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RISKY ALCOHOL CONSUMPTION

Introduction

MORE than 86% of Australians aged over 14 have drunk alcohol. It is so commonly used that many people may not realise it is a drug or that it can be harmful. Its pleasurable effects include feeling relaxed, happier and more confident, but because it is a CNS depressant, it inhibits brain functions, dampens the motor and sensory centres and makes judgement, co-ordination and balance more difficult. Risky behaviour is a common result of alcohol use. One in four (26.4%) Australians have put themselves at risk of short-term harm from alcohol at least once in the past 12 months.

GPs are uniquely placed to identify and intervene with patients whose alcohol use is hazardous or harmful. There is good evidence that brief alcohol interventions work. And because they are brief, they can be part of a usual GP consultation. They are easy to do and, in fact, GPs perform brief interventions all the time. We work with our patients to help them change their diet, reduce weight, increase exercise and adhere to medication. Intervening with alcohol use in the GP setting can be effectively done in the same way. It simply requires GPs to take a short quantitative history of alcohol use, provide information on healthier or safer options and offer further support, advice and referral if needed.

This article explains the 5As method (Ask, Assess, Advise, Assist and Arrange) to screen for, and assist patients engaging in, risky drinking (the management of patients with alcohol dependence is outside the scope of this article). GPs can help patients avoid, reduce or eliminate high-risk behaviours and negative consequences associated with alcohol use by integrating prevention and screening, brief intervention (BI), and referral to treatment or other services into their clinical practices.

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INSIDE

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This article has been developed with the support of the Australian Drug Foundation.

Effects of alcohol

PROBLEMATIC alcohol use poses higher health risks than many of us might realise. Across the world, alcohol causes significant harm to individuals and to society, affecting health (both physical and mental), safety, personal relationships, crime levels and economic productivity. Over 18% of Australians aged over 14 drink at a level that puts them at risk of alcohol-related harm over their lifetime. An Australian study, which examined the harm caused by a drinker to others, found that 28.5% of people reported being negatively affected by the drinking of a friend, family member, household member or coworker in the previous year. Worryingly, another national survey showed that over 13% of people aged 14 or older have driven a motor vehicle while under the influence of alcohol.

A German general population study of 18-64-year-olds found that annualised mortality rates were 4.6 times higher for women with alcohol dependence and 1.9 times higher for men with alcohol dependence compared with that of their peers.

Alcohol affects different age groups and cohorts in different ways. Issues particular to specific age and cultural groups are as follows:

Pregnancy, infancy and childhood

Drinking while pregnant can cause problems such as bleeding, miscarriage, stillbirth and premature birth. When a pregnant woman drinks, alcohol crosses the placenta. Excessive alcohol use can affect fetal development and lead to fetal alcohol spectrum disorders (FASD). These disorders are associated with slowed fetal growth, organ damage and facial abnormalities, and childhood difficulties with learning, memory or behaviour. Alcohol also appears to be a risk factor in SIDS. Alcohol reduces a mother's milk supply and also passes through the blood stream into breastmilk. This may affect the baby's feeding and sleeping patterns, as well as its psychomotor development.

Despite the significant health risks outlined above, 47.3% of Australian women drink while pregnant — albeit before knowledge of their pregnancy — and 19.5% of women continue to drink after knowledge of their pregnancy. Doctors can help prevent many fetal and infant health and developmental problems by advising women not to drink at all when pregnant, planning a pregnancy or breastfeeding. There is no proven safe level of alcohol consumption while pregnant or breastfeeding.

A specialised GP resource for assessing alcohol use in pregnancy is available through the Australian Government's Women Want to Know project (see "Online resources").

Youth and early adulthood

Risk-taking behaviours are common during adolescence and into young adulthood, and this includes risky alcohol consumption that may increase the likelihood of other risk-taking behaviours. For example, a survey of Victorian high-school students aged 17-18 found that those who reported binge drinking or compulsive drinking were more likely to report having had sex they later regretted. Significantly, alcohol also contributes to the three major causes of teenage death: injury, homicide and suicide.

Drinking during adolescence may cause harm because the brain continues developing into the early to mid-twenties. Drinking alcohol early is also linked to having problems with alcohol use later in life.

For these reasons, not drinking is the safest option for people under 18 years of age.

Despite the risks outlined above, many young Australians drink at a young age. A national representative survey in 2013 found that young Australians (aged 14-24) reported having their first full serve of alcohol at 15.7 years on average. Another survey of high-school students found that one in five students aged 12-17 are current drinkers, with 33% indicating that their parents gave them their last drink.

Indigenous Australians

Indigenous Australians are more likely to drink at risky levels than non-Indigenous Australians, although they are also more likely to abstain. Use of alcohol and other drugs contribute to the high rates of incarceration of Aboriginal and Torres Strait Islander people.

Middle and older age

Australians aged over 70 are the most likely group to drink daily. While younger people tend to experience alcohol-related harm during or immediately after drinking, older people experience more cumulative harm. They are also more likely to experience adverse effects from relatively small amounts of alcohol. One or two standard drinks a day can increase the risk of breast cancer in women, and even lower levels of consumption can increase the risk in women with an already elevated risk.

The most common causes of alcohol-related mortality for males are injuries (36%), cancers (25%) and digestive diseases (16%) and for women, cardiovascular diseases (34%), cancers (31%) and injuries (12%). About 2-6% of all cancers in this country are caused by the long-term, chronic use of alcohol, especially those of the mouth, breast and liver.

