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THE ROLE OF GENERAL PRACTICE SETTINGS IN THE PREVENTION AND MANAGEMENT OF THE HARM DONE BY ALCOHOL USE

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ABSTRACT

Phase I of the newly adopted WHO European Alcohol Action Plan includes among its objectives the strengthening of the contribution of primary health care to the prevention and management of the harm caused by alcohol. A WHO Working Group was convened to consider how this might be done and what role the primary care physician might play. The Group discussed research findings that suggest the usefulness of brief interventions by physicians in the primary health care setting, and proposed a model for intervention based on the levels of patients' alcohol consumption. The Group also discussed barriers to effective intervention and suggested strategies for overcoming them. Finally, the Working Group listed 12 competences needed by primary health care providers, suggested a number of important tasks at various levels and made recommendation on the education and training of primary health care physicians for their new role.

Keywords

FAMILY PRACTICE
ALCOHOLISM – prevent/control

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Introduction

The European Alcohol Action Plan was adopted by the Regional Committee for Europe in September 1992. Phase I of the Plan has four objectives, one of which is to strengthen the contribution of health care systems, and particularly primary health care, to the prevention and management of the harm caused by alcohol use. The Working Group was convened to consider the role of primary health care in this task.

The specific objectives of the Working Group were:

- to clarify the role of primary health care (or general practice) settings in the prevention and management of the harm done by alcohol use;
- to review the barriers to prevention and health promotion activities in these settings; and
- to consider strategies for increasing their capacity for preventing and managing the harm done by alcohol use.

The Working Group comprised 12 experts from 8 European Member States, 3 from Australia and Canada, 2 representatives of non-governmental and other organizations, 5 observers and staff of the WHO Regional Office for Europe. The participants included researchers, general practitioners, trainers, representatives of professional organizations, and people responsible for implementing policies and programmes on alcohol. The working papers and the participants are listed in Annexes 1 and 2, respectively.

Discussion

Why focus on primary health care physicians?

Although the Working Group focused on the primary health care physician (or general practitioner), it clearly recognized that the other members of the primary health care team, where they exist, may have an equally valuable role to play.

In many countries, primary health care physicians are the most numerous and easily accessible of all medical practitioners. They often have access to a wide range of support and specialist networks within a country's health care system. About 80% of their patients consult them annually. Empirical evidence suggests that patients have a high level of acceptance of advice from their primary health care physician. People with alcohol problems are known to make more use of primary health care services than the remainder of the population.

The early diagnosis of drinking problems in the primary health care setting could not only result in the immediate implementation of an appropriate treatment regime, but also prevent the mismanagement of physical conditions arising from excessive alcohol consumption, alleviate much human suffering and save valuable health care resources. Many people seem to expect their primary health care physicians to be concerned about issues such as alcohol and cigarette consumption, as part of physicians' increasing involvement in health promotion. For the patient, therefore, receiving advice on or treatment for alcohol problems in the primary health care setting may be less stigmatizing and difficult than receiving it in a specialist treatment centre.

Research findings

Since the late 1970s, a growing body of empirical evidence has suggested that minimal interventions can be as effective as traditional, specialist in- or outpatient treatment in the management of alcohol problems in clinical populations. More recently, people who receive brief interventions from primary health care physicians have been shown to reduce their alcohol consumption by a level significantly greater than that of people who receive no advice about their drinking. A brief intervention may be defined as an advisory or counselling session designed to inform a person of the effects of excessive alcohol consumption and to teach strategies for reducing it. These interventions may include bibliotherapy and follow-up or monitoring sessions.

In addition, some evidence indicates that, given specialist support, primary health care physicians can produce treatment outcomes in clinical populations that are equivalent to those of a specialist clinic. These studies may have some methodological problems and more

research is required to examine the effectiveness of different components of brief intervention procedures. At present, however, the evidence seems to suggest that interventions by physicians in primary health care settings are effective in preventing and managing the harm caused by alcohol use.

A model for intervention

A potential framework for primary health care intervention can be built using a model that views alcohol consumption as a health risk factor. This model proposes that the more a person drinks, the greater his or her risk of developing a drinking problem or becoming dependent on alcohol. Table 1 shows the framework for intervention.

