“Brief advice for heavy drinking:
The road from efficacy to efficiency”

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UNIVERSITY OF NEWCASTLE

Odhin project

SEVENTH FRAMEWORK PROGRAMME

1. Why advice is needed
2. Efficacy of advice
3. Effectiveness of advice
4. The advice gap
5. Increasing the efficiency of advice

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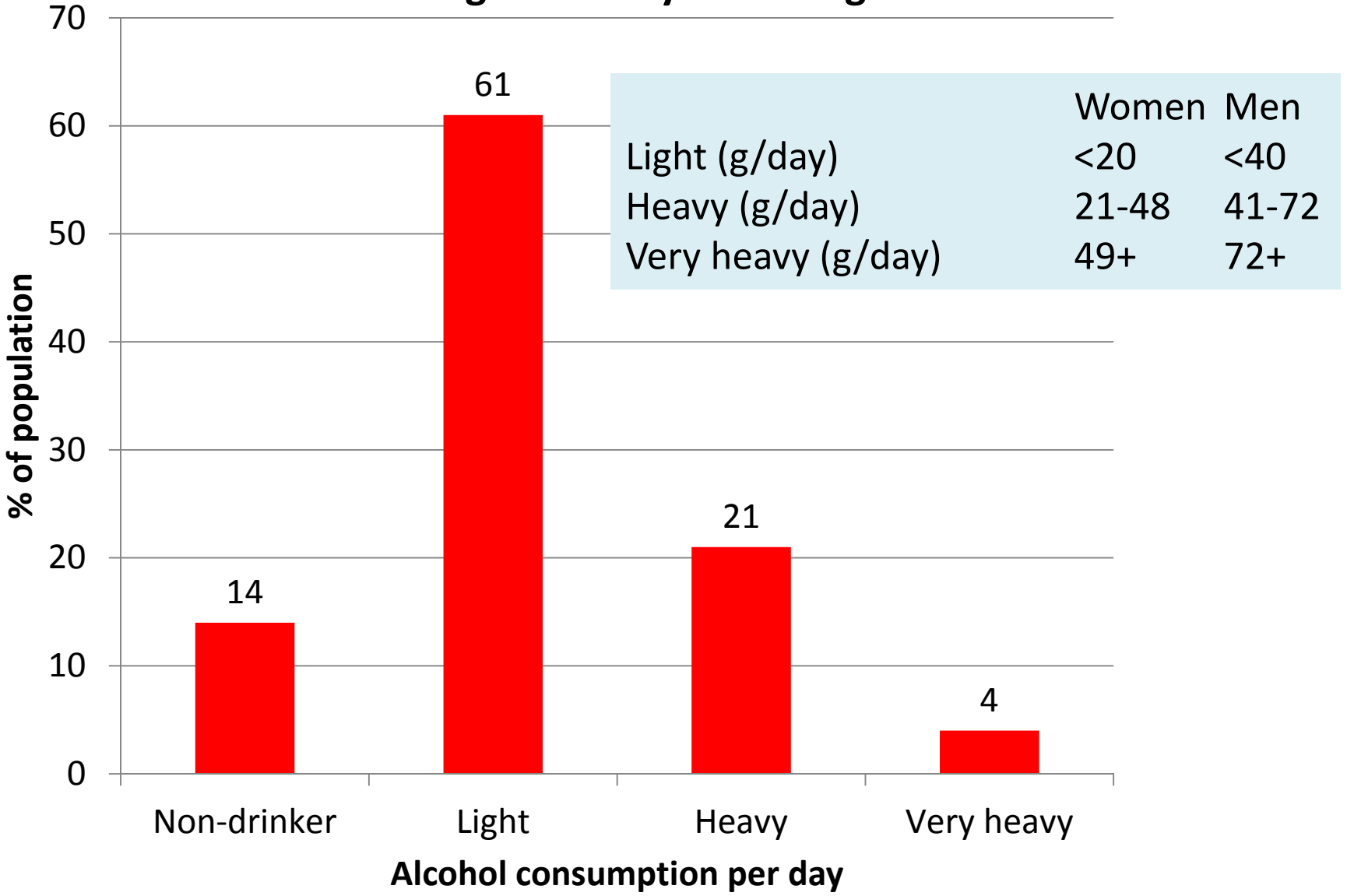
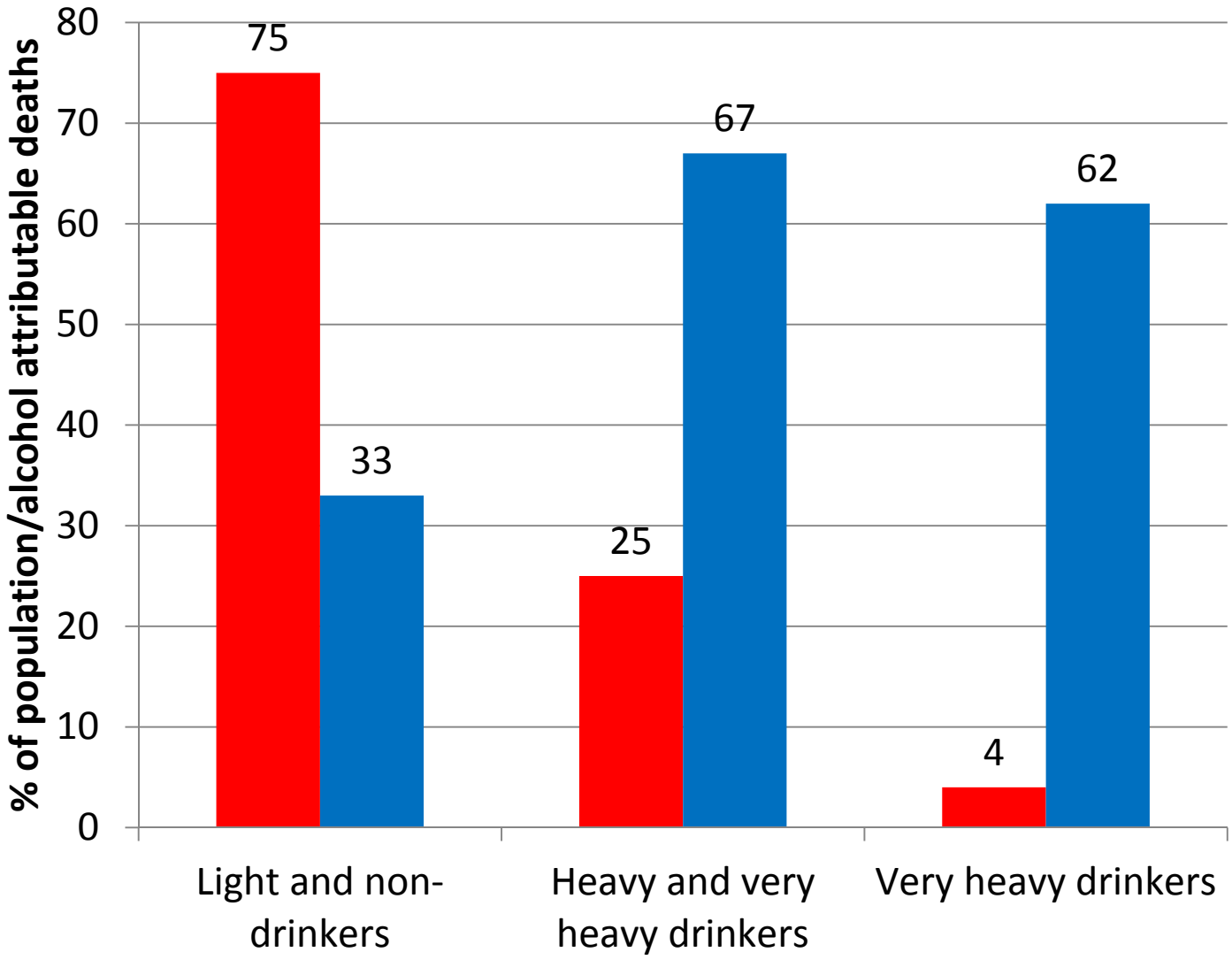
Distribution of daily alcohol consumption, adults aged 15-64 years living in EU



	Women	Men
Light (g/day)	<20	<40
Heavy (g/day)	21-48	41-72
Very heavy (g/day)	49+	72+

