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Intervention for excessive alcohol consumption in primary health care: Attitudes & practices of GPs in England ten years on

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Background



- > Excessive drinking is the second greatest risk to health & well-being in developed countries¹
- > In England 38% of men and 16% of women (8.2 million adults) are hazardous, harmful or dependent drinkers²
- > Primary care is ideal for screening and preventing alcohol-related problems³
- > Brief interventions reduce excessive alcohol consumption in primary care patients⁴
- > Lack of UK progress on alcohol intervention work despite rising costs of this problem recently reported⁵

¹World Health Organisation. Global Health Risks. 2009, WHO: Geneva

²Department of Health. ANARP. 2005, DoH: London

³Kaner, EF, et al. *Alcohol & Alcoholism*, 1999. **34**(4): p. 559-66

⁴Kaner, EFS, et al. *Cochrane Database of Systematic Reviews*, 2007(2): p.CD004148

⁵Health Care Commission Audit Commission. 2008, CHAI: London



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Previous survey of UK GPs³

- > Questionnaire developed for WHO project
- > GPs may miss 98% of excessive drinkers presenting to primary health care^{6,7}
- > GPs reported receiving more alcohol-related education than previously
- > GPs were prepared to counsel patients about reducing consumption but perceived a lack of effectiveness in doing so
- > On Short Alcohol & Alcohol Problems Perception Questionnaire⁸, GPs reported high role security but lower therapeutic commitment
- > Main barriers to BI for alcohol were insufficient time & training & lack of help from government policy, while availability of appropriate support services & evidence for BI were incentives.

³Kaner, EF et al. *Alcohol & Alcoholism*, 1999. **34**(4): p.559-66

⁶Anderson, P. *Alcohol and Primary Health Care*. 1996, WHO: Copenhagen

⁷Kaner, EF et al. *BJGP*. 2001 **51**(471):822-7.

⁸Anderson, P & S Clement, *Addiction*, 1987. **82**(7): p.753-759

Aims

Current study aimed to identify in 2009:

- > GPs' reports of preventive practice
- > GPs' reports of how secure and committed they felt in the role of treating alcohol problems
- > GPs' perceptions of the barriers and incentives to preventive work for alcohol

and to compare these with results from previous survey.

Method

- > Postal survey of 419 GPs (1 per practice) in Midlands, UK; 282 (73% of those eligible) responded.
- > Collected: demographic information; how often and why GP enquired about alcohol; numbers of blood tests & patients managed for alcohol per year.
- > Asked to rate preparedness and effectiveness re counselling patients for alcohol; SAAPPQ⁵ included for both problem (hazardous/harmful) & dependent drinkers.
- > Attitudes to 15 suggested barriers and 7 incentives to alcohol prevention
- > SPSS data analysis using paired or unpaired t-tests for continuous variables & chi-square tests for categorical data, with p-value of 0.01 taken to indicate statistical significance.

