harmful drinking and alcohol dependence in primary care. A national clinical guideline. Draft 2.11, 2003.

Appendix III. Outpatient Detoxification tapering doses

	Diazepam, 5 mg cps.	
Dosage	Low	High
1	1-1-1	4-4-4
2	1-0-1	4-3-4
3	0-0-1	3-3-4
4	STOP	3-3-3
5		3-2-3
6		2-2-3
7		2-1-3
8		1-1-3
9		1-1-2
10		1-1-1
11		1-0-1
12		0-0-1
13		STOP

Appendix IV. Medication for alcohol dependence[1]

Whether or not a medication should be prescribed and in what amount is a matter between individuals and their health care providers. The prescribing information provided here is not a substitute for a provider's judgment in an individual circumstance.

	Disulfiram	Naltrexone	Acamprosate
Action	Inhibits intermediate metabolism of alcohol, causing a buildup of acetaldehyde and a reaction of flushing, sweating, nausea, and tachycardia if a patient drinks alcohol	Blocks opioid receptors, resulting in reduced craving and reduced reward in response to drinking	Affects glutamate and GABA neurotransmitter systems, but its alcoholrelated action is unclear
Contraindi-cations	Concomitant use of alcohol or alcoholcontaining preparations or metronidazole; coronary artery disease; severe myocardial disease	Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analgesics; acute hepatitis or liver failure	Severe renal impairment (CrCl ≤30 mL/min)
Common side effects	Metallic aftertaste; dermatitis	Nausea; abdominal pain; constipation; dizziness; headache; anxiety; fatigue	Diarrhea; flatulence; nausea; abdominal pain; headache; back pain; infection; flu syndrome; chills; somnolence; decreased libido; amnesia; confusion
Usual adult	250 mg daily	50 mg daily	666 mg / 8 hours

[1] Modified from Helping patients who drink too much. A clinician's guide. 2005 Edition.National Institute on Alcohol abuse and alcoholism. US.

dosage			
Before prescribing	At least 12 hours after drinking. A disulfiram alcohol reaction can occur up to 2 weeks after the last dose. Warn about alcohol in the diet, medications and toiletries. Increased efficacy when supervised	Evaluate for possible current opioid use; consider a urine toxicology screen for opioids, including synthetic opioids. Obtain liver function tests.	Establish abstinence
Followup	Monitor liver function tests periodically	Monitor liver function tests periodically	
Length of treatment	At least 3 months	At least 3 months	At least 6 months

Appendix V. Referral to an addiction specialist

When to refer to specialized treatment

- Previous unsuccessful treatment attempts
- Severe complications:
    - Risk of withdrawal symptoms from moderate to severe.
    - Serious medical illness.
    - Family unable to provide support.
    - Psychiatric co morbidity.
    - Regular use of other addictive substances.
- Treatment cannot be managed by the PHC team.

MINIMUM SKILLS FOR PROVIDERS[2]

This document summarizes the skills needed by a PHC professional in order to manage appropriately and effectively patients presenting with hazardous or harmful alcohol use or alcohol dependence. Those skills are divided into 7 different areas which cover the whole spectrum of activities related to the topic: general abilities, screening, assessment, treatment planning, counselling, referral and documentation skills. Based on this document, a **Minimum Skills List** will be agreed.

GENERAL SKILLS:

1. Recognize the social, political, economic, and cultural context within which alcohol use exists, including risk and resiliency factors that characterize individuals and groups and their living environments.
2. Describe the behavioral, psychological, physical health, and social effects of alcohol on the person using and significant others.
3. Recognize the potential for alcohol use disorders to mimic a variety of medical and mental health conditions and the potential for medical and mental health conditions to coexist with alcohol use.
4. Understand the established diagnostic criteria for alcohol use disorders, and describe treatment modalities and placement criteria within the continuum of care.
5. Describe a variety of helping strategies for reducing the negative effects of alcohol.
6. Be familiar with medical, psychological and pharmacological resources in the treatment of alcohol use disorders.
7. Recognize that crisis may indicate an underlying alcohol use disorder and may be a window of opportunity for change.
8. Understand the need for and use of methods for measuring treatment outcome.
9. Understand the importance of self-awareness in one's personal, professional, and cultural life.
10. Understand the obligation of the addiction professional to participate in prevention and treatment activities.

SCREENING SKILLS

1. Gather data systematically from the client and other available collateral sources, using screening instruments and other methods that are sensitive to age, developmental level, culture, and gender.
2. Screen for psychoactive substance toxicity, intoxication, and withdrawal symptoms; aggression or danger to others; potential for self-inflicted harm or suicide; and co-occurring mental disorders.
3. Assist the client in identifying the effect of alcohol on his or her current life problems and the effects of continued harmful use.
4. Determine the client's readiness for treatment and change as well as the needs of others involved in the current situation.

[2] This Criteria have been designed as a summarized adaptation of: Center for Substance Abuse Treatment. Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice. Technical Assistance Publication (TAP) Series 21. DHHS Publication No. (SMA) 06-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

ASSESSMENT SKILLS

1. Select and use a comprehensive assessment process that includes but is not limited to:
   - History of alcohol and drug use
   - Past and current status of physical health, mental health, and substance use
   - Education and basic life skills
   - Socioeconomic characteristics, lifestyle, and current legal status
   - Use of community resources
   - Treatment readiness
   - Level of cognitive and behavioral functioning.
2. Analyze and interpret the data to determine treatment recommendations.
3. Seek appropriate supervision and consultation.
4. Document assessment findings and treatment recommendations.

TREATMENT PLANNING SKILLS

1. Establish rapport, including management of a crisis situation and determination of need for additional professional assistance.
2. Review the treatment options that are appropriate for the client's needs, characteristics, goals, and financial resources.
3. Apply accepted criteria for diagnosis of alcohol use disorders in making treatment recommendations.
4. Construct with the client and appropriate others an initial action plan based on client needs, client preferences, and resources available.
5. Use relevant assessment information to guide the treatment planning process.
6. Explain assessment findings to the client and significant others.
7. Examine treatment options in collaboration with the client and significant others.
8. Consider the readiness of the client and significant others to participate in treatment.
9. Prioritize the client's needs in the order they will be addressed in treatment.
10. Formulate mutually agreed-on and measurable treatment goals and objectives.
11. Identify appropriate strategies for each treatment goal.
12. Develop with the client a mutually acceptable treatment plan and method for monitoring and evaluating progress.
13. Reassess the treatment plan at regular intervals or when indicated by changing circumstances.

COUNSELING SKILLS

1. Establish a helping relationship with the client characterized by warmth, respect, genuineness, concreteness, and empathy.
2. Facilitate the client's engagement in the treatment and recovery process.

