

Managing alcohol
problems in general
practice in Europe: results
from the European ODHIN
survey of general
practitioners



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- ❑ Alcohol consumption is a wholly or contributory cause for more than 200 diseases, injuries and other health conditions with ICD-10 codes.
- ❑ For most diseases and injuries, there is a dose–response relationship with alcohol



- ❑ Heavy drinkers who reduce their drinking also reduce their risk of mortality in comparison to those who continue heavy drinking.
- ❑ The higher the level of drinking, the stronger the effects of a given reduction



- ❑ There is a wealth of evidence that demonstrates the effectiveness and cost-effectiveness of screening and brief advice programmes to reduce alcohol consumption, and alcohol-related mortality when implemented in primary health care.



- ❑ With strong government support for alcohol brief interventions, supported by financial and performance management arrangements, guidance and strategic leadership, and training, it is possible to increase alcohol screening and brief interventions (e.g., in Scotland).



- ❑ However, in many jurisdictions there is a large gap between need and provision of advice. Commonly, less than 10% of the population at risk are identified, and less than 5% of those who could benefit are offered screening and brief interventions in primary health care settings.



- ❑ We surveyed 2345 general practitioners (GPs) from Catalonia, Czech Republic, England, Italy, the Netherlands, Poland, Portugal, and Slovenia to provide further information to help improve increased screening and brief advice activity to reduce heavy drinking in primary health care settings throughout Europe

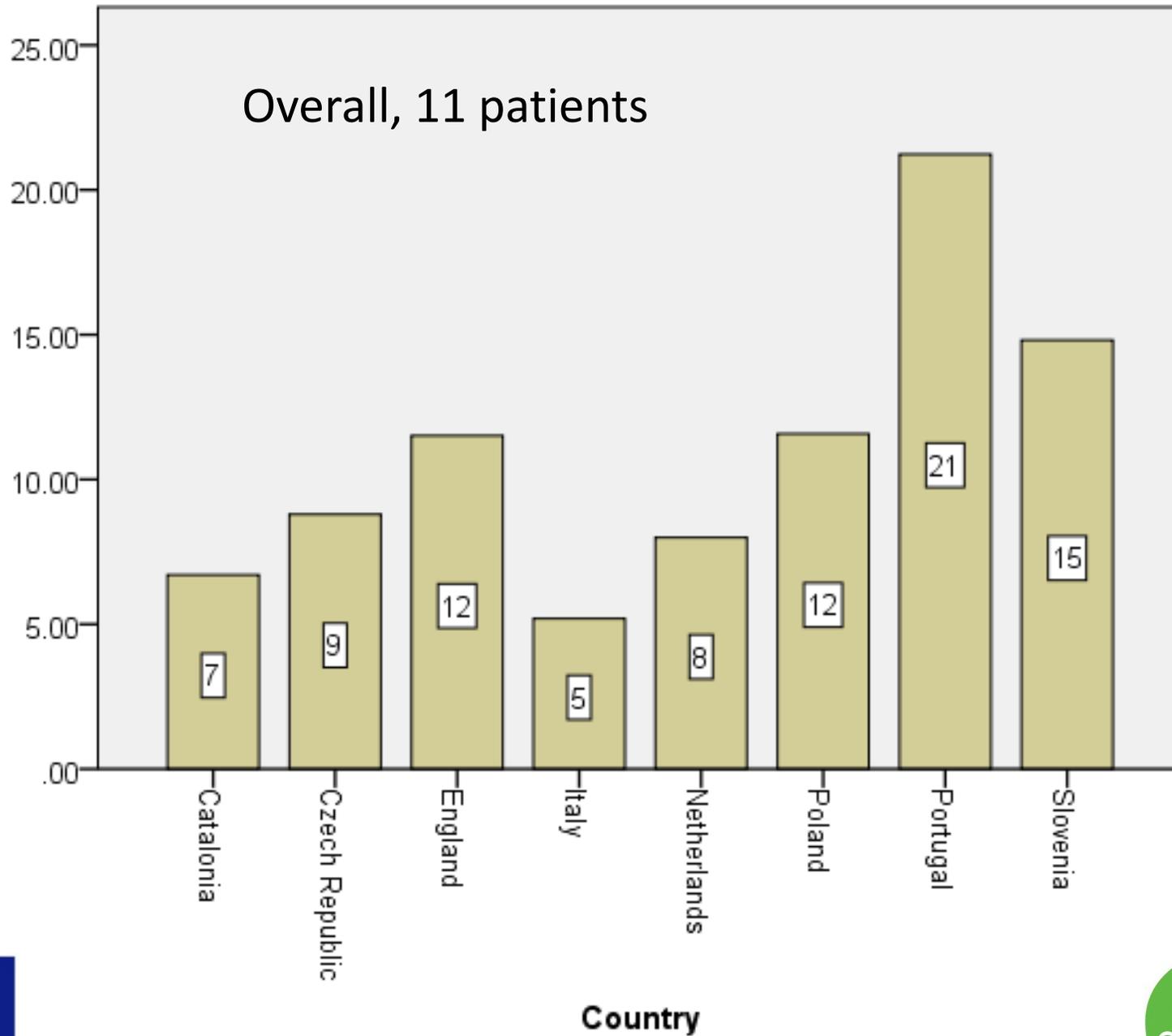


We asked them:

How many patients had they managed
for hazardous drinking or alcohol-related
problems in the previous year



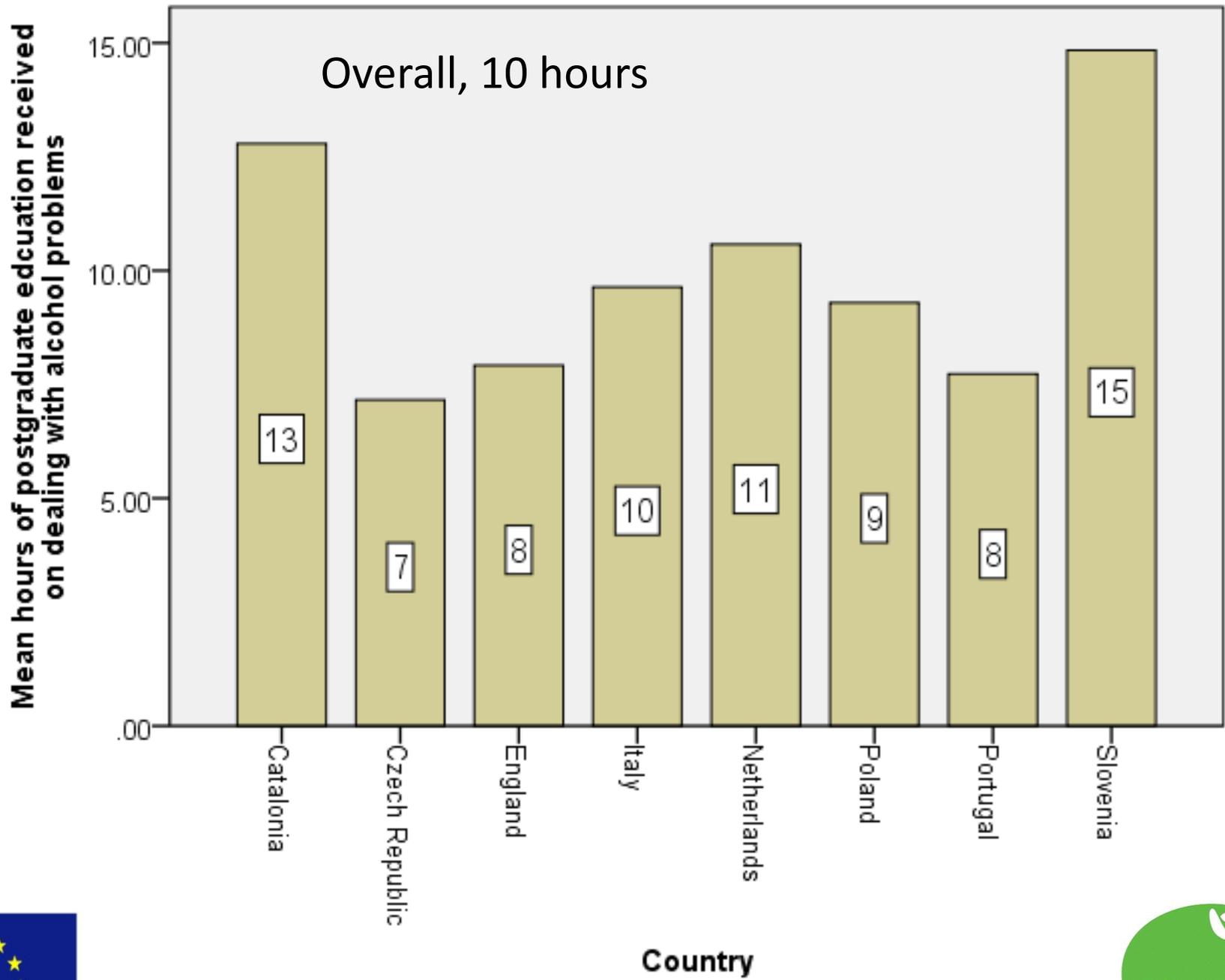
Mean number of patients managed with hazardous drinking/alcohol-related problems in previous year



□ We asked them:

how many hours of post-graduate training, continuing medical education or clinical supervision on alcohol and alcohol-related problems had they ever received

