CHAPTER 3

AUSTRALIA

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3.1. Introduction

3.1.1. Country description

Australia is an island continent in the Southern Pacific with a large land mass and a relatively small population of 20,012,948[1]. Indigenous Australians number 386,000 (approximately 2% of the population). Like other Western countries, the population is ageing, with a median age of 35.4 years in June 2001, compared with 29.6 years in 1981[1]. The distribution of the population aged 15-64 years has steadily increased, with an added increase in the proportion of those aged 65 years or more. In contrast, the proportion of children 0–14 years has steadily decreased, resulting in a shift in the age structure, and proportionate with the ageing population.

Australia's national health care delivery system covers all permanent residents of Australia and is largely financed by general taxes. In 2000-01 there were 726 public hospitals recorded nationally (excluding psychiatric hospitals). Private hospitals, which once provided uncomplicated non-emergency care, are today providing complex high technology services. The private sector primarily consists of medical and paramedical professionals who are self-employed and provide general practice services and specialist services (such as internal medicine, diagnostic imaging, pathology and physiotherapy). An increasing number of people are covered by private health insurance, particularly following the introduction of Lifetime Health Cover in 2000, which saw a rapid rise from 32% to 46% during 2000. Australia has 123 divisions of general practice, and in June 1995 there were 22,298 general practice and specialist medical businesses.

3.1.2. Alcohol-related problems in Australia

Over 85% of the general population of Australia drink alcohol at least occasionally. Alcohol use is not restricted to specific population groups or geographical areas. Per capita, Australians drink 7.7 litres of pure alcohol per year, comprising 101 litres of beer, 18.6 litres of wine and 1.1 litres of spirits. In 1991, Australia was ranked 17th in the world, and second among English-speaking countries in terms of total alcohol consumption.

Alcohol misuse continues to be a major health and social problem[1]. It remains one of the two major causes of substance-related mortality in Australia, accounting for approximately 5% of all deaths, translating to an average of 15.2 years of life lost per death[2]. It causes 50% of all motor vehicle accidents and is also a significant contributing or exacerbating factor for many health problems, including national health priority areas of injury, mental health, and cancer[3,4]. Australian Hospital episodes attributable to alcohol use can be seen in Table 1.

3.1.3. Brief history of responses to alcohol consumption

Traditionally, national responses to alcohol misuse have concentrated on the treatment of drinkers who are experiencing problems or who meet clinical criteria for alcohol dependence. Today, more treatment is conducted within a primary health care setting. Although general practitioners (GPs)

are not highly engaged in this field of work, promising developments include the availability of the alcohol pharmacotherapies, such as acamprosate and naltrexone from 2000, and the establishment of the Australian Chapter of Addiction Medicine in 2002.

TABLE 3.1

Alcohol-Attributable Hospital Episodes in Australia, by Age and Principal Diagnosis (1997-1998)

Principal Diagnosis	Age Group				
	0-14	15-34	35-64	65+	Total
Cancer	-	113	3,078	2,849	6,040
Alcoholism & liver cirrhosis	278	5,864	16,726	2,890	25,758
Cardiovascular disease	-	208	-7,622	-10,541	-17,955
Road injuries	410	3,711	1,442	283	5,846
Other	346	15,311	9,970	-2,284	23,343
Total	1,034	25,207	23,594	-6,803	43,032

Source: Ridolfo & Stevenson (2001)[5]

3.1.4. The place of brief interventions

Brief interventions have been developed for several forms of substance use now, most notably alcohol. There has been support for this approach by the Federal Government of Australia and state health departments.