3. Work with the client to establish realistic, consistent, achievable goals.
4. Promote client knowledge, skills, and attitudes that contribute to a positive change in alcohol use behaviors.
5. Encourage and reinforce client actions determined to be beneficial in progressing toward treatment goals.
6. Work appropriately with the client to recognize and discourage all behaviors inconsistent with progress toward treatment goals.
7. Recognize how, when, and why to involve the client's significant others in enhancing or supporting the treatment plan.
8. Facilitate the development of basic and life skills associated with recovery.
9. Adapt counseling strategies to the individual characteristics of the client, including but not limited to disability, gender, sexual orientation, developmental level, culture, ethnicity, age, and health status.
10. Make constructive therapeutic responses when the client's behavior is inconsistent with stated goals.
11. Facilitate the client's identification, selection, and practice of strategies that help sustain the knowledge, skills, and attitudes needed for maintaining treatment progress and preventing relapse.

REFERRAL SKILLS

1. Continuously assess and evaluate referral resources to determine their appropriateness
2. Arrange referrals to other professionals, agencies, community programs, or appropriate resources to meet the client's needs.
3. Explain in clear and specific language the necessity for and process of referral to increase the likelihood of client understanding and follow-through.
4. Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality rules and regulations and generally accepted professional standards of care.
5. Evaluate the outcome of the referral.

DOCUMENTATION SKILLS

1. Demonstrate knowledge of accepted principles of client record management.
2. Protect client rights to privacy and confidentiality in the preparation and handling of records, especially in relation to the communication of client information with third parties.
3. Prepare accurate and concise screening, intake, and assessment reports.
4. Record treatment and continuing care plans that are consistent with agency standards and comply with applicable administrative rules.
5. Document treatment outcome, using accepted methods and instruments.

QUALITY ASSESSMENT CRITERIA

At an individual level the quality of interventions concerning alcohol use of patients should be measured both through quality and quantity indicators.

Qualitative measures

Those criteria try to measure the knowledge, skills and attitudes of PHC professionals concerning alcohol.

- Measurement of knowledge: PHC professionals should answer correctly at least 70% of the questions of a multiple choice questionnaire. The questionnaire will contain 20 questions on SDU contents, validated screening tools, components of brief interventions, basic motivational principles, assessment of alcohol dependence and referral criteria.
- Measurement of attitudes: Attitudes of PHC professionals will be measured through an adapted version of the SAAPPQ. A score above ?? for role security and a score above ?? for therapeutic commitment should be obtained.
- Measurement of skills: Skills of PHC professionals will be evaluated using audiotaped or videotaped interventions, or through direct observation, using the MITI (Motivational Interviewing Treatment Integrity Code). A score above 4 in the empathy scale should be obtained.

Quantitative measures

- Rate of general screening, defined as the percentage of patients attending the consultation who are asked about their alcohol use through a validated instrument (ie, Audit, Audit-C, etc).
- Rate of high risk group screening, defined as the percentage of patients attending the consultation and included in a defined high risk group (adolescents, pregnant women, etc) who are asked about their alcohol use through a validated instrument (ie, Audit, Audit-C, etc).
- Rate of screening of new patients, defined as the percentage of new patients attending the consultation who are asked about their alcohol use through a validated instrument (ie, Audit, Audit-C, etc).
- Rate of interventions, defined as the percentage of identified patients (hazardous, harmful and dependent drinkers) who receive counseling, treatment or appropriate referral.
- Rate of documentation, defined as the percentage of medical records that contain clear information on the drinking habits of the patient

At a multidisciplinary team level, the assessment of quality should be done taking into account the percentage of professionals who accomplish the criteria stated above. There is a need to agree on what are the desirable levels, the acceptable levels, and the expected increase in SBI activity per year of implementation.

QUALITY ASSESSMENT PROTOCOL

Quality assessment training

Criteria to measure the knowledge, skills and attitudes of PHC professionals concerning alcohol:

- Measurement of knowledge: PHC professionals should answer correctly at least 70% of the questions of a multiple choice questionnaire. The questionnaire will contain 20 questions on SDU contents, validated screening tools, components of brief interventions, basic motivational principles, assessment of alcohol dependence and referral criteria.
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Based on Clinical Guidelines on Identification and Brief Interventions

Practice based protocols

The clinical guidelines recommend the introduction of practice based systems, including identification tools, protocols and aids and computerized support.

Quality assessment criteria

- The presence of a practice based protocol that includes:
- Who to screen for hazardous and harmful alcohol consumption
- What identification instrument to use
- Cut off criteria for assessment
- Cut off criteria for brief advice
- Main elements of brief advice
- Cut off criteria for brief counselling
- Main elements of brief counselling
- Cut off criteria for referral for specialist help

Use of an identification instrument

The clinical guidelines recommend the use of the first three questions of the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT-C).

Quality assessment criteria

Documentation of which validated identification instrument is used

Fuller assessment

The clinical guidelines recommend that male patients who score 5 or more with the AUDIT-C, or whose alcohol consumption is 210g of alcohol or more per week and female patients who score 4 or more with the AUDIT-C, or whose alcohol consumption is 140g of alcohol or more per week should be invited to complete the full ten item AUDIT for a fuller assessment.

Quality assessment criteria

- Documentation of which assessment instrument is used
- A review or audit of patient records (paper or electronic) of proportion of identification instrument positives that have documentary evidence of fuller assessment, and numerical recording of result of assessment, if relevant.

Identification of hazardous and harmful alcohol consumption

The clinical guidelines suggest a range of options for identifying hazardous and harmful alcohol consumption:

All patients by receptionist, nurse or physician;

All patients during certain time periods, for example, one month every 6 months;

All new patient registrations;

For certain age groups, for example middle aged men;

For patients with specified symptoms, diagnoses, signs and laboratory test results, or those who attend special clinics (e.g. for cardiovascular diseases or depression).

Quality assessment criteria

- According to option adopted for identifying hazardous and harmful alcohol consumption, a review or audit of patient records (paper or electronic) of proportion of denominator with numerical recording of alcohol consumption or of result of screening test.

Brief advice

Quality assessment criteria

- A review or audit of patient records (paper or electronic) of proportion of identification/assessment instrument positives that have documentary evidence of brief advice having been given, related to numerical result of assessment, if relevant.
- If resources permit, video-recording of consultation, with objective assessment of clinical skills, including Giving Feedback, Providing Information, Enabling a goal to be established, Giving Advice on Limits, and Providing Encouragement

Brief counselling

Quality assessment criteria

- A review or audit of patient records (paper or electronic) of proportion of identification/assessment instrument positives that have documentary evidence of brief counselling having been given, related to numerical result of assessment, if relevant.
- If resources permit, video-recording of consultation, with objective assessment of clinical skills, including Giving Brief Advice, Assessing and Tailoring Advice to Stage of Change and providing Follow-up.

