The risk of alcohol:

What primary care can do

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Luxembourg , 22 October 2013

PHEPA Primary Health Care European Project on Alcohol

BISTAIRS

Brief interventions in the treatment of alcohol use disorders in relevant settings

WHO COLLABORATIVE PROJECT ON IDENTIFICATION AND MANAGEMENT OF ALCOHOL-RELATED PROBLEMS IN PRIMARY HEALTH CARE

ADDICTIONS AND LIFESTYLES IN CONTEMPORARY EUROPE
Alice Rap
- REFRAMING ADDICTIONS PROJECT -

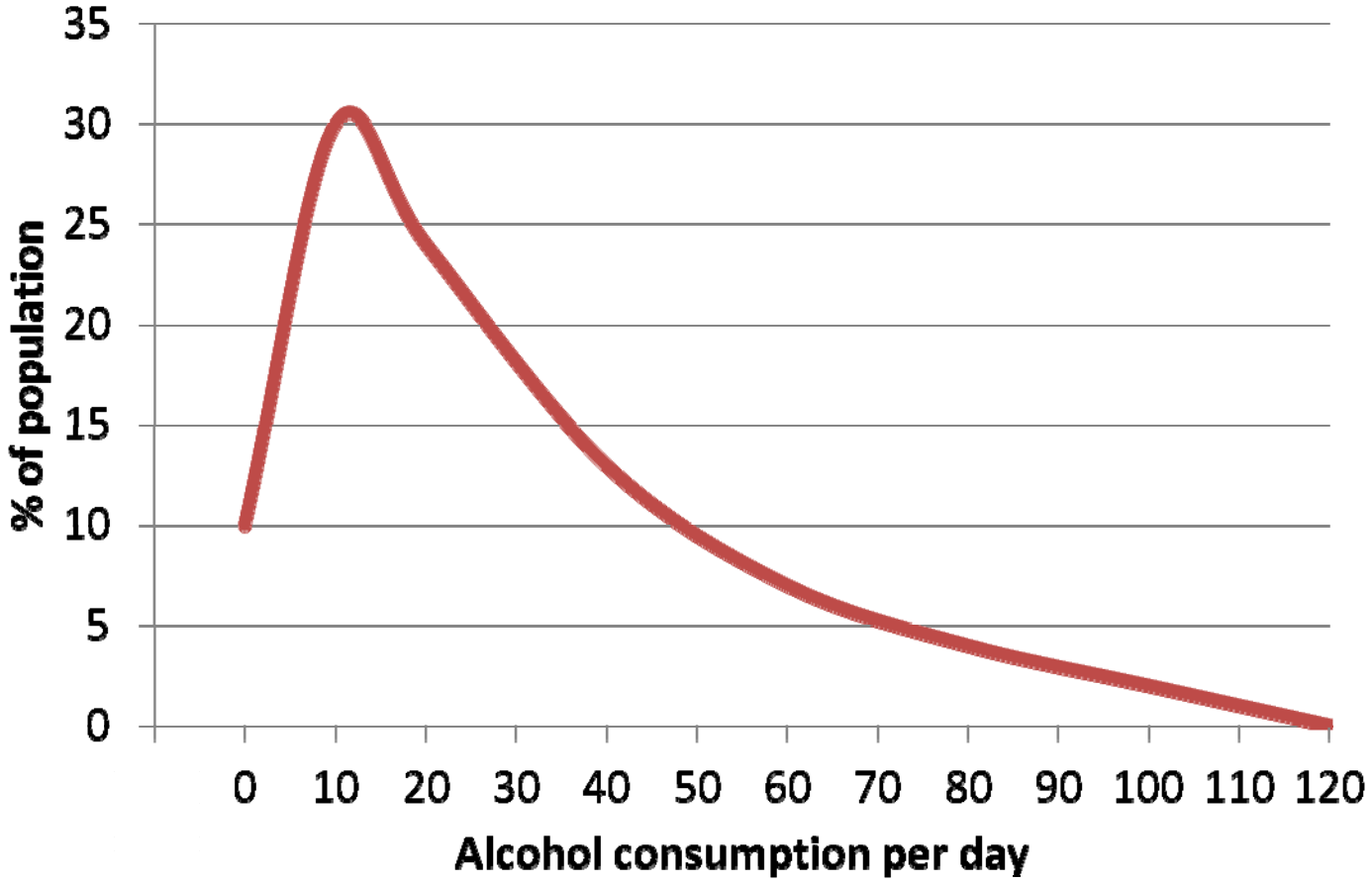
AMPHORA
Alcohol Public Health Research Alliance

Odhin project

1. The concept
2. The risk
3. Identifying and measuring the risk
4. Reducing the risk
5. The block
6. How to overcome the block

