REPORT FROM GENERAL PRACTICE 24

Alcohol - still a Balanced View?

Alcohol—
A Balanced View

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Peter Anderson

The Nick Heather Lecture

Santiago, Chile
INEBRIA 2018

REPORT FROM GENERAL PRACTICE **24**

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Where are we, 30 years on?

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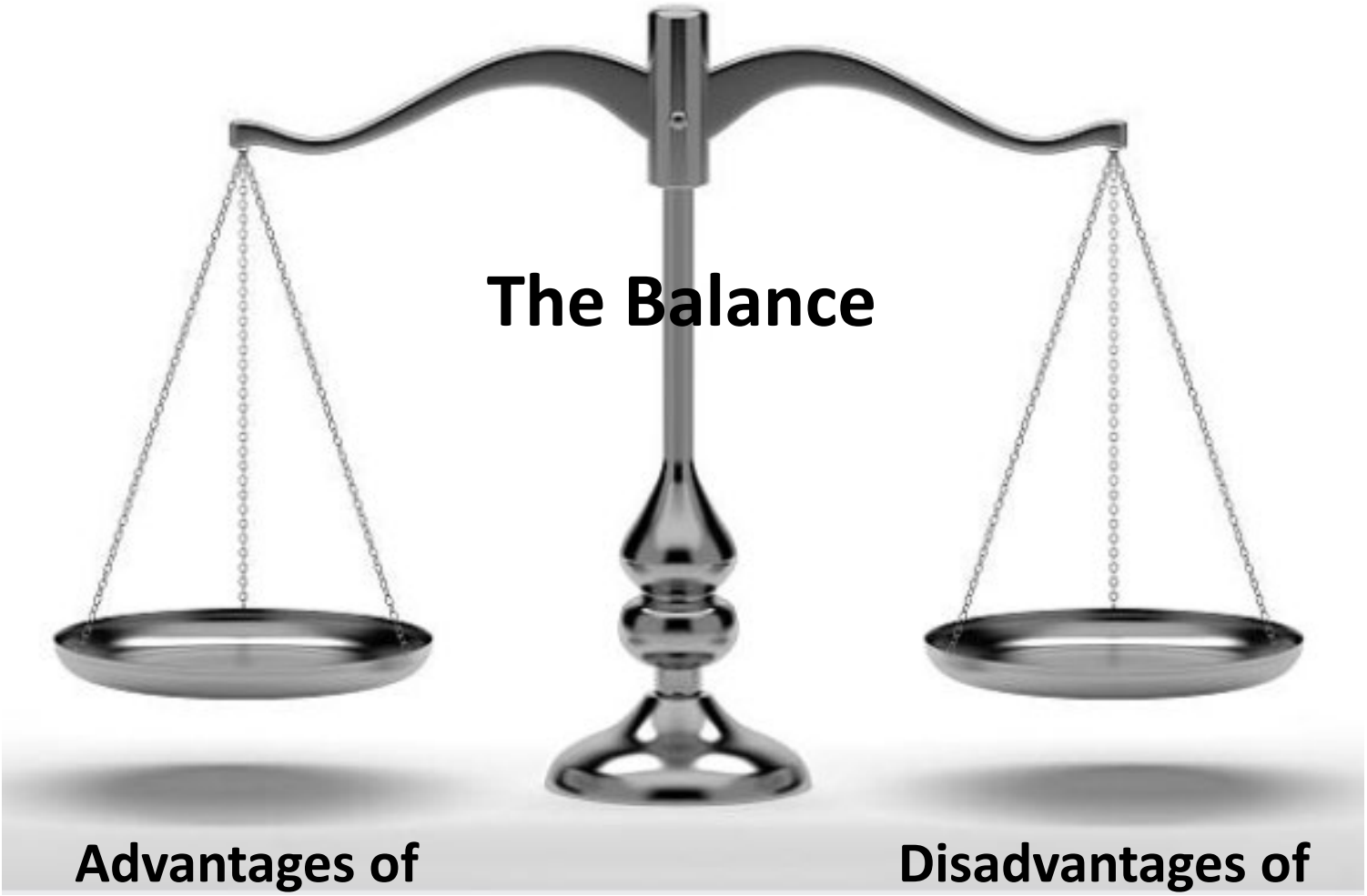
Not for alcohol

Not against alcohol

Goal to reduce the harm done by alcohol

The Balance

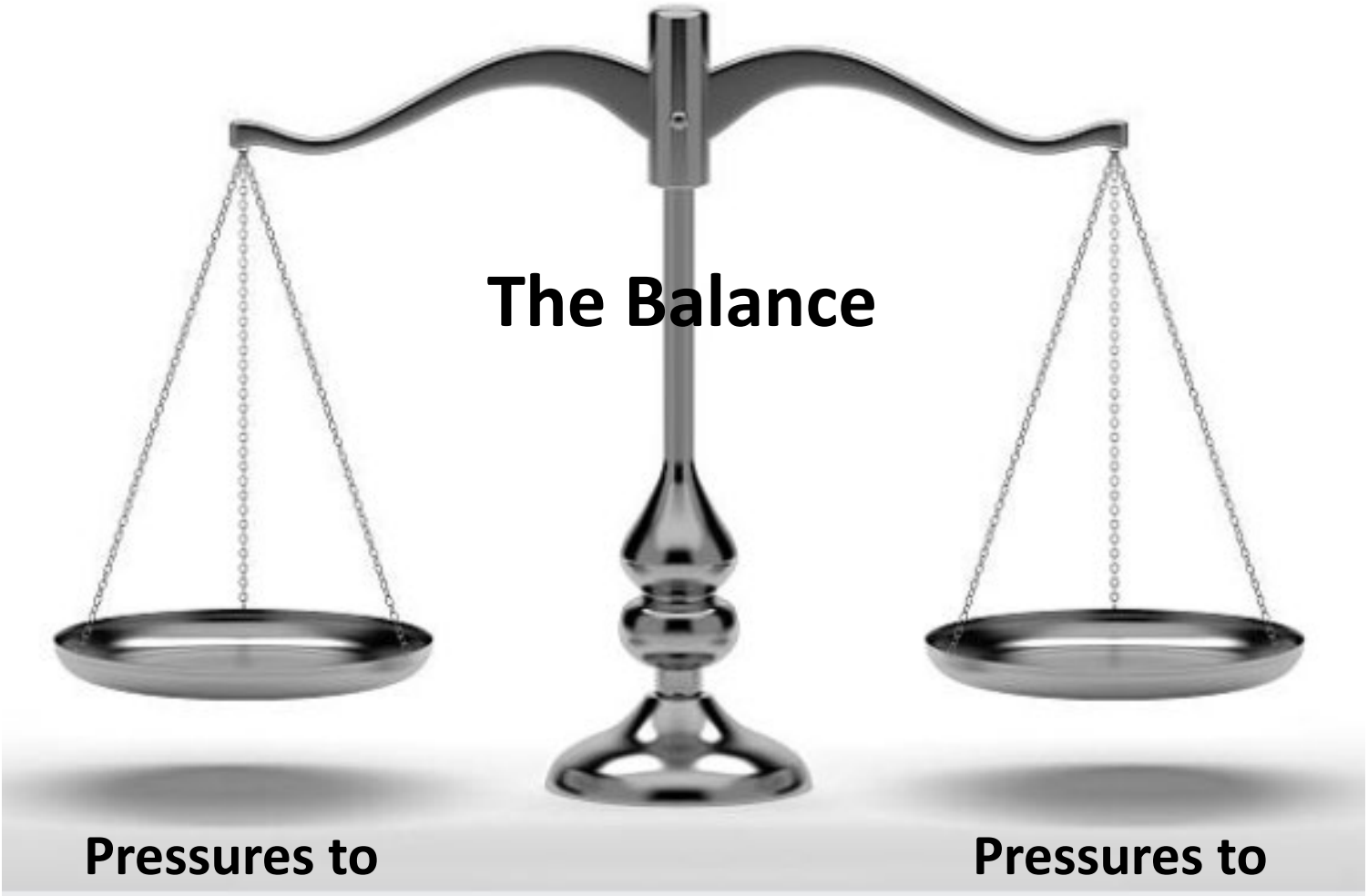


Advantages of drinking

Disadvantages of drinking

Determines where an individual lies on the continuum of consumption and harm

The Balance



Pressures to drink more

Pressures to drink less

Determines where an individual lies on the continuum of consumption and harm

Lighter drinking **Heavier drinking**

Role of GP to shift balance from heavier drinking …

Lighter drinking **Heavier drinking**

to lighter drinking…

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Examine report:

What does it say for us today?

Simplicity **Complexity**

We will look at the balance

Simplicity **Complexity**

We have gone too far in the direction of complexity

Simplicity **Complexity**

We need to shift balance back towards simplicity

Rebalancing to simplicity allows balance to be maintained, with one area of increased complexity

In other words, we are going to do away with four things, and add one thing

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Look at five things covered by the report:

1. **There are no dichotomies, no diseases – only continua**
2. **Alcohol is the risk factor**
3. **We measure consumption**
4. **Simple advice to cut down drinking**
5. **Community support to community agents**

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1. **There are no dichotomies, no diseases – only continua**

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"We do not subscribe to the view that alcoholism is in itself a disease"

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REPORT FROM GENERAL PRACTICE 24

"We do not subscribe to the view that alcoholism [alcohol abuse; alcohol use disorder; alcohol dependence] **is in itself a disease"**

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‘Instead, everyone’s drinking is spread along a continuum from one end with no harm to another end with great harm’

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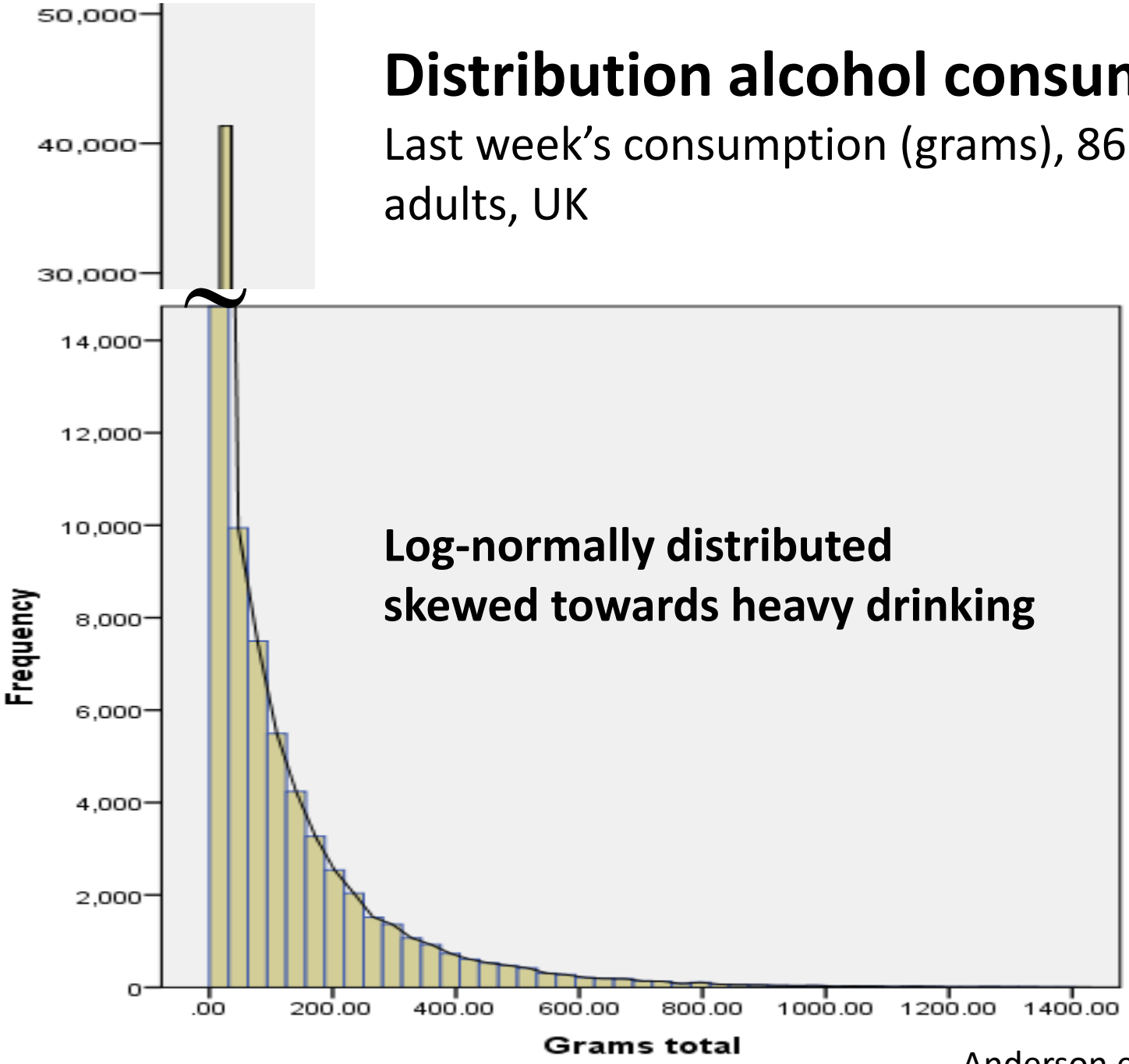
- In medical settings, and, indeed often in academic and lay settings, heavy users of alcohol are commonly dichotomized into those with an ‘alcohol use disorder’ or those with not.

- However, ‘alcohol use disorder’ is a clinical construct that is often used as a shorthand to identify individuals who might benefit from advice or treatment.

- But as a condition in itself, it is a medical artefact which occurs in all grades of severity, with no natural distinction between ‘health’ and ‘disease’, and no grounding in biology or nature.

Distribution alcohol consumption:

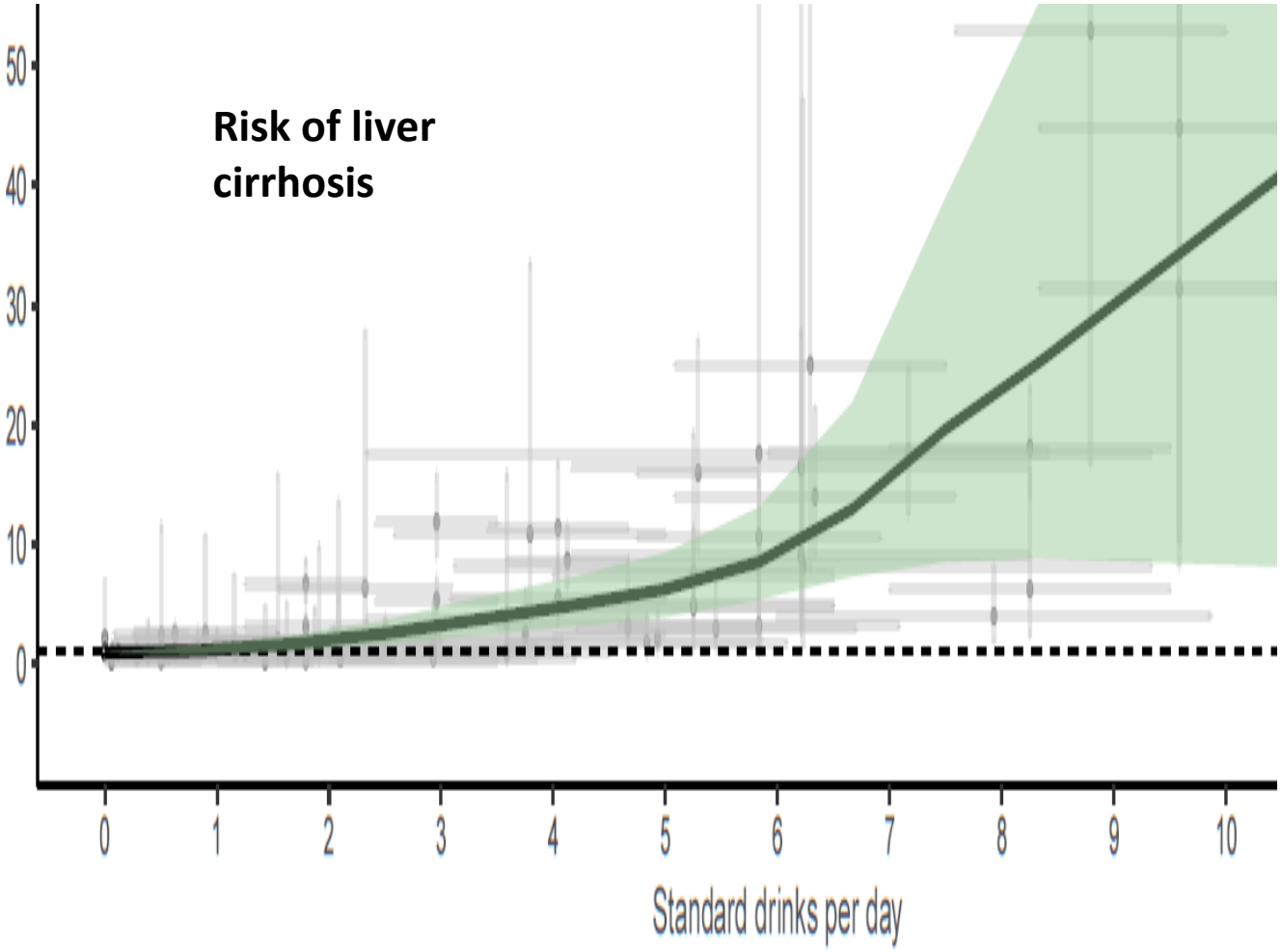
Last week's consumption (grams), 86170 adults, UK



Log-normally distributed
skewed towards heavy drinking

Anderson et al. 2018

Disease risk from alcohol is a continuous (often exponential) relationship

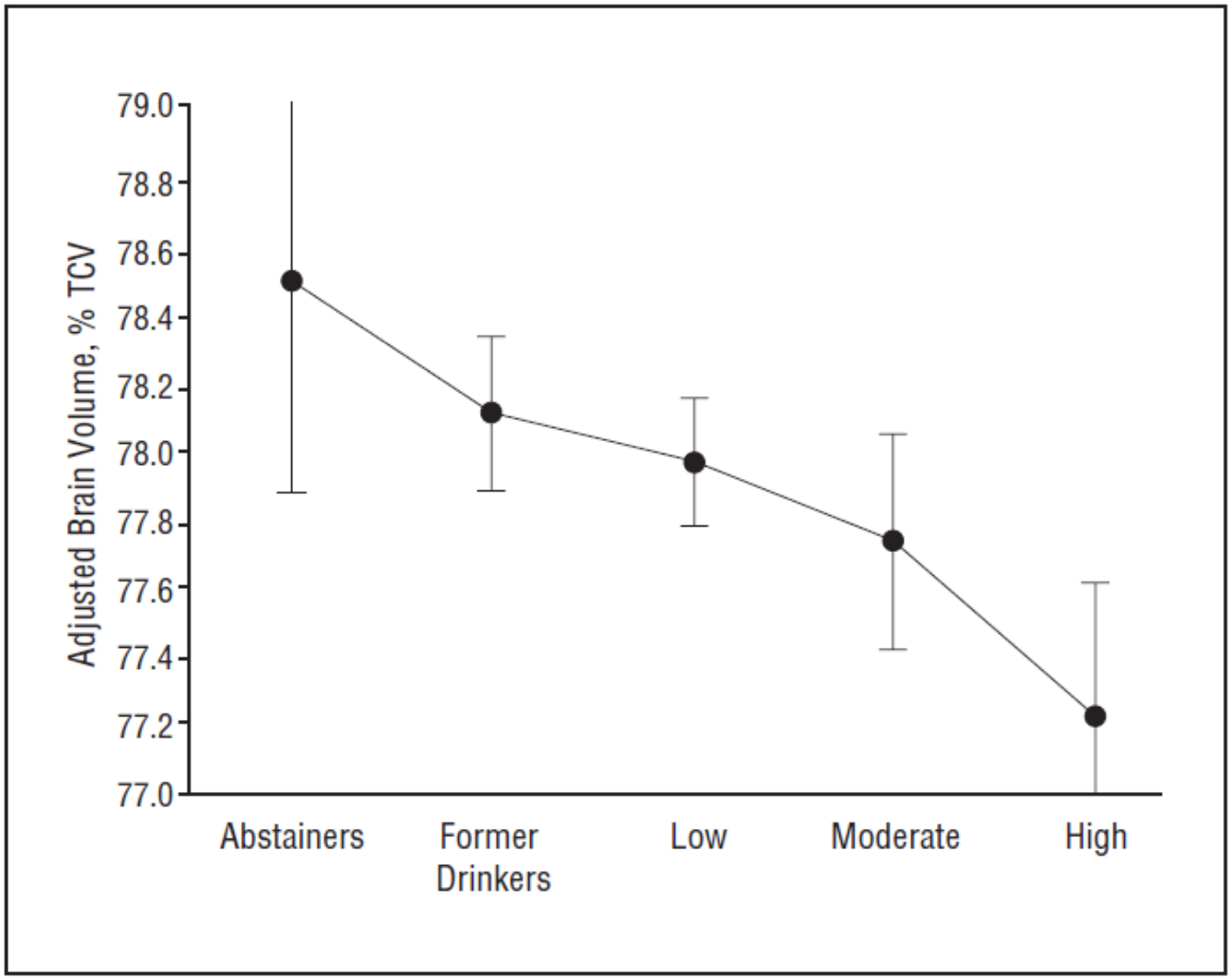


GBD 2016 Alcohol Collaborators, 2018

- Unmanaged heavy drinking can be associated with even further heavy drinking, often culminating in a more difficult to manage state due to associated brain atrophy.