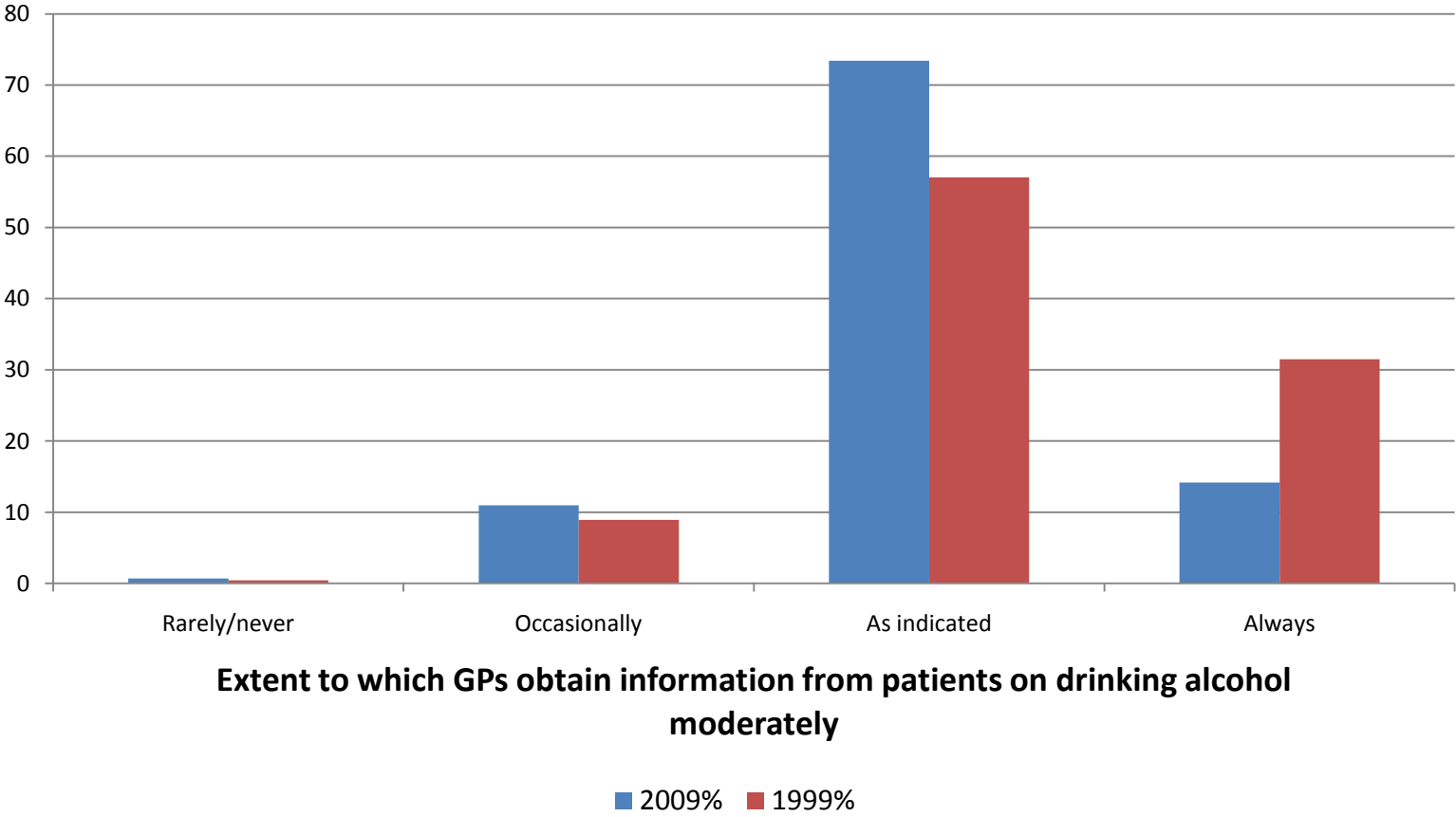


Results – preventive practice

- > Modal value of 1-6 patients managed for alcohol problems – trend towards more patients from 1999 ($\chi^2(5)=27.35, p<0.001$)
- > GPs reported requesting more blood samples annually for alcohol problems – modal value ‘>12 samples’ in 2009, ‘6-12 samples’ in 1999
- > Fewer GPs ‘always’ obtained information on patients’ drinking - 14% versus 32% in 1999 ($t(508)=4.001, <0.001$)