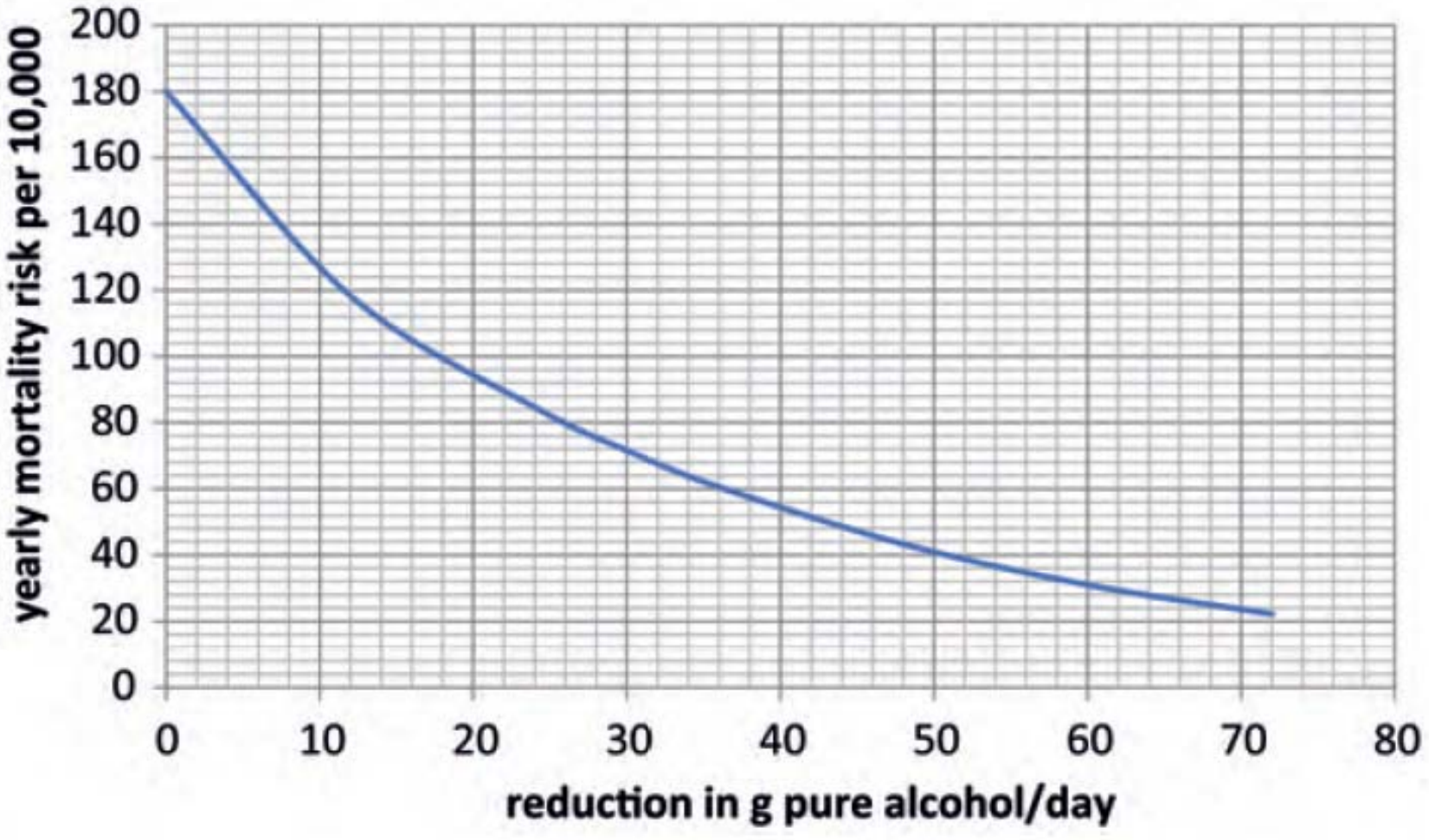
Rehm et al 2012

Distribution of alcohol consumption and alcohol-attributable deaths, adults aged 15-64 years living in EU



Rehm et al 2012

Reduction of alcohol intake in grams of pure alcohol per day in a ‘French man drinking 90g/day’ and associated mortality risk reduction (based on BI in hospital studies).



Rehm et al 2013

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Europeans drink too much, with heavier drinkers causing most of the European alcohol-related deaths. A man who reduces his drinking from 90g/day to 70g/day halves his risk of death in any one year.

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“The extent to which a specific intervention produces a beneficial result under ideal circumstances”

Last: a dictionary of epidemiology

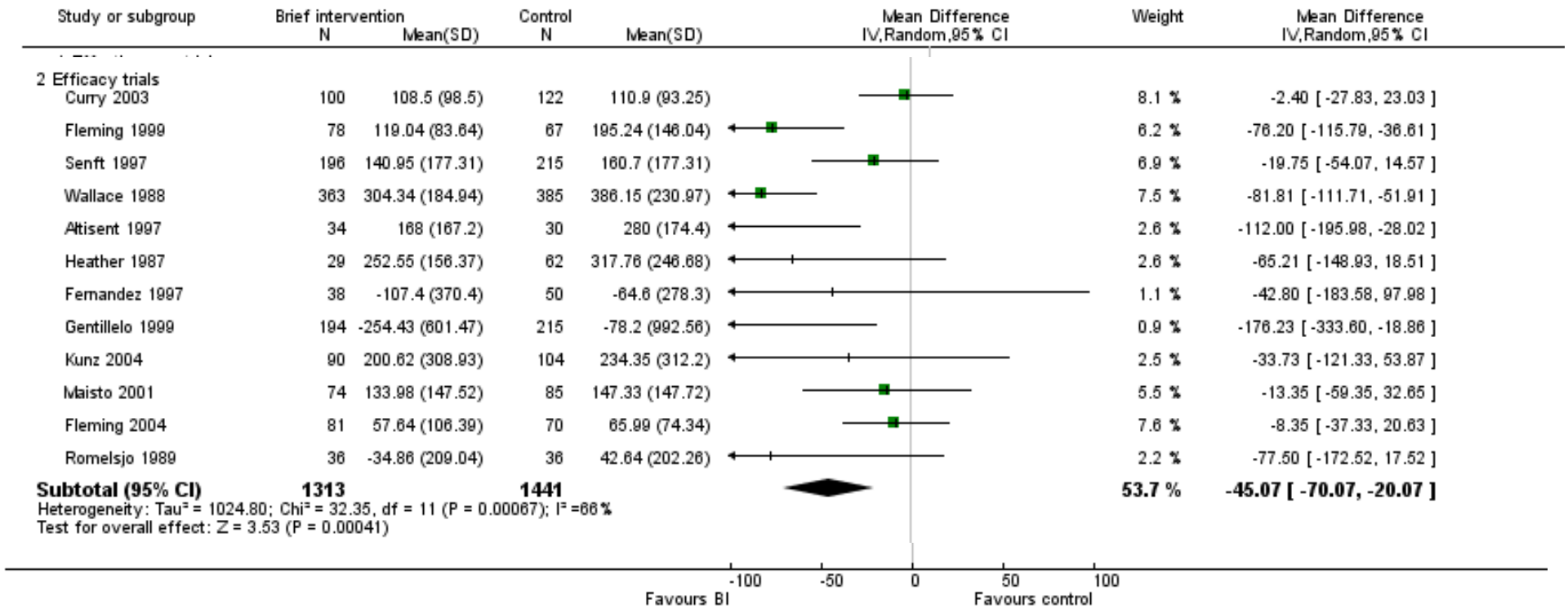
Efficacy/effectiveness score based on:

- Patients and problems
- Practice context
- Practitioners and therapists
- Intervention content
- Therapeutic flexibility
- Pre-therapy training
- Intervention support
- Intervention monitoring

Score of 0, efficacy to 12, effectiveness.
Dichotomized on basis of median.

Kaner et al 2007

Impact of brief intervention versus control alcohol consumption, grams per week



Kaner et al 2007

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Efficacy studies show that brief advice reduces heavy drinking.

