Alcohol Aware Practice Service Initiative

April 2005 – March 2006

Funded by the Health Service Executive

Final Report – August 2006

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Executive Summary

Alcohol problems have been presenting in epidemic proportions over the past two decades. Primary Care staff needs help and support to manage the range of alcohol problems that they encounter in their daily work.

The Alcohol Aware Practice Service Initiative was a partnership between Irish College of General Practitioners (ICGP) and the Health Service Executive (HSE) conducted over a one year period (2005-2006). It built on the success of the Alcohol Aware Practice Pilot Study (2002 – 2003). This service initiative involved nine sites (three GPs per site) and one counsellor on site on the basis of six hours per week. The geographical region was within the HSE Dublin Mid-Leinster and HSE North East.

The principal aims were to help patients with a range of alcohol problems and to determine whether Brief Interventions are effective in this area. Practice staff, including practice nurses were to screen patients for the range of alcohol problems including hazardous, harmful and dependent drinking and then to treat them accordingly.

The screening involved the use of the AUDIT questionnaire as well as consumption charts and clinical judgement.

Patients were screened on a random basis, in a targeted fashion or if they were 'help seeking'. Patients were then followed up at a three month interval to see whether the intervention had been successful at that stage. Patients, who would otherwise have been unable to access counselling elsewhere, had expert counselling available on site. The service was discrete and seamless. The service was free of charge to patients.

Comprehensive results are available in the report. Altogether 4,584 patients were screened. The results show that 61% of these patients were in the 'low/no risk' categories while 22% were in the 'hazardous' zone and 17% were 'harmful/dependent'. Following brief interventions and/or referral to the counsellor on site, patients were assessed to ascertain if the intervention had made any difference. This was predominantly a service initiative and the emphasis was on the benefits to patients and their families. Valuable lessons have been learned regarding both the service initiative and the recording/data analysis aspects.

Although the target for numbers screened by the practices appeared to be modest they proved to be very difficult to achieve and only two practices managed to reach the agreed target as well as some individual GPs.

The number of patients who were followed up in the life time of the initiative was a little disappointing. **However, we can confidently report that one half of patients who attended follow-up made good progress according to the Practice Staff, while according to the Counsellors, of those patients they saw, one third were maintaining abstinence and another third showed positive improvement.**

It must be remembered that many patients will follow up with practice staff over the next year and beyond. Evaluations after training, and one year on, reveal improvements on all criteria for practice staff relating to the screening and management of alcohol problems. Team work was very effective and there was universal approval of the counselling part of the initiative.

The report contains details about the strengths (for example, 'it can be done', 'benefits to patients and families', 'public ignorance regarding alcohol problems' and benefits for local areas) and difficulties (for example, 'attitudinal issues', practical problems', 'target numbers') of the initiative and detailed recommendations.

The recommendations include the following;

- Integration of Questionnaires into software and the use of a modified version of the AUDIT as an initial screening tool
- A dedicated researcher
- Reduced target numbers
- Tailored interventions
- Area deployment of counsellors but maintaining the on site aspect
- The development of the role of counsellor and practice nurse
- A roll out of the service to more GPs throughout the country with possible development of the initiative through the primary care teams/networks.

This is a successful partnership between the HSE and the ICGP and there are clear benefits to the health and well-being of patients and their families. There are also many advantages to the practice staff including team work, greater confidence and transferable skills. We gratefully acknowledge the support of the Health Service Executive without which this Initiative would not have been possible.

Contents

1. Background and Introduction

The Alcohol Aware Practice Service Initiative (AAPS) was developed as a partnership between the HSE and the ICGP. It arose as a result of a previous pilot study on Alcohol and Primary Care conducted by the ICGP. The Alcohol Aware Practice (AAP) pilot study, conducted over a one year period from 2002 – 2003[1], consisted of 10 practices, one from each of the former Health Boards, one of which (the practice in Baltinglass) was allocated a Counsellor on site for 6 hours per week.

In the pilot AAP, 2290 patients were screened. The results gave us a snap shot for the first time of alcohol problems in GP surgeries in Ireland. The results indicated that 19% of patients in a random survey were drinking above 'safe/low risk' limits and that relatively simple intervention and advice given by GPs and/or practice nurses can effectively reduce the patients' risk category at three month follow-up[2].

That study clearly indicated the advantages of having an alcohol counsellor on site in primary care. Screening rates for dependence were significantly higher in Baltinglass and the results for patients have been outstanding. All the professionals involved in Baltinglass reported a significant increase in their skills and confidence in dealing with alcohol problems in primary care. The 'one stop shop' for treatment of alcohol problems in primary care is very attractive to patients. They are less identifiable as patients with alcohol problems when attending their family doctors' surgeries and therefore less stigmatised. The results from Baltinglass made it clear that GPs are far more likely to find/screen alcohol problems when they have an immediate source of help. Thus 'role support' is crucial as indicated in the international literature[3].

Generally speaking, doctors have been reluctant to open the 'Pandora's box' for patients with alcohol problems for a variety of reasons. The principal reasons for such reluctance are due to busy schedules and lack of immediate referral sources. The original pilot demonstrated that they can have a very effective role.

Following discussions with the Health Service Executive, there was an agreement to run the AAPS in the Eastern region of the country and funding was secured for this initiative. The reason for this service initiative was to demonstrate that the previous results for screening and intervention could be replicated on a wider basis. Apart from the benefit to patients that was likely to ensue, it was felt that the primary care staff could be supported by the presence of the counsellor while undertaking a screening programme for alcohol problems. If patients were found to have significant alcohol problems there would be a resource on site, that is, the Counselling Service, to help to manage the more difficult cases. This would be a significant benefit to patients who had little or no access to counselling for funding or location reasons. The counselling on site was offered to all patients as a free service.

The final agreement was to run a service initiative that would involve 26 GPs (x8 sites, three GPs per site plus the original two GPs from Baltinglass who participated in the AAP). Advertisements were published in the medical media, counselling journals and sent by mail shots. Information was also placed on the ICGP website to attract interested parties. There was huge interest in this initiative and double the number of practices applied than could be accepted. Three times as many counsellors applied for the nine counselling positions that were available. Practices were selected on the basis of their need for such a service, if they had a counselling room available and also if they had broadband internet access as the results were to be recorded and sent using the internet. Location was considered and practices with a large percentage of GMS patients (medical card holders) were more likely to be included. Counsellors had to be accredited by the Irish Association of Alcohol and Addiction Counsellors. Following recruitment by way of submissions and interviews the practices and Counsellors were selected as per Section 1.1.

1.1 Participants

Nine sites in total; the participating practices and counsellors were as follows:

HSE Dublin Mid-Leinster, East Coast Area; (x2 sites)

Practice; Dr. John McManus (Bray)
Three GPs and one practice nurse actively involved.
Counsellor; Mr. John Cantillon
Description; Large GP practice in urban area with mix of GMS and private patients.

Practice; Dr. Nick Buggle/Dr. Siobhan McCabe (Arklow)/Dr. Ian Bothwell (separate practice).
Three GPs actively involved.
Counsellor; Ms. Mary Howley
Description; Two medium sized GP practices in urban area with mix of GMS and private patients.

HSE Dublin Mid-Leinster, South Western Area; (x4 sites)

Practice; Dr. Philip Wiehe (Crumlin, Dublin 12)
Three GPs and one practice nurse actively involved.
Counsellor; Mr. Tony Jordan
Description; Large GP practice in urban area with mix of GMS and private patients.

Practice; Dr. Kieran Harkin/Dr. Emer Loughrey (Inchicore, Dublin 8.)
Four GPs (2 part-time) and one practice nurse actively involved.
Counsellor; Ms. Rita Stanford
Description; Two large GP practices on same site in urban area with mix of GMS and private patients.

Practice; Dr. John Latham (Liberties, Dublin 8.)
Three GPs actively involved.
Counsellor; Ms. Áine Walsh (For three weeks approx then on sick leave and replaced by Ms Sheila Hawkins for the duration of the initiative)
Description; Large GP practice in urban area with mix of GMS and private patients.

Practice; Dr. Cait Clerkin/Dr. Pat Carolan, (Baltinglass, Co. Wicklow)
Two GPs actively involved
Counsellor; Mr. Donal Kiernan*, (was also involved from the outset with the original AAP study)*
Description; Large practice supported by practice Nurse, in rural town setting with mix of GMS and private patients. Also involved in pilot study.

HSE Dublin North-East, Northern Area; (x3 sites)

Practice; Dr. Austin O'Carroll (Mountjoy St, Dublin 7.)
Three GPs actively involved
Counsellor; Mr. Tony Jordan
Description; Large inner city practice with mix of GMS and private patients.

Practice; Dr. Nial O'Leary
Three GPs actively involved in the study.
Counsellor; Mr. Brendan Murphy
Description; Large practice in suburban Dublin with mix of GMS and private patients.

Practice; Dr. Mel Bates/Dr. Patricia Carmody (Fairview, Dublin 3)/Dr. John Delap (Coolock, Dublin 5).
Three GPs actively involved in the study. Two separate practices
Counsellor; Ms. Sheila Hawkins
Description; Two medium sized practices in suburban setting with mix of GMS and private patients.

Note: From a results and commentary perspective, the practices and counsellors will be anonymous from here on.

1.2 Timetable

The training, for all of the professional staff, took place in the months of February and March 2005. The screening phase of the study commenced in April 2005. Patients were screened until the end of January 2006. The AAPS concluded at the end of March 2006. A short period of extra time was granted to some practices in order to allow the counsellors to finish work with patients and to find alternative sources of help if appropriate.

2. Aims and Goals

2.1 Aims

To develop, at a general practice level, programmes of concerted action involving all practice staff, in order to prevent, detect and treat patient problems associated with alcohol:

- By increasing staff awareness and expertise
- By improving individual patient records of alcohol consumption
- By training doctors and where appropriate practice nurses to intervene effectively during every consultation where appropriate with patients and family members
- By maintaining intervention records
- By establishing practice policy on referral for more intensive care
- By developing practice advocacy for such services where they are currently inadequate
- By the appropriate use of screening instruments
- By categorising all patients through screening as, 'Low risk', 'Hazardous', 'Harmful' or 'Dependent' drinkers
- By developing management guidelines appropriate to each category, including support materials and follow-up based on this document and negotiated with participating staff
- By working with the counsellor on site to provide fast and discrete interventions to patients to improve their health and well-being and to develop team work.

2.2 Goals

The goals were as follows:

- To help patients with a range of alcohol problems
- To demonstrate that brief interventions are highly effective in this area
- To prove that integrated team work (i.e. working with an alcohol counsellor within primary care) is a most effective form of intervention
- To demonstrate that screening for alcohol problems is effective and quick
- To show that minimum training for GPs can develop vital skills that are helpful to patients and their families.

3. Methods

3.1 Materials

Each practice was supplied with **Training Packs** containing the following:

- Posters
  - Posters for discussion with patients on the relative risks of alcohol consumption and physical harm (Appendix 1)[4]
- Cage questionnaires and scoring systems[5]
- AUDIT questionnaires and scoring systems (Appendix 3)[6]
- Leaflets
  - 'Alcohol and your Body' leaflet (Appendix 2)[7]
  - 'You would like to stop drinking', and 'You would like to cut down your drinking' (Appendix 2)[8]
  - 'Less is More'(Appendix 2)[9]
- Evaluation forms (Appendix 4)[10]
- Results forms – Counsellors (Appendix 5)[11]

3.2 Training

Each of the practices and the counsellors were required to attend a half day training session. Three half day training sessions were held to accommodate all of the practices. One of these was held in the ICGP headquarters in central Dublin, one in Bray, Co. Wicklow and one on site in Dublin 8.

The following was covered in the training sessions and included in the training packs:

- Use of Materials
  - Posters
  - Leaflets
  - Methods of Intervention
  - Questionnaires
  - Computerised recording systems (Appendix 5)
  - Record Sheets
- Information on healthy/safe (low risk) alcohol consumption levels
- Clinical complications of hazardous, harmful and dependent drinking
- Working with the Counsellor (Appendix 7)
- Clinical skills
  - Brief Intervention[12]
  - Decision Balance[13]
  - Motivational Interviewing[14]
  - Prevention
  - Advice giving
  - Biological tests
  - Co-morbidity
- Treatment Methods
  - Withdrawals
  - Medication
  - Referral
- Helping the spouse/partner.

3.3 Practice Visits/ Support

The international experience and the previous study strongly suggest that the more support the practices received the better the outcome[15]. So, in addition to the training sessions, each practice was visited twice during the initiative by the Project Director. The first practice visit was conducted in September 2005 and the final one was in February 2006. These visits helped to encourage the practices to continue with the screening and gave all concerned vital feedback on the day to day problems associated with the interventions. In addition, there were numerous communications sent out and the practices and counsellors were in regular contact by phone. Every month the practices received by email a list of screenings completed and information regarding those who needed to be followed up. The practices were supplied with information on local and national treatment agencies and self-help groups. Local treatment centres were contacted by the counsellors to inform them that the initiative was being conducted. Three meetings were held at regular intervals for the counsellors. At the end of the initiative, a 'Think Tank' symposium was held to get more feedback on the whole initiative. There were ten participants from the practices including counsellors, GPs and practice nurses.

3.4. Exclusion Criteria and Comments

Patients were excluded if they were:

- under age14 (consent from parent age 14–16)
- terminally or acutely ill
- could not understand the process or refused to allow the screening to take place
- had been screened before

Notes:

1. The practices were also instructed not to screen if it was clearly inappropriate (e.g. when a baby is being vaccinated or someone was accompanying the patient) or when patients were too distressed.
2. By the end of the initiative only a tiny percentage (less than 1%) were excluded, because they did not want to be screened

3.5. Methods of Intervention/Screening Targets

There were three possible methods of intervention for patients:

- Random assessment
- Targeted interventions (practice staff suspect an alcohol problem)
- Help Seeking - Patient or family member comes and asks for help

The target for each GP was to screen and if necessary intervene with two patients each working day, for five days per week.

Note: At least one of these patients had to be randomly selected each day for screening (see Appendix 6 for more details of intervention methods). In all cases the methods used drew heavily on the skills derived from 'Motivational Interviewing' and 'Brief Interventions' which were taught at the training sessions. Training also included information on best ways/methods to assist family members.

4. Results

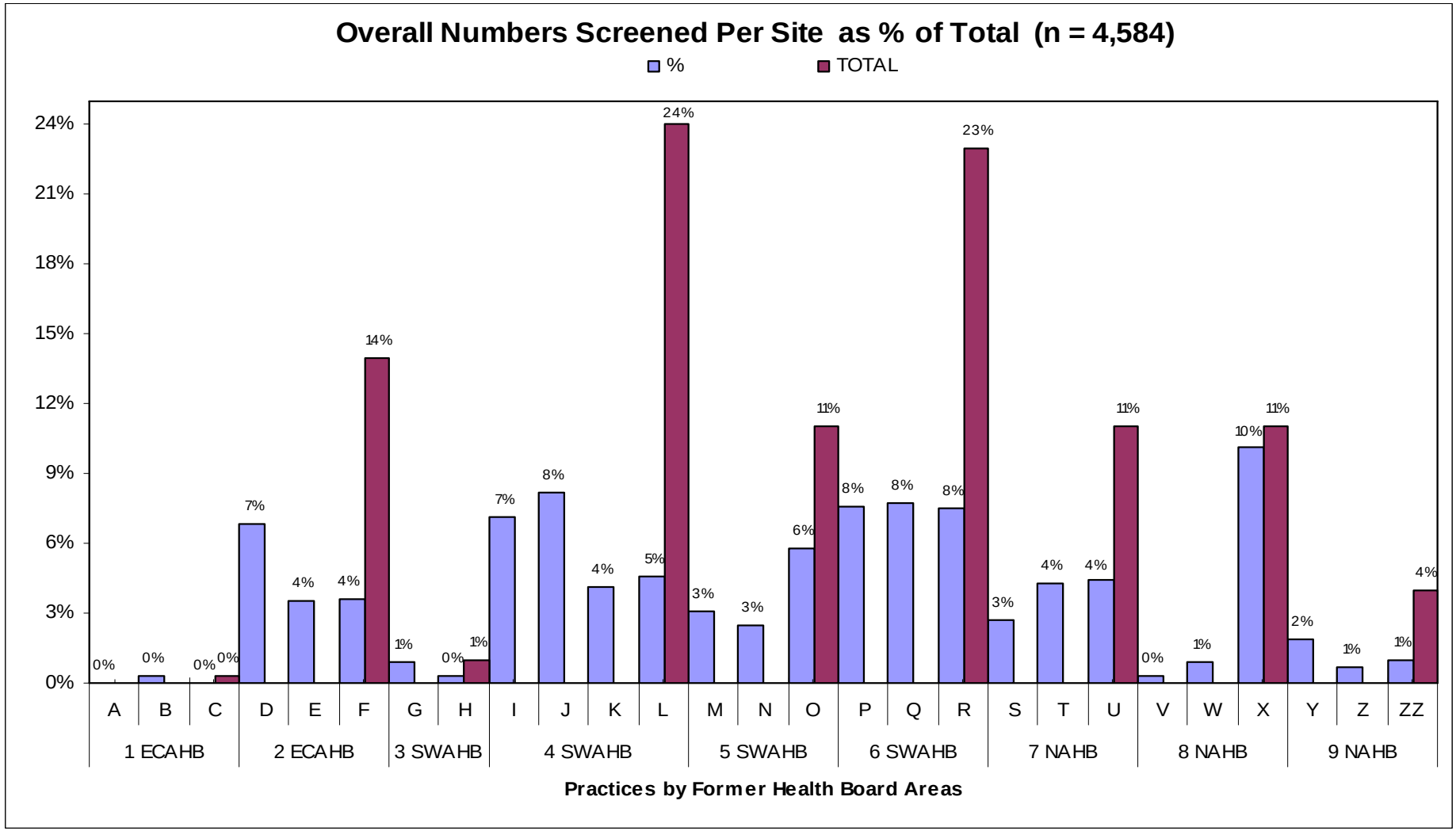
4.1 Results from Practice Screenings and Follow-up

The principal screening tool was the AUDIT questionnaire. The AUDIT is considered to be the most appropriate questionnaire for general practice[16]. It takes between two and eight minutes to complete for most patients and is a good way of raising the issue. It gives useful guidelines for drinking problems but clinical judgement remains essential. In consultation with our international colleagues, we chose a score of seven and eight for females and males respectively, as the main cut-off points. We used 7/8 -13 inclusive as likely indication of 'hazardous' drinking, 14 – 19 inclusive as an indication of 'harmful' drinking and 20 or over as probable 'dependence'. However, we gave the staff leeway to include their own clinical judgement if patients were on or close to borderline cut off points. They were also asked to record patients' weekly alcohol consumption. The staff used the 'consumption arrow' as another guide to help assign patients to the various risk categories. We also asked all screening staff to ask about binge drinking as the AUDIT is not as sensitive for binge drinking.