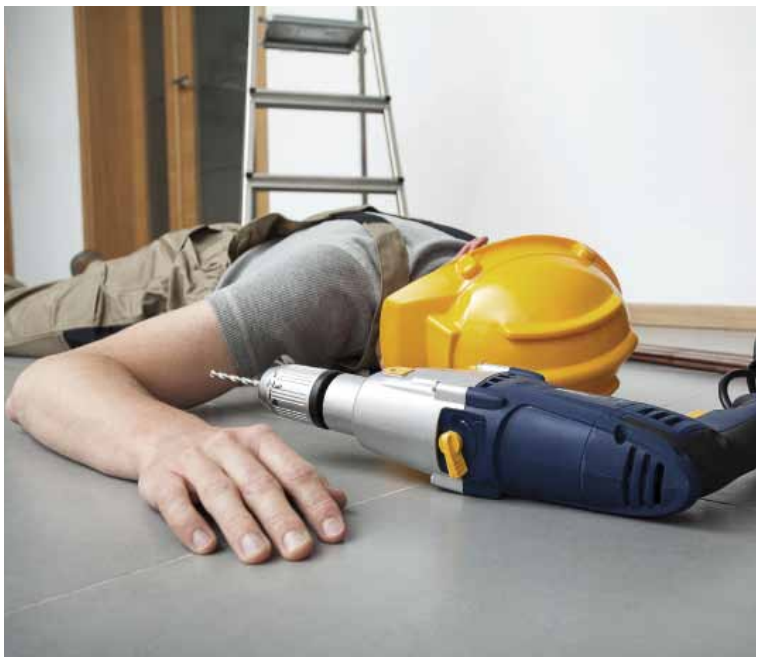
Alcohol use can contribute to weight gain, and there is convincing evidence that excess body fatness increases the risk of many cancers. The Cancer Council recommends that to reduce their risk of cancer, people limit their alcohol consumption or, better still, avoid alcohol altogether.

Benefits vs risks of moderate alcohol use

Physical harms

THERE is consistent evidence of an association between reduced CVD risk and lower levels of alcohol consumption; however, the strength of this relationship is subject to some debate. A recent meta-analysis found that this protective association differs by gender and outcome (ie, mortality vs morbidity), and hence this protective effect cannot be generally assumed for all drinkers. The levels of alcohol consumption that have been associated with cardiac benefits are relatively low, for example, one standard drink a day. However, even drinking at these low levels can increase the risk of other conditions, such as cancers. Therefore, researchers caution that the alcohol/cardioprotective relationship should not be viewed in isolation from other disease outcomes.

For GPs, one challenge is how to best communicate to patients the complexity of the health risk/benefit relationship of low alcohol consumption. Some authors suggest that it is important patients are aware there continues to be disagreement about the benefits of moderate drinking. GPs also need to convey that any health benefits of low to moderate drinking in older adults should be balanced with the risks of drinking experienced by that population — for older adults, drinking increases the risk of falls and related injuries, and motor vehicle accidents. These effects are heightened by interactions between alcohol and other medications.



Psychological harms

Alcohol use can adversely affect people who have a mental health condition. People drinking at levels that exceed the Australian alcohol guidelines are more likely to report higher levels of psychological distress than low-risk drinkers and abstainers. Alcohol use is linked to depression, with studies demonstrating that each can influence the onset of the other.

Boxes 1 and 2 outline the short- and long-term health risks of drinking.

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Box 1: Short-term risks of drinking

Health — Blackouts; impaired sexual performance; vomiting; headaches; slurred speech; blurred vision; adverse reactions to over-the-counter and prescription medications

Accidents and injuries — While driving; while operating heavy machinery; while swimming (and other water activities); falls (especially in older people)

Interpersonal behaviour — Lowered inhibitions; interpersonal conflict; criminal behaviour; risky sexual behaviour; inappropriate and violent behaviour, including the perpetration of sexual assault

Box 2: Long-term risks of drinking

According to the WHO, alcohol contributes to more than 200 different types of disease and injury

Physical — Alcohol-related brain damage; memory loss; personality changes; weight gain and obesity; loss of muscle tissue; lowered/impaired immune system; sexual dysfunction; infertility; liver diseases; heart diseases; cancer

Psychological — Depression; increased risk of suicide; alcohol tolerance and dependence

Employment and finances — Financial problems; reduced work productivity

Relationships — Conflict in interpersonal relationships; family breakdowns; contribution to domestic violence