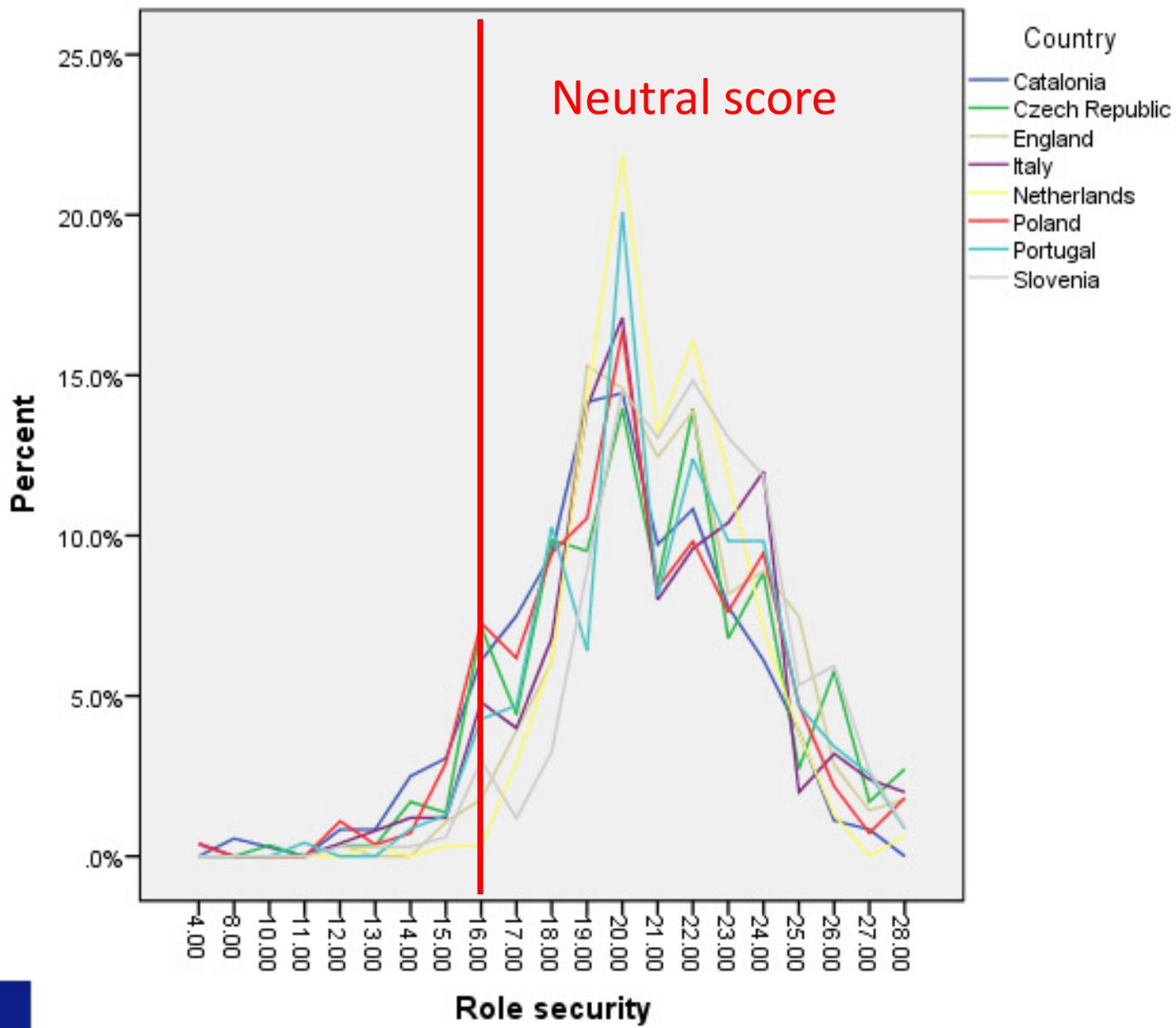




□ We measured their role security:

Using the short form of the Alcohol and Alcohol Problems Perception Questionnaire, how capable did they feel in working with patients with hazardous or harmful alcohol use