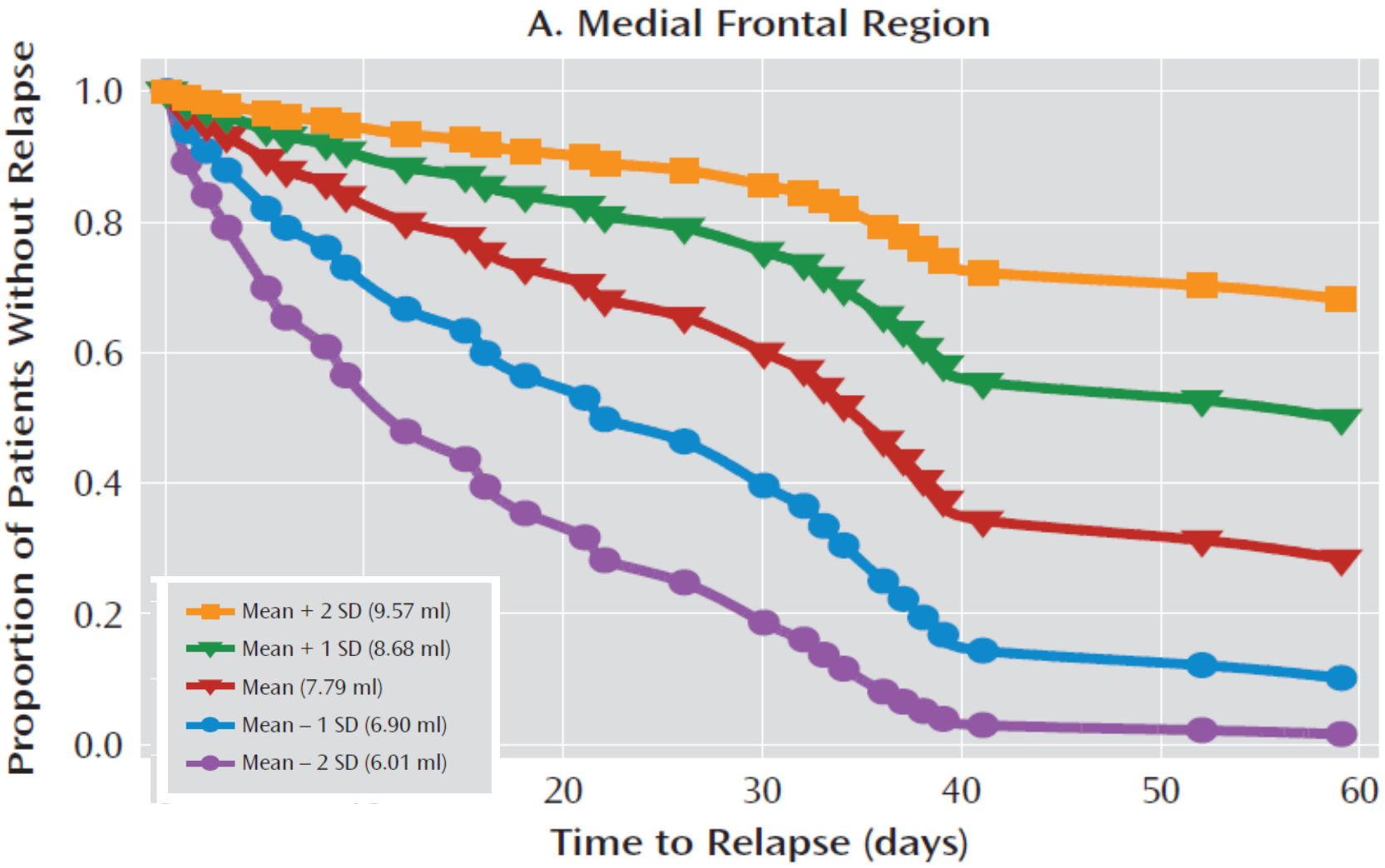
- The brain atrophy, though, is a consequence of the heavy drinking.

Relationship between drinking levels and brain volume from Framingham study



Paul et al. 2008

Gray matter volume deficits predict time to relapse in 'alcohol-dependent' patients

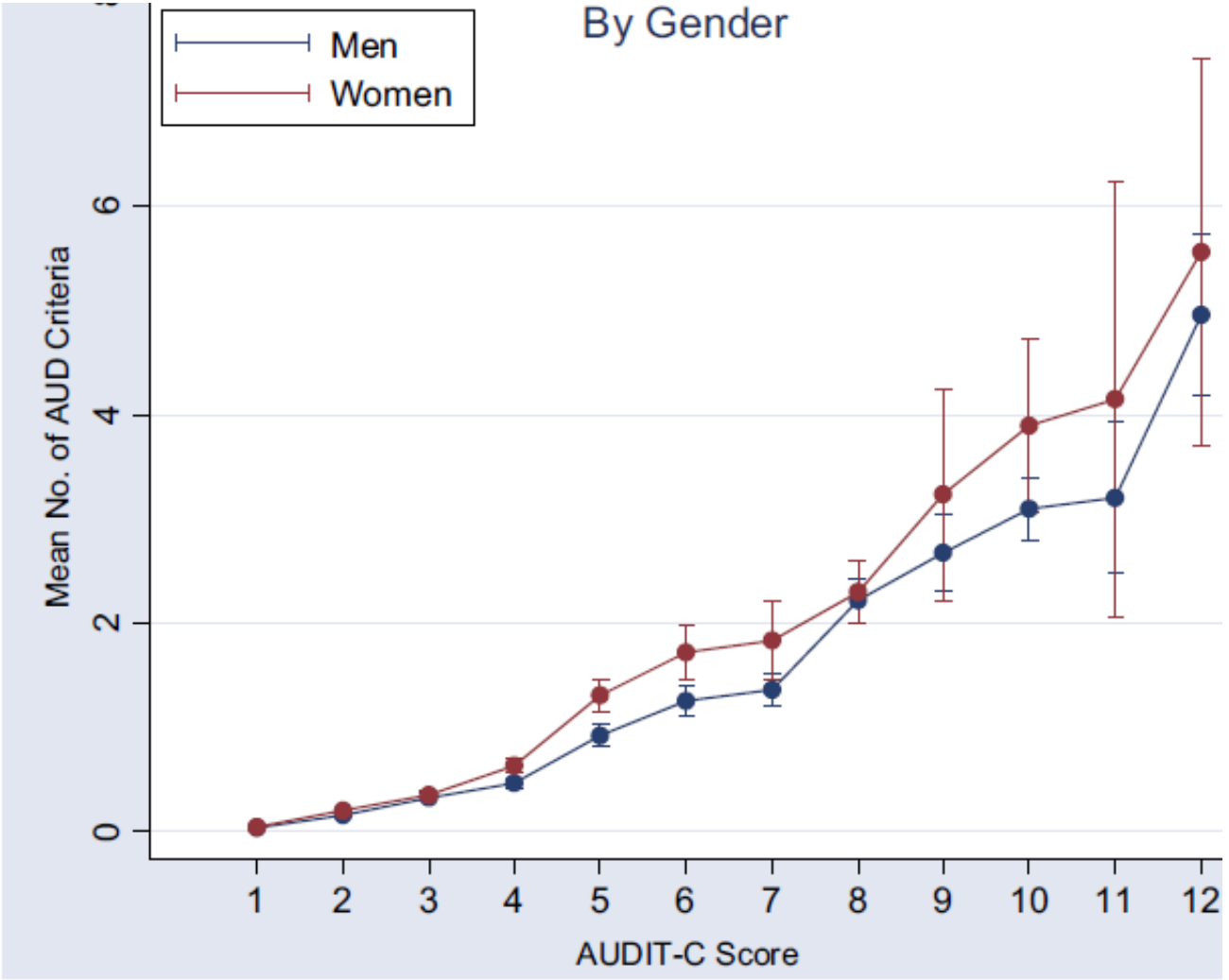


Rando et al. 2011

Alcohol dependence/alcohol use disorder: simply defined as a score on a checklist of symptoms

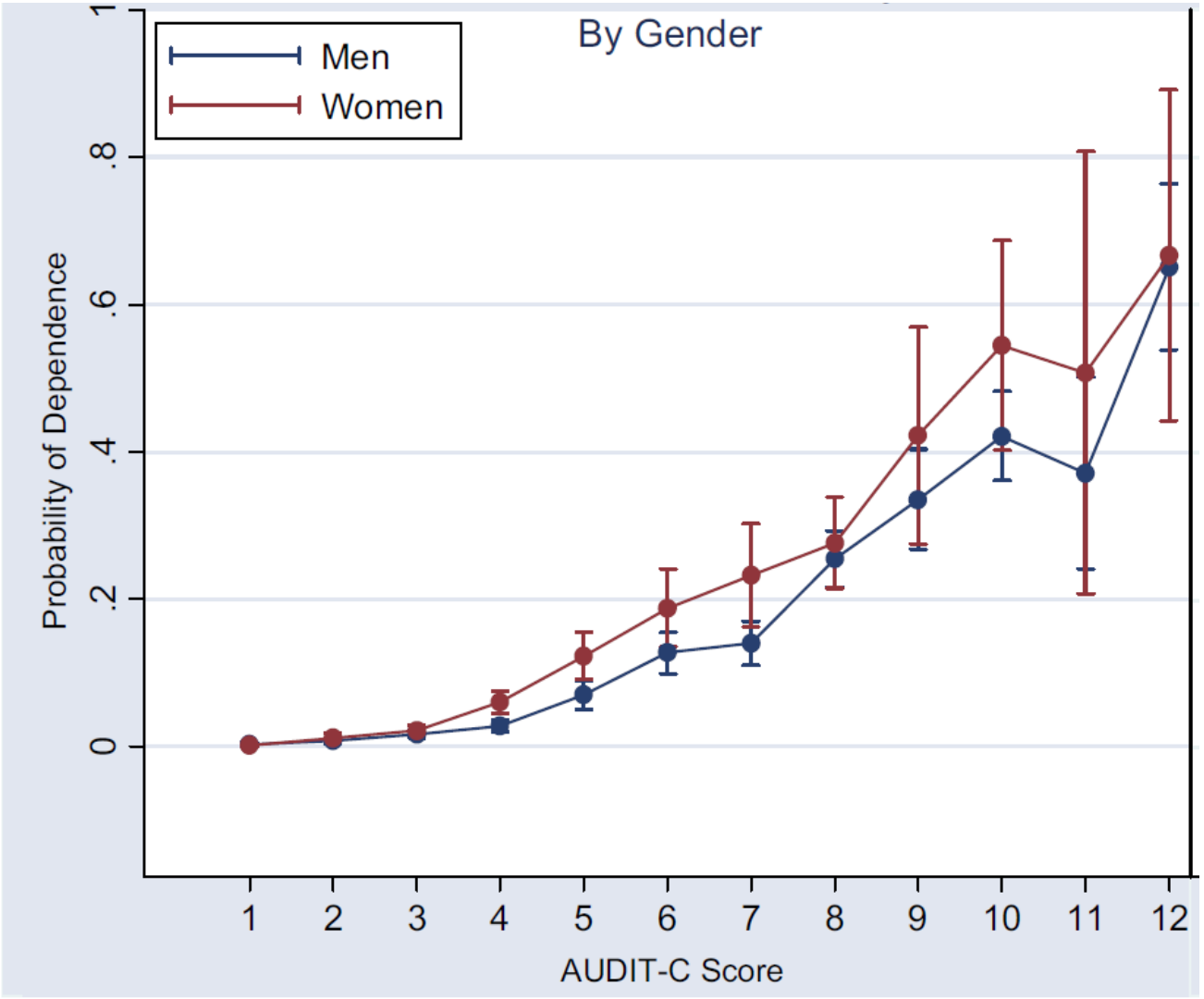
DSM–IV			DSM–5	
In the past year, have you:			In the past year, have you:	
Any 1 = ALCOHOL ABUSE	Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?	1	Had times when you ended up drinking more, or longer, than you intended?	The presence of at least 2 of these symptoms indicates an **Alcohol Use Disorder (AUD).** The severity of the AUD is defined as: **Mild:** The presence of 2 to 3 symptoms **Moderate:** The presence of 4 to 5 symptoms **Severe:** The presence of 6 or more symptoms
	More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?	2	More than once wanted to cut down or stop drinking, or tried to, but couldn't?	
	More than once gotten arrested, been held at a police station, or had other legal problems because of your drinking? ****This is not included in DSM–5****	3	Spent a lot of time drinking? Or being sick or getting over other aftereffects?	
	Continued to drink even though it was causing trouble with your family or friends?	4	Wanted a drink so badly you couldn't think of anything else? ****This is new to DSM–5****	
Any 3 = ALCOHOL DEPENDENCE	Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?	5	Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?	
	Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?	6	Continued to drink even though it was causing trouble with your family or friends?	
	Had times when you ended up drinking more, or longer, than you intended?	7	Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?	
	More than once wanted to cut down or stop drinking, or tried to, but couldn't?	8	More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?	
	Spent a lot of time drinking? Or being sick or getting over other aftereffects?	9	Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?	
	Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?	10	Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?	
	Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?	11	Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?	

There is a smooth line relationship between levels of alcohol consumption and the score on the checklist



Rubinsky et al 2013

There is a smooth line relationship between levels of alcohol consumption and the score on the checklist



Rubinsky et al 2013

Thus, “alcohol use disorder” is a diagnostic artefact.

No more is needed to consider what is called “alcohol use disorder” other than the amount of alcohol consumed.

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Simplifying (1):

Terms like 'alcohol dependence', 'alcohol use disorder' 'alcohol abuse' are not useful;

So, let's simplify and do away with them;

We only need the term 'alcohol use'

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2. Alcohol is a risk factor, that exists on a continuum; causes harm on a continuum; and has no risk-free level

Risk thresholds for alcohol consumption: combined analysis of individual-participant data for 599 912 current drinkers in 83 prospective studies

Angela M Wood, Stephen Kaptoge, Adam S Butterworth, Peter Willeit, Samantha Warnakula, Thomas Bolton, Ellie Paige, Dirk S Paul, Michael Sweeting, Stephen Burgess, Steven Bell, William Astle, David Stevens, Albert Koulman, Randi M Selmer, W M Monique Verschuren, Shinichi Sato, Inger Njølstad, Mark Woodward, Veikko Salomaa, Børge G Nordestgaard, Bu B Yeap, Astrid Fletcher, Olle Melander, Lewis H Kuller, Beverley Balkau, Michael Marmot, Wolfgang Koenig, Edoardo Casiglia, Cyrus Cooper, Volker Arndt, Oscar H Franco, Patrik Wennberg, John Gallacher, Agustín Gómez de la Cámara, Henry Völzke, Christina C Dahm, Caroline E Dale, Manuela M Bergmann, Carlos J Crespo, Yvonne T van der Schouw, Rudolf Kaaks, Leon A Simons, Pagona Lagiou, Josje D Schoufour, Jolanda M A Boer, Timothy J Key, Beatriz Rodriguez, Conchi Moreno-Iribas, Karina W Davidson, James O Taylor, Carlotta Sacerdote, Robert B Wallace, J Ramon Quiros, Rosario Tumino, Dan G Blazer II, Allan Linneberg, Makoto Daimon, Salvatore Panico, Barbara Howard, Guri Skeie, Timo Strandberg, Elisabete Weiderpass, Paul J Nietert, Bruce M Psaty, Daan Kromhout, Elena Salamanca-Fernandez, Stefan Kiechl, Harlan M Krumholz, Sara Grioni, Domenico Palli, José M Huerta, Jackie Price, Johan Sundström, Larraitz Arriola, Hisatomi Arima, Ruth C Travis, Demosthenes B Panagiotakos, Anna Karakatsani, Antonia Trichopoulou, Tilman Kühn, Diederick E Grobbee, Elizabeth Barrett-Connor, Natasja van Schoor, Heiner Boeing, Kim Overvad, Jussi Kauhanen, Nick Wareham, Claudia Langenberg, Nita Forouhi, Maria Wennberg, Jean-Pierre Després, Mary Cushman, Jackie A Cooper, Carlos J Rodriguez, Masaru Sakurai, Jonathan E Shaw, Matthew Knuiman, Trudy Voortman, Christa Meisinger, Anne Tjønneland, Hermann Brenner, Luigi Palmieri, Jean Dallongeville, Eric J Brunner, Gerd Assmann, Maurizio Trevisan, Richard F Gillum, Ian Ford, Naveed Sattar, Mariana Lazo, Simon G Thompson, Pietro Ferrari, David A Leon, George Davey Smith, Richard Peto, Rod Jackson, Emily Banks, Emanuele Di Angelantonio, John Danesh, for the Emerging Risk Factors Collaboration/EPIC-CVD/UK Biobank Alcohol Study Group*

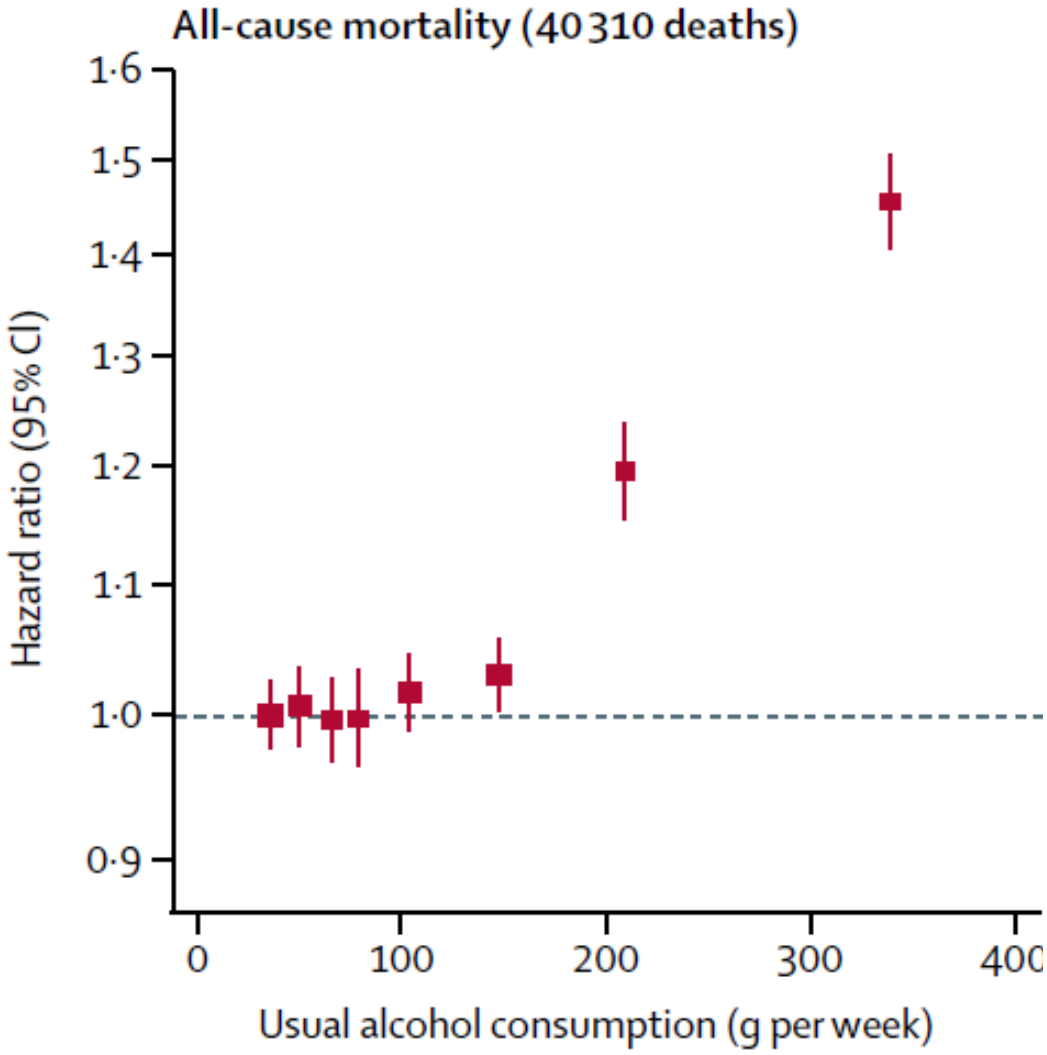
Summary

Background Low-risk limits recommended for alcohol consumption vary substantially across different national guidelines. To define thresholds associated with lowest risk for all-cause mortality and cardiovascular disease, we studied individual-participant data from 599 912 current drinkers without previous cardiovascular disease.