4.1.1 Initial Screening Data

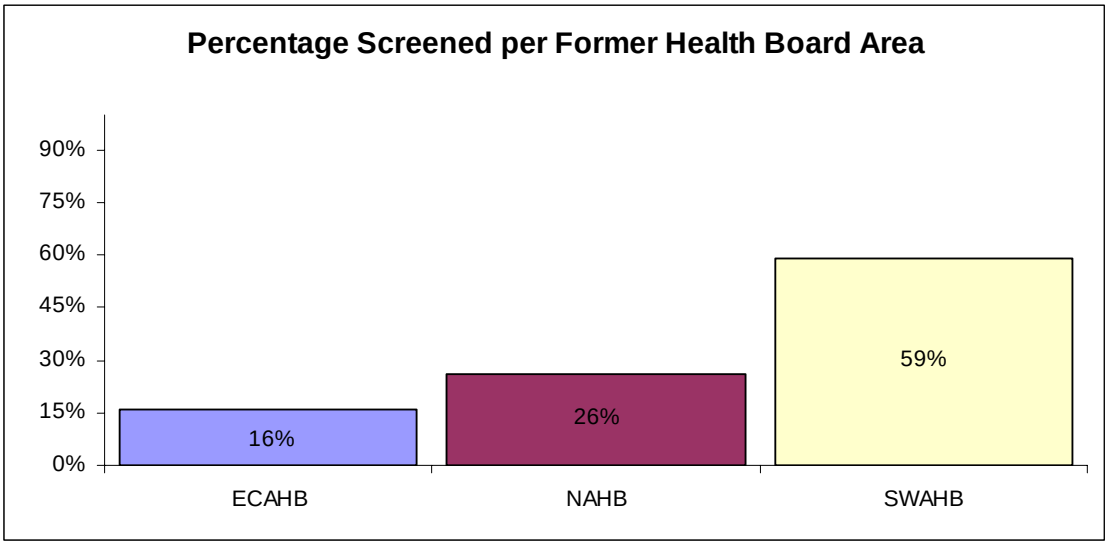
Overall 4,718 Patients were included on the initial screening results form. After 'cleaning' due to human error and repetition, a total of 4,584 patients were screened.

Figure 1.



Comments: As can be seen in Figure 1, there was a wide variety in the numbers screened across the nine sites and by individual doctors. In fact only two practices reached the original target and one other doctor exceeded the target. Most returned satcisfactory numbers and some returned little or no results.

Figure 2.



Comments: Over half of all screenings took place in the (former) South Western Area Health Board Area which provided most of the funding and had more sites including one site which also participated in the original pilot study.

Figure 3.

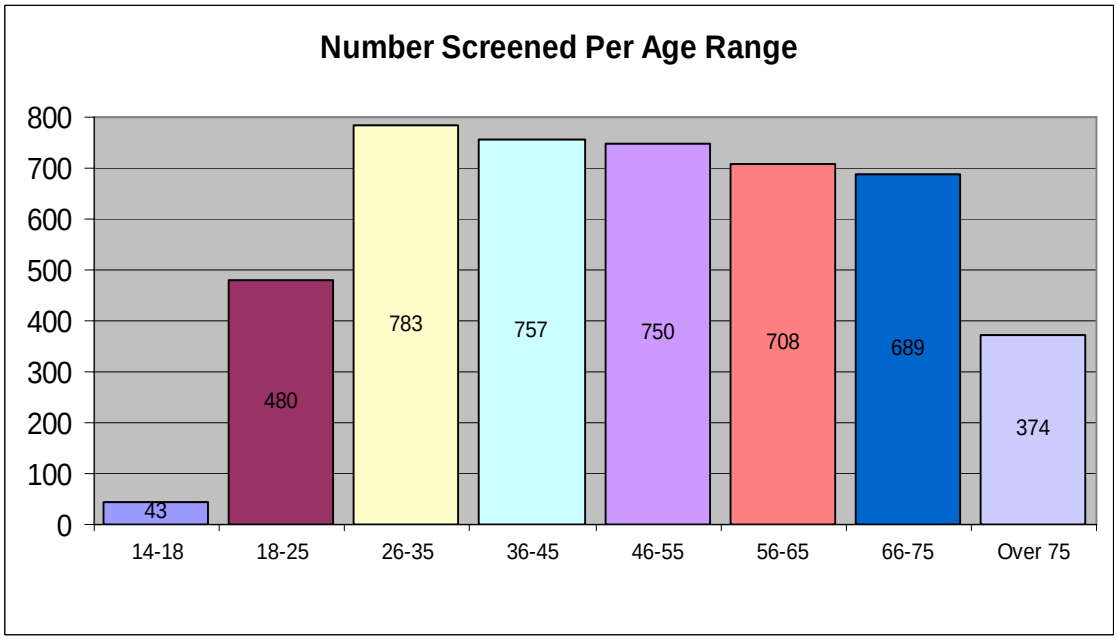
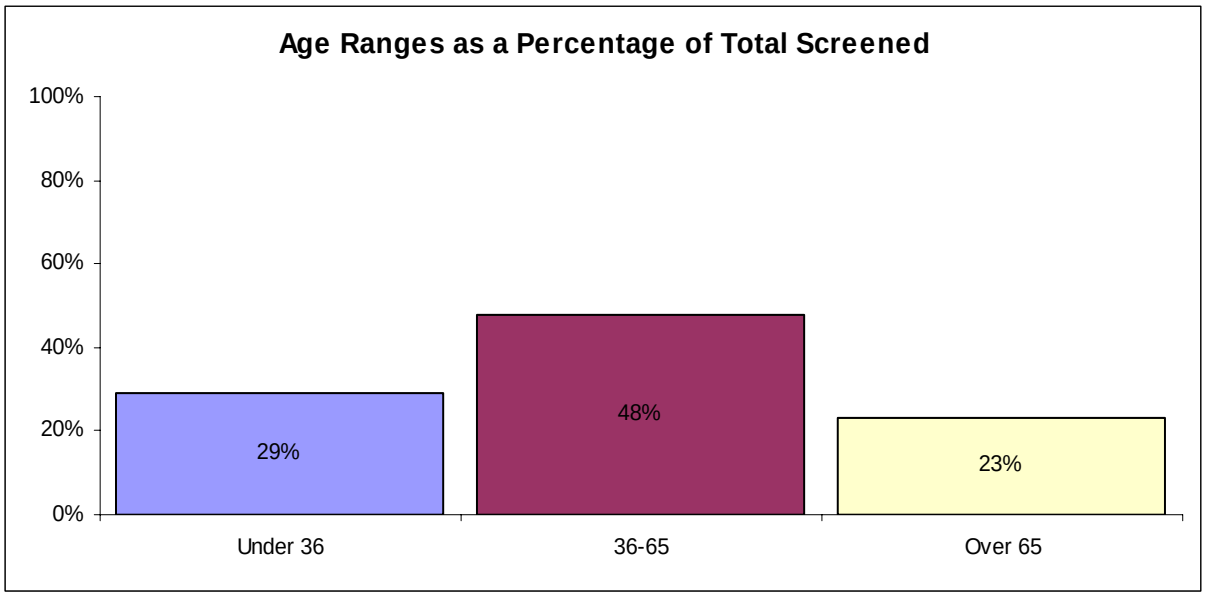
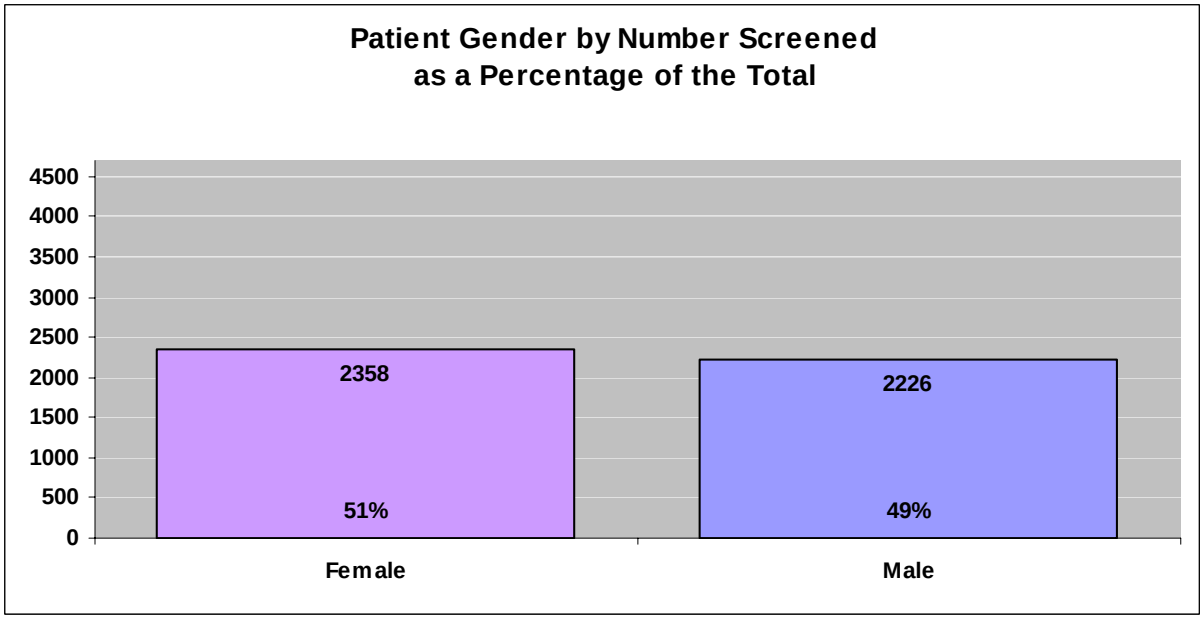


Figure 4.



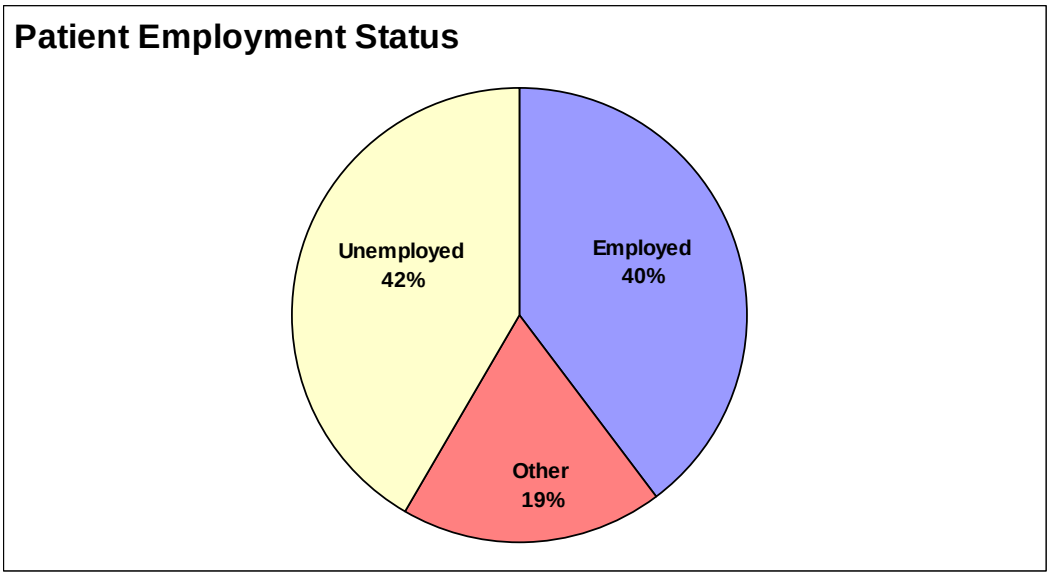
Comments: Looking at 10-year age groupings (Figure 3), the largest number of patients was in the 26-35 year group. When regrouped, we see that almost 50% of patients screened were aged 36-65 years (Figure 4). Patients were older (23% - over 65) when compared to national data (16%, nationally of those aged over 15) though comparisons are not easy due to different age groupings and age exclusion in this initiative[17].

Figure 5.



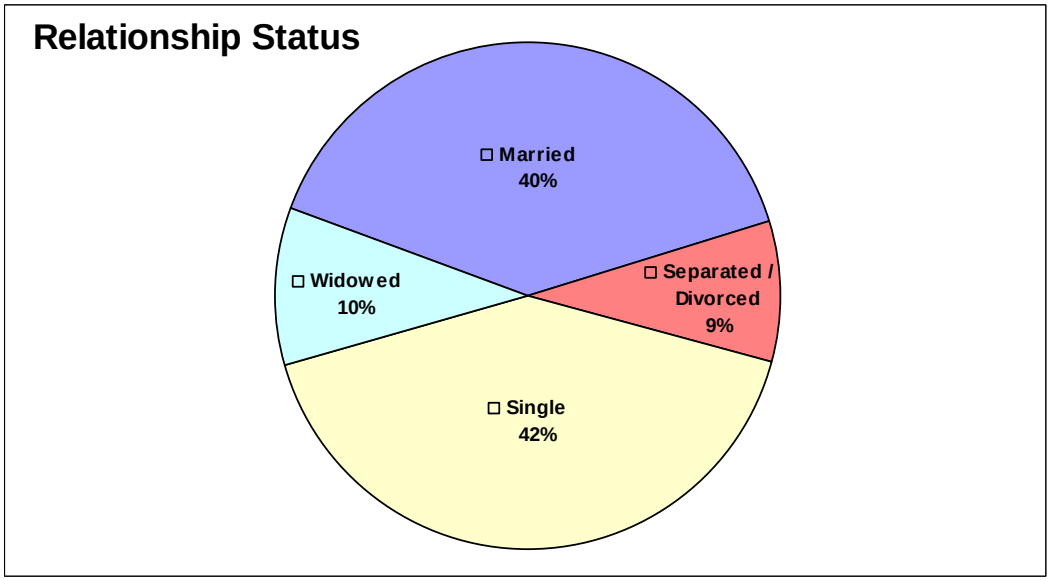
Comments: Similar numbers of males and females were screened. This is representative in terms of national population data; 49% male[18].

Figure 6.



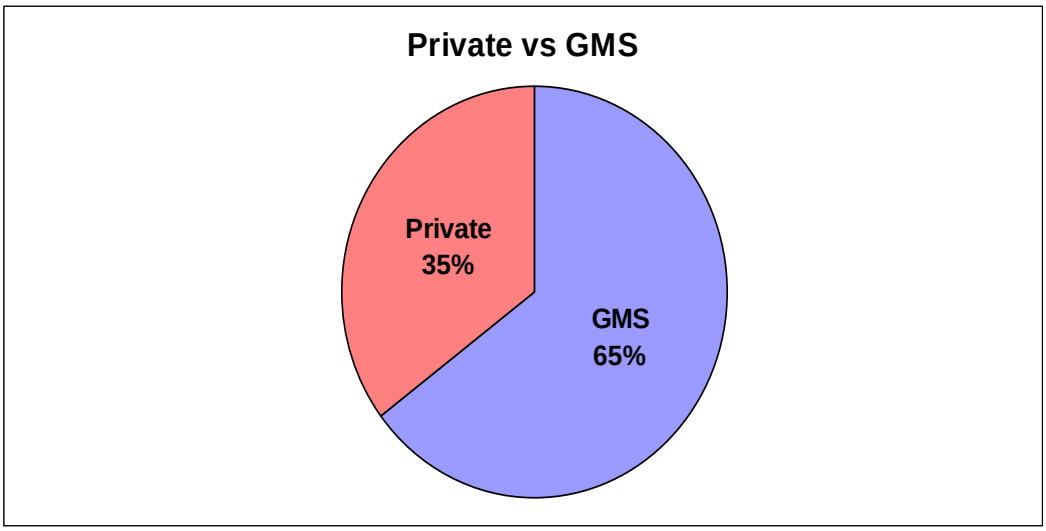
Comments: The employed/unemployed ratio was almost equal. 'Other' accounted for patients, who were students, engaged full-time in home duties, on employment schemes etc. There are a lower proportion of employed patients (40%) in this initiative compared to national statistics (67%). See comments under Figure 8[19].

Figure 7.



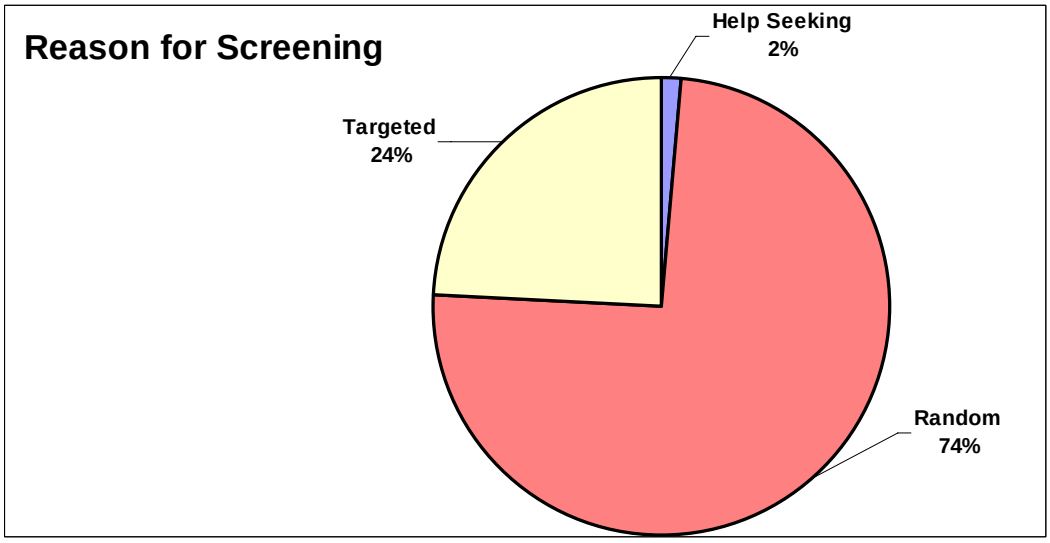
Comments: The breakdown of patients by maritial status shows that three out of five of those screened were currently not married. This is representative in terms of national population data; 42% single[20].