Table 1. A model for intervention

Risk level (Target population)	Intervention	Role of primary health care physician
Low (People with low consumption)	Primary prevention	Health promotion Advocacy Role model
Elevated (People with hazardous, harmful consumption)	Brief intervention	Identification Assessment Brief counselling Follow-up
Substantial (People dependent on alcohol)	Specialized treatment	Identification Assessment Referral Follow-up

Most people in the general population are at low risk of developing drinking problems because their consumption of alcohol is low. Nevertheless, people can obviously move from one risk level to another. To maximize the number of people remaining at the low-risk level, primary health care physicians could take a proactive, primary prevention

approach towards alcohol use by this sector of the population. Thus, the physician might become involved in health promotion activities related to alcohol and drinking. It is now widely recognized that dependent drinkers cause less alcohol-related harm to society than people whose hazardous and harmful levels of consumption put them at elevated risk of developing alcohol problems. These people should be the principal target of brief interventions conducted in the primary health care setting. Nevertheless, primary health care physicians also have a role in helping people who are at substantial risk of alcohol problems because of their dependence on alcohol. For example, the physician might recognize when specialist treatment is required and refer the patient to an appropriate source of help.

The value of this model lies in the fact that it outlines a possible role for the primary health care physician in relation to each risk level of consumption. In addition, countries can draw on and develop different parts of the model in accordance with the current structure, nature and functions of their primary health care systems. Further, the model highlights the proactive as well as the reactive role of primary health care physicians in the prevention and management of alcohol problems.

Barriers to effective involvement

A number of barriers can be identified to the prevention and management of alcohol problems in primary health care settings. The Working Group acknowledged the differences in the structure of primary health care services and expectations of the duties of primary health care physicians in different countries. Nevertheless, the barriers in countries seemed to share many similarities. The barriers are both attitudinal and practical in nature, and they appear to stem from at least three sources: the primary health care physician, the patient and the organizational practices or structure of the primary health care system.

Primary health care physicians, for example, may have difficulties in defining levels of risk, diagnosing alcohol problems in the absence of alcohol-related harm and presenting their diagnosis to patients. They may lack motivation to manage alcohol problems, believing that they have neither the knowledge nor the skills required. Concepts of the

nature of alcohol problems, the legitimacy of a proactive role and traditional medical models of successful treatment outcome may also serve as barriers to treatment. Patients, on the other hand, are often unwilling to ask the primary health care physician for help with alcohol problems, preferring help with related problems. Patients may doubt the appropriateness of treating alcohol problems in the primary health care setting and the qualifications and competence of primary health care physicians to do so. Organizational barriers may include the heavy workload of the primary health care physician and support staff, time constraints and financial discentives.

Members of the Working Group highlighted the importance of conducting more research at the local level to identify additional barriers to treatment in countries or regions. It was suggested that this research examine issues of both process (attitudes and beliefs) and outcome (what actually happens in the primary health care setting).

Strengthening primary health care setting involvement

Strategies for strengthening the involvement of primary health care in preventing and managing alcohol problems obviously need to be tailored to suit individual countries and health care systems. Nevertherless, some general strategies for addressing structural, professional, educational and support issues can be identified.

In relation to structural issues, many countries appear to need to review policies on the renumeration of primary health care physicians and teams and their work with alcohol problems. In addition, countries need to clarify the extent to which national/federal and local governments, professional organizations and, where applicable, insurance companies have the power to determine the nature of the alcohol-related services that can be provided in primary health care settings. Many primary health care physicians seem to be unhappy when outside agencies impose additional duties on them without prior consultation.

Overcoming what might be called the professional barriers to treatment means implementing strategies to resolve existing conceptual, attitudinal, motivational and practical stumbling blocks. Thus, for example, it is fundamental that primary health care physicians be

convinced, perhaps through wider dissemination of research findings, of their ability to deal with alcohol problems. Greater motivation would result from the modification of the traditional medical model's definitions, which equate successful treatment outcome with a cure, in favour of those that equate success with gradual improvements in drinking behaviour and attitudes. To encourage primary health care physicians to play a greater role in preventing alcohol problems, alcohol-related interventions should be integrated with interventions that already address other lifestyle problems (such as high blood pressure and poor diet). Clearer guidelines for defining risky levels of alcohol consumption and diagnosing alcohol problems would aid primary health care physicians in their task, as would the introduction of targets and minimum standards of competence for them to achieve.