Lancet 2018; 391: 1513–23

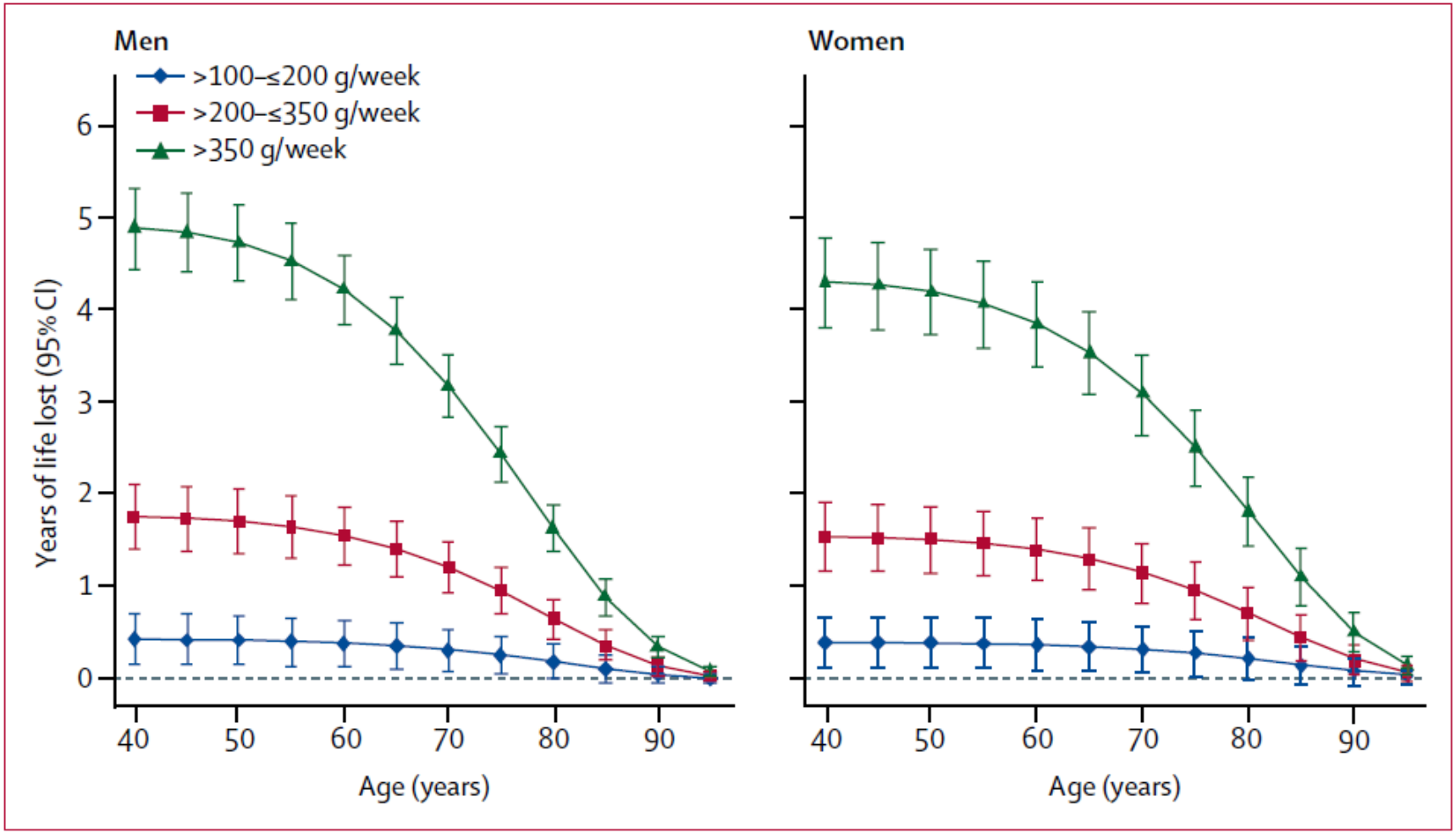
See Comment page 1460

*Other investigators of the Emerging Risk Factors

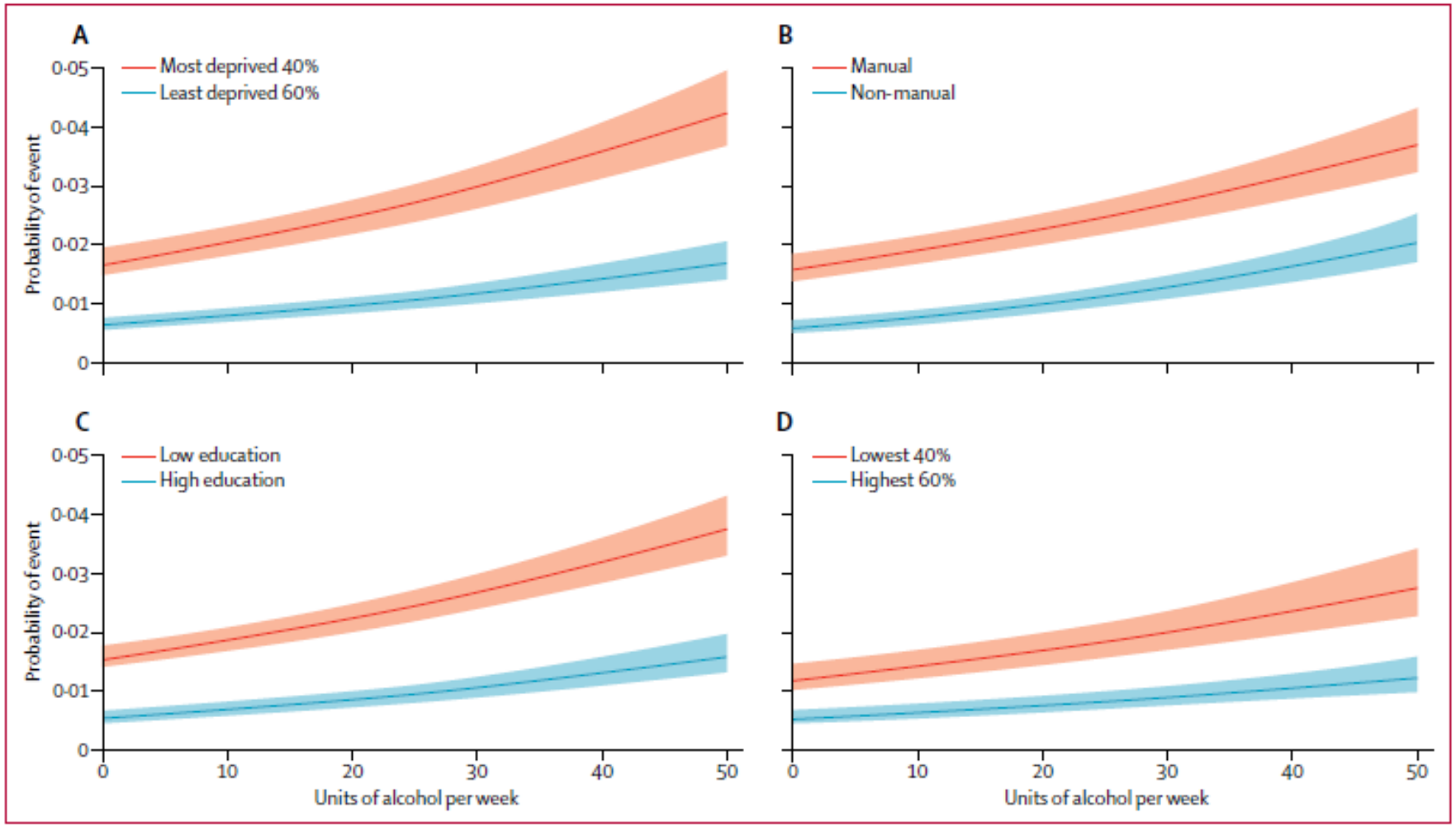


HR all-cause mortality

Reference category: 0-25 g alcohol/week

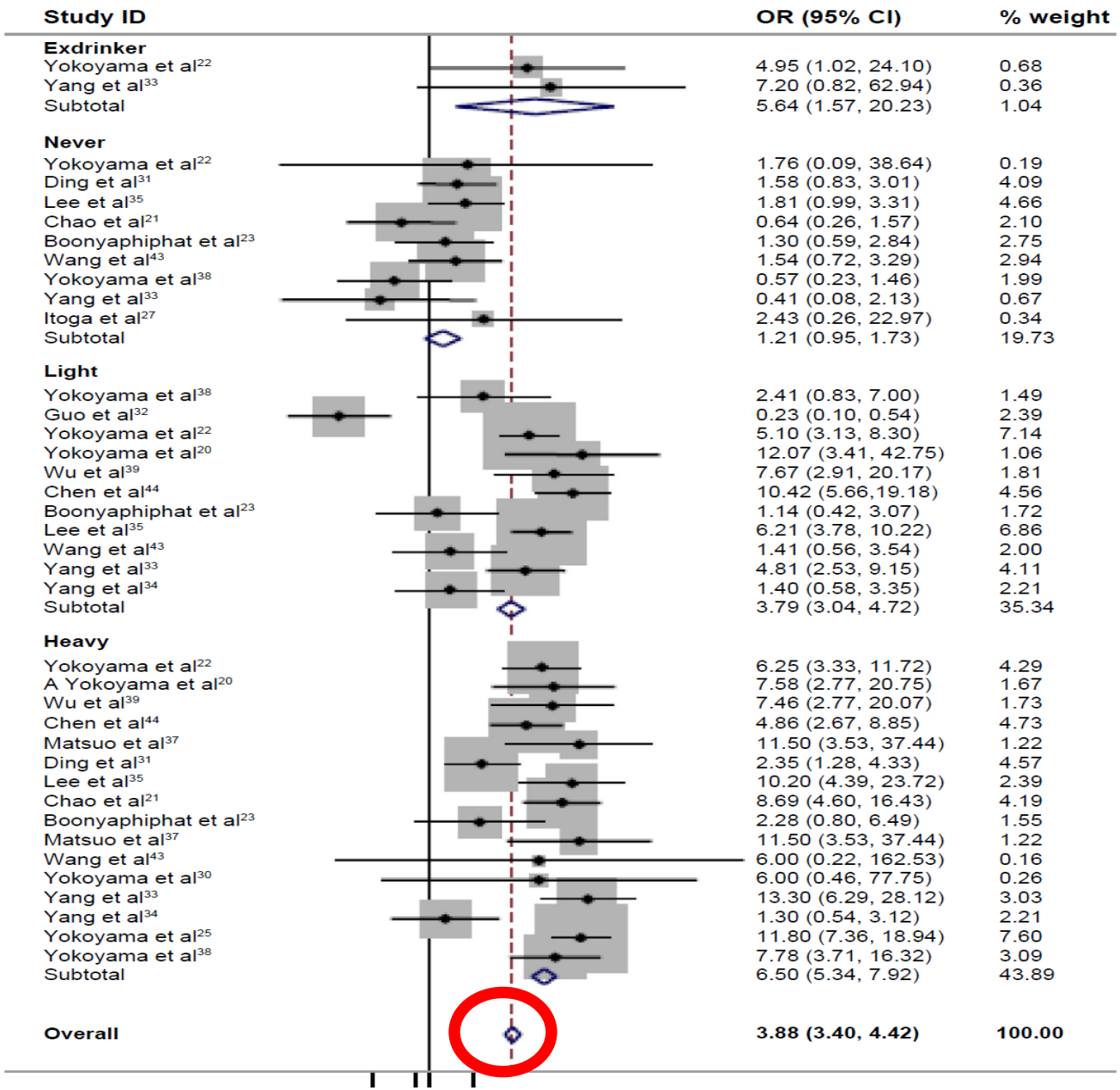


Loss of years due to alcohol by age
Reference category: 0-100 g alcohol/week



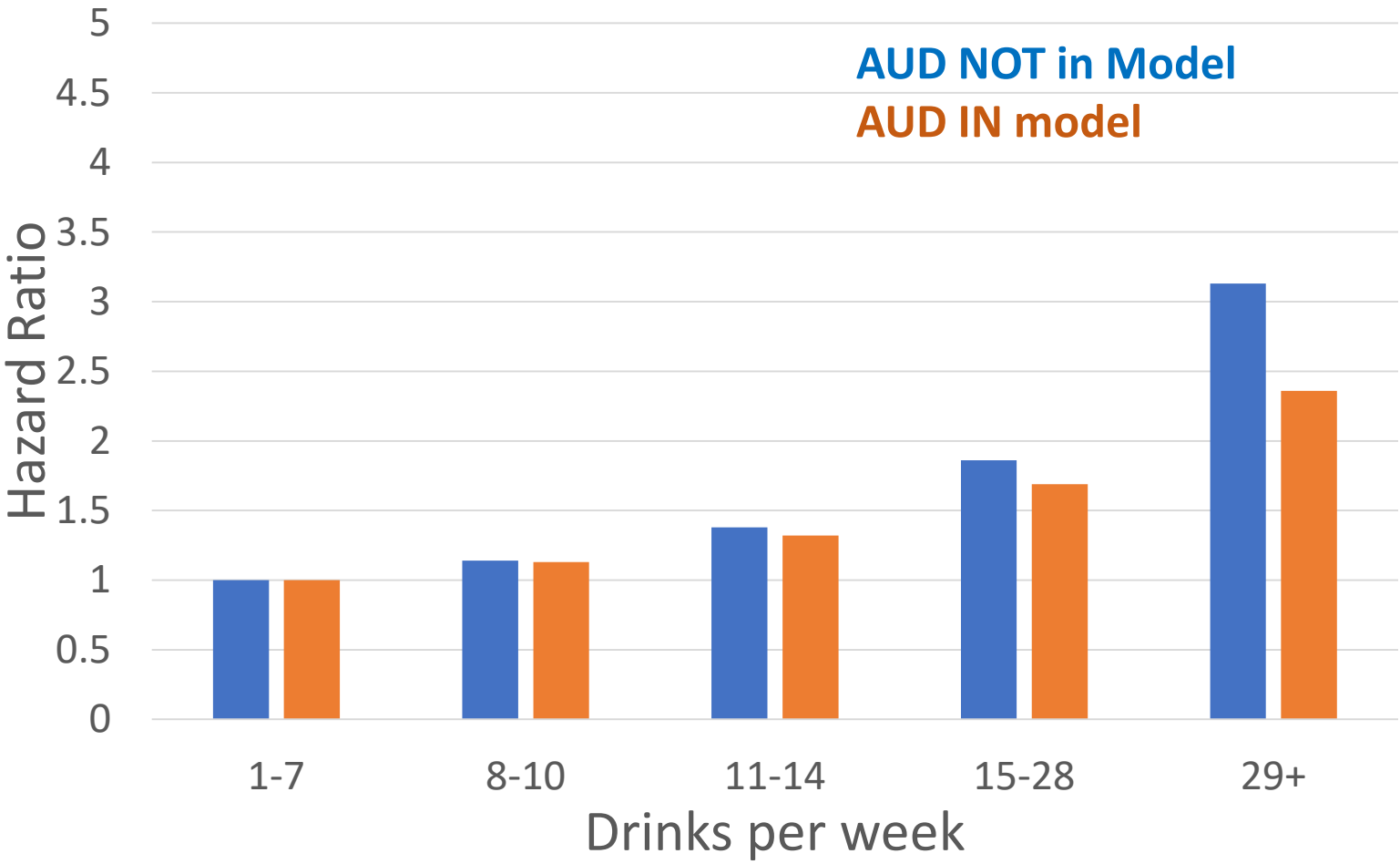
Linked cohort data from Scotland
Events are death and hospitalizations

Katikireddi et al. 2017



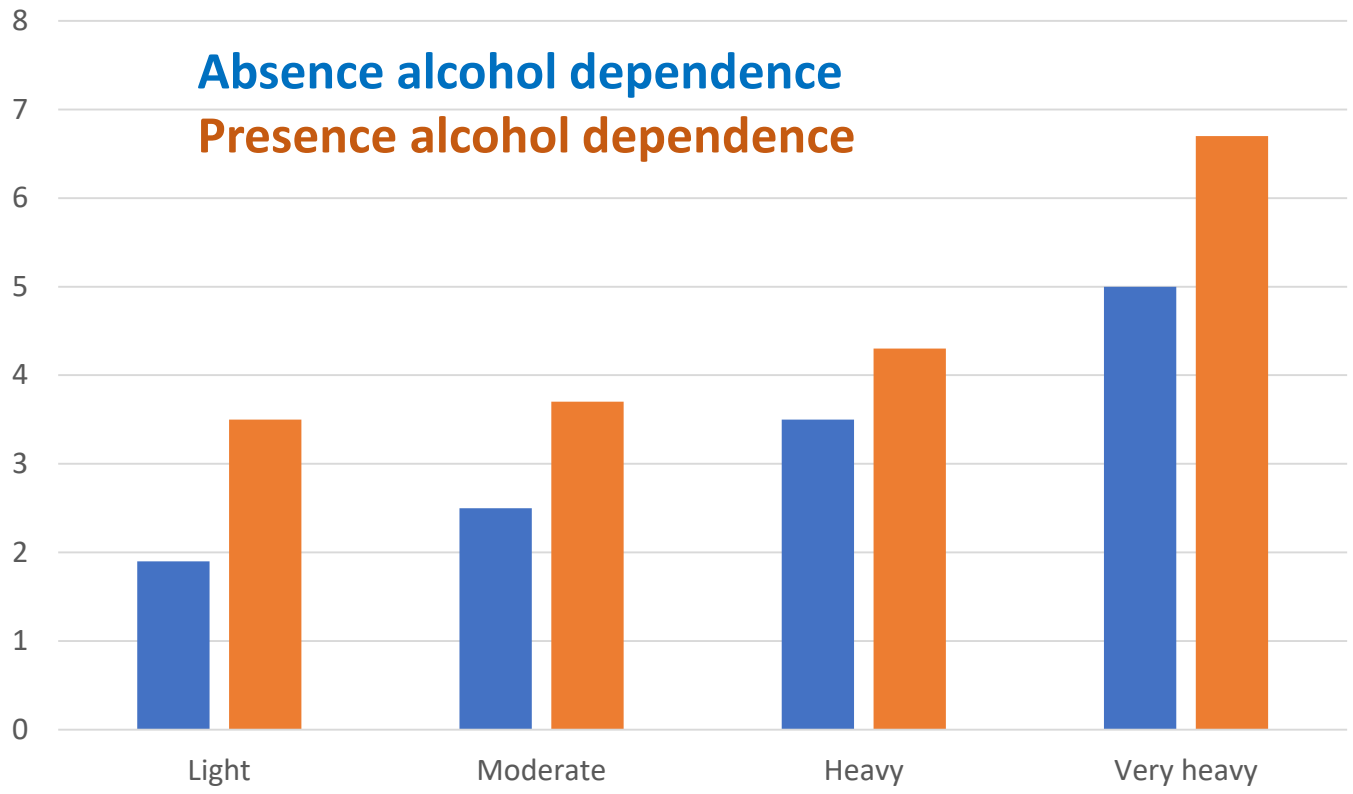
Risk of oesophageal cancer by ALDH2 AG genotype presence

Zhao et al. 2015



Risk of death by drinks per week with presence (yes/no) of AUD NOT in model and presence (yes/no) of AUD IN model; follow-up study of US army personnel

Lundin & Mortensen 2015



Number of drinks per week by drinking category by absence or presence of dependence; US adults, National Health Interview Survey

Dawson 2000

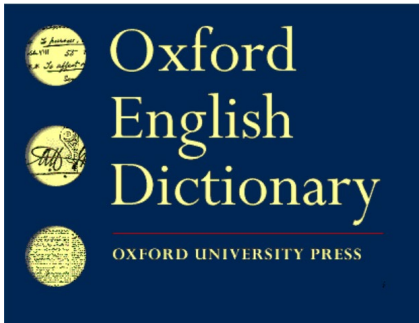
There has been a fashion to use phrases such as:

- **Harmful use of alcohol**
- **Unhealthy alcohol use**

Harmful: “Fraught with (carrying as an attribute) harm or injury; injurious, hurtful (having the quality of causing hurt or injury)”

Unhealthy: “Prejudicial or hurtful to health”

- ✓ As any alcohol has the attribute of causing harm, the terms harmful and unhealthy are redundant
- ✓ **We just need “use of alcohol”**



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Simplifying (2):

We do not need terms like 'harmful alcohol use' 'unhealthy alcohol use';

So, let's simplify and do away with them;

We only need the term 'use of alcohol', which exists on a continuum, increases harm with increasing consumption, and can be easily measured

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3. All we need to do is to measure consumption

We are <u>MEASURING</u>, we are <u>NOT SCREENING</u>

AUDIT-C Questions:	Scoring system					Your score:
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 – 9	10+	
How often do you have 6 or more units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Screening is:
"the presumptive identification of unrecognized disease or defect by the application of tests, examinations, or other procedures which can be applied rapidly. Screening tests sort out apparently well persons who probably have a disease from those who probably do not" (1951 US Commission on Chronic Illness)

As we have done away with terms, conditions and diseases, **there can be no screening**.

We are measuring alcohol consumption, as one measures blood pressure and blood glucose levels.