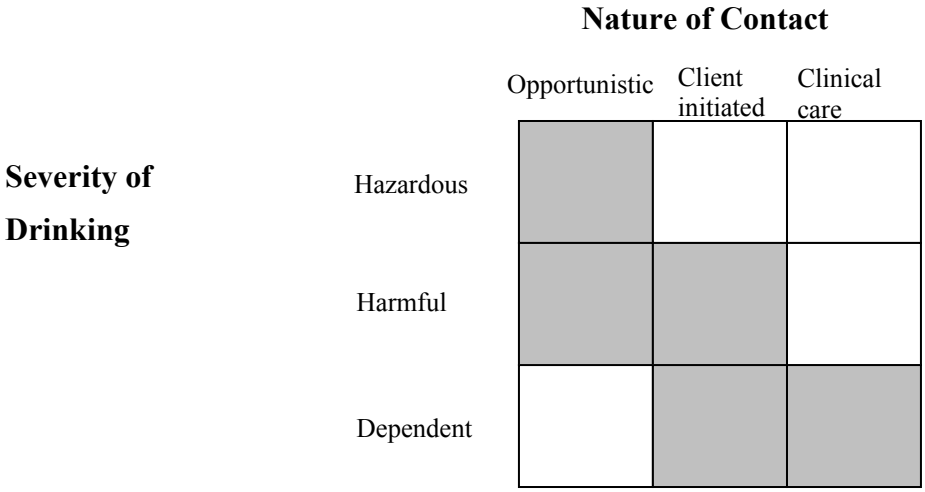
Brief interventions for hazardous and harmful drinking are broadly supported within the framework of the *Smoking, Nutrition, Alcohol and Physical activity* (SNAP) framework of the Commonwealth Department of Health and Ageing. As one of its primary aims, SNAP seeks to reduce the rates of hazardous and harmful alcohol use in Australia. The SNAP implementation group view general practice as being well-placed to act as advocates for health promotion, and achieve change in the risk status of individuals consuming alcohol at unsafe levels.

The concept of brief intervention in Australia is similar to that elsewhere. These interventions are designed to be delivered after hazardous consumption or an alcohol problem has been initiated by the client or identified opportunistically (see Figure 1). Support for this approach corresponds with the national shift towards prevention and early intervention, rather than late-stage treatment[6]. The goal of brief intervention is to help individuals reduce or eliminate hazardous and harmful alcohol use, thereby avoiding or minimising harmful consequences. With an overarching aim of encouraging responsible drinking behaviour, brief interventions incorporate psycho-education on drinking and its consequences, motivational and cognitive-behavioural principles[7], clear targets for reduced drinking and a series of step-by-step strategies to achieve it. Brief interventions have the additional benefit of being delivered in a manner that is personalised and free from judgement. Examples of brief interventions for alcohol developed in Australia include the 'Drinkcheck' and 'Drink-Less'[8], which are derived from those developed for the WHO Phase II trial, and

'AlcoholScreen'[9].

Australian investigators have identified that brief interventions are best implemented within a general medical practice setting, due to a number of advantages over other professional settings.

FIGURE 3.1
3x3 matrix of the interaction between different types of drinkers and the nature of treatment contact. Grey areas indicate the point of contact.



First, GPs are generally the initial and most frequent point of contact between the general community and the health care system. Second, hazardous and harmful drinkers present twice as often to primary health care as other patients[10]. Third, GPs are accepted as an authoritative source of health advice[11], with studies indicating that Australian patients expect and value being asked about alcohol intake during a medical consultation[12], possibly because this setting does not have the stigma associated with specialised treatment facilities. However, there still remains a gulf between the potential and the reality, which will be discussed below.

3.1.5. The evidence-base for screening and brief intervention

Internationally, there is now compelling evidence for the effectiveness of both screening and brief intervention to reduce hazardous and harmful alcohol consumption. Several meta-analyses of brief intervention trials have been published to date[12-14]. The latest study by Moyer et al.[14] showed a significant positive effect of brief intervention compared with control in 29 of 32 randomised controlled trials, with an average reduction in alcohol intake of 20%. There was no significant benefit of extended treatment compared with a brief intervention. In the WHO Brief Intervention trial, conducted in Australia and internationally, a 5-minute intervention reduced hazardous consumption by 27-30% compared with a non-intervention control group[15,16], with corresponding reductions in alcohol problem scores and biochemical abnormalities. In summary, brief interventions for hazardous and harmful alcohol consumption are well supported by the scientific literature and are considered among the most cost-effective internationally[17].

