

# Alcohol screening and brief interventions in primary care – Evidence and a pragmatic practice-based approach

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## Background

Risky alcohol drinking is a common problem in adults presenting in Australian general practice. Preventive health guidelines recommend routine delivery of alcohol screening and brief intervention (ASBI) by general practitioners (GPs). However, ASBIs have rarely been implemented successfully in a sustainable manner.

## Objectives

In this article, we explain the current state of empirical evidence for the effectiveness of ASBI in primary care and describe a pragmatic interpretation of how this evidence applies to routine care.

## Discussion

The empirical evidence surrounding ASBIs is complex. ASBIs are efficacious in research settings, but their effectiveness when compared with control interventions in real-world practice is less certain. Alcohol assessment within therapeutic doctor–patient relationships, rather than the specific formal tools, may be the ‘active ingredient’. A pragmatic, practice-based approach to early detection of risky drinking is to focus on strategies that allow asking patients about their drinking more regularly, documenting it, and using quality improvement methodology to improve alcohol recording data completeness for the practice population.

**R**isky alcohol use is a problem in Australia. The general population has consistently perceived ‘excessive alcohol consumption’ as the ‘drug of most serious concern’.<sup>1</sup> It is common – 30% of people aged 14 years or older are risky drinkers,<sup>1</sup> which represents 26% of adult patients in general practice.<sup>2,3</sup>

Alcohol screening and brief interventions (ASBIs) are recommended to be delivered by general practitioners (GPs).<sup>4–7</sup> The rationale is that if risky drinking is detected early, brief interventions can be delivered, and the burden of alcohol-related disease and injury in the population reduced.<sup>8</sup> With ASBIs recommended in routine practice, a basic empirical question must be answered: ‘Do ASBIs work in general practice settings?’

## The empirical evidence is complex

The ‘definitive’ reference often cited is the systematic review and meta-analysis by Kaner et al<sup>9</sup> published in the Cochrane Library. At face value, its findings are supportive of ASBIs. Participants who received ASBIs consumed, on average, four fewer standard drinks per week than the control group at one year follow-up.<sup>9</sup>

However, there are clinically meaningful uncertainties in these results, including a major sex difference. Men in the ASBI

groups reduced their mean alcohol intake by six standard drinks per week, whereas women reduced their intake by only one standard drink per week.<sup>9</sup> Moreover, there was moderate heterogeneity – that is, there was a lack of consistency in the results of the individual studies in the meta-analysis,<sup>10</sup> even within the male and female subgroups.<sup>9</sup> The implication is that there are clinically important contexts that influence the effectiveness of ASBIs.

## Efficacy versus effectiveness

The evidence base has been challenged recently by the publication of several large, pragmatic studies of ASBIs in general practice, which all found contrary results since the 2007 systematic review. Trials from Denmark,<sup>11</sup> England,<sup>12</sup> Wales,<sup>13</sup> the Netherlands,<sup>14</sup> and in a veterans affairs population in the US,<sup>15</sup> all demonstrated no or minimal effect of ASBIs, compared with the control intervention.

Recent academic commentary has recognised the issue of effectiveness, as opposed to efficacy. That is, even if ASBIs are efficacious in controlled settings, they might not be effective in real-world practice.<sup>16–18</sup> There remains disagreement as to whether ASBIs are effective in pragmatic practice. Some interpret the evidence firmly in the affirmative,<sup>19–20</sup> while others are more circumspect and trend towards the negative.<sup>16,17,21</sup>

### 'Active ingredient' of ASBI

An observation from the aforementioned pragmatic trials in general practice is that participants in the control groups, who received screening and usual care, had important reductions in risky drinking. The overall null result was the consequence of the control participants improving just as much as those who received the formal ASBIs package.<sup>12-15</sup> One encouraging interpretation of these findings is that the alcohol assessment process itself may be the 'active ingredient'. The effect of ASBIs may primarily be in encouraging individuals who are contemplating and able to reduce their drinking to do so.<sup>12,18,22</sup> This may explain why longer brief interventions are no better than shorter,<sup>9</sup> and why ASBIs are ineffective in people with more severe alcohol use problems.<sup>23</sup>

### Making ASBIs acceptable

The research agenda has been committed to the universal application of ASBIs, and has tended to ignore GPs' clinical viewpoints.<sup>24-27</sup> Dismissing this collective wisdom may have been a missed opportunity. The average GP has many years of lived experience interacting with patients in real clinical situations. Universal ASBI is seen and experienced by GPs as impractical,<sup>24,28,29</sup> and implementation that is contingent on the rigid adoption of a tool is unlikely to be successful.<sup>30</sup> On the other hand, targeted screening<sup>9,31</sup> and pragmatic case finding<sup>32</sup> appear to be acceptable to GPs.

Patient perspectives, which inform when and how ASBIs could be acceptably performed, have also been undervalued.<sup>27,30,33</sup> Consultation contexts are important; for instance, patients' acceptance of alcohol assessment varied from essentially everyone in some situations (eg presenting for diabetes, hypertension and mental health), down to less than half in other situations.<sup>33</sup> New patient registration<sup>31</sup> and preventive health clinics<sup>34</sup> are other highly acceptable circumstances for alcohol assessment. Although alcohol

discussions may not be welcome in a specific consultation,<sup>30,34-36</sup> patients see alcohol counselling as indicative of higher quality primary care.<sup>37</sup>

### Pragmatic, practice-based approach to risky drinking early detection

#### Ask patients about their alcohol drinking more frequently

It is possible that a substantial component of the benefit of formal ASBIs in routine practice is from simply engaging patients in a discussion about their alcohol use, within the context of the therapeutic doctor-patient relationship. Using a formal screening instrument such as the AUDIT-C, a modification of the Alcohol Use Disorders Identification Test (Table 1),<sup>38</sup> with a structured brief alcohol intervention may provide an over-and-above effect,<sup>19</sup> but, pragmatically, only if it is performed.