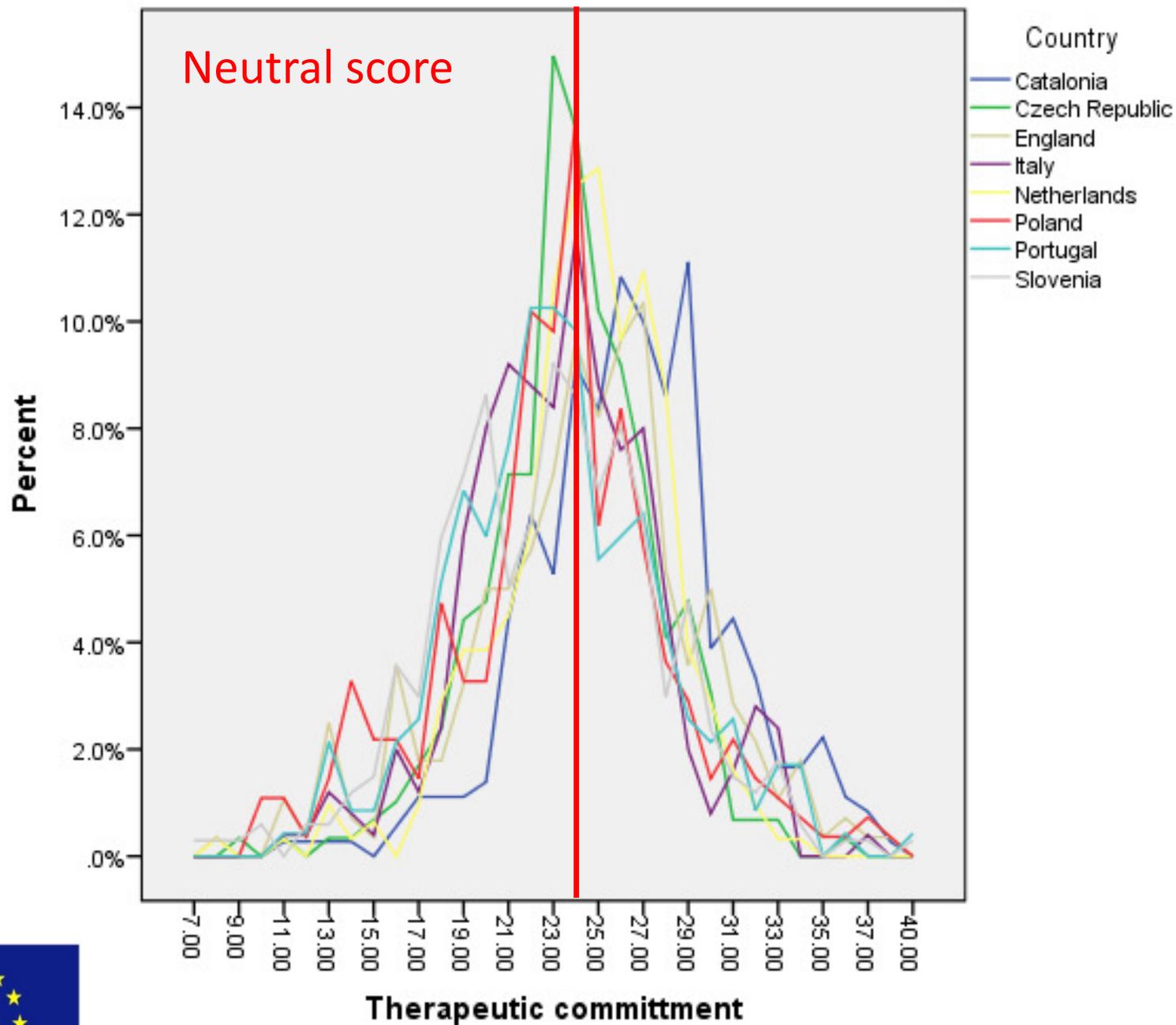




- ❑ We measured their therapeutic commitment:

Using the short form of the Alcohol and Alcohol Problems Perception Questionnaire, how motivated did they feel in working with patients with hazardous or harmful alcohol use





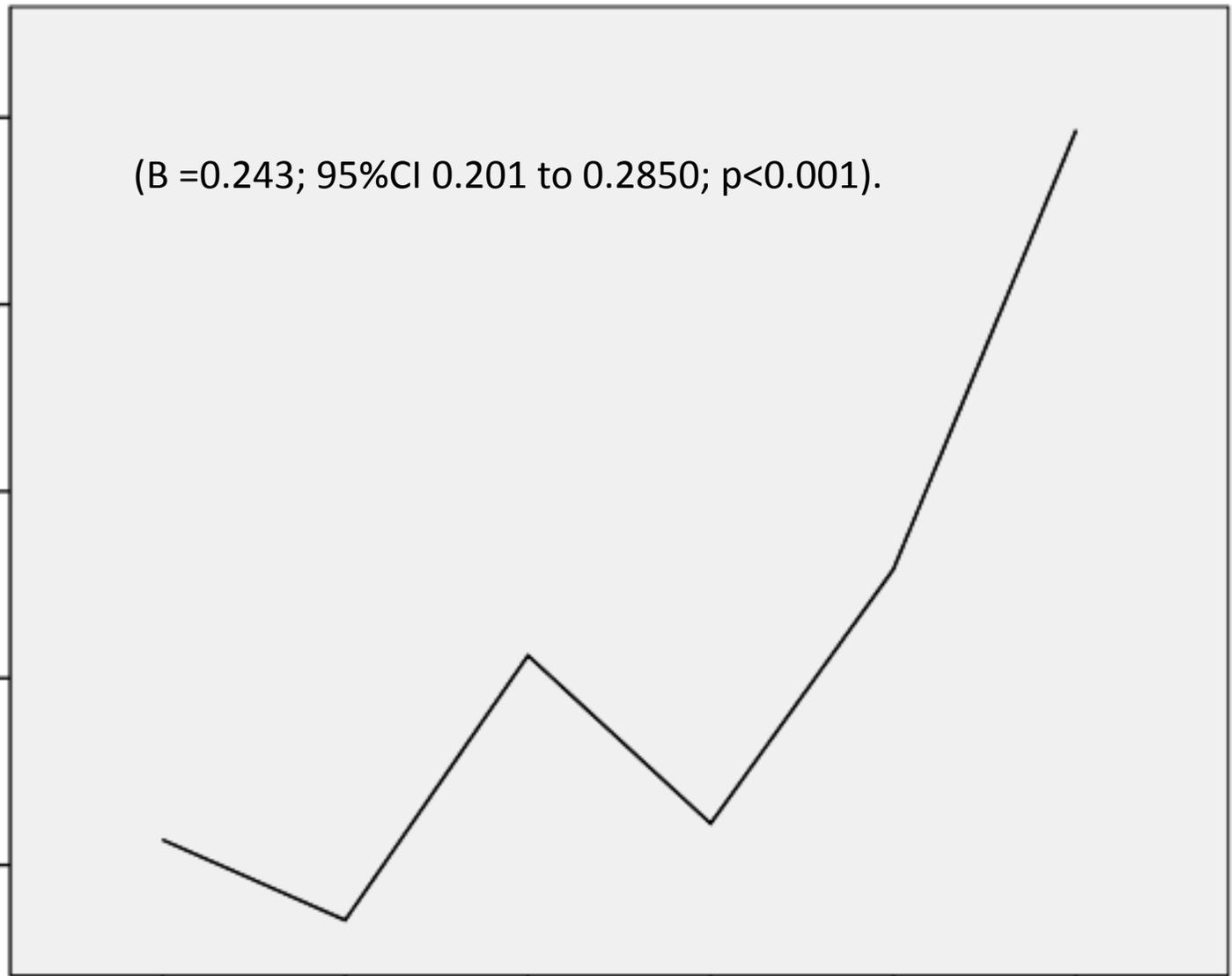
- ❑ Using mixed models with country as nested factor:

We estimated impact of hours of postgraduate education on number of patients reported as managed in previous year for their drinking



Mean number of patients managed with hazardous drinking/alcohol-related problems in previous year

(B =0.243; 95%CI 0.201 to 0.2850; p<0.001).



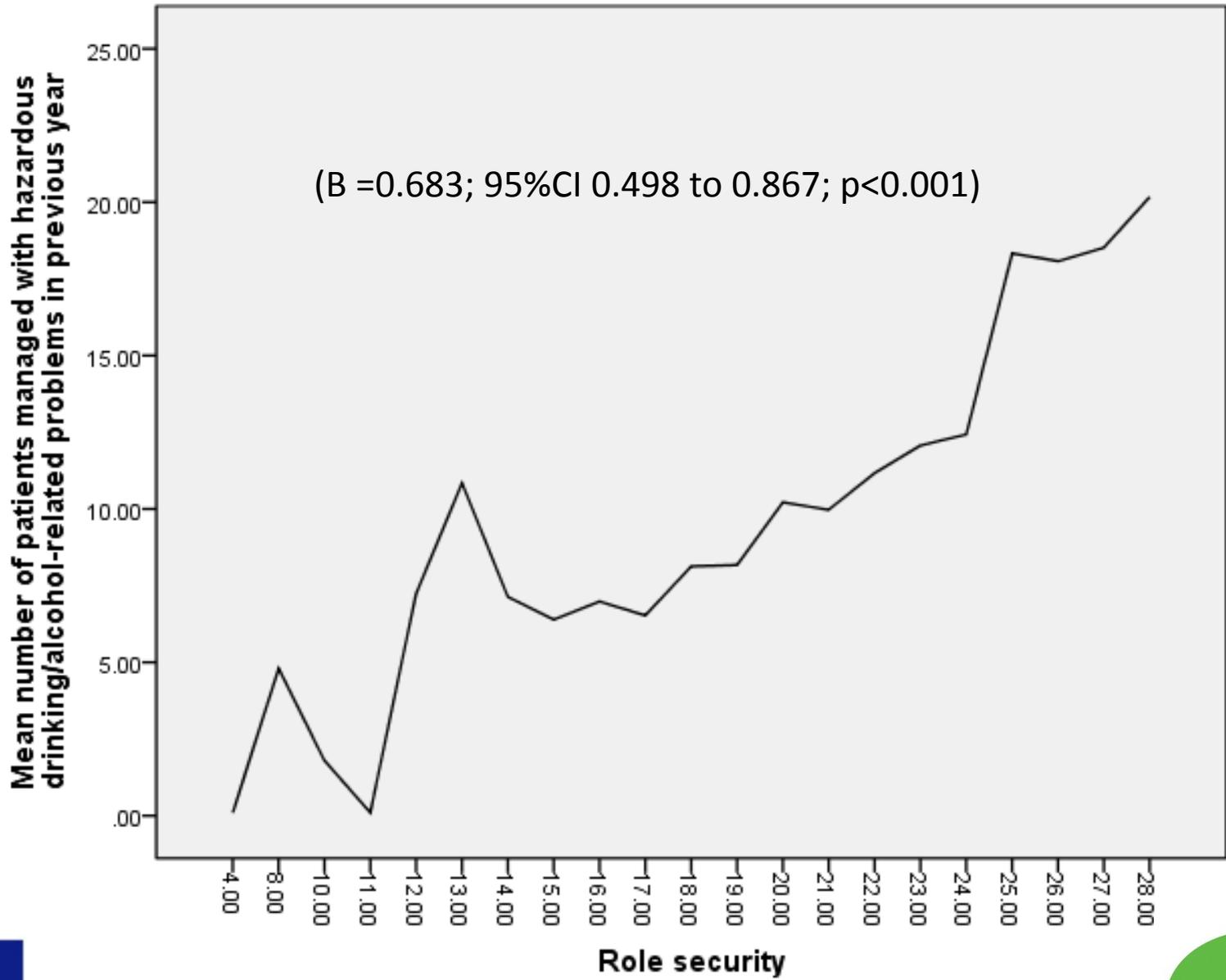
hours of postgraduate education received on dealing with alcohol problems



