Tackling alcohol misuse: opportunities and obstacles in primary care

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SUMMARY

Alcohol misuse is a major public health issue. Primary care has been recognized as an ideal setting for the health promotional activity needed to reduce the general population's alcohol consumption. This paper explores the background to the current belief that primary care is suitable for this work by examining the evidence of the potentially successful interventions the general practitioner (GP) can undertake with alcohol misusing patients, GPs' attitudes towards this work, and the impediments that exist. Computer searches of the MEDLINE database up to 1997 and a manual literature search of the bibliographies of published papers that were identified as relevant were carried out. Research points to GP interventions being effective, but it also provides evidence of their negative attitudes. It concludes that more training and support from local services are needed if primary care is to meet its rich potential.

Keywords: alcohol misuse; general practitioners; GP attitudes; health promotional activity.

Introduction

ALCOHOL misuse is a major public health issue, with huge costs to society.[1,2] The Royal Colleges of General Practitioners,[3,4] Physicians,[5] and Psychiatrists,[6] recent government policy,[7] and the scientific literature[8-11] all recognize the appropriateness of general practice for the health promotional work needed to reduce the general population's alcohol consumption. Screening instruments have been developed and tested,[12-14] and there is a growing body of evidence on the effectiveness of primary care interventions.[15-17] The large number of drinkers who deny their drinking problem, and are unmotivated to seek help,[18] is often cited as the reason for the difference between the known prevalence of alcohol misusers in society and those who seek help. However, there is a substantial literature that points to the reluctance of GPs to work with these patients. Ultimately, while GPs may be well placed to offer an intervention to the alcohol misusing patient, do they actually want to do this work?

This paper is an exploration of the background to the current belief that primary care is suitable for this work by examining the evidence of the potentially successful interventions that the GP can undertake with alcohol misusing patients, their attitudes towards this work, and what impediments exist.

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Method

Computer searches of the MEDLINE database up to 1997 and a manual literature search of the bibliographies of published papers that were identified as relevant were carried out. Those papers that explored the GP's work with alcohol misusing patients were selected for this review, along with papers and reports on the development of the primary care role in this field.

General practice as a setting for the detection of alcohol misuse

General practice is ideally placed for preventive work[19-20] because of its extensive access to the general population. In the United Kingdom a patient must register with a GP to receive care, and 98% of the population is registered.[21] During any year, a GP will see over 70% of their practice list, increasing to over 90% over five years.[15] However, having access alone does not mean that the primary care setting is ideal. The setting must also provide an atmosphere that is conducive to health promotion, targeting patients, and selecting interventions that produce the desired result; namely a patient who drinks less. The GP in the primary care setting is particularly well placed for this work because contacts made by doctors are mainly patient-initiated; thus, the patient is already attuned to health issues and is more likely to be receptive to a proposed behaviour change. These consultations offer educational opportunities that are specific and uniquely one-to-one, and are delivered by GPs who are viewed as credible and trusted educators.[20,22,23]

The efficacy of general practitioner brief intervention with patients

Primary care is recognized as a potentially effective setting for brief interventions that offer a mixture of advice, information, and health promotional literature to the targeted patient.[9,24-27] The value of brief interventions with alcohol misusers, both in general hospital and primary care settings, has been underlined in several research studies[28-31] and has captured attention because such interventions are cost-effective in targeting the most excessive drinkers. A systematic review by the Department of Health estimated that it costs as little as £20 to detect a problem drinker and deliver a brief intervention.[32] Studies strongly suggest that many drinkers do not need an intensive course of treatment in order to benefit.[16,30]

The literature review identified seven studies of brief interventions with alcohol misusing patients in primary care: the DRAMS (drinking reasonably and moderately) scheme;[16] the Medical Research Council's (MRC's) Lifestyle and Health Study;[15] the Hameenlinne study in Finland;[34] the Stockholm study;[35] the Australian Royal Prince Alfred Hospital study;[36] the Oxford study;[17] and the World Health Organization study.[37] These studies all had the general aim of measuring reduction in alcohol consumption following the intervention,[33] and all support the proposition that this is potentially a very effective method of health promotion and disease prevention.

All of these studies recruited non-dependent drinkers and randomly allocated them to control or study groups. All but one study[35] targeted both male and female drinkers. Demographic

factors such as age, marital status, and socioeconomic factors were not predictive of changes in drinking behaviour after an intervention,[17,37] although an intervention with men was more effective that with women.[15,17,37,38] In addition, GP interventions were more successful than non-intervention or other methods of intervention.[15,37,38]

While brief interventions may reduce individual consumption by very little, their public health value is potentially enormous.[39] The MRC study[15] noted that, if their results were applied to the United Kingdom, intervention by GPs could, each year, reduce, to moderate levels, the alcohol consumption of some 250 000 men and 67 500 women who currently drink to excess.