Thus, SBI or SBIRT, is no longer the correct term:

It should be MBI or MBIRT

The I in MBI or MBIRT is also wrong

As **M is also an I**

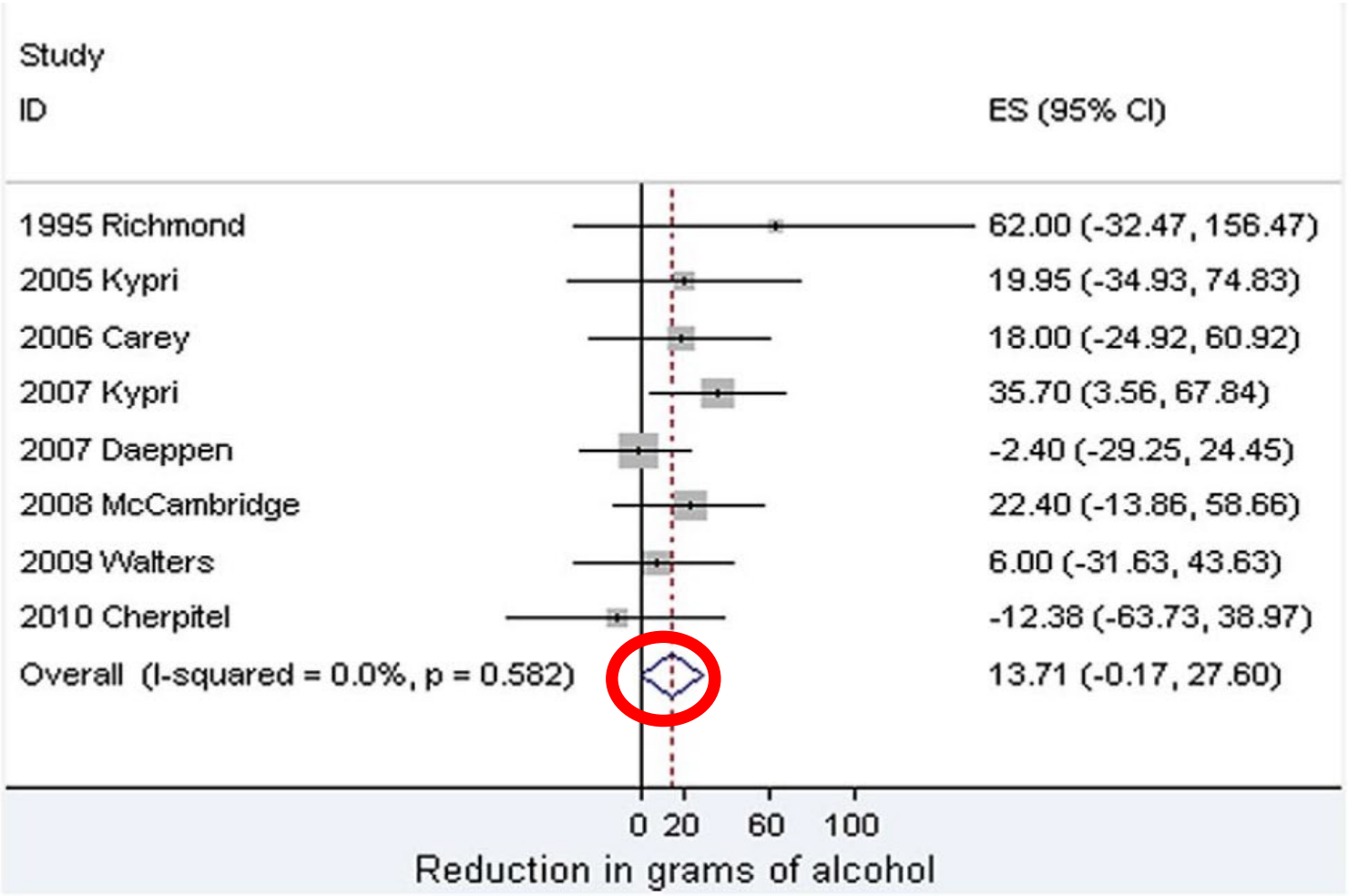


Figure 2. Meta-analysis of the effects of answering questions on total weekly drinking.
doi:10.1371/journal.pone.0023748.g002

McCambridge 2011

Thus, we need to:

Replace I for A (Advice)

It should be MBA or MBART

(We will get rid of RT later on)

Lighter drinking **Heavier drinking**

Role of GP to shift balance in favour of lighter drinking

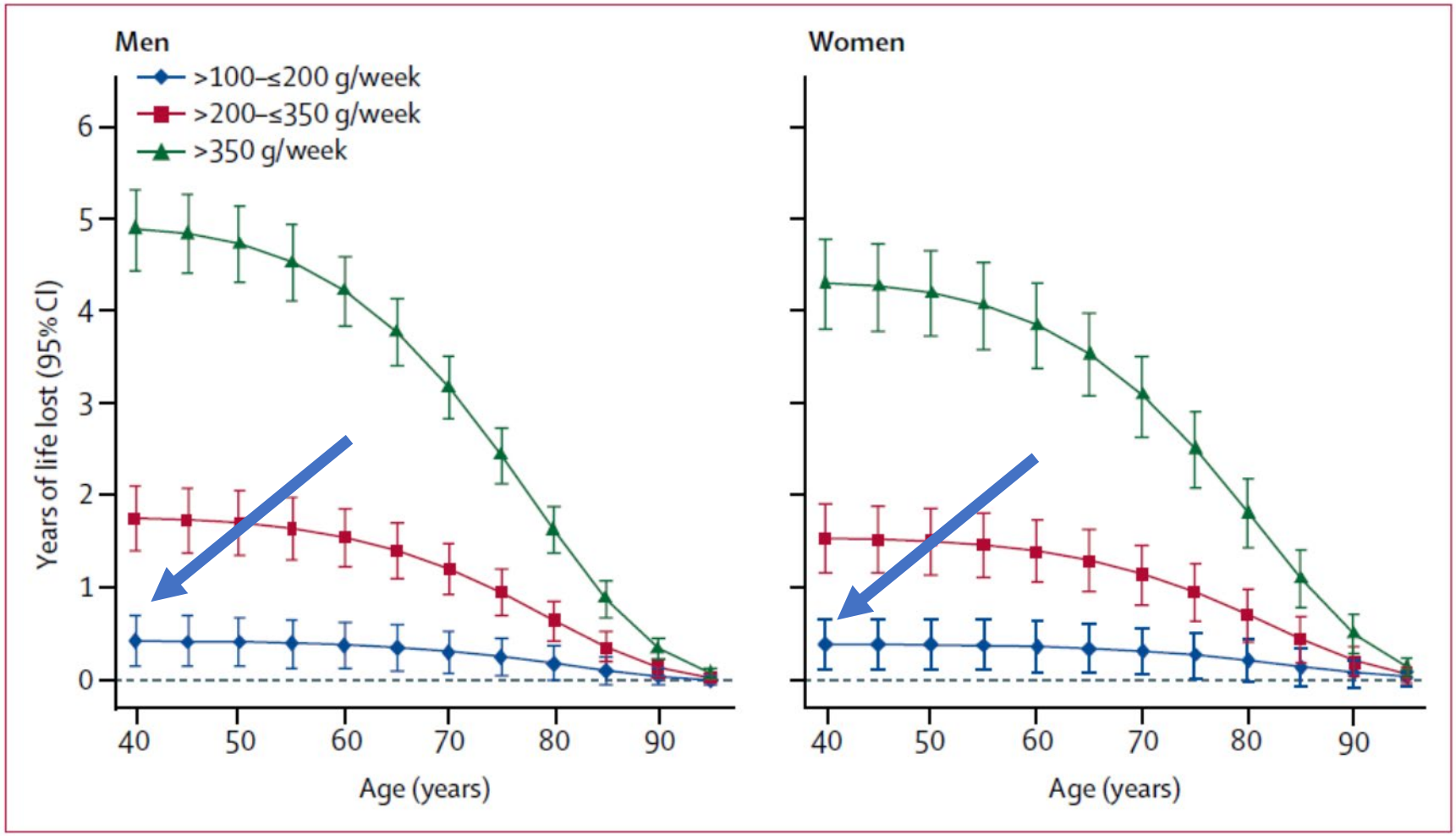
Lighter drinking **Heavier drinking**

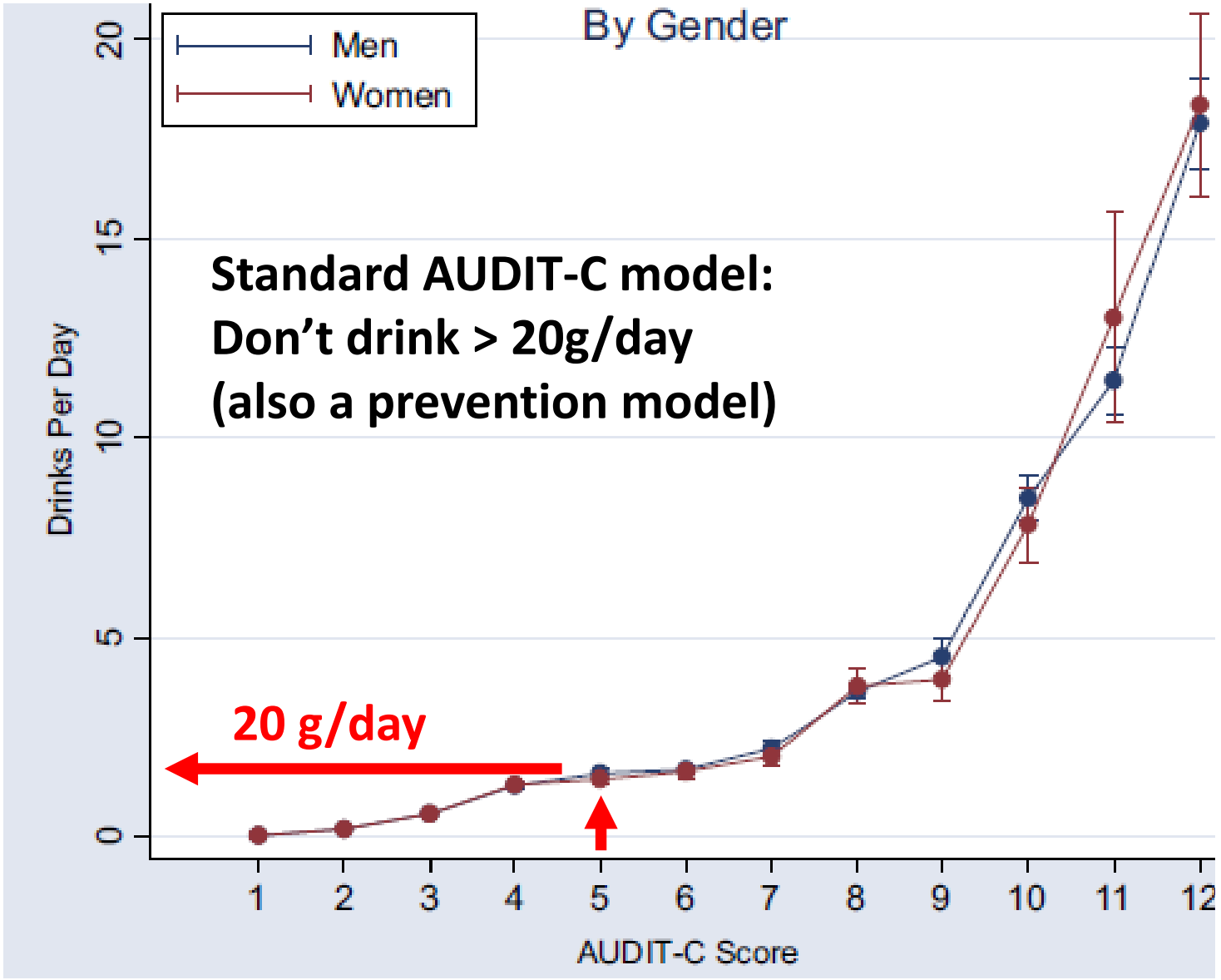
So, what are the thresholds of drinking for a response?

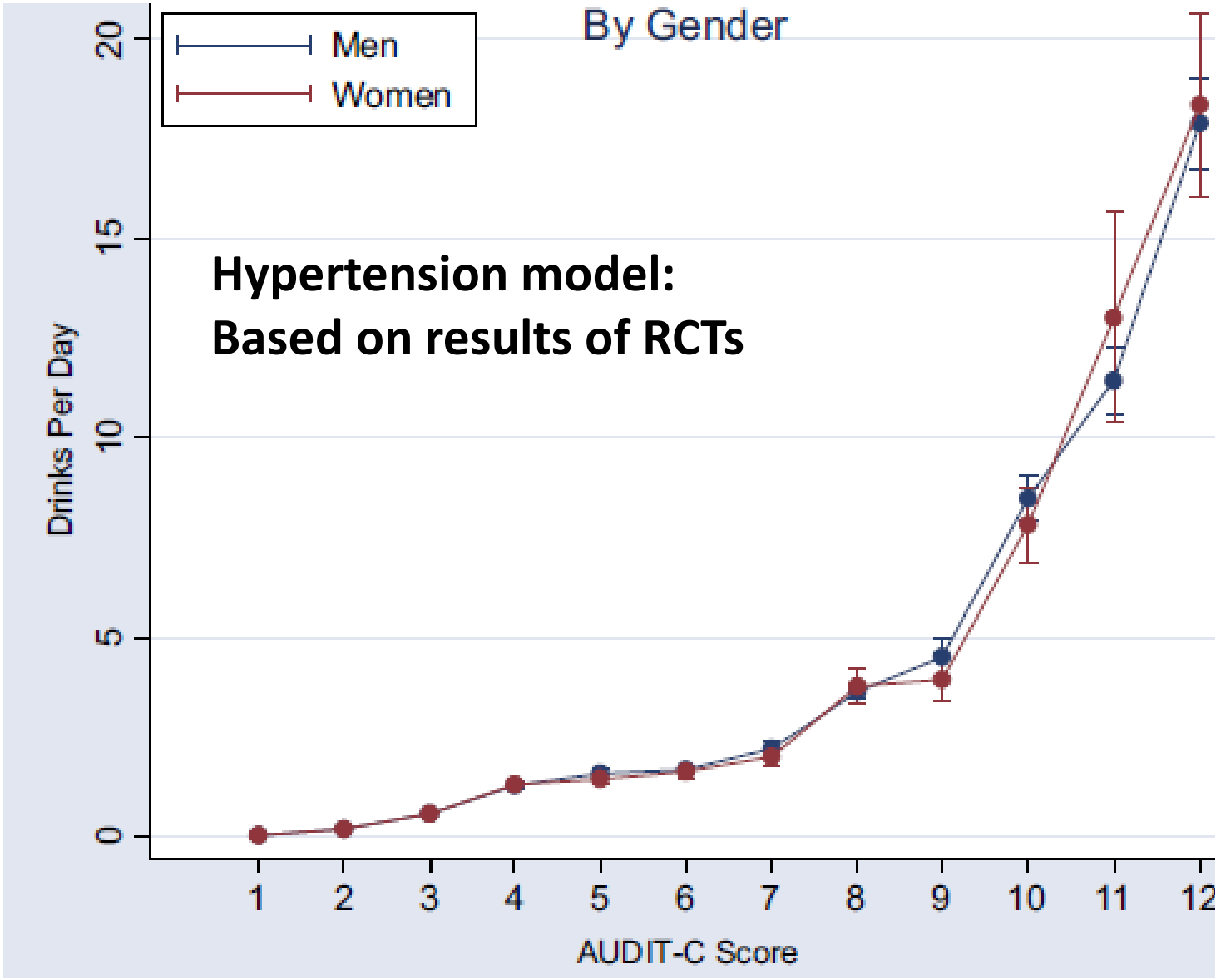
A continuum of thresholds:

i. The prevention model
ii. The standard AUDIT-C model
iii. The AUDIT-C model, based on the blood pressure model

Prevention model:
Don’t drink > 100g/week (14g/day)




By Gender
Men
Women
Drinks Per Day
0
5
10
15
20
Standard AUDIT-C model:
Don't drink > 20g/day
(also a prevention model)
20 g/day
1
2
3
4
5
6
7
8
9
10
11
12
AUDIT-C Score


By Gender
Men
Women
Hypertension model:
Based on results of RCTs
Drinks Per Day
0
5
10
15
20
1
2
3
4
5
6
7
8
9
10
11
12
AUDIT-C Score

In Hypertension, **levels of blood pressure that are chosen as thresholds** for advice and pharmacological treatment are determined by randomized controlled trials:

At what threshold level, does advice lead to a meaningful reduction in blood pressure?

So, for alcohol, we ask, at what threshold level, does advice lead to a meaningful reduction in alcohol consumption?

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Cochrane Database of Systematic Reviews

2007

Effectiveness of brief alcohol interventions in primary care populations (Review)

Kaner EF, Dickinson HO, Beyer FR, Campbell F, Schlesinger C, Heather N, Saunders JB, Burnand B, Pienaar ED

29 trials

Baseline consumption: 313g/week, 45g/day

Reduction: 38 grams/week

Kaner EF, Dickinson HO, Beyer FR, Campbell F, Schlesinger C, Heather N, Saunders JB, Burnand B, Pienaar ED.
Effectiveness of brief alcohol interventions in primary care populations.
Cochrane Database of Systematic Reviews 2007, Issue 2. Art. No.: CD004148.
DOI: 10.1002/14651858.CD004148.pub3.

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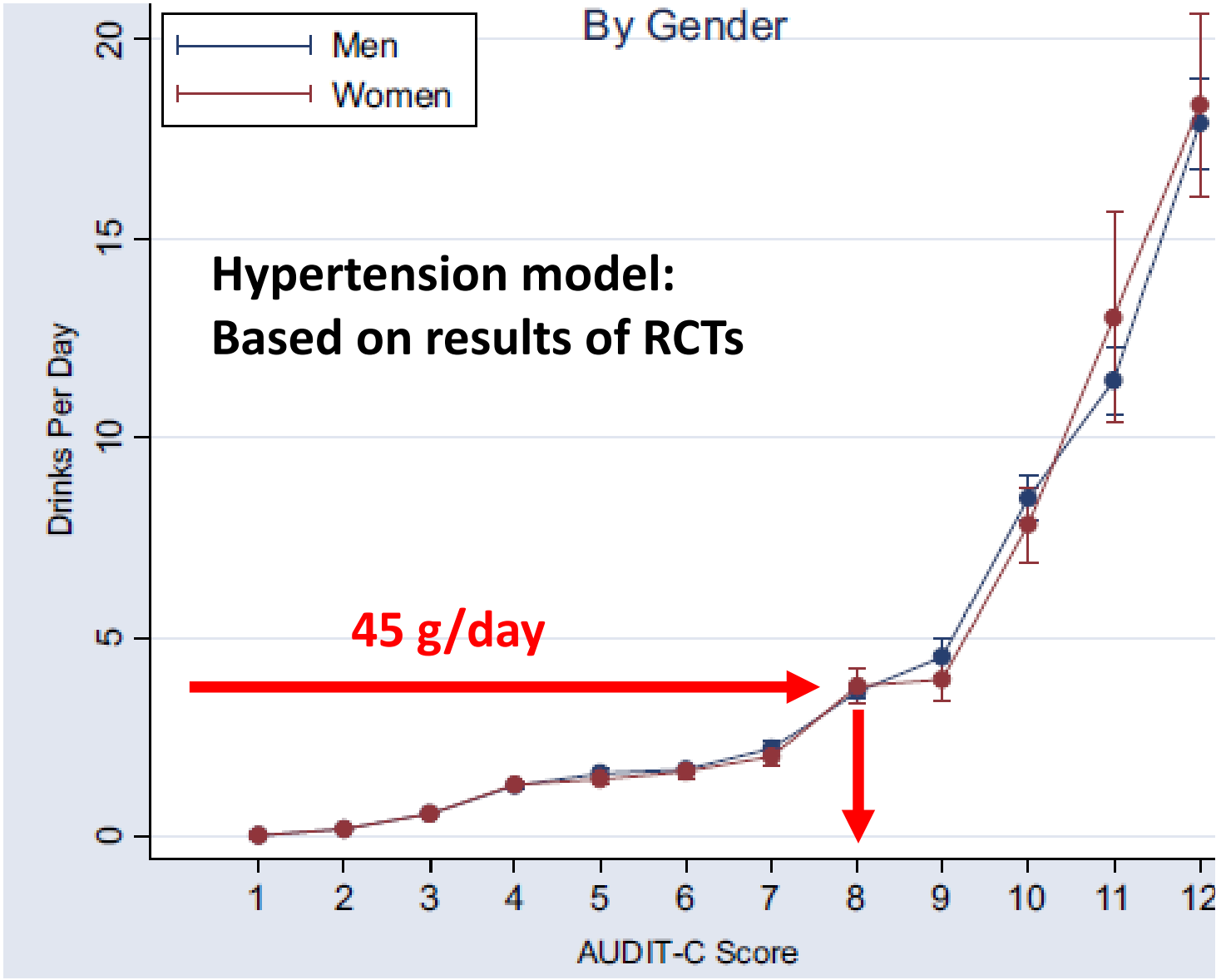
By Gender
Men
Women
Hypertension model:
Based on results of RCTs
45 g/day
Drinks Per Day
0
5
10
15
20
1
2
3
4
5
6
7
8
9
10
11
12
AUDIT-C Score

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DOI: 10.1002/14651858.CD004148.pub4.

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Kaner EFS, Beyer FR, Muirhead C, Campbell F, Pienaar ED, Bertholet N, Daeppen JB, Saunders JB, Burnand B

For two reasons:

Kaner EFS, Beyer FR, Muirhead C, Campbell F, Pienaar ED, Bertholet N, Daeppen JB, Saunders JB, Burnand B.
Effectiveness of brief alcohol interventions in primary care populations.
Cochrane Database of Systematic Reviews 2018, Issue 2. Art. No.: CD004148.
DOI: 10.1002/14651858.CD004148.pub4.

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Reason 1: trial settings

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Kaner EF, Dickinson HO, Beyer FR, Campbell F, Schlesinger C, Heather N, Saunders JB, Burnand B, Pienaar ED

24/29 trials implemented in general practice settings

Kaner EF, Dickinson HO, Beyer FR, Campbell F, Schlesinger C, Heather N, Saunders JB, Burnand B, Pienaar ED.
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2018

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Kaner EFS, Beyer FR, Muirhead C, Campbell F, Pienaar ED, Bertholet N, Daeppen JB, Saunders JB, Burnand B

38/69 trials implemented in general practice settings; 27/69 trials implemented in emergency care settings

Kaner EFS, Beyer FR, Muirhead C, Campbell F, Pienaar ED, Bertholet N, Daeppen JB, Saunders JB, Burnand B.
Effectiveness of brief alcohol interventions in primary care populations.
Cochrane Database of Systematic Reviews 2018, Issue 2. Art. No.: CD004148.
DOI: 10.1002/14651858.CD004148.pub4.

www.cochranelibrary.com

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Cochrane Database of Systematic Reviews

2007

Effectiveness of brief alcohol interventions in primary care populations (Review)

Kaner EF, Dickinson HO, Beyer FR, Campbell F, Schlesinger C, Heather N, Saunders JB, Burnand B, Pienaar ED

All settings: 38g/week

Kaner EF, Dickinson HO, Beyer FR, Campbell F, Schlesinger C, Heather N, Saunders JB, Burnand B, Pienaar ED.
Effectiveness of brief alcohol interventions in primary care populations.
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Kaner EFS, Beyer FR, Muirhead C, Campbell F, Pienaar ED, Bertholet N, Daeppen JB, Saunders JB, Burnand B

GP settings: 26g/week
A&E settings: 10g/week

Kaner EFS, Beyer FR, Muirhead C, Campbell F, Pienaar ED, Bertholet N, Daeppen JB, Saunders JB, Burnand B.
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DOI: 10.1002/14651858.CD004148.pub4.

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Reason 2: baseline consumption

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2007

Effectiveness of brief alcohol interventions in primary care populations (Review)

Kaner EF, Dickinson HO, Beyer FR, Campbell F, Schlesinger C, Heather N, Saunders JB, Burnand B, Pienaar ED

Baseline consumption: 313g/week

Kaner EF, Dickinson HO, Beyer FR, Campbell F, Schlesinger C, Heather N, Saunders JB, Burnand B, Pienaar ED.
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Baseline consumption: 183/week

Kaner EFS, Beyer FR, Muirhead C, Campbell F, Pienaar ED, Bertholet N, Daeppen JB, Saunders JB, Burnand B.
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DOI: 10.1002/14651858.CD004148.pub4.

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Figure 7. Meta-regression of quantity of drinking at 12 months on baseline consumption.