Figure 8.



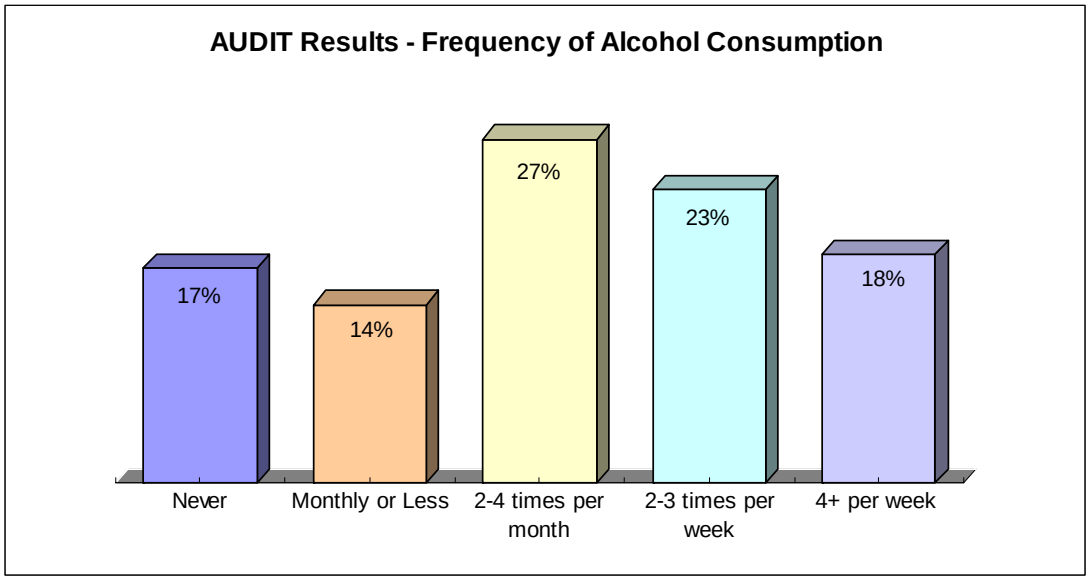
Comments: A greater proportion of those screened were GMS patients (65%) compared to the national population (35%)[21] however, this was an element of the study design with the service being provided free of charge so that general medical card holders (GMS) could mostly benefit.

Figure 9.



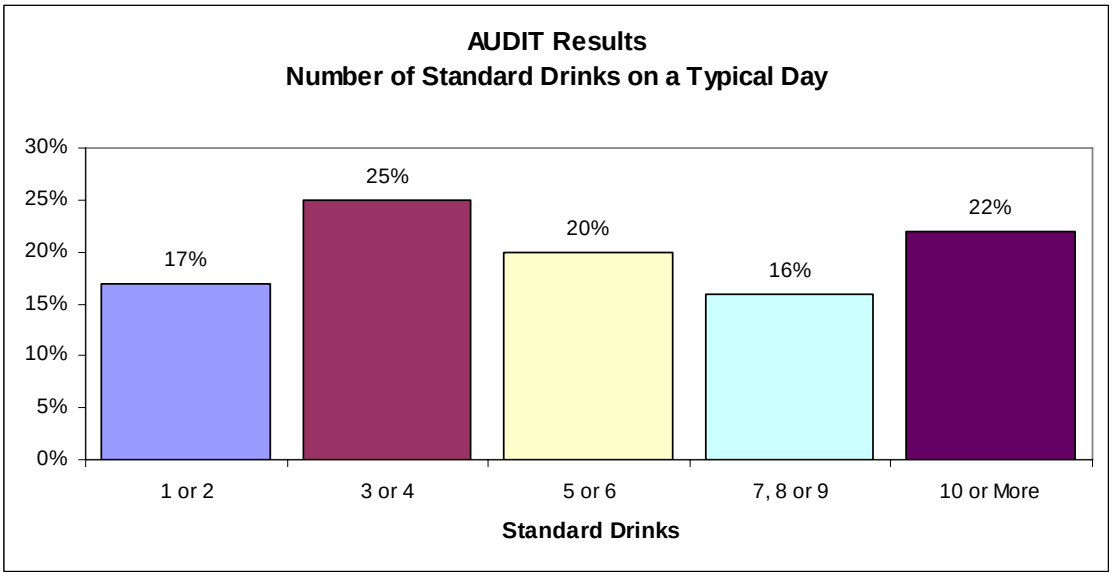
Comments: Figure 9 indicates the breakdown of patients by screening methods. Almost three-quarters of patients in the programme were 'randomly' screened while almost one-quarter were 'targeted'. As expected in a short initiative few patients came forward to seek help (though see comments in counsellors results section 4.2). If the initiative was to continue for longer and patients got to know of the service the numbers in the help-seeking group would be expected to increase.

Figure 10.



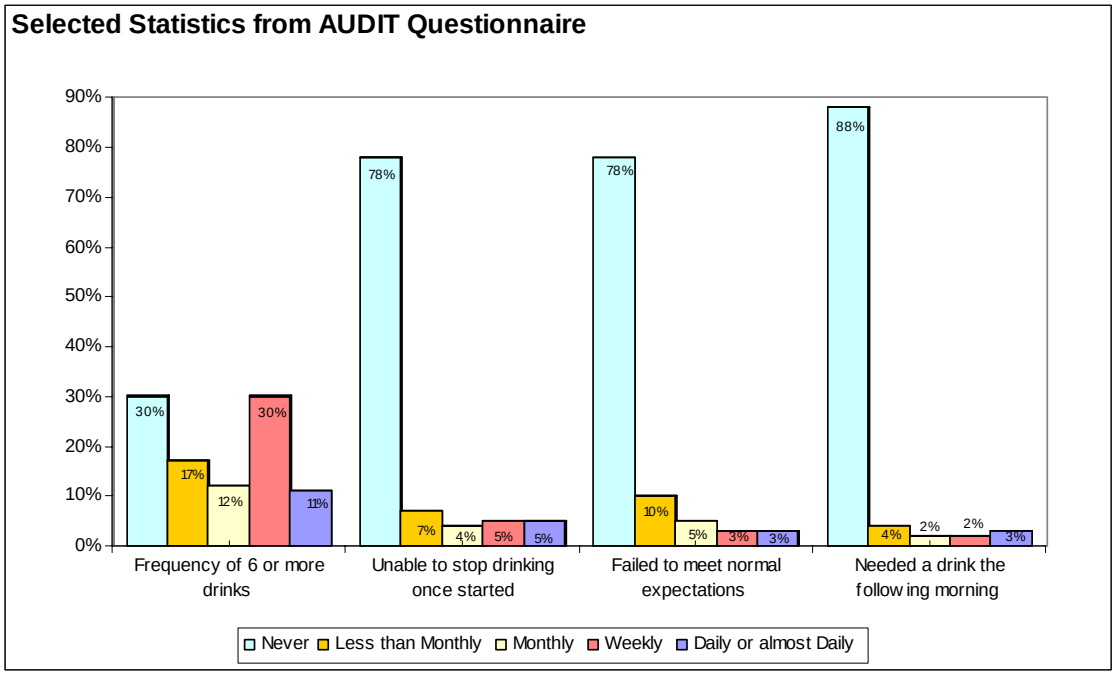
Comments: Figure 10 shows the frequency of consumption by patients in the programme – only 17% of patients never drink alcohol while 18% drink alcohol four or more times per week. The 'never' category is similar to the Slan findings for the Dublin region (15-17% across the three former health board regions)[22].

Figure 11.



Comments: Figure 11 shows the number of drinks per day for those who consume alcohol and reveal that 38% of patients were consuming seven or more standard drinks on a typical day.

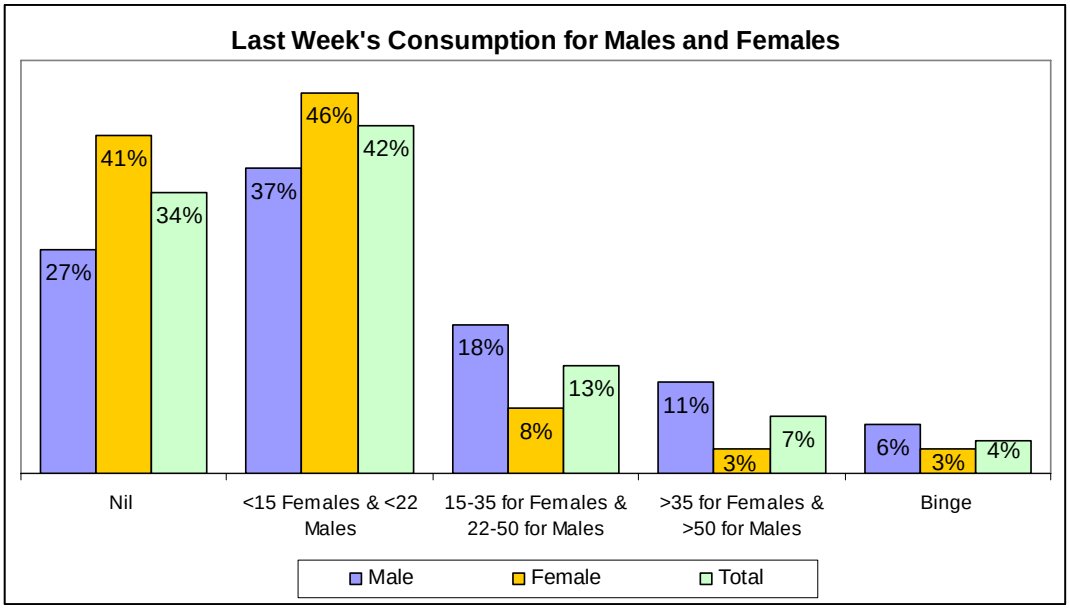
Figure 12.



Comments: The above figure includes selected data on those who consume alcohol, namely, the frequency of consumption of six or more drinks and some signs of alcohol disorders (loss of control, failure to meet expectations and 'early' morning drinking). Some of these questions were considered to be obtrusive by doctors/nurses and patients, particularly for those patients who clearly had no major problem with alcohol. One in ten respondents had a daily consumption of six of more drinks and 3% drank in the morning; on a weekly basis 10% were unable to stop drinking once started and 6% were unabe to meet normal expections.

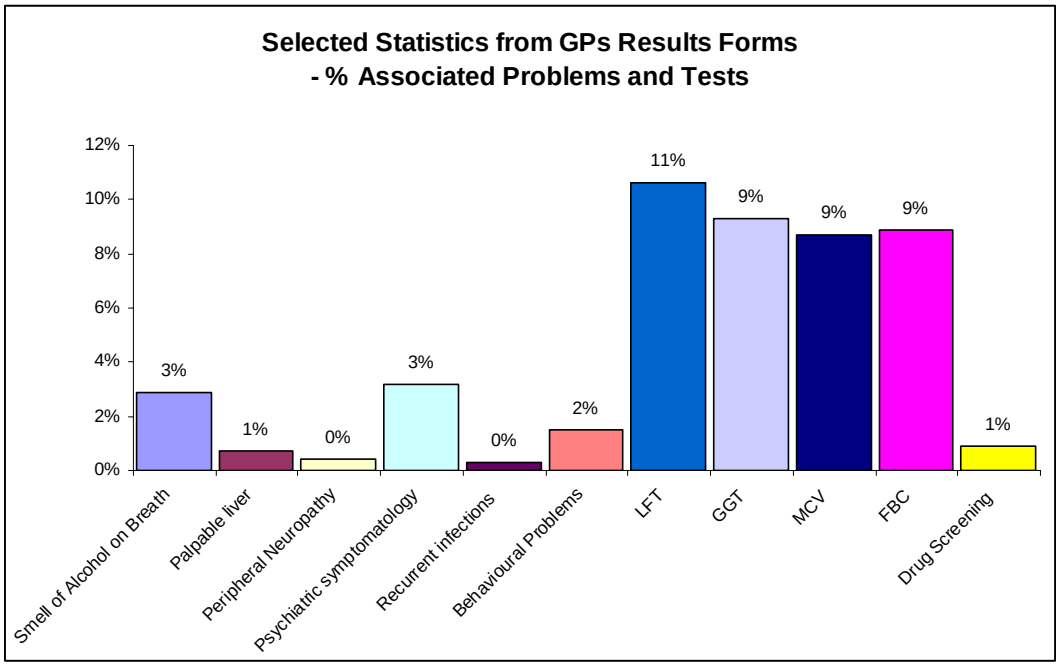
Other results obtained included 'Remorse/Guilt after drinking'; 14%, at least monthly, of those screened, 'Memory loss'; 13%, at least monthly, of those screened, 'Injury to oneself or others'; 6%, yes (in last year), 10%, yes (but not in the last year), of those screened and 'Concern expressed by relatives/other Health Professionals'; 19%, yes (in last year), 10% yes (but not in last year) of those screened.

Figure 13.



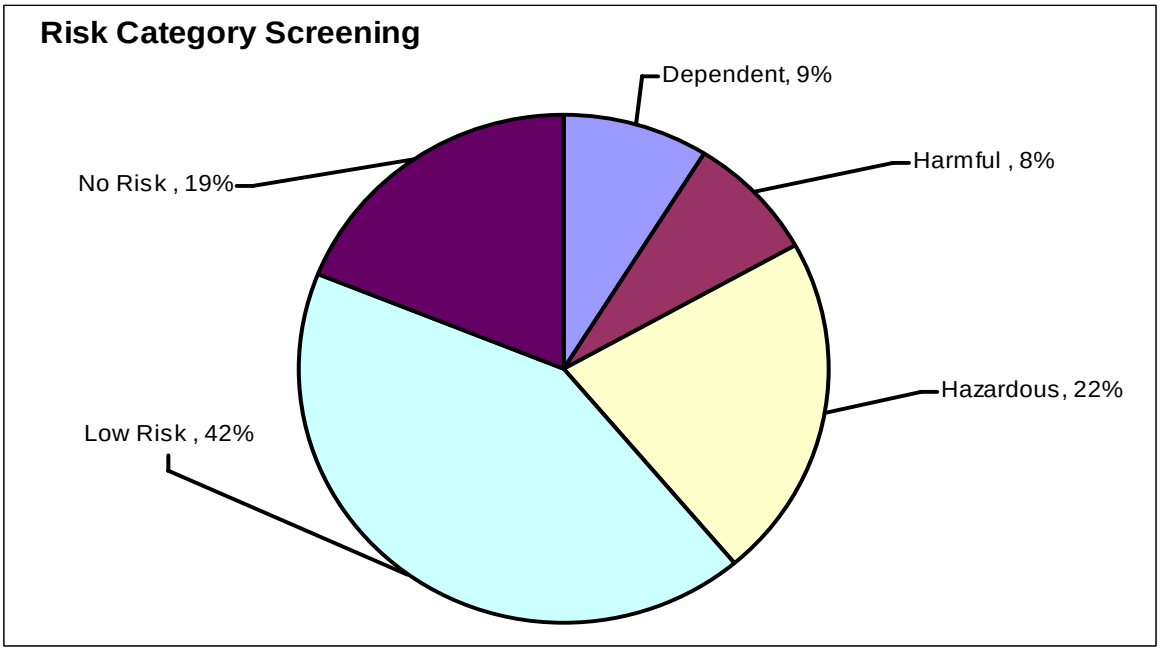
Comments: Another measure of problem drinking is the amount of alcohol consumed in the previous week. This is based on the consumption arrow and reveals as a general rule low risk, hazardous, and harmful and drinkers. Although a regular pattern would need to be established, the results indicate that 37% of the males screened and 46% of the females screened were in the low risk zone while 11% of males and 3% of females were in the harmful zone using these criteria. Note that 27% of males and 41% of females consumed nothing in the previous week when questioned. The figures for binge drinking are included but it was rarely noted on the results form.

Figure 14.



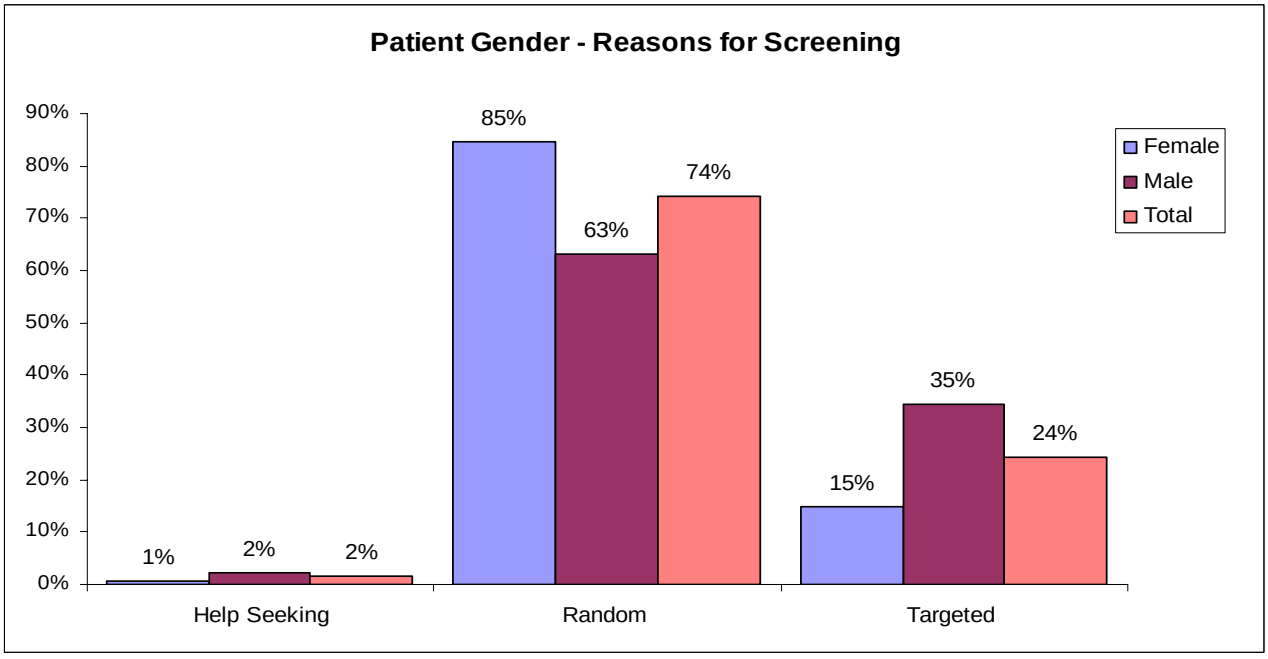
Comments: The above table gives an indication of the percentages of patients who had various symptoms and/or tests performed as a result of screening. Liver Function Tests were ordered for 11% of the total of patients screened; only 1% underwent a drug screening. Three percent of those screened had a smell of alcohol off their breath at the time of screening.