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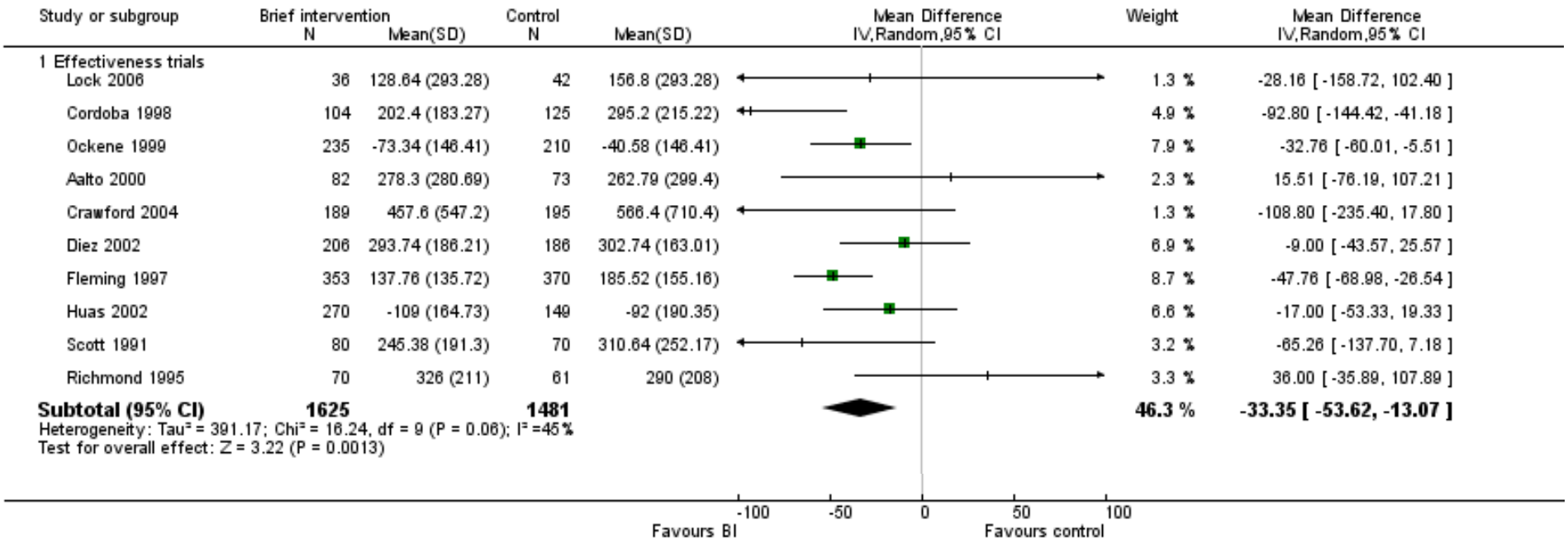
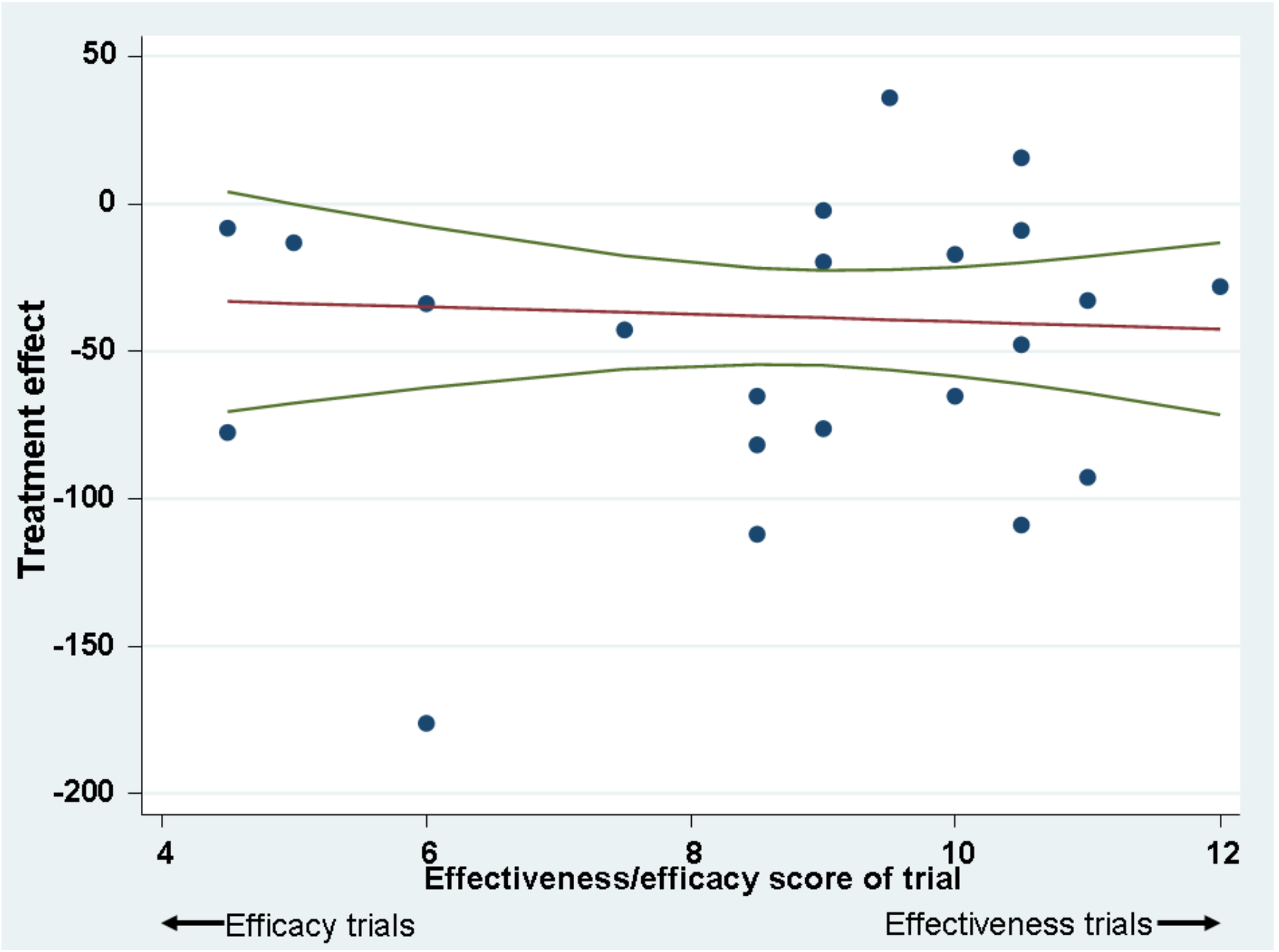
“The extent to which a specific intervention does what it is intended to do when deployed in the field in routine circumstances”

Last: a dictionary of epidemiology

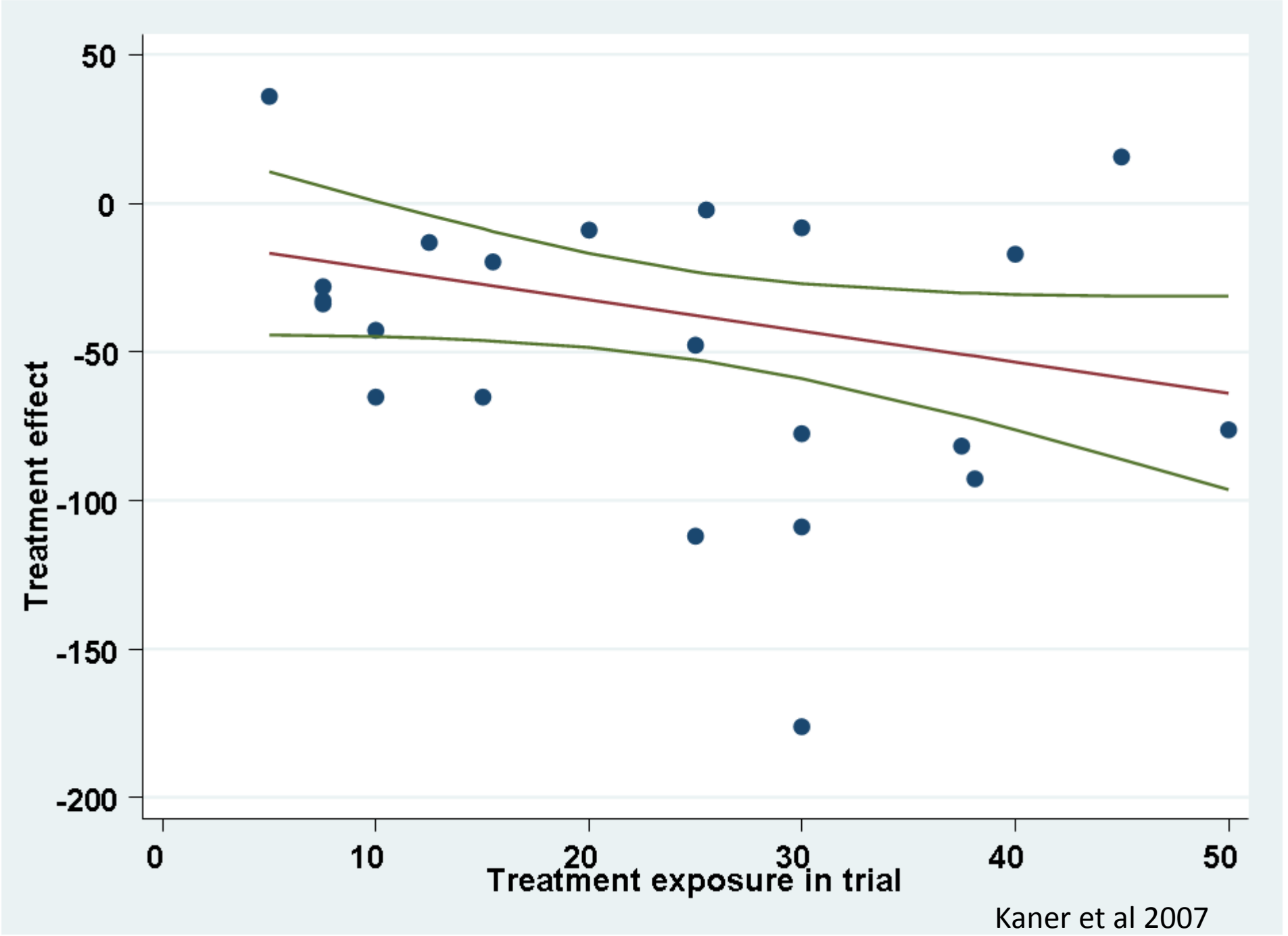
Impact of brief intervention versus control alcohol consumption, grams per week