Barriers to screening and intervention

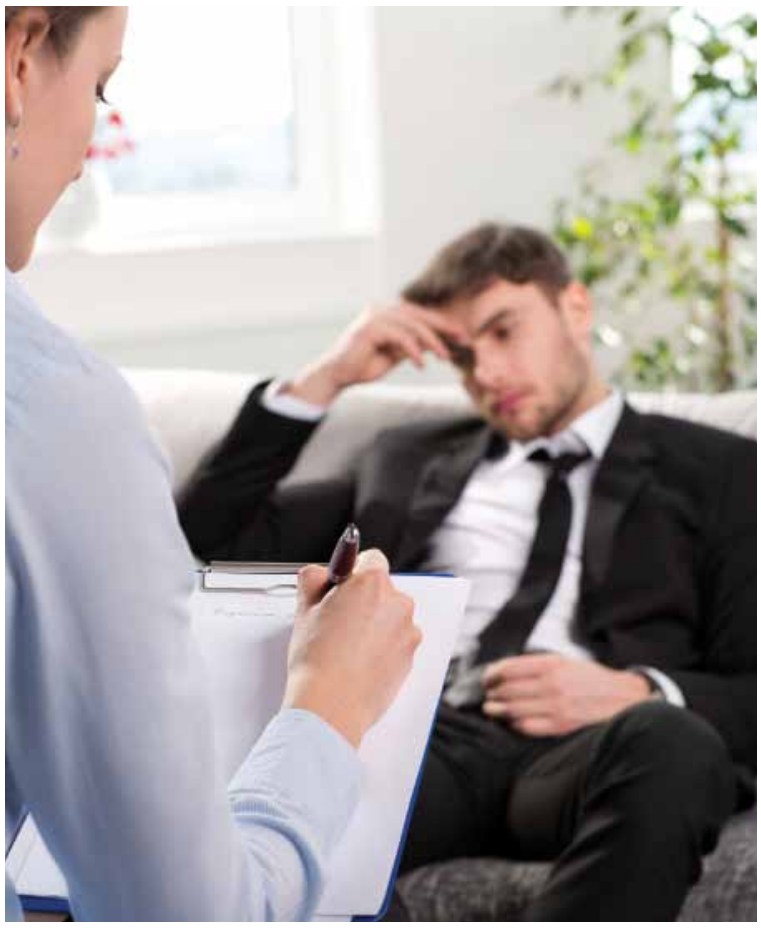
AS doctors, many of us assume we can detect alcohol dependence intuitively, despite it being difficult to define the problem exactly. Unhealthy levels of alcohol use span a continuum, ranging from use that may increase the risk of health problems through to obvious substance-use disorders. From the experience of addiction specialists, only a minority of people being harmed by their alcohol use resemble the archetypal 'alcoholic'.

Lack of screening

There is evidence that Australian GPs do not identify up to 70% of risky/high-risk drinkers. Likewise, a study in England suggested that GPs may be missing as many as 98% of excessive drinkers, while in a US community survey of 166,753 adults, only one in six patients overall — one in five current drinkers — and one in four binge drinkers reported ever discussing alcohol use with a doctor. Consider your typical day as a GP. How many patients present with symptoms such as hypertension, gastro-oesophageal reflux disease, osteoporosis, sleep problems, depression, anxiety or memory problems? Alcohol can be a cause of or contributor to these and many other common health problems. How often do you ask such patients about their alcohol use? If the answer is 'occasionally', 'rarely' or 'never', it is worth reflecting: what are the barriers that prevent you from discussing alcohol use with your patients?

Practitioner uncertainty

Just as some GPs tend to hesitate in discussing their patients' weight or obesity because of negative views or a sense that there is nothing they can do about it, similar attitudes can be at play in regard to alcohol use. According to one study, some doctors feel they are prying into a patient's private life when asking about alcohol use. Others doubt the usefulness of screening because they suspect some patients lie about their level of alcohol consumption. Some GPs lack confidence in their ability to counsel patients effectively on lifestyle issues, while others question the rationale of screening young drinkers, who may grow out of excessive drinking behaviour without intervention.



Just as some GPs tend to hesitate in discussing their patients' weight or obesity because of negative views or a sense that there is nothing they can do about it, similar attitudes can be at play in regard to alcohol use.

Some worry that screening conflicts with establishing rapport (especially with middle-aged and elderly patients). Furthermore, effective screening requires training, time and resources and can be perceived as interrupting the natural course of a consultation. Anecdotal evidence suggests that GPs also have a bias in whom they ask about alcohol use. For example, they are less likely to ask a young, well-dressed woman than an older, single man of a lower socioeconomic status.

Shame and stigma

Shame and stigma are major barriers to disclosure. In a survey across 14 different countries, 'alcoholism' scored fourth highest out of 18 in degree of social disapproval — only one step below a criminal record for burglary and more stigmatising than not taking care of one's children. In an unpublished study that surveyed 1138 NSW general practice patients, 34.7% reported feeling uncomfortable about sharing their waiting room with a patient being treated for alcohol dependency.

Doctors share many of the stigmatising attitudes and preconceptions of their communities. A study of NSW GPs found stigmatising attitudes were the most frequently reported barrier (72%) deterring GPs from providing treatment to the opioid-dependent. As a result, we are often responding to our patients morally rather than medically, which hinders us from making the best judgements about their care. As GPs, we should all be conscious of such biases, as they have adverse consequences for the patient, the doctor and the community in general. For example, patients who perceive discrimination by health professionals are less likely to complete treatment.

The impact of screening

Most doctors believe their relationships with patients are strong enough to provide systematic advice on sensible drinking. Of course, some patients react negatively when the subject of alcohol is raised, and others are uneasy or embarrassed and lie about their drinking behaviour. However, doctors say the odd negative reaction is counterbalanced by a positive reaction in most patients, who feel that their doctor is asking them these questions out of concern for their health and wellbeing. Research shows that pregnant women, for example, consider health professionals a dependable source of information on this topic.