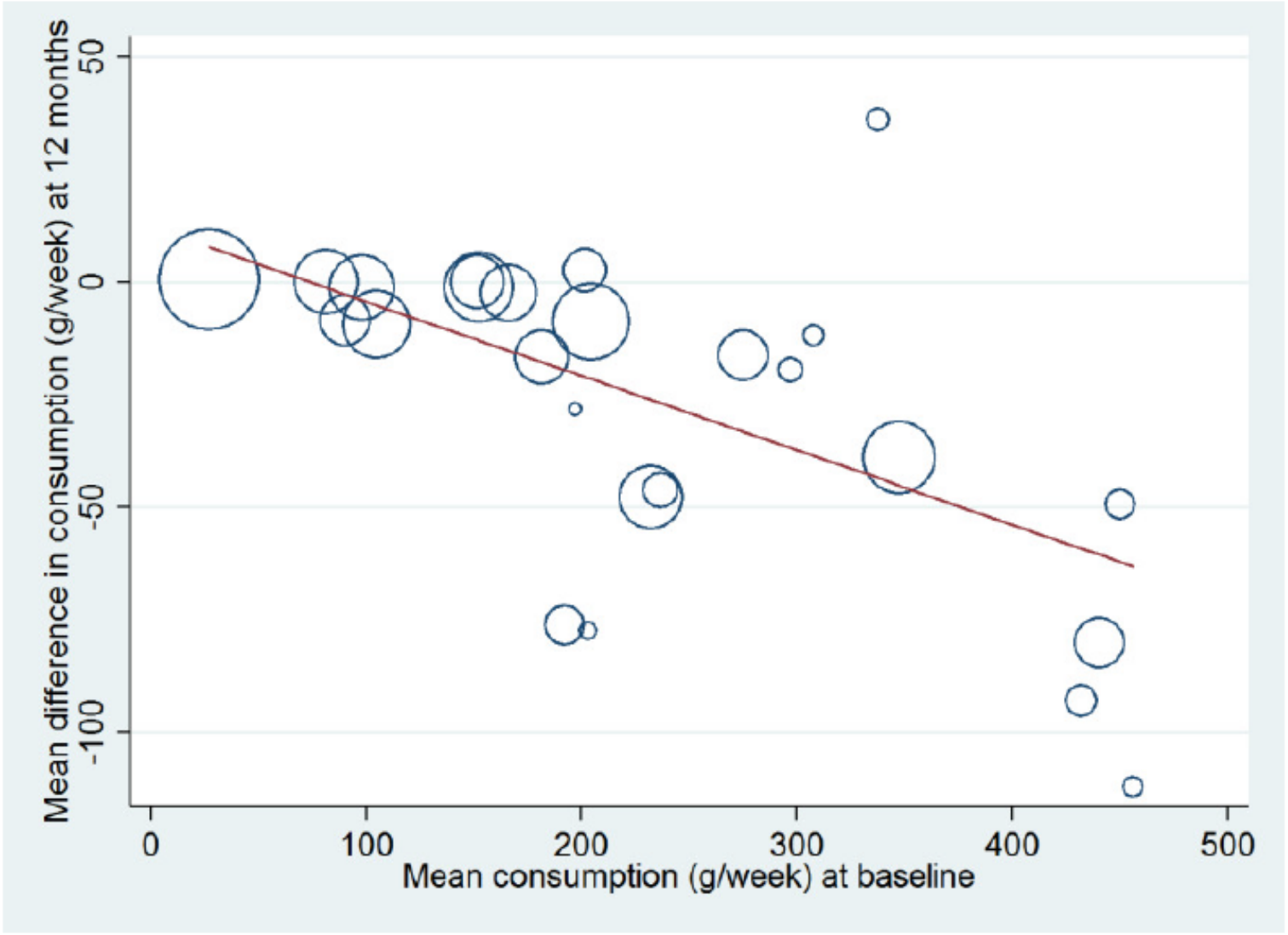


Figure 5. Meta-regression of quantity of drinking at 12 months on year of publication of trial.

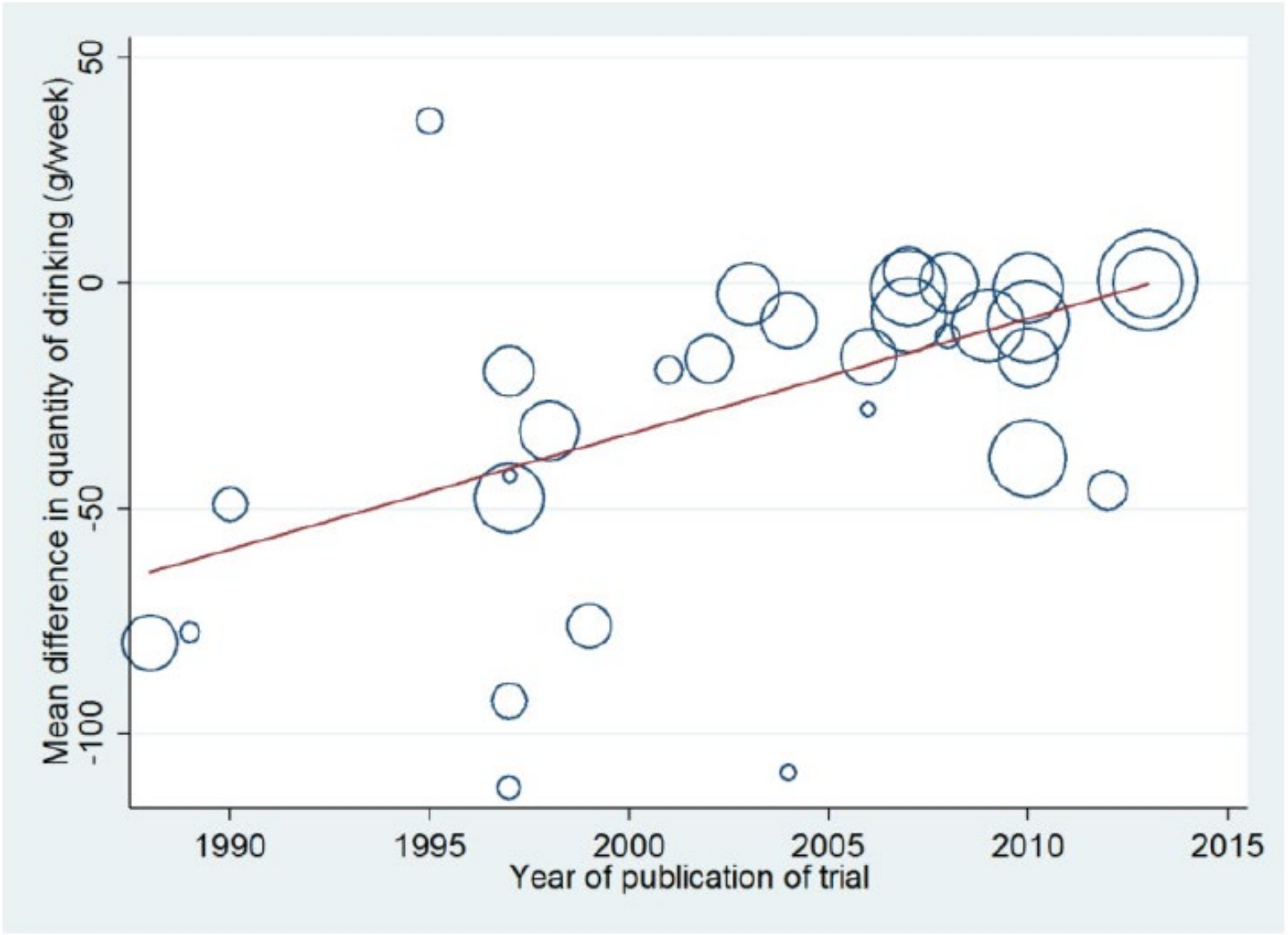
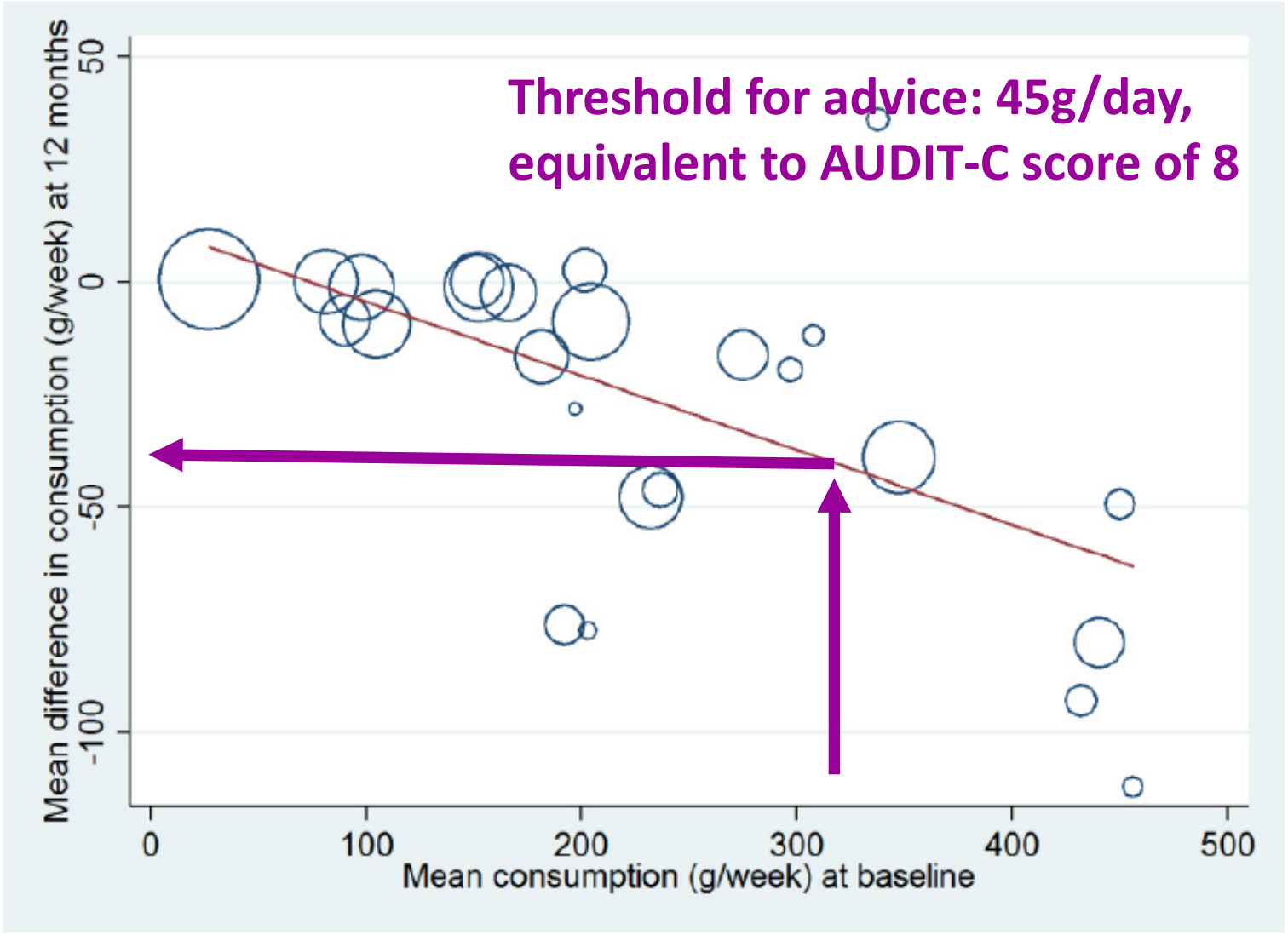
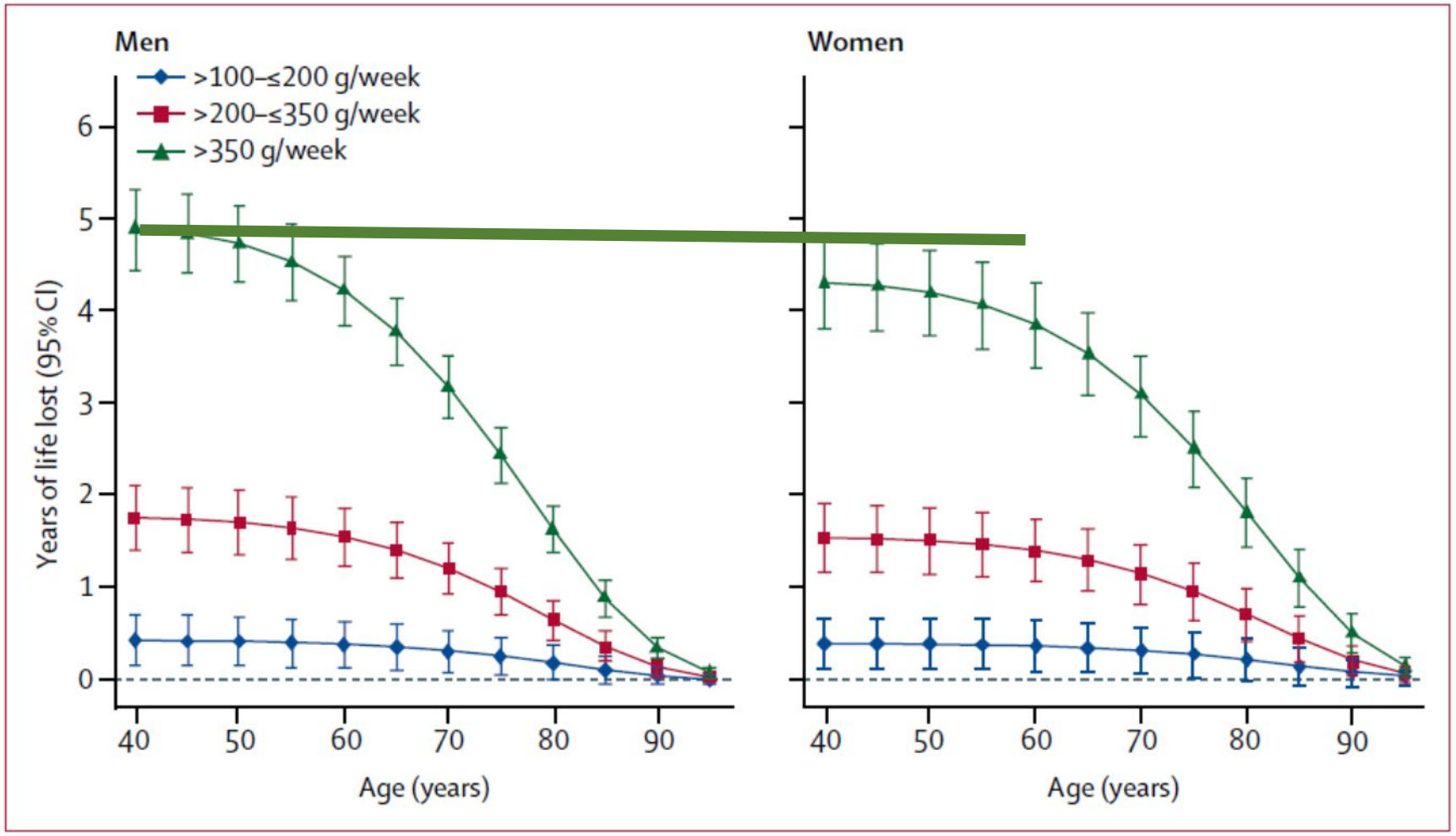


Figure 7. Meta-regression of quantity of drinking at 12 months on baseline consumption.



Same cut-off score for men and women



REPORT FROM GENERAL PRACTICE 24

Alcohol—
A Balanced View

ROYAL COLLEGE OF
GENERAL PRACTITIONERS

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Simplifying (3):

We measure alcohol use; AUDIT-C, being a useful instrument

Threshold for brief advice, based on RCT results, AUDIT-C = 8, same for men and women, equivalent to about 45 grams alcohol/day

REPORT FROM GENERAL PRACTICE 24

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4. Simplicity of advice to cut down drinking

SURNAME
Mr/Mrs/Miss .....

Age if under 12 years
yrs. | mths.

INITIALS AND ONE FULL FORENAME .....

Address .....

Pharmacy Stamp

Pharmacist's pack & quantity endorsement

No. of days treatment
NB Ensure dose is stated

NP

Pricing Office use only

Rx

Cut down on your drinking!

Signature of Doctor

Date

For pharmacist No. of Prescns. on form

IMPORTANT: Read notes overleaf before going to the pharmacy.

Form FP10 (Rev. 82)

Figure 8. Meta-regression of quantity of drinking at 12 months on treatment exposure (mean duration intervention for the participants in the trial), for trials comparing brief intervention with control.