3.1.6. Evidence-base for the training of GPs in providing brief interventions

There is a paucity of studies examining the effectiveness of training for GPs in providing brief interventions. The Australian arm of the Phase III of the WHO Collaborative Project, we examined training and support strategies for GPs. Onsite training, with the provision of attractive and user-friendly resource material, was found to be the most acceptable and achievable approach.

Internationally, best practice methods have been established for training GPs in providing screening and brief intervention. A systematic review of 102 randomised controlled trials of continuing medical education (CME) interventions to improve professional practice was conducted by Oxman and colleagues[18]. Results suggested that onsite training (educational outreach or academic detailing) was an effective educational approach for improving preventive medical approaches and screening. Therefore, onsite training is one of the few educational methods which has continuously demonstrated improved practitioner performance in the prevention and management of alcohol and substance misuse generally[19,20].

The cost-effectiveness of onsite training has been investigated. Wutzke et al.[20] examined the effectiveness of the Drink-Less intervention package as applied to (1) the costs associated with marketing the package to practitioners, (2) training and support costs, and (3) the costs of providing a brief intervention to 'at risk' drinkers. Results indicated that onsite training was cost-effective in promoting the uptake of brief interventions by practitioners, with increased numbers accepting the package, and an increase in number of patients subsequently screened.

3.2. Involvement in the WHO Brief Intervention Collaborative Studies

Australia has been a partner in the WHO collaborative studies since their inception in 1983. Australian investigators took a lead role in Phase I (John B. Saunders, Technical Focal Point 1985-1989) and Phase III (John B Saunders and Michelle Gomel, Technical Focal Points, 1992-1998). Accordingly, the Australian team was well-placed to embark upon Phase IV and engage in the systematic investigation of dissemination of brief interventions. The Australian team contributed to the development of the Phase IV Study Protocol and incorporated it into the local protocol and into several grant applications. Due to a number of factors, including a lack of finding, only partial achievements can be reported for Phase IV.

3.2.1. Formation of a Lead Organisation and Strategic Alliances

The lead organisation in Australia was the Centre for Drug and Alcohol Studies, School of Medicine, University of Queensland, which worked in close association with the Alcohol and Drug Service of Queensland Health within The Prince Charles Hospital and District Health Service, and with colleagues in the University of Sydney. The lead organisation's role was to initiate, organise and oversee the study and it was responsible for preparing intervention projects and establishing co-operative relationships with local organisations and individuals. A research group was established with members co-ordinating the design and implementation of the project. A steering committee was established to co-ordinate, oversee and provide advice about the implementation of the project.

The lead organisation also aimed to become a centre of learning excellence in the field of opportunistic brief interventions by:

- putting the existing research evidence and clinical knowledge about the effectiveness of SBI into a user-friendly form, and
- assembling a collection of brief intervention materials (e.g., early identification instruments,

intervention manuals, self-help publications).

Alliances were formed with the following organisations:

- Central and local government agencies responsible for funding and supporting special initiatives and projects in primary health care, particularly government departments responsible for public health policy.
- Government and other agencies interested in funding research into the reduction of alcohol-related harm through primary health care services
- Divisions of General Practice
- The Roads and Traffic Authority of New South Wales
- Prominent scientists, academics and practitioners with the influence to affect thinking in for example, primary health care, treatment and prevention of alcohol problems and primary care training
- Key educational and research institutions with expertise in SBI and/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 general practitioners, nurses, medical social workers, psychologists
- Charities, volunteer organisations, community groups and local community leaders that could contribute to the implementation strategy, particularly the communications strategy
- Potential sponsors of the implementation strategy

3.3. Customisation

Considerable progress has been made in customising brief intervention materials. The aims of customisation were to adapt the materials, interventions and approaches used in previous phases such that they would be suited to the (i) Australian professional population, (ii) settings where brief interventions could be adopted, and (iii) the patient population. It was also hoped to include a cost-benefit analysis and review of the training methods used.

3.3.1. Customisation of materials, interventions and techniques for delivery

In Phase III a brief intervention package, the Drink-Less Program, was developed and trialled. The package entailed the use of the AUDIT and a standardised set of materials. During Phase III many recommendations of potential variations were put forward by GPs and other health professionals to suit local conditions. This provided an opportunity to improve and fine-tune the materials for Phase IV in order to tailor both the screening and intervention to local needs and circumstances.