Figure 15.



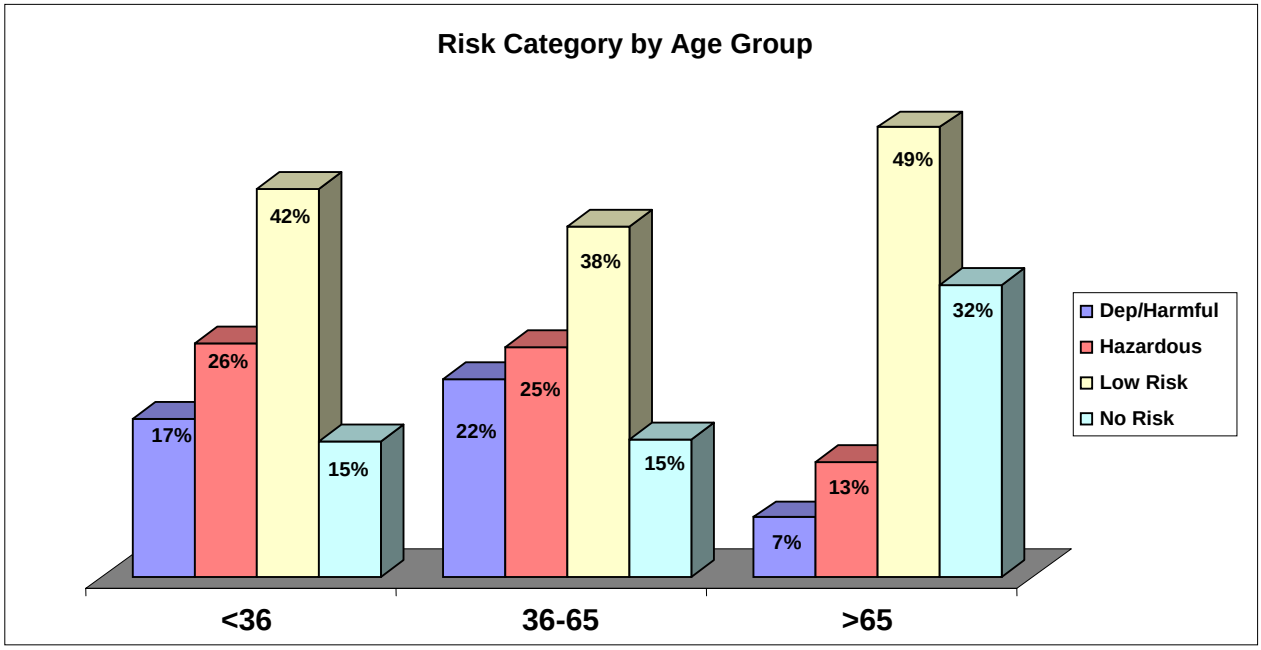
Comments: Using primarily the AUDIT questionnaire but also considering consumption charts and clinical judgement, the GPs were asked to allocate the patients to a risk category. The results indicate that 61% of the general practice population were in the no/low risk category, 22% in the hazardous drinking zone and 17% harmful/dependent. This is an increase on the results from the 2002/2003 study and may be due to changed patterns and a slightly lower cut-off point for hazardous drinking.

Figure 16.



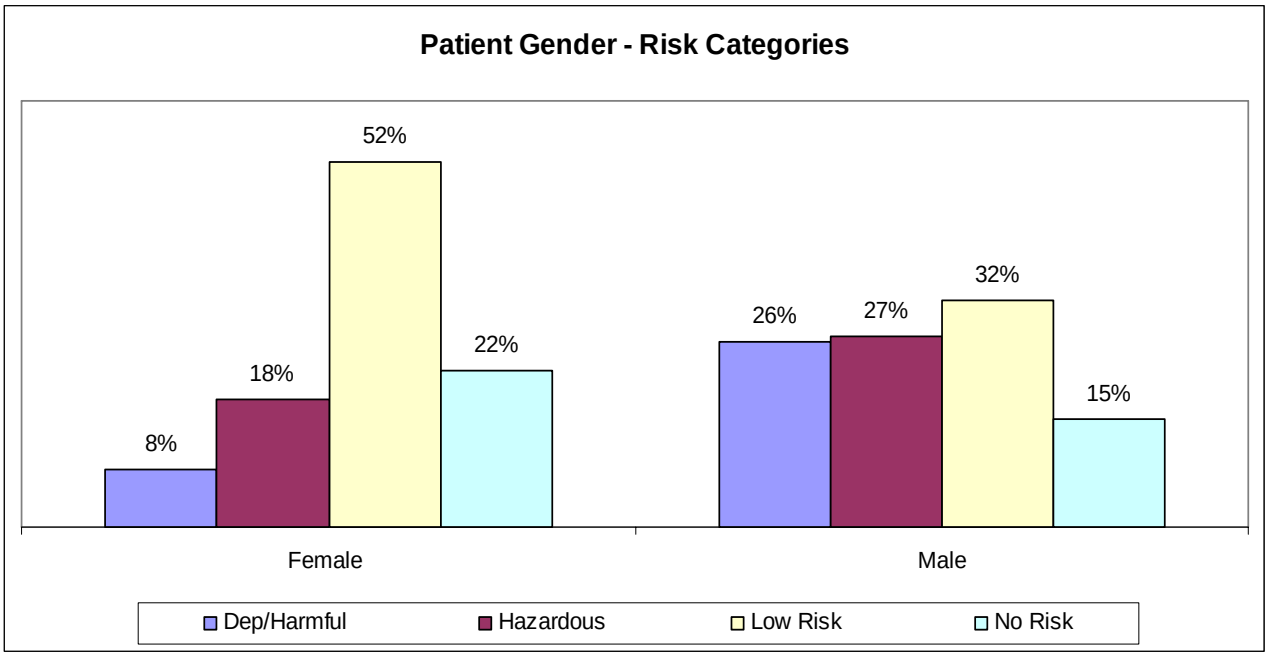
Comments: Figure 5 showed approximately equivalent proportions of males and females in the study, however, Figure 16 indicates that the screening inclusion method was significantly different ($p<0.05$) - 15% of females were 'targeted' compared to 35% of males. However (as noted in Figure 18), this was taken into account when comparing risk category status between males and females.

Figure 17.



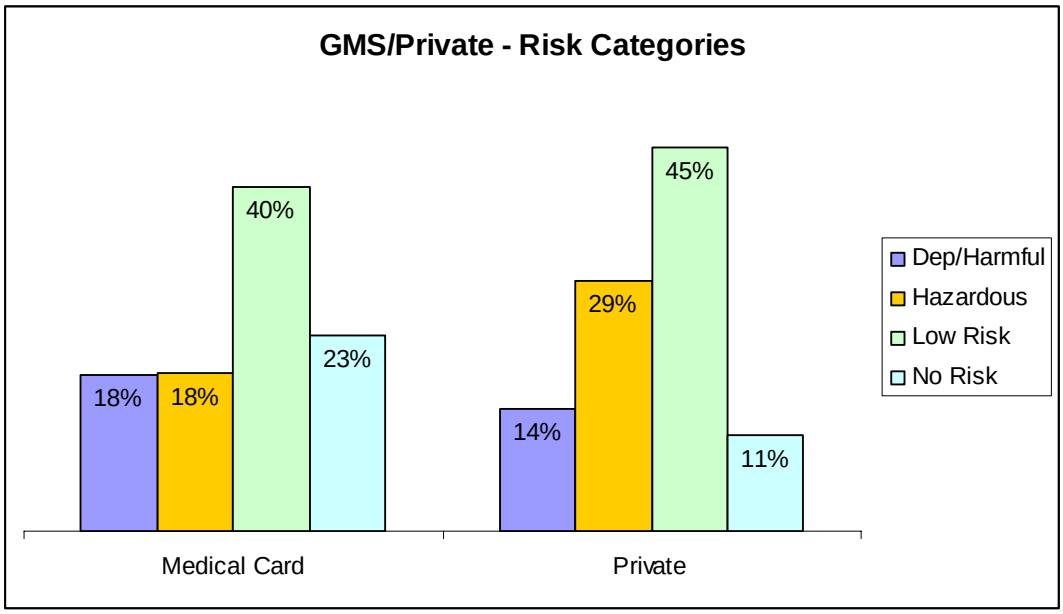
Comments: Figure 17 shows the risk category breakdown for each age group. There is a significant relationship between age group and risk category ($p<0.01$). The proportion of dependent/harmful and hazardous drinkers is substantially higher in those < 66 years, and although the proportion for these is similar in the two younger groups, of note is the slightly higher proportion of those in the dependent/harmful group in those aged 36-65 years compared to those aged < 36 years.

Figure 18.



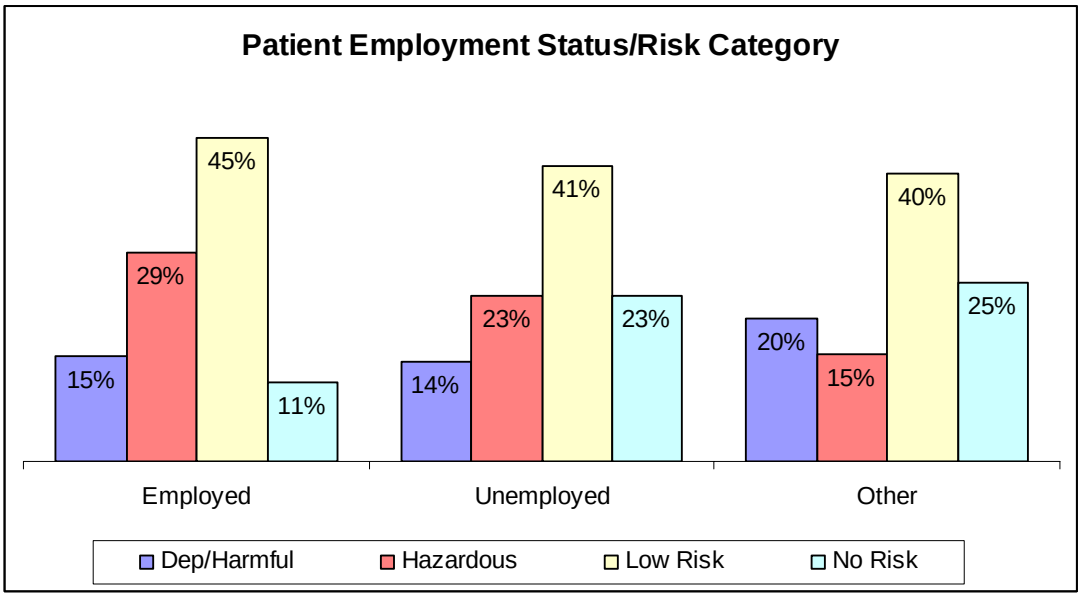
Comments: There is a significant relationship between risk category and gender ($p<0.01$) with a higher proportion of males in the harmful/dependent and hazardous categories, compared to females. A further analysis shows that this difference remains when screening reason (random or not) was controlled for.

Figure 19.



Comments: Overall, significantly ($p<0.01$) more non-medical card holders are in the higher risk categories compared to medical card holders.

Figure 20.



Comments: There is as significant relationship ($p<0.01$) between risk category and employment status with a higher proportion of the unemployed in the dependent/harmful category.

4.1.2 Follow-up Data

Follow-up data was recorded on 408 patients. Of these, 111 were not formally followed up due to the following; 39, refused, 31 could not be contacted, 31, other. However, there was confusion over who should be followed-up and in some cases referral to the counsellor constituted a follow-up. In such instances, the doctor did not believe he/she needed to follow-up the patient also. That written, the total number of patients who were followed up by the practices amounted to 297. The number that could have been followed up from the initial screening was as follows: 412 dependent, 366 harmful and 1,008 hazardous - a total of 1,786. However, large numbers in the hazardous group would have been given simple advice by the practice staff, as opposed to follow up, as per the instructions at training. Only a tiny percentage, (2%) was followed up from the low risk category at the original screening.

Figure 21.

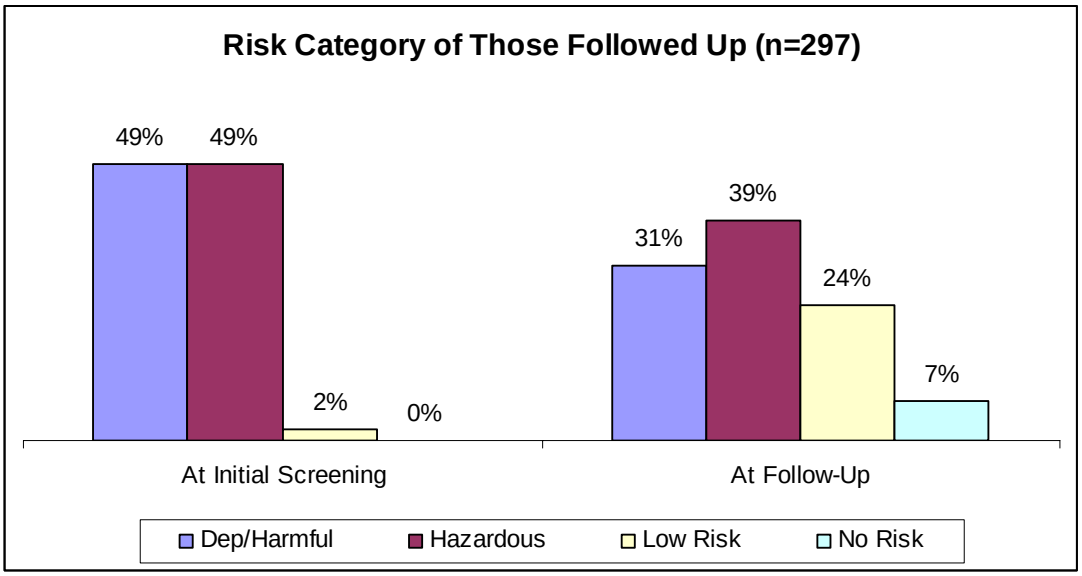
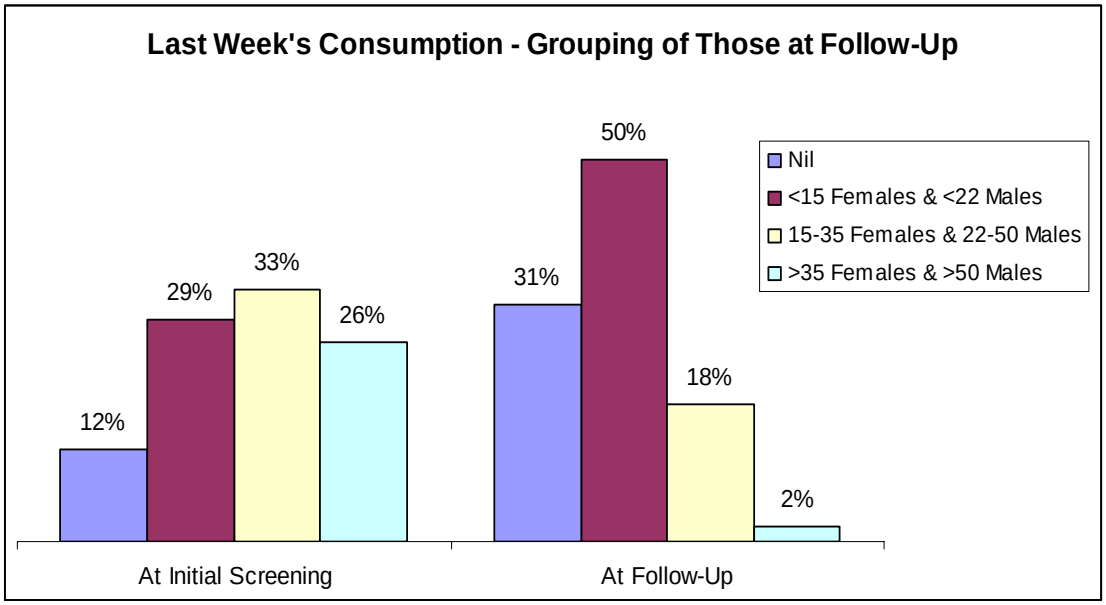
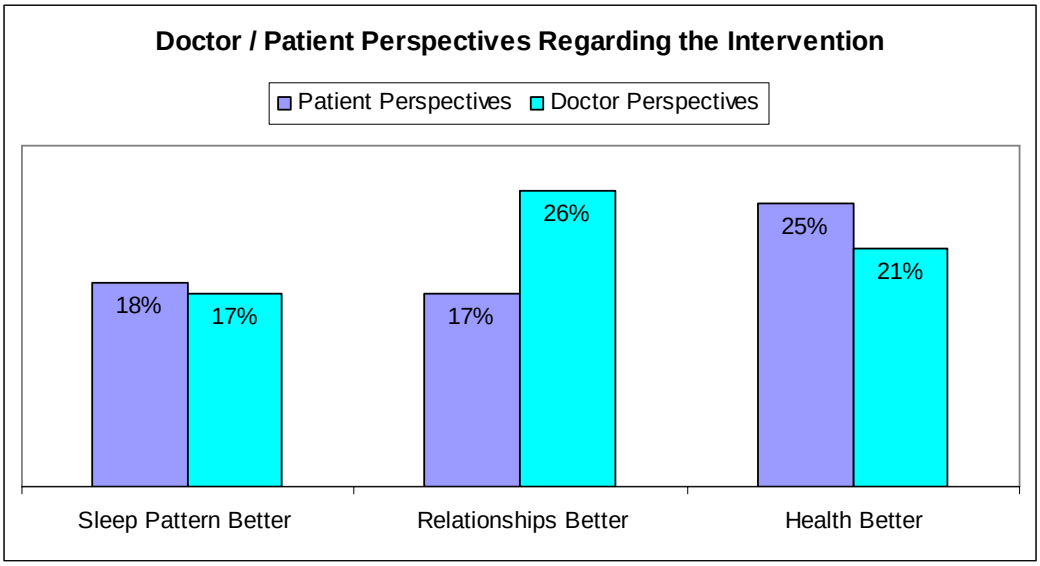


Figure 22.