- ❑ Using mixed models with country as nested factor:

We estimated impact of role security on number of patients reported as managed in previous year for their drinking

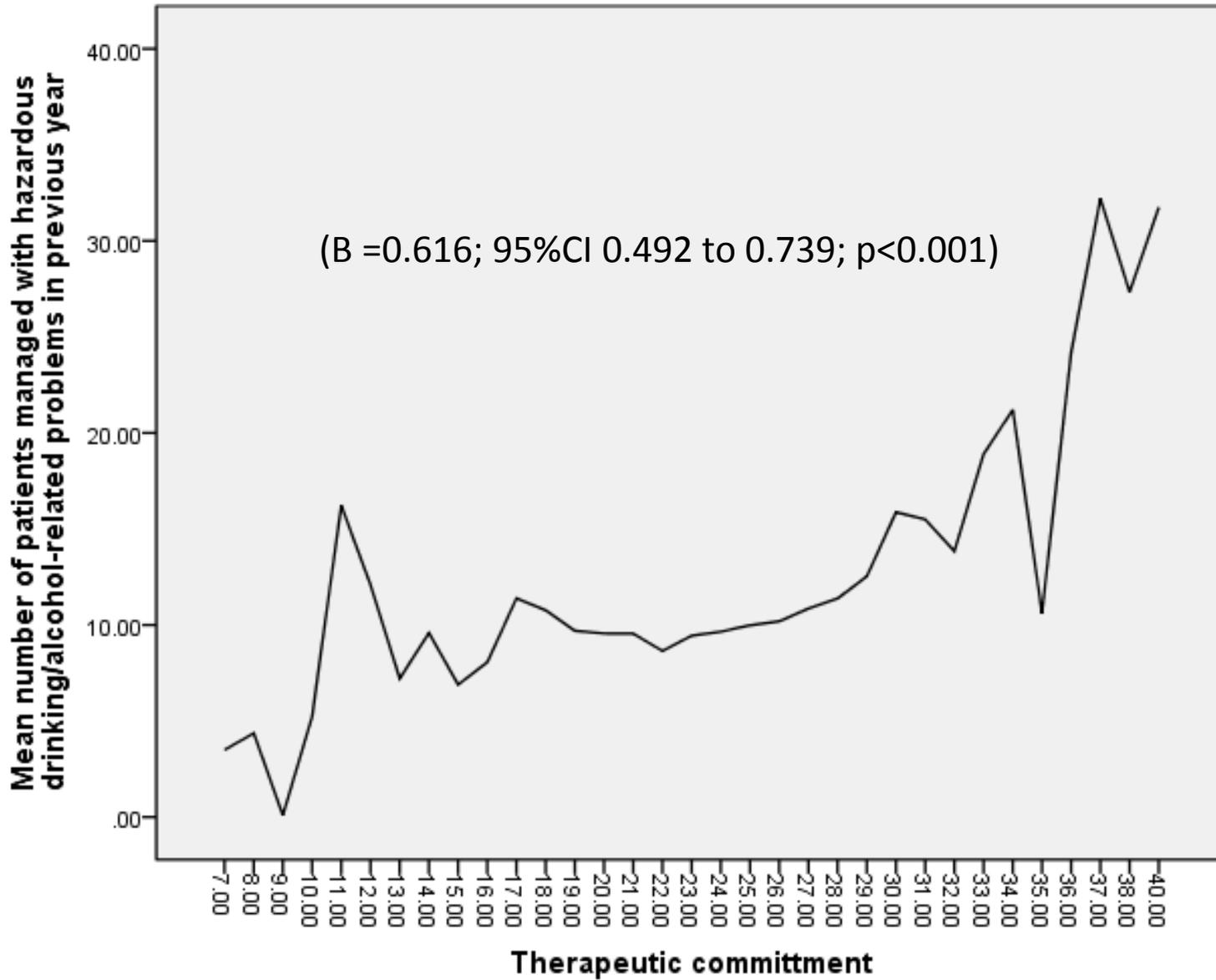




- ❑ Using mixed models with country as nested factor:

We estimated impact of therapeutic commitment on number of patients reported as managed in previous year for their drinking