Customisation of the screening instrument

For Phase III, the AUDIT screening questionnaire was adapted to Australian needs. The *Aus*AUDIT[21] included modifications to the first two questions of the AUDIT to reflect Australian National Health and Medical Research Council (NHMRC) guidelines for safe levels of consumption. In the Australian derivation, those drinking at hazardous and harmful levels according to the NHMRC consumption guidelines will necessarily be detected as high-risk from the first two questions alone. In a subsequent validation study of the *Aus*AUDIT, it transpired that the modified instrument lacked specificity (too many false positives). AUDIT was re-adopted as the main

national screening instrument.

Customisation of the brief intervention

It was anticipated that a modification of adaptation of the Drink-Less approach would form the intervention in Phase IV.

The Drink-Less Package: As mentioned above, the Drink-Less approach was developed for Phase III of the collaborative project. Drink-Less was based on validated techniques for early detection and treatment of hazardous and harmful alcohol use developed in the WHO Phase II trials. The intervention approach and materials were based on the 5-minute intervention technique shown to be effective in the multicentre WHO Phase II trial[15-16]. As well as the AUDIT and scoring template, the package consists of a handy advice card, patient booklet, and instruction brochures for receptionists and GPs. The program has been widely used in general practice since its development.

Revision of the Drink-Less Package: Between 2001 and 2003, the Drink-Less package was revised and updated by the collaborative team in Queensland working with colleagues from the University of Sydney. Revisions incorporated (a) feedback from focus groups; (b) WHO's revision of the AUDIT guidelines; and (c) new NHMRC alcohol guidelines. This work was supported by a grant from the Roads and Traffic Authority (RTA) of New South Wales. A professional graphic design company was engaged to submit new logo designs and new colours and graphics for consideration by the research group. The components were printed up in draft form and field-tested with local GPs . In response to their feedback, the Drink-Less package was then further refined and finalised. Drink-Less has been endorsed by the Australian Medical Association, the Royal Australian College of General Practitioners and the Royal Australian College of Physicians.

Training medical practitioners

A training program was designed to familiarise GPs with the revised Drink-Less intervention and to train GPs in the use of this approach. This was undertaken in conjunction with the RTA's initiative to combat drink driving using an alcohol ignition interlock device. The whole research team contributed to the training program. A presentation in PowerPoint format was developed and consists of two sections. The first hour (optional) gives a detailed background on alcohol problems and management in general practice; recognition of dependence on alcohol, management of outpatient alcohol detoxification, new pharmacotherapies and relapse prevention. The second hour commences with a brief description of the RTA Interlock program (see below) and continues with a practical session on the use of the Drink-Less package; including scoring the AUDIT, use of the handycard in advising the patient, arranging for ongoing treatment, referral if necessary and follow-up. Case studies further illustrate the use of the package.

Delivering the training program

General Practitioner Liaison Officers at all Divisions of General Practice in New South Wales were invited early in 2003 to ask their members (GPs) to participate in training sessions for Drink-Less. Those Divisions that had time slots available and sufficient interest from their members arranged for the Drink-Less program to be presented at one of their meetings. Continuing professional development (CPD) practice points were applied for from the Royal Australian College of General Practitioners and two points per hour are awarded to GPs who attend the training session (i.e. 4 points for the 2-hour program). Presenters at these sessions were: Prof John Saunders, A/Prof Kate Conigrave, A/Prof Paul Haber, Dr Elizabeth Proude (University of Sydney & Drug Health Services

CSAHS), Dr Hester Wilce of Central Sydney Division of GP and Dr Rose Neild of the Drug and Alcohol Unit, Hunter Health.

During 2003, 175 GPs attended these sessions throughout New South Wales. Evaluation forms were given to the participants at each session and 164 were completed. The results show that confidence in identification of alcohol problems and in conducting brief interventions grew after attending the program. For example, doctors feeling 'very confident' in their ability to identify at-risk drinkers rose from 12 (7%) to 82 (51%). Confidence in the ability to conduct brief interventions changed from 54 (33%) feeling 'slightly' or 'fairly' confident at pre-test to 74 (46%) at post-test, while those who stated they felt 'very confident' rose from 10 (6%) to 70 (44%). One hundred and thirty-seven (86%) felt 'fairly' or 'very' confident in understanding the requirements of the brief medical intervention for the RTA Interlock program.