Comments: Figures 21 and 22 compares the risk category and previous week consumption at initial screening and at the follow up visit of patients who were followed up by practice staff. The results show a notable and significant improvement overall with fewer of those participants now in the higher risk groups.

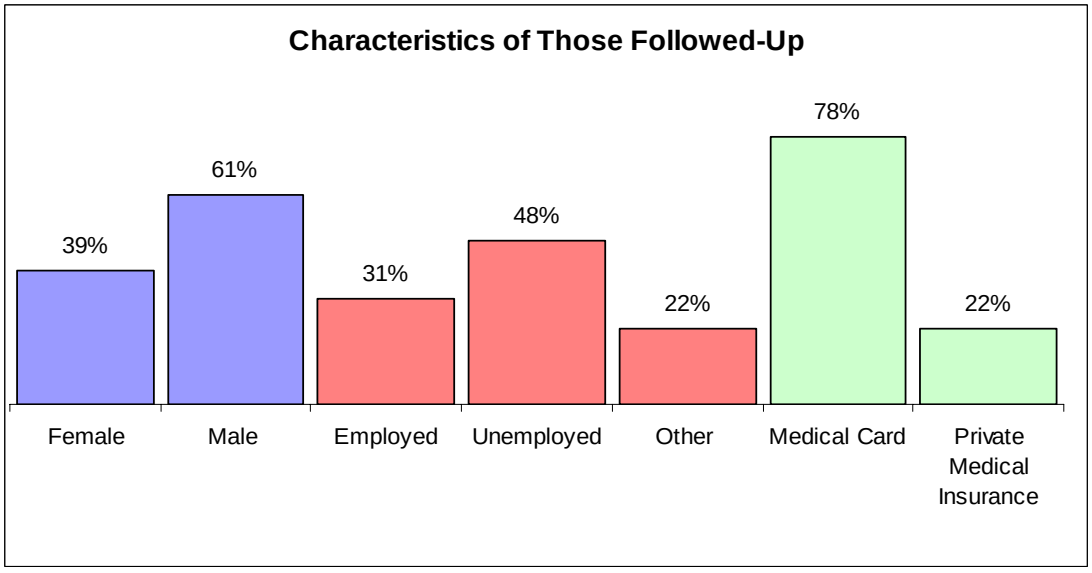
Figure 23.



Comments: This is perhaps the most important result of the initiative. Both patients and doctors/practice nurses were remarkably agreed on the improvements using selected subjective measurements as above. Please note however, this is only three months approximately after the screening and of course only refers to those screened and followed-up.

A central finding from a detailed investigation of the results indicates that while approximately 12% of patients were worse on follow-up, 50% approximately showed some improvement being in a lower risk category at follow-up. This was also reflected on analysis of the answers to the first three questions of the AUDIT questionnaire which were repeated at the follow-up sessions and shows similar improvements with regard to alcohol intake.

Figure 24.



Comments: Figure 24 gives some of the patient characteristics of those who were followed up. The profile of those who followed up was predominantly male, unemployed and a medical card holder.

A comparison with the profile of those originally screened shows that the male/female discrepancy here can be explained by the proportions of males/females in the higher risk groups at screening. However, this is not true with regard to employment and medical card status and hence the tendency to follow-up those unemployed and medical card holders would appear not to be solely based on risk factor profile.

Please see Appendix 8 for important comments made by the practice staff in free text re the patients who were due to follow-up. There is a wide variety of selected comments which reveal the panoply of attitudes and issue in this population in primary care.

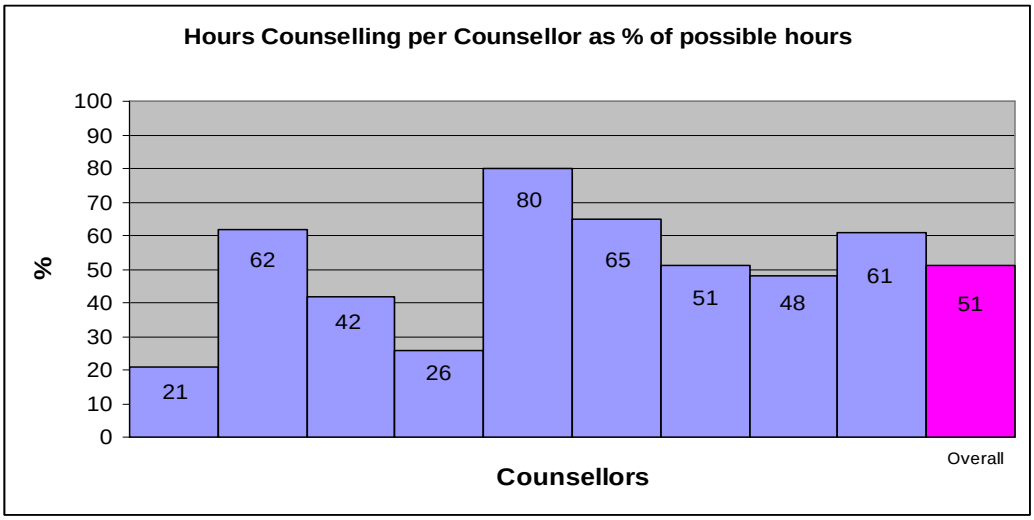
4.2 Analysis of Counsellor Statistics and Commentary

There were a total of eight Counsellors involved in this initiative, seven of whom were actively involved in the end as one of the counsellors was on sick leave. That counsellor was replaced by another counsellor, as a locum, who was already working in another practice on this initiative. Two counsellors covered two sites each. There was a wide variation across the practices in terms of numbers of patients referred to the counsellor as well as the number of patients seen by the counsellor. In most cases the numbers of patients seen by the counsellor reflected the degree to which the target number of screenings had taken place. In other words, the more patients screened by the primary care staff, the more patients were seen by the counsellors. However two of the sites did not reflect this trend. In these two sites it was clear that although the screening numbers were well below target the counsellor was working at almost full capacity. In one case this was due to the familiarity with the whole process and in the other it probably reflects the GPs' desire to get involved in the project to help patients. In the latter situation, they could not manage the recording aspects due to technical problems (IT and level of organisation), personnel issues and motivational factors (for example, one GP got involved to make up a site and he told the co-ordinator that his late arrival into the process meant he was less than sufficiently motivated).

All of the counsellors reported that they were well received and well integrated very early on in the process. They were considered to be part of the team. The counsellors and the GPs repeatedly said that they learned a great deal about each others roles. Many of the GPs for example were amazed to discover the depth of personal information exchanged by the patient with the counsellor and on the other hand the counsellors realised the importance of medical aspects in helping patients. The experience in Baltinglass during the original AAP study showed that the real benefits to the community came after the counsellor was embedded for some time.

In all, 657 patients were referred to the counsellors on site in all of the practices. Of these, 448 were actually seen. This is consistent with the statistics supplied by the practices, as 778 patients were screened in the Harmful/Dependent categories. The majority of patients seen by counsellors were in these categories.
The counsellors were allocated to the sites and expected to spend six hours per week in counselling. The estimated times available for counselling were worked out as follows**:** 52 weeks x 6 hours (minus holidays) = 46 x 6 = 276 based on six hours per week per site (except Baltinglass – 4 hours per week = 46 x 4 = 184). This does not take illness into account or other work such as attendances at meetings within the practice and at ICGP, discussions with practice staff, phone calls, report writing etc.

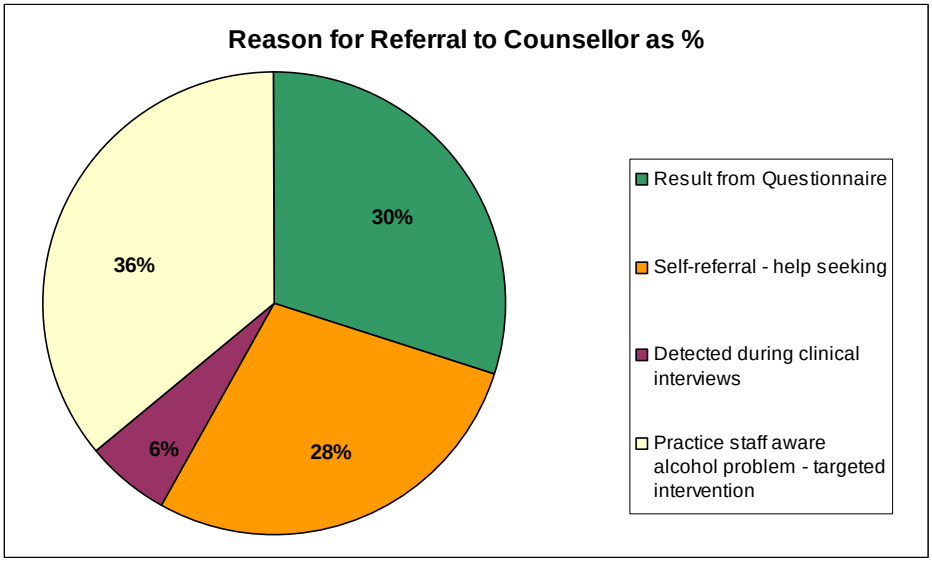
Figure 25.



Comments: Figure 25 shows that overall, roughly half of the counsellors' time was spent in direct counselling but this is estimated. It is based on the returns provided by the counsellor and indicates quite a high percentage of 'no shows'. One of the counsellors did an analysis of the "no shows". As anticipated, the rate of no shows is reduced if the patient can be engaged in the process in the first instant. "Attendance by those who accepted a third appointment or more increased to 69%". He goes on to add "given that the clients were ….. (in many cases) identified at random the average attendance of 55% for the first appointment is very good". The figures across the

board indicated that when a patient recognises that he/she has an alcohol problem attendance figures go up. The ability of the GP/practice nurse to motivate the patient to attend the counselling appears to be crucial. However, the above chart also indicates that some of the practices were not doing much screening and in some cases therefore had few patients to refer. The counsellors' statistics revealed that a larger number of patients were referred to them than reported by practice staff and this was due to the lack of recording in some practices. It also should be noted that when small numbers of patients were referred in some sites – more time was usually spent by counsellors with each client. The average number of sessions per counsellor was three per patient but there was a large variation in the numbers of sessions. One of the patients had 20 sessions for example. The age range of the patients was 14 – 88, according to the counsellors. More male patients attended than females, which is consistent with the AUDIT results with regard to the higher risk categories.

Figure 26.



Comments The above chart indicates the counsellors' perception of how patients were referred and is estimated. Of particular note is the counsellors' perception that a larger percentage attended because they were 'help-seeking' as opposed to the statistics provided by the practices. Note the large number of targeted patients referred to the counsellors.

Approximately 15% overall of patients seen by the counsellors had other addictions mostly hash, ecstasy, heroin, cocaine, prescribed medication – benzodiazepines, non-prescription medication. Small percentages were also on methadone maintenance. The counsellors also reported that 10% of referrals were depressed, of which 5% were considered to be suicidal. Other psychiatric type disorders mentioned in Counsellor Reports on counsellor reports included anxiety, agoraphobia and other phobias, eating disorders, coping with suicide in family, bi-polar, OCD, schizophrenia. A small but significant number of child sexual abuse cases in the past were also reported. The counsellors mentioned a range of physical problems and amongst the conditions listed were epilepsy, hypertension, arthritis, hep. C, HIV, cirrhosis, STI, and haemachromatosis.

The range of social problems affecting patients included domestic violence, loneliness, illiteracy, separation, and bereavement.

About 10% had previous treatment in some facility.

The resources used to help patients were predominantly Alcoholics Anonymous but also Al-Anon, Specialist Addiction Services, M.A.B.S. (Money Advice and Budgeting Services). The outcomes as reported by the counsellors are most encouraging.

As stated, there is a high level of emotional and psychiatric pathology in the patients that were seen during this initiative. Patients who would otherwise probably not be seen in any intervention setting, presented with extremely difficult personal circumstances including separation, physical violence, sexual abuse, depression, suicidal attempts, other forms of self harm and financial difficulties.

There were high rates of 'No shows' to the counsellors and this was a consistent finding. When the patient was engaged in counselling, as in turning up for the first appointment, the rate of no shows dropped dramatically. All of the practices developed ways of reducing no shows during the year, for example, some of the practices would text or ring the patient the day before to remind them to attend. These methods also served to improve attendance rates. As a result of the overall no show rates, the counsellors were probably under-utilised to some extent. Interestingly, the no show rate was much reduced in the practice which had a counsellor for the previous two and a half years which probably indicates the benefits of established teamwork and familiarity. Good working relationships and communication in a well bedded-in service would seem to improve the no show rate.

The practices were universal in their approval of the counsellor aspect of the initiative and were very satisfied with the service.

"Delighted with the Counsellor" – "A great resource, the team work is wonderful".

One of the GPs said at the time of the final practice visit: "Its a huge benefit to have family members looked after" but in fact there were relatively low numbers of family members (concerned persons) seen by the counsellors. It would seem that again the more bedded-in the service becomes the more family members will come forward and trust the service. It was also clear that those family members who were seen derived enormous benefit from the service. It is likely that primary care staff need more training regarding family members and more encouragement to refer them to counsellors.

The feedback received from patients clearly demonstrates that patients too were delighted with this seamless referral to a skilled professional on the site of their trusted family doctor.

A patient wrote to the Project Director via one of the counsellors. Herewith are excerpts from her letter: "I became aware of the (AAPS) --- through a notice posted in my GP's office --- I was losing a long battle against drink and desperate for help. The availability of the service free was definitely an answer to my prayers as I couldn't afford private counselling. I responded to the offer of help on the notice ---she has helped steer me through a pretty tough time in my life. I thank God for my sobriety daily --- as the pilot comes to an end I want to state that my participation in it has had an extremely positive impact on my life in a very short space of time. – I end this with appreciation and thanks to my counsellor and best wishes for the future to all those involved in providing the (AAPS)".

The benefits of cutting back are demonstrated by another letter this time from a counsellor. He said: "When he (the patient) arrived he was very down indeed and had gaunt features, unkempt hair and tatty clothes – he related how some days he didn't eat or clean himself and he had virtually become a recluse. --- I never once asked him to stop drinking and in the fourth session ---- he did remark how he had cut back on it -- the first helpful note was that his sleeping had improved -- (later on) -- he became appreciative for the support while admitting embarrassment for 'fouling up' – gradually a nice pattern of sleep returned, helped in no small measure by the reduction in his alcohol intake to a point where he finished with alcohol completely for a few weeks while also laying aside the dope -- (later on) – he revisited his family and was offered a job".

Another counsellor wrote a piece about the whole initiative that will probably be published elsewhere. The importance of team work and backing up the generalist with expert help is emphasised. Here are some of her insightful comments: "Counselling in primary care settings in Ireland is a new (ad)venture – in conjunction with primary presentation (the range of alcohol problems) the underlying issues presented by the clients could while multifarious be deemed almost generic in content. --- it became quickly obvious that the plethora of presentations demanded a level of therapeutic expertise not always possible to administer in brief interventions. Nevertheless positive outcome was achieved in many instances – not always in consumption reduction. -- On the subject of awareness, it has been exciting to watch the growth and maturing of same in GPs. ---Regardless of what the research outcome may be, the project was a success --- it has highlighted a specific need at primary care level; it has also accentuated the ability to adapt at multidisciplinary level ---- where the client is concerned no one size fits all. The Pandora's box has been opened and long may it remain so!"

The counsellors reported that one third of the patients they had seen, by the end of the initiative, were maintaining abstinence and another third showed some improvement.

A measure of this success is that at least two of the practices have retained the counsellor for a further year through various funding initiatives. Most of the others said that they would like to retain the counsellor but could not get funding. As a direct result of the initiative in Baltinglass a local counselling service has been set up that will serve all of the general practices in the area.

4.3 Summary and Further Comments

Altogether 4,584 patients were screened. The results give us another snap shot of the range of alcohol problems that present in GP surgeries in Ireland. This was only the second time that a systematic attempt to screen a GP population has been attempted and we have a great deal of data that will help to direct future studies. This was predominantly a **service** initiative and the emphasis was on the benefits to patients and their families. The statistical aspect of this initiative was always of secondary importance. Nevertheless, valuable lessons have been learned regarding both the service initiative aspect and the recording/data analysis aspects. Although the target for numbers screened by the practices appeared to be modest they proved to be very difficult to achieve and only two practices managed to reach the agreed target as well as some individual GPs. The recording forms were too detailed in retrospect and the method of providing the data via the website, although seeming to be a great idea at the start, proved too cumbersome for most of the GPs. General practice has so many demands on time that we need to ensure the good will that is in operation for such initiatives is maintained by making the whole thing easier to manage and to administer. Questions have to be raised as to the true random aspect of the screening. If, as suspected, the screening of random patients was not truly random it is probable that alcohol problems are still largely understated in general practice. Finally the follow-up of patients was also too difficult for most of the participants though many of the patients will be followed-up in due course. The three month cut-off for follow-up was too short and was put in place as a result of the short period for the initiative. ***Nevertheless, we can confidently report that one half of patients who attended follow-up made some progress according to the practice staff, while according to the counsellors, of those patients they saw, one third were maintaining abstinence and another third showed some improvement.***

Here follows more specifics on the difficulties and strengths emerging from this service initiative over the year.