Assessing and managing alcohol dependence

Quality assessment criteria

- A review or audit of patient records (paper or electronic) of proportion of patients positive for alcohol dependence based on the results of an identification/assessment instrument or clinical assessment that have documentary evidence of management of alcohol dependence or referral related to numerical result of assessment, if relevant.

CURRICULA FOR PHC PROFESSIONALS [3]

These education guidelines are intended to assist in establishing educational programs that will produce family physicians with clinical competence in the treatment of alcohol use disorders.

The knowledge, skills and attitudes concerning alcohol use disorders should be taught in both experiential and didactic format. With their own panel of continuity patients, Family Physicians should be able to demonstrate competence in screening, assessment, intervention with families and individuals, and referral. Family Physicians should also demonstrate competence in the primary prevention of alcohol use disorders, particularly for children, adolescents, and pregnant women.

Attitudes

A. Family Physicians shall understand that:
    1. Alcohol problems are preventable, diagnosable and treatable. These problems are chronic, commonly relapse and remit, and are both individual and family diseases.
    2. Like people with other medical problems, individuals and families with alcohol use disorders are to be respected, supported and treated by their family physicians.
    3. It is important to work with family members as a unit of care in the management of alcohol use disorders.
    4. Expressions of denial, dishonesty, anger, irrationality and other potentially offensive behaviors are often inherent symptoms of alcohol use disorders, to be expected, understood, accepted and managed by family physicians.
    5. Family physicians, working in concert with other medical and mental health professionals and lay self-help groups, can maximize the effectiveness of treatment for alcohol use disorders.

B. Family Physicians shall be aware of their own attitudes, their personal and family experiences, and the potential implications of these on the therapeutic relationship.

Knowledge

Family Physicians shall recognize:

A. The epidemiology of alcohol use disorders and its impact on society, including:
    1. Overall prevalence
    2. Risk factors for hazardous, harmful alcohol use and dependence
    3. Contribution to major causes of morbidity and hepatitis mortality by age groups, including cardiovascular disease, cancer, hepatitis, cirrhosis, homicide, suicide, motor vehicle accidents, trauma and acquired immune deficiency syndrome (AIDS).
    4. Association with family dysfunction, child and spousal abuse, violence and crime
    5. Risks to children and adolescents with parents who abuse alcohol

B. A practical definition of alcohol use disorders with reference to:

[3] This document is based on the Recommended Curriculum guidelines of the American Academy of Family Physicians (http://www.aafp.org/online/en/home/aboutus/specialty/rpsolutions/eduguide/substanceuse.html)

1. Cultural and subcultural norms
2. Tolerance and withdrawal

C. The disease concept of substance use disorders, including information on:
   1. Criteria for distinguishing hazardous, harmful use, and dependence
   2. The similarity of substance abuse to other chronic medical diseases
   3. Application of the disease concept in facilitating patient acceptance of a diagnosis and appropriate treatment

D. Familiarity with effective prevention strategies and an understanding that strategies may be primary (trying to dissuade starting), secondary (trying to curb early use before organic disease begins) and tertiary (trying to minimize the consequences of existing organic disease)

E. The natural history of alcohol use disorders

F. Relevant pharmacology, including:
   1. Concepts of tolerance, cross-tolerance, physical dependence, psychologic dependence, addiction and withdrawal
   2. Pharmacologic equivalents of various alcoholic beverages and the dose-response effect of alcohol on psychomotor skills including driving
   3. Presence of alcohol in commonly used medications
   4. Appropriate prescribing of potentially addictive medications, include opioid analgesics, sedative-hypnotics, and stimulants, with methods of monitoring for and preventing diversion, abuse, and addiction

G. Signs and symptoms of early and later alcohol use disorders, including:
   1. Psychosocial and behavioral changes in the individual and the family
   2. Symptoms, physical signs and laboratory evidence (e.g., chronic liver disease, track marks)
   3. Co-morbid biomedical and psychiatric diagnoses: Anxiety disorders, depression, hypertension, diabetes, hepatitis C, pancreatitis

H. Information on treatment and its effectiveness, including:
   1. Different stages of alcohol use disorders and the relevant goals of treatment at each stage
   2. The potential advantage and disadvantages of various treatment modalities including:
      a. Brief office interventions with patients and families
      b. Lay, self-help groups for persons affected with a substance use disorder and their families (e.g., 12-step programs)
      c. Professionally administered psychotherapies for individuals, families and groups
      d. Inpatient treatment programs
      e. Pharmacologic treatment, including management of withdrawal, pharmacotherapy of addiction and treatment for coexisting biomedical and psychiatric disorders

3. Outcomes of different treatment modalities - e.g., harm reduction, abstinence based programs, family systems

I. Special considerations in prevention, diagnosis, and treatment for:
   1. Pregnant women
   2. Children and adolescents
   3. Elderly
   4. Homeless
   5. Cultural groups represented in the residency's patient population
   6. Children in families with a history of alcohol and/or substance abuse disorders

J. Legal and ethical issues concerning:
   1. Confidentiality of medical records
   2. Laws regarding driving and alcohol use disorders

Skills

Family Physicians will demonstrate skills in the following areas:

A. Prevention
   1. Providing primary prevention as appropriate, especially for children and adolescents with a substance abusing parent, women contemplating pregnancy and persons at particular risk for, alcohol problems

B. Screening with appropriate instruments:
   1. All patients for alcohol use

C. Assessment
   1. Social, psychologic and physical problems in patients who screen positive for hazardous drinking or for alcohol abuse or dependence
   2. Readiness to change in all patients with hazardous or harmful, alcohol use

D. Treatment, office-based:
   1. Brief intervention
      a. With a goal of secondary prevention in persons with hazardous drinking but without symptoms and signs of alcohol dependence
      b. With a goal of abstinence, harm reduction or referral for further treatment in patients with alcohol dependence
   2. Motivational interviewing to facilitate behavior changes
   3. Inclusion of family in assessment and initial treatment

E. Pharmacotherapy and medical management
   1. The management of alcohol intoxication, and withdrawal
   2. The management of biomedical complications of alcohol use

F. Referral to specialized treatment programs and other community resources

G. Care of affected family members.

FACT SHEETS ON EIBI AIMED AT POLICY MAKERS

Alcohol: Health Care Advice

Background

The European Union is the region of the world with the highest levels of alcohol consumption per population (WHO 2004). 55 million European adults drink to dangerous levels.

Alcohol is the third greatest contributor to ill health and premature death after smoking and high blood pressure. **Hazardous** and **harmful** alcohol consumption is a leading cause of disability and premature death in Europe, leading to considerable costs and workload for the healthcare sector and harm to both adults and children.