Clinical approach and management

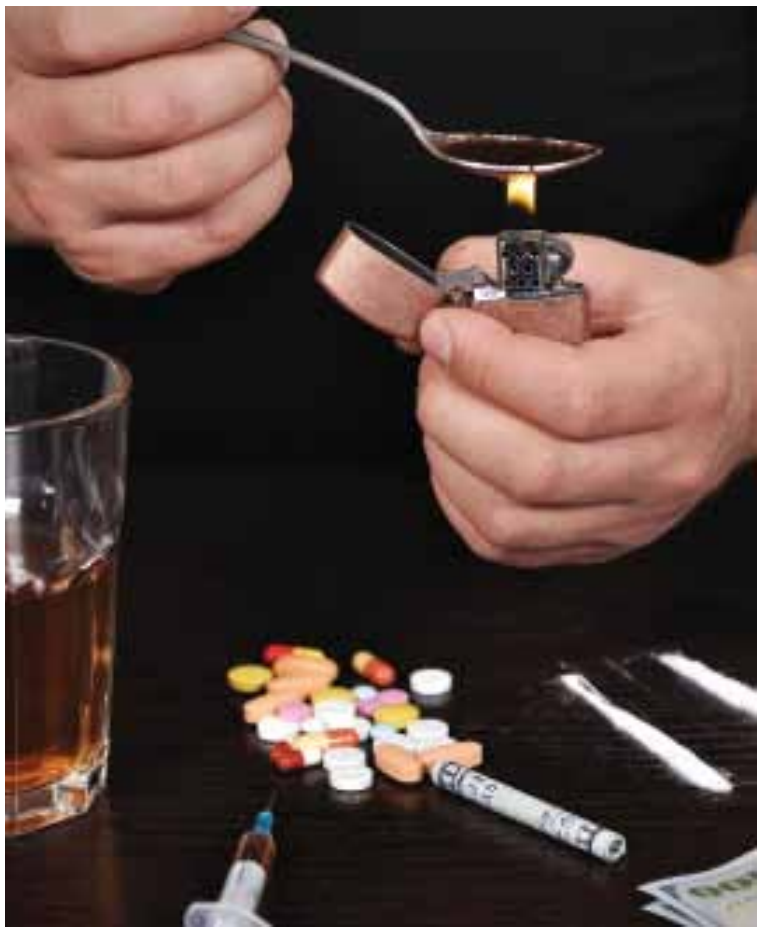
The 5As: ask, assess, advise assist and arrange

THE 5As is a widely recommended screening and brief intervention model for GPs. Although we focus here on alcohol use, the approach is also appropriate for smoking and use of illicit substances — such as cannabis, heroin, cocaine, ecstasy and other street drugs — or for misuse of prescription medications, such as opiates and benzodiazepines.

1. Ask

As GPs, we cannot help our patients with alcohol problems unless we ask them about their alcohol use. Given that 84% of Australians see a GP at least once a year, GPs have an excellent opportunity to interact with the 18.2% of Australians over 14 who exceed lifetime-risk guidelines and the 26% who exceed the single-occasion risk guidelines at least once a month.

However, alcohol-related issues are not usually the presenting problem for a patient seeing their GP. Furthermore, GPs tend to be time poor. For these reasons, screening all patients has been recommended. Failure to screen patients systematically means GPs miss an opportunity to help lower the risk of harm from alcohol use. Most signs of alcohol-related problems are not apparent early on. Thus, a GP who relies solely on observing signs of risky drinking will generally identify only late-presenting patients, leaving many other cases unrecognised until serious complications have developed.



Many instruments have been proposed for GPs to use to screen for drug use, with the number of questions ranging from one to over 70. However, in general practice, a single-question alcohol-screening test is useful: "How many times in the past year have you had four or more drinks in a day?" This question is currently recommended by the US National Institute on Alcohol Abuse and Alcoholism and has been adjusted for current Australian alcohol guidelines (see box 3).

Some people are at higher risk of harm from alcohol use — whether because of their drinking behaviours (eg, drinking and driving, binge drinking) or as a result of other factors. Even if they have not had more than four or more drinks on one day, for people in these higher-risk groups (see box 4), GPs should continue to the 'assess' phase.

From experience, other issues to be aware of as possible causes or results of alcohol use include child or adult sexual abuse, physical injuries, hypertension, insomnia, legal problems, trauma and work or family problems. Residents of nursing homes may also be misusing alcohol — undetected by care providers.

2. Assess

If a patient says they have had four or more drinks in a day over the past year, or if they are in one of the higher-risk groups, it is suitable to assess their level and pattern of alcohol use.

Start by asking what beverages they prefer, and then explain how many standard drinks each of these beverages is likely to contain (see figure 1). There are various sources for useful questions, such as the WHO's AUDIT (see box 5), although the AUDIT scoring meth-

odology may not be applicable, and you may not need to ask all 10 questions. Another useful assessment resource is the RACGP's SNAP guidelines. While the use of substances other than alcohol is beyond the scope of this article, it is important to acknowledge that people misusing alcohol may also be using prescription medications (eg, for chronic pain) and/or illicit substances, as well as tobacco. Use of these drugs may also need to be assessed if changes are to be successful.

The aim of this assessment is not to apply diagnostic labels, which may seem pejorative, but to understand the patient's amount and pattern of alcohol use and its health, psychological and social consequences. The discussion should help establish a relationship of engagement, rapport and trust, in which the doctor is non-judgemental and non-confrontational and reassures the patient of confidentiality.

