Alcohol-related problems in Australia: is there a role for general practice?

General practitioners are well placed to help patients with drinking problems, but, given the existing demand for conventional diagnosis and treatment, prevention might best be tackled through legislative and other means

ALCOHOL IS PROBABLY ONE OF HUMANITY'S oldest drugs, and is the most widely used drug in the Australian community.[1] In this issue of the Journal (*page 103*), the article by Graham and colleagues, on newer pharmacotherapies to help people with alcohol dependence,[2] highlights specific interventions that general practitioners can use to help their patients with more severe alcohol-related problems.

It is worth noting that most of the morbidity associated with alcohol use does not occur in people with dependence, but rather in those who have hazardous or harmful drinking patterns. The National Mental Health and Wellbeing Survey indicated that, among young men aged 18–24 years, the prevalence of harmful use of, or dependence on, alcohol was over 20%.[3] The 1998 National Household Drug Survey found that 18% of people surveyed admitted to driving, 30% admitted to verbally abusing another person, and 2% admitted to physically assaulting another person while under the influence of alcohol.[1] The acute health and social effects of alcohol intoxication are just as devastating as the long-term effects of chronically excessive alcohol consumption.

Many GPs have negative perceptions of dealing with people who have alcohol and other drug-related problems.[4] However, GPs can be very effective at altering the consumption habits of non-dependent drinkers.[5] If the matter is raised, most Australians who drink too much will respond to a structured discussion with their GP about their alcohol consumption patterns. This may be where the general practice "main game" ought to be. The first step in managing people with alcohol-related problems is to identify them, and currently the AUDIT questionnaire is accepted as the most appropriate screening tool in the general practice setting.[6] A copy can be found in the recent *Guidelines for preventive activities in general practice*.[7] Screening of all Australians over the age of 15 is recommended.

Brief intervention (see the Box) involves GPs raising the question of alcohol intake, and determining whether patients might consider changing their levels of consumption. If so, then risks and benefits of drinking are explored, strategies for reducing alcohol intake to safer levels are presented, goals are set, and follow-up is arranged. If patients do not wish to discuss their drinking, they can be given some printed information and the door left open for them to return if they change their minds. The intervention is quick and easily learnt. Many Divisions of General Practice across Australia offer training in brief intervention and motivational interviewing.

GPs can also help their patients overcome alcohol dependence, but interventions for this require more time. Detoxification in the community, supervised by GPs, can be a safe option,[8] and rural GPs supervise hospital-based detoxification on a regular basis. The use of anti-relapse medications such as acamprosate or naltrexone can help alcohol-dependent patients remain abstinent once they have undergone detoxification. However, as such patients ideally require counselling and support from professionals specifically trained in addiction, the GP's role is as a member of a team. The medication is only part of the assistance package.

Brief intervention — the steps

- Identify individuals in whom alcohol consumption is hazardous or harmful
- Determine the person's readiness for change
- If contemplating change, discuss the benefits of reducing drinking
- Suggest strategies for reducing consumption
- Negotiate goals
- Arrange follow-up

It should also be remembered that screening and therapeutic interventions for alcohol problems are just one of many competing demands on GPs. High blood pressure; diabetes; smoking; screening for breast, cervical and colorectal cancer; depression; domestic violence; falls — the list of competing preventive priorities seems endless. Where should alcohol fit into all of this? What are the opportunity costs? What are the workforce ramifications of these types of preventive activities? Is there spare capacity within general practice to address these tasks?

Clinical practice guidelines and recommendations about preventive activities are positive developments in themselves, but are rarely accompanied by any consideration of whether they are possible to implement on a broad and equitable basis. Despite significant philosophical shifts within general practice and a growing acceptance of the value of prevention, the dominant medical model remains diagnosis and treatment. This pervades the way that general practice functions, the way it is structured and the way it is remunerated. In a recent survey of general practice in 2000–2001,[9] alcohol-related activities did not rate in the "top 30" most frequently managed problems. This reflects a reality that most health bureaucrats are reluctant to acknowledge — what is being asked of general practice is often beyond its capacity to provide. The GP is stuck in the middle, trying to respond to the community demand for diagnosis and treatment, while at the same time being asked to do more and more on a preventive level. The pertinent question as to whether the (usually population health) problem is best tackled through the medical model is almost never asked. There are often other approaches to these issues that are more effective, but might be politically unpalatable. In the case of alcohol misuse, reducing access though higher levels of taxation

(resulting in a higher price), targeting public education campaigns, restricting advertising, random breath testing and increasing penalties for drink driving are all effective methods of reducing alcohol-related morbidity and mortality. In short, alcohol consumption is best addressed by public policy.