The contribution of the *WHO Collaborative Project on Detection and Management of Alcohol-related Problems in Primary Health Care* has been essential in the last 25 years (1982-2007) for the development of Brief Interventions on alcohol problems. With the participation of 11 European countries and Australia, the project has contributed to the development of AUDIT, a reliable and valid screening instrument for detecting hazardous and harmful drinkers in primary health care (PHC), to show the efficacy of the SBI tools, to learn the best way to encourage the uptake and utilisation of the screening and brief intervention package by PH professionals and to demonstrate how to implement such programmes in real "country" conditions.

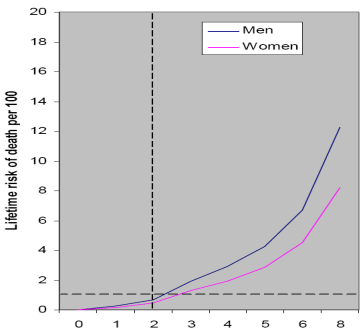
More recently the EU-funded *Primary Health Care European Project on Alcohol* (PHEPA) (2002-2008) while sharing the goal of achieving routine implementation of EIBI in PHC, entails the development and roll-out of four related products: (i) clinical guidelines (ii) a training manual (iii) a website containing an *Alcohol Management Database* for use by PHC professionals and others interested in the promotion of EIBI in primary care; and (iv) country-based strategies aimed at integrating EIBI for hazardous and harmful drinkers in the PHC systems of participating countries. Another WHO Collaborative Project seeks to disseminate brief interventions in the PHC systems of developing countries and a start has been made in South Africa and Brazil. Finally, an international network was formed (International Network on Brief Interventions for Alcohol Problems: INEBRIA) to share ideas and increase communication among researchers and practitioners interested in alcohol EIBI.

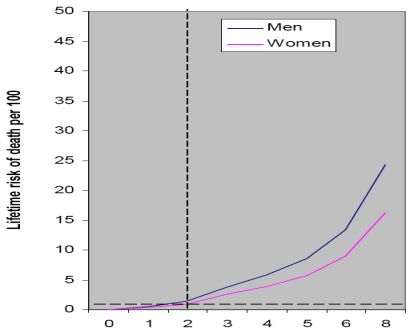
In addition to their achievements all these projects have contributed to an international movement dedicated to reducing alcohol-related harm by achieving the widespread, routine and enduring implementation of EIBI for hazardous and harmful alcohol consumption, a movement that is steadily gathering momentum.

- *Advice to people at risk by doctors or nurses in primary health care is an action area described as good practice and effective to prevent alcohol-related harm among adults – **EU strategy to support Member States in reducing alcohol-related harm**, 2006.*
- Health professions need to play an active role and be supported by health authorities to implement screening and brief intervention for hazardous drinking - Core areas and instruments for national action listed in the ***Framework for alcohol policy in the WHO European Region**, 2006.*
- Early identification and effective treatment in health-care settings of alcohol-use disorders, including in patients with co-morbid conditions, is proposed as a target area within the health sector response to reduce associated morbidity and mortality and improve the well-being of affected individuals and their families. Towards a global strategy on harmful use of alcohol ***Resolution WHA61.4 - Strategies to reduce the harmful use of alcohol***, 2008.

Describing alcohol consumption and alcohol related harm

Alcohol consumption can be described in terms of grams of alcohol consumed or in terms of standard drinks, where, in Europe, a standard drink commonly contains 10g of alcohol.





In the National Health and Medical Research Council study, the risk of alcohol-attributable injury death is more than 1 in 100 if a person drinks more than 2 drinks per occasion. The guideline for low risk of both immediate and long-term harm from drinking for men and women is 2 drinks (20g alcohol) or less in any one day.
It represents a drinking level that, for healthy adults, will reduce the lifetime risk of death from an alcohol-related injury or disease to less than 1 in 100.

Hazardous: >40g/day (♂)
>20g/day (♀)
Heavy episodic drinking: >60g per occasion

Hazardous alcohol consumption is a level of consumption or pattern of drinking that is likely to result in harm should present drinking habits persist; however, there is no standardized agreement for the level of alcohol consumption that should be taken as hazardous drinking, and, for many conditions, any level of alcohol consumption can carry risk.

Harmful drinking is defined (ICD-10 Classification of mental and behavioural disorders) as 'a pattern of drinking that causes damage to health, either physical (such as liver cirrhosis) or mental (such as depression secondary to alcohol consumption)'.

Alcohol dependence is a cluster of physiological, behavioural, and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that once had greater value.

Identifying hazardous and harmful alcohol use

AUDIT is effective in the identification of hazardous and harmful drinking in adults in primary care. Optimal screening thresholds for the detection of hazardous or harmful drinking using AUDIT appear to be ≥7 or ≥8 among men and ≥6 to ≥8 among women.

Shorter versions of AUDIT are effective in the identification of hazardous and harmful drinking in adults in primary care . The optimal screening threshold for the detection

AUDIT-C
How often did you have a drink containing alcohol in the past year? (frequency of drinking)
(0) Never; (1) Monthly or less; (2) 2-4 times a month; (3) 2-3 times per week; (4) 4 or more times a week.
How many drinks did you have on a typical day when you were drinking in the past year? (amount of alcohol consumed on an average drinking day)
(0) 1 or 2; (1) 3 or 4; (2) 5 or 6; (3) 7 to 9; (4) 10 or more. **How often did you have six or more drinks on one occasion in the past year?** (frequency of episodic heavy drinking)
(0) Never; (1) Less than monthly; (2) Monthly
(3) Weekly; (4) Daily or almost daily.

of hazardous drinking using AUDIT-C was ≥3 among men and women.

How to do it?

Ask the first three questions of the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT-C) incorporated into routine clinical practices and systems such as systematically asking all new patients when they register or when they attend for a health check Biochemical tests for alcohol use disorders are not useful for screening because elevated results have poor sensitivity, identifying only a small proportion of patients with hazardous or harmful alcohol consumption.

To whom?

Screen all adult patients for hazardous and harmful alcohol consumption, including patterns of episodic heavy drinking but if such an approach is not feasible, limiting screening to high risk groups (young to middle aged males; 18-44 years) or to some specific situations (pregnancy, or people with an illness or attending a clinic, for example, hypertension etc.) may be a feasible option.

How often?

There is no evidence to determine how frequently the measurement of hazardous and harmful alcohol consumption should be undertaken, but, unless there is a clinical reason, it probably should not be more often than once every four years. However it has not been found that systematic identification of hazardous and harmful alcohol consumption lead to adverse effects, such as discomfort or dissatisfaction amongst patients.

When to offer advice?

Brief interventions are defined as advice provided in primary health care that involves a small number of education sessions and psychosocial counselling.