Kaner et al 2007

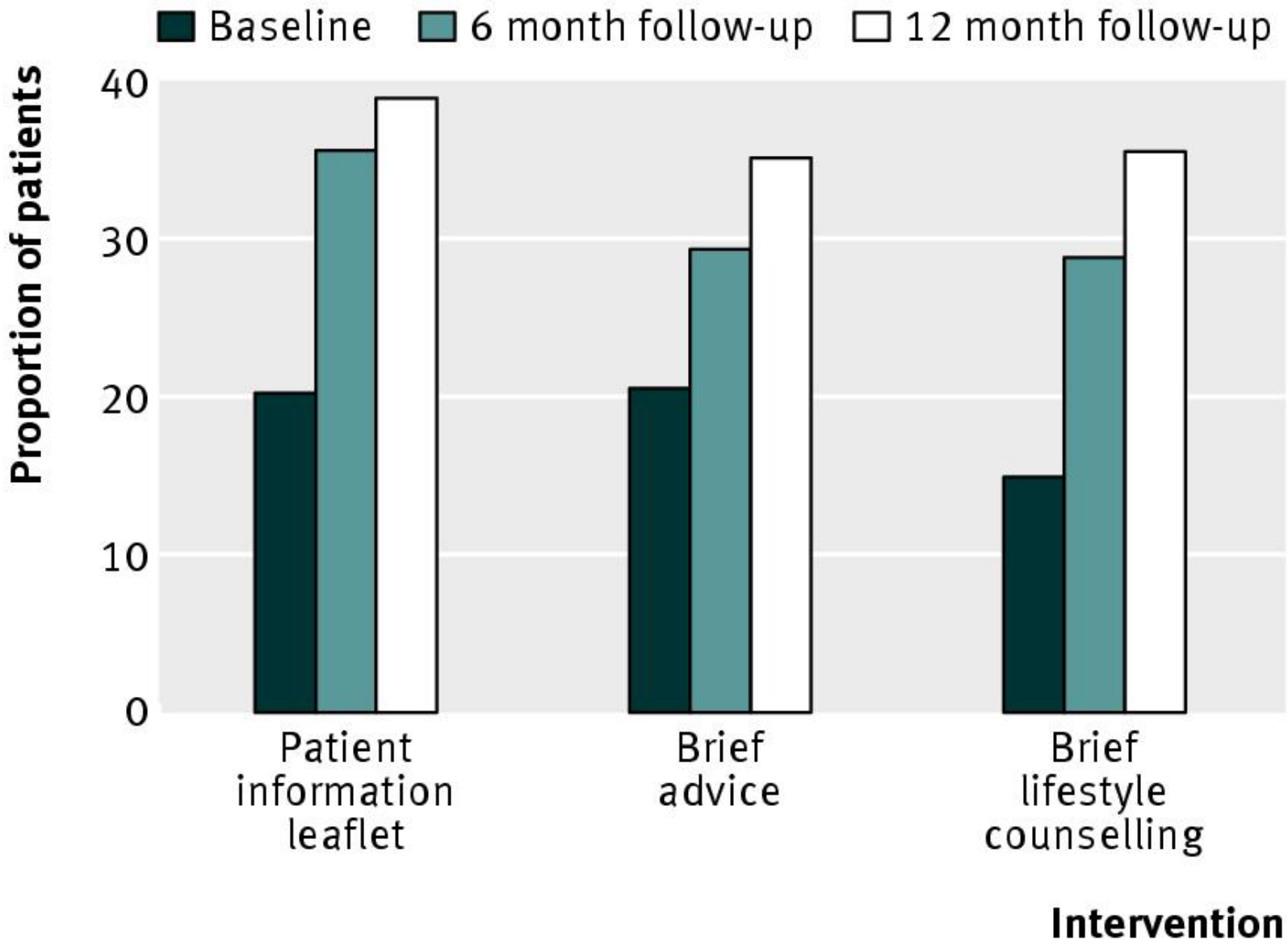


Kaner et al 2007



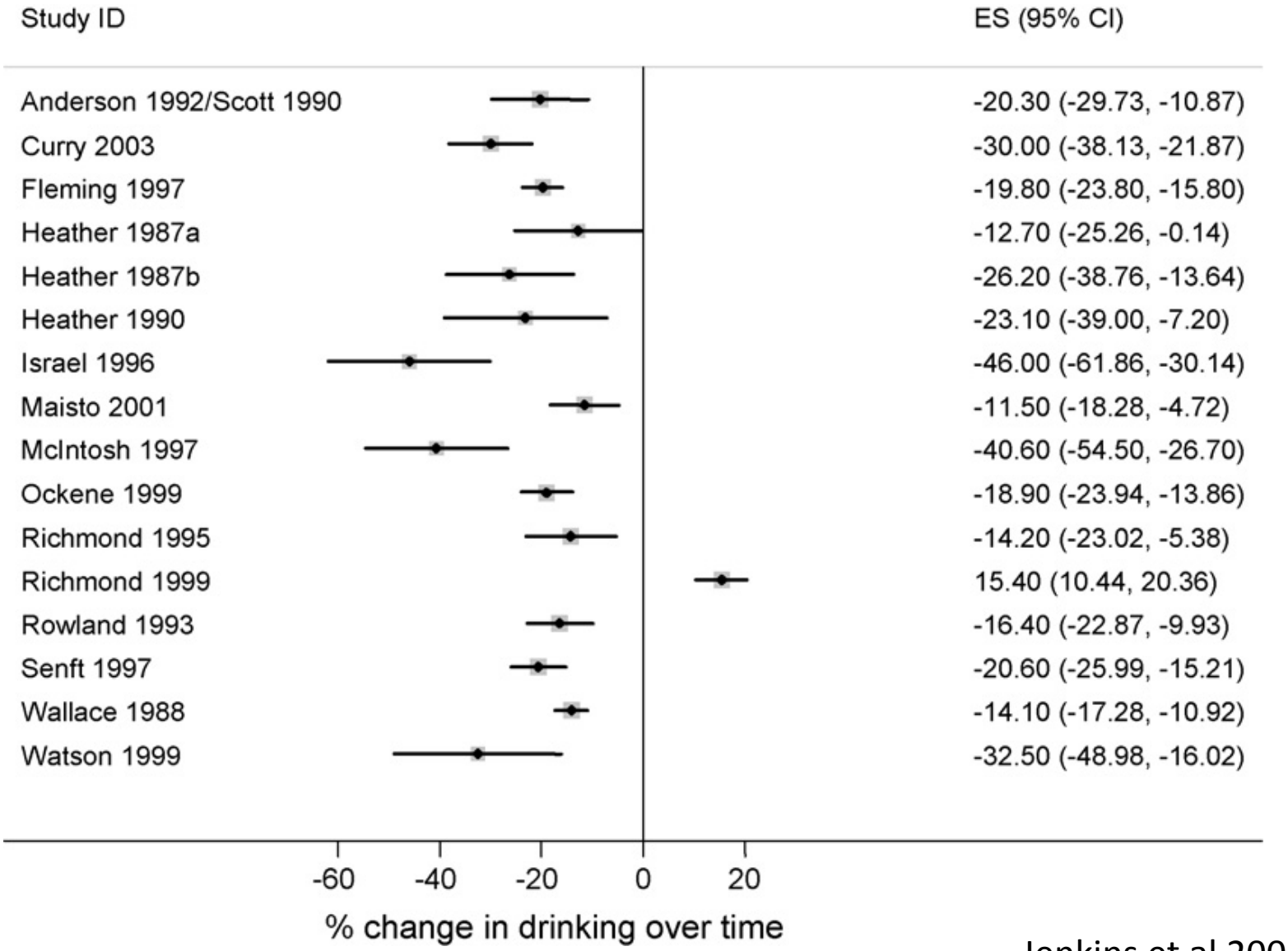
Kaner et al 2007

SIPS trial: Proportion of patients scoring <8 on AUDIT



Kaner et al 2013

Reduction in drinking in control groups over time in 16 intervention studies



Jenkins et al 2008

Among 38 studies cited in 20 reviews through October 2009, 16 met inclusion criteria.