3. Advise

The next step is to advise patients about safer alcohol use, using the Australian alcohol guidelines (box 3). You can begin by asking the patient what they know about safe drinking levels. While the aim is to help the patient reach their own conclusions on whether their alcohol use is risky, any information you provide should be based on empirical evidence — such the Australian alcohol guidelines — and an understanding of the effects of alcohol outlined previously.

According to the Australian alcohol guidelines, there is no safe level of drinking, but people can make informed decisions in order to minimise their risk of harm.

The guidelines are based on the 'standard drink' — any drink that contains approximately 10g of alcohol (12.5mL of pure alcohol). Different types of alcoholic drinks contain different amounts of alcohol (see figure 1). It is important to explain to patients that the servings we typically consume are often significantly larger than a standard drink. For example, the typical glass of wine served by a restaurant is actually one-and-a-half standard drinks.

4. Assist

Brief interventions

If your patient wishes to change their alcohol use, you can assist them to meet their goals through a brief intervention, which usually focuses on encouraging healthier alcohol choices rather than proposing total abstinence. Brief interventions are effective and, depending on which methodology is chosen, take as little as five minutes or less — or up to one hour. Just one — or several — sessions may be needed, but all this can be done as part of normal GP consultations. In general, the more severe the person's alcohol problem, the more time and intensity needed. Some patients might need particular assistance, for example, older people, who are more likely to forget medical advice but are at greater risk of drinking while taking medications.

Brief interventions work best with people whose alcohol use is risky or potentially risky but can also achieve reductions in alcohol use in people who are alcohol dependent. The latter group will generally require more intensive intervention and possibly referral to a specialist care facility.

Motivational interviewing

There is strong evidence that brief interventions in primary care help patients whose alcohol problem has been identified through screening. The approach is based on motivational interviewing, which aims to increase the person's capacity to make their own changes and take responsibility for their own actions. This is a non-judgemental, directive and patient-centred counselling style, designed to assist in exploring and resolving ambivalence in order to increase the person's motivation to change. The aim is for the patient to talk themselves into change. Motivational interviewing involves listening for patient defensiveness and resistance and then accommodating the resistance rather than arguing, labelling or judging. Open-ended questions are the most useful, for example: "What are the good things about your alcohol use?", "What are the not-so-good things about your

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Box 3: Australian alcohol guidelines

The following guidelines have been developed by the National Health and Medical Research Council to reduce the risks associated with drinking alcohol. The guidelines are for healthy men and women. People in higher-risk groups or with health problems (see box 4) might need to drink less than recommended below, or abstain completely, depending on their condition

Guideline 1

The lifetime risk of harm from drinking alcohol increases with the amount consumed

For healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury

Guideline 2

On a single occasion of drinking, the risk of alcohol-related injury increases with the amount consumed

For healthy men and women, drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion

Guideline 3

For children and young people under 18 years of age, not drinking alcohol is the safest option

Guideline 4

Maternal alcohol consumption can harm the developing fetus or breastfeeding baby

For women who are pregnant or planning a pregnancy, not drinking is the safest option

For women who are breastfeeding, not drinking is the safest option

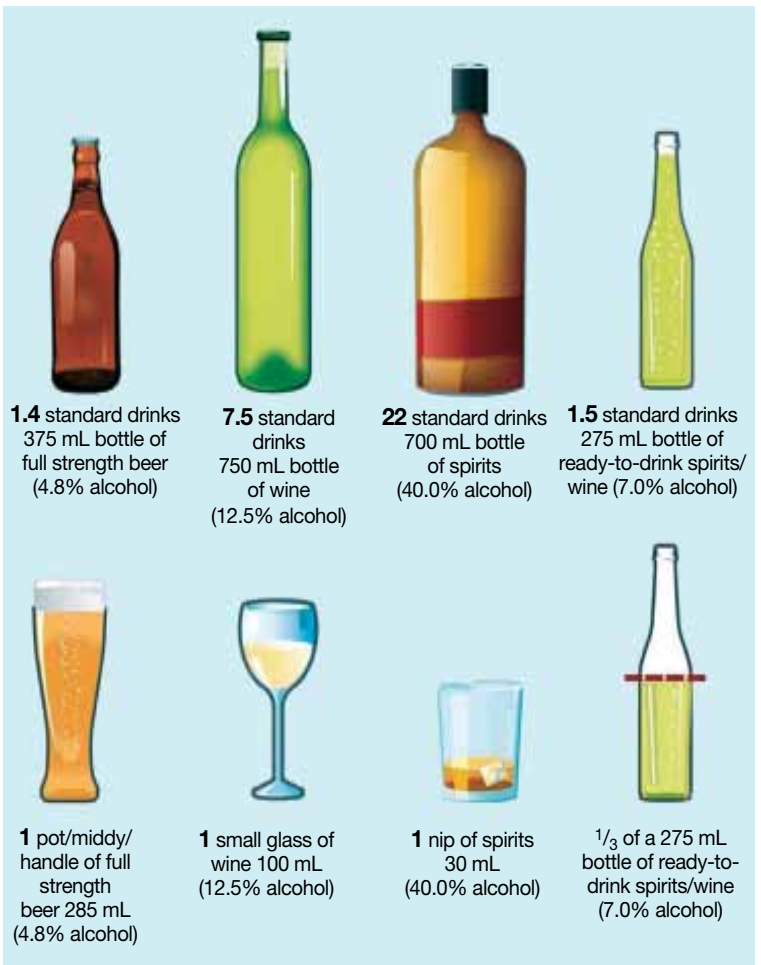

Figure 1: Examples of standard drink amounts contained in various beverages.