3.4. Reframing Community Understandings of Alcohol Issues

Australian communities have adhered strongly to the concept of 'alcoholism', creating an obstacle to understanding the range of alcohol-related problems. This may be, in part, due to a lack of research into the continuum of recreational to compulsive drinking, particularly with respect to recent Australian research. Furthermore, research into alcohol consumption patterns are generally based on the intensive and compulsive use categories due to greater accessibility. Emphasis on alcoholism has been reflected in Australia's history of disease model-oriented treatment approaches. As a result, many health professionals and members of the community understand this as the sole form of alcohol-related harm and often view all alcohol-related problems exclusively as dependence.

It has been the aim of the Australian investigators to work from a public health perspective and emphasise that harm is also experienced by drinkers whose problems are less severe than those of 'alcoholics', a stance endorsed by the National Health and Medical Research Council since the mid 1980s. Members of the Australian team (John B. Saunders and Brian McAvoy) worked with the NHMRC to develop guidelines and various resource documents. The NHMRC has developed a communication strategy with the aim of promoting the concept and understanding of risky drinking among health professionals and the community. This has been undertaken to support (i) the understanding that drinkers can be categorised according to a continuum, and (ii) the availability of brief interventions in the long term.

3.4.1. Communication targets

Three communication targets were devised for Phase IV of the project: the general public, health professionals and other stakeholders. Each of these strategies is described consecutively.

The general public

The international protocols suggested that a mass media campaign would be ideal to target the general public. In Australia it was decided that communication would be best delivered in local media campaigns and through a network of community activities and centres. As no funding was secured for this strand of the project, local purpose-designed media interviews have been provided by Australian investigators which have:

- communicated the concept of hazardous and harmful drinking and emphasised that abstinence is not the only intervention available for non-dependent drinkers;

- encouraged drinkers to seek advice about their drinking.

Health professionals

At a broad level, formalised links have been established with Divisions of General Practice throughout Australia. Through these links, general practitioners and other health professionals have been educated in seminars and workshops on knowledge and delivery of interventions for hazardous and harmful drinking. Education and training has been undertaken in the following areas:

- introducing the concept of hazardous and harmful drinking, and modifying understanding of 'alcoholism' and dependence
- information that detection rates of hazardous and harmful drinkers are poor and that health professionals encounter them unknowingly regularly during their work
- advice that it is possible to raise the issue of high-risk alcohol consumption without alienating patients
- information that they can have a large impact on reducing the risk from excessive and high-risk consumption with little additional effort
- education on the impact of hazardous and harmful, non-dependent drinking in both individual and public health terms
- information on the good evidence for the effectiveness of brief interventions.

In addition to the training program supported by the RTA grant, several other training workshops have been provided in Queensland, New South Wales and elsewhere in Australia. These workshops have outlined drinking according to a spectrum (where degree of drinking corresponds with degree of harm) and the most appropriate interventions for different drinkers. Workshops have also been conducted with other health professionals, and these have additionally taught the skills for implementing brief opportunistic interventions within a primary health care setting.

Other stakeholders

Other stakeholders are defined as those in the community demonstrating an interest, or potential interest, in reducing high-risk consumption of alcohol, including local government authorities, health and social services personnel, volunteer organisations and other organisations with the ability to influence community attitudes and behaviour. To date, this has varied in each state and community, with links being established with police and court services, Lions associations, Rotary Club and the Department of Veterans Affairs.