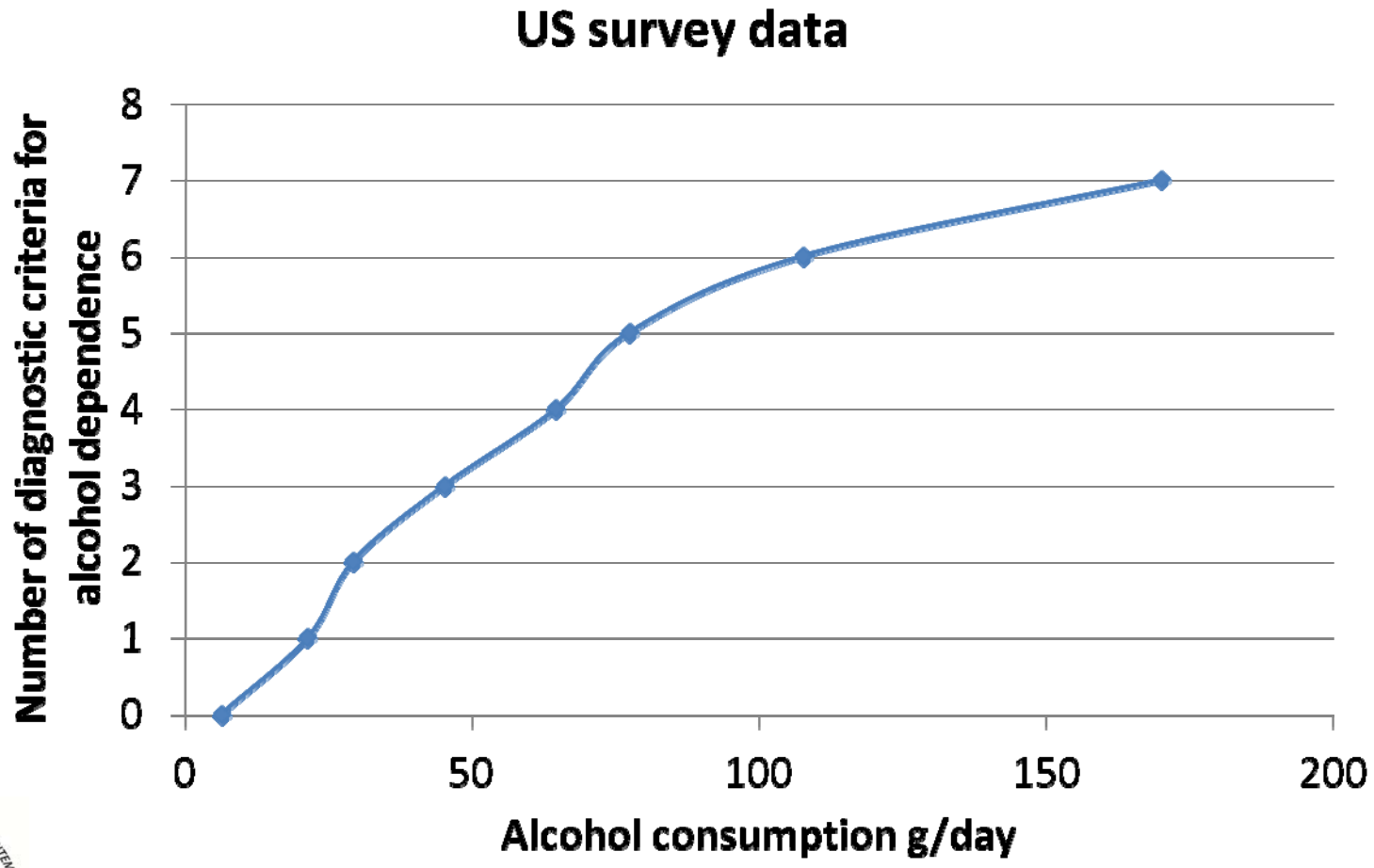
1. **The concept**

a. The concept is that drinking exists within a continuum, with a right hand tail. There are no dichotomies between people who are or who are not heavy drinkers.



1. The concept

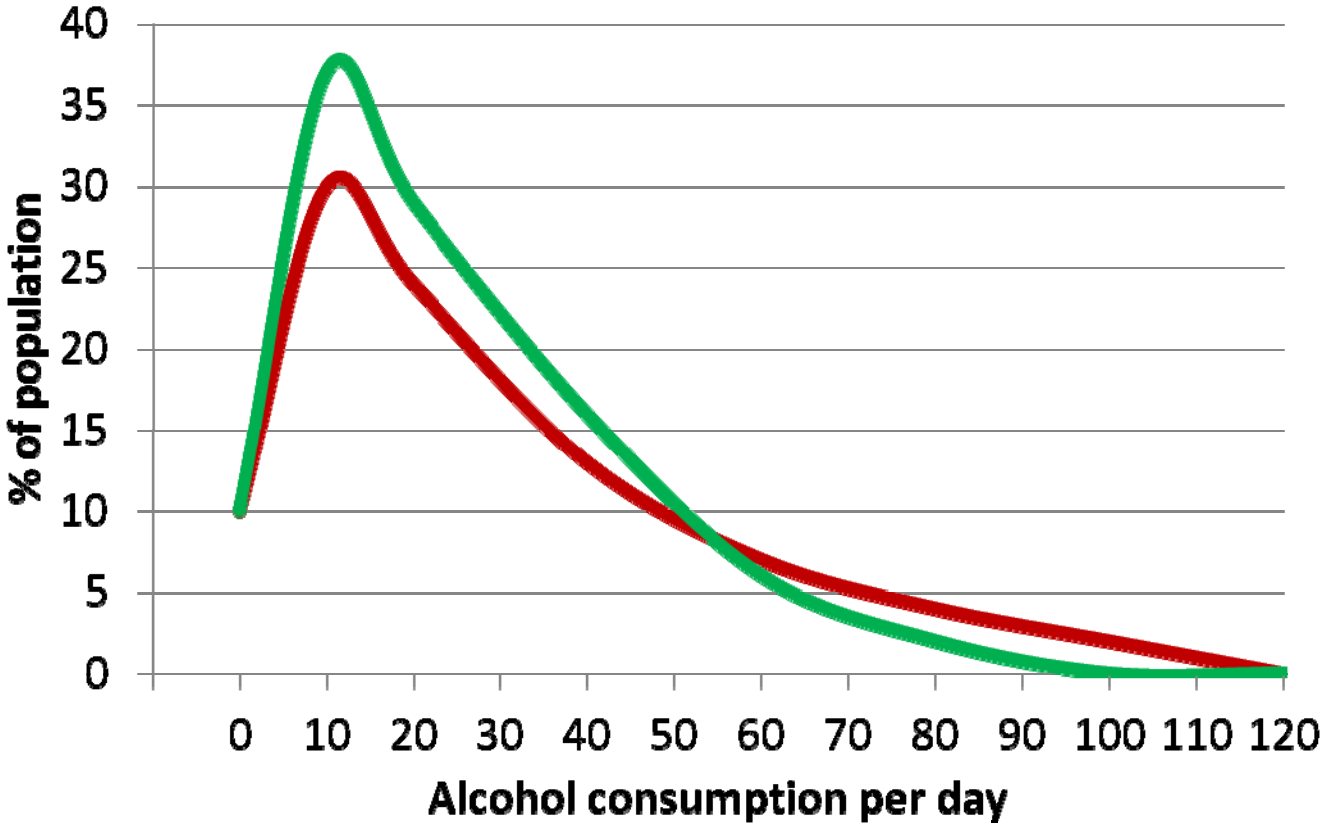
b. In fact, you need no more than heavy drinking to define alcohol use disorders and alcohol dependence .