Discussion should help establish a relationship of engagement, rapport and trust, in which the doctor is non-judgemental and non-confrontational and reassures the patient of confidentiality.

Box 4: People at higher risk of harm from drinking

People aged under 18 — become intoxicated more quickly, more likely to take risks while drunk, brain is still developing

People in their 20s — group most likely to binge drink, but their brain is still developing, even up to their mid-20s

Women who are pregnant, planning pregnancy or breastfeeding — risk to the child and increased risk of miscarriage

Older people — more likely to fall after drinking, become intoxicated more quickly because of changes in metabolism, likely to be taking other medications that may interact with alcohol

Those with a family history of alcohol dependence

Users of illicit drugs

People with liver disease, chronic pain or other physical morbidity

People taking other prescription medications, which may interact with alcohol

People with depression, anxiety, suicidality or other mental health problems

Homosexual or bisexual people — more likely to drink at risky levels (for both lifetime and single-occasion risk) than heterosexual people

Indigenous Australians — 1.5 times as likely to drink alcohol at risky levels for both single-occasion and lifetime harm as non-Indigenous Australians (also 1.4 times as likely as non-Indigenous Australians to abstain from drinking alcohol)

Box 5: Possible questions for assessing alcohol use quantity, frequency and type

The following questions are from the WHO AUDIT questionnaire, amended to meet the Australian alcohol guidelines. GPs may choose to ask all of these questions or just the ones deemed most appropriate and most useful

Quantity

How often do you have a drink containing alcohol?

How many drinks containing alcohol do you have on a typical day when you are drinking?

Dependence

How often during the past year have you found that you were not able to stop drinking once you had started?

How often during the past year have you failed to do what was normally expected of you because of drinking?

How often during the past year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Adverse effects

How often during the past year have you had a feeling of guilt or remorse after drinking?

How often during the past year have you been unable to remember what happened the night before because you had been drinking?

Have you or someone else been injured as a result of your drinking?

Has a relative, friend, doctor or another health worker been concerned about your drinking or suggested you cut down?

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alcohol use?" "When you compare the good and not-so-good things, where does it leave you?"

An important strategy in motivational interviewing is to explore discrepancies (differences between the patient's current alcohol use and related problems, and the way they would like their life to be, including their health and relationships with others) revealed by the answers to your open-ended questions. For example, "You have said that you think drinking at home every night is okay, but you have noticed that your children avoid you when you are drinking. How do you feel about that?" Or, "So, on one hand, you really enjoy drinking with your friends, and you do not think you drink more than they do. On the other hand, you have missed a lot of work from feeling unwell in the morning, and you are worried about the money you are spending on alcohol. So where does this leave you?"

Self-efficacy and setting goals

Expressing empathy, and support for self-efficacy, are key strategies in motivational interviewing. For someone who uses alcohol or other substances, changes of behaviour depend on their acknowledging and accepting that they alone are responsible for their own actions. Retaining a sense of personal control over their behaviour and its consequences is an important motivator for change and decreasing resistance. Language from a GP such as "You should stop using alcohol" is usually counterproductive, as it is likely to create resistance and defensiveness. When a patient expresses resistance, the GP should not argue in favour of change, as this puts the patient in the position of arguing against it. You need to let the patient know that you care about this aspect of their health and would like to work together with them to help them reach their goals.

Box 6: Scaling questions

How willing are you to make this change now on a scale of one to 10?
How confident are you that you can make this change on a scale of one to 10?
How important is it to you to make this change on a scale of one to 10?

Box 7: Examples of self-help strategies

Writing down any problems that alcohol use has caused over the past three months
Drawing up a balance sheet, weighing up the advantages and disadvantages of continuing the current pattern of alcohol use and of reducing or stopping
Writing down reasons to change the pattern of alcohol use
Keeping an alcohol-use diary (available from the Australian Drug Foundation), recording the time and place of drinking each day, who they were with, how much they drank and how much money they spent and then reviewing it at the end of each week
Using the diary to identify situations where they tend to drink more than they would like — such as with a particular friend who drinks heavily, at particular times, such as after dinner, or when experiencing a particular emotion, such as guilt or worry
Brainstorming ways of avoiding or dealing with these high-risk situations
Setting a goal for reducing alcohol use — for example, drinking only on weekends, no more than two drinks a day or drinking only with meals
Having a glass of water to quench thirst and in between drinks
Switching to smaller drink sizes and/or to low-alcohol alternatives
Thinking about ways of achieving the goal — for example, meeting friends at the beach or watching a movie rather than socialising at the pub, seeking help for the problem that is worrying them rather than using alcohol when feeling worried
Brainstorming ways of saying "no" to alcohol when it is offered by friends or colleagues — such as "No, thanks, I'm cutting down" or "No, thanks, I'm having a rest for a while, but you go ahead"
Following a healthy lifestyle — good food, plenty of sleep, regular exercise and activity, keeping busy with activities that don't involve alcohol
Giving themselves occasional treats that don't involve alcohol

Assistance requires the patient to set concrete, specific, quantifiable goals (eg, deciding to drink a maximum of seven drinks a week). You can support this process by using scaling questions on this goal (see box 6).