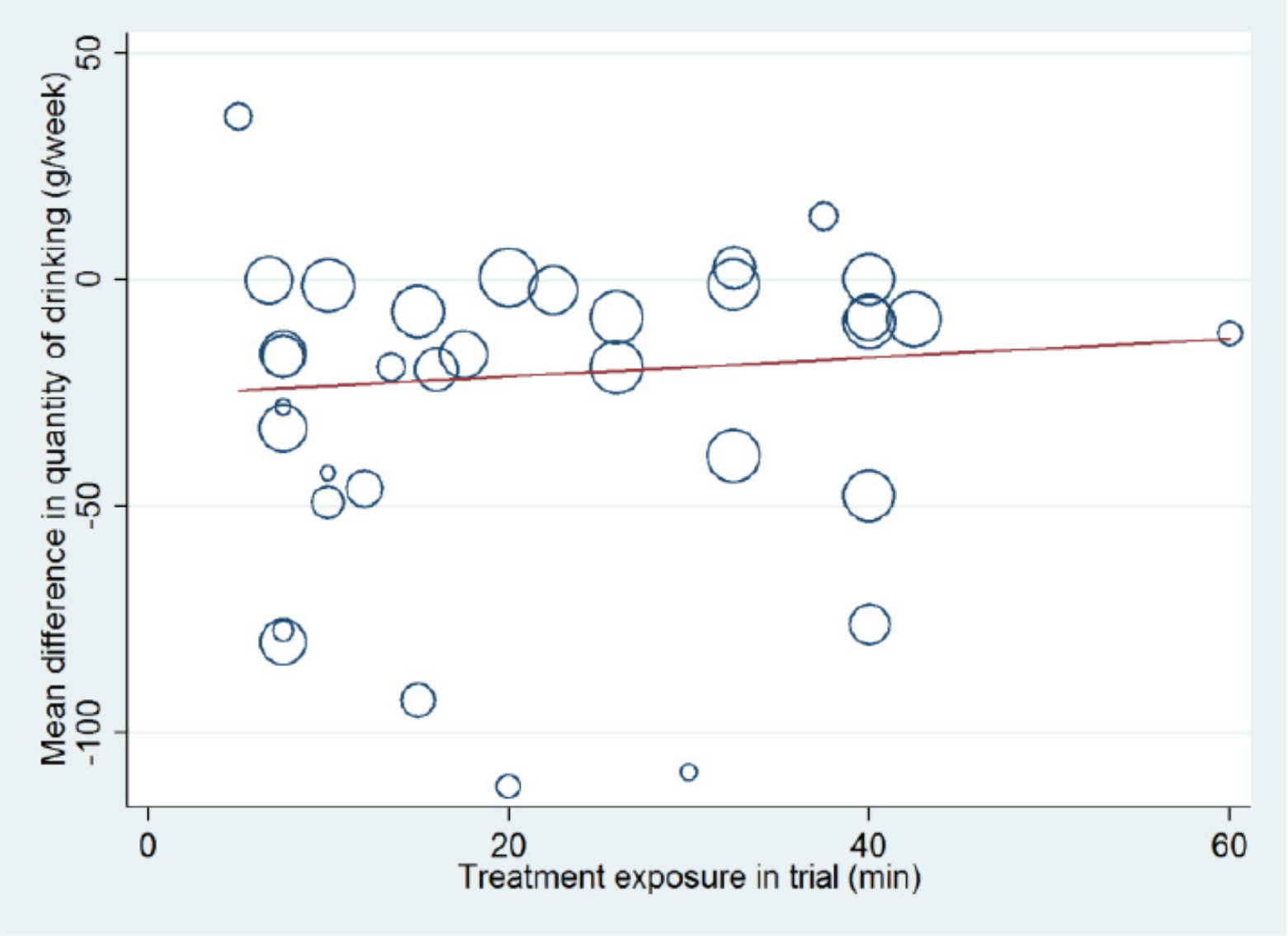
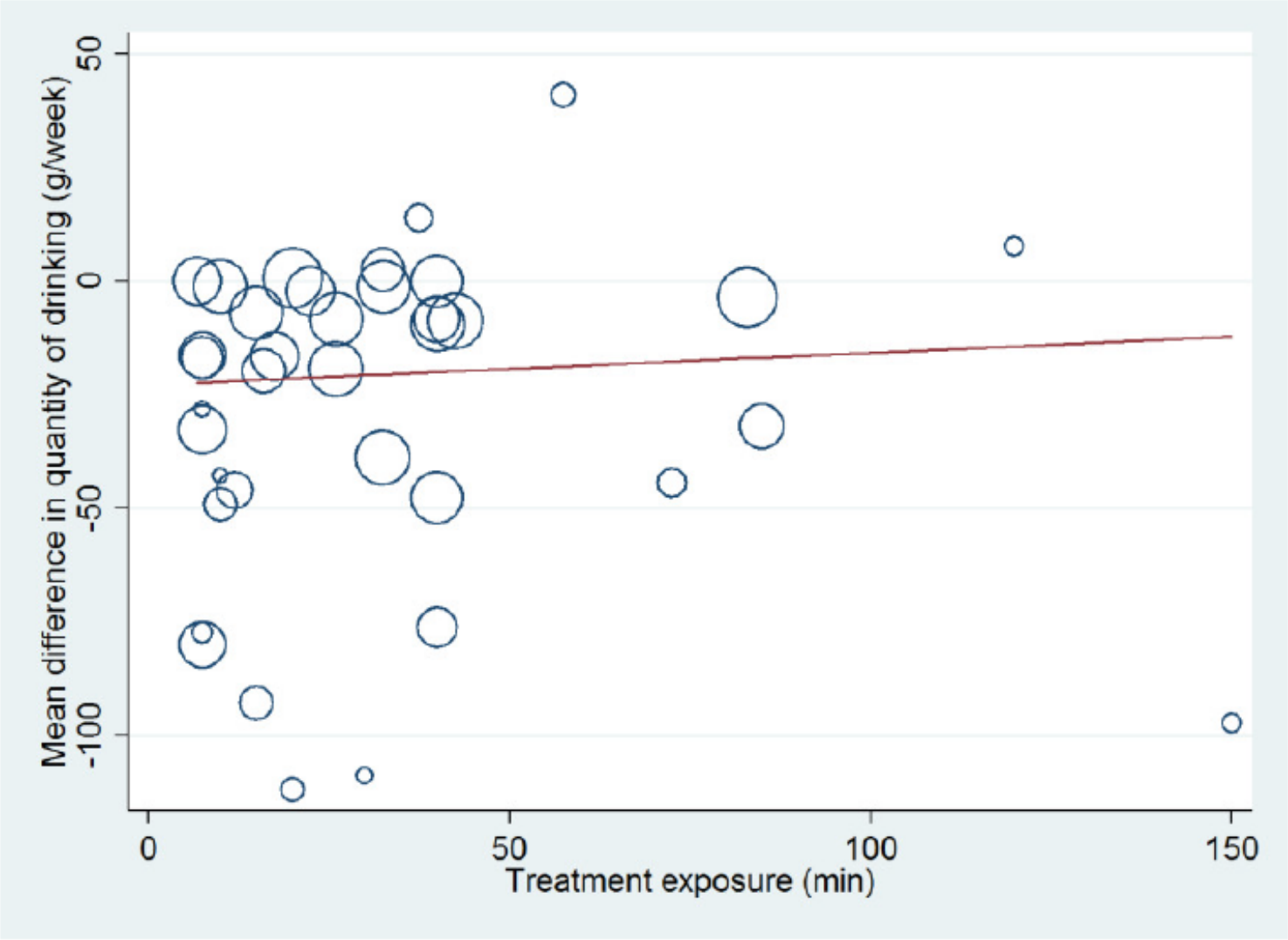
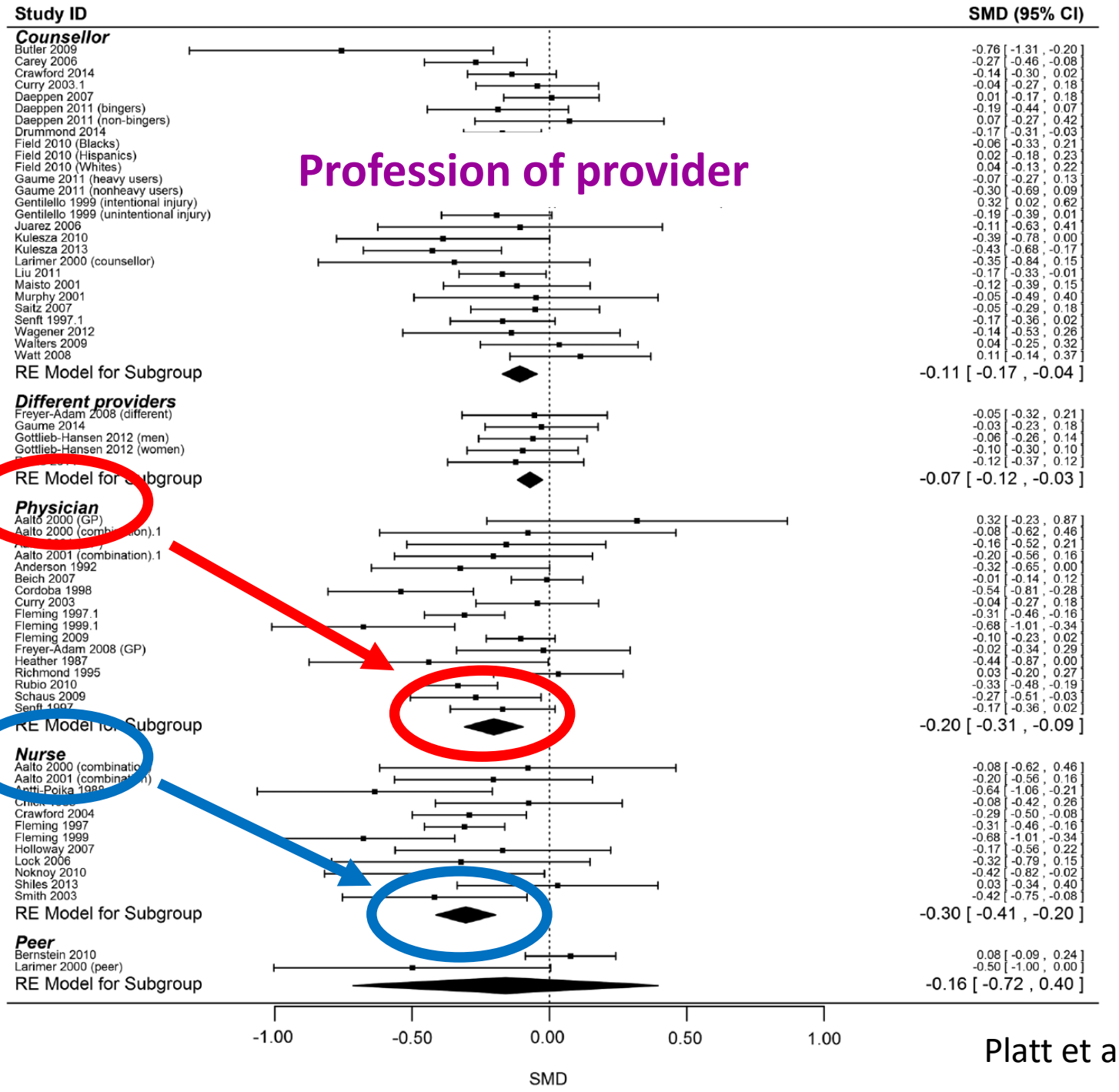
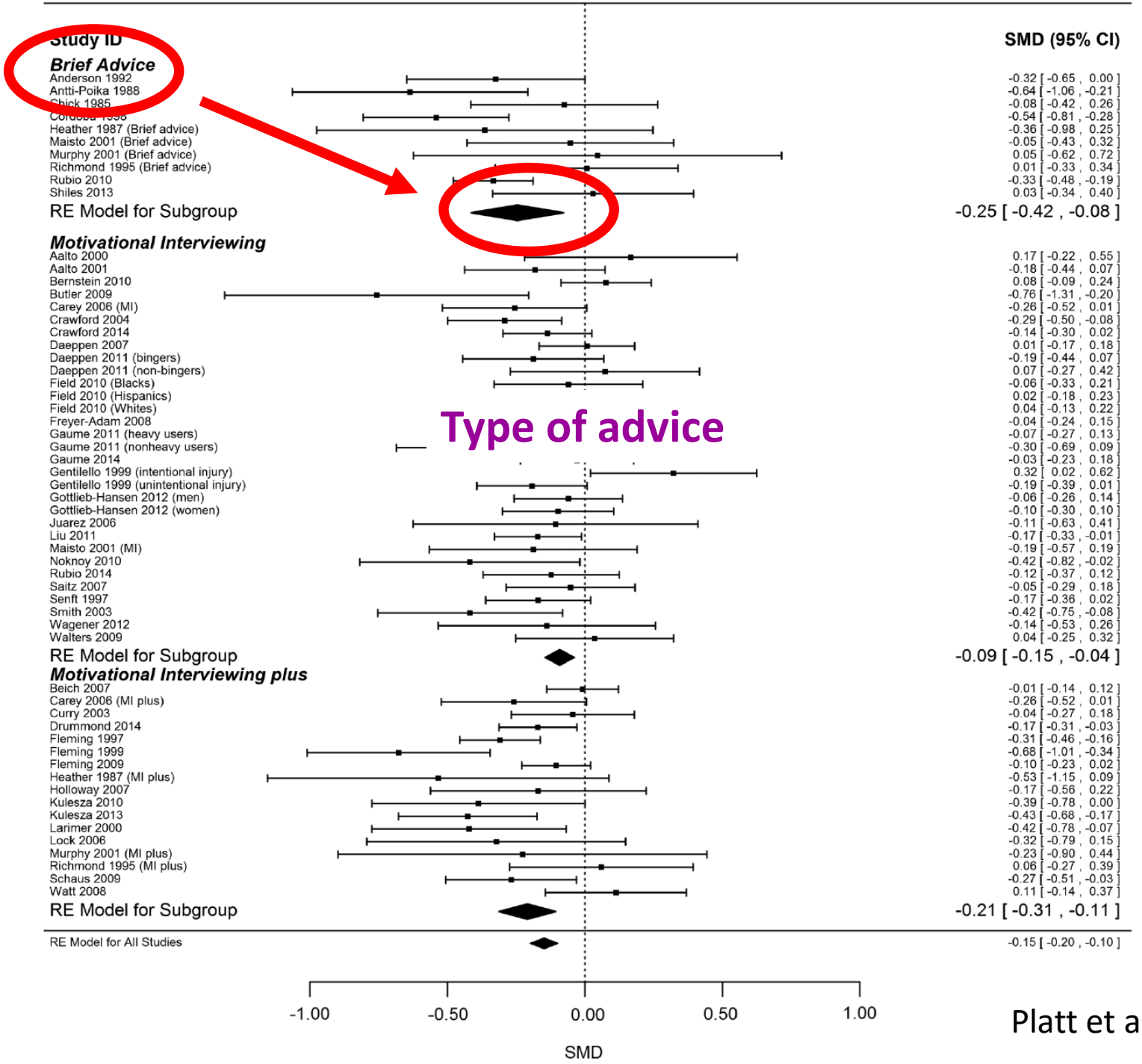


Figure 10. Meta-regression of quantity of drinking at 12 months on treatment exposure (mean duration of counselling for the participants in the trial), for trials comparing brief or extended intervention with control.

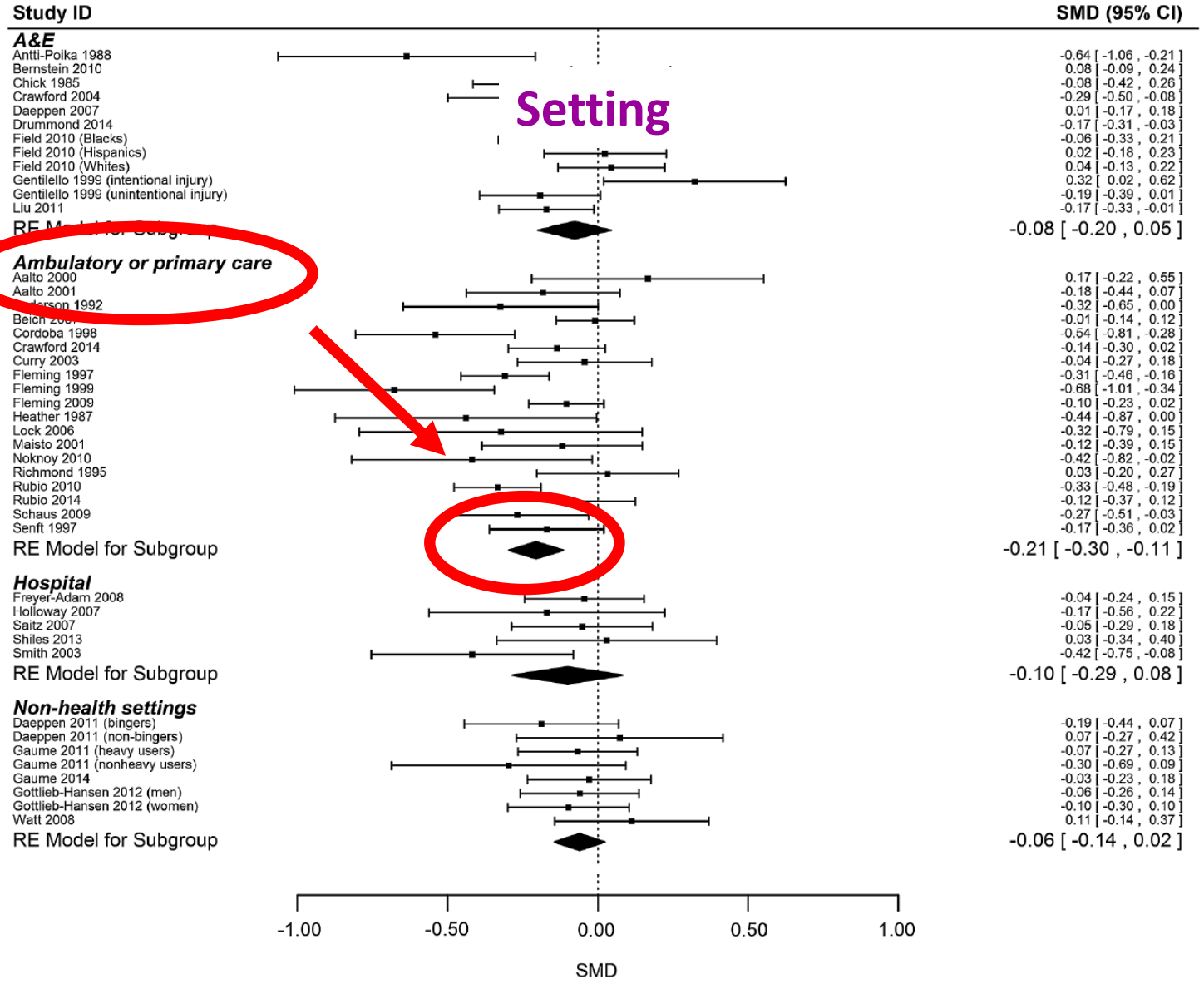




Platt et al. 2016



Platt et al. 2016



Platt et al. 2016

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GP settings: 26g/week

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2017

Personalised digital interventions for reducing hazardous and harmful alcohol consumption in community-dwelling populations (Review)

Kaner EFS, Beyer FR, Garnett C, Crane D, Brown J, Muirhead C, Redmore J, O'Donnell A, Newham JJ, de Vocht F, Hickman M, Brown H, Maniatopoulos G, Michie S

Digital interventions: 23g/week

Kaner EFS, Beyer FR, Garnett C, Crane D, Brown J, Muirhead C, Redmore J, O'Donnell A, Newham JJ, de Vocht F, Hickman M, Brown H, Maniatopoulos G, Michie S.
Personalised digital interventions for reducing hazardous and harmful alcohol consumption in community-dwelling populations.
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DOI: 10.1002/14651858.CD011479.pub2.

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Kaner EFS, Beyer FR, Muirhead C, Campbell F, Pienaar ED, Bertholet N, Daeppen JB, Saunders JB, Burnand B.
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Cochrane Database of Systematic Reviews 2017, Issue 9. Art. No.: CD011479.
DOI: 10.1002/14651858.CD011479.pub2.

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GP settings: 26g/week

Digital interventions: 23g/week

How do we marry these two together?

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Alcohol—
A Balanced View

ROYAL COLLEGE OF
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The Royal College of General Practitioners

Getting rid of the RT in MBART

WHO/MSD/MSB/01.6a
Original: English
Distribution: General

Thomas F. Babor
John C. Higgins-Biddle
John B. Saunders
Maristela G. Monteiro

AUDIT

The Alcohol Use Disorders Identification Test

Guidelines for Use in Primary Care

Second Edition

World Health Organization
Department of Mental Health and Substance Dependence

Box 6

Risk Level	Intervention	AUDIT score*
Zone I	Alcohol Education	0-7
Zone II	Simple Advice	8-15
Zone III	Simple Advice plus Brief Counseling and Continued Monitoring	16-19
Zone IV	Referral to Specialist for Diagnostic Evaluation and Treatment	20-40

Box 6

Risk Level	Intervention	AUDIT score*
Zone I	Alcohol Education	0-7
Zone II	Simple Advice	8-15
Zone III	Simple Advice plus Brief Counseling and Continued Monitoring	16-19
Zone IV	Referral to Specialist for Diagnostic Evaluation and Treatment	20-40

WHY?

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"Establish a plan or protocol for finding out about every patient's alcohol consumption, for recording and assessing that information and for acting upon it so as to reduce the health risk for as many patients as is practicable"

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"The majority of heavy drinkers and patients with alcohol problems can be helped by support from members of the primary care team. However, there are some patients whose care will need to be shared:

- **Severe medical and psychological problems**
- **Lack supportive family**
- **Care has previously failed"**

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"Not everyone can be helped adequately in general practice:

- **Severe intoxication and detoxification that cannot be safely done at home**
- **Liver disease**
- **Suicide risk"**

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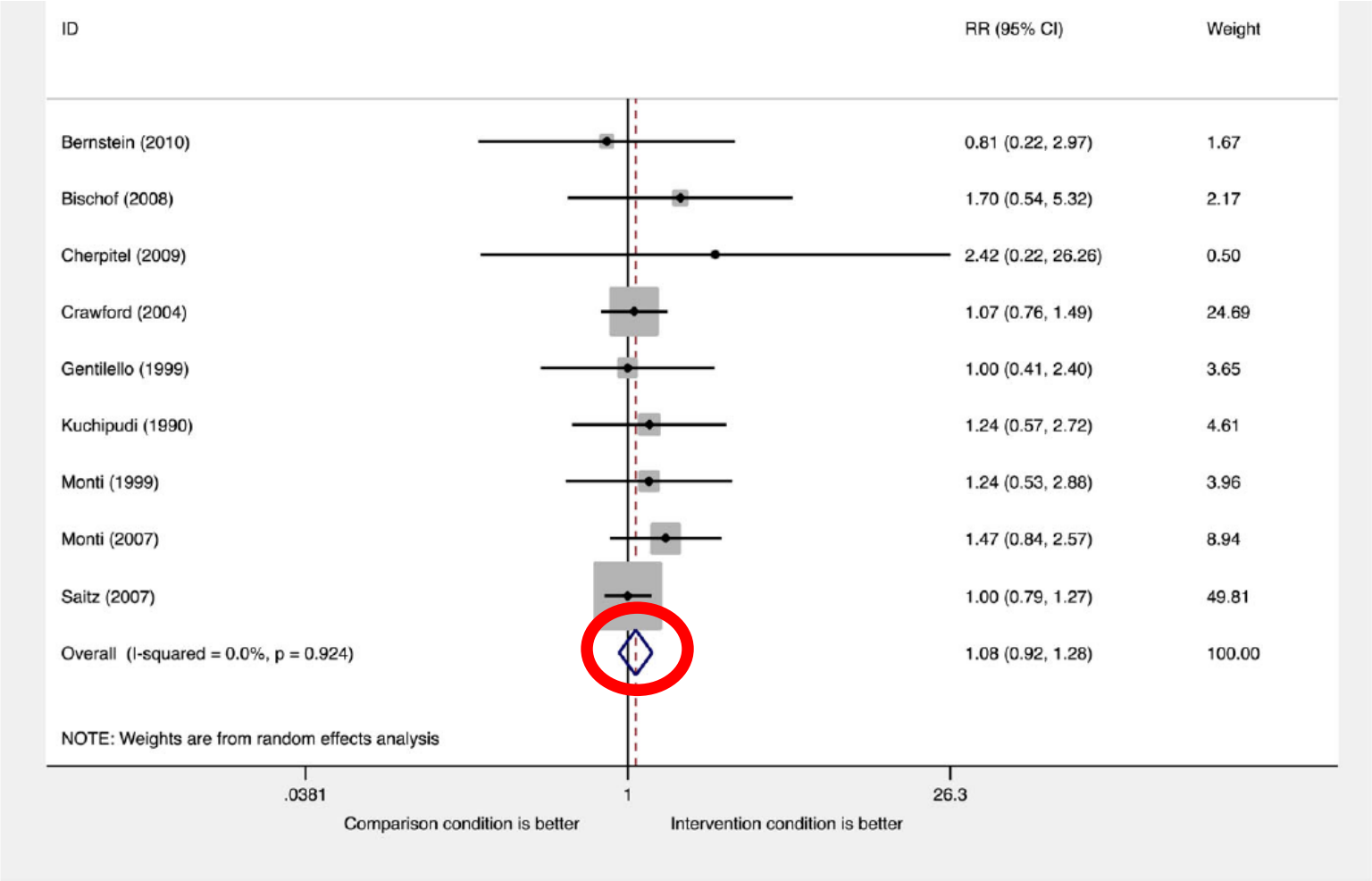
Thus, RT is the exception, rather than the rule, and is not a dichotomous entity.