Rehm et al 2013

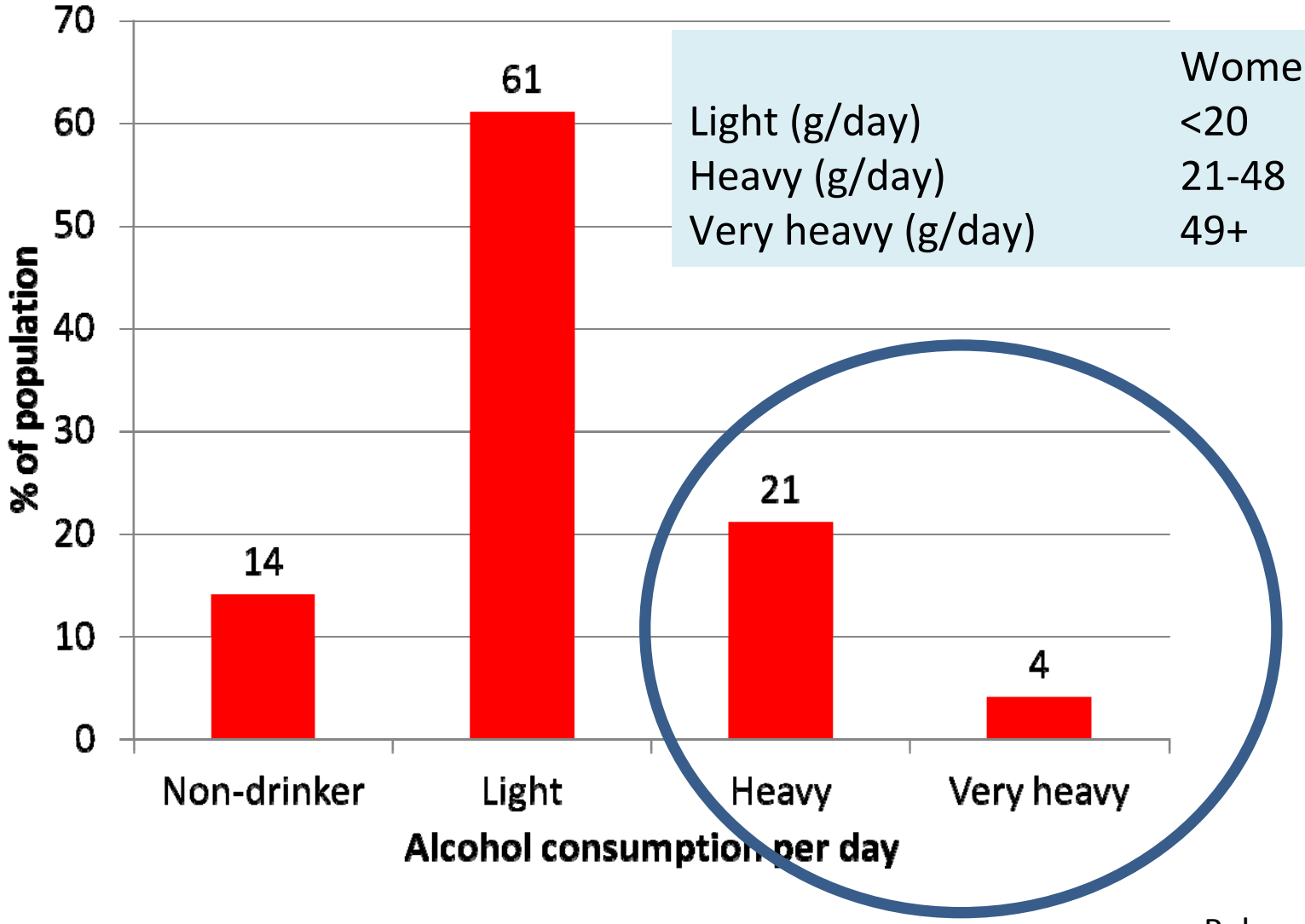
1. **The concept**

c. Drinkers move up and down the continuum, with associated risk in parallel. The role of brief advice is to support a shift towards lower risk drinking [from the **red line** to the **green line**].