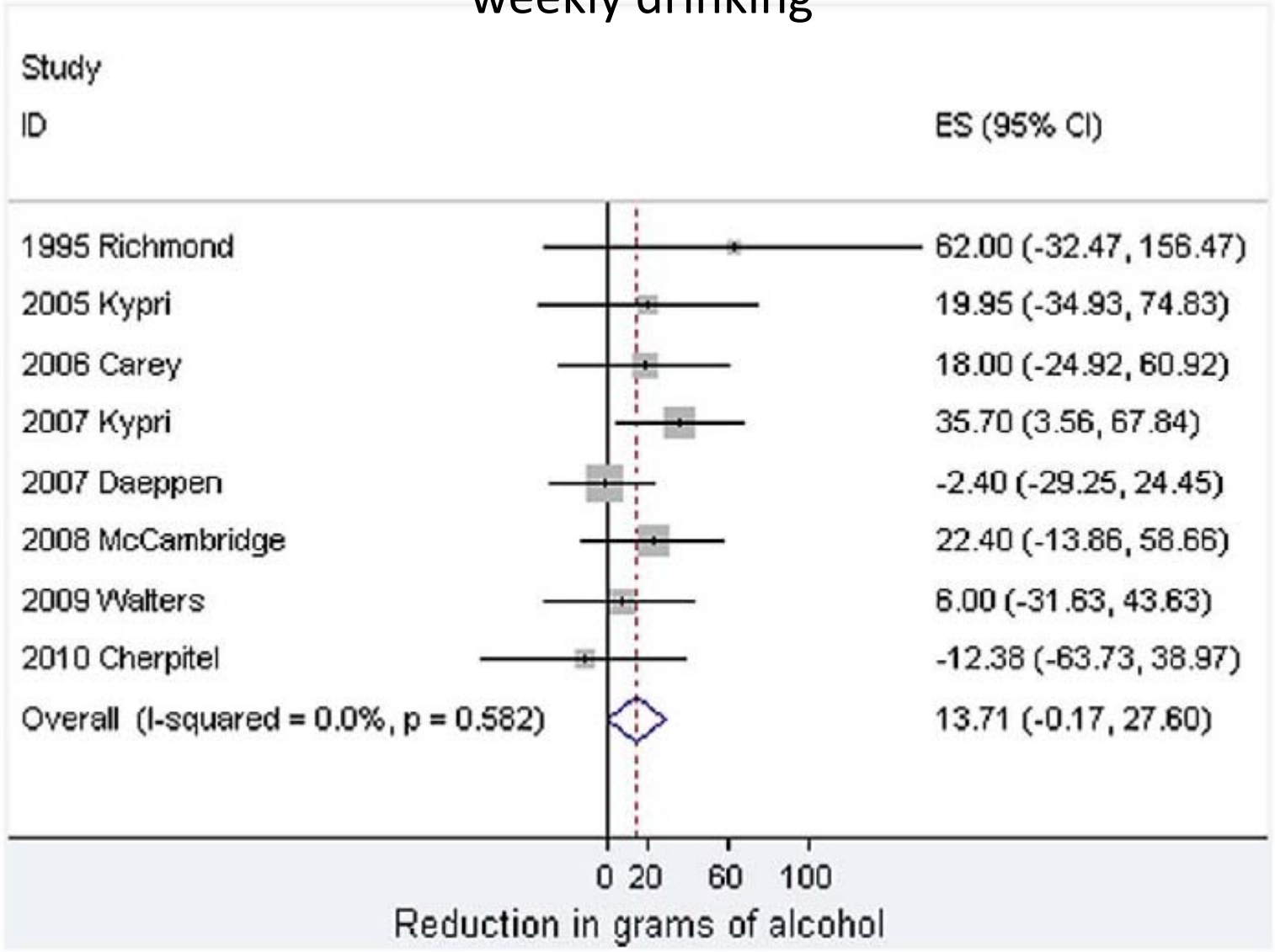
In just over half the studies, controls received alcohol specific handouts, advice and/or referral.

The number and depth of assessments were highly variable.

The percentage change in consumption in the control groups form baseline to follow-up ranged from -0.10 to -0.84 (mean -0.32).

Bernstein et al 2010

Reduction in drinking due answering questions on total weekly drinking



McCambridge & Kypri 2011

The Oxford GP Study had three groups:

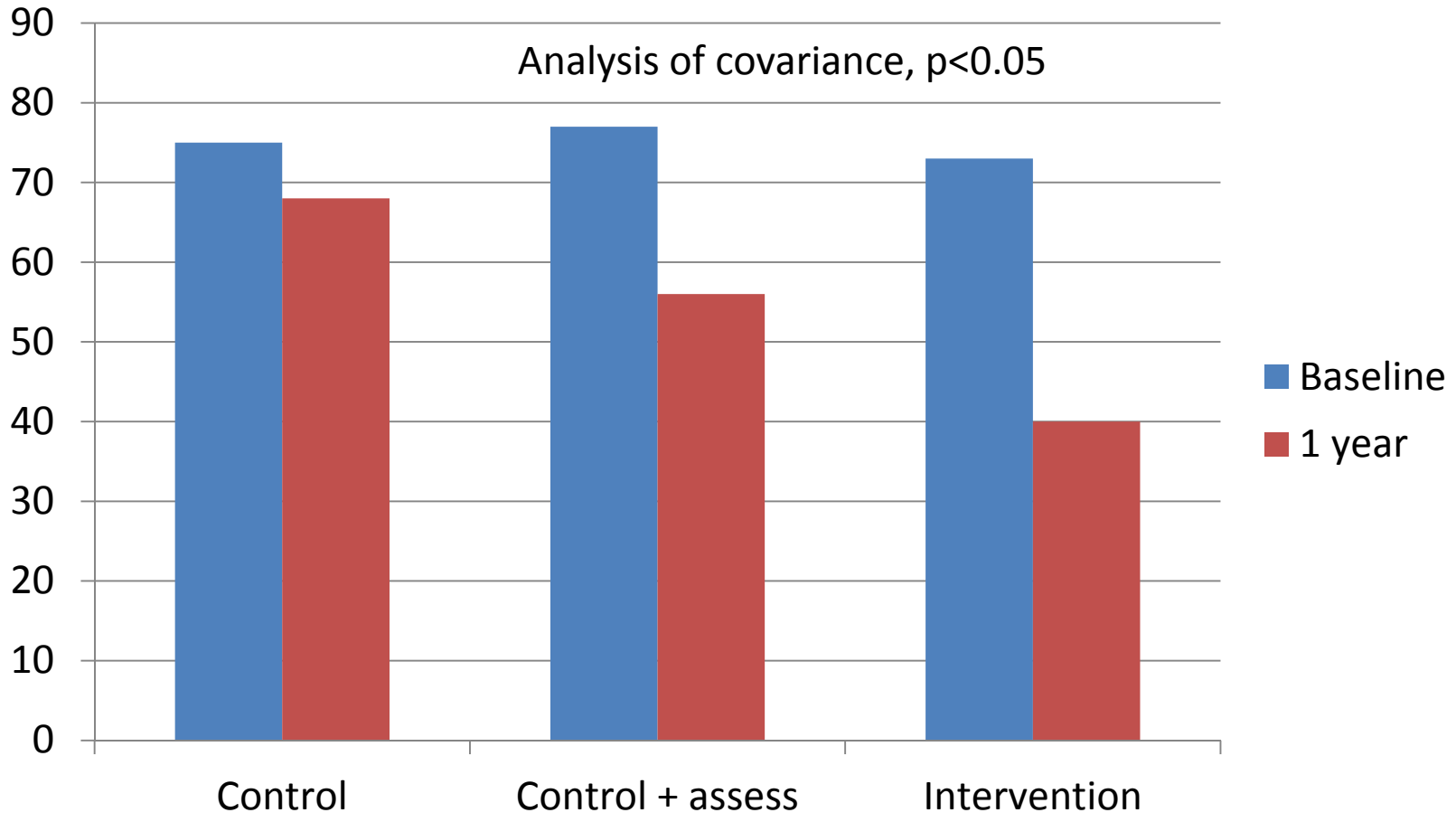
1. Control group who were only asked their alcohol consumption from quantity/frequency questions (equivalent to the first 2 AUDIT questions)

2. Control group who, in addition, completed:
   a. Week drink diary
   b. 4 alcohol-related problem scales
   c. Blood for gamma GT

3. Treatment group who, in addition, received:
   a. 10 minutes advice
   b. Self-help booklet

Anderson & Scott 1992

Alcohol consumption (g/day) by study group (men)



Anderson & Scott 1992

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Effectiveness studies show that brief advice reduces heavy drinking. Most studies are effectiveness studies and these are just as beneficial as efficacy studies. It seems that brief advice can be very brief - even just asking about alcohol use may have some effect.