GP ambivalence about this proposed role with alcohol misuse

The evidence suggests that primary care intervention is an effective and acceptable method of detection and intervention with alcohol misusers. Despite this, GPs are reluctant to treat alcohol problems. Anderson[40] found that few doctors gave advice on alcohol consumption or used readily available health education literature. Few GPs attended training on the issue, although such training was readily available in the area.[41] Heather,[17] in a trial study for the DRAMS scheme, found it difficult to promote interest among some doctors to take part in or to complete the study properly because of the unpopularity of working with problem drinkers, pessimism at the outcome of treatment, reluctance to raise the issue, and fear that they did not possess the necessary skills to treat the problem. Furthermore, Anderson[40] found that, although most of the doctors studied felt that they should be involved in treating alcohol problems, only 40% said that they actually were.

Although health promotion studies have found that patients view this work as part of their GP's role, most patients are more comfortable in consultations where lifestyle issues other than their alcohol consumption are discussed.[8,42-47] Strong[48] attributes this to the fact that the 'social' nature of alcoholism is inescapable – unlike in other consultations, the GP must deal with the social reasons why the patient is 'ill', and the fact that, ultimately, the 'cure' lies within the patient's own will to be cured.

The value the doctor places on health promotional activities is also a dubious issue. One study reported that 60% of GPs found diagnosis and treatment more interesting than health promotional work, and 45% felt that screening 'created more problems than it solved'.[49] The highly stressful nature of GPs' work must also be examined, especially in the light of the new demands of the 1990 contract.[50] Heavy workload, time pressures, practice administration[26,51-56] can all influence the GP's perception of the worth of preventive work, which is often viewed as not having a tangible outcome. Hannay *et al*[57] describe a much busier profession, while Sutherland and Cooper[50] report higher levels of stress and depression among GPs since the introduction of the new contract.

The potential success of interventions with alcohol misusers depends fundamentally on the willingness of doctors to treat these patients. Research supports the thesis that GPs have a potentially major role in detecting and treating alcohol problems, but it also points towards barriers to this work.

The problem of defining alcohol abuse

Doctors appear to have a dilemma with defining where excessive drinking becomes a problem. Alcohol consumption in society is a complex subject because alcohol is often used moderately, without side-effects, and in a socially acceptable way. Its use is commonplace, which makes the difference between acceptable drinking and problem drinking harder to define. The problems experienced by individuals because of their alcohol consumption can be physical, social, or psychological. Usually there will be variable combinations of all of these.[58] As such, the drinking population represents a continuum ranging from those who drink alcohol without problems, through to those who drink with problems at a level that allows them to function relatively normally, through to those who are dependent drinkers suffering withdrawal symptoms. Ultimately, individual GPs will have different opinions concerning what level of drinking constitutes a problem. Local drinking habits where consumption of large amounts of alcohol may be considered normal,[59] and the GP's own consumption,[40] can also influence opinions.

General practitioners have been found to use a variety of terms to describe alcohol misusers, finding it difficult to distinguish between alcoholics, excessive drinkers, and problem drinkers.[60-61] Research by Wallace *et al*[62] examined what professionals in the field deemed 'safe drinking levels' and found that there was no consensus. Strong[48] also found that there was no agreement between the doctors in this study for defining an alcoholic or at what point drinking becomes a problem. Mowbray and Kessle,[61] in a study of GPs, found that only 42% differentiated between alcoholics and dependent drinkers, using the presence of dependence as their criteria. The research points to a real lack of knowledge about the fundamental concepts underpinning alcohol misuse and dependence, and the definitions of problem and dependent drinking. Lack of knowledge has made doctors less likely to enquire about alcohol use,[63] to be less aware of interventions,[64-65] and to perceive the identification of and intervention with alcohol misusers as not their role.[64] McLean[65] believed definition to be a central issue, and considered that statements of the disease model of alcoholism stood as a major barrier to the effective management of the problem drinker by the GP. Consequently, the GP should be encouraged to view alcohol use along a continuum and seek information about alcohol consumption routinely.

Methods of avoidance of intervention with alcohol misusers

Lack of knowledge is not the only issue: some GPs actively avoid working with alcohol misusers. Thom and Tellez[41] found that doctors were so uncomfortable with the issue of problem drinking that they developed strategies to avoid making a diagnosis; addressing the issue only if it was raised by the patient first, attempting to expose the problem without directly confronting it, through probing without asking direct questions, and stopping if the patient is denying an alcohol problem. Others only mentioned alcohol misuse if they were presented with related medical symptoms. Many doctors felt that, if alcohol misuse was not the reason for consultation, to mention it would be an invasion of privacy. Others sent the patient for tests for evidence of the problem drinking and this gave them a legitimate opportunity to discuss it.