2. The risk

a. One in four of EU citizens aged 15-64 drink heavily

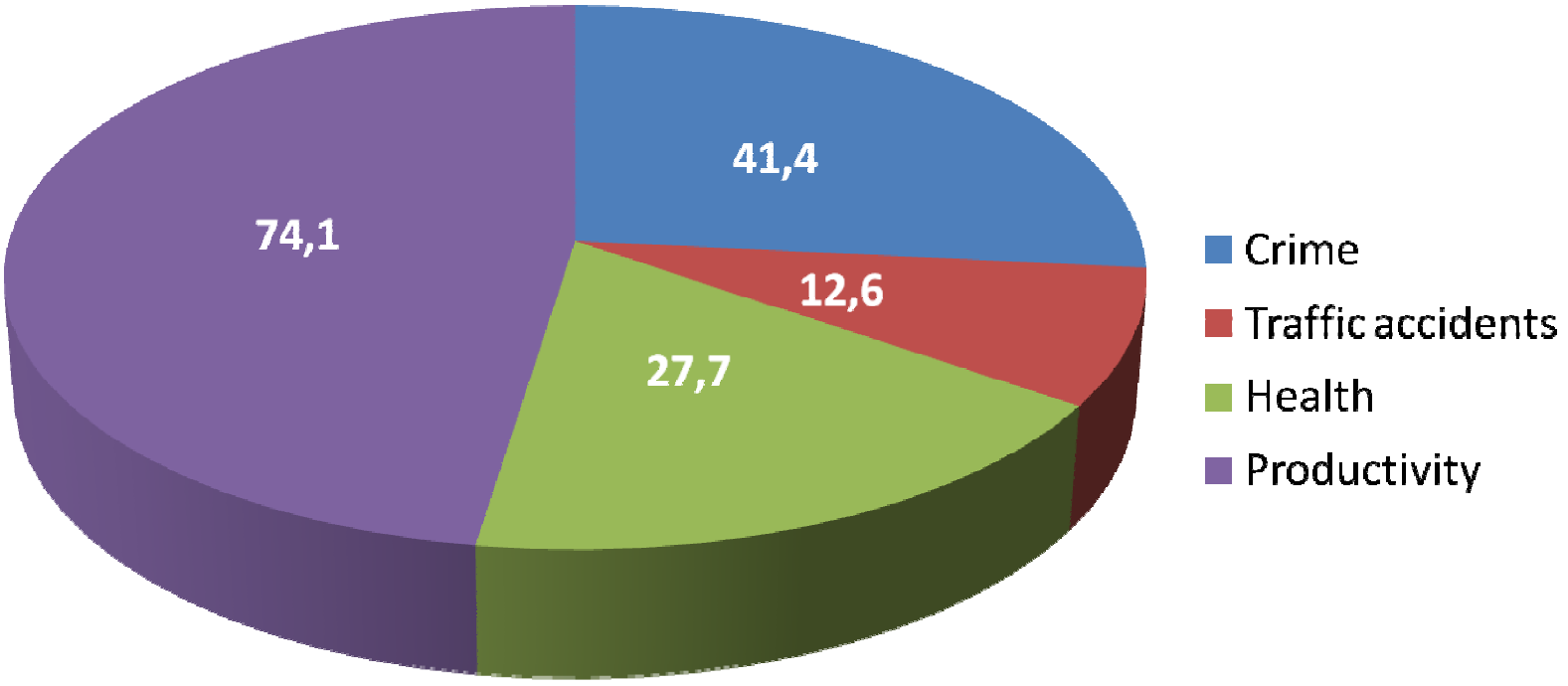


	Women	Men
Light (g/day)	<20	<40
Heavy (g/day)	21-48	41-72
Very heavy (g/day)	49+	72+

Rehm et al 2012

2. The risk

b. The risk affects health (premature death), emergency departments (injuries), work place (productivity), and criminal justice system (crime), as well as harm to people other than the drinker

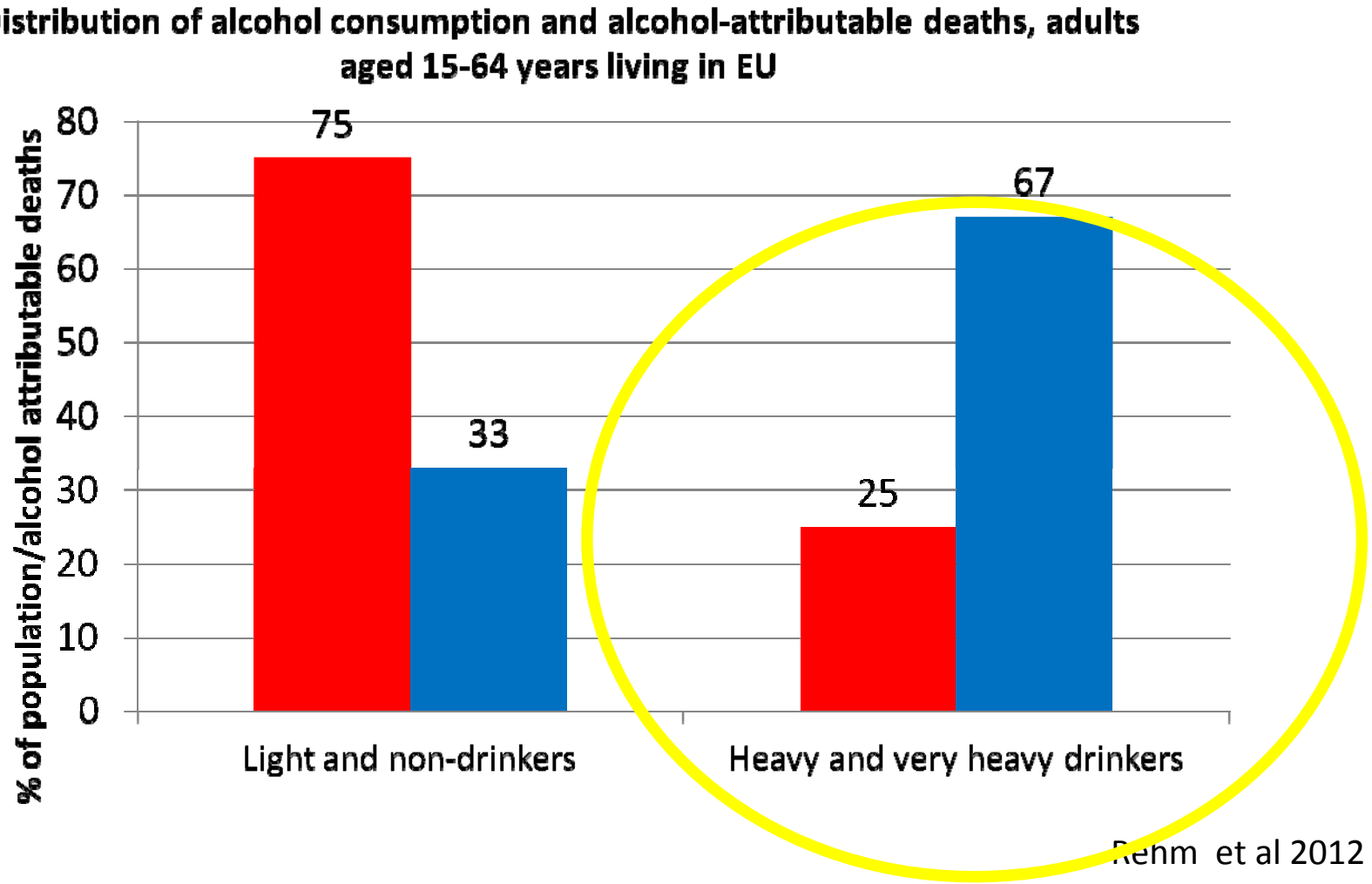


Social costs due to alcohol EU 2010 (€155 billion)

Anderson & Baumberg 2006, updated

2. The risk

c. The greatest health gain is by helping heavy drinkers reduce their consumption. A 'French man' drinking 90g/day would half his yearly risk of death from 18/1000 to 9/1000 if he cuts out 20g/day