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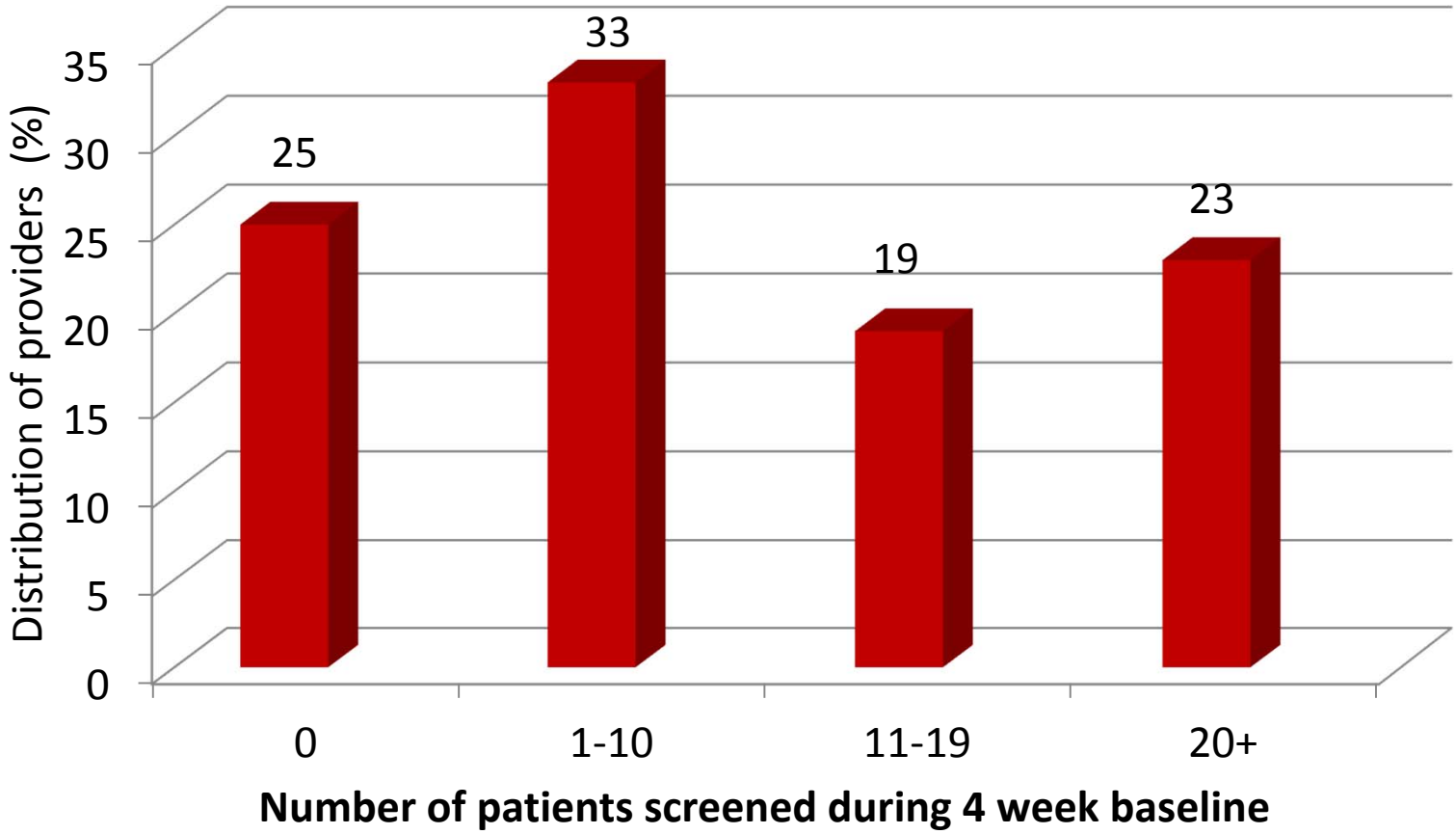
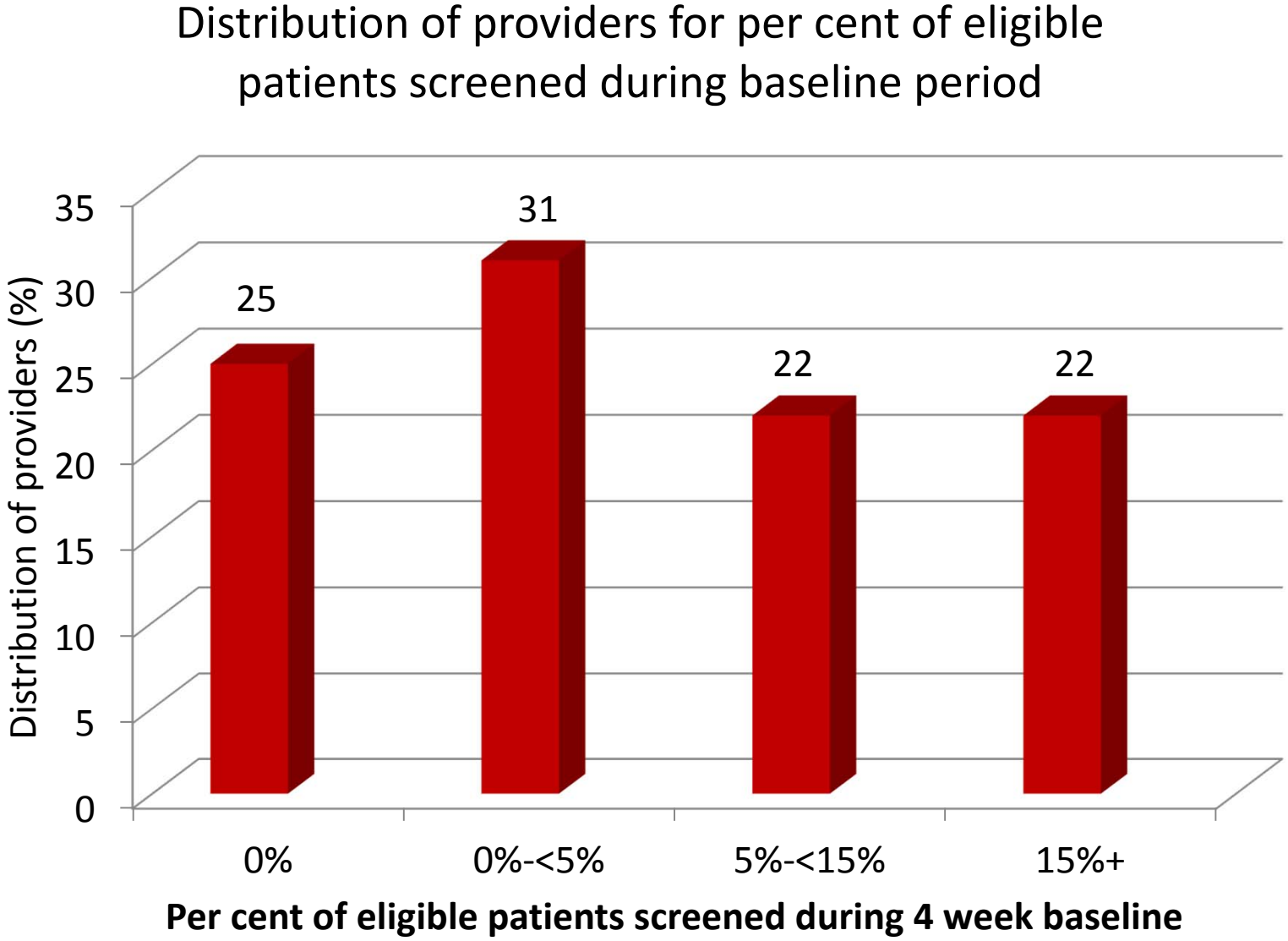
In the 5 countries of the ODHIN study (Catalonia, England, Netherlands, Poland and Sweden), about **24%** of the population aged 15-65 years drink 20+g alcohol per day (women) and 40+ (men), all of whom would be AUDIT-C positive.

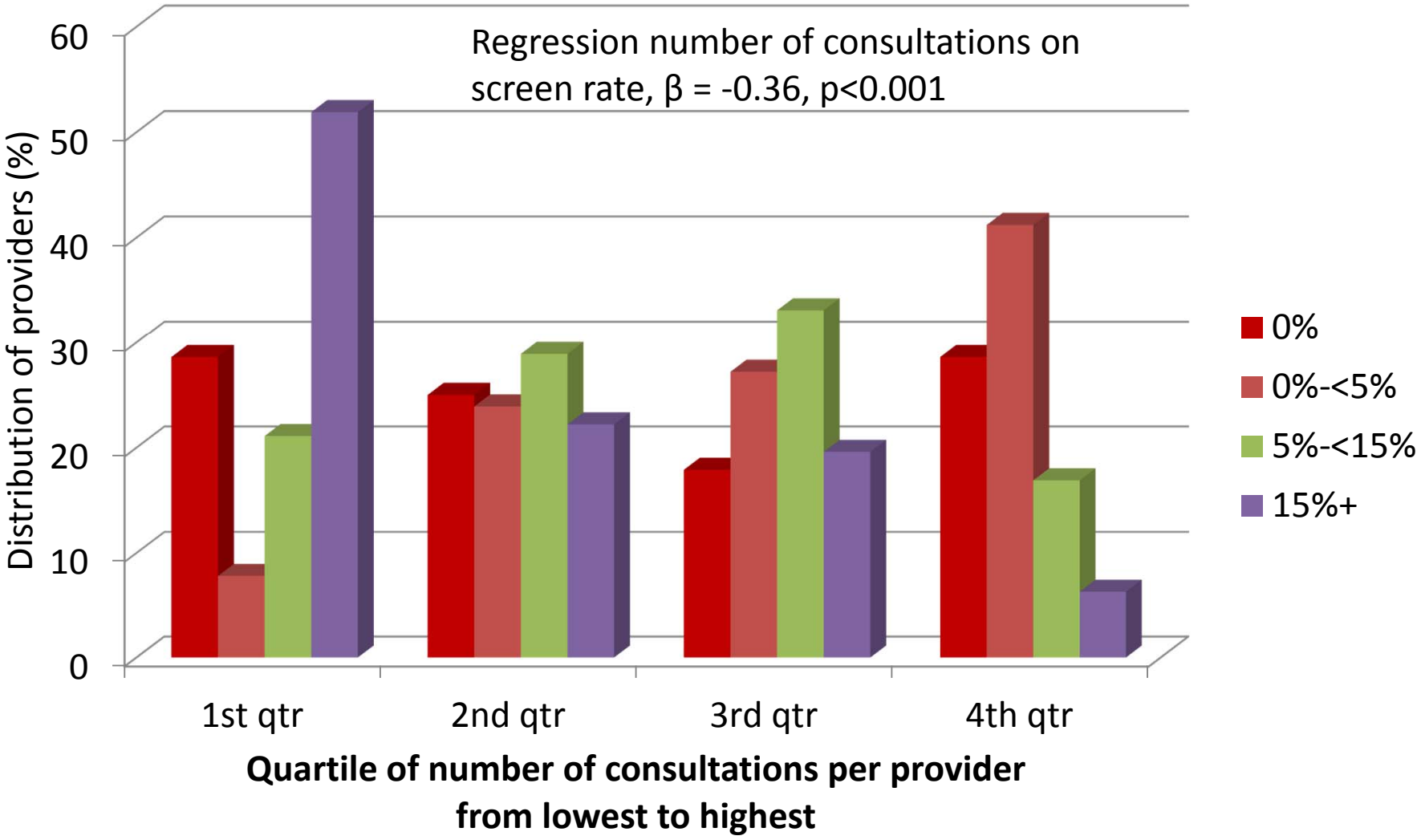
Over the 4 week baseline measurement period in the ODHIN study, only **1.3%** of 18-65 year olds who consulted their GP were identified as AUDIT-C positive, only some 1 in 20 of the prevalence estimate.