You can discuss specific self-help strategies, such as those listed in box 7.

5. Arrange

The final step in the 5As model is to arrange the next steps. For the great majority of patients, this will involve arranging follow-up with you rather than referral to another provider. Brief interventions work best for non-dependent but risky users of alcohol, and they can mostly be managed in a GP setting.

On the other hand, people who are dependent on alcohol may require specialist services. Most people who have alcohol dependence would like to be able to drink moderately. However, this is rarely achievable for them — a study spanning 60 years found that only 11% of alcohol-dependent subjects could maintain non-dependent drinking over this period. Such a patient may initially try to set goals for moderate drinking — in which case, your role is to support their efforts — using the strategies previously described. But eventually they may conclude that they cannot maintain drinking at a safe level and wish to stop altogether. Sudden withdrawal from alcohol for an alcohol-dependent person can be risky and should, ideally, be supervised by a practitioner with the skills and support to do this or a specialist service that is familiar with current best practices, including thiamine supplementation and appropriate pharmacotherapy options. Alcohol withdrawal is potentially life-threatening. Practitioners who are not experienced in managing this withdrawal should ask for assistance and consider the need for hospital admission.

Online resources

Have a question about this article? Join the free webinar on 'Helping your patients who are drinking at risky levels', Tuesday, 17 February 2015, 7-8pm AEDT, run by the Australian Drug Foundation with speakers Dr Hester Wilson and Dr Paul Grinzi
www.druginfo.adf.org.au/druginfo-seminars/webinars

References

Available on request from howtotreat@cirrusmedia.com.au

Additional online resources available on request from howtotreat@cirrusmedia.com.au

Other management considerations

Maintenance and relapse

FEW people trying to stop or reduce their use of alcohol (or any other drug) will succeed immediately. Lapses into old behaviours should be seen as part of the learning process rather than as failure; for many people, change becomes easier with each attempt, and generally, the risk of relapse decreases with time. GPs are well placed to assist patients at times of relapse by offering non-judgemental support and encouragement, and helping to review which strategies worked and which did not. It is important to help patients focus on identifying high-risk situations and developing specific techniques to manage or avoid them. Reward, support and affirmation also contribute to long-term success.

Assisting family members

Family members of people with an alcohol dependency may also need extra support. Research suggests that parents, spouses and children of people dependent on chemicals (including alcohol) have significantly higher levels of physical and psychological morbidity and use of health services than the general population. In 2008, some 803,000 people a year called a health service because of someone else's drinking. Women and younger adults are more likely to report being affected by the drinking of a family member.

The children of parents who have an alcohol- or drug-related problem are at higher risk of abuse and neglect, developmental and behavioural problems or of developing an alcohol or other drug problem themselves. Child protection services might need to be brought in; therefore, GPs should be familiar with their obligations for mandatory reporting of suspected child abuse and neglect, which differ by state and territory. Primary care can assist family members and also indirectly help the person wishing to reduce their alcohol use, as family support is crucial to success.

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Case studies

Case study one

MARY, aged 52, has been a patient of your practice for years. She attends for a Pap smear and breast check today. You take the opportunity to ask her about her alcohol use. She becomes upset and says: "Doctor, I'm so glad you asked me. I'm very concerned about my drinking. Since my divorce, I've found myself drinking every day. And since my youngest son left home six months ago, I've been drinking a bottle of wine a day."

On further questioning, Mary says she is a non-smoker, uses no other drugs and takes no medications, although she did use cannabis in her twenties. She says one of her close friends has been concerned about her drinking, and she would like to cut back. On discussion, she decides she will cut down her drinking to one to two glasses every second day and decides to make this change immediately.

You arrange follow-up for two weeks. On review, Mary says she is very happy because she has been able to make the change in her drinking, which she now realises

was a result of feeling sad and lonely. She has joined a gym and restarted a weekly dance class with a close friend.

Case study two

Ben, aged 25, attends your GP practice for a WorkCover certificate after lacerating his hand at work. When asked what happened, he says he was not concentrating as he was hung-over after a big weekend with his mates. He reports drinking 12 to 15 beers every Friday, Saturday and Sunday night. He doesn't smoke tobacco, he has used cannabis a few times, he has never used psychostimulants or opioids, he has never injected and he has no other significant medical history. He has driven his car when intoxicated a few times. His girlfriend is very concerned about his drinking.

You advise Ben on his risky alcohol consumption and discuss the problems it has caused him. He decides that he needs to cut down his drinking. One week later, Ben says he has not been successful in changing his drinking. You run through what happened, and Ben realises that it is really hard for him not to drink around some of his mates, as he feels pressure to drink in their company. He decides he will skip going out with his mates for a weekend.

Ben returns one month later and says he was able to cut down his drinking for two weeks, but then he went to watch the footy and ended up drinking 15 beers again. He says he realises he feels much better when he doesn't drink, and he is getting on better with his girlfriend.

Ben attends six months later for travel vaccinations because he and his girlfriend are planning a six-month trip around Asia. He tells you that he drinks on average four beers once a month now and is happy with this level of alcohol consumption.