Difficulties

Problems with the *Survey Monkey package* (Data collection): Although this method of recording seemed like a great idea and it was relatively low cost, it turned out to be too cumbersome. A number of the practices did not have Broadband internet access and even those that did found it difficult to use. Some of the practice staff were not comfortable filling in the form with the patient and attempts to fill in the results forms later on were very inconvenient.

Personnel and practical problems for some practices: General practice is vulnerable to small changes in circumstances and personnel as it is so dependent on human resources. Several of the practices experienced practical and personal difficulties that unfortunately disrupted the smooth running of this initiative. Personal illness and bereavement, staff leaving and difficulties finding replacements, information technology difficulties and a busy and demanding environment all contributed to targets being unmet in many cases.

Follow-up period too short: A three month follow-up period for patients is not sufficient to monitor change or indeed to determine if change is established or transitory. However, as the length of the service initiative was for one year we needed to try to establish if the interventions were effective hence the 3 month follow-up period. It is important to note that patients will eventually be followed up in primary care at some stage. There is also often a time lag between a patient being given advice and the patient actually taking action in terms of seeking further help. The primary care staff obviously can not insist on change but rather their role is to try to point out where patients *could* make lifestyle changes and advise accordingly.

'Phase two' issues: The practice in Baltinglass informed us that we need a 'phase 2' strategy. The difficulty for them was that they had done a lot of screening of patients in the first few years of their involvement in this initiative and thus were in a unique position vis-à-vis all of the other practices in this current initiative. Early on they suggested that they should be allowed to conduct only targeted interventions and this was agreed. If there are to be future initiatives, consideration will have to be given to this aspect. It is likely that we will recommend that practices that have done substantial screening would move to targeted interventions.

Target numbers set too high: Primary care staff are extraordinarily busy. In addition most of the practices we selected are in busy areas and are involved in lots of other studies. Although ten patients per week as a screening target seemed reasonable at the start, it was clear that it was too big a target for almost all of the practices as time went by and especially at the peak times for illness and attendances at Christmas and in January. Unfortunately, the target numbers for screening also adversely affected the follow-up numbers. The practice staff told us that the screening took longer than expected in many cases. Some of the doctors felt they had to do a lot of preparation talk before introducing the questionnaire and this added considerably to the time it took to complete the screening. This was compounded by I.T. difficulties too.

Disorganisation: The larger the practice, as a general rule, the better the organisation. It was clear that the whole process worked better when a dedicated person was nominated to organise the initiative. Another aspect of disorganisation was from the administration side of things. There was confusion as to the way in which patients should be followed-up. The issue of follow-up was not clarified sufficiently at the training sessions or at the practice visits. Most of the practice staff did not follow-up patients if they were referred to the counsellor on site.

Counsellors under-utilised: The counsellors were concerned that their time was not fully utilised in one to one consultations with patients. They were conscientious in their desire to make a difference for the sake of the patients and their families as well as to ensure that the AAPS was seen to be working. However, time is needed to establish this service and for the practice staff to learn how to work with a counsellor and vice versa. A year is an insufficient time for this process to be fully established and to ensure that it all works smoothly.

Stopping a service that is beneficial to patients is very frustrating: Although the AAPS was contracted for a year, there was the hope that it would be continued. Stopping a service that is useful for patients and self-evidently beneficial to team work is very frustrating and leaves a gap in service provision. While it is accepted that a relatively new service has to be trialled, future studies should be geared to a three year period at least, assuming of course that we have ironed out some of the other difficulties.

Attitudinal issues and consultation styles: It is clear that certain doctors and other primary care staff are more comfortable screening for alcohol problems than others. However, it is not clear as to why this pertains. A possible explanation relates to consultation style. In one of the practice sites for example, one of the doctors had no difficulty asking patients to get involved in the screening and 'flew through' the process in a very effective way. One of his colleagues described a difficulty in asking patients about their alcohol use and was more circumspect in seeking permission from patients to conduct the screening. This aspect was teased out further at practice visits and at the final think tank. It appears that a barrier to screening involves a fear or perception that the process will make no difference. One GP put it like this "it was clear to me that these patients were set in their ways and me asking about their consumption had little or no chance of making a difference". One GP overheard a patient mocking the screening and this seemed to affect her confidence in the possibility of creating any change. Another GP said that the patient's alcohol consumption was well down the priority list and that asking a patient to reduce their drinking or cut it out altogether would be "unfair, given all of the other serious social and health problems affecting (him)". Still another GP said, "we get frustrated when we see little or no change". Another GP was concerned about the insurance consequences from screening although this issue was covered in the training sessions. This selection of views may indicate excuses for not doing the screening or reaching the targets but it is the view of the Project Director that consultation style is an issue and needs further exploration. An attitudinal session as part of the training would probably uncover and maybe ameliorate this barrier to screening and intervention. GPs also need to have confidence in the screening tools and their own skills if the intervention is to be effective.

Best placed: It is often said that GPs are 'best suited' to deal with this issue. A GP complained that this was stated about practically every clinical area of intervention - "we are best placed for everything but we can't cope with everything that is thrown at us".

Strengths

It can be done: In keeping with numerous studies around the world we have demonstrated that screening and brief interventions are effective and can be accomplished even in the busy constraints of primary care in Ireland. From a situation where practically no screening or interventions were being undertaken, except in extreme circumstances, we have now completed two studies on alcohol in primary care. It is hoped and believed that the experience gained by all of the participants will be carried forward into their ongoing working lives to the benefit of patients and their families. The notion of risk categories and how to ascertain a patient's risk category (Low risk, Hazardous, Harmful and Dependent drinking) as opposed to turning a blind eye to alcohol problems or of making a simple distinction between no problem and alcoholism are clearly established in the participating practices. We provided an alcohol counsellor on site to support the work of the primary care staff when they uncovered more serious alcohol problems. We also provided the counsellor because of the great difficulty experienced by GPs in accessing services for public patients. The previous AAP study indicated that GPs were unlikely to 'find' alcohol problems if they had no way of effectively managing them. All of the practices were delighted to work as a team with the counsellor and patients clearly benefited from this approach. The absence of comprehensive services for public patients cries out for the need for this service in primary care. A seamless, quick referral process, on site, in primary care is clearly the way to go in the future.

Dedicated person to organise screening makes it more effective: A dedicated professional within the practice to manage the screening, appointments with the Counsellor and follow-up appointments made a huge difference in terms of the efficacy of the initiative and in ensuring that the targets were achieved. It also helped to reduce 'no shows'.

Benefit to patients and families: Although the number of patients followed-up within the time frame of the AAPS was relatively small, it is clearly evidenced that patients benefit from this service both from the practice staff statistics and from those of the counsellors. There were some outstanding individual outcomes and there are likely to be more successful outcomes as time goes on. As the service develops the benefits to families should be more obvious judging from the experience in Baltinglass.

Public information and patient ignorance aspects: This service initiative has revealed serious gaps in patients' knowledge of alcohol problems. In particular there are huge gaps in understanding of consumption limits, risk categories and binge drinking and of their impact on health and well being. Normalisation of heavy drinking due to aggressive marketing and cultural factors has contributed to our alarming problem. Gender aspects and differences in relation to alcohol are clearly also not generally understood. The AAPS has made a huge difference in educating the general public on all of these aspects.

More knowledge re this population and primary care attitudes: The AAPS has provided a great deal of information regarding alcohol in the general population and information on what works and what does not.

Importance of team work: Team work is very effective. The generalist approach needs the back up of specialists and the notion of the 'one-stop shop', that could be a vision for primary care, works. There is no doubt that the provision of such services in primary care reduces the pressure on Accident and Emergency services. Where the practice nurse was involved, the services were certainly enhanced. Unfortunately few practice nurses were invoved in this initiative.

Easy integration of counsellors: Any possible problems regarding integration of counsellors did not materialise in this initiative. All of the counsellors were fully integrated very early on. This indicates the ease with which the primary care staff accommodates change and welcome support.

Associated additional effects for local area: Some of the counsellors are to continue in the practices through funding of various kinds.This is a tribute in itself to the value placed on this service by the practices. The associated additional value to the local communities is hard to estimate or evaluate but these may be far reaching and develop in unexpected directions. There is now a service for counselling in the local area in Baltinglass that resulted directly from the two initiatives. Such a spread of services will mean that all of the GPs in an area can ensure their patients benefit from counselling.

Negligible number of refusals from patients to participate: The AAPS demonstrates yet again that patients do not object to being asked about their alcohol consumption. Only a tiny percentage objected and patients expect to be asked about their drinking habits.

More confidence in dealing with alcohol problems: The AAPS evaluation shows that the primary care staff developed more confidence in all aspects of managing alcohol problems. As the skills needed and used for motivational style interviewing and in brief interventions are replicable, it is likely that confidence gained in this initiative will be transferable to other clinical areas. It is probable that the participants will have greater confidence in dealing with other lifestyle issues such as relationship problems, cigarette cessation, emotional and mental health issues and other drug problems. It remains unclear whether or not the skills and confidence gained will continue over time.

5. Evaluation

5.1 Analysis of Evaluation Forms

The participating GPs, practice nurses and counsellors were all asked to fill in an evaluation form at the end of the training session at the start of the initiative and again one year on just at the end of the initiative. There were 28 replies (out of a possible total of 40) to the first evaluation made up as follows: 20 GPs, four counsellors and four practice nurses. There were 15 replies (out of a possible total of 40) to the second evaluation made up as follows: eight GPs, four counsellors and three practice nurses. A third evaluation will take place in one year from now to assess the ongoing benefits to the participants. (In particular to ensure that the gains from this initiative have been maintained over a longer period of time for all of the participants). The results from both completed evaluations indicate widespread satisfaction with the training and the terms and references of the AAPS.

At the initial evaluation, only one reply said the training period was too short (a practice nurse), four said it was too long (all GPs) and the rest (23) said it was the correct time period for the training. The respondents were asked to rate the training programme from a scale ranging from 'Useless – Somewhat Useful – Useful – Very Useful – Other' (please specify); 17 said 'very useful', seven 'useful' and the rest (four) said 'somewhat useful' while no one described it as 'useless' or 'other'.

A summary of the other results are in the table below. Note the rating scale we used was: Very Poor 0 – 1, Poor 2 – 3, Fair 4 -5, Good 6,- 8, Excellent 9 – 10.

	Initial Evaluation (After initial training session)	**Second Evaluation (One year on, just before the end of the AAPS)**	**Comment**
Skills in dealing with Alcohol Problems	Mean Score 5 Highest 9 Lowest 2	Mean Score 6 Highest 9 Lowest 4	Mean score improved slightly
Knowledge of Alcohol Withdrawal	Mean Score 5 Highest 9 Lowest 2	Mean Score 6 Highest 9 Lowest 4	No change though mean score improved slightly
Awareness of Referral Services	Mean Score 5 Highest 9 Lowest 2	Mean Score 5 Highest 9 Lowest 4	No change in awareness of referral services, though lowest score improved
Knowledge of Weekly consumption levels	Mean Score 6 Highest 9 Lowest 2	Mean Score 8 Highest 9 Lowest 4	Improvement in knowledge of weekly consumption levels
Ability to Use Questionnaires	Mean Score 5 Highest 10 Lowest 2	Mean Score 8 Highest 10 Lowest 4	Good improvement in use of questionnaires
Knowledge of Brief Intervention	Mean Score 5 Highest 10 Lowest 3	Mean Score 7 Highest 9 Lowest 4	Quirky result but higher mean score for knowledge of brief intervention
Confidence in Dealing with Alcohol Problems	Mean Score 5 Highest 10 Lowest 3	Mean Score 7 Highest 9 Lowest 4	Particularly notable is the improvement in confidence to deal with alcohol problems. Mean goes from 5 -7 over the year

23

Commentary: Although the numbers are small in the second evaluation it is clear that all of the indices to rate improved attitudes/knowledge and skills, at one year follow-up, are enhanced. The respondents were also asked to give their opinions on the following areas (outlined below is a selection of feedback):

A. Personal Comments

At the initial evaluation, almost all respondents expressed optimism about the programme and commented on skills deficits. All the primary care professionals were delighted with the prospect of having a counsellor on site.

At the second evaluation, the feedback was hugely enthusiastic for the project and for the counsellors but the target numbers were considered too high by most of the GPs. December was seen as a very difficult time to screen because of all of the seasonal viruses etc. One GP and one counsellor described the service as a 'huge learning curve'. Several were upset that this 'frontline' service was coming to an end at a time 'when it is only really bedding down'. One doctor said that 'no one was annoyed by being asked' and that surprised him. A GP perhaps caught the flavour of the feedback in this section, "biggest problem in the past was fear of opening Pandora's box – but now the counsellor can sort whatever comes out!"

B. Gaps in the Service

At the initial evaluation, almost all of the respondents noted the absence of counselling services or inaccessibility of counselling services for GMS/Public patients. One GP put it like this, “Main gap is accessibility (to treatment services) in a timely fashion. Like all good services the good ones have long waiting lists”. Very few beds for detoxification of public patients were also mentioned a number of times. The ignorance around ‘safe’ weekly consumption levels was also highlighted.

At the second evaluation, though the number of respondents was smaller, almost all commented on poor access to public health counselling and treatment services. “More counsellors needed” was repeated a number of times. Absence of counselling for methadone patients was also highlighted. One of the counsellors felt that the pressure of screening and follow-up could be relieved if the counsellor got involved in this aspect of the initiative.

C. Lessons for Future Studies

An emphasis should be put on developing team work because that “was the best part of this initiative” was repeated several times. Reduce the target numbers for screening, simplify/reduce the results forms and improve the IT aspects were all regularly mentioned. Regular meetings between the counsellor and the primary care staff “is a must for future initiatives”.

5.2 Costings

The cost of the study excluding the Project Director’s time and salary was in total; €277,332 (HSE East Coast area; €65,000, HSE Northern area, €97,500 and HSE South-Western area €114,832 – nb. administrative areas at the time of the initiative’s commencement). Included in the total was a practice incentive which amounted to €10,000 per site (reduced for the one smaller site pro rata) and this was to help to cover the cost of the consulting room for the counsellors, stationery, phone calls, expenses etc. The payment of the practice incentive was dependent on reaching screening targets.

The benefit/cost analysis was not undertaken but it is quite clear that this is a highly cost effective initiative.

6. Recommendations

Integration of Questionnaires into existing software: A key recommendation coming from these results is that we must invest in software to support those GPs who are interested in screening and brief interventions for alcohol problems. A nationwide development of software that would include all of the screening tools as well as the scoring systems and flagging procedures (i.e. an ‘alarm bell’ for certain cut-off scores) would make a big difference and would ensure that more patients and families would benefit.

Dedicated researcher to visit practices to support research aspects of initiative: If funding could be found, it would be a major asset to have a dedicated researcher appointed to collate the results and to visit all the practices to source the results. These resources would be essential if there is to be an expanded Alcohol Aware Service to practices.

Shorter questions on result forms and shorter questionnaire: Although a lot of progress has been made in the recording result forms we used they can be further shortened. Ideally, all the necessary results should fit onto the one form. The counsellors’ recording form should be similarly shortened. It is also recommended that the ‘AUDIT C’ be used as the initial screening tool for alcohol problems. This involves the first three questions of the AUDIT questionnaire and can be integrated verbally into any consultation. It would have the added bonus of not having to ask patients difficult questions regarding their alcohol consumption as per the full AUDIT questionnaire when it is obvious that alcohol is not an issue for them.

Reduced target numbers: A more realistic target would be 10 patients to be screened per site per week. This should ensure that the targets are adhered to and that the follow-up interviews would be fully completed. It would have the added advantage that it could be averaged out over the year of screening so that at peak pressure times fewer numbers would be screened. The counsellors could also become involved in the screening process if they had ‘no shows’ or were slack at some periods of time. Finally, practice nurses could take a more active role in screening and interventions for alcohol problems if time allowed.

Tailored interventions for specific groups of patients: This would be an advanced form of intervention and would involve tailoring advice to suit different patients. An obvious example would be to talk to young patients about calorie content of alcohol. Another example would be to review medication use in terms of alcohol contraindications and side-effects.

Counsellors to be employed for all practices in an area rather than to one specific practice: Better and more equitable use of resources would suggest that the counsellors should be employed by area so that all GPs in a geographical area could benefit from their work. However, it would be essential that they would be based on site in each of the practices.

Targeted interventions: Random screening is still recommended and in any practice the ideal would be that everyone is screened for alcohol problems at least twice in their life-time. However, it may be more economically and clinically efficient to target patients on the basis of presenting symptoms. All new patients to the practice could be screened as well as patients undergoing men's and women's health check-ups or occupational health referrals. For a full list of symptoms see Appendix 6[24].

Training Issues: Although training takes time, it is vital that attitudinal barriers need to be explored and discussed in some detail at future training sessions for similar projects.

Primary Care Teams: The extension of this AAPS might be incorporated as part of the current HSE Primary Care Team initiative. In any event this initiative should be rolled out to a larger number of practice sites throughout the country as it is clearly beneficial and cost effective.

Role of the Practice Nurse: In any future initiatives the role of the practice nurse should be enhanced and developed.

7. Conclusions

This service initiative has been another important step in our understanding of how alcohol problems are managed in primary care. Another 24 GPs and a small number of practice nurses have developed confidence and skills to manage alcohol problems more effectively. A number of alcohol counsellors have been successfully integrated into the primary care teams. Patients who would not have been able to avail of a professional counselling service have benefited from an on-site seamless referral service. The evaluation demonstrates that confidence levels amongst the practice staff were clearly increased and that most of the practices will continue to screen and treat patients with alcohol problems.