General practice needs to focus on what it does best: diagnose and treat. There will be some circumscribed areas of prevention where the medical model fits well or where it is an important part of the whole picture. If we decide that alcohol consumption is one such area, then general practice needs to be adequately resourced to undertake this new task. However, there will be opportunity costs. There is good evidence that we can have a positive impact on alcohol consumption patterns, but we currently do not focus on this area in a substantial way because of real competing priorities that our community has placed before us.

Chris Holmwood

General Practitioner
Primary Mental Health Care Australian Resource Centre
Department of General Practice, Flinders University, Adelaide, SA

1. Australian Institute of Health and Welfare. 1998 National drug strategy household survey: first results. (Drug Statistics Series) Canberra: AIHW, 1999. (AIHW catalogue no. PHE 15).
2. Graham R, Wodak AD, Whelan G. New pharmacotherapies for alcohol dependence. *Med J Aust* 2002; 177: 103-107.
3. National survey of mental health and wellbeing. Report 2. Canberra: ABS, 1998. <http://www.health.gov.au:80/hsdd/mentalhe/resources/reports/pdf/mentalhealth.pdf>
4. Durand MA. General practice involvement in the management of alcohol misuse: dynamics and resistances. *Drug Alcohol Depend* 1994; 35: 181-189.
5. Bien TH, Miller WR, Tonigan JS. Brief interventions for alcohol problems: a review. *Addiction* 1993; 88: 315-335.
6. Dawe S, Mattick R. Review of diagnostic screening instruments for alcohol and other drug use and other psychiatric disorders. Canberra: AGPS, 1997.
7. Royal Australian College of General Practitioners. Guidelines for preventive activities in general practice. *Aust Family Physician* 2002; 31 S (May): 59-60.
8. NSW Health Department. NSW detoxification clinical practice guidelines. Sydney: The Department, 1999. <http://www.health.nsw.gov.au/public-health/dpb/publications/pdf/detoxification _clinicalpractice_guidelines.pdf>
9. Britt H, Miller G, Knox S, Charles J, et al General practice activity in Australia, 2000-2001. Canberra: Australian Institute of Health and Welfare, 2001. *(*AIHW cat no.GEP 8). ❑

NEW DRUGS, OLD DRUGS

New pharmacotherapies for alcohol dependence

Robert Graham, Alex D Wodak and Greg Whelan

ABSTRACT

- Two pharmacotherapies recently introduced in Australia, acamprosate and naltrexone, provide a major advance in the treatment of severe alcohol dependence, a common condition leading to a considerable burden of illness and major costs to the community.
- Acamprosate and naltrexone reduce alcohol intake, and increase the likelihood and prolong the duration of abstinence (Level I evidence).
- Compared with naltrexone, the benefits of acamprosate have been confirmed in a larger number of studies involving larger numbers of patients with longer durations of follow-up. Unlike naltrexone, acamprosate appears to achieve a sustained benefit.
- There is no known interaction effect between alcohol and acamprosate or naltrexone.
- Both drugs are well tolerated, although naltrexone blocks the action of opioid analgesics.
- Adjunctive psychosocial treatment with close follow-up is required for acamprosate and recommended for naltrexone.
- As yet, no studies have reported a reduction in mortality following the use of any pharmacotherapy for alcohol dependence.

MJA 2002; 177: 103–107

ALCOHOL ACCOUNTED for an estimated 3668 deaths and 95 917 hospital separations in Australia in the 1996–97 financial year.[1] Alcohol-related deaths in Australia declined from 460 per million population in 1990 to 369 per million in 1997.[2] The net economic cost of alcohol to the economy in 1992 was estimated to be $4.5 billion (this estimate includes increased healthcare expenditure and costs to industry from impaired productivity, increased accidents and absenteeism).[3]

Prevention and treatment of alcohol-related problems has been improving in recent decades. In the 1980s, brief interventions[4] were developed for problem drinkers who reject abstinence or are unsuitable for this treatment goal. Brief interventions involve a combination of techniques, including motivational interviewing, feedback to patients of likely adverse consequences of current drinking, self-monitoring of drinking, developing a contract for future drinking, providing strategies to cut down drinking, and regular follow-up. Most clinicians try to discourage patients with life-threatening complications from alcohol from pursuing brief interventions.

Recently, more effective pharmacological treatments have been developed for alcohol dependence. The aetiology, natural history, compliance with and response to treatment of alcohol dependence are similar to those for other common, chronic, relapsing–remitting conditions readily accepted by the medical profession as worthy of treatment.[5] Treatment of alcohol dependence has been shown to sub-