3.5. Establishing and Evaluating Demonstration Projects

The Australian arm has been unable to secure major funding for the Phase IV work. The most significant financial support has come from the RTA. The research team has submitted a number of funding applications, each of which was adjusted to the funding body's specific requirements, without losing integrity to the project objectives. The research applications are listed below:

- National Health and Medical Research Council: 1999, 2000, 2001, 2002

- The Alcohol Education and Rehabilitation Foundation: 2002
- The Prince Charles Hospital Foundation: 2001
- Commonwealth Department of Health and Aging: 2000

It was anticipated that, following the customisation process, the communications strategy and the formation of collaborative alliances, an implementation project would take place. The minimum requirement of the international protocol was a demonstration project(s) which would show that widespread dissemination of brief opportunistic interventions in primary health care in a local area is possible and viable. It was anticipated that the project would generate additional feedback about the practicalities and process of dissemination that could be used to feed back into the implementation process in future.

Each project plan submitted included a range of measures of impact (such as awareness of hazardous and harmful use as an issue in both primary health care and the general population and the degree of coverage in the local media), process (such as the availability of alcohol materials used in primary health care, the extent of screening and the extent of brief or other intervention for alcohol use) and outcome (such as self-reported alcohol intake, number of drink driving or drunkenness offences, alcohol-related hospitalisations, children at risk, mortality).

3.6. Concluding Section

The lack of success in obtaining major funding for Phase IV was a great disappointment, particularly as the previous phases had been well supported. In addition, the environment in which brief interventions would be implemented also appears less conducive than previously thought. In an examination of general practice activity in Australia (2000-2001), Britt and colleagues[22] reported that alcohol was rarely addressed within the general practice encounter, even though two of the five most frequently managed problems, namely hypertension and depression, are often alcohol-related. An alcohol intervention (general and specific advice-giving or counselling) comprised only 0.4% of all encounters. Within the study, the AUDIT was administered to 31,543 individuals aged 18+ years. 24.1% of patients reported 'at risk' levels of alcohol use. Thus, despite evidence supporting the effectiveness of brief alcohol interventions, and the large number of hazardous drinkers attending general practice, an appropriate intervention is rarely offered.

During Phase III, Saunders and Wutzke[16] identified several barriers to the provision of screening and brief interventions by GPs which may go towards explaining the lack of uptake in Australia. Barriers included: (1) educational limitations, notably a lack of awareness of the effectiveness of brief alcohol intervention, and of the conditions and problems (excluding physical ones) that could arise from harmful alcohol use; (2) a lack of resource materials, including questionnaires, intervention guidelines and patient self-instructional materials; (3) logistical barriers, such as a lack of time and heavy workloads; and (4) attitudinal barriers, such as a lack of self-confidence and self-efficacy in delivering an effective intervention, with low expectations of success.

Another possible reason for the limited uptake by GPs may be the large number of preventive medicine interventions available to them. It is estimated that GPs receive an average of 3-4 kilograms of materials per month on the effectiveness and cost-effectiveness of various interventions. As a possible result of this barrage, GPs appear to be engaging in preventive interventions in a highly variable manner and using interventions that do not often correspond with health priority areas[10].

A final barrier to brief interventions in general practice may involve deciphering who owns the consultation. Unlike some other countries, patients are not allocated to a GP in Australia. Instead, patients are somewhat similar to consumers and can pick the GP according to their own needs. With the growth of patient empowerment, GPs may have become somewhat driven by the patient's primary concerns.

Taking into account some of the environmental issues faced by GPs, the following recommendations have been made:

Education Programs

1. Skills development: Suitably designed training courses that are available face-to-face and in electronic form need to be promoted to GPs to impart the knowledge and skills needed for screening and brief intervention for alcohol misuse.
2. Education courses should also address the issue of ownership of the consultation. Perhaps a view that emphasises mutual responsibility and conjoint ownership of the consultation would facilitate that alcohol screening and brief intervention should be a routine part of this role.

National Government and Peak Bodies

3. In light of GP workload and inundation of preventive medicine opportunities, it is recommended that, based on mortality and morbidity statistics, a list of prioritised issues be developed for GPs to manage as part of their core role.
4. National government bodies should carefully assess and monitor trends in alcohol consumption and misuse, and examine the priority given to alcohol interventions.
5. They should examine specifically whether incentives for primary health practitioners to promote brief interventions should be incorporated into relevant policies and practices.
6. To enhance role legitimacy for GPs, the media could be engaged to develop public communication strategies to emphasise the hazards of risky drinking and the role of the GP in discussing these issues.

3.7. References

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