Brief intervention framework

assess alcohol consumption with a brief screening tool followed by clinical assessment as needed;
advise patients to reduce alcohol consumption to moderate levels;
agree on individual goals for reducing alcohol use or abstinence (if indicated);
assist patients with acquiring the motivations, self-help skills, or supports needed for behaviour change;
and **arrange** follow-up support and repeated counselling, including referring dependent drinkers for specialty treatment.

Primary health care professionals should offer brief advice

(♂) Male patients who score:

- 5 or more with the AUDIT-C,
- 8-15 with the full AUDIT (patients scoring 16 or higher may need more intensive help)
- or whose alcohol consumption is 280g of alcohol or more per week

(♂) Female patients who score:

- 4 or more with the AUDIT-C,
- 8-15 with the full AUDIT (patients scoring 16 or higher may need more intensive help)
- or whose alcohol consumption is 210g of alcohol or more per week.

Effectiveness of Brief Interventions

Brief advice heads the list of evidence-based treatment methods (Mesa Grande Study) and behavioural skill training and pharmacotherapy dominate the remainder of the top 10 list of treatment methods supported by controlled trials (Ref).

There is a very large body of research evidence on alcohol brief advice, all reaching conclusions which favour the effectiveness of brief advice in reducing alcohol consumption to low-risk levels among hazardous and harmful drinkers.

Alcohol intervention in primary care contexts results in significant reductions in weekly consumption for men (average drop of about 6 standard drinks per week) but not for women (although this may be partly due to low statistical power) (*Kaner et al. 2008*).

Even very brief interventions may be effective with little evidence for an additional positive impact resulting from an increased dose of intervention.

There is mixed evidence of **longer-term effects** of brief advice. Effectiveness is certainly maintained for up to one year and maybe for up to four years. There are some continuing benefits for alcohol use, binge drinking episodes and frequency of excessive drinking for intervention groups 4 years after intervention (Fleming *et al.* 2002) but these do not last more than 10 years (Wutzke *et al.* 2002). Booster sessions would be necessary to maintain the effect over this period of time.

There is evidence that brief advice significantly reduces hospital days and admissions, mortality and absenteeism. In the study of *Kristenson et al. 2002* up to 50% reduction in all cause mortality was observed over six years and maintained at 10-16 years follow-up.

Brief interventions appear to be to similarly effective for young and old. They appear to be more effective for less serious problems. The evidence to date suggests that interventions during pregnancy are less effective.

Costs and cost effectiveness of brief interventions

Brief interventions in primary care settings are cost-effective. It has been estimated that for every 1,000 patients cared for by a general practitioner, it would cost €2200 a year on average throughout the European Union to set up and maintain an identification and brief intervention programme.

It has also been estimated that at a cost of €1900 per year of ill-health and premature death prevented, primary health care brief interventions for hazardous and harmful alcohol consumption are amongst the cheapest of all medical interventions that lead to health gain. In other words, if a primary health care provider is going to undertake a new activity, giving brief advice to patients with hazardous and harmful alcohol consumption will give one of the best health benefits for the practice population than spending ten minutes doing almost anything else.

Cost effectiveness

The WHO CHOICE model found that brief advice programmes delivered to 30% of the at risk population was cost effective in all regions of the world, varying from I$2000 per DALY saved in western pacific countries such as China, to I$2600 in eastern European countries, such as Russia, to I$3800 in south American countries, such as Brazil (6). Applying this to the E.U. gives an estimated 408,000 years of disability and premature death avoided at an estimated cost of €740 million each year.

Implementing identification and brief intervention programmes

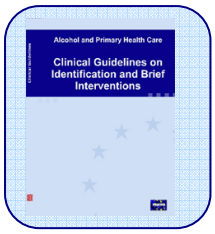
In Phase III of the WHO Collaborative project on how to implement programs on detection and Management of Alcohol Problems in Primary Health Care it was concluded that "to increase the experience and effectiveness of general practitioners in working with alcohol problems, both education and training and provision of a supportive working environment to improve confidence and commitment are required".

General practitioners who work in a supportive work environment *-one in which identification and counselling materials, training and support with difficult cases were all available* -feel more positive – secure and committed about working with alcohol problems; they advise and manage a greater number of patients.

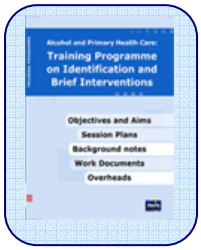
Providing training and giving practice-based support works, (with even limited support of one practice visit and ongoing telephone advice) increasing identification and counselling rates of primary health care providers by nearly one half, whereas the simple provision of guidelines is likely to have little effect. Both appear equally effective, but providing both is more effective than either alone. It does not necessarily seem that more intensive support is better but unless the support is geared to the needs and attitudes of the general practitioners, it will not work and over the long term it may even have a detrimental effect.

The provision of specialist help increases the activity of primary and secondary health care providers.

The demonstration projects of the Phase IV of the collaborative project entitled "*Development of Countrywide Strategies for Implementing Early Identification and Brief Intervention in Primary Health Care"* reflected the need by governments to recognise the full extent of alcohol-related harm and to persuade authorities to include alcohol EIBI in health promotion campaigns and strategies and in plans for the regulation and reimbursement of PHC activity.



The PHEPA project, a continuation of the previous project, has contributed to the integration of health promotion interventions for hazardous and harmful alcohol consumption into primary health care professionals' daily clinical work by raising awareness of alcohol-related issues, especially in the area of risky drinking, by enhancing the PHC skills in the management of alcohol-related issues and providing policy makers and health authorities with tools (guidelines, training materials, database, assessment tool and country strategies, etc.) that allow them to promote the dissemination of SBI techniques in PHC settings.



Questions for Consideration by Policy Makers

? What problems does drinking bring to PHC?

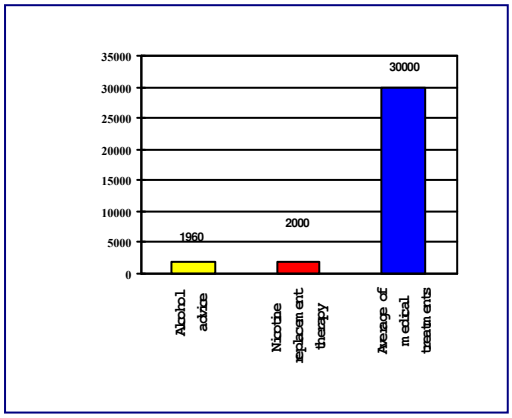
More than 60% of adults visit their GP at least once a year and these visits represent an opportunity to identify individuals who may be using alcohol at hazardous and harmful levels and offer brief advice.

However, BI are rarely embedded in routine clinical practice by health care providers. Only a small proportion (1 in 80) of hazardous and harmful drinkers and (1 in 20) dependent drinkers are being identified in primary care and few patient records (8%) contain any indication that alcohol use was recorded.