Rehm et al 2012

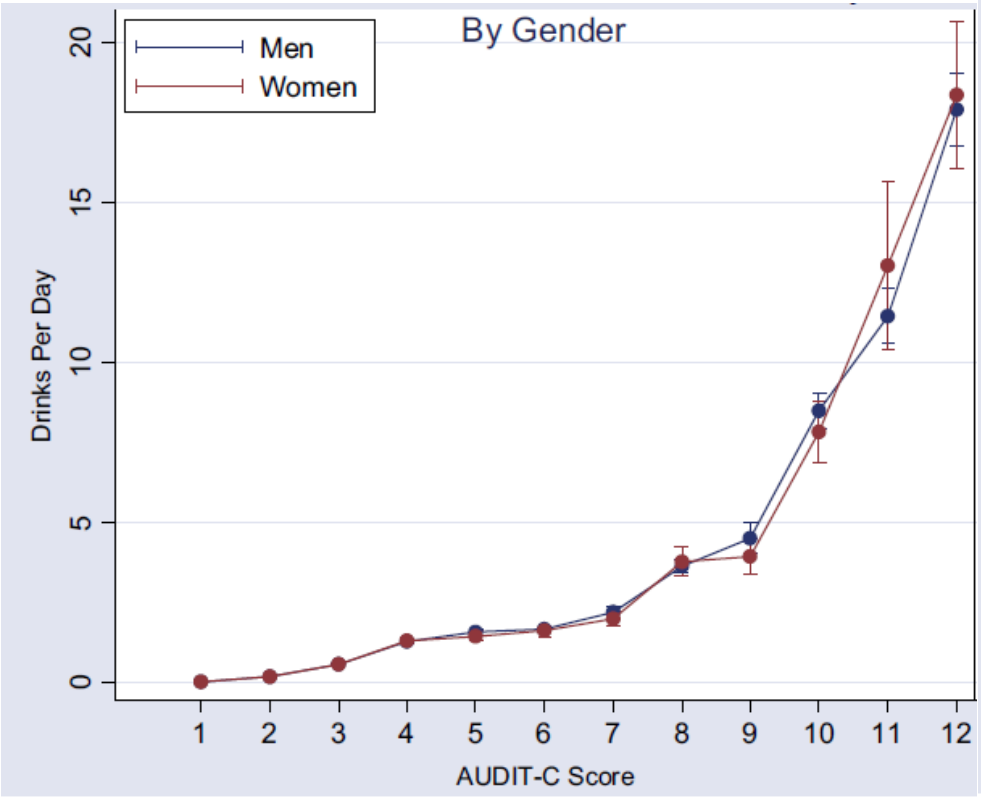
3. Identifying and measuring the risk

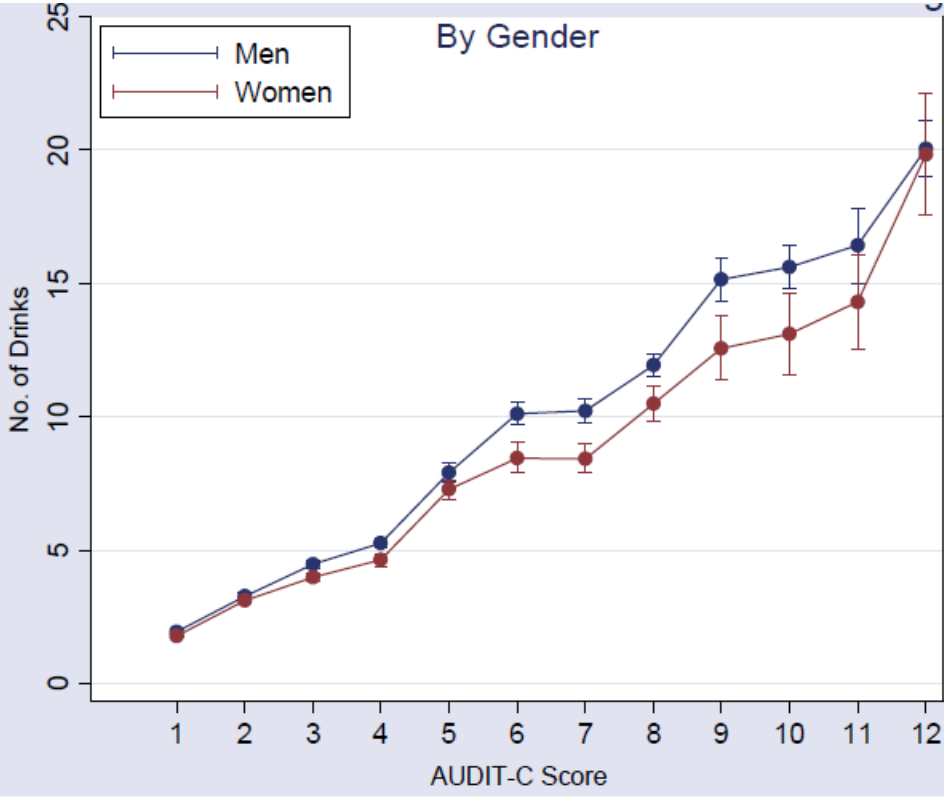
a. Out of a range of instruments that have been developed and tested, nothing beats AUDIT-C in terms of research base, validity, sensitivity, specificity, and simplicity.

AUDIT-C Questions:	Scoring system					Your score:
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 – 9	10+	
How often do you have 6 or more units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Scoring: A total of **5+** for men and **4+** for women indicates increased or higher risk drinking and is therefore AUDIT-C positive.						

3. Identifying and measuring the risk

b. AUDIT-C measures what we are dealing with - alcohol, and heavy alcohol use





AUDIT-C score by drinks per day by max no. drinks consumed in 1 day

US NESARC data on 26,546 adults

Rubinsky et al 2013

3. Identifying and measuring the risk

c. Targets should be set for identification

Over the next 10 years, 40% of the registered primary health care adult population should have been screened.

