

6 Alcohol use

6.1 Background

There have been small public health gains in reducing alcohol consumption in recent years. However, alcohol use is the second leading cause of drug-related death in Australia after tobacco (Australian Institute of Health and Welfare 1996). It is estimated that 44% of male drinkers and 30% of female drinkers drink regularly to excessive levels (Mattick & Jarvis 1993). Regular excessive drinking of alcohol can affect the heart, liver, brain, pancreas, muscles, lungs, skin, nervous system, intestines and the testes in males. Binge drinking of large amounts results in suppression of the central nervous system and in stomach inflammation and toxic damage to the bowel. Binge drinking is also associated with suicide and falls, motor vehicle and pedestrian accidents. Regular binge drinkers can experience the same sort of effects as regular heavy drinkers.

National Health Priority Areas also recognises alcohol as an important modifiable cause of premature death and disability in Australia (Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1999a). The national objective is to reduce the prevalence of high consumption among adults and secondary school students. Population indicators for excessive alcohol consumption have relied on self-reported alcohol use through:

- ABS National Health Surveys;
- ABS Population Survey Monitor;
- NHF Risk Factor Prevalence Surveys;
- National Campaign Against Drug Abuse; and
- National Household Survey.

Comparable data on alcohol use can be obtained through the SAND program, which also allows investigation of the relationship between each category of alcohol use and the morbidity managed at encounter. In assessing the effects of alcohol use on health, it is important to ascertain how frequently a person drinks alcohol and the quantity he or she drinks. BEACH uses three items from Section A of the World Health Organization's (WHO) Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al. 1993). Together, these three items can separate hazardous/harmful drinkers from others not at risk (non-drinkers and responsible drinkers). The nine additional items of AUDIT allow further discrimination of problem drinkers into hazardous or harmful drinking categories. AUDIT is a useful tool as it can easily be used in full, by GPs to screen patients before making a more thorough assessment of problem drinkers only.

6.2 Research questions

1. What is the prevalence of hazardous/harmful alcohol consumption in general practice patients?
2. Is hazardous/harmful drinking in general practice patients associated with particular patient profiles?

6.3 SAND questions

Box 6.1: Alcohol use

GPs asked the patient (18+ years):

