

Alcohol, Strategy and Primary Care

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Government Strategy

- Crime - £7.3 bn
- Lost productivity - £6.4 bn
- NHS - £1.4 - 1.7 bn
- Human suffering - ?

Cabinet Office Strategy Unit "Interim Analytical Report"

<http://www.number10.gov.uk/output/page4498.asp>

Government strategy: treatment

- Screening
- Brief intervention
- Specialist referral in the community
- Specialised residential services
- Mutual help / self help

One or Two Thoughts

- Alcohol interventions work
- Specifically:
 - Brief Interventions work
 - Long term support and follow up add value
- UK primary care is well placed to contribute to this
- Experience with helping opiate users in primary care is increasingly positive

BUT

- Efforts to involve GPs in alcohol related work have broadly failed for more than 30 (60) years

Not Covered Today

- Detoxification
- Prescribing options
 - Disulfiram
 - Acamprosate
 - Naltrexone
- “Specialist” psycho-social interventions
- Existing service provision and systems in Oxfordshire

Overview

- What we knew when I was a boy
- Alcohol use over the life cycle
- Treatment effectiveness
- Brief interventions and long term support
- Delivering help
 - Why primary care?
 - To screen or not to screen?
 - Stepped care

1978 Maudsley Alcohol Pilot Project (wwkwiwab)

- Role Legitimacy (not my job)
- Role Adequacy (not confident or skilled)
- Role Support (Shaw et al 1978)
 - Time available
 - Specialist support
 - Clear and ACCEPTABLE guidelines
 - Support from Government policies
 - Policy / Economic context in primary care
 - (SSA 1999. Tackling Alcohol Together)

Alcohol use over the life cycle

- Northern European drinking pattern
- Highest prevalence of heavy drinking
“dependence syndrome” and “problems” occur
in young men
- Physical and mental health consequences (other
than “accidents” and hangovers) are usually
long delayed
- Thereafter steady reductions in consumption
“dependence” and problems

Recent Changes

- Increasing consumption among
 - Women
 - Young people

Treatment effectiveness

- Consistent findings
 - Treatment is effective
 - Simple and brief interventions (plus research follow up) are as effective as complex and long interventions
 - Empathic skilled therapists do best

What is a brief intervention?

- Definitions of intention, duration and content vary, but typically:
 - Reduce alcohol consumption
 - 1-4 sessions
 - Frames
 - Feedback
 - Advice
 - Empathy
 - Responsibility
 - Menu
 - Self Efficacy (optimism)

Brief interventions

- **Mesa Grande** Miller et al (2002)
- **Brief Interventions in Treatment seeking (and Non-treatment seeking) populations**
Moyer et al (2002)

Mesa Grande (Miller et al 2002)

- 46 treatment modalities
- 3 or more controlled trials
- Regardless of population severity and whether or not “clinical populations”

MOST and BEST QUALITY evidence of efficacy is for...



Brief interventions (1 or 2 sessions)

“Treatment Seekers” (Moyer et al 2002)

- Up to 4 sessions of treatment (but...)
- 20 studies
- Brief vs “more extended” treatments: “statistically homogeneous”
- ***Treatment effects fade after 3-6 months (therefore need for longer term motivational enhancement)***

In UK Primary Care

- Wallace et al (1988)
 - 47 group practices
 - Randomised controlled trial
 - Assessment, advice, written information, up to 5 follow up appointments
 - Men: Proportion of XS drinkers fell by 44% vs 29% and fall in GGT at 12 months
 - Women: 48% vs 29% no fall in GGT in women at 12 months
- Anderson and Scott (1992) similar findings

BUT

- “Ideal” research conditions
 - Enthusiasm
 - Volunteers
 - Time limited
- Researchers not GPs did the screening and the recruitment
- Other studies (using primary care staff) much less impact

Long term support and follow up

- E.G. 3 relevant studies
 - Project MATCH (*passim*)
 - Moos and Moos (2003)
 - McLellan (2002)
- “Rapid entry into treatment and the duration of treatment ... may be more important than the intensity of treatment... providers should consider structuring their programmes to emphasize continuity rather than intensity of care.” (Moos and Moos, 2003)

To Screen or Not to Screen

- The evidence base draws heavily on studies of service attenders who have been screened to identify heavy or problem drinkers to have an intervention before (or at the time of) alcohol related harm.
- This has always been considered a good thing (by researchers and public health) UNTIL

Beich et al, 2002 BMJ

- Qualitative study of 24 Danish GPs involved in WHO Phase IV study
- “GPs who have tried a screening and brief intervention programme ... find the extra workload onerous and ***have problems in establishing rapport*** with excessive drinkers located by screening” (my emphasis)
- “The programme disrupts normal patterns of work and cooperation in the GP setting while failing to detect and deal with some problem drinkers”

Debate (BMA website)

- Pro-screeners

- “The misleading conclusions of the article, based on flawed study design, lack of tailoring, and failure to review the published literature, are hazardous to the implementation of alcohol brief interventions in primary health care and thus also to potentially significant improvements to public health.” (Seppa)

- Others

- Results “STARTLING”
- The customers (GPs) are probably right and certainly have history and experience on their side
- More research needed (?)