Distribution of providers (%) for numbers of patients screened (n) during 4 week baseline (average of 250 consultations/provider)

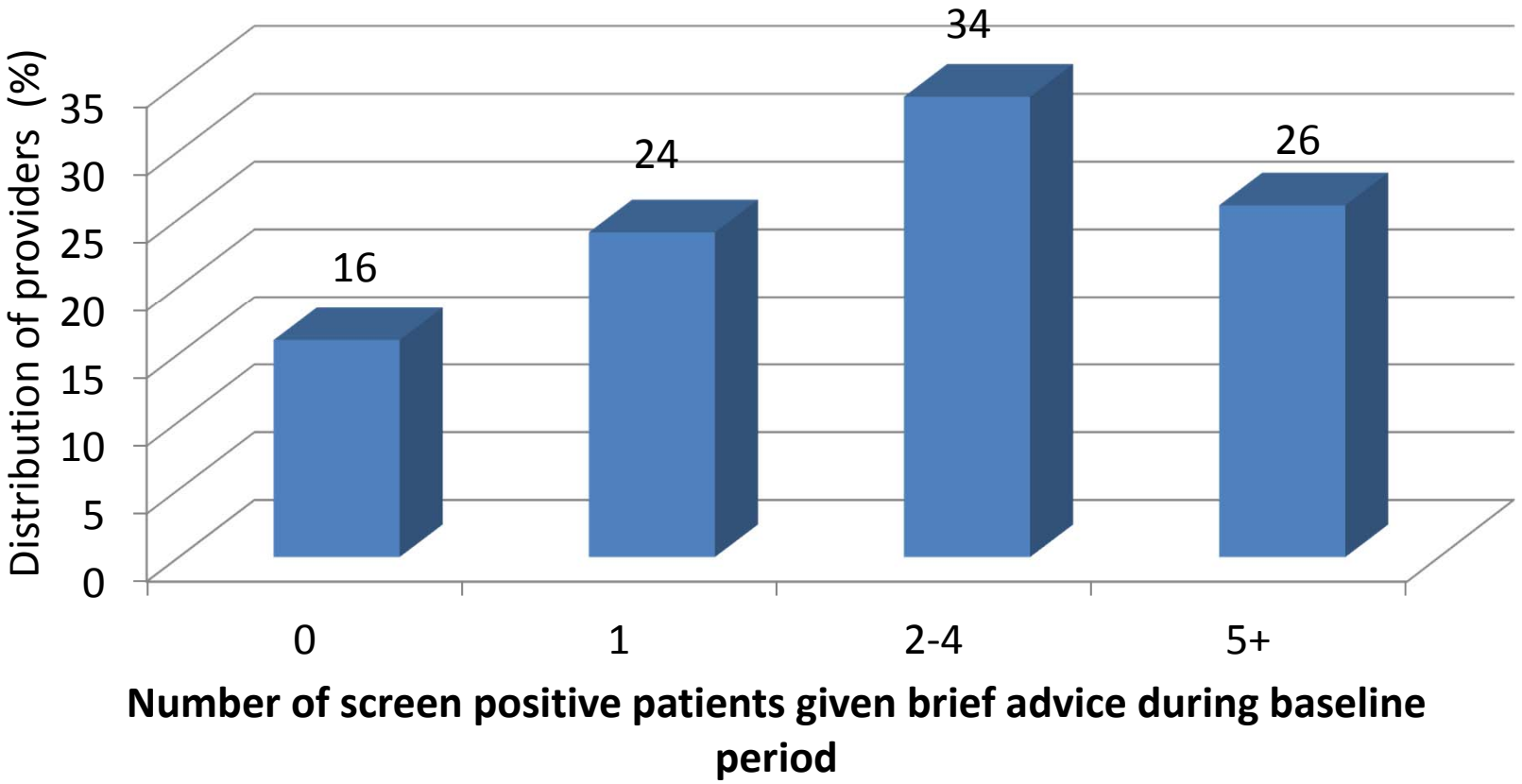


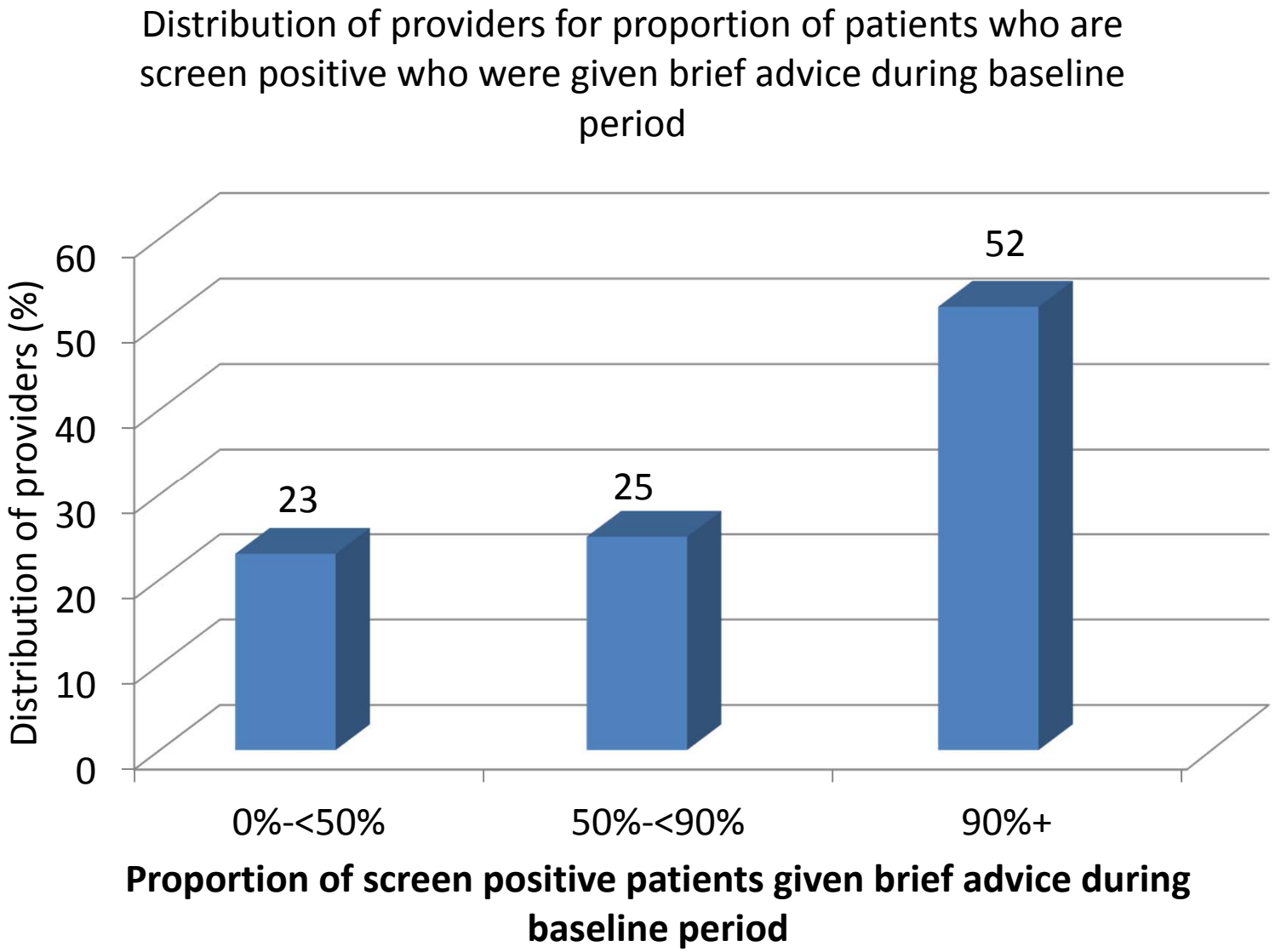

Distribution of providers for per cent of eligible patients screened during baseline period
Distribution of providers (%)
35
30
25
20
15
10
5
0
25
31
22
22
0%
0%-<5%
5%-<15%
15%+
Per cent of eligible patients screened during 4 week baseline