Our initiative proves that primary care can be effective in this area and that patients do benefit. Using early identification, brief intervention techniques and counsellors on site we have demonstrated the efficacy of this initiative.

At least one-third of patients who were screened and followed up made significant progress and another third made positive progress.

We also learn from international studies that GP attitudes are crucial to screening and intervention[25] yet traditionally they have been reluctant to get involved[26]. This reluctance is probably because of the mistaken belief that those who are dependent do not respond to interventions. 'Therapeutic commitment' is well established as a motivating force for GPs[27].

Future initiatives will have to cut down on paper work and ensure uniform software for all the practices to facilitate recording and results.

8. Thanks

There are so many people to thank for their help on this initiative.

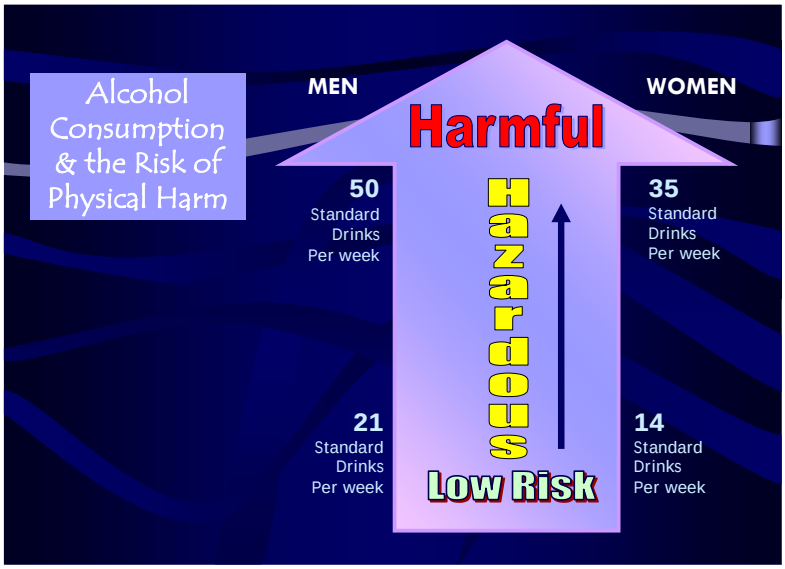
Dr. Peter Anderson (UK) The well known international expert who gave his advice and opinion freely.

All the practice staff, counsellors and patients who participated in this Initiative.

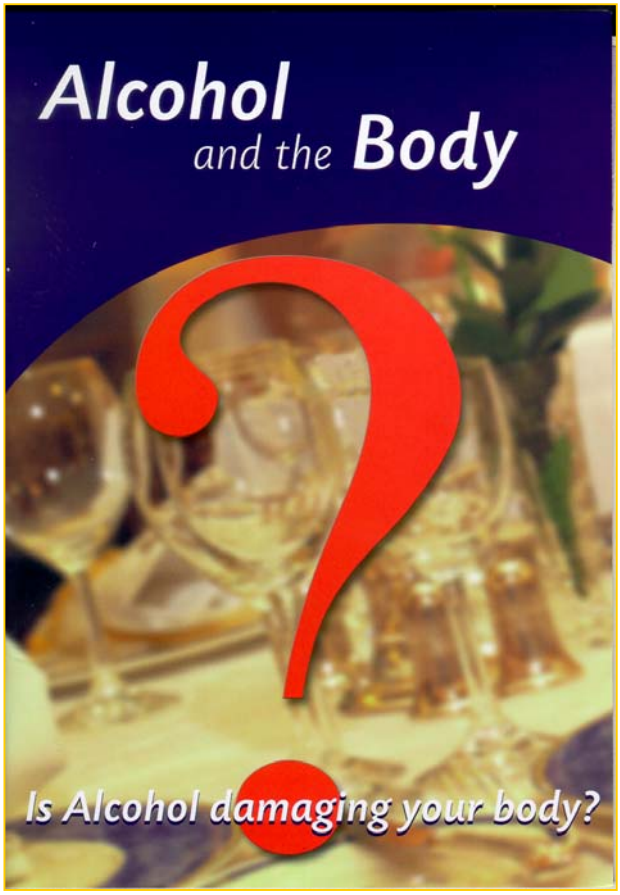
The management committee made up of representatives from the HSE and the ICGP: Mr. Fionan O'Cuinneagáin CEO, ICGP, Dr. Michael Boland, ICGP, Mr. Rolande Anderson, Alcohol Project Director, ICGP, Ms. Niamh O'Rourke, Acting Director of Primary Care, HSE Dublin Mid-Leinster (East Coast), Ms. Catherine Brogan, Acting Director of Mental Health and Addiction, HSE Dublin Mid-Leinster (South West) and Ms Patricia Scully, Acting Director of the Stanhope St. Treatment Centre, HSE.

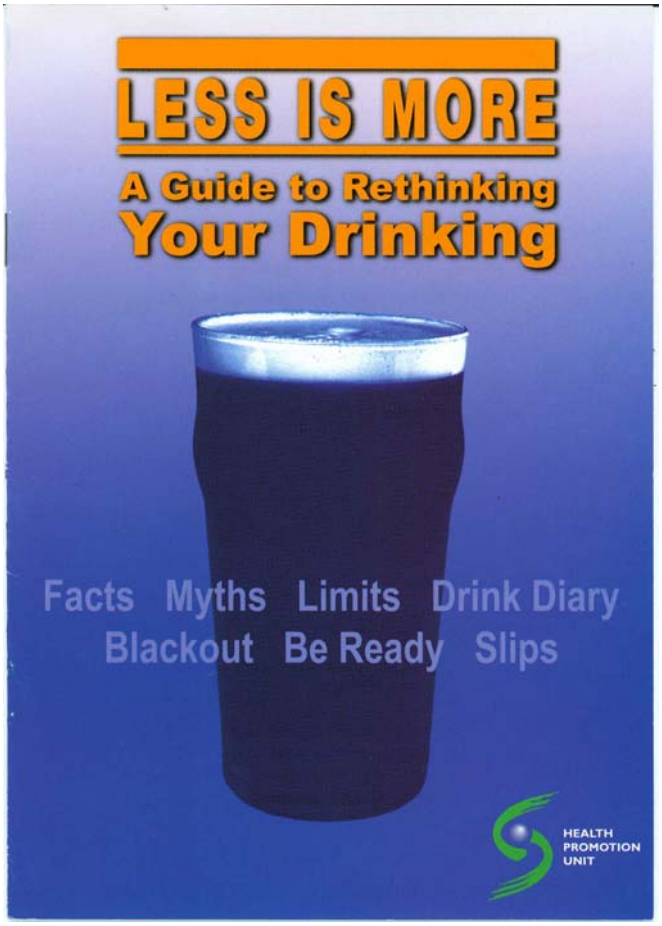
9. Appendices

Appendix 1



Appendix 2 - Some of the Leaflets used for AAPS





Alcohol Aware Practice Service Initiative

Patient Information Sheet (1)

You would like to cut down on your drinking:

Why?

Your Doctor/Practice Nurse/Counsellor will have discussed the results of the questionnaire(s) with you and tried to assess your ability and 'readiness to change'. The results have indicated that your drinking habits could be bad for your health. The leaflet, 'Alcohol and the body' will give you some more information.

How?

- Keep a diary of your daily and weekly consumption (Remember as a general rule, low risk drinking means less than 21 standard drinks for an adult male and 14 standard drinks for an adult female).
- Try to drink no more than 3 standard drinks per day for males and 2 standard drinks per day for females.
- Have at least 2 or 3 non drinking days.
- Avoid fast drinking and binge drinking.
- Sip your drinks and drink slower.
- Drink water and/or non alcoholic drinks between drinks.
- If you drink spirits dilute them with water and soft drinks.
- Avoid drinking in rounds.
- Set a date to change.
- Consider telling your close family and friends.
- Stick to your 'guns', set a limit that is realistic for you.
- Have an explanation ready for people who push you to drink, for example; 'Doctor's orders', or 'I want to cut down for a while', or 'I was drinking too much'.
- Treat yourself for succeeding.
- List the 'pros and cons'.

Some of the advantages;

- You will sleep better.
- You will have more energy.
- Food will taste better.
- You are more likely to develop leisure activities and get involved in exercising.
- You will have more disposable income.
- You will not put on as much weight.
- Your memory and intellect will be sharper.
- Your emotions will be more stable.
- Your health will improve.

A follow-up appointment will be made to help support you with this change.

Alcohol Aware Practice Service Initiative

Patient Information Sheet (2)

You would like to stop drinking:

Why?

Your Doctor/Practice Nurse/Counsellor will have discussed the results of the questionnaire(s) with you and tried to assess with you your ability and 'readiness to change'. The results have indicated that your drinking habits are bad for your health, and there are signs of dependence. This will also seriously affect all other aspects of your life.

How?

Changing from heavy or harmful drinking to abstinence will not be easy and you need to carefully prepare and use all available supports.

- You may be referred to an Alcohol specialist for further help and assessment. Your family may also need to be involved in this process. This will be an opportunity to resolve other personal issues as well.
- Work out and list the pros and cons of change yourself.
- Set a start date.
- Consider telling your close family and friends.
- Think about joining a self-help group such as 'Alcoholics Anonymous' and/or 'Anew' (for females).
- Talk to someone who has gone through this process of change before.
- Decide what times and places put you most at risk and take steps to develop alternative interests and leisure pursuits.
- Ask your Doctor for more details. The Doctor may prescribe medication to help you to stop.
- Read literature on the subject.
- Reward yourself for success.

Some of the advantages;

- You will sleep better and have more energy.
- Your appetite and eating patterns will gradually improve.
- You will have more time for leisure activities.
- You will have a more positive outlook on exercise and fitness.
- You will have more disposable income.
- You are likely to have much better relationships with family and friends.
- Your memory and intellect will be sharper. You will have more confidence and self-esteem.
- You should be more reliable and your work performance and/or attendance are likely to improve.
- You are less likely to be depressed.
- Your health will improve.

A follow-up appointment will be made to help support you with this change.

Appendix 3 – Screening Tool Questionnaires and Scoring Systems

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year. Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer in the box at the right.

1. How often do you have a drink containing alcohol?

(0) Never
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week ☐

2. How may drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more ☐

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily ☐

Skip to Question 9 & 10 if Total Score for Questions 2 & 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily ☐

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily ☐

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily ☐

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily ☐

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily ☐

9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year ☐

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year ☐

If total is greater than recommended cut-off, consult User's Manual.

Record Total Here ☐

Audit Scoring System

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

WHO Pamphlet[6]. Note scoring system can be altered for different countries.

The CAGE Questionnaire

- Have you ever felt the need to **CUT** down on your drinking?
- Have you ever felt **ANNOYED** by someone criticising your drinking?
- Have you ever felt **GUILTY** about your drinking?
- Have you ever felt the need for an **EYE-OPENER?**

Two positive answers is considered a positive test and warrants further assessment.

Audit Scoring System

- **Items 1-8 score 0, 1, 2, 3, 4 respectively**
- **Items 9 and 10 score 0, 2, 4 respectively**
- **Then carefully add up the total score**

The scoring system for the Audit is generally accepted as follows;

- **For FEMALES with a score of 7 or more but less than 14**
- **For MALES with a score of 8 or more but less than 14**

Then

Your patient is drinking too much or your patient has previously had problems with drinking (e.g.) injury or binge drinking (check item 3) BUT your patient is unlikely to be physically dependent on alcohol

Possible/Suggested Action

Advise your patient to cut down on drinking

Steps

1. **Inquire about any high response on questionnaire**
2. **Go through options/ways of cutting down**
3. **Give leaflet(s)**

For MALES and FEMALES with a score of 14 or more

Then

- **Your patient has problems with drinking and**
- **Your patient is likely to be physically dependent on alcohol**

Possible/Suggested Action

- **Explain to patient that he/she has signs of physical dependence and should stop drinking**
- **Use leaflets or booklets**
- **Indicate that the patient should have a thorough physical examination including blood tests**

Note;

1. *This questionnaire is not diagnostic and referral to specialists will be necessary in most cases of dependence. Clinical judgment taking other factors into account should always be used.*
2. *High scores on the first three items in the absence of elevated scores on the remaining items suggest Hazardous drinking.*
3. *Elevated scores on items 4 through 6 imply the presence or emergence of Alcohol Dependence. High scores on the remaining items suggest Harmful drinking.*
4. *Ask about binge drinking.*
5. *Carefully check if patient scores between 13 and 17.*

Appendix 4

The Alcohol Aware Practice Service Initiative
2005-6

Evaluation Form

Respondents were asked to;

1. Rate the Training Programme

A. Too short ☐ Too long ☐ Correct time ☐ Other ☐

Other (specify) _____

B. Useless ☐ Somewhat useful ☐ Useful ☐ Very Useful ☐

Other (specify) _____

2. Rate the following using the following scoring system.

Very Poor	**0-1**
Poor	**2-3**
Fair	**4-5**
Good	**6, 7, 8**
Excellent	**9 -10**

- Skills in dealing with alcohol problems
- Knowledge of acknowledge withdrawal
- Awareness of referral services
- Knowledge of weekly consumption levels
- Ability to use questionnaires
- Knowledge of brief intervention
- Confidence in dealing with alcohol problems

Respondents were also asked to outline;

a. personal comments
b. gaps in services
c. lessons for future initiatives
(all free text)

Appendix 5

Alcohol Aware Practice Service Initiative 2005/2006 – Counsellor form

1. Patient Code No: _____ **2. Age:** _____

3. Sex: Male / Female **4. Number of Children:** _____

5. Date of Initial Referral: _____

6.

Reason for Referral:

Positive Result from Questionnaire – random	☐	**Self referral – help seeking**	☐
Detected during clinical interview	☐	**Practice staff aware of alcohol problem – targeted intervention**	☐

7. Attender: Patient Spouse/Partner Child Parent Other

8. Type of referral: Hazardous Harmful Dependence

9. Symptoms at time of referral:

physical psychological / psychiatric social cross-addiction

work attendance yes / no

10. Clinical Investigations / Examinations:_____

11. Previous treatment if any : _____

12 . Action

• **Patient did not cooperate**	☐	• **Dexox** **a. Home**	☐
• **Brief Intervention**	☐	**b. Hospital**	☐
• **Counselling**	☐	**c. GP assisted**	☐

Medication Prescribed:

_____

_____

_____

Referral

▪ **Alcohol Counsellor**	☐	▪ **Treatment Centre**	☐
▪ **Psychiatrist**	☐	▪ **Other**	☐

13. Number of attendances with counsellors: _____

14. Referral Support services used:

▪ **AA**	☐	▪ **Al-anon**	☐
▪ **Hostel**	☐	▪ **Anew**	☐
▪ **GA**	☐	▪ **NA**	☐
▪ **Other Counsellor**	☐	▪ **Outpatient service**	☐
▪ **Inpatient service**	☐	▪ **Psychiatric**	☐
▪ **Specialist addiction**	☐	▪ **General Hospital**	☐

15. Outcome

▪ **abstinence**	☐	▪ **reduced intake**	☐
▪ **family change**	☐	▪ **medical symptoms**	☐
▪ **ongoing counsellor necessary**	☐	▪ **relapse**	☐
▪ **re-entry**	☐	▪ **recurrent non-attender**	☐

16. Revised Category:

No change ☐ **Low Risk** ☐ **Hazardous** ☐ **Harmful** ☐ **Dependence** ☐

Notes:_____

_____

_____

Appendix 6

Intervention Methods

Intervention Method 1 - Random Assessment

The GP will screen one patient per session, maximum of two per day, and this patient will be identified by the receptionist for alcohol problems on a random basis (every 6th patient, for example). If the patient is excluded the GP must then take the next patient etc.

The GP will seek verbal consent from the patient to use the A.U.D.I.T. questionnaire.
Patients should also be asked about binge drinking. Binge drinking is defined as six or more standard drinks on a regular basis.

Using these methods and principally the result from the Audit the Patient will be allocated to the following risk groups;

- Low or No Risk
- Hazardous
- Harmful and/or Dependence

Clinical judgement and tests (if necessary) may also be used to help assess the patients' risk category.

Based on previous studies, it is likely that there will be approx 60% of all patients in low risk group, 25-30% in hazardous group and 5-15% in the Harmful/Dependence group. The patients' Audit scores should be recorded in their personal notes together with any form of intervention used.
Sub Group One; Low Risk Group Patients who score in the low or no risk categories should of course be informed of the result and encouraged to maintain their low risk status. Sub Group Two; Hazardous GroupPatients who are in 'Hazardous' risk category, will be offered

- simple advice and brief intervention to cut down on their alcohol consumption.
- one of the leaflets that will be recommended.
- the patients should be informed that they will be followed up in three months time as part of the study. (The follow up session is intended to assess progress and to record if the patient has managed to alter his/her consumption levels/patterns.) If there is any doubt that the patient might be in the Harmful/Dependence risk range, a further assessment should be arranged with the Counsellor.

Sub Group Three; Harmful/Dependence Group

Patients who score in the 'harmful/dependence' risk range should be offered help as appropriate.

This will usually involve;

- an assessment with the Counsellor.
- further treatment if necessary in consultation with the treatment team (GP, Counsellor and Practice Nurse) and taking into account the patient's health, insurance and other cover for treatment and family/social circumstances.
- an assessment of the patient's mental state.
- the provision of a leaflet on alcohol problems.
- an assessment of motivation, in particular the patient's ability to abstain or cut back.
- detoxification if necessary (if it can be provided safely within primary care).
- blood tests, if necessary.
- regular follow-up as in normal practice procedures.

Once again patients in this category will be formally seen again in three months time by the GP to assess progress for the purpose of the initiative results etc.

In all cases, the results should be returned on line in detail. A second form will be sent out to the GP for those patients who require follow-up prior to the follow-up appointment.

