Alcohol disorders in Canada: the need for intervention

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Editorial

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Résumé

DANS CE NUMÉRO (PAGE 1529) le Dr Christiane Poulin et ses collègues signalent qu'en 1994, 4,1 % des Canadiens étaient alcooliques et que, de ce nombre, près de 85 % ne suivaient pas de traitement. Cette situation indique le besoin pour les médecins de soins primaires d'utiliser davantage le dépistage et de brèves interventions face aux problèmes d'alcool. La perception générale d'inefficacité de ces types d'interventions a fait obstacle à leur utilisation. Cependant, selon de nombreuses études documentées, ces interventions contribueraient *effectivement* à diminuer les problèmes de santé liés à l'alcool chez les patients et dans la population. Même si aucune intervention particulière ne s'applique à tous les patients, les avantages éventuels généraux d'une intervention accrue en cas d'alcoolisme sont énormes.

In this issue (page 1529) Drs. Christiane Poulin, Ikuko Webster and Eric Single report on the prevalence of alcohol disorders in Canada. Their study is important for a number of reasons. It is one of the first attempts to employ a problem-based survey instrument in assessing the prevalence of alcohol problems in Canada; based on this measure, 4.1% of Canadians had an alcohol dependence in 1994. It identifies puzzling but potentially important differences between provinces in the prevalence of alcohol-related problems, in particular alcohol dependence. Finally, it points to the potential value of the CAGE questionnaire in identifying people with alcohol dependence.

Excessive alcohol consumption is a significant health and economic problem in Canada. Alcohol abuse was a factor in 6701 deaths in this country in 1992,[1] including 2372 in Ontario alone.[2] Clearly, alcohol abuse is an important public health issue that needs to be dealt with. What, then, can we do?

One answer to this question is suggested by Poulin and colleagues: physicians should increase their use of screening and brief interventions for alcohol problems and should refer patients to other addiction services where necessary. Significant efforts have been made in recent years to increase the use of such interventions; these efforts have included identifying needs for and making innovations in medical education,[3] and developing and promoting the use of specific screening instruments and interventions.[4,5] However, several barriers to physicians' use of screening and brief interventions have been identified. These include pressures of time, concerns about offending patients and a long-standing scepticism about the effectiveness of these measures.[6,7]

Do interventions work?

In 1953 Gibbins[8] identified many approaches to the treatment of alcohol problems that now seem either amusing or barbaric. These included religious conversion, long-term institutional care, elevation of blood sugar level, spinal drainage, electroconvulsive therapy, serotherapy and hemotherapy, and the use of pharmacologic agents such as benzedrine sulfate, atropine, strychnine, emetine, apomorphine and gold salts. Gibbins concluded that few, if any, of these approaches were of any use. Although his pessimism about specific measures was probably warranted, it is unfortunate that a general pessimism about the effectiveness of *any* intervention for alcohol abuse has persisted. Evaluations of various forms of treatment have frequently failed to provide firm evidence of effectiveness. A decade

ago, the authors of a comprehensive review concluded that "treatments for alcohol problems with demonstrated enduring effectiveness do not exist, regardless of treatment orientations or treatment goals."[9]

This view is now changing, partly because of the continuing evolution of interventions for alcohol problems. The most important factor in this attitudinal shift, however, is the emergence of research demonstrating the significant benefits of intervention. Most of this research has examined the effects of treatment with respect to behavioural, psychosocial and clinical measures of alcohol abuse. The types of screening instruments used in evaluations of screening and brief interventions in health care settings have included the CAGE questionnaire, the Michigan Alcoholism Screening Test (MAST), the Alcohol Use Disorders Identification Test (AUDIT) and the Trauma Scale. Interventions found to be successful have ranged from 5 minutes of advice on sensible drinking habits to brief counselling on setting and achieving drinking goals.[10–12] One study[12] showed that 30 minutes of counselling (supplemented with reading materials and exercises involving monitoring drinking behaviour) had a significantly stronger impact than simple advice on reducing drinking and alcohol-related problems. The counselling was based on cognitive–behavioural techniques developed by Sanchez-Craig[13] and adapted for presentation by medical staff.

Two randomized trials of relatively brief interventions found significant reductions in alcohol-related mortality in the intervention groups;[14,15] other research suggests that a dose–response relation exists between treatment and a reduction in mortality rates.[16] This intriguing finding may be confounded by factors that influence drop-out from treatment and should be interpreted cautiously. Nonetheless, findings from meta-analyses support the conclusion that interventions reduce alcohol-related problems.[17]

Of interest from a broader perspective is evidence that increased treatment of alcohol problems has been an important determinant of reductions in rates of death from cirrhosis in North America.[18,19] Public health authorities, who previously considered that treatment had little impact on population levels of alcohol problems, have now recommended the incorporation of treatment of alcohol abuse within comprehensive public-health programs to reduce alcohol problems and in particular advocate the increased use of screening and brief interventions in medical practice.[19]

Research results so consistently demonstrate the value of screening and brief interventions by primary care physicians that any doubts about their effectiveness should be put to rest. They are a valuable measure that can significantly improve the health of individual patients. Moreover, their benefits may also be observed in reductions of rates of alcohol-related morbidity and mortality at the population level.

Do interventions always work?

Clearly, no intervention works every time for every person. Professionals who work with people with alcohol problems often find it easier to identify failures than successes, and most are appropriately circumspect about the benefits of their interventions. However, this caution in interpreting outcomes should not obscure the significant value of the systematic use of screening and related interventions.

Evaluations of treatments of alcohol abuse often compare 2 or more treatments without reference to an untreated control group. It is frequently the case that no significant differences in outcome are found between groups. Very recently, the authors of perhaps the most expensive and carefully conducted evaluation of treatment of alcohol abuse reported to date found no differences in outcome among 3 different types of intervention.[20] However, these findings do not answer the basic question of treatment effectiveness. Typically, evaluative studies have found substantial reductions in alcohol problems from the pretreatment to posttreatment phase. The results of comparative studies should not be taken as evidence that treatment does not work, but rather that we still have much to learn about improving outcomes by using different types of interventions for different patient groups.

Conclusion

Concerns about the effectiveness of screening and brief interventions for alcohol abuse should not present a barrier to their greater utilization. Indeed, evidence of their benefit is impressive. Important questions remain, of course, with regard to the relative effectiveness of different types of interventions and to finding ways to predict who will best respond to these types. However, it seems safe to predict that increased use of proven measures will improve the health of individuals and the population. In view of Poulin and colleagues' finding that 85% of Canadians with an alcohol dependence do not seek help, the need for screening and brief interventions is great. So, too, is the potential for a positive impact.

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