Identifying and Addressing Risky Drinking

Lessons Learned and Next Steps

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Overview

- Problem — Burden, risks and costs of risky alcohol use
- Good News — Evidence supports screening and interventions within primary care
- Bad News — Primary Care is not routinely carrying out these practices.
- Challenge — Implementing these practices within already busy clinical settings
- Viable Model — Research conducted in collaboration with Saskatchewan clinics
- Opportunity — Collaboration with Manitoba clinicians to refine and adapt model

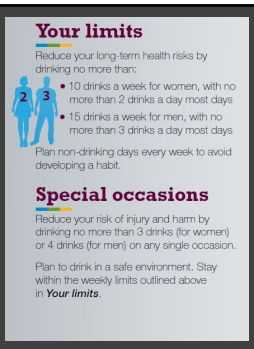
The Problem

The burden of disease associated with alcohol consumption, especially non-dependent risky drinking, is considerable.

The impact on patients is reflected in increased risk for onset or worsening of preventable chronic illness including some forms of cancer, heart disease and diabetes. *(Canada's Low Risk Drinking Guidelines)*

The costs to health systems and communities are significant. The costs attributable to alcohol are equal to all illicit drugs combined. *(Centre for Addiction and Mental Health)*

At a population level, the lion's share of alcohol's costs are associated with moderate risk drinkers, rather than high risk (dependent) drinkers. *(Centre for Addiction and Mental Health)*



The Good News

General adult screening in primary care for risky alcohol use is a recommended opportunity to improve patient health outcomes through prevention and early intervention. *(US Preventive Services Task Force)*

The evidence supports primary care-based general screening of adults as well as brief interventions for adults with moderate risk patterns of alcohol use. *(US Preventive Services Task Force)*

Risk Factors

Amount and frequency of drinking (initial screen using AUDIT-C)

Extent of already experienced health problems and other harms (secondary screen GAIN-SS)

Note: Likely chemical dependence (addiction, alcoholism) seen as risk factor for onset worsening of health problems, rather than as primary harm. Lack of control over drinking makes it even harder for patient to address these problems.

Risk Levels

Low Risk

Elevated Risk

Moderate Risk

High Risk

Moderate vs High Risk

This moderate risk group is associated with a larger burden of disease and injury as well as greater health system costs than the high risk group.

However, the brief intervention costs for moderate risk drinkers are much lower than the treatments required for high risk drinkers and the likelihood of positive health outcomes is much greater.

Brief interventions to help moderate risk drinkers adjust their behaviors toward healthier patterns can reduce the number who might go on to become high risk.

Helping moderate risk drinkers within primary care rather than referring them, may reduce the wait lists for specialized treatment services that should be reserved for patients at high risk.

Care pathways: If low or elevated risk …

If screening indicates low risk (drinking within Canada's low risk drinking guidelines or LRDG), then the clinical response is reinforcement of good health behavior.

If screening indicates elevated risk (drinking beyond the LRDG, but still without significant harms), then the clinical response is to advise the patient of health risks.

"Screening is an opportunity for prevention."

- Peter Butt MD, Dept of Family Medicine, University of Saskatchewan

Care pathways: If moderate risk …

If screening indicates that the patient is at moderate risk (drinking beyond the LRDG and experiencing some harms, but non-dependent), then evidence supports the use of primary care-delivered 'brief interventions' (BI).

BI = helping patient reassess their readiness to change + helping patient determine and engage in their behavioral change work

Brief Interventions

Brief interventions involve a set of evidence-based steps to help increase and sustain patient readiness for change and then to facilitate patient self-change work.

This is much the same as helping patients to move toward losing weight, stopping tobacco use or better managing their diabetes.

While most brief interventions studied for risky drinking have been delivered by family physicians, there is also support for delivery by nurses and nurse practitioners in primary care.

Alcohol brief interventions could be delivered in some cases through self-guided workbooks or online modules if adequate supports were in place.

Care pathways: If high risk …

If screening indicates high risk (exceeding the LRDG and also likely dependent or with concurrent mental health issues), then the patient is an appropriate candidate for referral to specialized treatment.

The Bad News

Widespread practice of systematic screening for risky drinking using effective tools has been limited, in part due to the lack of viable implementation models.

The Challenge

The challenge is no longer one of demonstrating efficacy or cost-effectiveness.

We need to develop models and policies that make it viable for busy family medicine practitioners to conduct alcohol screening, interventions and referrals as needed.

"We now have to view the lack of SBIR uptake as an implementation science problem."

- Michael Fleming MD (Institute of Medicine), Depts of Family Medicine and Psychiatry, Northwestern University.

Towards a Viable Model

We had some success in developing and piloting a set of implementation practices in a one year collaboration with family medicine clinics in Saskatchewan. This developmental research was supported by Health Canada's Drug Treatment Funding Program (DTFP).

Manitoba has now acquired its own DTFP support from Health Canada to build on what we learned in Saskatchewan. More on this in a moment.

Patient Flow Results

664 adult patients seeking routine care in two clinics were offered our initial behavioral health screen [AUDIT-C included] in the waiting room. 98% accepted.

43% of these screened positive for being at more than low risk.

Patients who screened positive were asked secondary screening questions by a *primary care counsellor* [GAIN-SS]. Approximately 65% of these agreed to the secondary screen.

97% of those identified as moderate risk on the secondary screen agreed to brief intervention and 81% of those who screened as high risk agreed to a referral to specialized services.

Qualitative Results

Clinicians and managers tended to strongly agree that the model …

- addressed a gap in patient care
- helped improve understanding of patients' needs
- was easy to understand and apply
- was relevant to the health needs of patients
- provided feasible ways to identify patients' levels of risk related to alcohol
- could help improve the quality and impact of primary health care services.

Lessons Learned

- Screening needs to be done with highly efficient validated tools.
- Screening needs to be conducted with two tools, rather than one.
- Screening needs to avoid stigma by being handled as routine health questions.
- Screening questions need to be self-completed to conserve practitioner time.
- Information technologies are needed to further increase efficiency and reduce error.
- Clinicians may need alternatives to delivering brief interventions face-to-face.

An Opportunity

There are three main enhancements to the model that will piloted in Manitoba:

1. A tablet app with a patient self-completed behavioral health screener (same questions as before) in order to make the screening steps (including scoring) even more efficient.

2. A workbook that guides the patient and clinician through the brief intervention process. The workbook in effect becomes a clinician script for doing face-to face brief interventions with patients.

3. A web version of the workbook that would enable self-guided brief interventions for those patients screened to be engaging in moderate risk drinking, but where a face-to-face BI is not practical or desired.