Intervention Method 2 - Targeted Intervention

The GPs' task is to try to identify those patients who are more likely to have a problem with alcohol from their case loads. In this intervention the focus should be on symptoms. Patients who have the following range of symptoms are more likely to have alcohol problems;

- 'Tired all the time'
- Headaches
- Blood pressure
- Skin problems
- Anxiety
- Depression
- Vague symptoms
- Recurrent infections
- Relationship problems
- Sexual Problems
- Accidents
- Sleep disturbance
- Weight loss or weight gain
- Stomach complaints
- Looking for Certs/Absenteeism
- Patterns of attendance
- Combination and or pattern to above complaints

These are just a small example of the type of problems that may present. Patients may well present with established signs of alcohol problems such as liver problems.

The GP will seek consent from the patient to use the A.U.D.I.T. questionnaire and depending on the result will allocate the patient to the following risk groups;

- Low or no risk
- Hazardous
- Harmful and/or Dependence and proceed as in Intervention one.

Intervention Method 3 - Patient Asks for Help

Even in the circumstance where a patient presents looking for help with an alcohol problem, the GP should use the AUDIT questionnaire to establish the risk category.

Patients should be treated as per their risk category as in previous sections.

Note; In all cases, a patient, notwithstanding their own 'low or no risk' result may reveal concern about a relative and if so that family member should be offered a session with the Alcohol Counsellor.

Appendix 7

Role of Alcohol Counsellor

Specific task

The Counsellors' main role is to provide counselling services for family members or patients with alcohol problems who are referred from the Practice/Site in which he/she is working.
An assessment of the patient's risk status should be carried out in conjunction with the primary care team and appropriate help offered.

In some cases this will involve help towards abstinence from alcohol and in some cases advice re reducing consumption. All the normal procedures involved in alcohol counselling should be followed as well as the ethical guidelines as set down by the IAAAC.

The patient and/or family should be seen as regularly as necessary and/or referred to other treatment services. If there is any doubt as to the client's psychiatric health the opinion of a psychiatrist should be sought. Full use and information about community services such as financial counselling services, marriage guidance and legal options etc should be made available to clients.

Each Counsellor should keep records regarding outcome, suitability of referrals, number of attendances etc.

Hours and Location

Each Counsellor will provide service for patients free of charge within each selected Practice. One Counsellor will support each site on the basis of 6 hours per week. These hours are flexible and should be arranged to suit the service as best as possible. The Counsellor will work with 3 GPs. In some cases this will mean attendance at only one Practice or the hours may need to be split between practices as necessary. The Practices will all be located within the old ERHA area so the practices will be located in Dublin, Wicklow, Carlow and Kildare.

Records

All notes taken in the surgery will remain the property of the Surgery and the usual care needs to be taken to ensure confidentiality for the patient. Confidentiality can be offered to the patient but will refer to the whole primary care team. The usual terms in relation to confidentiality will apply in the case of child protection issues and self-harm, however decisions about such cases must be discussed at team level and a consensus must be reached.

Meetings

At least one formal meeting should be arranged between the GPs and the Counsellor to discuss progress and management of patients every fortnight. Informal meetings should happen on a regular basis and as necessary.

Management/Supervision Issues

The Counsellors will work as equal members of the team and their will be no hierarchy within the Practice. However each Counsellor is asked to be mindful of the fact that they will be working within the Property of the relevant GP(s) and should respect the property accordingly.

The Counsellor must be in regular supervision and continue to be an accredited member of IAAAC. Management of this initiative is the responsibility of the ICGP in conjunction with ERHA.

The Project Director on Alcohol will be responsible for the overall management of the Initiative and he will be in regular contact with all personnel involved in the initiative, in a supportive role. In the event of disputes between GPs and Counsellors or other issues that can not be resolved he will have the authority to advise and adjudicate. In some cases a Counsellor may be transferred to a different site/location if problems persist.

A Counsellor who is proven to have behaved unethically as per the Ethical guidelines set down by the IAAAC will be suspended from duty and the contract will come to an end. Every Counsellor must have professional indemnity insurance.

A formal contract will be signed prior to commencement of the initiative

Appendix 8

Select Comments from Primary Care Staff.

..slight reduction in intake, no significant change as was borderline anyway

Attended……now drinking less, depression is improved on medication, better sense of well being.

audit was consciousness raising.

back on the drink after break-up with partner

Binge pattern drinking on monthly basis, occasional glass wine in between. Intervention made no difference as doesn't get the chance to go out very often.

Bingeing but not frequently. No alcohol since Christmas.

Cut back on drink because of worry about his son.

Diagnosed with moderate to severe hypertension so this was a motivating factor to reduce alcohol as well. BP now well controlled after three months.

When attended shortly after intervention reported that her intake had reduced++ and felt better.

Difficult to ascertain if any change in C2H5OH consumption since AUDIT 'solemnly swear' is going to reduce now.

Drank less but not because of the survey. 'No real reason'.

Drinking around bereavement reaction.

Ex alcoholic began to slip, now has reduced intake as is on Warfarin for a dvt.

Gone from daily drinking to binge drinking with dry periods. Attending AA meetings on a regular basis.

Had been off drink a few months, then relapsed and admitted to hospital with GI bleed, then stopped drinking again and remains abstinent.

Had one slip requiring hospitalisation now well, and not drinking.

Had stopped drinking and saw counselor, then defaulted and was drinking again, subsequently stopped drinking again and went back on antabuse, currently off alcohol.

Has attended counselor on second referral and found it very helpful.

Has been thinking about what I said.

Has had to cut down on binge drinking as is now on Warfarin for heart disease.

Has made him think and has cut down.

Has reduced alcohol but now wants to receive treatment for Hepatitis C so would like to stop altogether – today commenced on Campral and referred to Counsellor within practice

Have not asked questionnaire but much improved.

In denial, unlikely to change.

Intervention made no difference, has slightly reduced intake himself over past month.

Much reduced cans of beer.

Much more aware that was drinking in a harmful way. Has decreased drinking, also aware of dangers of reactive drinking.

Ongoing treatment but has recently stopped drinking and started Campral.

Only drinks once a week and less so in last month.

Originally had score 24. Then developed severe diarrhoea which was drink related. Resolved to stop alcohol and see counsellor. Did so at least twice.

Past h/x of alcholism, beginning to slip again and is now off alcohol.

Patient couldn't remember audit or brief intervention!!

Patient did not attend appointment for completion of three month follow-up. However patient has made an effort, but needs counselling for an eating disorder.

Patient felt it made him consider his alcohol intake more.

Patient is more informed.

Reduced from harmful/dependent drinking down to hazardous.

…..has reduced alcohol consumption with brief intervention.

Last year 60 units a week and said had cut down to 30 this year.

sober at present.

…..still drinking heavily, but has reduced by 50%.

……still drinking more than recommended safe level, esp. in view of Hep C, but less than previously and gastric symptoms resolved.

…….still over recommended intake but has reduced and feeling better, better lifestyle now.

Still relatively high consumption but much reduced. BP now under control had been raised.

Appendix 9 - Questionnaire & Follow-up Results Forms Used by GPs/Practice Nurses

First Phase Alcohol Aware Practice Study 2005-2006 Exit this survey >>

*** 1. Date of Screening:**

Date of Screening: Day | Month | Year

*** 2. Practice Code**

*** 3. GP Name**

GP Name and Health Board Area: GP Name | Health Board Area

*** 4. Patient ID Number:**

*** 5. Patient's Date of Birth:**
Date/Month/Year please enter as DD/MM/YYYY

*** 6. Age Range:**

- 14 - 18
- 18 - 25
- 26 - 35
- 36 - 45
- 46 - 55
- 56 - 65
- 66 - 75
- Over 75

*** 7. Patient Gender:**

Female Male

*** 8. Patient Relationship Status:**

- Married
- Single
- Separated/Divorced
- Widowed

*** 9. Patient Employment Status:**

- Employed
- Unemployed
- Other e.g. Self-Employed, Employment Scheme etc. (please specify)

*** 10. GMS/Private Status:**

- Medical Card
- Private

*** 11. Visit Code OR Reason for Screening**

- Random
- Targeted Intervention
- Help Seeking

2. AUDIT (Alcohol Use Disorders Identification Test)

12. How often do you have a drink containing alcohol?

Never (0) | Monthly or Less (1) | 2-4 times a month (2) | 2-3 times a week (3) | 4 or more times a week (4)

If Answer to Question 12 is Never (0) please skip to Question 20 and 21

13. How many standard drinks of alcohol do you have on a typical day when you are drinking?

1 or 2 (0) | 3 or 4 (1) | 5 or 6 (2) | 7, 8 or 9 (3) | 10 or more (4)

14. How often do you have 6 or more standard drinks of alcohol on one occasion?

Never (0) | Less than monthly (1) | Monthly (2) | Weekly (3) | Daily or almost daily (4)

If answers to Questions 13 and 14 amounts to Zero (0) please skip to Questions 20 and 21

15. How often during the last year have you found that you were not able to stop drinking once you had started?

Never (0) | Less than monthly (1) | Monthly (2) | Weekly (3) | Daily or almost daily (4)

16. How often during the last year have you failed to do what was normally expected from you because of drinking?

Never (0) | Less than monthly (1) | Monthly (2) | Weekly (3) | Daily or almost daily (4)

17. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never (0) | Less than monthly (1) | Monthly (2) | Weekly (3) | Daily or almost daily (4)

18. How often during the last year have you had a feeling of guilt or remorse after drinking?

Never (0) | Less than monthly (1) | Monthly (2) | Weekly (3) | Daily or almost daily (4)

19. How often during the last year have you been unable to remember what had happened the night before because you had been drinking?

Never (0) | Less than monthly (1) | Monthly (2) | Weekly (3) | Daily or almost daily (4)

20. Have you or someone else been injured as a result of your drinking?

No (0) | Yes, but not in the last year (2) | Yes during the last year (4)

21. Has a relative or friend or doctor or another health worker been concerned about your drinking or suggested you cut down?

No (0) | Yes, but not in the last year (2) | Yes during the last year (4)

*** 22. Record total score here (even if zero):**

If total is: 7 or More but Less than 14 for Adult Females and 8 or More but less than 14 for Adult Males the usual advice is to cut back; Between 14 and 19 (both sexes) brief intervention to cut back or cut out is indicated;
20 or More (both sexes) usually involves referral to a specialist.

This questionnaire is not diagnostic and clinical judgement should always be used.

*** 23. Audit Score:**

- Nil or Zero (No Risk)
- Less than 7 for Adult Females and Less than 8 for Adult Males (Low Risk)
- 7 or More but Less than 14 for Adult Females and 8 or More but Less than 14 for Adult Males (Hazardous)
- Between 14 and 19 (Harmful)
- 20 or More (Dependent)

24. Last Week Consumption:

	Female	Male
Nil		
Under 15 standard drinks for adult Females OR Under 22 for adult Men		
15 - 35 for Females 22-50 for Men		
Over 35 for Females Over 50 for Men		
Binge Pattern		

25. Clinical Examinations - Other Observations

Smell of alcohol on breath	Palpable liver	Peripheral Neuropathy	Psychiatric symptomatology	Recurrent infections	Behavioural problems

*** 26. Risk Category at Screening. Choose ONE status ONLY:**

No Risk - Teetotal	No Risk - In Recovery	Low Risk	Hazardous	Harmful	Dependence

27. Blood Tests to be carried out:

LFT	GGT	MCV	FBC	Drug Screening

*** 28. Does the Patient require Follow-up (Follow-up is indicated for Patients in Hazardous, Harmful or Dependent categories)**

Yes No

<< Prev **Print before Proceeding >>**

. Reminder

If you need/wish to Print any information before submitting your responses please click PREV and choose the FILE menu and PRINT option. Your answers should still be on screen until you submit them.

When you are ready to send in your responses please choose the SUBMIT option.

Thank You

<< Prev **Submit >>**

Three Month Follow-Up

Exit this survey >>

ONLY FOR THOSE WHO ARE IN THE HAZARDOUS, HARMFUL OR DEPENDENT CATEGORIES.

*** 1. Patient ID Number (as per previous consultation):**

*** 2. GP Name**

	GP Name	Health Board Area
GP Name and Health Board Area		

*** 3. Patient's Date of Birth:**
Date/Month/Year please enter as DD/MM/YYYY

*** 4. Did the Patient Follow-Up**

- Yes
- No

5. If answer to question 4 is NO please choose appropriate reason:

- Refused
- Could not be contacted
- Other (please specify)

6. Date of Follow-Up:

	Day	Month	Year
Date of Follow-up			

7. Tick which Blood Tests were definitely carried out:

	Yes
LFT	
GGT	
MCV	
FBC	
Drug Screening	

8. Results of Blood Tests Performed, for example MCV - returned to normal on repeat OR LFT still raised etc.

9. Medication Prescribed in the last 3 months:

- Nil
- Disulfiram
- Acamprosate
- Anti-biotics
- Withdrawal medication
- Vitamins
- Tranquillisers (Short-term course)
- Tranquillisers (Other than above)
- Anti-depressants
- Other (please specify)

10. Action:

- Encouragement
- Brief intervention
- Detox at home
- Referral for Acute Medical Detox
- Referral to Counsellor within Practice
- Referral to outside Counsellor
- Referral to Psychiatrist
- Referral to Specialist Treatment Agency
- Other (please specify)

11. Last Week Consumption:

	Female	Male
Nil		
Under 15 standard drinks for adult Females OR Under 22 for adult Males		
15 - 35 for Females 22 - 50 for Males		
Over 35 for Females Over 50 for Males		
Binge Pattern		

12. How often do you have a drink containing alcohol?

Never	Monthly or Less	2 - 4 times a month	2 - 3 times a week	4 or more times a week

13. How many standard drinks of alcohol do you have on a typical day when you are drinking?

Nil	1 or 2	3 or 4	5 or 6	7, 8 or 9	10 or more

14. How often do you have six or more standard drinks of alcohol on one occasion?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily

15. Patient Review of Symptoms:

	Better	Worse	No Change
Sleep Pattern			
Relationships			
Health			
Specific Symptoms			

16. From Patient's perspective did Intervention help?

Yes - Better	No - Worse	Unchanged
○	○	○

17. Doctor Review of Symptoms:

	Better	Worse	No Change
Relationships	☐	☐	☐
General Health	☐	☐	☐
Specific Symptoms	☐	☐	☐

18. In Doctor's opinion did Intervention help?

Yes - Better	No - Worse	Unchanged
○	○	○

19. Risk Category at Follow-Up
Choose ONE Status ONLY based on Clinical Opinion and Last Week Consumption (see Consumption Arrow and Question 11)

No Risk - Teetotal	No Risk - In Recovery	Low Risk	Hazardous	Harmful	Dependence
○	○	○	○	○	○

20. Comments
:

Next >>

10. References

1. Anderson, R., Dalton, Y., Alcohol Aware Practice Pilot Study 2003, Final Report, published by the Irish College of General Practitioners.
2. Ibid.
3. Shaw, S., et al, "Responding to Drinking Problems" Croom Helm (UK) 1978.
4. Adapted from Morgan, M., and Ritson, B., "Alcohol and Health – a Handbook for Medical Students and Medical Practitioners". The Medical Council on Alcohol, (UK), 2003 also adapted for 'Alcohol and your body leaflet', see reference 7.
5. Mayfield, D., Mc'Leod, G., Hall, P. "The Cage Questionnaire", American Journal of Psychiatry 131:1121-1123. 1974.
6. The Audit Questionnaire. Babor, T. et al "The Alcohol Uses Disorders Identification Test: Guidelines for Use in Primary Care." WHO. Document WHO/PSA/92.4 1992. also Babor, T. et al "Brief Interventions for Hazardous And Harmful Drinking". WHO/MSB 101.6B. 2001.
7. Alcohol and Your Body Leaflet, produced by the Mater Hospital, in Dublin for patients in conjunction with Merck Pharmaceuticals. 2002.
8. Two leaflets developed for the original study, by Mr. Rolande Anderson and Dr. Ann Hope based on many other leaflets internationally and adapted for this initiative.
9. 'Less is More' Leaflet produced by the Health Promotion unit, Department of Health and Children. Dublin.
10. Developed for AAP study and adapted for current initiative by Anderson, R., and Dalton, Y.
11. Developed for AAP study and adapted for current initiative by Anderson, R., and Dalton, Y.
12. Gual, A., Anderson, P., Segura, L., and Colum, J., (2005). Alcohol and Primary Health Care: Clinical Guidelines on Identification and Brief Interventions. (Note; A product of Phepa EU project www.phepa.net, same reference for training manual produced by Phepa) Contains references to Brief Interventions. There are numerous articles on Brief Interventions in the literature.
13. Described by Rollnick S., Mason, P., Butler C., in "Health Behaviour Change – A guide for Practitioners", Churchill Livingstone 2000.
14. The best reference book on Motivational Interviewing is; Millar, B., and Rollnick, S. "Motivational Interviewing – Preparing People for Change" 2nd Edition, Guildford Press 2002.
15. See for example, Anderson P., "Alcohol and Primary Care" WHO Regional Publications European Series No. 64. Copenhagen 1996 and see Phepa documents op cit.
16. Gual, A., Op. cit.
17. Central Statistics Office, Dublin. (C.S.O.) 2002. www.cso.ie.
18. Ibid.
19. Ibid (2005).
20. Ibid (2002).
21. Taken from the Health Service Executive website. www.hse.ie
22. Slan – The National Health and Lifestyle Surveys 2003. Health Promotion Unit. Department of Health and Children, Dublin. www.healthpromotion.ie
23. Anderson, R., Dalton, Y., op cit. Developed for AAP study and adapted for current initiative by Anderson, R., and Dalton, Y.
24. Anderson, P. op cit
25. Mc'Avoy, B.R., Lock, C.A., Heather, N., Kaner, E., "Our Healthier Nation: are GPs willing and able to deliver? A survey of attitudes to and involvement in health and lifestyle counseling (UK) 1979.
26. Ibid.
27. Cartwright, A.K.J.,"The Effect of Role Insecurity on the Therapeutic Commitment of Alcoholism Counsellors" Institute of Psychiatry (UK) 1979 and same author "The Attitudes of Helping Agents towards the alcoholic client: the influence of experience, support, training and self esteem", British Journal of Addiction, 413-431 1980.