So, we only need MBA

Measurement and Brief Advice

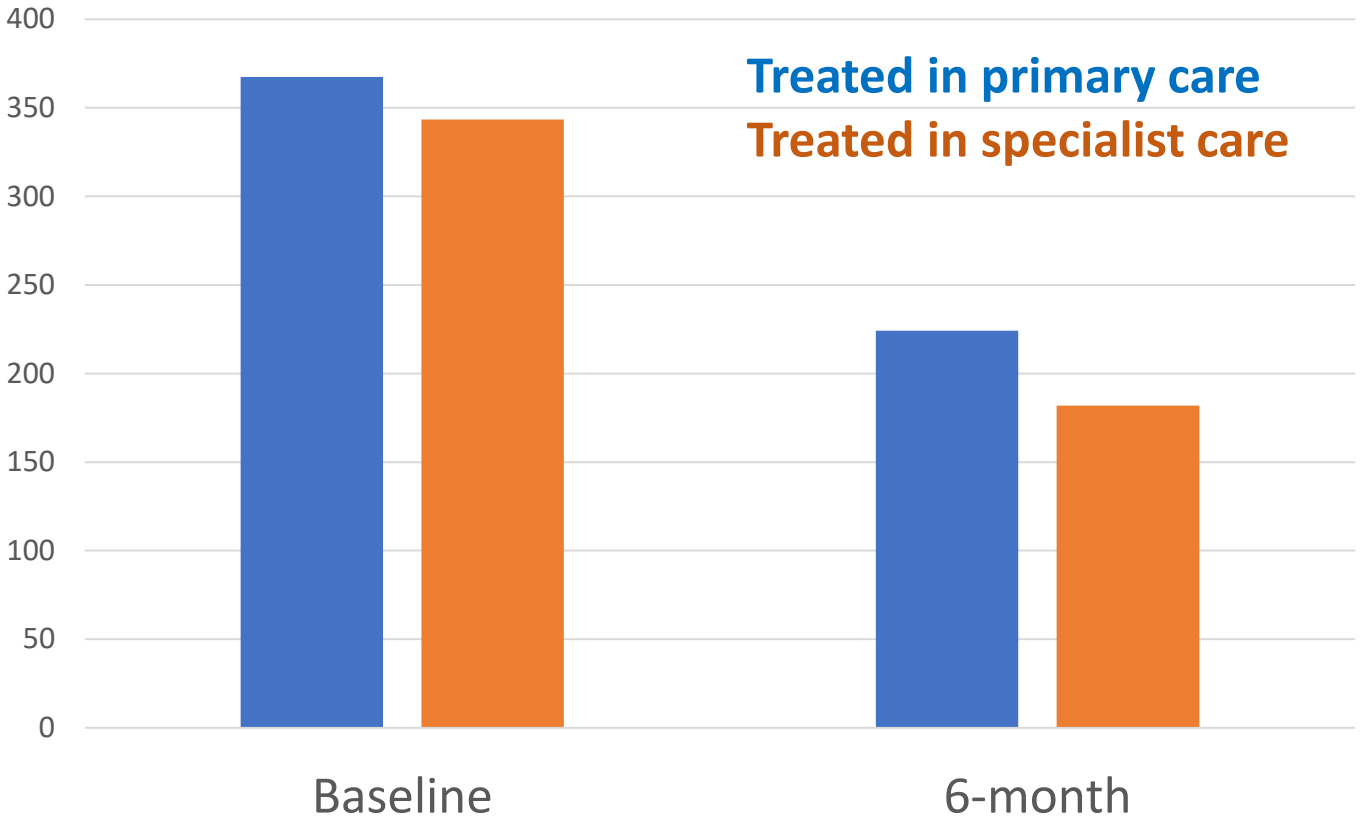
In any case, the R does not work

Meta-analysis of studies of the efficacy of brief alcohol interventions in referring people to higher levels of alcohol related care



Glass et al. 2015

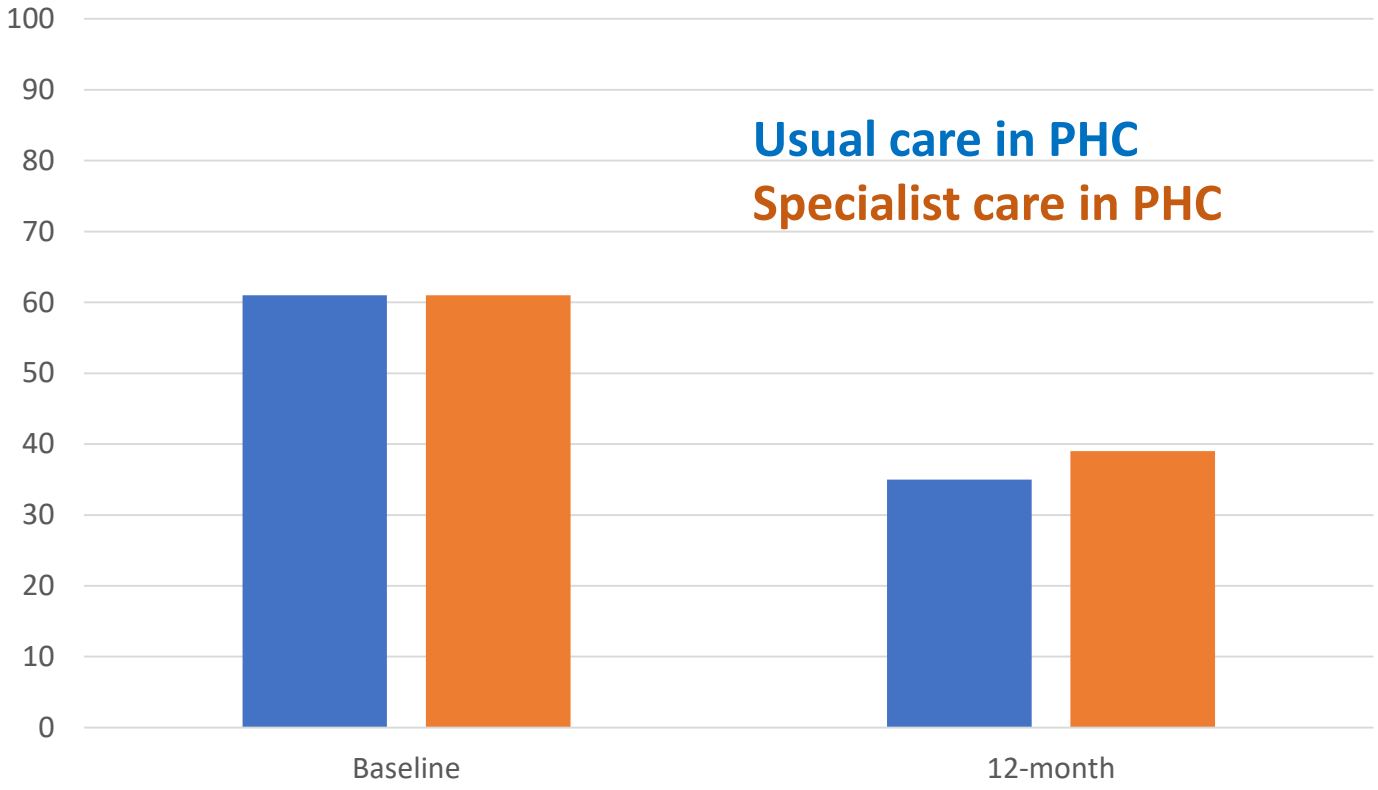
For the same type of patient, treatment in specialist care is no better than treatment in primary care



Weekly alcohol consumption (grams) for 288 Swedish adults fulfilling ICD-10 criteria for alcohol dependence, randomly allocated to treatment in primary care or specialist care

Finn et al. 2018

For the same type of patient, specialist care in PHC is no better than usual care in PHC



Per cent previous 28 days that were heavy drinking days for 304 US Veterans with AUDIT-C score ≥ 5 for men and ≥ 4 for women randomly allocated to usual or specialist care in PHC

Bradley et al. 2018

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Simplifying (4):

Only short simple advice is needed, preferably delivered by a nurse or physician, preferably in primary health care

Sharing care with specialist services is the exception, rather than the norm, and not determined by dichotomous decision making

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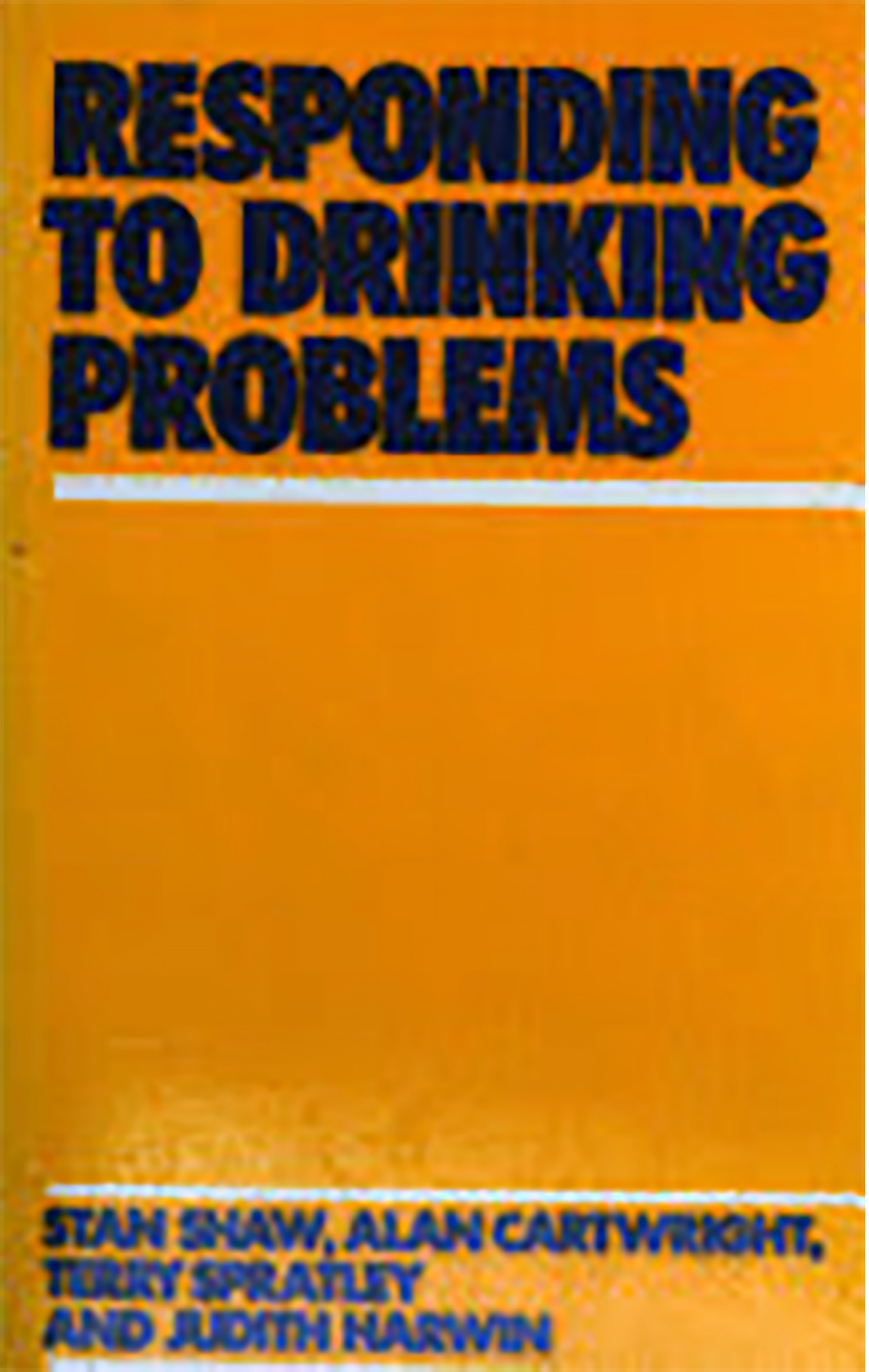
5. Community support to community agents

RESPONDING TO DRINKING PROBLEMS

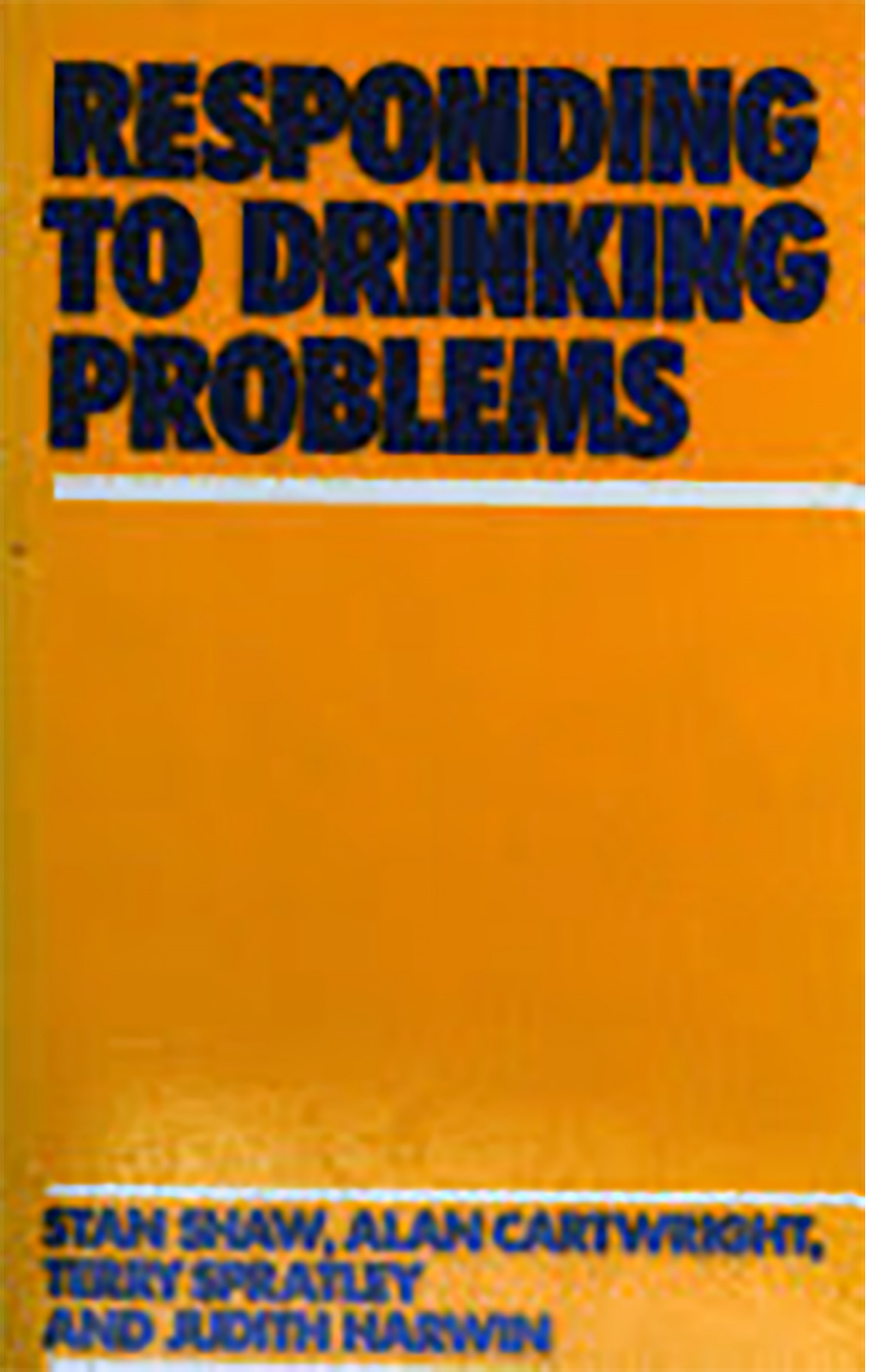
STAN SHAW, ALAN CARTWRIGHT, TERRY SPRATLEY AND JUDITH HARWIN



Coined the term:

Community Agents

- Primary health care physicians
- Primary health care nurses
- Social workers



Developed and demonstrated the model:

Training

⇒ **Improved role security and therapeutic commitment**

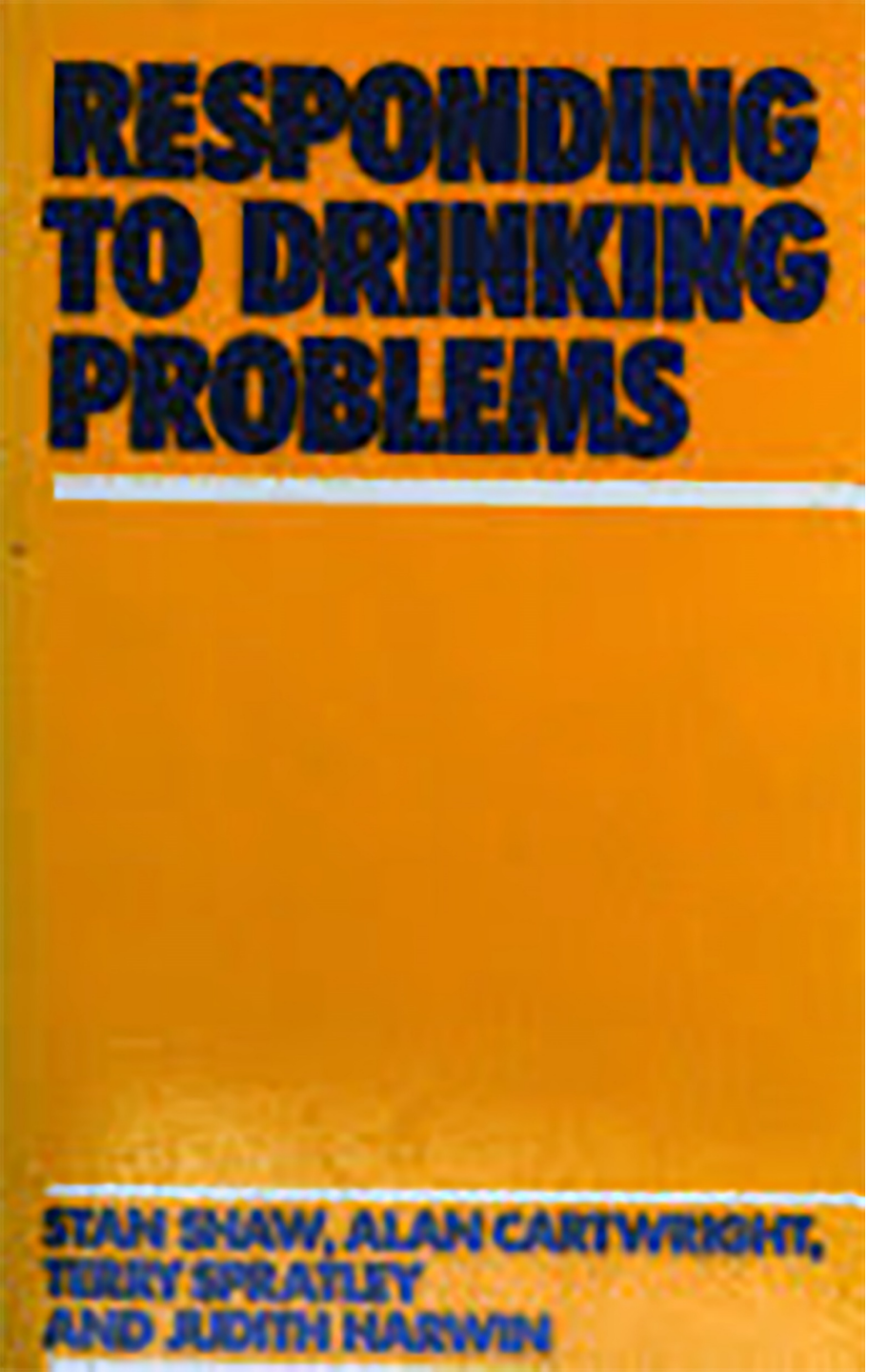
⇒ **More patients managed for drinking**

⇒ **Improved role security and therapeutic commitment**

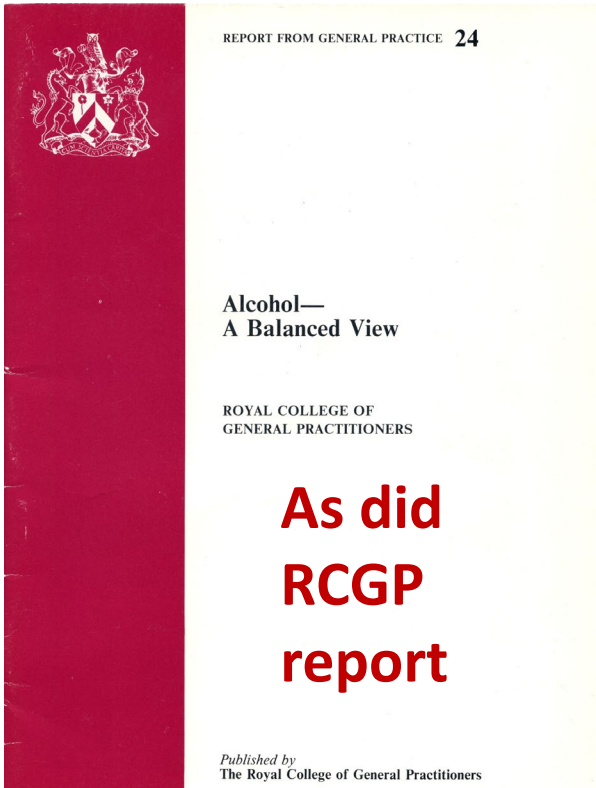
⇒ **More patients managed for drinking**