While denial and resistance are sometimes encountered from persons with alcohol dependence, harmful and hazardous drinkers are rarely uncooperative. On the contrary, experience indicates that almost all patients are cooperative, and most are appreciative when health workers show an interest in the relationship between alcohol and health. In general, patients perceive alcohol screening and brief counseling as part of the health worker's role, and rarely object when it is conducted according to the recommended procedures.

? What are the costs to the health services?

At a cost of €1900 per year of ill-health and premature death prevented, primary health care interventions for hazardous and harmful alcohol consumption are amongst the cheapest of all medical interventions that lead to health gain. In words, if a primary health care provider is going to undertake a new activity, giving brief advice to patients with hazardous and harmful alcohol consumption will give one of the best health benefits for the practice population than spending minutes doing anything else.



brief

other

ten

? What are the costs of implementation?

It has been estimated that for every 1,000 patients cared for by a general practitioner, it would cost €2200 a year on average throughout the European Union to set up and maintain an identification and brief intervention programme, a total cost to the Union of some €800 million.

DALYs prevented per 100,000 population:	
Taxation (current + 40%)	137
Random Breath Testing (RBT)	25
Restricted access (sales)	25
Advertising ban	46
Brief physician advice (25% coverage)	95

At an intervention cost of €220,000 per 100,000 population, the World Health Organization has estimated that brief physician advice with 25% coverage would save 95 years of ill-health and premature death (DALY) per 100,000 population, 9% of all ill-health and premature death caused by alcohol. Less than current taxation with a 40% tax increase, but more than the introduction of random breath testing, restricting sales of alcohol and banning advertising.

? What are the benefits of implementation?

Screening and brief intervention programmes lead to reductions in hazardous and harmful alcohol consumption, reductions in the harm done by alcohol, and reductions in deaths. A very conservative estimate found that for one adult patient to benefit 385 need to be screened, much more efficient than screening for hypertension (1250) or for colorectal cancer (3300). Eight patients with hazardous and harmful alcohol consumption need to be advised for one patient to benefit, twice as efficient as brief advice for smoking cessation. Brief interventions also save lives, *282 patients need to receive advice to prevent one death within one year (ref).*

? What is the cost effectiveness of interventions?

In one US study, the average per subject benefit of intervention was estimated as US$1151, comprised of savings in emergency department and hospital use (US$531) and savings in crime and motor vehicle accidents (US$620) (Fleming *et al.* 2000). The average cost of the intervention was US$205 per subject, representing a benefit cost ratio of 5.6:1.

The benefit-cost analysis of the 48 month follow-up suggested a $43,000 reduction in future health care cost for every $10,000 invested in the early intervention (Fleming *et al.* 2002). The benefit-cost ratio increased when including the societal benefits of fewer motor vehicle events and crimes. Another US study compared the cost-effectiveness of a strategy of alcohol screening and intervention to a strategy of no screening (Kraemer et al 2004). They found that screening and intervention yielded savings of $300 and prevented 0.05 years of ill-health and premature death per man or woman screened.

? How should training be delivered?

Unless the training and support is geared to the needs and attitudes of the general practitioners, it will not work and over the long term it may even have a detrimental effect. In the WHO Phase III study it was found that physicians' initial attitudes affected the relationships between training and support in identification and brief intervention and subsequent changes in attitudes. Training and support only increased identification and brief intervention rates for those who were already role secure and therapeutically committed. Both role security and therapeutic commitment deteriorated over the course of the study. Providing support did not improve subsequent role security and therapeutic commitment and for those who were already role insecure and therapeutically uncommitted, actually made their role security and therapeutic commitment worse. The experience of identification and brief intervention did not increase role security and therapeutic commitment. For those who were already role insecure, the experience of brief interventions actually made role security worse.

Thus, in the absence of role security and therapeutic commitment, the impact of professionally and organizationally based programmes is considerably diminished. Although the importance of acquiring experience of dealing with drinking problems in a supportive environment has been emphasized as a crucial element in securing professional commitment for the detection and management of alcohol problems, unless the emotional responses of the general practitioners are taken into account, the impact of such support will not achieve its full potential.

? Are guidelines and other support materials important?

Yes but especially if provided in combination with training and a supportive working environment. Providing training and giving practice-based support materials works increasing identification and counselling rates of primary health care providers by nearly one half, whereas the simple provision of guidelines is likely to have little effect.

In this context, the introduction of practice-based systems, including identification tools, protocols and aids and computerized support increases identification rates and increases advice giving rates.

Integrated evidence-based guidelines for brief advice on hazardous and harmful alcohol consumption should be developed and implemented upwardly to harmonize the quality and accessibility of care.

It does not necessarily seem that more intensive support is better than less intensive support. Promising programmes are those that have a specific focus on alcohol, and those that combine both educational and office based interventions.

? Is funding important, and how?

Within primary health care activity and within the alcohol treatment field, there should be an urgent reorientation of resources to deliver identification and brief intervention programmes for hazardous and harmful alcohol consumption.

There are strong financial and health arguments as to why financers of health services should provide funding for primary care based identification and brief intervention programmes for hazardous and harmful alcohol consumption.

? How should it be monitored?

The Phepa project developed an assessment tool aimed at monitor the adequacy of brief intervention programmes for hazardous and harmful alcohol consumption. It comprises five dimensions, defined and structured by the Ottawa Charter for Health Promotion[44], public health, supportive environments, personal skills, community action and health care systems.

Using the tool provides a baseline measurement of services for managing hazardous and harmful alcohol consumption, identifying areas where services may require development or strengthening; provides a mechanism for monitoring service provision over time; allows sharing of information and examples of practice between countries and regions; and provides a mechanism for coalitions or partnerships to discuss and have a shared view on services for managing hazardous and harmful alcohol consumption.