GPs have found it difficult to implement screening questionnaires broadly in routine practice.<sup>24,28,29</sup> Simply asking all patients aged 15 years and older about their alcohol drinking more frequently is an important first step,<sup>4</sup> especially in addressing the under-detection of risky drinking.<sup>39</sup>

#### Focus initial changes on contexts that are highly acceptable to patients

A case is often made that although discussions on alcohol can be morally charged and uncomfortable for patients<sup>30</sup> and GPs,<sup>24</sup> the assessment should occur regardless. Pragmatically, interpersonal 'face work' preserves doctor-patient relationships<sup>40</sup> and needs to be acknowledged and respected. It may be better to go for the 'low-hanging fruit' first by targeting initial clinical behaviour change in presentation scenarios

Table 1. AUDIT-C questionnaire<sup>38</sup>

Questions	Score
<b>How often do you have a drink containing alcohol?</b>	
Never	+0
Monthly or less	+1
2-4 times a month	+2
2-3 times a week	+3
4 or more times a week	+4
<b>How many standard drinks containing alcohol do you have on a typical day?</b>	
1 or 2	+0
3 or 4	+1
5 or 6	+2
7 or 9	+3
10 or more	+4
<b>How often do you have six or more drinks on one occasion?</b>	
Never	+0
Less than monthly	+1
Monthly	+2
Weekly	+3
Daily or almost daily	+4

Risky drinker: Male - AUDIT-C ≥5; Female - AUDIT-C ≥4

where alcohol assessment has been demonstrated to be acceptable to most patients:<sup>30,33</sup>

- new patients
- health assessments and preventive health consultations
- chronic disease assessment and care planning (eg for hypertension, diabetes, gastro-oesophageal reflux disease)
- mental health assessment and care planning (eg for anxiety, depression)

### Make use of strategies that improve patient acceptance of alcohol discussions

Patients' acceptance of alcohol discussions can be understood using a three-factor model.<sup>30</sup> A number of strategies can be considered by using this model (Table 2).

### Use a whole-of-practice, quality improvement method

Approaching the issue from a whole-of-practice (compared with individual clinician) perspective might be an effective strategy. For instance, measuring alcohol recording data completeness (the proportion of the practice population with alcohol intake recorded in the electronic health record system) can be a useful statistic for driving change. For many practices, this metric can initially be surprisingly low.<sup>41,42</sup>

Quality improvement methodology may be well suited to changing

practice systems<sup>43</sup> in implementing preventive care.<sup>44</sup> Previously, this has been disseminated in general practice through the Australian Primary Care Collaboratives Program.<sup>45</sup> In a nutshell, this method involves practice level agreement (using PDSA [plan, do, study, act] cycles) of:<sup>44</sup>

- goals – 'what do we set as our target for alcohol recording data completeness in the electronic health record?'
- measures – 'how often and how will these be discussed amongst the practice team?'
- changes – 'what are we going to attempt implementing?'

### Discussion

There are few clinical fields where the apparent gap between evidence and practice is as wide as in ASBIs. The literature describes well-developed ASBI tools that few have been able to implement in regular practice.<sup>27</sup> However, the evidence suggests that the beneficial effects of ASBIs is not 'all or none'. At the individual practice level, the better implementation strategy may be to focus on asking patients about their drinking more regularly, documenting it, and using quality improvement methodology to improve data completeness for the practice population.

This approach fits better with the workflow of general practice and is perhaps philosophically better aligned with it. Early studies of GPs' beliefs and

attitudes identified that GPs perceived managing drinking issues as a process of negotiation, over a long-term doctor–patient relationship.<sup>26</sup> Formal ASBIs are intensive, and may need to be supported by broader community and policy interventions to be sustainable and meet their theoretical potential.<sup>18,21,29</sup>

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**Table 2. Strategies to improve the acceptability of alcohol assessment**

Model factor <sup>30</sup>	Strategies
The perceived relevance of the alcohol dialogue	<ul style="list-style-type: none"> <li>• Establishing a clear reason for the alcohol discussion; for instance, explicitly linking alcohol use and the potential impact on the reason for presenting and any existing disease states</li> <li>• Using a health promotion framework (eg smoking, nutrition, alcohol, physical activity [SNAP])<sup>7</sup> in the discussion</li> </ul>
Approach and language of the alcohol enquiry	<ul style="list-style-type: none"> <li>• Using a collaborative consultation style, use of a friendly tone and avoid appearing interrogative</li> <li>• Negotiating the agenda of the consultation and respecting that patients might want their primary concern addressed first</li> </ul>
Unease about the moral dimension of alcohol consumption	<ul style="list-style-type: none"> <li>• Asking for permission and being sensitive that some patients may feel uncomfortable or unwilling to have these discussions</li> <li>• Using language pertaining to health risks, rather than moral language such as 'sensible drinker' and 'drinking in moderation'</li> </ul>

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