<ul style="list-style-type: none"> ◆ <i>How often do you have a drink containing alcohol?</i> ◆ <i>How many standard drinks do you have on a typical day when you are drinking?</i> ◆ <i>How often do you have 6 or more standard drinks on one occasion?</i> 	<p><i>Never</i> <i>Monthly or less</i> <i>Once a week</i> <i>2–4 times a week</i> <i>5+ times a week</i></p> <hr style="width: 20%; margin: 10px auto;"/> <p><i>Never</i> <i>Monthly or less</i> <i>Once a week</i> <i>2–4 times a week</i> <i>5+ times a week</i></p>
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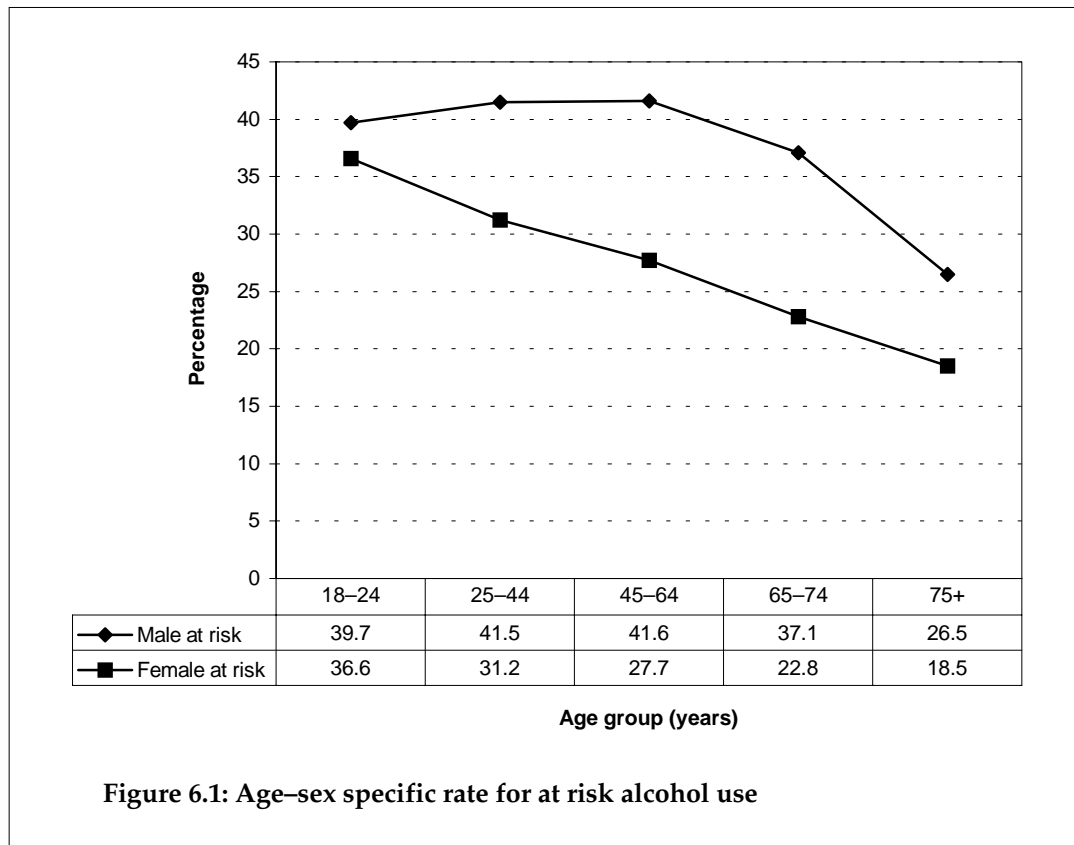
Notes:

1. A standard drinks chart was provided to each GP to assist the patient in identifying the number of standard drinks consumed.
2. Together these three questions assess 'at risk' alcohol use. The scores for each question range from 0–4. A score of 5+ for males or 4+ for females suggests that the person's drinking level is placing them at risk.

6.4 Results

Sample size (18+ years) was 29,230 patient encounters from 984 GPs.

Overall, 31.9% (95% CI: 31.0–32.8) of patient encounters were with adults who are considered to be drinking 'at-risk' levels of alcohol. Male patients had a higher rate of at risk drinkers (38.4%; 95% CI: 36.5–40.3) than female patients (27.7%; 95% CI: 26.4–28.9). In general, the proportion of female at risk drinkers decreased with age with less than 20% of female patients of 75 years and over considered at risk because of alcohol use (Figure 6.1). In contrast, the proportion of males considered at risk increased with age, with a decline occurring only for those aged 65 years or more. Investigations into the association of alcohol use and problem managed (ICPC-2 chapter level) revealed no apparent increase or decrease in rates of management of specific problems at encounters where the patient was an at risk drinker. The influence of age and gender was not controlled for in any of these comparisons, and will be the subject of further analysis in later reports.



6.5 Discussion

Early intervention is a proven and effective method of reducing alcohol consumption in hazardous and early stage problem drinkers before greater harm can be done (Mattick & Jarvis 1993; Bien et al. 1993; Richmond & Anderson 1994). In a population health framework there are benefits from early intervention aimed at promoting responsible drinking. General practice is ideally placed for screening and initiating early brief intervention techniques. At one in three encounters with adult patients, the GP will be dealing with a person drinking ‘at-risk’ levels of alcohol.

Patients feel that the GP should be asking them about drinking and GP advice is acceptable and appropriate (Richmond et al. 1997). Numerous studies in Australia and the United Kingdom have shown that GP provision of brief advice can result in a 25–30% reduction in alcohol consumption and a 45% reduction in the number of excessive drinkers (Richmond & Anderson 1994). Appropriate referral can also be made through adequate assessment of alcohol use, problems associated with use, readiness to change and self-efficacy.