In addition to strategies aimed at increasing professional commitment to addressing alcohol problems, other strategies should address medical practitioners' need for more training and education on alcohol and alcohol-related problems. In some countries, core modules on alcohol and its effects are already part of training schemes for medical students and primary health care physicians. Such modules should be introduced on a wider scale. Initiatives of this kind should aim not only to improve knowledge about the physical, psychological and social consequences of alcohol use but also to impart practical skills in diagnostic, assessment and case management procedures. Future training and educational programmes should be monitored and assessed for their effectiveness.

Finally, issues of the help available to primary health care physicians in their new role must be addressed. First, a review should be made of the nature and extent of support available to primary health care physicians from within the health care system (such as specialist support), from community organizations and departments of local and national/federal government. The resulting information would form the basis for constructing strategies for improving support and intersectoral collaboration, if needed.

In general, strategies designed to strengthen the involvement of primary health care in the prevention and management of the harm caused by alcohol use should display at least three important characteristics. Rather obviously, such strategies must be able to be implemented

at the local level; they should reinforce one another and, when possible, they should be framed so as to conform with current medical practices and beliefs. They should not appear either too novel or too theatening to people working in primary health care.

Outcomes

The meeting of the Working Group had three immediate outcomes.

First, the Group listed 12 competences that primary health care physicians and teams need for the successful management of patients' potential or established alcohol problems. These include acquiring knowledge about alcohol and its effects and appropriate diagnostic and clinical skills, and developing the ability to chose and implement appropriate intervention and care plans. Each physician or team member should have:

(*a*) a knowledge of the prevalence of hazardous and harmful alcohol consumption, and of related physical, psychological and social problems;

(*b*) a knowledge and appreciation of the effects of patients' alcohol problems on their partners and families;

(*c*) an awareness of his or her attitudes to alcohol;

(*d*) the ability to identify the various physical, psychological and social indications of a drinking problem;

(*e*) the ability to communicate accurate information on alcohol and alcohol-related problems in an appropriate context, to patients or their relatives;

(*f*) the ability to distinguish between low-risk, hazardous/harmful and dependent levels of alcohol consumption;

(*g*) the ability to manage the physical consequences and complications of acute intoxication;

(*h*) the ability to take an accurate drinking history;

(*i*) the ability to recognize signs of alcohol-related disease;

(*j*) the ability to interpret laboratory results accurately;

(*k*) the ability to choose an appropriate management plan, that is, brief advice/intervention or referral to appropriate colleagues or clinics; and

(*l*) the ability to direct and manage patient detoxication at home.

Second, the Working Group suggested tasks to be accomplished at the individual, local and national levels and Region-wide (Table 2). These tasks are concerned with:

- the interest and motivation, knowledge and skills of primary health care physicians; and
- patients' risk of alcohol problems.

Taking the example of patient risk, at an individual level one might expect the primary health care physician to record risk levels for each of his or her patients, while at a European level one might hope to see the establishment of databases giving information on consumption per person and statistics on alcohol-related mortality and morbidity.

Third, the Group made recommendations on training and education on alcohol and alcohol problems for adoption by medical colleges or faculties of general practice in the Region. These recommendations are:

(*a*) list the objectives of educational and training programmes
(*b*) describe the context for such programmes
(*c*) broadly outline their contents
(*d*) highlight the need for a multidisciplinary approach to training.

1. Education and training should develop in primary health care physicians the knowledge, skills and attitudes needed to deal with alcohol and alcohol-related problems.

2. Teaching on alcohol and alcohol-related problems should be included in medical education for general practice at all levels:

- undergraduate education
- postgraduate training for general practice
- continuing medical education.

3. At the undergraduate level, such teaching should be coordinated by academic departments of general practice and/or public health, where they exist.

4. Education and training programmes should impart:

   - an understanding of the behavioural and social determinants of alcohol use and alcohol-related problems;
   - a knowledge of the medical, psychological and social consequences of alcohol use, and their diagnosis and management;
   - an understanding of the role of the individual, family, community, medical and related professions, and government dealing with alcohol problems; and
   - a knowledge of the principles and methods of health promotion, disease prevention and screening.