Studies by Boulton and Williams[66] and also by Driessen *et al*[67] found that many doctors opted out of addressing alcohol problems in these patients altogether. Studies also point to consistent underdiagnosis of alcohol problems within general practice. Reid *et al*[68] found that, of 40 patients identified as high-risk drinkers, only 27.5% were considered high-risk drinkers by their GP. In contrast, 90% of doctors interviewed by Mowbray and Kessel[61] said that they were comfortable in asking a patient about their alcohol consumption. However, almost 40% of these doctors

never took an alcohol history, even when they believed the patient had a problem. Doctors cited various reasons for this: some felt that work with alcohol misusers was 'pointless' as the patients 'always let the doctor down', some expressed the hope that the patient would 'change anyway', and some believed it was better to see if the problem became worse before intervening. A desire to avoid confrontation was expressed by many GPs, as was the difficulty of handling patients with drinking problems.

The research discussed so far has pointed to a profession that has a basic lack of knowledge about the fundamentals of alcohol misuse, that avoids working with 'alcoholics', and has little faith in its own abilities to detect and treat the problem. The concept of 'role insecurity' has been put forward by, what is often regarded as, the seminal study in the field, the Maudsley Alcohol Pilot Project (MAPP) research,[18] which provided an explanation for this apparent lack of desire and lack of comfort to work with alcohol misusers. The concept consists of three factors: first, anxiety about 'role adequacy' by virtue of the lack of skills and training GPs possess; secondly, anxiety about 'role legitimacy' by virtue of their uncertainty about whether alcohol misuse was their responsibility; and thirdly, anxiety about 'role support', where GPs are fearful about where to turn should they need help with a client. This culminates in the doctor suffering 'role insecurity' when confronted with an alcohol misusing patient.

More recent work[69] on the surface echoes the MAPP[18] as GPs continue to perceive the alcohol misusing patient negatively. However, this more recent work found that GPs recognize the appropriateness of the primary care setting for this work and, as such, felt 'role legitimate'. They, nevertheless, still did not feel sufficiently trained ('role adequate') or supported by local alcohol services ('role supported').

Discussion

The scientific literature has provided much evidence of the potential effectiveness of the primary care practitioner to detect and manage alcohol misuse. Government policy continues to place emphasis on the primary care setting to undertake health promotion. Research points to GP interventions being effective, but it also provides evidence of their negative attitudes. In the midst of the debate about the role of primary care with alcohol misusing patients is the fact that, more than five years on into the *Health of the Nation* strategy,[7] alcohol targets are not being met. The health promotional work to meet these targets was to be undertaken mainly in primary care. Why, when primary care has such unique access to the general population, is so little impact being made on the alcohol consumption of this population? Little progress has apparently been made, since the MAPP, that has pointed towards the pivotal role of training and support for the health care worker coming into contact with alcohol misuse patients. However, a recent study[69] has identified GPs who are identifying alcohol misusing patients routinely, perceive themselves to be 'role legitimate', and recognize the appropriateness of the primary care setting for this work. Several issues remain to be urgently addressed if the full potential of the primary health care team in this important area of health promotion is to be realized.

The research evidence points to a professional group among whom many are uncertain about their own skills and abilities to work with alcohol misusers. At least two approaches to tackling this problem can be immediately identified. First, there is still a need for information and training for primary care workers through the provision of guidelines on how to detect and manage problem drinkers. Twenty years after the MAPP, the lack of training should not still be an issue, but it remains so. Awareness must be raised of the screening and educational instruments available to aid identification of and education about alcohol misuse. Training, while essential, must also be organized so that it does not represent an unreasonable burden on the busy primary care professional. A recent study[70] suggested that GPs do not recognize that mental health training is a priority, and the need for drug and alcohol addiction training is a major concern for many. In addition, the study identifies small group workshops combined with lectures as the doctors' preferred method of training. A review of the continuing medical education literature[71] suggests that training does not change physician performance, but identifies the need for a combination of training delivery methods to maximize effectiveness. The existing continuing postgraduate educational system has been criticized for being ineffective and irrelevant to GPs' training needs.[72-74] GPs are busy professionals and need training that is not just relevant and effective but that is also accessible. Programmes must be organized within existing educational systems where possible, or within the practice to reduce loss of time. These programmes, where possible, should also have postgraduate education accreditation.

The second approach to the problem that GPs have with regard to dealing with alcohol misusers is to provide better support/consultancy services that, by their existence, empower and enable the GP. One particular major problem facing GPs is the dependent drinker in crisis who needs to be seen by the specialist services quickly. Often a telephone call, to reassure and advise the doctor may be all that is needed, while occasionally an immediate specialist inpatient admission may be required. However, there can be no doubt at this point that the primary care sector currently feels very much alone when dealing with the more severe cases of alcohol misuse.

Evidence points to a professional group who are undertaking much more work than ever before. Attitudes towards alcohol misusing patients are improving, with work in this area being seen as part of the GP's role. Primary care is not unwilling, but needs to be provided the means, through training and support, to fulfil its rich potential.

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