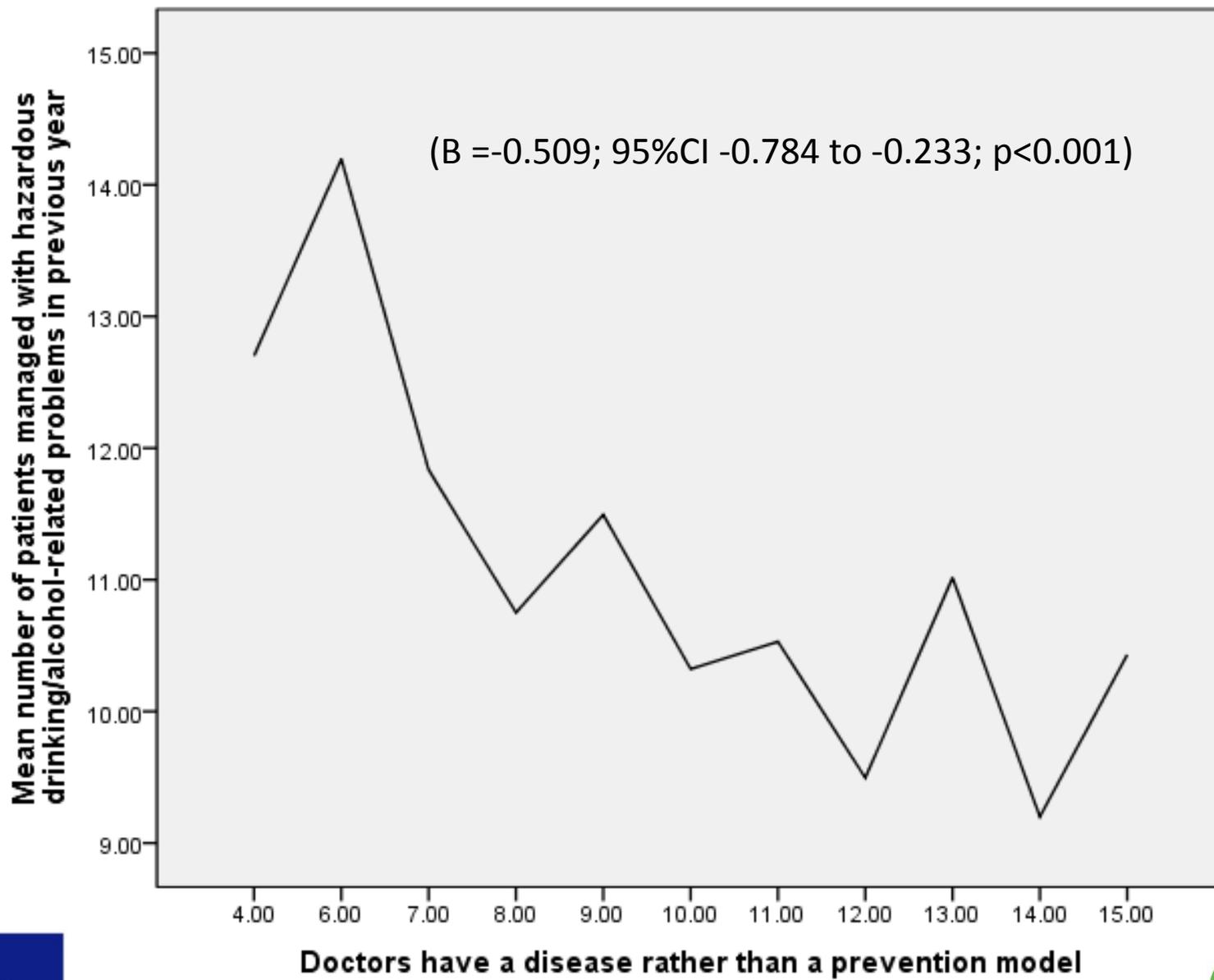


- We created two domains of facilitators for increased screening and brief advice activity ('availability of support materials and training', and 'availability of financial incentives') and two domains of barriers ('doctors have a disease rather than a prevention model', and 'do not regard prevention as a medical responsibility').



- ❑ We estimated the impact of the domains on number of patients reported as managed in previous year for their drinking
- ❑ Only the domain 'doctors have a disease rather than a prevention model' was found to be related to number of patients reported as managed in previous year for their drinking (domain not substantially influenced by education on alcohol)