5. A multidisciplinary approach should be advocated at all educational levels.

6. Physicians should gain an understanding of the need for intersectoral collaboration in the prevention and management of alcohol-related problems.

7. Education and training programmes should be based on the findings of up-to-date research.

Table 2. Tasks at various levels in the prevention and management of the harm caused by alcohol use

Level	Primary health care physician (PHCP)		
	Interest and motivation	Knowledge, skills and behaviour	Information on patient risk/prevalence of alcohol problems
Individual	1. Ask the PHCP: "Are you interested in undertaking risk assessment with your patients?"	1. Ask the PHCP: "Do you routinely assess patients' risk of alcohol problems?"	1. Ask the PHCP: "Do you record risk levels (low risk; hazardous/harmful; dependent) for all patients' alcohol consumption?"
	2. Ask the PHCP: "If you had the opportunity, would you be interested in improving your work on patients' use of alcohol?"	2. Make a case scenario assessment of the PHCP's ability to diagnose alcohol problems	
Local	1. Determine the percentage of PHCPs answering "yes"/"maybe"/ "no" to the questions above	1. Determine the percentage of PHCPs answering "yes"/"maybe"/ "no" to question 1 above	1. Estimate the percentage of all PHCPs' patients at each risk level
		2. Measure performance on case scenario	
National	1. Calculate the percentage of PHCPs in country who answer "yes"/ "maybe"/"no" to the questions above	1. Where possible, estimate the percentage of PHCPs who specialize in treating alcohol problems	1. Estimate alcohol consumption per person
	2. Establish whether PHCP professional organizations have policy statements on alcohol and the WHO European Alcohol Action Plan	2. Discover whether medical training includes mandatory or optional alcohol education	2. Establish national databases on: alcohol-related mortality morbidity and traffic accidents, and cirrhosis of the liver
		3. Determine the percentage of PHCPs who routinely assess patients' risk of alcohol problems	3. Determine the percentage of the population at risk

Table 2. *(contd)*

European Region	1. Determine the number of countries that support the WHO Action Plan	1. Determine the percentage of countries with mandatory or optional alcohol education in medical training	1. Establish European databases on consumption per person and mortality/ morbidity statistics
	2. Determine the percentage of PHCP professional organizations with a policy statement on alcohol		

Annex 1

LIST OF WORKING PAPERS[a]

ICP/ADA 038/6	The role of general practice settings in the prevention and management of the harm done by alcohol use, by J. Saunders
ICP/ADA 038/7	The evidence for the effectiveness of general practice interventions for individuals with hazardous alcohol consumption, by P. Anderson
ICP/ADA 038/9	Methods of cooperation between general practitioners and a specialized treatment institute, by R. Mader
ICP/ADA 038/10	Alcohol and general practitioners, studies of their views, by B. Rush
ICP/ADA 038/11	General practice involvement in alcohol misuse: dynamics and resistances, by M.-A. Durand
ICP/ADA 038/12	Strategies for enhancing the capacity of general practice settings in the prevention, detection and management of alcohol use, by H.L. Hoeksema
ICP/ADA 038/13	Structural opportunities for enhancing the role of general practice – the UK General Practitioner Contract, by P. Evans
ICP/ADA 038/14	Training of general practitioners – the experience in the Russian Federation, by K. Pohkis
ICP/ADA 038/15	Training of general practitioners, by S. Feselmager and W. Beiglböck

[a] Copies can be obtained from the Alcohol , Drugs and Tobacco unit, WHO Regional Office for Europe, Scherfigsvej 8, 2100 Copenhagen Ø, Denmark.

ICP/ADA 038/16 Targets and audit, by O. Aasland

ICP/ADA 038/17 Levels of competence and quality control for general practitioners in the prevention, detection and management of alcohol use, by A. Roche

ICP/ADA 038/18 A statement on training in general practice, by P. Evans

Annex 2

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TARGET 17

TOBACCO, ALCOHOL AND PSYCHOACTIVE DRUGS

By the year 2000, the health-damaging consumption of dependence-producing substances such as alcohol, tobacco and psychoactive drugs should have been significantly reduced in all Member States.

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