Conclusion

GPs need to be proactive in order to have a positive influence on alcohol use in our communities and help reduce the many physical, psychological, social and economic harms it causes. GPs have an important role to play in screening, assessing and offering brief interventions. Asking our patients about their alcohol use as a matter of course opens the way for us to help them decrease their risk of harm and is easily done in the primary care setting. A non-judgemental approach to alcohol use is needed to guide people towards self-change through techniques such as motivational interviewing. Through these processes, GPs can identify important opportunities to change health behaviour and prevent alcohol problems with a significant proportion of patients.

How to Treat Quiz

Risky alcohol consumption
— 6 February 2015

INSTRUCTIONS

Complete this quiz online and fill in the GP evaluation form to earn 2 CPD or PDP points.
We no longer accept quizzes by post or fax.

The mark required to obtain points is 80%. Please note that some questions have more than one correct answer.

GO ONLINE TO COMPLETE THE QUIZ

www.australiandoctor.com.au/education/how-to-treat

1. Which of the following TWO statements about the epidemiology of alcohol-related harm are correct?
a) One in 10 Australians has put themselves at risk of short-term harm at least once in the past 12 months
b) Nearly 20% of Australians aged over 14 drink at a level that puts them at risk of alcohol-related harm
c) Almost 30% of Australians report having been negatively affected by the drinking of a friend, family member, household member or coworker in the previous year
d) About 1% of people aged 14 or older report having driven a motor vehicle under the influence of alcohol

2. Which of the following TWO statements regarding the effects of drinking during pregnancy and young adulthood are correct?
a) Alcohol appears to be a risk factor for SIDS
b) Up to one in 100 Australian women reports continuing to drink while knowingly pregnant
c) Alcohol is a contributing factor in the three major causes of teenage death: injury, homicide and suicide
d) One in 100 school children aged 12-17 reports being a current drinker

3. Which of the following TWO statements regarding the effects of drinking in Indigenous and older Australians are correct?
a) Indigenous Australians are more likely to drink at risky levels than non-Indigenous Australians, although they are also more likely to abstain
b) Australians aged over 70 are the least likely age group to drink daily
c) Four or more standard drinks a day can increase the risk of breast cancer in women
d) Up to 6% of all cancers in Australia are known to be caused by long-term, chronic use of alcohol

4. Which of the following THREE are short- and long-term risks potentially associated with alcohol use?
a) Adverse reactions to over-the-counter and prescription medications
b) Risky sexual behaviour
c) Autoimmune inflammatory conditions
d) Weight gain and obesity

5. Which of the following TWO statements regarding barriers to screening for alcohol use are correct?
a) Most people who are being harmed by their alcohol use are instantly recognisable by their appearance, dress or social situation
b) Up to 70% of risky or high-risk drinkers are not identified by their GPs as being at risk
c) Worldwide, shame and stigma are major barriers to disclosure of alcohol use
d) GPs are immune to negative attitudes around alcohol use, which means they are easily able to respond to patients who use alcohol in a risky way in a non-judgemental fashion

6. Which of the following TWO statements regarding screening for alcohol-related problems are correct?
a) Alcohol-related issues are typically not the presenting problem when a patient at risk from alcohol use presents to the GP
b) Most signs of alcohol-related problems manifest early
c) The question "how many times in the past year have you had four or more drinks in a day?" has limited use as a screening test for risky alcohol use because it is not sufficiently comprehensive
d) It may be worth screening residents of nursing homes for risky alcohol use, as this may be occurring without the knowledge of care providers

7. Which of the following THREE groups are at increased risk of harm from alcohol use?
a) Those with a family history of alcohol dependence
b) People in their 20s
c) Heterosexual females
d) People with concomitant pain or physical morbidity

8. Which of the following THREE questions are useful when assessing quantity, frequency and type of alcohol use?
a) Have you ever drunk alcohol?
b) How many drinks containing alcohol do you have on a typical day when you are drinking?
c) How often during the past year have you felt guilt or remorse after drinking?
d) Has a relative, friend, doctor or another health worker been concerned about your drinking or suggested you cut down?

9. Which of the following TWO statements regarding interventions for risky alcohol use are correct?
a) Brief interventions have limited effectiveness and are too time-consuming to complete in routine general practice
b) Brief interventions are not effective for people who are alcohol-dependent
c) The aim of motivational interviewing is for the patient to talk themselves into change
d) A useful motivational interviewing technique is to explore discrepancies between the patient's current alcohol use and how they would like their life to be

10. Which of the following THREE self-help strategies can assist patients to reduce risky alcohol use?
a) Writing down reasons to change the pattern of alcohol use
b) Using a diary to identify situations where they tend to drink more than they would like
c) Brainstorming ways of saying "no" to alcohol when it is offered by friends or colleagues
d) Cutting out all treats, including alcohol

CPD QUIZ UPDATE

The RACGP requires that a brief GP evaluation form be completed with every quiz to obtain category 2 CPD or PDP points for the 2014-16 triennium. You can complete this online along with the quiz at **www.australiandoctor.com.au.** Because this is a requirement, we are no longer able to accept the quiz by post or fax. However, we have included the quiz questions here for those who like to prepare the answers before completing the quiz online.

Australian Doctor Education

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NEXT WEEK

Gout is the most common inflammatory arthritis. This means most GPs will need to make management decisions influenced by the disease. This How to Treat reviews the pathogenesis, clinical features and management of this common condition in general practice. The author is Clinical **Associate Professor Neil McGill**, rheumatologist at the University of Sydney and Royal Prince Alfred Hospital, Camperdown, NSW.