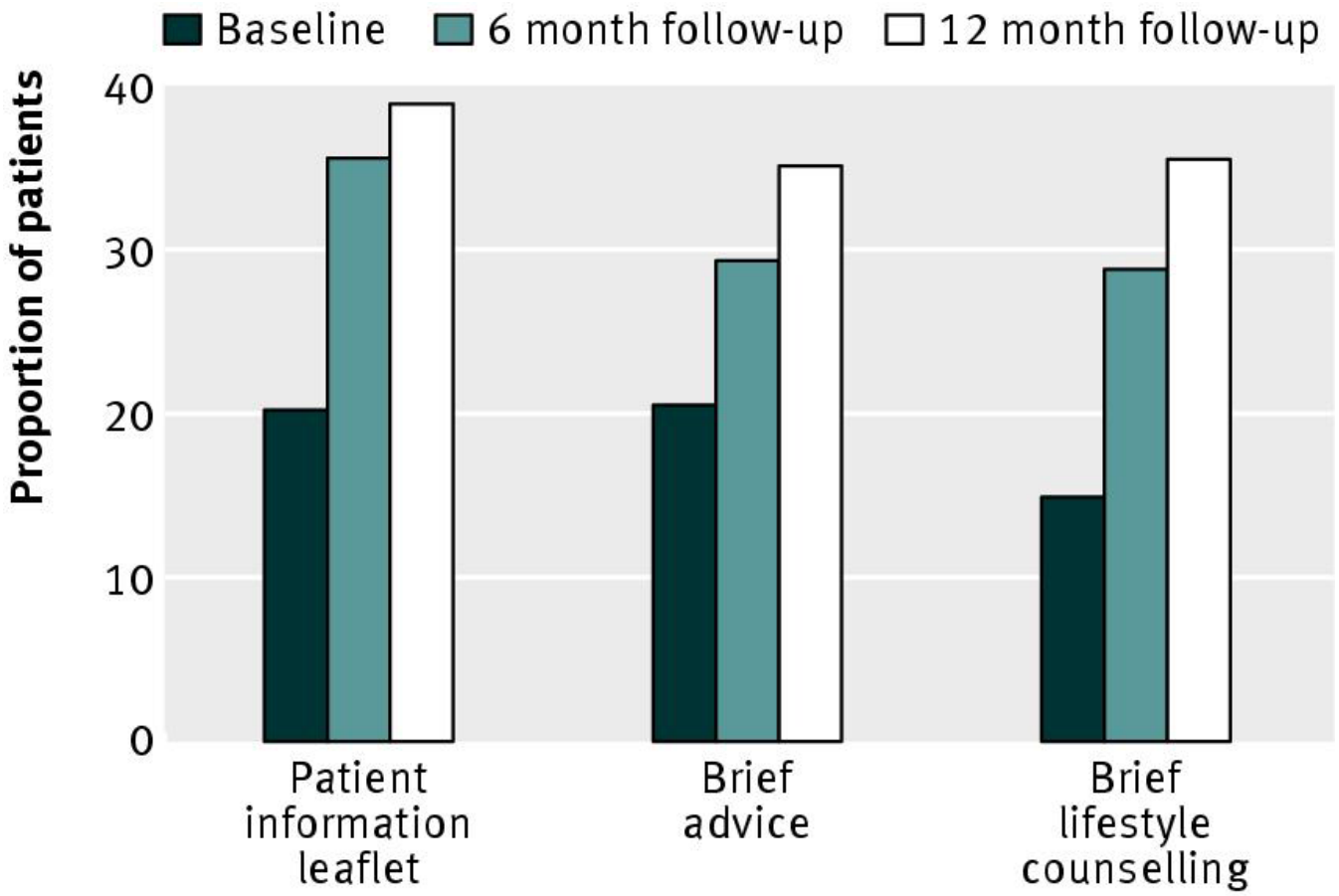
[Based on screening all newly registered patients]

It us up to provider units to decide how to achieve this:

- Screen at next consultation
- Screen at next registration
- Screen demographic groups (e.g., middle-aged men)
- Screen those with related problems (e.g., raised blood pressure)

4. Reducing the risk

a. Brief advice works in primary health care settings, and such advice can probably be quite brief.



UK SIPS study in PHC - % patients AUDIT–ve by intervention

Kaner et al 2013

4. Reducing the risk

b. As shown in England, Italy, Netherlands and Poland, screening and brief advice in PHC is cost effective and can be cost saving.

In England, it has been estimated that nurse-based screening all newly registered patients with AUDIT-C and nurse-based 5 minute advice for AUDIT-C positives, would:

- Cost £95 million over 10 years
- Save the health service £215 million over 30 years
- Have net saving of £120 million over 30 years

Purshouse et al 2013

4. **Reducing the risk**

c. Systematic reviews find the evidence base for the effectiveness of brief advice:

Emergency departments: less clear but +ve

Workplaces: not at all clear

Social welfare/criminal justice settings: almost non-existent

UK SIPS studies suggested that giving feedback and a patient leaflet is as good as brief or extended advice in emergency care and criminal justice settings.