Key Facts

Alcohol is a leading cause of ill-health and death in the EU

- Alcohol is the 3rd leading risk factor for ill-health and death in the EU
- 7.4% of all ill-health and premature death in the EU is due to alcohol
- 55 million European adults drink to dangerous levels
- For age15-29yrs 25% of all male deaths and 11% of all female deaths are due to alcohol
- 80million Europeans aged 15 years plus reported binge drinking at least once a week in 2006
- Some 23 million Europeans are dependent on alcohol in any year

Health risks

Alcohol, cancer and vascular disease

- Alcohol is a carcinogen, causing cancer of the oral cavity and pharynx, oesophagus, stomach, colon, rectum and breast, with no safe level.
- Persistent use damages the liver and can lead to liver cirrhosis or cancer
- Alcohol increases the risk of stroke, and, in high doses, coronary disease and heart failure

Alcohol and risk taking, violence, accidents and injury

- Alcohol intoxication increases the risk of unsafe sex therefore increasing transmission of sexually transmitted infections and unwanted pregnancies
- 4 of every 10 homicides in the EU (>2000) are attributable to alcohol 10 000 suicides a year (1 in 6) are attributable to alcohol

Alcohol and pregnancy

- Alcohol is a teratogen, affecting the development of the baby.
- Drinking during pregnancy can damage the foetus and increase the risk of miscarriage
- Each year in the EU approx. 60 000 babies are born below normal birth weight due to alcohol

Alcohol and children/young people

- Brain development in young people and children is damaged by alcohol use
- Alcohol is estimated to be the cause of 16% of cases of child abuse
- Over 1 in 8 of 15-16 yr olds have been drunk more than 20 times in their life

GUIDANCE FOR GPS

Author; Rolande Anderson (ICGP, Ireland)

Context - What is EIBI? Why EIBI? (efficacy of EIBI and the extent of the problem)

EIBI = Early Identification and Brief Intervention

Alcohol is a drug of dependence. The European Union is the region within the World with the highest proportion of drinkers and with the highest levels of alcohol consumption per population. It has been estimated that at least fifteen percent of the adult population drink at hazardous levels and approx six per cent drink at harmful levels. It may be considerably higher. Alcohol is the cause of at least 60 different types of diseases and conditions including accidents and injuries, psychiatric (especially depression) and behavioural disorders, gastrointestinal conditions, cancers, cardiovascular diseases, immunological disorders, lung diseases, muscular and skeletal disorders, reproductive disorders and pre-natal harm (especially fetal alcohol syndrome disorders). Alcohol is also a principal cause of social type harm including absenteeism, street and domestic violence and other crime and road traffic accidents. Alcohol can devastate families and cause family members to have a wide variety of alcohol related physical, emotional and psychiatric symptoms and conditions. General Practice professionals encounter all of these issues on a daily basis and often only treat the presenting complaint without knowing how to intervene effectively. The Doctor/Practice Nurse/Dietician/Counsellor within General Practice all have the potential to make a huge difference to help patients and their families who struggle in life as a result of alcohol problems. There is considerable ignorance amongst the general population about health risks associated with alcohol as well as about guidelines for risky drinking and gender differences. The Primary Care health professionals could reduce this ignorance very significantly by becoming actively involved in early identification and brief interventions.

What is EIBI? Early Identification and Brief Interventions for alcohol problems

Early Identification;

Early Identification of alcohol problems is an essential precursor to Brief Interventions. The attempt is to help patients who are having alcohol related health problems as early as possible. There are a range of alcohol problems that present in primary care.

Brief intervention;

A treatment strategy in which structured therapy of short duration (typically 5-30 minutes) is offered with the aim of assisting an individual to cease or reduce the use of alcohol or (less commonly) to deal with other life issues. It was designed in particular for general practitioners and other primary health care workers.

Brief Interventions are of proven efficacy in terms of cost and outcome. The skills involved in Brief Interventions for alcohol problems are readily transferable to other areas, for examples, smoking cessation, drug problems and other lifestyle issues. Brief Interventions for alcohol are at the top of the league of evidence-based treatment methods. There exists now a large body of evidence from over 50 controlled trials for their effectiveness. They are most effective for hazardous and harmful drinking. The number needed to treat (NNT) is about 8 for both hazardous and harmful alcohol consumption and for alcohol related harm. This means that eight patients at risk need to be

offered advice for one to benefit. This compares very favourably to other conditions that present in primary care. For example, the NNT for smoking is between 10 and 20 depending on whether nicotine replacement therapy is used. Furthermore there is some evidence to suggest that brief interventions can reduce alcohol related mortality.

Instructions for primary care staff

Alcohol problems in Primary Care;

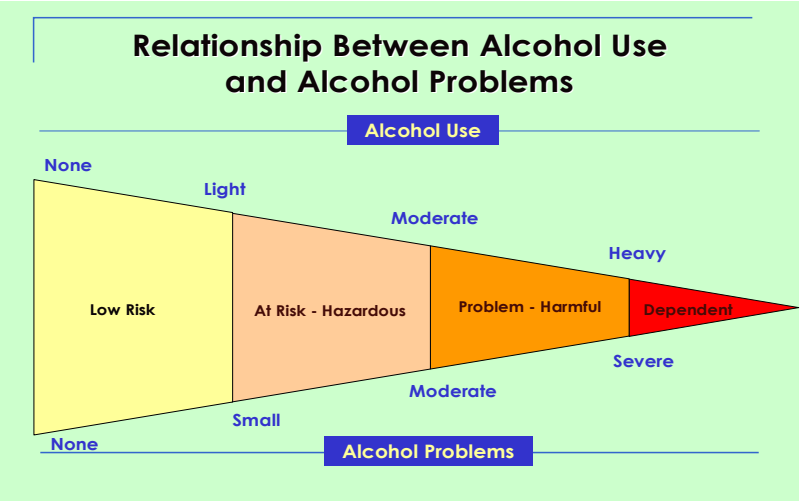
Hazardous Drinking; Is a level of consumption or pattern of drinking that is likely to result in harm should present drinking habits persist. It also constitutes any drinking by pregnant women, children under 16 years of age and patients who are very ill or receiving various treatments or those patients who perform activities that are not advised when drinking.

Harmful Drinking; A pattern of drinking that causes damage to health, either physical or mental.

Dependence on alcohol; Is a cluster of psychological, behavioural, and cognitive phenomenon in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that once had greater value.

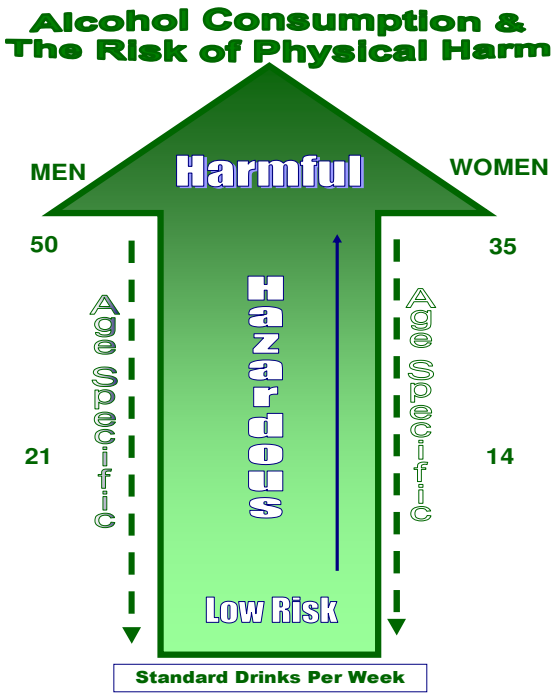
Heavy Episodic Drinking; Sometimes called binge drinking which can be particularly damaging to health. Regular consumption of at least six standard drinks. In most countries the biggest concern is the tendency to regularly 'drink to get drunk'.