Debate (BMA website)

- [the] proposal that GPs should be advised to restrict alcohol interventions to patients in whom “signs of alcohol playing a negative role in case history [are] present” undermines the aim of early identification, thus returning us to the practice of considering intervention only when it was already *too late* to prevent harm.
 - (Heather, Anderson Gual and Seppa)

Screen and screen and screen until I'm sick

- For
 - Identifies some (depending on what will happen next)
 - Pleasing to the public health sensibility
- Against
 - How, on planet earth would you actually do it?
 - Time consuming
 - Misses some / most of those with serious problems
 - Doesn't necessarily lead to any action
 - DOESN'T HAPPEN

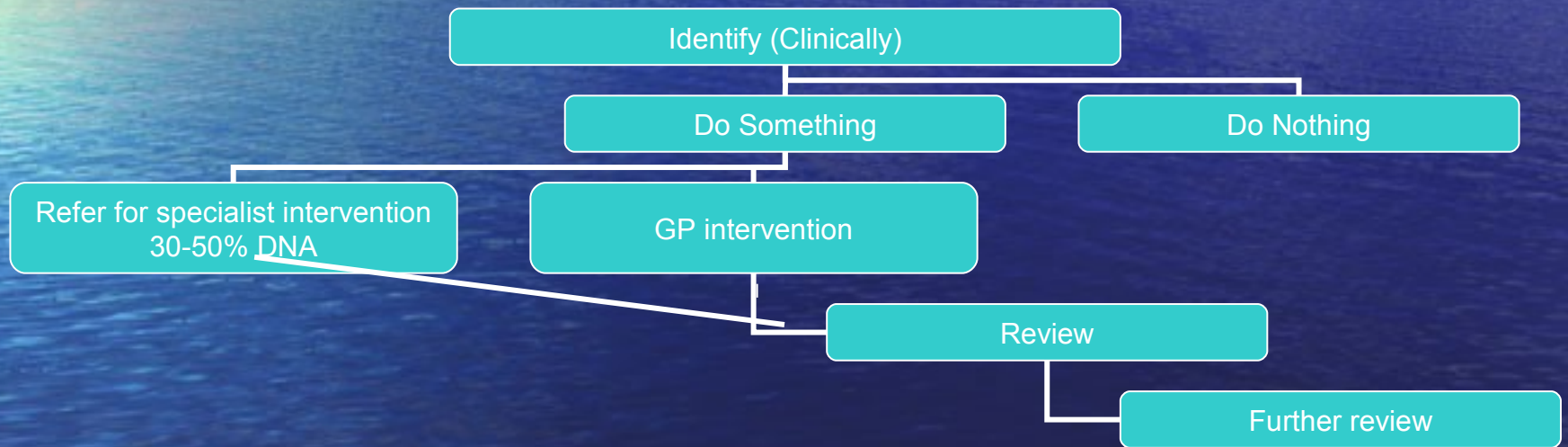


So back to basics

Why Primary Care?

- 98% of population have a GP
- 2/3 visit per year
- 90% visit per 5 years
- Heavy drinkers visit twice as often as light drinkers
- Average GP sees 364 hazardous or harmful drinkers per year (most do not need to fill in a questionnaire to be identified)
- Most heavy drinkers seeking help go to their GP first

Care Pathway



What should be in the GP “do something” box

- Feedback objective information
 - Leaflet on Units / Drink Diary
 - FBC and GGT
- Discuss Responsibility for change
- Advise on the above (ALWAYS AFTER ASKING)
- Provide list of helping options (Self and Agencies) GET CONSENT FOR REFERRAL
- Empathy (best predictor of outcome)
- Self efficacy (OPTIMISM)
- THEN MONITOR

Or more simply

- Ask “do you have any concerns about your drinking?”
- Listen carefully
- Give them a leaflet full of good stuff and invite them to monitor and compare their consumption with the recommended level
- Offer them a blood test to check for liver damage
- Explain that it should be possible for them to reduce their drinking, most people do over time, there is good advice on how to do it (and other sources of help) in the leaflet
- Offer to see them again to review progress (give test results, discuss any other concerns, refer for more help if necessary etc)

Training

- Can it take more than half a day to learn to do that?
- Rollnick warns that brief interventions are not as easy as they look... but it depends what you mean by a brief intervention...
- And the alternative is usually NO intervention

Stepped care

- If changes don't occur, then the GP is still best placed to monitor and encourage change over time
- Specialist (more intensive) interventions may be necessary as well from time to time

New GP Contract 1

- Develop a register of all alcohol misusers
- Undertake brief interventions and offer support for behavioural change
- “Prescribe” follow up treatment (in-house or by referral)
- Detoxication (community)
- Routine use of assessment tools

New GP contract 2

- Liaison with local specialist services
- Appropriate training
- Annual review: audit of
 - Those identified
 - Advice and treatment offered
 - Number of patients who have reduced
 - Feedback from misusers and carers

New GP Contract 3

- Accreditation: experienced, trained, competent, qualified
- Payment: £1000 retainer plus £200 per patient per year

What can we learn from drug Shared Care experience?

- It can be done (Feedback)
- Give GPs the lead in steering how it develops (Responsibility and Menu)
- Provide training but keep it simple (Advice)
- Payment does no harm (Empathy?)
- Facilitate what GPs are good at anyway
 - Happily this is precisely what works (Self efficacy)