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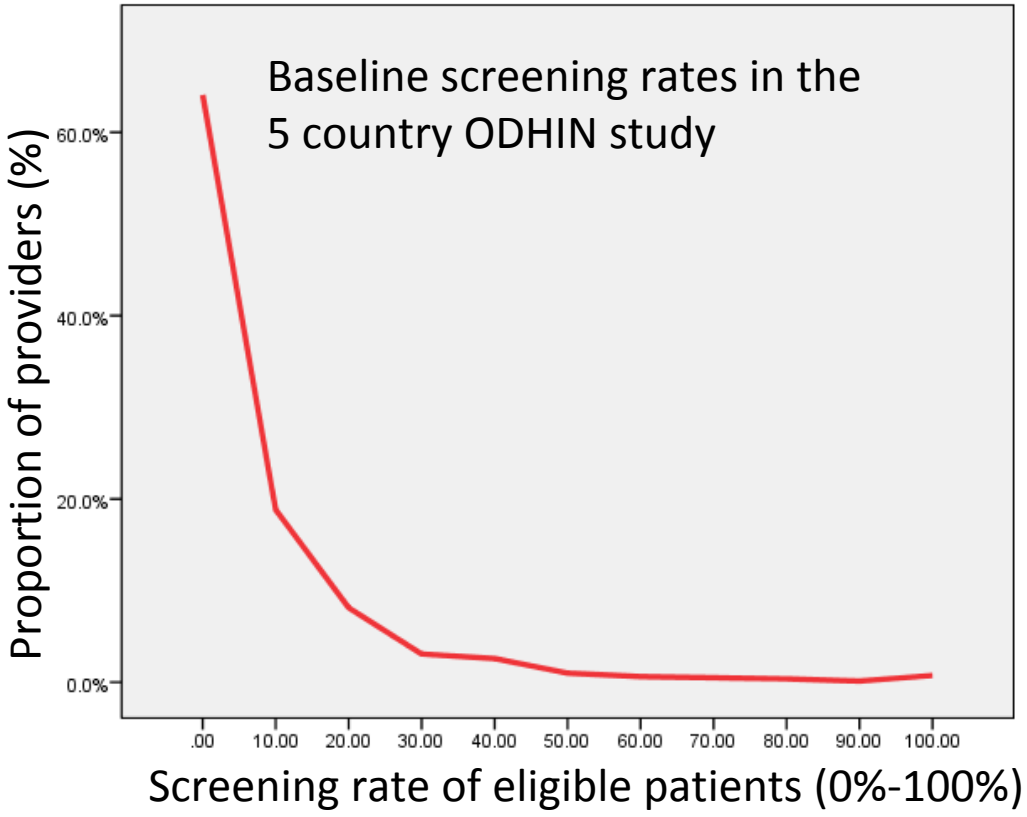
5. The block

a. ODHIN study - Catalonia, England, Netherlands, Poland, Sweden

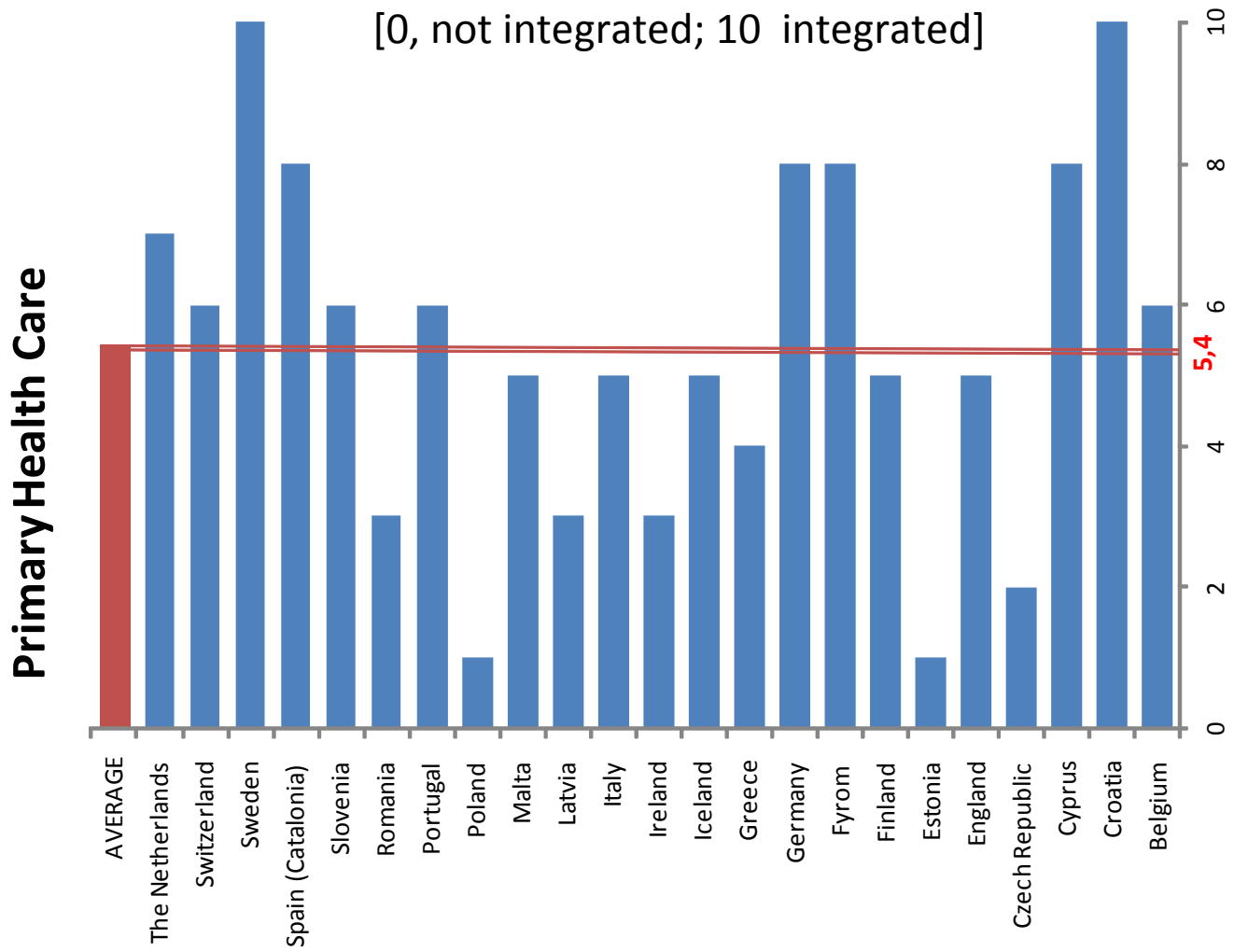
Proportion of 18-65 year olds who consulted GP identified as AUDIT-C +ve during routine practice: **1.3%**

Real prevalence: **24.0%**



5. The block

b. Expert opinion of extent to which brief advice is integrated in work of PHC as are diabetes or hypertension



5. The block

c. There is evidence for changing provider behaviour.