Figure 1: Obtaining information on patients' drinking



Results – training

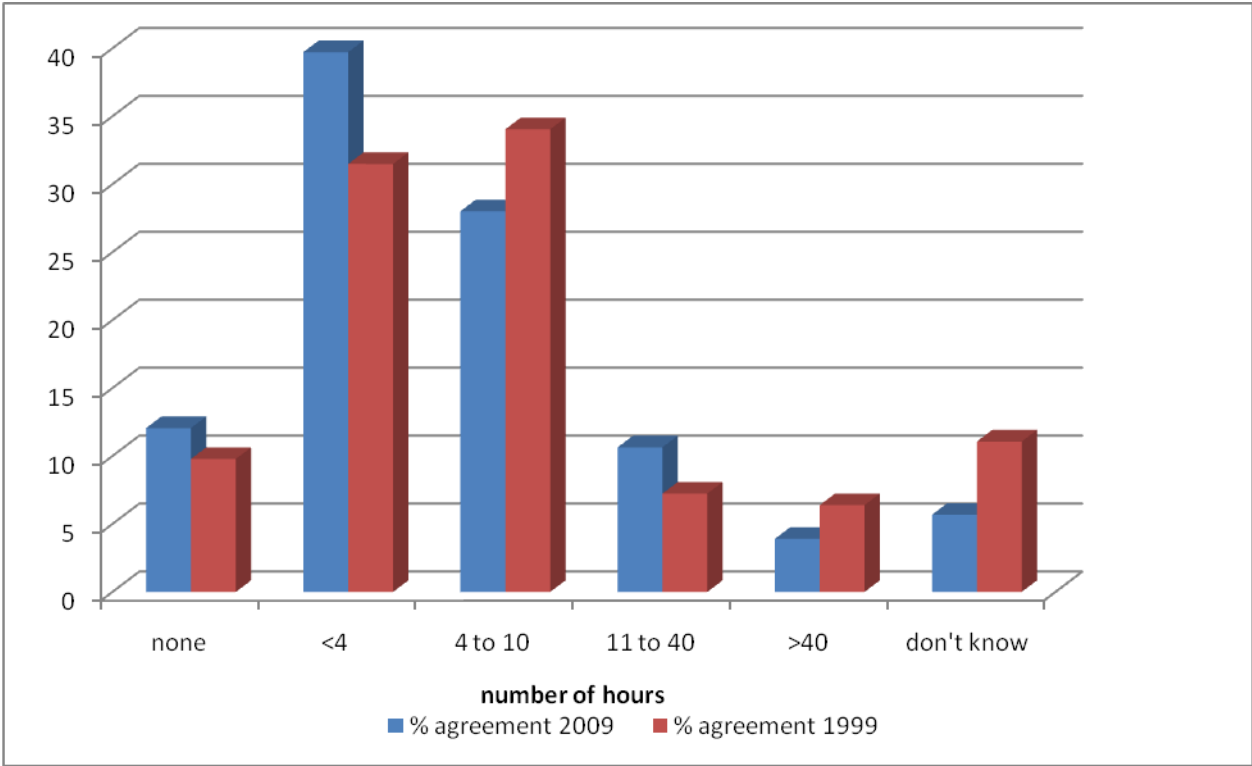
- > GPs reported lower rates of postgraduate training, continuing medical education or clinical supervision on alcohol than in 1999



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Figure 2: No. of hours of postgraduate training, continuing medical education or clinical supervision on alcohol



Results – self-efficacy

Most GPs said they were prepared to counsel patients to reduce alcohol

Most felt effective in doing so

Most felt GPs could be more effective given information and training

These figures were all significantly higher than in 1999

	2009 %	1999 %	t	df	p
Prepared to counsel for reducing alcohol consumption	94	81	-4.39	507	<0.001
Self effective in helping patients reduce alcohol consumption	60	21	-9.29	497	<0.001
GPs effective in helping patients reduce alcohol consumption given adequate information and training	82	56	-6.70	499	<0.001



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Results – SAAPPQ

SAAPPQ Component	% agree 2009	% agree 1999	t	df	p
<i>With problem drinkers:</i>					
Adequacy	78	72	-2.756	496	0.006
Legitimacy	88	87	0.126	501	0.900
Motivation	42	23	-2.445	497	0.015
Self-esteem	53	20	0.303	495	0.762
Satisfaction	15	13	-1.469	501	0.143
<i>With dependent drinkers:</i>					
Adequacy	69	61	-2.882	499	0.004
Legitimacy	87	87	0.091	501	0.927
Motivation	35	24	-3.182	499	0.002
Self-esteem	49	28	-1.729	493	0.084
Satisfaction	12	7	-2.198	500	0.028

Results – barriers to intervening for alcohol

Perceived barrier	2009 % agreement	1999 % agreement
GPs are too busy	63	69
GPs not trained in counselling	59	58
GPs lack suitable counselling materials	46	47
GPs are not responsible for preventive health	23	38
GPs have disease model training	21	40
Alcohol not an important issue in general practice	14	28

Results – incentives to intervening for alcohol

Perceived incentive	2009 % agreement	1999 % agreement
General support service availability	87	80
Early intervention proven successful	81	75
Patients requesting health advice	80	72

Discussion



- > UK GPs report more preventive practice in respect of patients' alcohol consumption than 10 years ago but less routine enquiry about drinking
- > Levels of postgraduate training in treating alcohol reported by GPs are low & lower than 10 years ago
- > GPs report being more prepared to tackle alcohol problems and potentially effective in doing so, but see greater potential given training & information
- > GPs report low motivation, satisfaction and self-esteem in intervening for alcohol use. They may often feel too busy to intervene; they may not feel supported in doing so; or they may doubt the effectiveness of early intervention.



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Conclusions

Alcohol intervention in primary care might be encouraged with:

- > further training for GPs
- > further support available to GPs
- > prioritising alcohol in the GMS contract



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