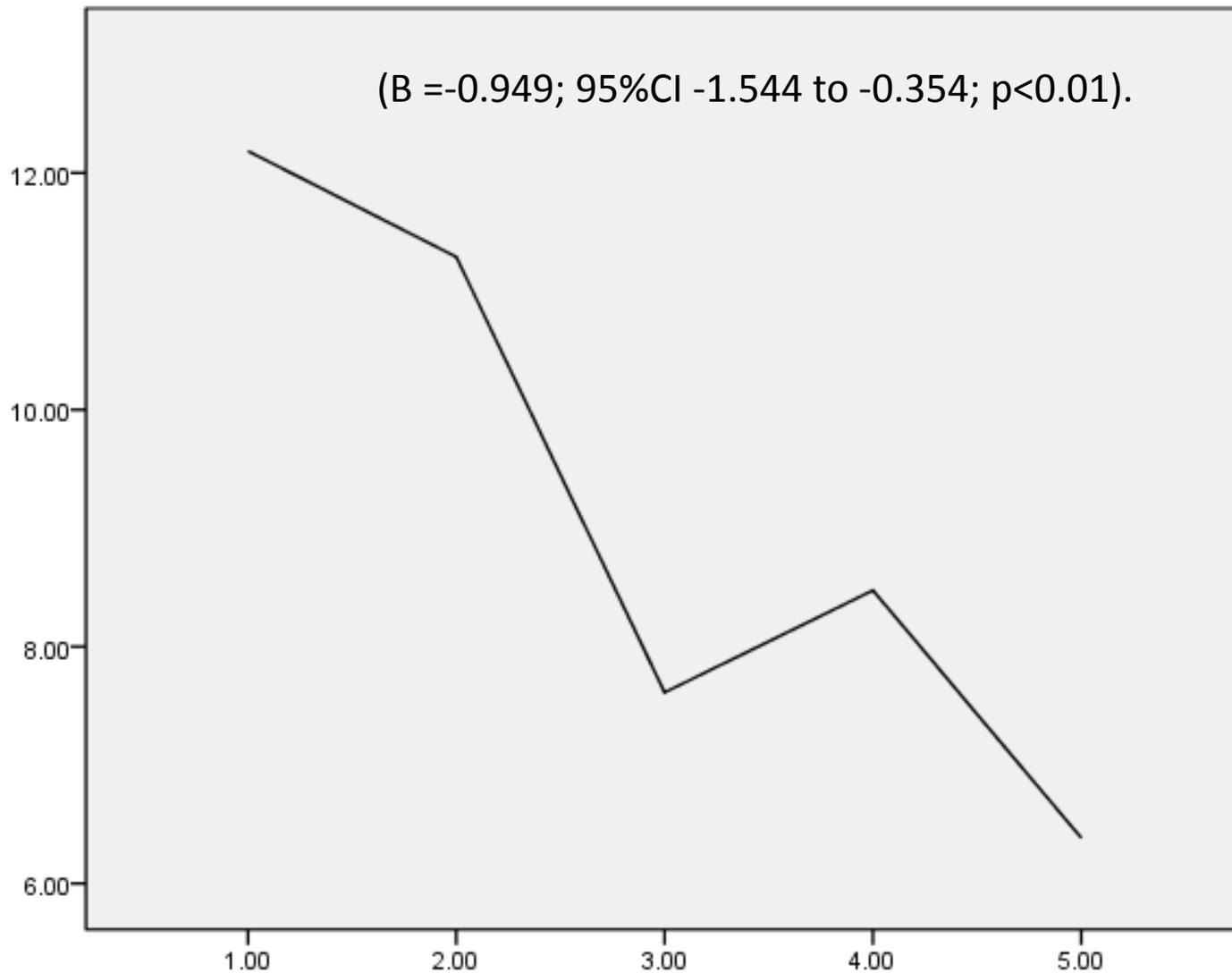
- ❑ We created three domains of views on alcohol policies ('should restrict advertising and place warning labels'; 'price influences consumption'; and, 'individuals should be responsible for managing their own drinking') and two domains on effective policies ('regulatory policies work'; and, 'youth oriented policies work')



- ❑ We estimated the impact of the domains on number of patients reported as managed in previous year for their drinking
- ❑ Only the domain ‘individuals should be responsible for managing their own drinking’ was found to be related to number of patients reported as managed in previous year for their drinking (domain not influenced by education on alcohol)



Mean number of patients managed with hazardous drinking/alcohol-related problems in previous year



individuals are responsible enough to protect themselves from alcohol-related harm



- ❑ The first caveat of this study is that, with the exceptions of England, Czech Republic and Poland, response rates were less than 50%. In all countries, except England, where it was restricted to one region, the sample represented the different regions of the country as a whole and was representative of the age and sex profile of general practitioners practising in each country or region.
- ❑ It is possible that the respondents included doctors with a higher interest in alcohol issues than non-responders, although the extent to which this is the case is not known.



- ❑ The second caveat is that the questionnaire provides self-report data, with no external means of validation.
- ❑ The third caveat is that the design is a cross sectional survey and the analyses rely on correlational relationships between different items in the survey, making the inference of causal pathways problematic.



- The first conclusion is that GPs who reported higher levels of education for alcohol and alcohol problems and GPs who felt both more secure and therapeutically committed in managing patients with such problems reported managing a higher number of patients.



- The second conclusion is that GPs who reported that doctors tended to have a disease rather than prevention model of alcohol problems and those who felt that drinking was a personal rather than a medical responsibility reported managing a lower number of patients.



Recommendations

It is worth exploring the extent to which:

1. improved education;
2. targeting screening to comorbid conditions (such as high blood pressure or using pharmacotherapy in primary health care (disease model)); and
3. a shift to personalized health care in which individual patients are facilitated to undertake their own assessment and management (individual responsibility)

might increase the number of heavy drinkers who receive feedback on their drinking and support to reduce their drinking.