Educational strategies

6 reviews + in favour; 3 reviews -/+ in favour

Financial reimbursement

3 reviews -/+ in favour

E-health

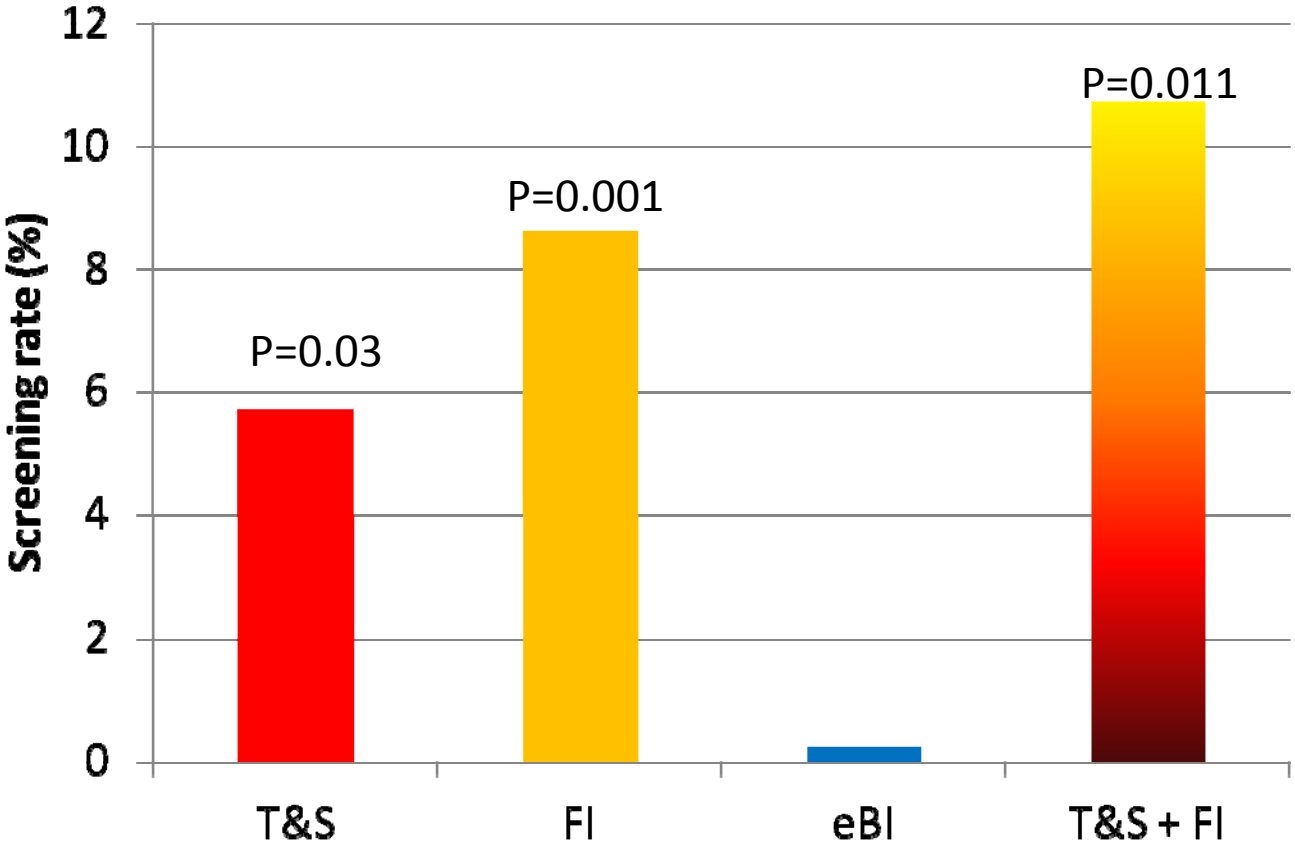
13 reviews + or ++ in favour; 9 reviews -/+ in favour

Multifaceted interventions

7 reviews + in favour; 2 reviews -/+ in favour

6. Overcoming the block

a. ODHIN trial, preliminary results for Catalonia and Sweden.



Absolute differences in screening rates per provider
(12 week implementation period – baseline)
for intervention groups over and above control group

6. Overcoming the block

b. BISTAIRS guidance.

Primary health care

Main problem implementation; focus on commissioners and financers of services to implement brief advice programmes in routine care.

Accident and emergency departments

Main problem implementation; focus on professional bodies to develop systems to implement brief advice in routine care.

Occupational health services

Main problem is inconsistent evidence; focus on professional bodies to develop systems to implement and evaluate brief advice in routine practice.

Social service and criminal justice systems

Main problem is lack of evidence; focus on professional bodies and research funding bodies as to how evaluate brief advice in routine practice.

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6. Overcoming the block

c. Measuring progress (assessment tool)

16/23 EU countries assessed (70%) reported the presence of clinical guidelines for brief advice programmes;

but, in only 4 of these (25%) had there been any studies assessing their implementation.

Conclusions - 1

The focus of what we are trying to do is to reduce heavy drinking, and thus its negative outcomes to the drinker and those surrounding the drinker, through identification and brief advice programmes in primary care settings;

Widespread implementation may also reduce some of the stigma associated with very heavy drinking.

Conclusions - 2

We think that the focus should be in trying to improve what is happening in primary health care - it is here that the evidence base for effectiveness, cost effectiveness and implementation is greatest – far greater than in any other primary case setting.

But, there is an enormous amount of unfinished business to deal with - i.e, country wide implementation.

Conclusions - 3

It is not so clear what should be done in other settings - emergency departments, workplace or social welfare and criminal justice systems. We need more evidence to guide policy. Gaining this evidence, however, should not compromise the great need to implement programmes in primary health care.

For these other settings, if there is a need to do something, probably the best thing to do is to give simple feedback and an information and self-help leaflet.

Conclusions - 4

Primary health care is a very busy setting, with time pressures and many competing demands. It makes sense therefore to keep things simple – use the AUDIT-C (three questions) and 5 minutes advice with a patient self-help leaflet.

AUDIT-C can be embedded with other lifestyle questions, and does not need to be administered at every consultation. It could be used when patients newly register, for at risk demographics (e.g., middle aged males), or at risk conditions (e.g. raised blood pressure).

Conclusions - 5

Health systems should support implementation through clinical guidelines, training and support systems, other available resources (e.g. eBI), and, possibly, targeted financial incentives.

Conclusions - 6

Implementation needs much better regular monitoring and reporting, based on targets:

Over the next 10 years, 10% of all heavy drinkers that exist in the population should have been given brief advice in primary health care.
[Based on **all** newly registered adults being screened and **two-thirds** of those identified as positive being given brief advice]

Thank you for your attention

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