Traditionally alcohol problems were equated with alcohol dependence. The range of problems is in fact on a continuum and can be depicted as follows;



Individuals can move from low risk to hazardous and harmful drinking or vice versa at any stage of their lives.

Hazardous and harmful drinking to physical health can also be estimated by primary care staff using a weekly consumption chart involving standard drinks. While this is a crude estimate it does provide a useful talking point and a good introduction to this topic;



Definition of Standard drink; What constitutes a standard drink differs from country to country but is roughly equivalent to one standard measure of wine, spirits or a glass (250 ml) of beer.

The diagram indicates that the more an individual drinks the more he or she is at risk of health problems. ***There is no level of alcohol consumption that is risk free.*** Obviously considerably younger and older individuals should drink even less to avoid hazardous and harmful consumption. The limits for hazardous drinking per week are set at a low level and may need adjustment in some countries.

Armed with all of the above knowledge the following style of Brief intervention (Ask, Assess, Assist and Arrange) is recommended (with practice the initial session should take between 5 and 15 minutes, if someone is screened as dependent it will take a little longer);

Ask

Just Ask! – but show concern, interest and empathy

- The approach and manner of the primary care professional is essential. In general terms the practitioner should be genuinely interested and seek permission to ask about alcohol.
- Training will enhance the skills that are required. The principal should be to use a motivational style of interviewing. Guidelines and training documents are available from Phepa "Primary Health Care European Project on Alcohol" (www.Phepa.net)

- Patients expect to be asked about their alcohol consumption and patterns by primary care staff. Patients generally trust their family doctors and practice nurses. Very few patients will object to being asked

You can make a big difference! - - - - to the future health and well-being of patients and their family by asking and intervening.

- There is a great deal of ignorance and some confusion about basic information regarding alcohol amongst the general population. Primary care staff have an important role in informing patients about issues such as risky consumption limits, gender differences, age specific issues, links between depression and alcohol, sources of further information, sources of help and much more besides
- Remember 'patients' are often family members who are presenting with symptoms that are caused directly or indirectly by alcohol problems at home

Assess

- Patients can be relatively easily identified and informed of their risk category (low risk, hazardous, harmful, dependent) by asking about frequency of consumption and amounts consumed. Questionnaires are very helpful. The score is important but so too is the discussion and it is a useful way to engage the patient in a discussion about their drinking.

  AUDIT 'C' is a good initial starting point and the full AUDIT questionnaire can be used if the patient scores above the cut-off point.

AUDIT 'C' Questionnaire

1. How often do you have a drink containing alcohol?	
(0) Never (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	☐
2. How may drinks containing alcohol do you have on a typical day when you are drinking?	
(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more	☐
3. How often do you have six or more drinks on one occasion?	
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	☐
Scores in brackets on the left hand side, put in box on right and add up **TOTAL**	☐

Recommendation:	*Ask these questions from memory and do a mental "tot". Use full A.U.D.I.T. if score in AUDIT 'C' is:: > or = 5 for adult men >or = 4 for adult women*

and/or Use consumption 'Arrow' Chart; and if concerned (i.e. above hazardous, harmful limit) do full A.U.D.I.T.

A.U.D.I.T. Scores:

> or = 7 for adult women, 8 for adult men	- 14 = likely to be hazardous
Both sexes	15 – 19 = harmful
Both sexes	20 + = likely dependence

Use clinical judgement in all cases but especially with borderline scores

NB. there is no stereotype of a person with a drinking problem

Patients in the low risk category should be encouraged to continue at low risk consumption. With simple advice and perhaps some literature and follow-up, patients mostly in the hazardous and some in the harmful range are likely to reduce their drinking and change their risk status. Brief Interventions can also be helpful to identify and treat patients in the dependent category. Primary care staff should also refer patients for more detailed help if they are in the harmful/dependent categories, though some patients will spontaneously recover in these categories too.

Who should be screened and how often should patients be screened?

This is a matter for each practice to decide. All new patients as a minimum should be screened. Random screening and targeted screening (related to symptoms, patterns of attendance and/or family information) is the ideal. Again ideally all patients within a practice should be screened at some stage and then re-screened within 2-3 years. Due to practical obstacles, like time and resources, a more limited approach to screening may have to be adopted.

Assist

- with presenting complaint. Patients are more likely to change if there is a link between the presenting complaint and alcohol. For example if it can be established that headaches are due to alcohol consumption, change is more likely
- encourage patients to change, by using brief intervention, motivational techniques, gentle persuasion, mutual respect, sincere concern and patience
- explain screening results sensitively and inform patients of the advantages of cutting down or stopping, such as improved health, relationships and financial status
- don't jump to conclusions - there could be other explanations than alcohol for the presenting symptoms
- provide practical assistance;

– ***if in hazardous category patients might be advised to;***

  - set a date to cut down and look for support
  - keep a weekly diary of consumption
  - water down alcohol and drink slowly
  - drink water and/or soft drinks between alcoholic drinks

- put alcohol on their least favoured hand at meals and have a glass of water on the favoured hand so that they drink less
- avoid solitary or secretive drinking
- never drink and drive
- keep active and develop interests
- continue to ask for help from family, friends, self-help groups and professionals

- ***if in harmful/dependent category patients might be advised to;***

- discuss methods of stopping and how to stay stopped
- set a date to stop drinking and look for support
- drink water and/or soft drinks
- keep active and develop interests
- consider taking specific medication that reduces craving or is a deterrent, if appropriate
- attend specialist Counsellors and/or Psychiatrists as appropriate.
- attend support groups such as (e.g.) Alcoholics Anonymous, if appropriate
- undergo specialist detoxification, or arrange same, as appropriate.
- take vitamins as necessary
- read recommended literature including leaflets
- continue to ask for help from family, friends, self-help groups and professional

Arrange

- arrange a follow up appointment and continue to be actively involved
- relapse should be addressed as a learning opportunity and the approach should be based on patience and long term goals
- arrange appropriate continuing prescriptions, tests and appointments if necessary
- consider arranging a consultation with family members to support
- suitable reading
- arrange for someone in recovery, that you know and trust, to talk to the patient in confidence

International research shows that 30% of patients make significant changes to their alcohol consumption following brief interventions by primary care staff. A significant percentage also change their risk category. Follow-up is an essential component. Patients may change even if they do not follow up and their may be a time lag between the intervention and a positive change. ***Do not be discouraged if there is no immediate improvement.***

Further Reading;

- Phepa Guidelines and Training Documents (www.Phepa.net)
- Sign (Scottish Intercollegiate Guidelines Network) (www.sign.ac.co.uk)
- Alcohol in Europe (A Public Health Perspective), Anderson, P. and Baumberg, B.