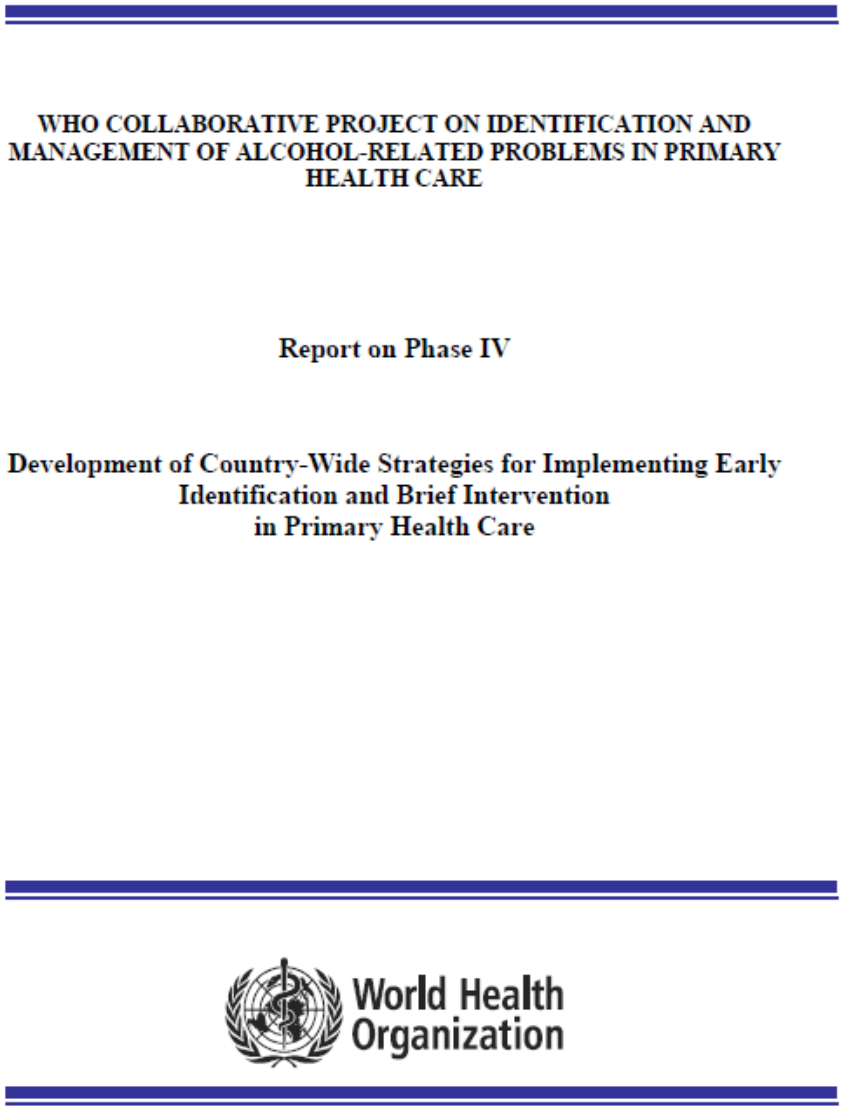
Confirmed by ODHIN project

Odhin project



Stressed need for community-based role support



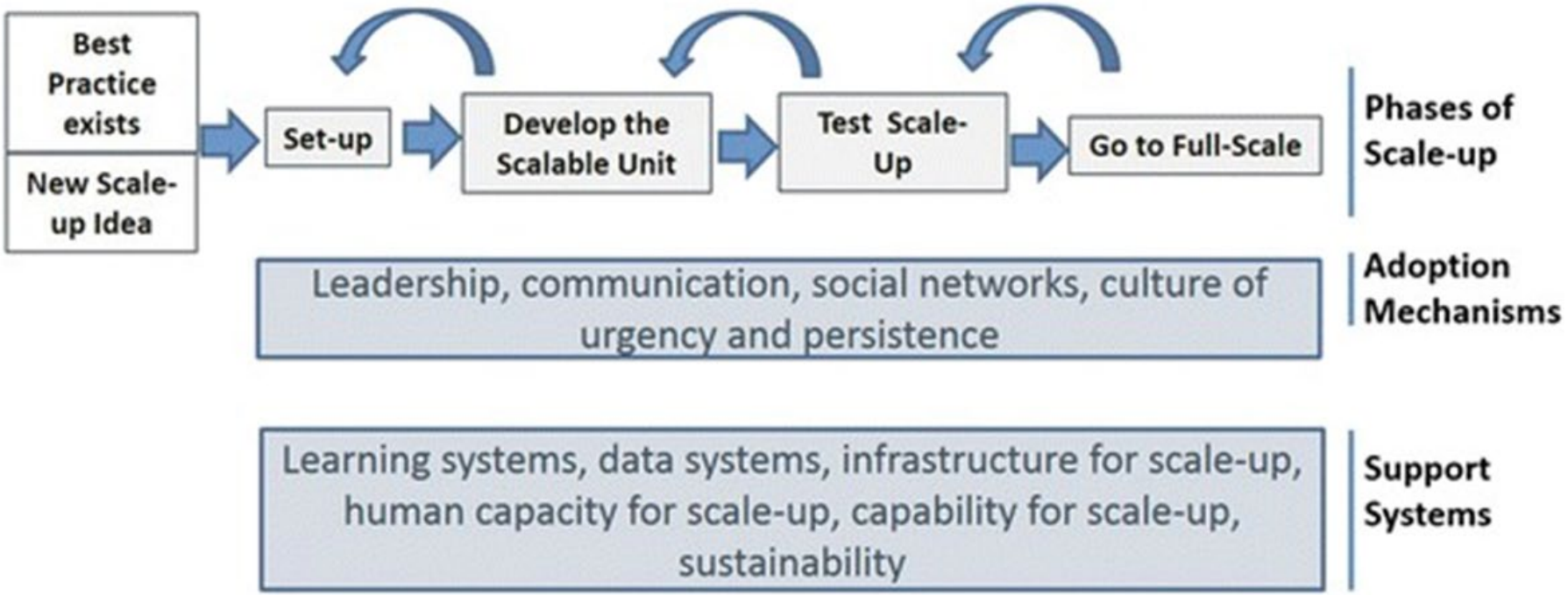


- **reframing views about alcohol away from a view of 'alcoholism' to a broader understanding of alcohol problems is essential for both professionals (through training) and the public (through mass media campaigns)**

- **the establishment of a lead organization is essential, gathering endorsements from a range of organisations and individuals that are highly relevant to the aims of the work**

SCALA

SCALE-UP OF PREVENTION AND MANAGEMENT
OF ALCOHOL USE DISORDERS AND
COMORBID DEPRESSION IN LATIN AMERICA



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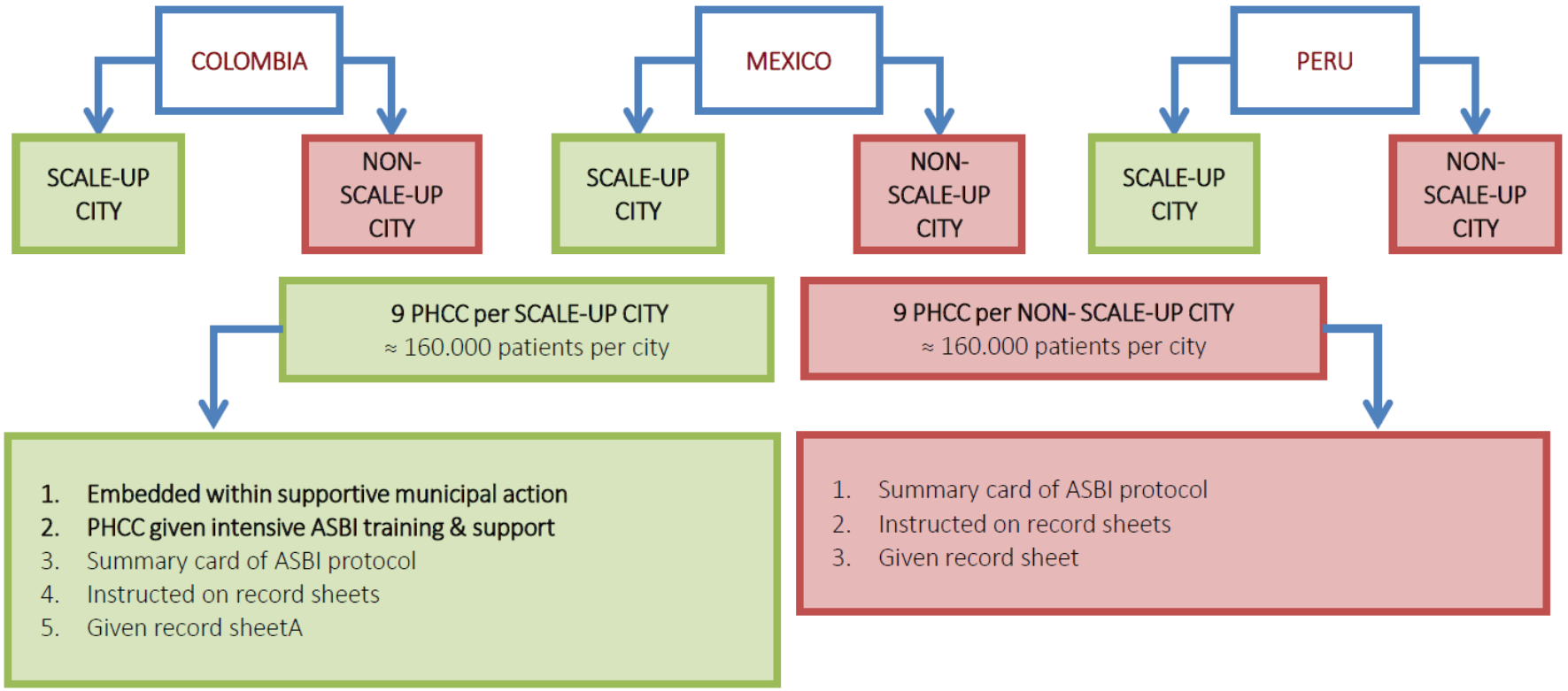
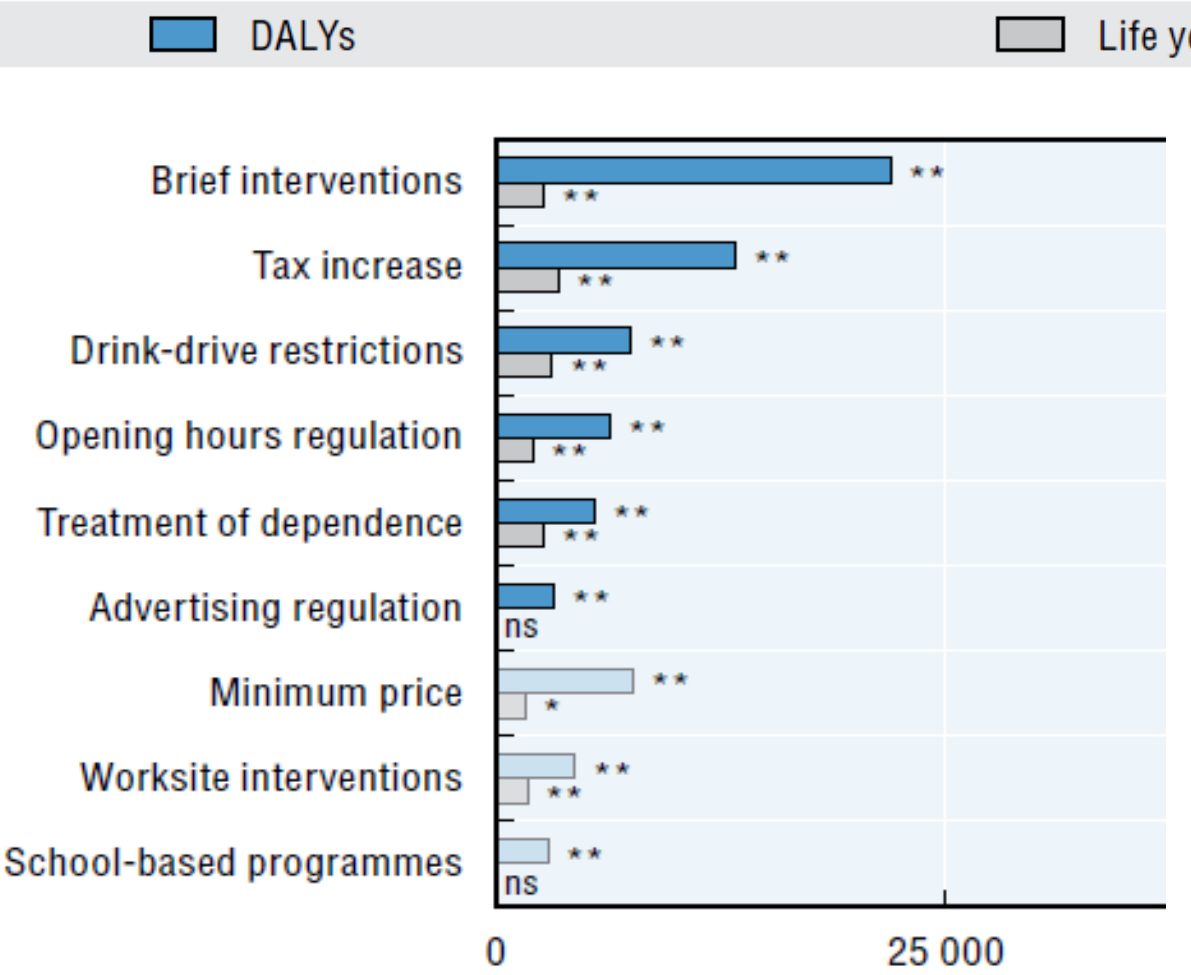
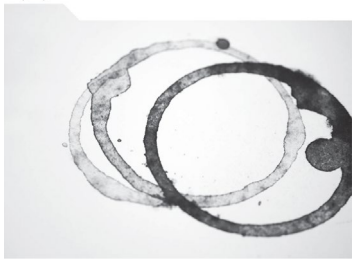


Health outcomes at the population level, average number per year

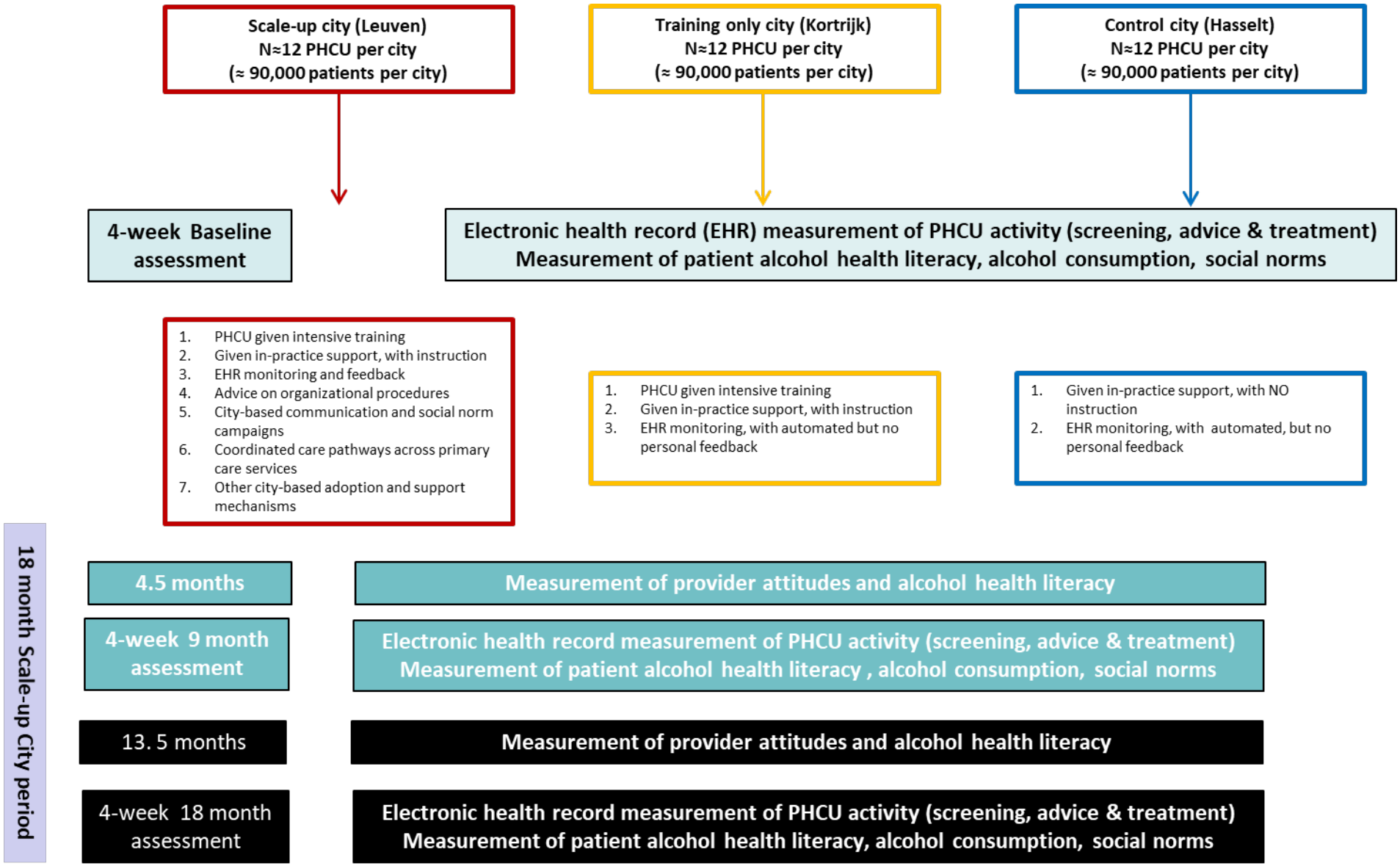


Example of Canada

Tackling Harmful Alcohol Use
ECONOMICS AND PUBLIC HEALTH POLICY



OECD


Scale-up city (Leuven)
N≈12 PHCU per city
(≈ 90,000 patients per city)
Training only city (Kortrijk)
N≈12 PHCU per city
(≈ 90,000 patients per city)
Control city (Hasselt)
N≈12 PHCU per city
(≈ 90,000 patients per city)
4-week Baseline assessment
Electronic health record (EHR) measurement of PHCU activity (screening, advice & treatment)
Measurement of patient alcohol health literacy, alcohol consumption, social norms
1. PHCU given intensive training
2. Given in-practice support, with instruction
3. EHR monitoring and feedback
4. Advice on organizational procedures
5. City-based communication and social norm campaigns
6. Coordinated care pathways across primary care services
7. Other city-based adoption and support mechanisms
1. PHCU given intensive training
2. Given in-practice support, with instruction
3. EHR monitoring, with automated but no personal feedback
1. Given in-practice support, with NO instruction
2. EHR monitoring, with automated, but no personal feedback
18 month Scale-up City period
4.5 months
Measurement of provider attitudes and alcohol health literacy
4-week 9 month assessment
Electronic health record measurement of PHCU activity (screening, advice & treatment)
Measurement of patient alcohol health literacy , alcohol consumption, social norms
13. 5 months
Measurement of provider attitudes and alcohol health literacy
4-week 18 month assessment
Electronic health record measurement of PHCU activity (screening, advice & treatment)
Measurement of patient alcohol health literacy, alcohol consumption, social norms


FEDERAL RESERVE NOTE
10
GL 64739922 A
L12
THE UNITED STATES OF AMERICA
We The People
THIS NOTE IS LEGAL TENDER FOR ALL DEBTS, PUBLIC AND PRIVATE
SERIES 2004 A
Treasurer of the United States.
Secretary of the Treasury.
TEN
HAMILTON
DOLLARS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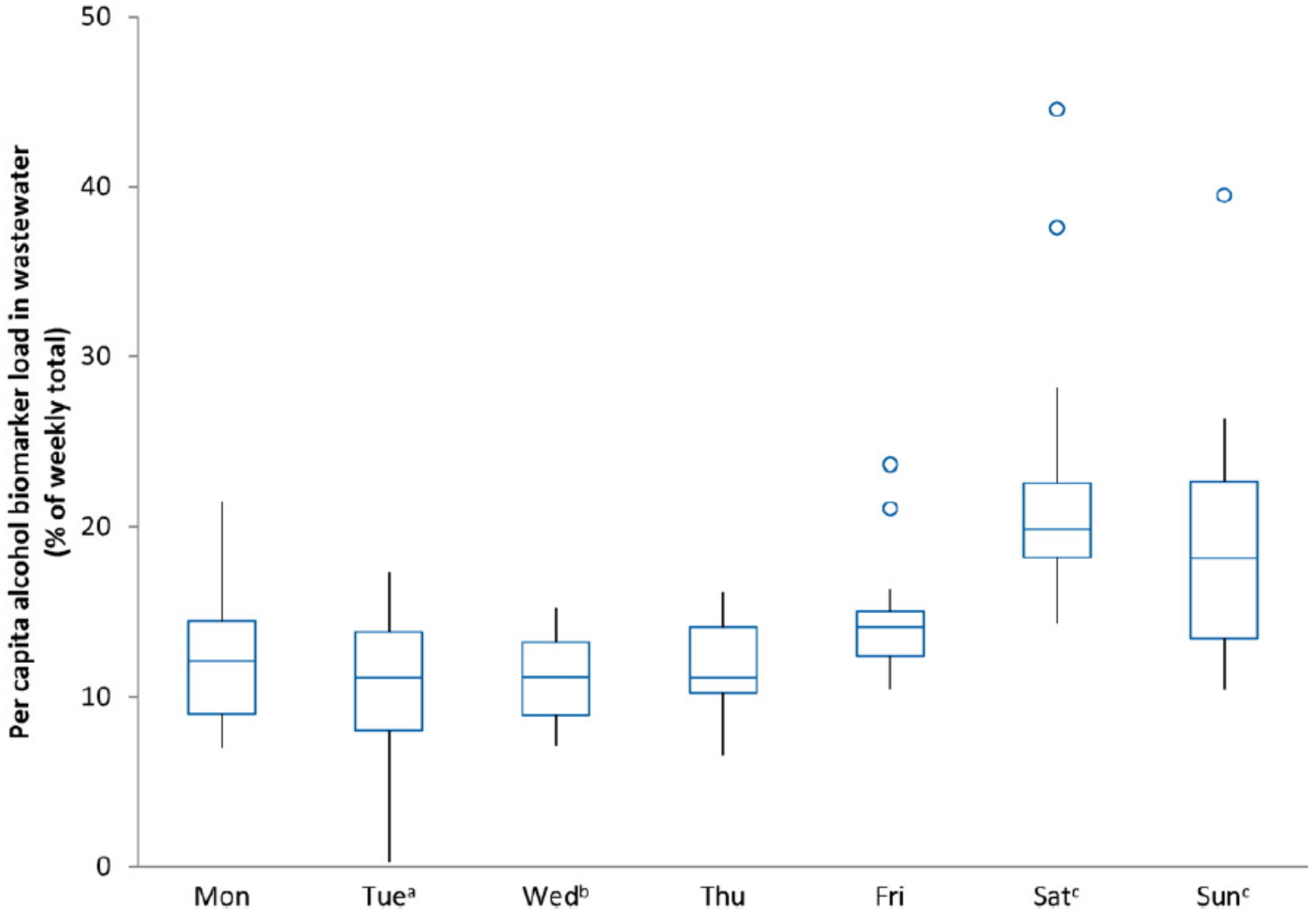
TEN
HAMILTON
DOLLARS


ethyl sulphate (EtS)



Ryu et al. 2016.

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Adding one thing (5):

Community support for community agents

Evaluate community outcomes, with a bucket of wastewater

REPORT FROM GENERAL PRACTICE 24

In summary:

Alcohol—
A Balanced View

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1. **There are no dichotomies, no disorders, no diseases – only continua of alcohol use and continua of the harm done by alcohol use**

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2. Alcohol is the risk factor, not harmful use of alcohol or unhealthy use of alcohol; there is no level of consumption that is risk-free; beyond 50g alcohol/day, nearly 5 years of life are lost

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3. **We measure consumption of alcohol; we are not screening. Based on evidence from RCTs, an appropriate threshold for advice is an AUDIT-C score of 8 for both men and women, equivalent to about 45g alcohol/day**

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A Balanced View

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4. **Simple short advice to cut down drinking is all that is needed to have an impact; the care of some patients will need to be shared; referral for treatment is not the norm and is not a dichotomous decision based on a score.**

The acronym is MBA:

Measure and Brief Advice

REPORT FROM GENERAL PRACTICE 24

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5. **Community agents undertake MBA; they need community support**

Research needs to study the impact of MBA at the community level; there are opportunities to do this; wastewater analyses of ethyl sulphite provide an objective outcome measure

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Thank you for your attention

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