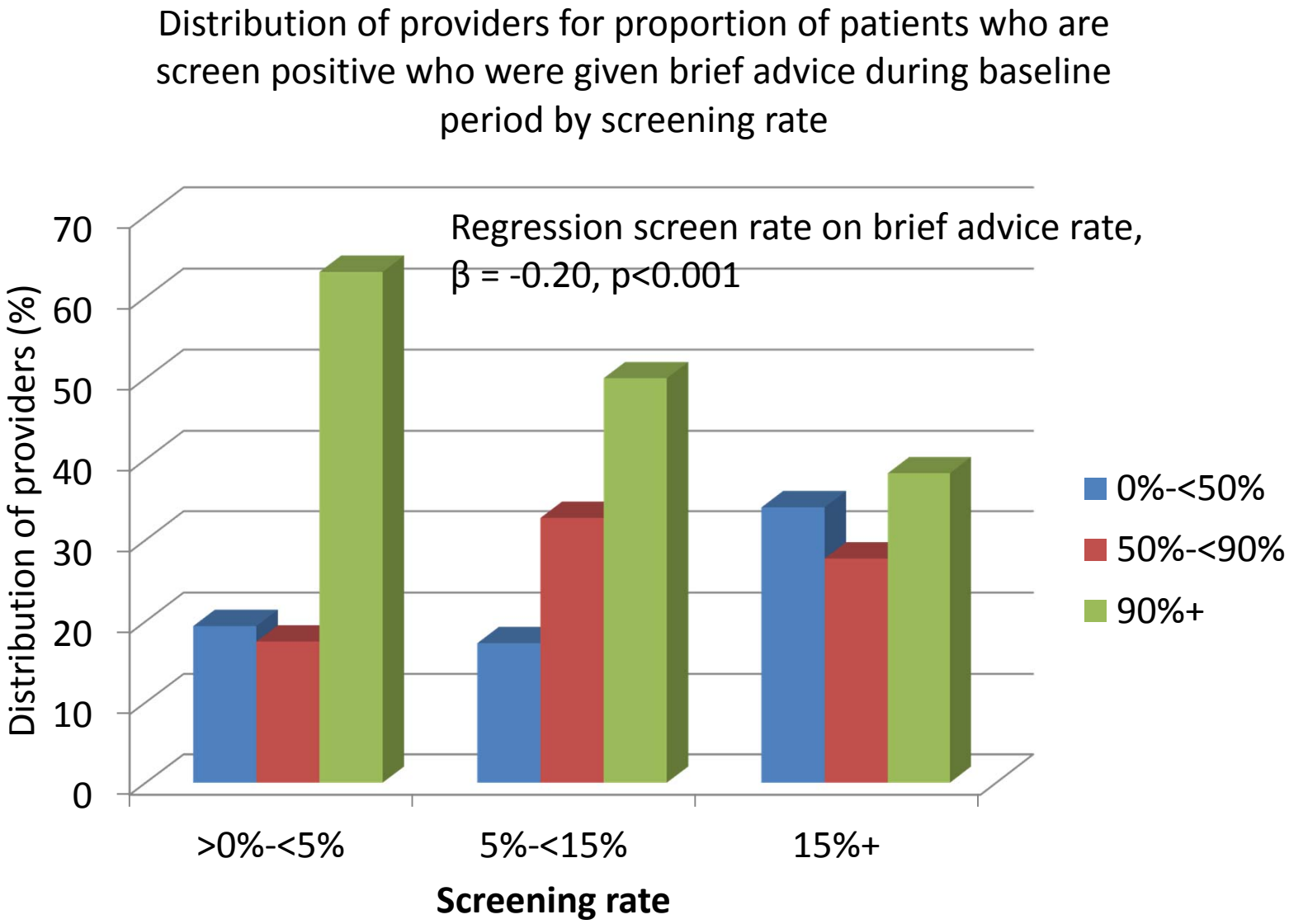
Distribution of providers for per cent of eligible patients screened during baseline period by quartile of number of consultations per provider



Distribution of providers for number of screen +ve patients given brief advice during baseline period
(average of 2.8 screen +ve patients/provider)




Distribution of providers for proportion of patients who are screen positive who were given brief advice during baseline period
Distribution of providers (%)
60
50
40
30
20
10
0
23
25
52
0%-<50%
50%-<90%
90%+
Proportion of screen positive patients given brief advice during baseline period


Distribution of providers for proportion of patients who are screen positive who were given brief advice during baseline period by screening rate
Regression screen rate on brief advice rate, β = -0.20, p<0.001
Distribution of providers (%)
70
60
50
40
30
20
10
0
>0%-<5%
5%-<15%
15%+
Screening rate
0%-<50%
50%-<90%
90%+

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Most providers hardly screened, more so those who saw more patients. However, most providers advised most of their AUDIT-C +ve patients, particularly if they were less busy screening.

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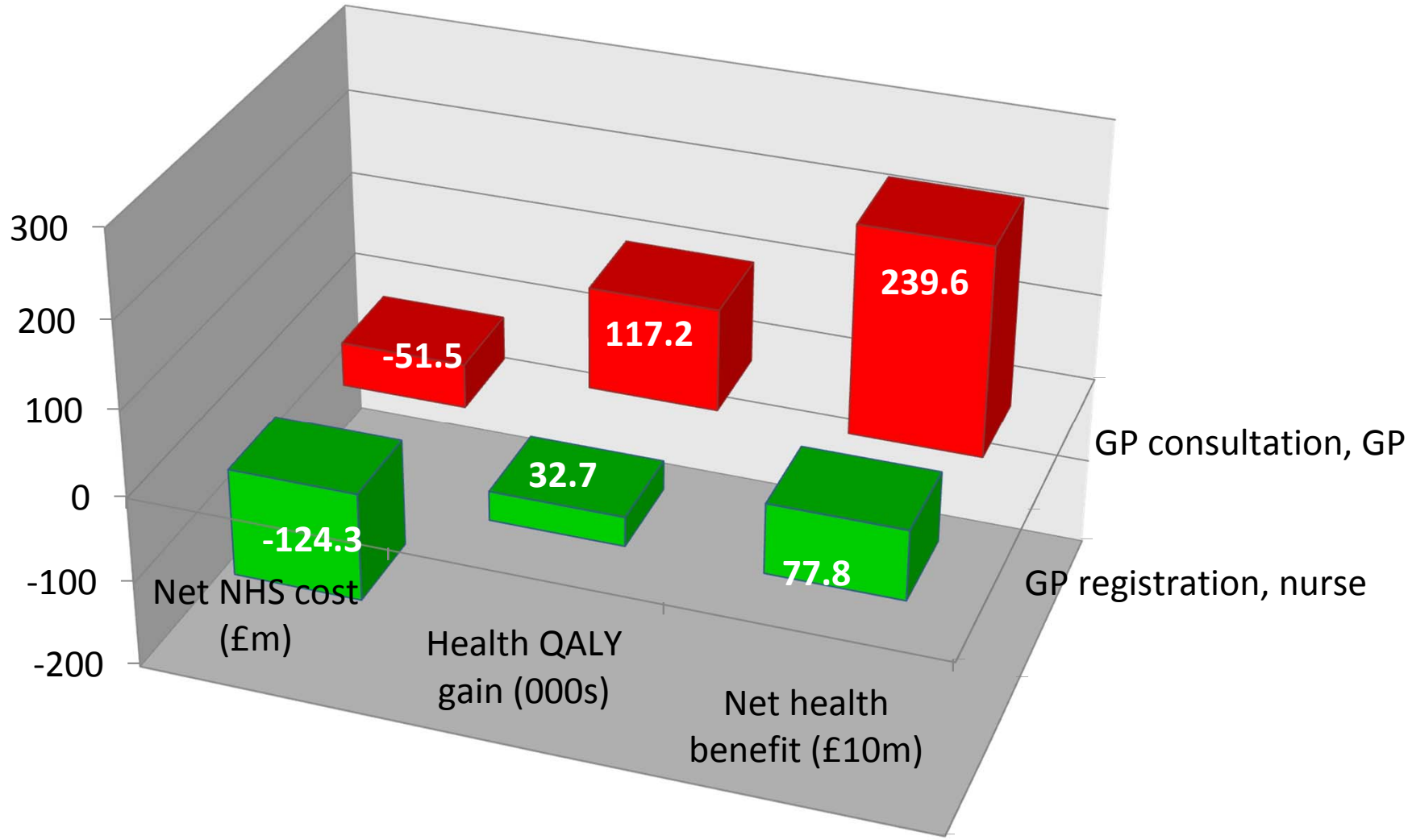
“The effects achieved in relation to the effort expended in terms of money, resources and time”

Last: a dictionary of epidemiology

Impact of AUDIT-C 3 screening and 5 minute intervention, England



Source: Purshouse et al 2009

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If we could get PHC providers to screen and advise, health systems could save money (as well as improving health). ODHIN raises the question, can we improve screening rates without compromising brief advice rates. Toni will tell us in the next presentation.